Three Studies of Transitions of Young People in Public Care: A Focus on Educational Outcomes

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Abstract

The educational outcomes of children in care, as they prepare for and eventually complete the transition out of care, have been the subject of a growing body of research. Despite the progress made, no unified theory of risk and protective factors associated with educational outcomes has yet arisen from the longitudinal, cohort, and cross-sectional studies conducted with youth in care. This dissertation presents three papers that examine the effects of risk and protective factors on a range of educational outcome variables. The studies follow the timeline of a young person preparing for transition, moving into supported transitional living, and then eventually exiting care altogether.

Study 1 presents cross-sectional and longitudinal tests of the generalizability of many of the risk and protective factors identified by O'Higgins, Sebba, & Gardner (2014) in their systematic review of predictors of educational achievement among young people living in foster or kinship care. The cross-sectional sample consisted of 3,662 young people aged 12 to 17 years who were residing in out-of-home care in Ontario, Canada. An additional longitudinal sample was composed of a subsample of 962 young people from the cross-sectional sample who had also been assessed 36 months later with the AAR-C2-2010 during year 13 (2013-2014) of the OnLAC project. Supporting evidence for twelve of the twenty factors identified by O'Higgins *et al.* are revealed in the broad cross-sectional study and for the four factors that were found to predict change in academic success over a longitudinal timeframe suggest we are on the right track. Study 2 uses a lag-as-moderator approach to see if the time between assessments influences the predictive capacity of variables assessed when the young person was in care to predict educational variables evaluated when the youth had completed the transition to support independent living. Results from this thorough methodological study of gap length over six

years of OnLAC data are encouraging: 87.5% of the predictors tested for statistical moderation effects by the length of time between assessments were shown to be stable predictors across all gaps (i.e., no moderation by gap length effect). Study 3 presents a pilot 12-month follow-up study conducted with young people at the point of a major transition within or from child welfare services, comparing their characteristics with those of samples from the general population.

When assembled together, the three studies provide a foundation towards the formalizing of a list of risk and protective predictors of educational outcomes (namely, academic success, educational attainment, educational aspirations, and NEET status) originally selected from a systematic review that identified a range of factors to be associated with the educational outcomes of youth in care (O'Higgins, Sebba, and Gardner; 2014). Additionally, this dissertation presents a series of recommendations regarding the management and multiple imputation of missing data and the use of Lag as Moderator statistical methods in child welfare research.

General Introduction

Child Welfare Context

In 2008, the Ministry of Children and Youth Services (MCYS) of Ontario formed the Child Welfare Outcomes Expert Reference Group (CWOERG). The CWOERG, of which Professor Robert Flynn (the research supervisor of the present dissertation author) was a member, had the mandate of recommending key outcomes for all children and youth in out-of-home care (i.e., receiving child welfare services) or those undergoing significant transitions within or exiting the child welfare system in Ontario. Additionally, CWOERG was tasked with specifying the required conditions for reaching these outcomes. In their report, published in 2010, CWOERG presented a new framework for Ontario, centered on five strategic outcomes: safety, permanency, greater educational achievement, a higher degree of resilience, and smoother transitions to emerging adulthood. Each of these strategic outcomes was viewed as connected to the others. The formulation of this set of strategic outcomes was intended to further the transformation process through which child welfare policy and program delivery in Ontario would shift from a primary emphasis on outputs (i.e., services delivered) to one on outcomes (i.e., benefits realized by children and families). For purposes of the present dissertation, it is the strategic outcomes of greater educational achievement, a higher degree of resilience, and promoting smoother transitions that is of greatest relevance. The CWOERG (2010) mentioned that while two major Canadian data sources on children and youth, namely, the National Longitudinal Survey of Children and Youth (NLSCY; Statistics Canada, 2010) and the Youth in Transition Survey (YITS; Statistics Canada, 2011), provide longitudinal data on the transition to adulthood of Canadian youth in the general population, they say little about the transitions of youth in care. As a result, the CWOERG (2010) also advocated that studies based on relatively

large and representative samples of youth in transition be conducted. Similarly, Flynn and Vincent (2008) offered a series of recommendations for improving research on the transitions of young people leaving care in Canada. Echoing CWOERG, they underlined the importance of large-sample studies where the transition experiences of young people transition out-of-care could be directly compared to the experience of transition experienced by the age-peers in the general population. This, they argue, would allow policymakers and child welfare workers to operate on solid empirical footing (Flynn & Vincent, 2008). Thus, both CWOERG (2010) and Flynn and Vincent (2008) recommended that large-sample prospective studies be conducted in order to contrast the transition experiences of young people leaving care with those of Canadian youth in the general population. The three studies that are presented as part of this doctoral dissertation represent a direct response to this call and are aimed at helping address what is a large void in our knowledge.

Objectives and Contribution

The focus on this general introduction will be to position this dissertation and each study within the appropriate context. The relevant literature for each study is reviewed at length within their respective introductions. Study 1, in particular, details the available literature on predictors of educational outcomes for children in care. Inspired by the results of a systematic review conducted at Oxford University (O'Higgins, Sebba, & Gardner, 2014), study 1 presents the first empirical test of a broad model of contextual and individual, risk and protective factors associated with educational achievements for children in care. An important discussion about missing data theory and how best to manage missing data from a statistical and methodological point of view in order to maximize analytical power is also presented in detail. Study 2 presents a complex test of the methodological and statistical concept that length of time between

measurements (“lag” or “gap”; Selig, 2009) may have a powerful impact on any association that might be measured. This concept is discussed in detail and tested methodically by using 6 years of data taken from a large database of data collected from children in care on an annual basis. Lastly, study 3 presents the pilot of the first prospective study conducted in Canada. Approximate comparisons are drawn from regional norms provided by Statistics Canada. It is through these thorough applications of various new theoretical, statistical, and methodological methods that I hope to make a broad contribution to the research area of the educational of children in care and earn my doctoral degree.

Study 1: Risk and Protective Factors Associated with Academic Success of Children in Care: Generalizability of Predictors Suggested by a Systematic Review

The Ontario Association of Children's Aid Societies (OACAS, 2014) stated that 23, 341 children had been in care during the 2013-14 fiscal year. Unfortunately, children in public care demonstrate poorer health, education, employment, and general well-being when they exit care, compared with young people of the same age in the general population (Blome, 1997; Buehler, Orme, Post, & Paterson, 2000; Cheesbrough, 2002; Dregan, Brown, & Armstrong, 2011; Harris, Jackson, O'Brien, & Pecora, 2009; Jackson, 2013; O'Higgins, Sebba, & Gardner, 2014). The connection between lower average educational achievement and being "in care"[1] is quite consistent (Berridge, 2012; Goddard, 2000; O'Higgins, Sebba, & Gardner, 2014; Scherr, 2007; Trout *et al.*, 2008), such that a review by Trout, Hagaman, Casey, Reid, and Epstein (2008) found that the majority of children in care perform in the "low average" or "low" range academically, with higher frequencies of school changes, grade repetition, absenteeism, and expulsion. Scherr's (2007) meta-analysis revealed that children in care experience a greater number of special education needs, are more likely to repeat a grade, and are more frequently expelled or suspended than their age-mates in the general population. Statistics from the English Department of Education reveal that the educational-achievement gap is present as early as age 7 (in mathematics and language arts) and that the gap becomes larger with age (DfE, 2013). Jackson (2010) found that by the time the majority of their age peers in the general population are beginning college or university, only a small minority of children in care (5%) are beginning their post-secondary education.

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[1] Although this term is often defined differently in the literature, in this paper we will use the term "in care", as suggested O'Higgins, Sebba, & Gardner (2014), as an overarching term for children in the care of government, private, or charitable agencies or organizations.

Although researchers have suggested many pre-care or in-care experiences as influences leading to the lower educational attainment frequently seen in children in care, O'Higgins, Sebba, & Gardner's (2014) systematic review was the first to attempt to identify from the international literature the full range of predictive factors that would enable a relatively complete model of the educational achievement of children in care to be established. The objective of the present study is to establish and test a list of predictors of educational outcomes based on the associated factors identified in O'Higgins *et al.*'s (2014) systematic review. O'Higgins, Sebba, & Gardner located 36 studies that met the inclusion criteria: the studies had to have been published in 1990 or after; the young people had to have been 5 to 18 years of age and living in foster or kinship care[2] at the time of the research; the studies had to have used quantitative methods and to have examined the association between one or more factors and educational outcomes (O'Higgins, Sebba, & Gardner, 2014).

Educational achievement was conceptualized in a variety of different ways in the studies included in the systematic review. The most common outcome measure was academic competency, as measured by grades or literacy level, for example. Approximately half of the measures of academic competency were in the form of composite measures, with data reported by different sources (e.g., teachers, child welfare workers, young people, etc.; O'Higgins, Sebba, & Gardner, 2014).

O'Higgins, Sebba, & Gardner (2014) found that 73 different factors in her 36 studies had been identified as potential predictors of educational outcomes. These predictors were grouped into 20 conceptual categories and further subdivided into 4 categories: (1) individual-level

[2] Some studies included children in group homes (or residential care). These were only included if the majority of the children in the study were in foster care or kinship care.

factors; (2) peer- and- family-level factors; (3) social work and care placement factors; and, (4) school-level factors (O'Higgins, Sebba, & Gardner, 2014). Relatively few of these factors emerged in enough studies to be deemed *consistent* predictors of educational outcomes, with most being described as *mixed* predictors that were either statistically significant only in some studies or else tested in too few studies to qualify as consistent (O'Higgins, Sebba, & Gardner, 2014). These findings reflected in part the heterogeneous nature of the studies reviewed as well as the varied ways each conceptual variable was operationalized. For this reason, the review did not include a meta-analysis.

In the end, O'Higgins, Sebba, and Gardner's (2014) systematic review identified factors that were consistently associated with educational outcomes in only three of her 20 conceptual categories: gender, minority ethnicity, and caregiver educational aspirations. The remaining 17 categories consisted of factors that were associated with educational outcomes in some studies, but not associated in others. In the present study of the generalizability of O'Higgins, Sebba, and Gardner's associated factors, we were able to use 19 OnLAC variables as operational indicators of 15 of her 20 categories: (a) age; (b) gender; (c) minority ethnicity[3]; (d) mental health and well-being[4]; (e) behavioural problems[5]; (f) special educational needs; (g) caregiver aspirations; (h) reason for entry: neglect; (i) age of first entry into care; (j) number of placements; (k) placement instability; (l) foster placement type; (m) school instability; (n) youth educational aspirations; and, (o) grade retention.

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[3] This factor was represented as two different OnLAC variables.
[4] O'Higgins, Sebba, & Gardner (2014) presented this as a single factor, including indicators of both *negative* mental health as well as *positive* mental health. Negative mental health was represented by one variable, and positive mental health by two OnLAC variables.
[5] This factor was represented by two OnLAC variables.

We did not have OnLAC measures of the following categories: overall intelligence quotient, birth-family characteristics, placement with siblings, and total length of time in care (since first entry)[6]. A fifth factor, French language[7], was excluded (either the language that the AAR was completed in or the language in which the youth mainly receives his or her education) due to low frequency (French: 2.7% and 2.9% respectively) and a lack of correlations with our academic outcome variables. A sixth factor, home-based caregiver school involvement (e.g., the young person's caregiver is available to help with homework, etc.) was also excluded because preliminary analyses showed that it was unrelated (i.e., uncorrelated) with our measure of educational achievement. For the sake of parsimony, only the literature for the predictive factors included in the present study will be reviewed. (For information on the excluded factors, see O'Higgins' (2014) systematic review.)

Individual Child-Level Factors Associated with Educational Achievement Among Young People in Care

Age. O'Higgins, Sebba, and Gardner (2014) found mixed support for age as a predictor of educational achievement, and studies of youth in the general population show little or no association between age and academic performance (Evans, 2001, 2004; Hegar & Rosenthal, 2009; Perzow *et al.*, 2013). For children in care, O'Higgins, Sebba, and Gardner's (2014) reported that six studies found that older children performed worse than their younger peers, while three studies demonstrated the reverse. She suggested that these mixed results may be related to other factors that had been omitted from the studies in question, such as different care

[6] Although, at first glance, this could be calculated by subtracting current age from age at first entry into care, many children in the child welfare system often spend several years entering and exiting the case system, making a true measure of this variable in the absence of a complete in-care history impossible to obtain.
[7] The OnLAC interview can be completed in either English, French, Other, or a Inuit / Native language. French is the most common language, after English.

histories or later entry into the child welfare system (O'Higgins, Sebba, & Gardner, 2014). Only one study had controlled for age of entry into care and length of time in care when examining the impact of age on educational attainment (Evans, 2004), finding no association between age and educational achievement.

Gender. In the general population and among young people in care, females typically display greater academic achievement than males of the same age (e.g., DfES, 2007; Miller, Vincent, & Flynn, 2009). O'Higgins, Sebba, and Gardner's (2014) identified 14 studies in which females in care performed better than males (Burley & Halpern, 2001; Cheung *et al.*, 2012; Evans, 2001, 2004; Flynn *et al.*, 2013; Hegar & Rosenthal, 2009; Kirk, Lewis, Brown, Nilsen, & Colvin, 2012; Pears, Kim, Fisher, & Yoerger, 2013; Smithgall, Gladden, Howard, Goerge, & Courtney, 2004; Stein, 1997; Townsend, 2012; Turpel-Lafond, 2007; Wise *et al.*, 2010; Zima *et al.*, 2000), as well as eight studies in which there was no gender difference in academic achievement (AIHW, 2007, 2011; Geenen & Powers, 2006; McNichol & Tash, 2001; Perzow *et al.*, 2013; Sawyer & Dubowitz, 1994; Shin, 2003; Weiss & Fantuzzo, 2001). Nevertheless, O'Higgins, Sebba, and Gardner's (2014) note that the findings related to gender as a factor associated with educational outcomes are mixed, but largely reflect gender differences in the general population.

Ethnicity. O'Higgins, Sebba, and Gardner (2014) found that ethnic minority status was usually negatively related to educational outcomes, but not for all ethnic minorities nor in all countries. In the North American child-welfare context, Aboriginal children (in Canada; Mitic & Rimer, 2002; Turpel-Lafond, 2007) and African-American children (in the USA; Burley & Halpern, 2001) have been found to be at greater risk of poor academic outcomes when compared to their age peers. It is important to note that many Black Canadians distinguish themselves

from African-Americans and some may prefer "Caribbean-Canadian" to "African-Canadian" (Walcott, 2003). Roughly 30% of Black Canadians are of Jamaican heritage (Milan & Tran, 2004), and an additional 32% of Black Canadians trace their heritage to other Caribbean countries or to Bermuda (Milan & Tran, 2004). O'Higgins, Sebba, and Gardner (2014) found that Asian heritage was linked with higher overall test scores, although these results were limited to grade 6 (year 6) in primary school. Hispanic heritage revealed mixed findings, with some studies indicating a level of academic performance that was sometimes better than, equal to, or worse than the level of achievement of African Americans (in the USA; Burley & Halpern, 2001; Hegar & Rosenthal, 2009; Smithgall et al, 2004).

Overall, these results suggest that ethnic minority status, *per se*, may not be a risk factor for educational outcomes, but rather may be a proxy for other variables, such as poverty (Burgess, 2014; O'Higgins, Sebba, & Gardner, 2014). Among young people in care in Ontario, those of First Nations, Métis, and Inuit (FNMI) or Black-Canadian heritage are the two largest ethnic minorities. Moreover, poverty at the individual and community levels is a known risk factor of major proportions in both Aboriginal (Fallon, Chabot, Fluke, Blackstock, MacLaurin, Tommyr, 2013) and in Black-Canadian communities (Contenta, Monsebraaten, & Rankin, 2014). We thus included Aboriginal (FNMI) and Black-Canadian minority ethnicity status as separate dichotomous predictors.

Mental health and well-being. Although conceptualized by O'Higgins, Sebba, and Gardner (2014) as a singular theme, we operationalized this factor in two ways: *negative* (e.g., mental health difficulties) and *positive* mental health (e.g., well-being). Only two of the studies in O'Higgins, Sebba, and Gardner's (2014) systematic review examined the link between mental health difficulties and educational achievement. Shin (2003) found no link between educational

outcomes and self-reported symptoms of anxiety, depression, loss of control, positive affect, emotional ties, or life satisfaction. Perzow *et al.* (2013) found that dissociative symptoms were linked with lower academic competence and a standardized measure of academic achievement but not with teachers' or caregivers' evaluations of the young person's academic competence.

Only one study (Flynn *et al.*, 2013) investigated well-being as a predictor of educational outcomes, with higher well-being (operationalized as a higher score on a measure of internal developmental assets, such as commitment to learning, positive identity, etc.[8]) associated with better educational outcomes both cross-sectionally and longitudinally. Although the relationship of suicidality with educational outcomes among children in care has not been extensively studied (O'Higgins, Sebba, & Gardner, 2014), we included it in the present study because we thought that it might prove to be a useful indicator of mental health difficulties and a useful predictor of educational success. Also, we operationalized well-being as internal developmental assets and positive mental health.

Behavioural problems. O'Higgins, Sebba, and Gardner (2014) identified eight studies that explored the relationship between behavioural problems and educational outcomes. Behavioural problems were measured in a variety of ways, such as deviant peer relationships, internalizing behaviours, substance abuse, or attention problems. In three studies that used operational definitions of behavioural problems that were consistent with that adopted in the present research (see Method section), higher levels of behavioural problems were associated with lower academic outcomes (O'Higgins, Sebba, & Gardner, 2014).

[8] Additional details are provided in the measures section.

Soft-drug use. This factor was conceptualized under behavioural problems by O'Higgins, Sebba, and Gardner (2014). Only one study in her review explored the effects of substance abuse on literacy, with Shin (2003) reporting that drug abuse predicted poorer reading skills. Flynn and Tessier's (2011) study of the link between protective and risk factors and educational and employment outcomes identified soft-drug use as a significant risk factor for educational attainment among youths residing in supported independent living.

Special educational needs. O'Higgins, Sebba, and Gardner (2014) located seven studies in which special educational needs (e.g., academically-related impairments) were associated with poorer educational outcomes and four in which there was no such link. Flynn and Tessier (2011) found in a sample of young people residing in supportive independent living that academically-related impairments (defined as having a learning disability, developmental disability, or attention-deficit/hyperactivity disorder) significantly predicted educational attainment and aspirations.

Caregiver or Placement-Level Factors Associated with Educational Achievement Among Young People in Care

Caregiver educational aspirations. Higher educational aspirations on the part of caregivers for the young person under their care were significantly linked with better educational outcomes in three papers in O'Higgins, Sebba, and Gardner's (2014) systematic review, namely, Flynn *et al.* (2013), Cheung *et al.* (2012), and Wise *et al.* (2010).

Neglect as a reason for entry into care. Relatively few studies have examined the relationship between childhood maltreatment (including neglect and several abuse subtypes) and educational outcomes (O'Higgins, Sebba, & Gardner, 2014), and those that have done so often do not look at children in care specifically. Overall, results are mixed regarding the association

between these two factors (childhood maltreatment and educational outcomes). These varied results may reflect problems in how maltreatment is operationally defined or the fact that important details about the duration or severity of maltreatment are often omitted. More thorough and refined methodologies may help us understand the nature of the relationship between maltreatment subtypes and educational outcomes (O'Higgins, Sebba, & Gardner, 2014). In a separate review of the literature on the effect of various maltreatment histories on the educational outcomes of children in care, Romano, Babschishin, Marquis, and Fréchette (2014) cited several maltreatment-related reasons that may account for lower educational success, including neglect, exposure to multiple types of maltreatment, early onset of maltreatment, or multiple changes in place of residence. The authors also noted tentative findings supporting a potential birectional relationship between mental health difficulties and academic achievement deficits.

In the present study, two relevant variables were originally included as potential predictors in the present study: neglect as a reason for entry into care, and the total number of maltreatment types cited by the child welfare worker as reasons for the youth's entry into care. In preliminary analyses, the total number of maltreatment types was found to be uncorrelated with educational success and was thus excluded. Only neglect was ultimately retained, because it is the most frequently reported type of maltreatment in both Canada (Trocmé *et al.*, 2010) and the United States (USDHHS, 2011).

Age of first entry into care. O'Higgins, Sebba, and Gardner (2014) state that too few studies have been conducted to conclude whether age of first entry into care is related to educational outcomes. What evidence they did find, though, indicated that children who come into care after the age of 12 may have poorer educational outcomes – perhaps, O'Higgins *et al.* added, because older children (i.e., adolescents) enter care more frequently for behavioural

reasons than do younger children. Thus, it may be a higher level of behavioural difficulties rather than older age, *per se,* that may be related to worse educational outcomes.

Placement stability or instability. O'Higgins, Sebba, and Gardner's (2014) noted placement stability has been defined conceptually and operationally in many different ways in the literature on out-of-home care. In the present study, we defined it as (1) the length of time the young person in care had resided with his or current caregivers, anticipating that greater placement stability would be positively associated with academic success, and (2) the number of different caregivers the young person has had during their time in public care.

Although more frequent changes in caregivers in the general population are negatively associated with children's educational progress (Haveman, Wolfe, & Spaulding, 1991; Mehana & Reynolds, 2004), the results for children in care have been mixed (O'Higgins, Sebba, & Gardner, 2014). Some studies have found no link between a high number of caregiver changes and a range of educational variables (e.g., AIHW, 2007; Aldgate *et al.*, 1992; Berger *et al.*, 2009; Burley & Halpern, 2001; Pears *et al.*, 2012; Sawyer & Dubowitz, 1994; Townsend, 2012), whereas others have suggested that frequent caregiver changes are a risk factor for educational outcomes (e.g., Geenen & Powers, 2006; Petrenko *et al.,* 2012, Zima *et al.*, 2012).

Placement type. There are three types of public care placements in many jurisdictions: foster care, kinship care, and group homes (O'Higgins, Sebba, & Gardner, 2014). In foster care, young people live with an unrelated family (Sinclair, 2005), whereas in kinship care they live with individuals who are part of their extended family, such as grandparents, aunts or uncles, or cousins (Winokur, Holtan, & Batchelder, 2014). Lastly, young people living in group homes are housed communally with other youths, in groups of varying sizes, under the supervision of

several adult caregivers (Sinclair, 2006; Whittaker, 2006). In 2010, McClung and Gayle identified residing in a group home (named "residential care" in Scotland) as a significant predictor of poorer academic outcomes for looked-after youth in Scotland. Flynn *et al.* (2013), however, found that a negative relationship between placement in a group home and lower average marks disappeared once other individual-level risk factors were included in their hierarchical regression model, indicating that these additional risk factors, including more severe behavioural difficulties and greater educational needs mediated the original relationship (Flynn *et al.*, 2013; O'Higgins, Sebba, & Gardner, 2014). It is important to note that O'Higgins *et al.*'s (2014) systematic review focused exclusively on kinship care and foster care (additional details can be found in the review by Winokur *et al.*, 2014).

School-Level Factors Associated with Educational Achievement Among Young People in Care

School instability. Frequent transfers from one school to another can cause disruptions in the academic progress of children in the general population (Heinlein & Shinn, 2000; Mehana & Reynolds; 2004). Among children in care, although the overall picture is somewhat mixed, O'Higgins, Sebba, and Gardner (2014) concluded that school instability may be a risk factor for educational achievement, such that we included it as a predictor in the present study.

Grade retention. O'Higgins, Sebba, and Gardner (2014) found that grade retention (the young person having been held back for one or more school years) sometimes predicted more negative educational outcomes, although the results were mixed. We thus included a measure of grade retention in the present research.

Young people's educational aspirations. Among the 36 studies reviewed by O'Higgins, Sebba, and Gardner (2014), Shin (2003) found a positive relationship between the

academic aspirations of young people in care and their educational achievement. In the general population, a similar link has been found between a young person's educational aspirations and his or her attainment (Gorard *et al.*, 2012). Following O'Higgins, Sebba, and Gardner's suggestion that the academic aspirations-achievement link be further studied among young people in care we included this predictor in the present research.

Summary

O'Higgins, Sebba, and Gardner's (2014) systematic review uncovered a relatively small number of consistent predictors and a larger number of mixed or inconsistent predictors of educational outcomes. From the data set of the Ontario Looking after Children (OnLAC) project, we were able to include the following 19 operationalized variables drawn from 15 of O'Higgins, Sebba, and Gardner's (2014) 20 identified factor: age, gender, caregiver educational aspirations, behavioural problems, soft drug use, minority ethnic status (Aboriginal/FNMI and Black-Canadian), special educational needs, one measure of mental health difficulties (suicide risk), two measures of well-being (internal developmental assets & positive mental health), reason for entry: neglect, age of first entry into care, placement instability, length of time with the current caregiver, foster placement type, school instability, youth educational aspirations, and grade retention.

Study Objectives

The primary objective of the present study was to conduct an empirical test, using large cross-sectional and longitudinal samples, of the generalizability of the risk and protective factors identified by O'Higgins, Sebba, and Gardner (2014) in their systematic review and for which we had operational measures in our OnLAC data collected in 2010/2011 (project wave 10). The secondary objective was to evaluate the role of gender as a possible moderator of the predictors

of academic success for which we had OnLAC measures. This last element is exploratory in nature. As presented earlier, the role that gender plays in predicting educational outcomes is unclear. Specifically exploring how gender may interact with other factors associated with educational outcomes might help shed greater light on the role of gender in influencing educational outcomes.

Hypotheses

Prior to testing the generalizability of O'Higgins, Sebba, and Gardner's predictors in a series of hierarchical regression models, we grouped the predictors into four conceptual categories: contextual risk factors or individual risk factors (all of which we expected to be negatively associated with educational success), and contextual protective factors or individual protective factors (all of which we anticipated would be positively related to educational success). We used Masten's (2006) definitions of risk and protective factors as, respectively, predictors of undesired outcomes or desired outcomes. Table 1 presents the predictor variables in their respective categories. Note that we are using the more widely used term "protective factors" to include factors that Masten (2006) might term "promotive factors".

For conceptual reasons, we entered these four types or categories of predictors into our cross-sectional and longitudinal hierarchical regression models in the following order: contextual risk, individual risk, contextual protective, and individual protective factors. In accordance with Masten's (2006) conceptualization of resilience theory as presupposing the existence of risk or adversity, we entered the two types of risk predictors before the two types of protective predictors. Also, within the risk-related and protection-related categories, we wanted to examine

the explanatory power of the individual factors only after accounting for the variance attributable to the conceptually more distal contextual factors.

We hypothesized that in the cross-sectional and longitudinal regression models, each category of predictors would account for a statistically significant increment in the amount of variance explained in the dependent variable, educational success. We also hypothesized that many of the contextual or individual predictors would also be statistically significantly associated with educational success, at one or more steps in the hierarchical regression models.

Finally, we explored the role of gender as a possible moderator of the association of each of the contextual or individual predictors with educational success. We did so by testing the statistical significance of a series of multiplicative terms—one at a time—formed by multiplying gender by each of the contextual or individual risk or protective predictors. As this moderator analysis is exploratory, we offer no particular hypotheses for each particular multiplicative term - other than we expect gender to play a moderating role for some of our predictors in terms of their differential influence on the academic success of girls and boys.

Method

Service Context

The Ontario Looking After Children (OnLAC) project has been mandated since 2006 by the Ontario Ministry of Children and Youth Services (MCYS). Annual assessments are conducted to monitor the service needs and developmental outcomes of young people who have been in care for a year or more. In the 41 local Children's Aid Societies (CASs) that participate in the OnLAC project, child welfare workers conduct informational interviews each year with

caregivers (i.e., foster parents, kinship parents, or group home staff) and young people in care (if they are 10 years of age or older).

Participants

Cross-sectional sample. The initial cross-sectional sample consisted of 4,384 unduplicated young people, aged approximately 12 to 17 years, drawn from wave 10 (2010-2011) of the Ontario Looking After Children (OnLAC) project (Flynn, Dudding, & Barder, 2006; Flynn *et al.*, 2009; 2011). From the initial cross-sectional sample of 4,384 young people in care, a total of 722 were removed for various overlapping reasons, representing roughly 16.5%: some were in types of placements other than foster, kinship, or group homes (e.g., they were in psychiatric or mental health facilities, custody or detention facilities, shelters, etc.), whereas others had exact ages outside of the targeted age range, had data missing on their age of entry into the care system, or had data missing on their current progress in reading or math.

Most of the 722 young people that were removed were done so as part of the selection criteria (for example, ages outside of the targeted age range). In order to verify for biases that might have been introduced by their exclusion, we examined these 722 young people more closely. A comparative analysis revealed that our sample of 3,662 young people did not differ greatly from those 722 young people that were omitted in terms of ethnicity (both FNMI and black) and academically-related impairments. However, those young people that were excluded were more likely to be young men and to be slightly older[9].

The final cross-sectional sample was composed of 3,662 young people in care who had been assessed with the AAR-C2-2010 during wave 10 (2010-2011). There were 2,054 males

[9] Those excluded: 51.5% male vs. final sample: 56.1%; Average age of those excluded: 15.9 years old.

(56.1%) and 1,608 females (43.9%), whose exact ages in wave 10 ranged from 11.51 to 17.99 years (M = 15.10 years). Most were living in foster or kinship homes (2,938, or 80.2%), with a minority (722, or 19.7%) in group homes. We included the group home residents for two reasons. First, O'Higgins, Sebba, and Gardner (2014) had found no significant difference between the educational achievement of young people living in foster versus kinship homes. Second, we were interested in casting a broader practice and policy net by comparing young people living in foster or kinship homes versus group homes, a comparison we have made in previous research (Flynn & Tessier, 2011; Flynn, Tessier, & Coulombe, 2013).

Longitudinal sample. The initial longitudinal sample consisted of 1,125 youths whose approximate ages were between 12 and 17 years at the first and follow-up assessments. The young people were mainly 12-14 years of age at OnLAC wave 10 (Time 1; 2010-2011) and, three years later when assessed again at wave 13 (Time 2; 2013-2014), were mostly 14-17 years of age. For the same reasons as were described in the case of the cross-sectional sample, a number of young people (n = 163) were eliminated. This left a final longitudinal sample of 962 young people in care, composed of 565 males (58.7%) and 397 females (41.3%) whose exact ages at Time 1 ranged from 11.68 to 15.83 years (M = 13.51) and, at Time 2, from 14.27 to 17.98 years (M = 16.48). Most of the youths in the longitudinal sample were living in foster care or kinship care homes (836, or 86.9%) at Time 1, with a minority residing in group homes (126, or 13.1%).

Instrument

In the OnLAC project, information is gathered each year on children or adolescents who have been in care for one year or more by means of the 2010 revision of the second Canadian

version of the Assessment and Action Record (AAR-C2-2010, hereafter "AAR"). The following developmental outcome domains are covered: health, education, identity, family and social relationships, social presentation, emotional and behavioural development, self-care skills, and developmental assets. Age-appropriate AAR forms exist for infants or children aged 0-12 months, 1-2 years, 5-9 years, or 10-11 years, and for adolescents or young adults aged 12-15 years, 16-17 years, and 18-21+ years. Information to complete the AAR is gathered during a conversational interview in which several people participate: the young person (if aged 10 or over), the caregiver, and the child welfare worker. In both waves 10 and 13, we used merged data sets for youths aged 12-15 years and 16-17, respectively.

The AAR is mainly comprised of items drawn from the National Longitudinal Survey of Children and Youth (NLSCY; a longitudinal survey conducted by the Canadian government following the well-being and development of individuals from birth through early adulthood; Statistics Canada, 2011), as well as numerous reliable and valid tools available in the public domain (e.g., the Total Difficulties Scale from the Strength and Difficulties Questionnaire; Goodman, 1997). Additional details regarding the AAR are available upon request. Child welfare workers and caregivers undergo a 2-day training program on the use of the AAR with youth in care. In our sample, 92.4% of child welfare workers and 92.8% of caregivers had completed this training.

Measure of Dependent (Criterion) Variable: Academic Success

Following procedures similar to those described in Cheung *et al.* (2012), we created a multiple-informant measure of the young person's educational academic success from data provided by the caregiver, the child welfare worker, and the young person in care (Cheung *et al.* did not include data from the young person.) This triangulation procedure was intended to

capture the different perspectives of each of the three informants (Achenbach, McConaughy, & Howell, 1987; Cheung *et al.*, 2012; Renk, 2005). We note that order to complete an AAR, each young person must be in care for a minimum of 1 year. This is intended to give the caregiver(s) and child welfare worker sufficient time to get to know the youth and their capacities, review report cards, communicate with their school, attend parent/teacher conferences, etc. The child welfare worker was present in 94.7% of the AAR interviews, at least one caregiver was present in 84.4% of the AAR interviews, and the young person was present was 94.8% of the AAR interviews. Two individuals were present for 20.3% and at least three individuals were present for 76.0% of the AAR interviews.

The child welfare worker answered AAR questions about the young person's attainment of two educational objectives. Objective 1 asked whether the youth's educational performance matched, was somewhat below, or was seriously below his/her ability. Objective 2 asked whether the young person was acquiring many, some, or no special skills and interests. Higher scores indicated greater educational success. Additionally, child welfare workers were asked if the young person, in comparison with his or her age group, was (1) ahead by one or more grade levels; (2) at grade level; or (3) behind by one or more grade levels. Based on their knowledge of the young person's school work, including report cards, the caregiver rated how the youth was doing in reading and other language arts (spelling, grammar, and composition), mathematics, and overall academic performance. Ratings were on a 3-point scale, ranging from 3 (very well or well), 2 (average), or 1 (poorly or very poorly). Finally, young persons rated how well they thought they were doing in their school work (2 = well or very well; 1 = average; 0 = poorly or very poorly).

After the multiple imputation of missing data (described in a later section), the 7 component items for T1 Academic Success were standardized, converted to z-scores, and added together to form a single T1 academic success outcome variable. The latter was itself standardized and then converted to a T-score, with a mean of 50 and a standard deviation of 10. In order to ensure strict comparability between the T1 and T2 versions of the dependent variable (academic success), the 7 component items for T2 Academic Success were standardized on the means and standard deviations of each of their respective T1 counterparts, after the multiple imputation of missing data. These 7 T2 components were then summed to form a single T2 academic success outcome variable that, in turn, was standardized on the mean and standard deviation of the T1 academic success measure. Finally, the T2 Academic Success dependent variable was converted to a T-score, with a mean of 41.62 and a standard deviation of 11.11.

Measures of Independent (Predictor) Variables

Contextual Risk Factors

Age of first entry into care. Each young person's child welfare worker was asked to provide a response (in years and months) to the following question: "How old was … when he/she was placed in out-of-home care for the very first time (at this or another child welfare agency)?" Data for months was divided by twelve to convert the information to decimals of a year and added to the reported years of age. (For youths whose age was missing (n = 267), additional information was sought on this variable in either Wave 11 or Wave 13. Agreement between two of three data points was taken as acceptable. In cases where the discrepancy was larger than 1.0 year, an average age was calculated (unless some reported ages were out of the range of possibility, such as a reported age that was greater than the current age of the young person). In cases where the discrepancy was less than 1.0 year, the younger age was accepted.

For those youths who still had missing data, the reported age at the time of their *first* AAR was used.

Neglect as a reason for entry into care. As noted earlier, neglect was the only reason for entry into care used in the present study, as it is the most frequently reported type of maltreatment in both Canada (Trocmé *et al.*, 2010) and the United States (USDHHS, 2011) and has been identified as potentially associated with lower educational success (Romano *et al.*, 2014). Child welfare workers were asked to "mark all that apply" from a list of primary reasons for the young person's current admission to care: physical harm, sexual harm, neglect, emotional harm, domestic violence, abandonment/separation, problematic behaviour, or other. A dummy variable was created, such that those youths for whom neglect had been marked were assigned a 1 and those for whom neglect had not been marked were assigned a zero.

School instability. The item in the AAR pertaining to this measure read as follows: "Other than the natural progression through the school system, how many times (if any) has … changed schools since birth?" Responses could range from 0 (No changes in school (other than natural progression through the school system)) to 5 (8 or more changes).

Caregiver instability. To explore this factor, we employed the following item from the AAR, which was answered by the child welfare worker: "How many changes in main caregivers has … experienced since birth?" Because this variable was highly skewed in both the cross-sectional and longitudinal samples, we used a log (10) transformation. Prior to this transformation and to multiple imputation, the mean number of caregiver changes since birth in the cross-sectional sample was 4.59 (SD=3.9) and in the longitudinal sample was 4.22 (SD=3.38).

Grade retention. This variable was assessed in the AAR by asking caregivers: "Has … repeated a grade at school (including kindergarten)?" Responses were coded as a dummy variable, with 0 = No and 1 = Yes.

Individual Risk Factors

Exact Age. The AAR asked child welfare workers to report the young person's current age. However, review of the data (i.e., the child welfare worker's report of the youth's age) for this variable indicated occasional important discrepancies (> 1.0 year occurred less than 0.02% of the time) between the youth's reported age and his/her actual age at Time 1. Thus, the young person's exact age was calculated, with the date of birth subtracted from the date on which the Time 1 AAR was started. If this date was absent, the date on which the Time 1 AAR was completed was used; if this second date was also absent, the date on which the Time 1 AAR was signed by a supervisor was substituted. If this last date was missing, the age reported by the child welfare worker was accepted. In cases where the discrepancies were more dramatic (i.e., >2.0 years), the birth date and the Time 1 AAR dates were verified for transcription errors.

Academically-related impairments. We computed an index of academically-related impairments, based on our previous research (Flynn & Tessier, 2011; Flynn *et al.*, 2013). The AAR asked the child welfare worker to indicate, in the case of the young person in care, which long-term health conditions out of a list of 17 had been diagnosed by a health professional. Three cognitively-related long-term health conditions were selected for their relevance to academic outcomes: Attention deficit/hyperactivity disorder, learning disability, and developmental disability. When selected, each of these three conditions was assigned a 1 (yes); when not selected, each was assigned a zero (no). A total score on these items was formed by

adding the answers to the individual items, ranging from 0 (no cognitively-related long-term health conditions) to 3 (all three long-term cognitively-related health conditions). Two other items, assessing the young person's rating of his/her own difficulties with memory and problem-solving, were also used to improve the multi-informant nature and overall validity of the cognitive impairment measure. To the AAR item, "How would you describe your usual ability to remember things?", the young person provided a rating from 0 (Able to remember most things) to 3 (Unable to remember anything at all). Similarly, to the AAR item, "How would you describe your usual ability to think and solve day-to-day problems?", the youth's responses could range from 0 (Able to think clearly and solve problems) to 3 (Unable to think or solve problems). The scores from the 3 long-term health condition items and the scores from the two memory and problem-solving items were then added together (prior to multiple imputation) in order to form an overall cognitive impairment measure, ranging from 0 to 9, with a higher score indicating a greater level of impairment.

Minority ethnic status. Ethnicity in the OnLAC project is determined by asking each young person to which ethnic or cultural group(s) did their ancestors belong. Twenty-five ethnicities are listed, and the youth may select as many as apply. Aboriginal (First Nations, Métis, and Inuit, or FNMI) minority ethnic status was indicated if the young person selected "First Nations", "Métis", or "Inuit". Black-Canadian minority ethnic status was indicated if the young person selected either "African (e.g., Somalian, South African)" or "Caribbean (e.g., Haitian, Jamaican)". Both ethnic minority statuses were coded as dummy variables, in which 1 = FMNI Status and 0 = Other, and 1 = Black-Canadian ethnic status, and 0 = Other.

Behavioural problems. We measured behavioural problems with the Total Difficulties scale of the Strength and Difficulties Questionnaire (SDQ; Goodman, 1997), which is part of the

AAR. The SDQ uses parent or caregiver ratings to assess mental health problems in children and youth aged 4-17 (Goodman, 2001; Goodman & Goodman, 2011; Goodman & Gregg, 2010). The 20-item Total Difficulties scale is calculated by summing 4 5-item subscales: emotional symptoms, conduct problems, hyperactivity, and peer problems. Each of the 20 items are scored as 0 (Not True), 1 (Somewhat True), or 2 (True), with the total score on the Total Difficulties scale ranging from 0 to 40, with a higher score reflecting a greater level of behavioural problems.

Soft-drug use. We defined soft-drug use as the frequency of alcohol consumption, cigarette smoking, and marijuana use. For alcohol consumption and cigarette smoking, young people in care were asked on the AAR to respond to three items: "Do you smoke cigarettes (or use other tobacco products)?"; "Which of the following best describes your experience with drinking alcohol in the past 12 months?". Responses were made on a 4-point scale, ranging from 0 (Not at all) to 3 (Daily). For marijuana use, on the other hand, the young people in care were asked two separate questions: First, the young people were asked "Have you ever tried drugs?" and asked to respond "Yes" or "No". If they answered "yes" to this item, the youth were subsequently asked and, "Which of the following best describes your experience with marijuana and cannabis products (also known as a joint, pot, grass, or hash) during the past 12 months?". Responses were again coded for frequency, ranging from 0 (No at all) to 3 (Daily). Responses of "no" to the first questions were integrated into the second item as "0" (Not at all) in order to create a singular item of marijuana-use. The three soft-drug use items were then combined to create an index of soft-drug use, ranging from 0 ("No soft-drug use") to 9 ("Daily soft-drug use of 3 substances"). The total score on this soft-drug use index proved to be significantly skewed, in both the cross-sectional and longitudinal samples, such that we dichotomized the index, creating a dummy variable (1 = Soft-drug users, 0 = Non-users).

Suicide risk. The AAR posed three questions to the young person in care: "During the past 12 months, have you attempted to hurt yourself?"; "During the past 12 months, did you seriously consider attempting suicide?", and "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)?". The two first items were dichotomies (1 =Yes, 0 = No). There were three response options to the third item (2 = Yes, 1 = No, 0 = I did not attempt suicide within the past 12 months). These three items were subsequently combined to form an index of suicide risk, ranging from 0 to 4. As this variable was significant skewed in both samples, it was dichotomized (1 = Suicide risk, 0 = No suicide risk).

Contextual Protective Factors

Caregiver educational aspirations. The AAR asked the caregiver, "How far do you hope … will go in school?" The response options covered a wide range of academic levels (e.g., Secondary or high school, Apprenticeship program, A university degree). These responses were recoded into a scale corresponding to the approximate number of years of formal schooling required by each degree or diploma in Ontario (e.g., Secondary or high school was assigned a value of 12 years).

Placement type. The child welfare worker identified the type of placement in which the young person currently resided, with 17 placement types as possible options (including "Other" and "Whereabouts unknown or unapproved"). Only those young people currently residing in kinship care, foster home, or group home placements were retained in the present study. As O'Higgins, Sebba, & Gardner's (2014) systematic review (based largely on Winokur, Holden, & Batchelder's [2014] systematic review) found no difference between the educational outcomes of

children in foster versus kinship care, we created a dummy variable in which these two "familial" types of placements were combined and contrasted with group-home placements (1 = foster or kinship care home, 0 = group home).

Time lived with current caregiver. The AAR posed the following question to the child welfare worker: "How long has … been living with his/her current caregiver?" (in years and months). Because this variable was highly skewed, it was transformed by means of a square root function, prior to multiple imputation.

Individual Protective Factors

Internal developmental assets. The AAR measure of the 40 developmental assets was based on the list of developmental assets produced by the Search Institute (Scales, Benson, Leffert, & Blythe, 2000). There are 20 internal assets, reflecting the young person's acquired resilience-promoting resources or strengths in four categories: commitment to learning (sample asset: "… is actively engaged in learning); positive values (sample asset: … accepts and takes personal responsibility); social competencies (sample asset: … has empathy, sensitivity, and friendship skills); and, positive identity (sample asset: … is optimistic about personal future). The caregiver evaluates whether the young person possesses each internal asset (1 =Yes; 0 =No or Uncertain). Because the total score on the internal asset scale was significantly skewed, it was transformed by reflecting it, taking its square root, and then re-reflecting it, such that a higher transformed score corresponded to a greater level of internal assets.

Gender. In the AAR, the child welfare worker identifies the gender of the young person in care (1 = female, 0 = male).

Positive mental health. The young person completes the 14-tem Mental Health Continuum - Short Form (MHC-SF; Keyes, 2002) which is the main AAR measure of positive mental health. The tool has demonstrated its usefulness and validity in several domains. Higher scores on the MHC-SF have been found to predict lower overall mortality (Keyes & Simoes, 2012), lower levels of suicidal behaviour (Keyes *et al.*, 2012), higher academic performance (Keyes *et al.*, 2012), and a lower risk of future stress-related depressive episodes (Grant, Guille, & Sen, 2013). The young person answers 14 items on a 6-point scale (0 = Never, 5 = Every day), such as "During the past month, how often did you feel good at managing the responsibilities of your daily life?". These 14 items were summed to create an overall positive mental health score. Because the total score was significantly skewed, it was transformed by reflecting it, taking its square root, and then re-reflecting it, such that a higher transformed score corresponded to a greater level of positive mental health.

Young person's educational aspirations. In the AAR interview, the young person was asked how far they hoped they to go in school. The response options ranged from "secondary or high school" to "more than one university degree". These responses were then recoded to reflect the number of years of formal schooling required in Ontario to attain the diploma or degree in question (e.g., "a university degree" was assigned a value of 16 years).

Gender as a Potential Moderator: Gender-by-Predictor Multiplicative Terms

Eighteen multiplicative terms were formed, prior to running the multiple imputation process for missing data. Each multiplicative term was calculated by multiplying each predictor by the gender variable (Aiken & West, 1991). When added, one at a time, in an extra step in the hierarchical regression models (i.e., after all the predictors has already been entered and thus

partialed out), each multiplicative term became a statistical interaction term. If the latter added a statistically significant increment ($p < .05$) to the total amount of variance explained in the regression model, this was taken as evidence that gender moderated the predictor in question. That is, the strength of the relationship between the predictor and the criterion variable (academic success) was seen as significantly different for males and females.

Data Analysis

Missing data and multiple imputation. In the literature on missing data, statisticians have defined three types of missing data: Missing completely at random (MCAR), Missing at random (MAR), and Not missing at random (NMAR; Graham 2012; Little & Rubin, 1987; Rubin, 1976; Schafer & Graham, 2002). In simple terms, these terms can be defined as follows. In data that are MCAR, the missing data points are unrelated (probabilistically) to any of the individual's other responses (akin to flipping a coin). In data that are MAR, on the other hand, the missing data points *may* be related only to the individual's *observed* responses. Lastly, in data that are NMAR, the missing data points for an individual are related to their observed responses *and* their unobserved responses (in other words, the missing data, itself; Graham, 2012, Schafer & Graham, 2002). Generally, it is not possible to determine the precise nature of missing data, and MAR can be assumed (Schafer & Graham, 2002). In 2001, Collins, Schafer, and Kam showed that incorrectly assuming that missing data are MAR could frequently have only a minor impact on estimates and standard errors.

Historically, missing data have been excluded from multivariate analysis, such as ANOVA and multiple regression, so that any analysis is conducted using only complete cases (in other words, using listwise deletion [LWD]; Graham, 2012; Schafer & Graham, 2002). Although popular, this method presents several problems. Unless the researcher can be certain

that the missing data are MCAR, any results pertaining to a subsample of complete cases may be biased in unknown ways and therefore risk being unrepresentative of results based on the full population (Schafer & Graham, 2002). Moreover, in multivariate analyses encompassing numerous items/variables, low proportions of missing data on different variables may result in a large percentage of the sample being discarded, with a concomitant substantial reduction in statistical power (in our case, 2,248 cases [61.4% of our sample] would have been discarded with LWD).

Graham (2012) and Schafer and Graham (2002) present simulations of the impact of LWD (as well as other techniques, such as single imputation, means substitution, reweighting, etc.) on parameter estimates and confidence intervals. In the end, Graham (2012) recommends managing missing data by employing a three-step data-preparation and multiple-imputation process: (1) using an Expectation Maximization (EM) algorithm (in this case, for covariance matrices) to generate maximum likelihood parameter estimates for the sample in question; (2) imputing an initial complete dataset from these EM parameters once the EM algorithm has converged (in other words, once the EM estimated parameters do not vary meaningfully from iteration to iteration after a certain point); and (3) using data augmentation (DA) and multiple imputation (MI) to generate *m* datasets (where *m* is equal to the number of imputed datasets) based on the results of the two previous steps. Graham (2012) recommends the computer program NORM (version 2.03) to complete these steps. These imputed datasets are then combined and reintegrated using the MI Automate program to make them useable by SPSS 22.

As a final point, Graham, Olchowski, and Gilreath (2007) recommend a larger number of imputations (*m*) than the smaller number of imputations (e.g., 3 to 5; Rubin, 1987) previously accepted by missing data theorists. Graham *et al.* (2007) demonstrate the substantial impact of

the number of imputations on statistical power, particularly with small effect sizes. For small effect sizes and up to 50% missing information, the authors recommend a minimum of $m = 40$ to sustain a power reduction <1%.

In light of the foregoing discussion and recommendations, we carried out two separate MIs using NORM 2.03: one for the larger cross-sectional sample, and another for the smaller longitudinal subsample. Table 8 lists the variables in both imputation models, which include (a) all of the variables included in the regression model, including the 14 *raw* variables that were combined into the Time 1 and Time 2 dependent variables; (b) all of the multiplicative ("interactions"[10]) terms; and (c) auxiliary variables[11]. Table 8 also lists the percentage of missing data for all of the independent and dependent variables in both samples. Appendix A contains a step-by-step instructional guide prepare by the current author for helping researchers in conducting multiple imputation using NORM 2.03 and MI Automate in a simple and straightforward manner.

It is important to note that some of the imputed values were outside the range of the scales, and thus were considered *implausible* values. These values were maintained; however, as statisticians have demonstrated that substituting plausible values for implausible values may create greater bias than simply preserving the originally imputed implausible values (e.g.,

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[10] Graham (2012) recommends anticipating all potential interactions to be tested *a priori* and including these in the imputation model, or, as he puts it: *"the imputation model must be at least as complex as the analysis model*" (Graham, 2012, p. 62). He further explains that by omitting interaction terms from the imputation model, the imputation model essentially assumes that the correlation between the omitted interactions terms and all other variable is $r = 0$. In other words, any correlations between the study variables and any interactions terms calculated post-imputation will be suppressed (biased) towards zero (Graham, 2012).

[11] These auxiliary variables are excluded from the regression model, but are used to assist the multiple imputation process. Variables that are highly correlated with the study variables, or that may be related to *missingness*, can be included to help "*boost"* the MI steps (as recommended in Graham, 2012, p.74).

Horton, Lipsitz, & Parzen, 2003). As a result, the sum of the reported post-imputation values, particularly for dichotomous variables, may be less than 100% (e.g., soft-drug use).

The cross-sectional sample MI model was composed of 47 variables, including 7 that were combined into the dependent variable. The EM algorithm converged normally in 17 iterations. The highest percentage of missing data was present in the wave 10 positive mental health variable (24.03%). No cases had missing data on every variable.

The longitudinal sample MI model was composed of 59 variables, including 14 that were combined into the two dependent variables (7 variables each). The EM algorithm converged normally in 31 iterations. The highest percentage of missing data (excluding auxiliary variables) was found in the T1 positive mental health variable (26.09%). No cases had missing data on every variable.

Hierarchical regression analyses. A series of hierarchical regression analyses were conducted , with the academic success dependent (criterion) variable regressed in four successive steps on the four categories (or "blocks") of predictor variables: contextual risk factors, individual risk factors, contextual protective factors, and individual protective factors. Each block was tested separately to see if it added a statistically significant increment to the total amount of variance accounted for.

In sum, two cross-sectional hierarchical regression analyses were conducted with wave 10 academic success as the dependent variable, one with the cross-sectional sample (N = 3,662), and one with the longitudinal subsample (N = 962). In addition, one longitudinal analysis was conducted, employing wave 13 (Time 2) academic successes as the dependent variable and including wave 10 (Time 1) academic success as a control variable. The longitudinal model thus

tested the capacity of our predictive model to explain *change* from wave 10 to wave 13 in academic success. This type of analysis of change is recommended by Cohen & Cohen (1983) as a special case of analysis of partial variance. The inclusion of the wave 10 academic success variable as a new block 1 meant that the longitudinal analyses consisted of 5 rather than 4 successive blocks. Finally, the 18 multiplicative ("interaction") terms were tested in sequential fashion, one at a time, by adding each as an additional block in the three hierarchical regression models described above (Aiken & West, 1991).

Results

Descriptive and Psychometric Results

Table 2 displays the means (or percentages for dichotomous variables), standard deviations, Cronbach's alphas, theoretical range, and skewness for all study variables. Approximately one fifth of both the cross-sectional sample and longitudinal subsample reported no academically-related impairments at Time 1 (20.6% & 19.4%, respectively). Although excluded from the imputation model and the regression models for the longitudinal subsample, the mean age for the young people in the longitudinal subsample at Time 2 was 16.48 (SD=0.84).

Young people in the longitudinal subsample differed from those in the broader cross-sectional sample in important ways: On average, youth in the longitudinal subsample entered care at a younger age; were more likely to have experienced neglect as a reason for entry into care; were less likely to have been held back a grade in school; were younger in age at Time 1 (T1); were less likely to be soft-drug users; were less likely to be at risk of suicide; and had lower average scores on the positive mental health scale.

The internal consistency (Cronbach's alpha) for T1 soft-drug use, prior to imputation and subsequent dichotomization, was acceptable for the cross-sectional sample (α=0.61) and good for the longitudinal subsample (α=0.82). Internal consistency was reduced for this scale in the cross-sectional sample due to lower correlations between alcohol use and the other two smoking measures (marijuana and cigarettes). This might be an artefact of age and age-variance of the two samples: the young people in the longitudinal subsample were generally younger (mean age = 13.51 years) and more narrowly dispersed (*SD*=0.86), as compared to the broader cross-sectional sample, which was older (mean age = 15.10 years) and more variable in age (*SD*=1.61). Consistent with this supposition, the number of soft drug non-users had fallen to 41.6% three years after the Time 1, more closely resembling results from the broader cross-sectional sample. Although excluded from the hierarchical regression models, T2 soft-drug use was included as an auxiliary variable in the multiple imputation for the longitudinal subsample. The internal consistency coefficient for T2 soft-drug use, prior to imputation, also reflected a closer relationship between alcohol, cigarette, and marijuana consumption (α=0.82), suggesting some age-related factor at play.

Suicide risk was also dichotomized prior to multiple imputation due to significant skewness. Coefficient alphas prior to dichotomization and multiple imputation for Suicide risk were acceptable (rather than good) for both the cross-sectional sample and the longitudinal subsample sample (α=0.69 and α=0.58, respectively). Among those who reported suicidal

ideation, self-harm behaviour, or suicidal action, most had scores of 1 (12.8% and 9.3%)[12], whereas fewer had scores of 2 (2.6% and 2.8%), 3, or 4 (1.4% and 0.8%; 2.4 % and 0.8%).

T1 positive mental health mean scores, prior to transformation and imputation, for each group were 55.13 (n = 2,782; *SD*=12.26) for the cross-sectional sample and 57.55 (*n* = 711*; SD*=10.62) for the longitudinal subsample (out of a possible score of 70). The means for Internal developmental assets, prior to transformation and imputation, were 13.35 (*n* = 3,190; *SD*=5.12) and 14.07 (n = 849; *SD*=4.77) for the cross-sectional sample and the longitudinal sample, respectively (out of a possible maximum of 20).

In the longitudinal sample, there was an important decline of the young people in care's academic success scores from a mean T-score of 50 at T1 to a mean T-score of 41.62 at T2. This represents a large effect size (*d = 0.7)*. A more in depth examination of the scale components revealed that two factors, namely language skills achievement and mathematics achievement, represented the largest contributors to the overall decline. Two other factors (overall school achievement and if the youth is behind or ahead of their cohort) were found to have remained stable from T1 and T2.

Finally, as cited in the introduction, some authors have suggested the type of placement in which a young person finds him or herself (group homes, for the most part), might be a proxy for higher degrees of behavioural problems and academically-related impairments (e.g., Flynn *et al.*, 2013; O'Higgins, Sebba, & Gardner, 2014). Indeed, this might have been the case in the present study, as youth with higher SDQ total difficulties scores and greater academically-related impairments were over-represented in group homes (compared to foster and kinship care), with

[12] Each of these percentages represents values from the cross-sectional sample & the longitudinal subsample, respectively, and prior to dichotomization and imputation.

an average of 2.3 academically-related impairments (vs. 1.9) [$\chi^2(16, N=3,662) = 71.16, p = 0.00$] and average SDQ total difficulty scores of 16.57 (vs. 11.68) [$\chi^2(72, N=3,662) = 335.11, p = 0.00$] for the overall cross-sectional sample.

Intercorrelations

Tables 3 and 4 reveal the correlation matrices for all variables in the cross-sectional sample and the longitudinal subsample. As expected, most of the predictor variables (17 of 19) were significantly correlated with the dependent variable in the cross-sectional sample. In the longitudinal subsample, on the other hand, 15 of 19 factors were significantly correlated with the outcome variable, a difference that may have been to the lower level of statistical power in the smaller longitudinal sample.

Hierarchical Regressions

Cross-sectional sample (N = 3,662). Table 5 displays the results for the cross-sectional hierarchical regression conducting using the cross-sectional sample. Contextual risk factors (step 1), individual risk factors (step 2), contextual protective factors (step 3), and individual risk factors (step 4) all accounted for statistically significant increments of explained variance for academic success at Time 1 (T1). The overall variance accounted for in academic success at T1 by the whole model was 38.2% (R^2=.382). Individual factors, taken together, represented the largest proportion of the variance (ΔR^2= .293) in academic success accounted for by the model, as opposed to that accounted for by contextual factors (ΔR^2=.089). Risk factors also played a larger predictive role (ΔR^2=.252) than protective factors (ΔR^2=.130) in explaining variance in academic success. Globally, twelve of the nineteen factors (63.16%) in the model were significant predictors of academic success (6/11 risk factors; 6/7 protective factors). The single strongest predictor of academic success, in terms of effect size, was T1 Internal Developmental

Assets (standardized beta =.314); followed distantly by T1 Behavioural Problems (standardized beta =-.129), Academically-related impairments (standardized beta =-.123) and, T1 Caregiver Aspirations (standardized beta =.106), although these latter three represent moderate effects sizes, as compared to the large effect size of T1 Developmental Assets (effect size interpretations according to Keith, 2006).

Notably, three risk factors (age of first entry, school instability, and caregiver instability) were significant predictors when taken separately, but were no longer significantly predictive once contextual protective factors were included. This may be due to the inclusion of length of time with current caregiver (a proxy for placement quasi-permanency), a variable that was strongly correlated (r =.381 to .399) with these three risk factors. Neglect as a reason for entry, on the other hand, was a significant predictor of academic success only after contextual protective factors were included and remained so in the final, complete model. This suggests the impact of early neglect for youth in care may explain a part of their current academic success, even when other risk and protective factors are accounted for.

Longitudinal Subsample (n = 962)

Cross-sectional hierarchical regression. Table 6 contains the results for the cross-sectional hierarchical regression conducted using the longitudinal sample. Once again, each step accounted for statistically significant increments of variance in academic success at T1. The total amount of variance accounted for by the model was 38.8% (R^2=.388). Similar to the cross-sectional analysis with the larger sample, individual factors (ΔR^2=.319) accounted for greater explained variance than contextual factors (ΔR^2=.068); and, risk factors (ΔR^2=.300) accounted for greater explained variance than protective factors (ΔR^2=.088) in the final block. Overall,

seven of the nineteen (36.84%) predictors in the model were statistically significant in this subsample (4/11 risk factors; 3/7 protective factors). As in the previous hierarchical regression, a large effect size was attributed to T1 developmental assets (standardized beta = .266). Ranked in decreasing importance, another four variables revealed moderate effect sizes: T1 behavioural problems (standardized beta = -.185); academically-related impairments (standardized beta = -.181); T1 caregiver educational aspirations (standardized beta =.120); and, T1 youth educational aspirations (standardized beta = .091).

Interestingly, age of first entry into care and T1 time with current caregiver were statistically significant predictors until step 4, when individual protective factors were added, suggesting mediation by these other predictors. T1 soft-drug use was statistically significantly predictive only until the protective factors were included (step 3), again suggesting mediation. Conversely, neglect as a reason for entry became statistically significant only after individual risk factors had been included, possibly indicating some collinearity, as in the cross-sectional sample regression.

Longitudinal hierarchical regression. Finally, Table 7 shows the results for the longitudinal hierarchical regression conducted using the longitudinal sample. Here, it is change in academic success that is being predicted, as T1 academic success was added as a first step in the hierarchical regression predicting T2 academic success. Every step provided statistically significant increases in explained variance for academic success at Time 2. The total amount of variance accounted for in changes in academic success was 20.9% (R^2=.209), with most of the variance explained by T1 academic success (ΔR^2=.134). The other predictors accounted for an additional 7.5% of the variance (ΔR^2=.75). Four of the 19 predictors (20.05%) were found to be statistically significant predictors (T1 internal developmental assets; gender; T1 positive mental

health; T1 soft drug use). These predictors were all individual factors, and three of the four were protective factors. T1 caregiver instability was predictive only until the individual risk factors had been entered into the model at step 3, T1 behavioural problems was predictive only until the contextual protective factors were included, at step 4; and T1 caregiver educational aspirations was predictive only until the individual protective factors had been added, in step 5.

Regarding effect sizes, only one predictor of change in academic success revealed a moderate effect size (T1 internal developmental assets, standardized beta =.117). The other three statistically significant predictors exhibited small effect sizes (gender, T1 positive mental health, and T1 soft drug use).

Gender as a Moderator of the Predictor Variables

Statistically significant interaction effects for gender as a moderator variable were detected in both cross-sectional hierarchical regressions, but not in the longitudinal regression. The interaction of Gender X T1 Caregiver Educational Aspirations was a significant predictor of T1 academic success in both the larger sample [N=3,66; *F change* (1, 3641) =17.09, *p*=.000] and the smaller longitudinal subsample [n=962; *F change* (1, 941) = 5.365, *p* =.023]. This moderation effect by gender suggests that T1 caregiver educational aspirations had a different impact on young women in care than they did on young men in care. This is reflected in differing slopes for both groups in the linear equations related to each gender. Figure 1 is a graphic representation of the divergent relationship T1 caregiver educational aspirations has on the T1 academic success of boys and girls in care. The graph reveals that the slope related to caregiver educational aspirations as they predict academic success is steeper for young women, suggesting caregiver aspirations (especially beyond 12 years of formal education) are more directly related to higher academic success for girls in care than for boys.

The interaction of Gender X Placement Type, additionally, was found to be significantly predictive of T1 academic success only in the larger cross-sectional sample [N=3,662; *F change* (1, 3641) =7.59, *p*=.006]. As this interaction effect refers to two dichotomous variables, it can be best visualized and interpreted through a clustered bar graph (Weinberg, Abramowitz, & Goldberg, 2008). Figure 2 is a visual representation of the differential effect T1 placement type has on the T1 academic success of boys and girls in care. This graph reveals that the differences in T1 academic success between boys and girls in group homes is much narrower and in the opposite direction than for boys and girls in foster and kinship care homes.

Discussion

Predictors of Academic Success

The aim of this paper was to propose and test a model of risk and protective factors associated with educational outcomes based on factors identified in O'Higgins, Sebba, and Gardner's (2014) systematic review. Moreover, this study represents one of the first large-scale empirical studies of risk and protective factors related to educational outcomes of children in care. Results from the two cross-sectional hierarchical regression analyses offer supporting evidence for a predictive model of risk and protective factors and generally support the hypotheses. Of the 19 predictors of educational outcomes for children in kinship or foster care identified by the authors that were operationalized in this study, twelve were found to predict academic success in cross-sectional analyses. Table 8 summarizes the conceptual factors found to be statistically significant predictors of academic success for children in care, when all other factors are accounted for. The fact that soft drug use is a predictor of lower educational performance and other factors (e.g., internal developmental assets, experiencing greater well-being, etc.) predict higher educational performance helps to understand the kinds of interventions

that may be needed to improve educational outcomes for youth in care. Some of these factors are more likely to be candidates for investment and intervention by foster care systems and for child welfare workers to focus on (for example, reducing soft drug use; encouraging greater permanency planning, etc.) and hopefully positive change for the young person in care; Whereas immutable factors (e.g., gender or race) are, understandably, unlikely to be the target for change but rather may be factors that need to be taken into account (or specifically targeted for group intervention) in practice or policy interventions. Generally, the factors identified in this study (Table 8) reflect the findings of O'Higgins, Sebba, and Gardner's (2014) systematic review and, in terms of face validity, echo the experience of child welfare workers and young people in care about what is related to overall academic success.

Results from the longitudinal hierarchical regression analysis provide interesting insights into which factors, among those identified by O'Higgins, Sebba, and Gardner's (2014) systematic review, were predictive of *changes* in academic success over a three-year period from T1 to T2. Only individual factors were found to be predictive, and of these, mostly protective factors predicted greater change in academic success. Table 9 provides a summary of the conceptual factors that were statistically significant predictors of change in academic success for children in care, when all other factors were accounted for. The most salient finding may be the important decline in overall academic success from T1 and T2. Further analysis of this decline revealed that drops in language skills and mathematics were particular areas of decline. This may reflect the increasing difficulty of these classes during the age-period studied (from 13.5 to 16.5, or approximately grade 8-9 to grade 10-11) and the challenges faced by youth in transition to high school.

It is encouraging that most of the factors identified in Table 9 are already the target of several interventions. The present study provides additional strength to the evidence base supporting these interventions and validation for investment in these interventions as possible methods of increasing the academic success of youth in care. Additionally, the frequency of soft-drugs use of, the number of internal assets possessed by, and the well-being experienced by a young person in care may be related to one another through some fourth unmeasured factor that is more directly linked with greater change in academic success. More study of what might predict change in academic success (and of other educational outcomes) is warranted, and could provide additional valuable insights to inform interventions.

Overall, internal developmental assets proved to be a valuable protective factor, predicting both academic success concurrently, but also greater growth in academic success three-years later for the young people in care in the OnLAC sample. This reflects findings from previous studies by the present authors (e.g., Flynn & Tessier, 2011; Flynn, Tessier, & Coulombe, 2013).

Regarding the gender as moderator analyses conducted in this study, we must note that the results should be interpreted with caution. Two predictors (caregiver educational aspirations and placement type) of academic success were found to be significantly moderated by gender when analysed in a cross-sectional regression. For caregiver educational aspirations, it appears that higher caregiver educational aspirations are more strongly related to higher academic success scores for females than they are for males, although this difference does not appear at lower caregiver educational aspirations. Regarding placement type, young women in foster and kinship care outperform their male counterparts, a relationship that appears to be inversed (or non-existent) for those young people in group homes. This may be an indication that young girls

in group home (typically represented by those individuals with greater behavioural problems) are more similar to young men in group homes. Additional research on the relationship between these subgroups and educational outcomes would provide greater insight. However, these statistically significant results represent approximately 11.1% (2 of 18) of the moderation analyses conducted in this study – a percentage that may be no better than chance – particularly given the large power associated with a large study sample (Cohen & Cohen, 1983).

Unrelated Factors

Of the seven factors that were not found to be predictive of academic success, six (87.71%) were risk factors and only one (14.29%) was a protective factor. This is despite risk factors being overrepresented in our final overall model (12 risk factors vs. 7 protective factors). These results, though, present interesting findings that are not entirely surprising. As previously discussed, it was anticipated that placement type would not be predictive in the final model, as it has been hypothesized that it is a potential proxy variable for greater academically-related impairments, behavioural difficulties, and perhaps poverty (e.g., O'Higgins, Sebba, & Gardner, 2014). As two of these factors were included prior to placement type in the regression equation, it is possible that placement type would have been a significant predictor of academic success had it been placed earlier in the equation and before these other factors. In the results section, the proposition that placement type may be a proxy variable for greater academically-related impairments or greater behavioural difficulties was further supported when statistically comparing the two placement type groups. This analysis revealed that young people in group home care reported greater behavioural problems and a greater number of academically-related impairments than their peers in foster and kinship care.

Similarly, it is possible that age at first entry into care, school instability, and caregiver instability, which were initially predictive of academic success, but failed to be statistically significant predictors in the final model, were collinear with one of the factors present in block 3 (contextual protective factors). The correlation matrix reveals that these factors might have been overshadowed by the variable representing the length of time spent with the current caregiver. This explanation seems plausible on the surface, given that youth who enter care at a younger age have the potential to remain with a caregiver for a longer period of time; youth who remain with their caregiver for a longer period of time might be more likely to remain in the same school; and, likewise, youth who report a high number of caregivers cannot be expected to have spent a long period of time with their current caregiver. Further exploration of these relationships is warranted.

It is also not entirely surprising that FNMI minority ethnic status was not found to be predictive of academic success. In the OnLAC sample, some FNMI youth in care in Ontario are served by five CASs that do not participate in the OnLAC project and thus do not show up in our OnLAC samples. On the other hand, the FNMI youths that are part of the OnLAC project are served by 40 of the 41 CASs that do participate in the OnLAC project and are educated in virtually the same proportions in community schools as their non-FNMI peers (Flynn, Miller, & Vincent, 2014).

Regarding the conceptual factor of mental health difficulties, the scale used to gauge suicide risk in our sample represents a measure of extreme symptoms of suicide and self-harm. It does not capture other, perhaps lesser, forms of depressive affect, nor does it capture other mental health difficulties that might be experienced by young people (e.g., anxiety or eating-

related problems). More nuanced and more varied measures of mental health difficulties might reveal different results and better inform relevant practice and interventions.

Exact age varied greatly in the cross-sectional sample, with a standard deviation spanning nearly the entire age-range. Given its low correlation between age and our outcome (r=-.066), it is not surprising that it was not a significant predictor of academic success in our regression models. However, exact age was much narrower in the longitudinal subsample, a reflection of the three-year gap between assessment periods (youth in this sample were restricted to being between ages 12-14 at T1 and 15-17 at T2). This might explain why exact age was predictive of academic success in the cross-sectional hierarchical regression on the longitudinal subsample (n=962) but not in the larger sample (N=3,662). Overall, results of the non-significant relationship between these seven variables and academic success provide additional data supporting their *mixed* or *inconsistent* nature as predictor of educational outcomes.

Limitations and Directions for Future Research

This study represents one of the largest cross-sectional and longitudinal empirical assessments of the predictors of education in the domain of child welfare, with a sufficiently large sample to deliver the statistical power to detect even small effect sizes (Cohen, 1988; Lewis, 2006). Moreover, no other previous study of predictors of educational outcomes for children in care has been as well-grounded in the literature, thanks to the framework and guidance provided by O'Higgins, Sebba, and Gardner's (2014) systematic review. Nevertheless, there were important limitations in this study. First, the data collected by the OnLAC project did not enable us to operationalize all the predictors identified in O'Higgins, Sebba, and Gardner's (2014) systematic review, namely intelligence, birth family characteristics, placement with siblings, and total length of time in care (since first entry).

Additionally, some FNMI young people, who live in relatively isolated and remote regions of Ontario, were excluded from our sample. This is largely because the 6 CASs that serve them do not participate in the OnLAC project. Although the reasons they opt to not participate are not known, we can hypothesize that political/cultural reasons, geographic isolation, and the varied use of FNMI languages may be relevant to non-participation in the OnLAC project. Future studies may wish to explore what factors are specifically related to the academic success of FNMI children and youth in care.

Despite the measure of academically-related impairments is relatively crude and has less than desirable internal consistency (α = .53 and .56 for the cross-sectional and longitudinal samples, respectively), the complete measure demonstrated good convergent and divergent validity – particular with those measures related to academic tasks (such as the T1 and T2 outcome measures). While a more robust measure of academically-related impairments would be preferable for future studies, this variable appears to have captured some distinct element of each youth's academic abilities and challenges.

Although the child welfare workers and caregivers undergo training before completing the AAR and each AAR goes through rigorous procedures to ensure the validity and reliability of the data we have analysed, we must note that this data faces the same type of errors that all self-report measures face. Namely, we cannot know how conscientious each respondent is, nor how social or demand pressures may influence the responses (especially since the youth, the caregiver, and the child welfare worker are frequently present during the AAR interview). Nevertheless, the young people appear to be fairly critical of their settings, fairly honest about their socially-negative elements, and relatively consistent from year-to-year. Lastly, the present

study relies on the secondary data from the OnLAC project, as data from the AAR is intended for institutional use.

In identifying 12 predictors that did generalize from O'Higgins, Sebba, and Gardner's (2014) systematic review and 7 that did not, we have added to the stock of knowledge that can be used to understand the educational success of young people in care and to design interventions that may improve their rate of success. It should be kept in mind, however, that our operationalization of academic success is not the only way of measuring this variable, and that there are other educational outcomes that we have not considered here. Future research should continue to test the generalizability of the full range of variables identified by O'Higgins, Sebba, and Gardner's (2014) in their systematic review, using other large child-welfare samples in other countries. We can hope that such efforts will pave the way for greater understanding of the foundations of academic success among young people in care and for creating interventions that improve their educational outcomes.

Study 2: Does the Time Gap Between Assessments Made of Young People in Care and Later in Transitional Living Modify Our Ability to Predict Their Educational Outcomes?

In the 2011 federal census, Statistics Canada (2011) counted a total of 47,885 children and youths in foster care in Canada, of whom 11,375 were in Ontario. Although this number excluded an important number of children who were receiving child welfare services on a short-term basis or else from organizations excluded from the national census, such as Aboriginal reserves, these data represented the first time that the Canadian government had attempted to count the number of young people in care nationally (Kirkey, 2012). Among the 11,375 young people in foster care in Ontario, the 2011 census reported that 3,235 young people were between the ages of 15 and 19 years and either preparing to make a transition from public care or already doing so (Statistics Canada, 2011). The census also reported that there were another 1,140 young people in care in Ontario who were older than 19. These young people were already residing in the supported transitional living program known since May, 2013, as Continued Care and Support for Youth (CCSY) and previously known as Extended Care and Maintenance (ECM; Bay Consulting Group, 2010; CPSCW, 2010). Supported transitional living programs, common in Canada and the United States, are intended to support young people's educational, vocational, and personal progress as they prepare to exit public care (Knoke, 2009). These programs often provide financial support to encourage young people's completion of secondary school, participation in post-secondary education (apprenticeships, college, or university), or direct entry into the labour market (Flynn & Tessier, 2011; Knoke, 2009; Stapleton & Tweedle, 2010).

In a review of the limited research on transitions within or from public care in Canada, Flynn and Vincent (2008) suggested that many Canadian youths in transition experience

challenges similar to those experienced by young people leaving care in the United Kingdom, as described by Stein (2006). Stein portrays a "journey into adulthood that is both accelerated and compressed" (p.274), in comparing the entry into adulthood for youth in care to that of young people in the general population. Moreover, transition from care to young adulthood is a metaphorical one-way street, with little or no possibility of a safe return to care should they struggle with the increased demands they encounter without the benefit of the emotional, instrumental, or financial support often provided by families in the general population (Stein, 2006). Stein contrasts the "expectation of instant adulthood" with the extended period of maturation that young people in the general population frequently enjoy, noting that such an expectation renders even more difficult the experience of integration into the adult world for young people transitioning out of public care. These findings are amply supported by the results of Dunkoh, Underhill, and Montgomery's (2006) systematic review of independent living programs. They found that young people leaving care in the US and UK are typically younger than their age peers in the general population and more likely to be homeless, unemployed, or dependent on public assistance. Young people leaving care also experience more frequent physical or mental health difficulties, engage in a greater number of risk behaviours, and are more likely to be involved with the criminal justice system (Dunkoh *et al.*, 2006).

In the Midwest Evaluation of Adult Functioning of Former Foster Youth (henceforth, Midwest study), a prospective longitudinal study conducted by Courtney and his colleagues (2004 through 2011), 732 youths in Illinois, Iowa, and Wisconsin were interviewed at age 17 or 18 as they were preparing to transition out of care. Most of these young people were interviewed again when they were 19, 21, 23-24, and 26 years of age. Taking advantage of the fact that young people in Illinois could stay in care until their 21st birthday, whereas those in Iowa or

Wisconsin had to leave care by their 19th birthday, Courtney, Dworsky, and Pollack (2007) found that at the third wave of the Midwest study, when the young people were aged 21, those in Illinois were four times as likely to have attended college and 3.5 times more likely to have completed at least one year of college than those in Iowa or Wisconsin. Moreover, the former foster youths in Illinois were also more likely to have received independent living services related to education, financial management, housing, and health education, to have had more positive earnings, and to have delayed pregnancies.

The findings by Courtney and his colleagues, as well as common experience, suggest that the number of years between the initial and follow-assessments is likely to make a difference, in terms of our ability, especially in the individual case, to predict accurately from the initial assessment what the outcome is likely to be at the follow-up time-point. In the Midwest study (Courtney *et al.*, 2007), the age-related policy difference between states ensured that many of the inter-state comparisons made between the initial assessment (wave 1, conducted when the former youths in care were aged 17 or 18) and wave 2 (when the youths were aged 19) would have shown far fewer differences than comparisons conducted at wave 3 (when they were 21). This is no doubt the case in part because the longer the time lag between assessments, the more circumstances may change, making prediction more difficult.

We were interested in exploring this question of the relationship between the length of the time gap between assessments in the context of the Ontario Looking After Children (OnLAC) project (Flynn, Dudding, & Barber, 2006). In the OnLAC project, yearly assessments are mandated by the Ministry of Children and Youth Services for young people who have been in care for one year or more and are served by one of 41 local Children's Aid Societies (CASs) in Ontario. Although the time lag between annual OnLAC assessments in successive years is

intended to be approximately 12 months, for logistical reasons the actual time gap can vary considerably (as is discussed further in the measures section). To investigate the potential impact of this actual variability in the timing of OnLAC assessments, we drew on the theoretical work of Selig and his colleagues (Selig, 2009; Selig, Preacher, & Little, 2012).

In his doctoral dissertation on the subject of the time gap (or lag) and longitudinal data, Selig (2009) argued that the time gap between assessments in research should receive the same deliberate, thoughtful consideration that is typically given to other issues that may be limitations in any study, such as statistical power or measurement error. Selig (2009) suggested that adopting the assumption that the relationship between variables A and B is unaffected by the time gap between measurements in longitudinal studies necessarily involves the additional assumption that any change resulting from A's influence on B is either stable (i.e., unchanging after the initial effect) or continuous and unidirectional. The study by Courtney *et al.* (2007) also suggests that differences in the time gap between assessments can lead to quite divergent results, interpretations, and conclusions.

In their chapter on interpreting causal relationship in panel data, Pelz and Lew (1970) demonstrated through a series of simulations that the choice of time gap or lag can influence the magnitude and even the directionality of the effect of one variable on another. Using a simple 2 variable X 2 measurement-point simulation, the authors first determined a specific time gap at which variable A altered B, and another gap at which time variable B altered A (a bidirectional relationship). By varying the time gap in several analyses, their results were radically altered in terms of which variable *caused* the other, the sign of this relationship (e.g., whether increases in A increased or decreased B), and the extent of this relationship – showing that incorrect

conclusions were all too easy to draw if the time gap between assessments is not considered (Selig, 2009).

Selig (2009) demonstrated the influence of the time lag by drawing from empirical data collected by Kanfer and Ackerman (1989) on 140 United States Air Force Trainees. Data were collected on 6 repeated training tasks (essentially a repeated-measure design, using variables B_1, B_2, etc.), as well as on a measure of intellectual ability from some months before the training exercises (variable A). Analyzing these data and assuming equal intervals between all of the assessments, Selig showed that the autoregressive effect[13] diminished as data were used from each subsequent time point (e.g., autoregressive effect of B_2 on B_1 > B_6 on B_1). This is not surprising, as test-retest correlations have been demonstrated to weaken as time between assessments increases and practice effects might be involved (e.g., Thorndike, 1933). Selig (2009) also demonstrated a similar diminishing predictive relationship by regressing the outcome A on criterion B_1, then B_2, then B_3, etc., further illustrating the importance of considering the time gap in longitudinal analyses.

Although the idea of finding and implementing the *optimal* time gap to detect maximal effect might be appealing to many theorists, particularly those interested in causal modelling, Selig (2009) noted that the choice of time gap in the real world is more likely to be guided by convenience, necessity, or tradition.[14] His three recommendations to countering these tendencies were as follows: rely on theory and experience to inform the choice of lag; measure frequently, in order not to miss the optimal time; and use meta-analytic methods to review many studies and determine whether the length of the time gap between assessments moderates effect sizes (Selig,

[13] In essence, a test-retest correlation used to determine if the results from data collected at Time 2 depends on the results of data collected at Time 1 (Selig, 2009).
[14] An obvious exception to this is frequently used in clinical trials for various drugs, treatments, etc.

2009). As these methods may not always be possible or available to researchers, he offered another recommendation: intentionally vary the time gap and then test for moderation effects. This would minimize the impact of a poorly chosen time gap and the subsequent risk of drawing incorrect conclusions, as well as offer the possibility of expanding the overall comprehension of the effects under examination.

Expanding upon his thesis research, Selig and his colleagues (2012) presented a new approach, termed *lag as moderator* (LAM), to understanding time-dependent relationships and to planning data collection in longitudinal, cohort, or panel studies. They illustrated the LAM approach with both simulated and empirical data and a variety of statistical methods, including autoregressive effects, linear regression analyses, and quadratic regression analyses. They added that although they were able to demonstrate that the time lag between assessments functioned as a moderator of effects, more research was needed, both of a planned, *a priori* nature, as well as secondary, *a posteriori* analyses of existing data sets, to evaluate the utility of LAM (Selig *et al.*, 2012).

Study Objective

The multi-year, large-sample OnLAC data base appeared to offer a promising opportunity to assess the practical implications of LAM, one relatively unique in the realm of child welfare research in which LAM has not been examined previously. In the OnLAC project, data collection is mandated to take place once during each 12-month period. In reality, however, the *true* time gap can be much more variable. Moreover, we can imagine that child welfare workers would not want to target certain risk factors for intervention if, in fact, they do not ultimately affect educational outcomes – even if they might appear to have an impact in the immediate future. In the present study, we sought to determine whether a longer or shorter time

gap separating an initial and follow-up OnLAC assessment moderated the association of selected risk or protective predictors on several educational outcomes among young people in care. Previously, Flynn and Tessier (2011) had found in a cross-sectional study that four protective factors (gender, age, developmental assets, and self-care skills and resources) and two risk factors (soft-drug use and number of academically-related impairments) were able to predict the educational attainment, educational aspirations, and NEET (not in education, employment, or training) status of young people in transitional living. In the present research, we asked whether, using an expanded risk and protective-factor model, we could use OnLAC assessments made when young people were aged 16 or 17 and still in care to predict their educational and employment outcomes several years later, when they were 18 to 21+ years of age and residing in supported transitional living. We included gap (or lag) length in our model, both as a main effect and as a potential moderator of the other predictors.

Hypotheses

Based on the LAM research of Selig (2009) and Selig *et al.* (2012) and on previous child-welfare research (Courtney *et al.*, 2007; Flynn & Tessier, 2011; Stein, 2006), we hypothesized that the following characteristics on the part of young people would be protective and predict more positive educational or employment outcomes: residing in a family-type placement (foster or kinship home); female gender; being older; having a greater number of internal developmental assets; and exhibiting stronger academic performance. Conversely, we hypothesized that certain other youth characteristics would function as risk factors, predicting less favourable educational or employment outcomes: a greater number of academically-related impairments; a higher level of behavioural problems; and a higher level of soft-drug use (i.e., of cigarettes, alcohol, or marijuana). We also hypothesized that the length of the time-gap between the first and second

OnLAC assessments would moderate the association of the various protective and risk predictors with several educational outcomes, such that among young people in care who had experienced shorter time-gaps, the relationships between the predictors and educational outcomes would be stronger than among those who had experienced longer time-gaps.

Method

Service Context

The young people in care in this study were drawn from the data base of the OnLAC project (Flynn, Dudding, & Barber, 2006) in 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011, 2011-2012, and 2012-2013 . These years represent, respectively, OnLAC years 6, 7, 8, 9, 10, 11, and 12 (Flynn *et al.,* 2006; 2009). As mentioned earlier, the OnLAC project gathers information from 41 local Children's Aid Societies (CASs) in a yearly assessment interview of each youth in care who has been in care for a minimum of 12-months, as mandated by the Ontario Ministry of Children and Youth Services. The aim of the OnLAC project is to assess the service needs and development outcomes of children in care in the province and to provide up to date information to inform the young person's plan of care for the next 12 months. The OnLAC data are also intended to enable local CASs to improve their decision-making and practices and to allow the province to enhance its policies by furnishing detailed information on the outcomes experienced by virtually all of the children served by the 41 CASs that participate in the project.

Instrument

As part of the OnLAC project, each young person in care is interviewed annually using a structured conversational interview: The Canadian adaptation of the Assessment and Action Record (called "AAR" henceforth). There are eight age-appropriate formats of each AAR, of

which three were used in this study: 12 years old to 15 years old; 16 years old to 17 years old; and, 18 years old or older. The latter group are in the Continued Care and Support for Youth (CCSY) program, previously known as Extended Care and Maintenance (ECM; Bay Consulting Group, 2010; CPSCW, 2010). Each AAR conversational interview is conducted by a child welfare worker and contains questions covering nine domains: background; health; education; identity; social and family relationships; social presentation; emotional and behavioural developmental; self-care skills; and, developmental assets (40 items adapted from the work of the Search Institute; Scales *et al.*, 2000; Flynn *et al.,* 2009; 2013). Answers are provided by the young people themselves (if aged 10 or over), the child welfare worker, and the caregiver.

The AAR is mainly comprised of items drawn from the National Longitudinal Survey of Children and Youth (NLSCY; a longitudinal survey conducted by the Canadian government following the well-being and development of individuals from birth through early adulthood; Statistics Canada, 2011), as well as numerous reliable and valid tools available in the public domain (e.g., the Total Difficulties Scale from the Strength and Difficulties Questionnaire; Goodman, 1997). Additional details regarding the AAR are available upon request. Child welfare workers and caregivers undergo a 2-day training program on the use of the AAR with youth in care.

During the initial years covered by this study (2006-2007 to 2009-2010), the 2006 version of the second Canadian adaptation of the AAR (AAR-C2-2006; Flynn *et al.*, 2009) was used across the province. In 2010-2011, a revised version of the AAR (AAR-C2-2010; Flynn *et al.*, 2011) replaced the 2006 version (see Appendix D for an example of the 2010 version of the AAR, for 16-17 year olds).

Data Preparation

The fact that two different versions of the AAR were used during 2006-2013 added substantially to the complexity of the data-preparation process. In particular, the response options of several variables of interest in the current study were modified, with options sometimes added or removed, etc. (See the measures section for details.) The data for the Time 1 variables (predictors) were collected with the 2006 version of the AAR for roughly half of the sample (53.9%), whereas the data for the Time 2 variables were gathered with the 2010 version of the AAR for 90.0% of the sample.

The initial sample for the current study included 517 unduplicated young people who (a) had completed an AAR at least once between the ages of 12 and 17 years and (b) had completed an AAR at least once after the age of 18 years. Five young people were excluded from our final sample because they did not fit these screening criteria (final $N = 512$). The AARs taken from the OnLAC waves when the young people were 17 or less were categorized as potential sources of the data for Time 1 (T1; predictor data). The AARs used during waves when the young people were 18 years old or over (ECM-CCSY form) were categorized as potential sources of the data for Time 2 (T2; outcome data). On average, each young person had 1.41 potential AARs for T1 (range 1 to 3; $SD = .53$) and 1.41 potential AARs for T2 (range 1 to 4; $SD = .64$). Given that the objective of the study was to gauge the impact of the length of time between assessments (gap length) as a moderator of several predictive factors that have previously been associated with educational outcomes, the potential AARs that were selected for T1 and T2 were chosen in order to maximize this gap length. In other words, in the case of more than one T1 and/or T2 assessment for a particular youth, we selected the earliest T1 assessment the latest T2 assessment.

In order to merge these multiple data points spanning several different collection waves into a combined database representing T1 and T2 data, individual responses for the items under scrutiny and for each young person were meticulously copied, wave by wave, into new T1 and T2 variables. Checking and cross-checking was conducted several times in order to ensure proper copying of every variable. Appendix C1 displays the number of cases and percentages of the total sample that were drawn from each wave of the OnLAC project to form the final T1 and T2 data. Table C2 presents the number of cases and percentages of the total sample for each approximate gap length. It is important to note that the approximate gap length represents the numeric difference between OnLAC project waves. As explained in the measures section, this number was shown to be only very approximate in some cases, such that another variable (exact gap length) was calculated and used in the study as a more precise continuous variable.

Participants

The study sample consisted of 512 young people in care, of whom 237 (46.3%) were male and 275 (53.7%) were female. Data on the protective and risk factor predictors were gathered while the young people were still in care (at Time 1, when aged 17 or younger). The outcome data were gathered when the young people had moved to supported transitional living (at Time 2, when aged 18 or older). Thus, the young people in the sample were aged 15.08 to 18.01 years old at Time 1 (M = 16.80, SD = .54) and 17.49 to 21.81 years old at Time 2 (M = 19.02, SD = .88). While in care (at Time 1), most of the young people were in foster homes or kinship care homes (324, or 63.3%), whereas 189 (36.9%) were residing in group homes or other types of provincially-sponsored living arrangements. While in CCSY-ECM (at Time 2)[15], the

[15] Living arrangements when the youth were in ECM (at Time 2) were not part of the multiple imputation model. As a result, this data is taken from a pre-imputation sample of n=509.

majority of the sample were in supported independent living arrangements (329 or 67.6%), whereas 53 (10.9%) were living with relatives (but not in foster care) and 105 (21.6%) were residing in "other" accommodations[16].

Measures

Table 10 provides descriptive information on all of the study variables, including means (or percentages), standard deviations, alpha coefficients (for multi-item scales), theoretical and actual ranges, and skewness. None of the variables were significantly skewed, such that transformations were not needed.

1. **Educational Outcome (Criterion) Variables**

From the CCSY-ECM AARs, three educational outcomes were selected. These were chosen for two reasons. First, they represent outcomes that we have used in our previous research (e.g., Flynn & Tessier, 2011), allowing us to better understand the possible moderating effects of gap length on the relationships between our predictors on these outcomes. Second, the educational outcomes were not included in Tessier's (2014a) empirical test of factors identified in O'Higgins, Sebba, & Gardner's (2014) systematic review of the factors associated with educational outcomes. By including these outcomes in this second study, we sought to deepen our understanding of factors associated with the longitudinal prediction of educational outcomes, add to the findings of Tessier (2014a), and contribute to the literature on factors associated with the educational achievement of children in care.

[16] On the ECM AAR, these are the only three response options; therefore it is unclear what the "other" category may include.

Educational attainment and educational aspirations. During the AAR conversational0 interview, each young person was asked to select the highest grade of school, or the highest diploma, certificate, or degree above the high school level, which he or she had completed. Eight response options were available, ranging from "less than grade 9" to "university degree". Similarly, to ascertain educational aspirations, each young person was asked to say what the highest level of education was that he or she would like to get. For this second question, nine responses were available, ranging from "secondary or high school" to "more than one university degree". For both of these outcome variables, responses were recoded to reflect the years of formal education required for the level aspire to (e.g., a secondary or high school diploma was coded as 12 years of formal education; one university degree was coded as 16; etc.). The T2 educational attainment response categories, therefore, ranged from 8 = less than 9th grade[17] to 16 = one university degree; whereas the T2 educational aspirations response categories ranged from 11 = less than high school diploma to 18 = more than one university degree.

As noted earlier, the AAR underwent substantial revisions in the version published in 2010. For educational attainment, different categories were grouped together in the two versions of the CCSY-ECM form of the AAR, and new categories were added. In order to maintain consistency, all non-university post-secondary educational (PSE) options (e.g., technical school, apprenticeship programs, college of applied art and technology, etc.) were grouped into one "Non-university PSE" category. The response options for educational aspirations were also revised in the 2010 AAR, with different categories grouped together. In order to accommodate these differences, the final T2 educational aspirations response categories were "Less than high school diploma" (11); "High school diploma or graduation equivalent" (12); "Non-university

[17] 9th year of schooling

PSE (CEGEP, College, PCC, Apprenticeship, Vocational School, CAATS)[18] (14); "One university degree" (16); and, "More than one university degree" (18).

NEET status. Youth who, at the time of the T2 CCSY-ECM interview, were not currently enrolled in an educational institution, not participating in some form of training, and were not employed for pay were classified as having NEET status (i.e., not in education, employment, or training). In the final imputed data, 102 young people (19.2%) were classified as having NEET status and 410 young people (80.08%) as non-NEET.

2. Predictor Variables

Exact Gap Length. The precise length of time between the initial and follow-up AAR assessments (exact gap length) was used as a control and moderator variable in the three regression models (one for each of the educational outcome variables) to determine whether shorter or longer lengths of time between assessments had any effect on the relationship between the protective and risk factors and the outcomes. Initially, gap length was calculated as the simple numeric difference between waves in the OnLAC data base (for example, Wave 10 minus Wave 6 would represent a 4-year gap). This variable was used to select the OnLAC waves from which the Time 1 and Time 2 variables for each sample member were drawn.

When we were preparing these data for analysis, however, it became evident was revealed that the simple between-wave gap length value could be misleading, as each CAS, child welfare worker, and young person were only required to complete the AAR interview within a given 12-month period, often without taking into account when the last AAR had been

[18] PSE = Post-secondary education; CEGEP = Collège d'enseignement général et professionnel; PCC = Private Career College; CAATS = College of Applied Arts and Technology.

completed. For instance, a wave 8 AAR might be completed in March, 2008, and a wave 9 AAR might be completed in November, 2009. While technically only one year apart in terms of OnLAC waves (or years), the *true* gap length between assessments would be approximately 20 months. To get a more faithful accounting of the length of time between assessments, *Exact Gap Length* was calculated. This variable was determined precisely by subtracting the date that the Time 1 AAR was started from the date that the Time 2 AAR was started. If this date was absent, the date on which the T1 AAR was completed was used. If this second date was also absent, the date on which the T1 AAR was signed by a supervisor was substituted. Finally, if this last date was missing, the original gap-length value was accepted. The number of days between assessments was then expressed in terms of years. Figure 3 shows a histogram of exact gap length.

T1 placement type. In the AAR interview, the child welfare worker selects one of 17 descriptions that best describes the young person's current placement. For the regression analyses, this variable was dichotomized into foster and kinship care (= 1) versus all others (= 0) to maximize our sample size and because we expected that young people placed in smaller, familial settings (i.e., in foster or kinship care) would be more likely to succeed (McClung & Gayle, 2010).

Academically-related impairments scale. This index consisted of the total number of educationally-related long-term conditions diagnosed by a health professional, as reported by the young person's child welfare worker, combined with the young person's self-ratings of their memory and clear thinking/problem-solving abilities. The long-term educationally-related conditions were limited to ADHD (attentional deficit, hyperactivity disorder), learning disability, and developmental disability. The young people rated any memory difficulties on a 4-point

scale, ranging from "able to remember most things" to "unable to remember anything at all". Clear-thinking and problem-solving difficulties, on the other hand, were rated on a 5-point scale ranging from "able to think clearly and solve problems" to "unable to think and solve problems". Both the memory and problem-solving items were recoded into 3-point scales and then combined with the long-term condition index to form a 9-point index of overall cognitive impairment.

T1 behavioural problems. Behavioural problems were operationalized by using the Total Difficulties Scale of the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). This scale, which is included in all versions of the AAR, includes a total of 20 items divided equally into 4 domains (conduct problems, emotional symptoms, peer problems, and hyperactivity/inattention). The young person's caregiver rated the youth on a 3-point scale (0 = Not true, 1 = Somewhat True, and 2=True) for a total score ranging between 0 and 40.

T1 soft-drug use. Three AAR items were combined to form an index of each young person's soft drug use. During the AAR interview, they were asked to report the frequency of (a) smoking cigarettes, (b) drinking alcohol, and (c) consuming marijuana. As the response options for these scales had changed significantly between the two versions of the AAR, each youth's responses were coded into dichotomous items (0=Non-user; 1 = User) and then combined with the other elements to form a 4-point index of soft-drug use, ranging from 0 (Non-user of soft drugs) to 3 (User of 3 soft-drugs).

T1 internal developmental assets. Both versions of the AAR contain identical Developmental Assets (external and internal) scales inspired by the research of the Search Institute (Scales, Benson, Leffert, & Blythe, 2000). Internal assets, representing the young

person's positive identity, positive values, commitment to learning, and social competencies, were of particular interest, as they have been shown to be consistent predictors of a variety of educational outcomes in several previous studies (Flynn & Tessier; 2011; Flynn, Tessier, & Coulombe, 2013; Tessier, 2014a). On these 20 items, child welfare worker rated the youth as possessing or not possessing each asset (for example: "… accepts to take personal responsibility").

T1 academic performance. Each young person's academic performance was rated on 4 separate items by their caregiver. Based on their knowledge of the youth's school work, the caregiver rated how the young person was doing in literacy (reading and other language arts [spelling, grammar, composition]), mathematics, science, and overall. The response options consisted of a 3-point scale (0 = Poorly or very poorly, 1 = Average, and 2 = Very well or well). In the AAR-C2-2010, the caregiver could also report that the youth does not take one of these subjects in school; however, as this response option was not available in the AAR-C2-2006, such these responses were coded as missing data.

T1 exact age. Similar to the gap-length variable, it became obvious that the young person's age reported by the child welfare worker sometimes varied from their actual age (for example, the youth may have had a reported age of 17 but an actual age of 15). Although this occurred in very few cases (the difference between the reported age and the true age was greater than 1 year in less than 0.02% of cases), and in order to obtain the most accurate information possible, the date that the T1 AAR interview was started was subtracted from each youth's birth date. If this date was absent, the date on which the T1 AAR was completed was used; if this second date was also absent, the date on which the T1 AAR was signed by a supervisor was

substituted. Finally, if this last date was missing, the age reported by the child welfare worker was accepted. The resulting values were expressed in years.

Gender. The child welfare worker reported the young person's gender. Responses were coded such that 1 represented females and 0 represented males.

3. Exact Gap Length as a Potential Moderator of the Predictor Variables

Prior to running our multiple imputation process to estimate missing values, eight multiplicative ("interaction") terms were formed as the product of the multiplication of two terms (i.e., AB = A X B; Aiken & West, 1991). Exact gap length was multiplied by each of the eight protective and risk predictors to form the statistical interaction terms (e.g.., exact gap length X soft drug use = interaction term for exact gap length and soft-drug use).

Data Analysis

Missing data and multiple imputation. Missing data were managed following the same procedures as described in Tessier (2014a) in study 1 of the present thesis. Appendix D presents the variables in the imputation model, including all the variables in the three regression models, and all interaction terms[19]. Following the recommendations presented in Tessier (2014a), as summarized from Graham (2012), a single multiple imputation model was constructed for all three regression models, as each model was based on the same sample of 512 young people. NORM 2.03 was used to complete the following steps: (1) the Expectation Maximization (EM) algorithm generated maximum likelihood parameters for estimates for our sample; (2) an initial

[19] Auxiliary terms were excluded for the sake of parsimony. Information is available upon request.

complete dataset was imputed using these EM parameters after convergence[20]; and, (3) Data augmentation (DA) and multiple imputation were used to generate 40 datasets. These 40 datasets were then combined using the MI Automate program and integrated into SPSS, version 22.0 (IBM Corp., 2013) in order to conduct our analyses. Our imputation model contained 20 variables (plus 5 auxiliary variables). The EM algorithm converged normally in 30 iterations. The variable with the highest percentage of missing data was T1 academic performance (22.85% missing). No cases were missing data on every variable.

Hierarchical regression analyses. The two outcomes expressed in terms of years of formal schooling, namely, the highest level of education attained and the highest level of education aspired to, were regressed on four successive blocks of variables (control factors, contextual factors, risk factors, and finally, protective factors) in separate hierarchical longitudinal regression models. The third outcome, the Non-NEET versus NEET dichotomy, was regressed, using sequential logistic regression, on the same four blocks as the hierarchical linear regressions. All analyses were conducted using SPSS 22.0 (IBM Corp., 2013).

Results and Discussion

Descriptive and Psychometric Results

Table 10 displays the means (or percentages for dichotomous variables), standard deviations, Cronbach's alphas, theoretical and observed ranges, and skewness for all of the study variables. Approximately 27.9% of the final, imputed sample scored 0 on the cognitive impairment scale, whereas only roughly 8.4% scored 4 and higher on this scale. At time 1, 324 (63.3%) of the young people resided in foster or kinship care; most of these (296, or 57.8% of

[20] As noted in Tessier (2014a), this initial dataset represents unbiased parameter point estimates that can be used for certain analyses, such as coefficient alpha analyses and to establish standardized betas in a regression equation (Graham, 2012). It is not suitable for hypotheses testing, however, as it may underestimate standard errors.

the total sample) were in foster care. Approximately half of the 188 young people in the "all others" category resided in group homes (n=98).

Post-imputation, 214 (41.8%) of the young people were considered "Non-users" of soft drugs at Time 1, with a fairly equal distribution amongst the other three categories (17.2% reported using 1 soft drug, 18.0% reported using 2 soft drugs, and 23.1% reported using 3 soft drugs). Interestingly, at Time 2, the percentage of non-users had fallen to approximately 23%, with 26.8%, 27.0%, and 23.1% using 1 soft drug, 2 soft drugs, and 3 soft drugs, respectively. The mean for time 2 internal developmental assets was 13.65 (*SD* = 4.85), an increase from time 1. The majority of the young people in CCSY-ECM had either completed Grade 11 (180, or 35.2%) or had acquired their high school diploma or equivalent (186, or 36.3%), although an important minority had completed only grade 10 or less (123, or 24.0%). Very few (23, or 4.5%) had completed any post-secondary education. Over half of the young people in CCSY-ECM aspired to some form of non-university post-secondary education (280, or 54.7%). Another 159, or 31.1%, aspired to one university degree or more. Lastly, approximately 73 (14.3%) young people aspired to a high school diploma or less.

Intercorrelations

Table 11 shows the intercorrelations of all the study variables. All of the predictors except T1 Exact Age were significantly correlated with the first outcome variable, educational attainment, and most were also significantly correlated with the young person's educational aspirations and NEET status. Interestingly, exact gap length, T1 exact age, and gender had the fewest significant correlations (3 and 4 out of 12, respectively). Measures of internal consistency were good for T1 behavioural problems, T1 academic performance, T1 Internal developmental assets, and for T1 soft drug use, but only moderate for T1 academically-related impairments.

Hierarchical Regression Models

Educational attainment. Table 12 shows that in the regression for educational attainment, each step in the model accounted for a statistically significant increment in the variance explained. The total amount of variance in T2 educational attainment accounted for by the predictors was 35.9%. The risk-factor block explained the largest proportion of variance attainment (ΔR^2= .148). At one or more steps in the model, all of the predictors except internal developmental assets and gender, added in the last step, were significantly associated with educational attainment. The relationship between T1 internal developmental assets and T2 educational attainment appeared to be mediated by T1 soft drug use. Gender did not predict educational attainment, despite previous positive results (e.g., Flynn & Tessier, 2011; Tessier, 2014a). The single strongest predictor was exact gap length (standardized beta (β) = .306), followed by T1 exact age (β = .200), T1 soft drug use (β = -.196), and T1 academic performance (β = .194). Academically-related impairments was a significant predictor when it was added in block 3, but did not remain so in the final model, once protective factors were accounted for. This is not surprising, considering the strong negative correlations this factor shared with both T1 internal developmental assets and T1 academic performance.

Youth educational aspirations. Table 13 shows that in the regression for T2 youth educational aspirations, statistically significant increments in the variance explained were observed only in the last three steps of the model. Exact gap length (in step 1) was thus unrelated (as a main effect) to young people's educational aspirations. The total amount of variance in T2 educational aspirations accounted for by the regression model was 15.8%. Once again, the block containing risk factors accounted for the largest increase in the variance accounted for (ΔR^2=.103). Relatively few predictors were associated with educational

aspirations at any step, with only placement type, academically-related impairments, and gender statistically significant predictors. Among these, only gender and academically-related impairments remained in the final model, suggesting some mediating effect by academically-related impairments on placement type. Overall, the strongest predictor in terms of effect size was academically-related impairments ($\beta = -.223$).

NEET status. Table 14 shows the results from the sequential logistic regression in which NEET/non-NEET dichotomy was the outcome variable. Although an imperfect measure of the proportion of variance explained, a *pseudo-*R^2 value suggested that our prediction model accounted for 17.9% of the variance in T2 NEET Status (Nagelkerkes' R^2=.179). Placement type was the only consistent predictor of whether the young person would be involved or not in education, employment, or training. This was a roust relationship, with the odds of being a NEET increasing by 51% if a young person was in the "all others" (rather than foster or kinship care) type of placement at time 1. Academically-related impairments was a statistically significant predictor of NEET status only before protective factors were included in the model, although with a *p*-value of .08, it remained predictive at the level of a trend. Most of the risk and protective factors had odds ratios that were very close to 1, suggesting little increase or decrease in the odds of being a NEET versus non-NEET based with related increases or decreases in these factors.

Exact Gap Length as a Moderator of the Predictor Variables

Overall, exact gap length was not a statistically significant moderator of any of the protective or risk factors in the prediction of T2 educational attainment. With T2 educational aspirations as the criterion variable, exact gap length significant moderated two predictors, T1 exact age and T1 soft drug use, and in the prediction of T2 NEET status, it significantly

moderated T1 placement type. It is important to note that any interpretation of the right-hand side of the graphs presented in the following sections (where gap length > ~2.7 years) must take into account the overall distribution of gap lengths (Figure 3). Approximately 70% of the study sample has gap lengths below the approximate point of convergence in two of the models (~2.7 years). At longer gap lengths, very few individuals are represented. About 10.5% of the sample had gap lengths over 3.5 years, even fewer had gap lengths over 4.0 years (less than 5%). Thus, interpretation of regression equations at these higher values of time gap may be misleading.

Exact gap length as a moderator in the prediction of T2 educational aspirations. The exact gap length-by-T1 exact age interaction term was statistically significant in predicting T2 educational aspirations ($\Delta F(1, 500) = 4.836$, $p = .028$). Figure 4 depicts this significant disordinal interaction. In order to facilitate the interpretation, T1 exact age was trichotomized into three categories[21]: a T1 younger group (1.0 SD below the mean, aged ~16.26 years and younger, shown with the dotted line), a T1 older group (1.0 SD above the mean, aged ~17.34 years and older, shown with the dashed line), and a mean age group (represented by the solid line). Figure 4 shows that at short time gaps between assessments of T1 and T2, younger age is predictive of higher academic aspirations and older age predicts lower academic aspirations. This difference can be intuitively understood: younger individuals at Time 1 may still be naïve about their true capacities in the short term, and may aspire to unrealistically high academic achievement. Older youth at Time 1, though, may be more experienced and thus demonstrate more tempered educational aspirations when measured in the near future (e.g., 6-months or a year). The relationship between T1 exact age and T2 academic aspirations decreases as time gaps between assessments approach 3.0 years. After this point, Figure 4 seems to indicate that

[21] *n = 107 (20.9%); 308 (60.2%); and 97 (28.9%) for each of these categories, respectively.*

the inverse relationship is present, where older age at Time 1 predicts higher academic aspirations at Time 2 – although any interpretations after the point of convergence are speculative.

The interaction of Exact Gap Length X T1 Soft Drug Use was a statistically significant predictor of T2 Educational Aspirations [N=512; *F change* (1, 500) = 9.686, *p* =.002]. Figure 5 displays the plot lines for each of the T1 soft-drug use groups as they relate to the predicted values of T2 educational aspirations. The nature of this disordinal interaction is easier to interpret: Each increase in T1 soft-drug use (from using no soft drugs to using 3 soft drugs) reduces ratings of T2 educational aspirations, when the gap length between assessments ranges from 6 months to roughly 3.5 years. This relationship appears to weaken as more time is permitted to pass between assessment periods. As before, interpreting any relationship past roughly 2.7 years from our data may be misleading.

Time Gap Moderating Prediction of T2 NEET Status. The ordinal interaction of Exact Gap Length X T1 Placement Type was statistically significant predictor of T2 NEET Status [$\chi 2$ (1) = 4.844, p = .028]. Figure 6 provides a visual representation of this interaction, where young people either in familial-type placement settings (foster & kinship care) or all other types of placements related to predicted probabilities of T2 NEET Status (y-axis). In short time gaps between assessments, being in an familial-type placements appears to be nearly unrelated to T2 NEET status, whereas the odds of being a NEET at Time 2 appears to remain stable over all time gaps for those young people residing in "other" placement types at Time 1. Over longer periods of time, it appears that the risk of being a NEET at time 2 increases steadily for longer inter-measurement times, until a point where familial-type settings vs. "other" placement types

converge and essential share the same degree of predictive risk of T2 NEET status, although interpretation at this extremely long time gap between T1 and T2 may be misleading.

Discussion

The present study was conducted in order to test the lag as moderator (LAM) concept recommended by Selig (2009) and Selig *et al.* (2012) in order to gauge the potential impact that the variable nature of the *true* time-lapse between OnLAC annual assessments might have on our ability to detect differences. This is the first time that this method (LAM) is used in longitudinal research in child welfare. The most surprising finding from this study is that for 21 out of the 24 (87.5%) LAM tests conducted, gap length (or lag) was shown to have no statistically significant moderator effect on predictors of three separate educational and employment outcomes. This suggest that for data collected through the OnLAC project on children in care, even under conditions when the data are manipulated in order to maximize the gap between assessment points, most predictors are not seriously altered by varying the length of time between assessments from 6 months up to several years.

Nevertheless, it is still worth attending to the three variables that were found to have their relationship with educational outcomes be moderated by the intervening period of time between evaluations. From our findings, we can infer that when attempting to explore the relationship between T1 age and/or T1 soft-drug use and educational outcomes measures sometime later, additional steps should be taken in order to adequately measure the length of time and incorporate this measure of gap length in the planned data collection. Similar, a measurement of the time lag between measurement periods should be considered when trying to predict T2 NEET status from T1 Placement Type. As a more tentative interpretation, these findings may suggest that whatever benefit or additional risk to educational outcomes is provided by being

younger, using a great number of soft-drugs, or being housed in a group home at one time may dissipate the greater the length of time since the young person has transitioned out of that setting. In this way, these results can be cautiously interpreted as being a hopeful sign for those young people in care who are currently using a greater number of soft-drugs or housed in group homes.

Regarding our other hypotheses, seven of our eight protective and risk factors were statistically significant predictors of educational attainment at any time in the regression equation, and 5/8 remained statistically significant predictors in the final model, when all factors were included. When predicting educational aspirations, 3 of 8 selected protective and risk were statistically significant at any point and two remained in the final model, whereas these numbers were only 2/8 and 1/8 when predicting NEET status. These findings are consistent with Flynn & Tessier's (2011) study, and these findings continue to provide good evidence for an overall model predicting better educational outcomes for children in care. Particularly, educational attainment remains the outcome that is most associated with the selected predictors, possibly because this variable is a more objective outcome compared to educational aspirations. Unlike the findings of Flynn & Tessier (2011) internal developmental assets was not a consistent predictor of all three outcomes. This may be because Flynn & Tessier used the combined external and internal developmental assets in their study, whereas we restricted our scale to solely the internal developmental assets. Another possibility may be collinearity between internal developmental assets and several other predictors (for instance, several have correlations with internal developmental assets of $r > .3$)

Placement type was a statistically significant predictor of educational attainment and NEET status, but was only a statistically significant predictor prior to the inclusion of the risk and protective factors for educational aspirations. Placement type and academic performance, in

fact, share similar standardized betas in the final model with gender, a factor that was found to be a predictor of educational aspirations. This is different from the hierarchical regression on educational attainment, where the standardized betas roughly match the factors found to be statistically significant predictors. It is important that we note, though, that the interpretation of these standardized betas can be misleading: these results may be artefacts of the multiple imputation process (i.e., a single imputation) and the more stringent results, taken from the pooled results of the 40 multiply-imputed datasets, are more trustworthy and these are what determines what factors are deemed statistically significant (Graham *et al.,* 2007).

Another factor, academically-related impairments, was also found to be a statistically significant predictor for not only educational attainment and aspirations in their final regression models, but also for NEET status prior to the inclusion of the protective factor block. Again, this may be due to some collinearity between the academically-related impairments variable and (1) academic performance (r = -.326) and/or (2) internal developmental assets (r = -.357).

This study adds to the knowledge base discussed at length in study 1 (Tessier, 2014a), presenting complementary findings for conceptually related predictors and different educational achievement outcomes than used by Tessier (2014a). Lastly, the preliminary findings identified in this study suggest that more fine-grain statistical methods, perhaps through trajectory analysis, could be useful in clarifying the path of certain predictors of educational outcomes over time.

Limitations

This study had a number of important limitations. The non-mandatory implementation of the AAR to CCSY youth meant that it was impossible to ensure that the study sample was a true representation of all CCSY youth in Ontario and even more difficult to verify how reflective this

sample was of youth transition out of care in Ontario, in general (i.e., non-CCSY youth transitioning into independent living). As we further limited our pool of potential participants to those with at least two assessments spanning the study period, this may have also introduced certain unknown biases.

The data analysed for this research was not intended for use as a lag-related longitudinal dataset. Not only are we reliant on secondary date intended for institutional use, but this kind of post-hoc application of theory led to unavoidable comprises on the quality of certain variables. For example, although exact gap length and exact age can boast being calculated from raw variable (e.g., birthdates and signature dates), practical considerations such as dates not being available, or mistranscribed, made for imperfect variables. Moreover, if the study had been planned as a test of variable lags between assessments, the overall distribution of time lag could have been more normally distributed, offering more confidence in interpreting any statistically significant moderation effects. Lastly, Selig (2009) and Selig and colleagues (2011) note that studies using LAM are still in their developmental stage and it is unclear yet what the overall impact of these studies might be. In this context, it is important not to overestimate the importance of this study employing this methodological approach.

Study 3: A Pilot 12-Month Follow-up Study of Crown Ward Transitions: Comparison with Young People in the General Population

In 2011, several Children's Aid Societies (CASs) in a region of Ontario combined their resources to fund a study of the transition experiences of Crown Wards in their care. The CAS wanted to know how their Crown Wards were faring in their transitions and to use this knowledge to enhance their clinical practices and organizational policies. Crown Wards[22] are children or adolescents who, in the judgment of an Ontario court, must be taken under the responsibility of the province for their protection. Crown Wards are placed in the care of a local Children's Aid Society (CAS), one of 46 that cover the province as providers of mandated child-protection services. CASs act *in loco parentis* for the young people in their care, as stipulated in the Ontario Child and Family Services Act (Article 63. (1)): "the Crown has the rights and responsibilities of a parent for the purpose of the child's care, custody and control and has the right to give or refuse consent to medical treatment for the child where a parent's consent would otherwise be required, and the Crown's powers, duties and obligations in respect of the child ..... shall be exercised and performed by the society caring for the child."

In Ontario, the provision of support services by a CAS ends on the young person's 18th birthday, unless they sign an agreement with the CAS to enter its Continued Care and Support for Youth (CCSY) program. This transitional living program provides emotional, residential, and financial support for the young person up to the age of 21 if he or she agrees to focus on certain goals, such as completing high school and acquiring a secondary school diploma, enrolling in post-secondary education, in a university, college, or apprenticeship program, or entering paid employment (Flynn & Tessier, 2011). Some local CASs in Ontario provide CCSY

[22] Defined in the Child and Family Services Act of Ontario (Article 57. (1)).

services to young people who are older than 21, even though such support is usually intended to end upon the youth's 21st birthday (MCYS, 2011).

Supported transition living programs are intended to help youth in care to navigate the challenges of moving from adolescence to independent adulthood. Although the literature on transitions within and from care is sparse in Canada, previous research suggests that Canadian youth leaving care experience the same kinds of difficulties as those in other countries (Flynn & Vincent, 2008). As many as 6,000 young people exit care each year in Canada due to "aging out," that is, reaching the legal age at which public care is terminated (Mann-Feder, 2011). This sudden change in status can be difficult, when we consider that these youth often to do not have the benefit of the emotional, social, and financial assistance that is typically available to their age peers in the general population (Dunkoh, Underhill, and Montgomery, 2006). In North America, young people exiting care, compared to individuals of their age in the general population, are frequently more at risk of being homeless, living in poverty, relying primarily on public assistance, being involved in the criminal justice system, being unemployed or underemployed, and experiencing difficulties with substance use and abuse (Beaupré & Flynn, 2014; Courtney, Dworksy, Lee, & Raap, 2010; Courtney, Flynn, & Beaupré, 2013; Mann-Feder, 2011; McEwan-Morris, 2006; Rutman, Hubberstey, & Feduniw, 2007; Tweedle, 2005). Youths transitioning out of care also have lower levels of educational attainment, are more likely to be parents at a young age, and are at greater risk of being victimized (Mann-Feder, 2011).

Flynn and Vincent (2006) interpreted the results of the relatively few Canadian studies of transition as indicating that many youth in care in Canada appear to experience the same kind of problematic transitions just mentioned. As Stein (2006) has found in the UK, transitions among Canadian people in care are compressed into a shorter time period and, as a result, are often more

hurried and less successful, compared with those of the transitions of young people of the same age in the general population. Beaupré and Flynn (2014) found, in their review of the Canadian literature on transitions, that care leavers in Canada are more likely than young people in the general population to have lower educational attainment, greater reliance on social assistance as a main source of income, more fragile social support networks, increased risk of housing instability, and greater involvement in the criminal justice system. Flynn and Vincent (2008), like the CWOERG (2010), suggested that prospective studies are needed to compare the transition trajectories of youths in the child welfare system with those of their age peers in the general Canadian population.

Types of Transition

As mentioned earlier, in the present research--one of the first prospective studies of transitions in child welfare in Canada – we wanted to study prospectively the transition process among Crown Wards to help our four partner CASs improve their clinical practices and organizational policies. Rather than limiting ourselves to care leavers, however, as almost all previous transition research has done in child welfare, we decided to also include young people who were about to make (or who had very recently made) transitions while still remaining *within* the care system, under the supervision of their local CAS. We conceptualized transition as consisting of six different types (Beaupré & Flynn, 2014): (1) Leaving the child welfare system entirely; (2) Going home on a trial basis, usually to the family of origin, but with the CAS file remaining open to permit an easy return to care if such became necessary; (3) Remaining in the same living situation in order to start a post-secondary education program, while continuing to receive support from the local CAS; (4) Moving to a different living situation, to start post-secondary education, while continuing to receive support from the local CAS; (5) Moving to independent

living, while continuing to receive support from the local CAS; and (6) Starting full-time work, while either moving to a different living situation or else remaining in the same one and continuing to receive support from the local CAS.

Study Objectives

We had two objectives in conducting this pilot, small-sample research, one of the first prospective follow-up studies to have been carried out in Canada to date. The primary objective was to compare the background characteristics and outcomes – in the areas of education, mental health, and soft-drug use – of our sample of Crown Wards to their age peers in the general population. Specifically, how did the young people in transition within or from the four CASs compare in terms of background characteristics and outcomes to young people of roughly the same age in the general population? The secondary objective was to examine the extent to which variables assessed in wave one of the study, conducted just before or just after the point of transition, allowed us to predict how well the Crown Wards would be faring on the educational, mental health, and soft-drug outcomes 12 months later, at wave 2.

Working Hypothesis

In relation to the primary study objective, and basing ourselves on the literature reviewed earlier, we formulated the working hypothesis that our small sample of 39 Crown Wards would fare relatively poorly compared with their age peers in the general population, both in terms of their background characteristics and in terms of their educational, mental, and soft drug-related outcomes (Blome, 1997; Buehler, Orme, Post, & Paterson, 2000; Cheesbrough, 2002; Dregan, Brown, & Armstrong, 2011; Harris, Jackson, O'Brien, & Pecora, 2009; Jackson, 2013; O'Higgins, Sebba, & Gardner, 2014). It was understood that any such comparisons would of necessity be only approximate, at best, as there would inevitably many uncontrolled differences

between our sample and youths of roughly the same age in the general population. In relation to the secondary objective, we explored the ability of selected wave 1 variables to predict the wave 2 educational, mental health, and soft-drug outcomes, assessed 12 months later.

Method

Participants

The follow-up sample consisted of 39 Crown Wards who were interviewed at wave 2 of the larger study on which the present was based (Beaupré & Flynn, 2014). These 39 participants accounted for 81% of the 48 originally interviewed 12 months earlier during wave 1 of the larger study, close to the point of transition. The 9 attriters between waves 1 and 2 were either unreachable or withdrew their consent. Of the 39 participants, 29 (74.4%) were females and 10 (25.6% were males. The mean age of the sample was 20.2 years old (SD = 1.6). The majority of the participants reported their ethnicity as Caucasian (79.5%), with First Nations, Métis, or Inuit youth representing the next largest ethnic group (12.82%). Nineteen of the 39 participants (48.7%) said that they had left care as of wave 2. Of the 20 still in care at wave 2, 19 (48.7%) were in the transitional living (i.e., CCSY) program.

Instrument

The structured interview schedule used at the 12-month follow-up (wave 2) was adapted from the wave 1 instrument, with an important change: as many measures as possible in the wave-2 interview schedule were taken from the Canadian Community Health Survey (CCHS; Statistics Canada, 2012), to permit normative comparisons. The main normative comparison group consisted of CCHS-12 respondents from the general population who were in the same age category and from the same region of Ontario as the 39 Crown Wards participants. When this

comparison group did not yield the necessary comparative information, we used a larger CCHS-2012 comparison group from the same age category and from the Ontario population as a whole. Some other questions were also adapted from the Assessment and Action Record from Looking after Children (Flynn, Vincent, & Legault, 2009). The English version of the wave-2 structured interview schedule can be found in Appendix E.

Measures

Demographic factors. Ten demographic factors were assessed at wave 2, mainly with dichotomous measures: age (in years); gender (1 = female; 0 = male); ethnicity (1 = white; 0 = other); in-care status (1 = exited care; 0 = still in care); marital status (1 = single, never married; 0 = married or common law[23]); being a parent (1 = yes; 0 = no); having an ADHD (attention deficit, hyperactivity disorder) diagnosis (1 = yes; 0 = no); having a learning disability diagnosis, (1 = yes; 0 = no); having a developmental disability diagnosis (1 = Yes; 0 = No); and (for females), having been pregnant in the last year (1 = yes; 0 = no).

Soft-drug use. Five variables were measures of soft drug-related behaviours: marijuana use in the last 12 months (1 = yes; 0 = no); being a cigarette smoker (1 = yes; 0 = no); the number of cigarettes smoked per day (for smokers only); the frequency of alcohol consumptions (1 = not at all, 4 = daily); and a measure of binge drinking (defined as having five or more drinks on one occasion, with 1 = never to 6 = more than once a week). A soft-drug use scale

Mental health and well-being. Two measures of mental health and well-being were used: a positive mental health scale and a perceived-distress scale.

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[23] Living "common-law" is a term used in Canada to refer to cohabitating and living in a conjugal relationship with an individual who is not your spouse (a term reserved for married partners) for a period of at-least 12 continuous months (Canada Revenue Agency, 2014).

Positive mental health scale. During the wave-2 telephone interview, the young person responded to 14 items from the Mental Health Continuum-Short Form (MHC-SF; Keyes, 2002), which was also employed in the CCHS-2012 (Statistics Canada). Higher scores on the MHC-SF have been found to predict lower overall mortality (Keyes & Simoes, 2012), lower levels of suicidal behaviour (Keyes *et al.*, 2012), higher academic performance (Keyes *et al.*, 2012), and a lower risk of future stress-related depressive episodes (Grant, Guille, & Sen, 2013). The young person answers 14 items on a 6-point scale (0 = never, 5 = every day), such as "During the past month, how often did you feel good at managing the responsibilities of your daily life?" These 14 items were summed to create an overall positive mental health score.

Perceived Distress Scale. The K10 version of this scale was developed from an original pool of 612 items drawn from a variety of depression and distress assessment tool (Kessler *et al.*, 2002). The 6 and 10 question forms have previously shown good effectiveness in measuring non-specific distress (Furukawa *et al.,* 2003). This scale was taken from the CCHS (Statistics Canada, 2012) and integrated into the wave-2 structured interview schedule. Each young person was asked how frequently they experienced 10 symptoms of distress, such as, "How often did you feel sad of depressed?" Responses are assessed with a 6-point scale ranging from 0 = none of the time to 5 = all of the time.

Education and employment. The measure of educational attainment was modeled after the question in the AAR interview. Each youth was asked what the highest certificate, diploma, or degree that he or she has completed to date. A list of seven options was presented, from the lowest (less than high school or its equivalent) to the highest (a university certificate, diploma, or degree above the bachelor's level). The young person's educational aspirations were measured in a similar fashion, asking him or her how far he or she would like they go, if they could go as

far as they wanted. The same list of response options was presented as for the educational attainment question. Lastly, three dichotomous items asked whether the young person was currently in school (1 = yes; 0 = no), in training or coop for school or work (1 = yes; 0 = no), and if they were currently employed (1 = yes; 0 = no). From the answers provided on these three questions, NEET Status was derived (NEET means Not in education, employment, or training; 1 = NEET; 0 = Non-NEET).

Data Analysis

Comparisons in Terms of Standardized Mean Differences (Cohen's *d*). Drawing on the literature presented earlier and from the findings of the two studies presented as part of this thesis (Tessier, 2014a; Tessier, 2014b), a limited set of variables was selected on which to compare the responses of the 39 Crown Ward participants with the responses of 164 members of the CCHS-2012 general-population sample who lived in the same region of the Ontario as the 39 Crown Wards. When this CCHs-2012 subgroup did not furnish the needed comparative data, we sought it in the responses of 894 CCHS-2012 sample members who lived in Ontario as a whole.

It is understood that the normative comparisons we made between the 39 Crown Wards and the 164 (or 894) members of the general-population samples from the CCHS-2012 were only approximate, with no attempt to provide an individually matched normative comparison group. We made simple comparisons between our sample of 39 Crown Wards and the larger CCHS-2012 comparison groups from the same region of Ontario or, when necessary, from Ontario as a whole. This permitted a rough comparison of how the Crown Wards were faring.

On selected demographic variables, learning-related health conditions, and educational, mental health, and soft drug-related outcome variables, we used Wilson's Practical Meta-

Analysis Effect Size Calculator (Wilson, 2014), available on the Campbell Collaboration website, to calculate standardized mean differences and 95% confidence intervals that allowed comparisons to be made between the Crown Ward and CCHS-2012 samples, expressed in the form of Cohen's *d*. In these approximate comparisons between the Crown Wards and representative samples from the general population, from either the same geographic area of the province or from the province as a whole, means and standard deviations for continuous variables and binary proportions for dichotomous variables, were used to calculate Cohen's *d*s.

Correlations

Our secondary objective was to explore the extent to which variables assessed at wave 1, near the point of transition, would allow us to predict the care status and educational, mental health, and soft-drug outcomes at the 12-month follow-up assessment among the 39 Crown Wards. We used Spearman rho correlation coefficients in these analyses because they are less susceptible than Pearson correlation coefficients to distortion in small samples due to extreme values (outliers). The Spearman coefficients were also useful in analyses involving several non-normally distributed variables in our Crown Ward sample, including T2 binge drinking.

Results and Discussion

Normative Comparisons between the Crown Ward and CCHS-2012 Samples

Table 15 displays the comparisons we made between the study 3 sample of 39 Crown Wards and the CCHS-2012 samples. Of 18 comparisons involving the CCHS-2012, 15 were made with the local general-population sample drawn from the same region of Ontario as the Crown Wards (maximum $N = 164$), and 3 were made with the Ontario-wide general-population sample (maximum $N = 984$). In terms of their respective background characteristics and

learning-related health conditions, the Crown Ward and CCHS-2012 samples were quite different, confirming that any comparisons of outcomes could only be very approximate because of the important uncontrolled differences between the samples.

Compared with the CCHS-2012 sample in question, the Crown Wards were found to be statistically younger, composed of a significantly higher proportion of females, of similar ethnic composition, significantly more likely to be married or in a common-law relationship, and significantly more likely to include female members who had been pregnant within the last year. Regarding learning-related characteristics, the Crown Wards were also markedly different from the CCHS-2012 Ontario general-population sample, with much higher proportions of participants who had ADHD or learning-disability health conditions (all findings at $p < .05$). Nonetheless, our study mirrored the findings of previous studies (e.g., Beaupré & Flynn, 2014; Courtney, Dworksy, Lee, & Raap, 2010; Courtney, Flynn, & Beaupré, 2013; Mann-Feder, 2011; McEwan-Morris, 2006; Rutman, Hubberstey, & Feduniw, 2007; Tweedle, 2005) – essentially, the Crown Wards in our study were found to be at greater risk and to have poorer outcomes (particularly in the areas of mental health and educational attainment) when compared to youth in the general population from their geographical area.

With respect to educational outcomes, the Crown Wards had a lower level of educational attainment, were no more or less likely to be enrolled in school, were much less likely to be employed and much more likely not to be enrolled in education or employed. In terms of mental health outcomes, the Crown Wards had a lower mean level of positive mental health and a much higher score on a measure of distress. Finally, with regard to soft drug-related outcomes, the Crown Wards were more likely to have used marijuana in the last year, more likely to be

cigarette smokers, smokers of more cigarettes per day (among daily smokers), lower consumers of alcohol, and no greater or lesser likelihood of being binge drinkers.

Predicting Wave 2 Follow-up Outcomes from Wave 1 Variables

Table 16 shows the association (Spearman correlation coefficients) between selected Time 1 predictors and Time 2 outcomes. T1 age was, not surprisingly, a good predictor of whether the Crown Ward was still in care or not at the 12-moth follow-up, as well as of T2 educational attainment. Older Crown Wards as of T1 also tended to have more positive T2 mental health and less frequent T2 use of cigarettes or marijuana. Surprisingly, gender was unrelated to T2 educational outcomes, and females had lower T2 mental health but less frequent T2 cigarette smoking or binge drinking. Greater T1 behavioural difficulties (as measured by the Total Difficulties scale of the SDQ) was associated with lower T2 educational attainment, less positive T2 mental health, and more frequent T2 smoking of marijuana. A greater number of T1 internal developmental assets predicted higher T2 educational attainment, higher T2 educational aspirations, and, surprisingly, greater T2 binge drinking. More frequent T1 cigarette smoking was associated with lower T2 educational attainment, less positive T2 mental health, more frequent T2 cigarette smoking, and more frequent T2 marijuana smoking. More frequent T1 alcohol use was, perhaps surprisingly, associated with a lower likelihood of T2 NEET status and a lower level of T2 distress. Finally, more frequent T1 marijuana use predicted more frequent T2 marijuana use and a higher level of binge drinking.

Discussion

The significance of the results of the present study may be stated fairly succinctly. It will be recalled that our primary objective was to compare a sample of 39 Crown Wards with general population samples drawn from the CCHS-2012, in terms of their background characteristics,

learning-related health conditions, and educational, mental health, and soft drug-related outcomes. Based on the literature on transitions in child welfare, we formulated the working hypothesis that our sample of Crown Wards would be found to have fared rather poorly, compared with their age peers in the general population, on all counts. It was understood that such comparisons would of necessity be approximate, as many uncontrolled differences would probably exist between our sample of Crown Wards and youths of approximately the same age in the general population.

The findings provide strong support for our working hypothesis and are in line with what many transition researchers have previously found, both in the UK (Dunkoh, Underhill, and Montgomery, 2006) and in North America (Beaupré & Flynn, 2014; Courtney, Dworksy, Lee, & Raap, 2010; Courtney, Flynn, & Beaupré, 2013; Mann-Feder, 2011; McEwan-Morris, 2006; Rutman, Hubberstey, & Feduniw, 2007; Tweedle; 2005). Overall, a recurring portrait from these studies has emerged, found in our own small sample as well: young people in transitions, compared to children or youths of their age in the general population, are often at greater risk of homelessness, poverty, public assistance, involvement in the criminal justice system, unemployment or underemployment, and difficulties with substance use. Youths in transition also tend to have lower levels of educational attainment, are more likely to be parents at a young age, and are at greater risk of being victimized (Mann-Feder, 2011).

Our sample was exposed to greater risks than their general-population peers to their longer-term development, in that a higher proportion were engaged in marital or common-law relationships, no doubt contributing to a considerably higher probability of pregnancy in the females in the sample. Also, our Crown Wards were coping with much higher rates of ADHD and learning disabilities, the result in part of what were doubtless higher rates of maltreatment

and trauma at a young age. Related to these formidable obstacles to successful transitions, the Crown Wards had lower educational attainment and were less likely to be in either education or employment. They also had a lower average level of positive mental health and a much higher level of distress. Finally, rates of cigarette smoking and marijuana consumption were higher among the Crown Wards.

Regarding the second objective of the study, a number of robust correlations were observed between variables assessed when the young person was about to undergo, or had recently undergone, an important transition and variables evaluated at the 12-month follow-up. It was interesting that age appeared to function as an important protective factor, with older youths more likely to have left the care system and to have experienced greater educational attainments, more positive mental health, and less use of cigarettes and marijuana. Gender, on the other hand, did not display its expected protective role vis-à-vis educational outcomes, and females had less positive mental health, although they also had lower rates of cigarette smoking and binge drinking. The existence of behavioural difficulties at the time of transition appeared to pose a significant obstacle to successful outcomes at follow-up, in terms of educational attainment, positive mental health, and marijuana smoking. Internal developmental assets, finally, emerged as particularly important for better educational outcomes.

The fact that youth who had greater behavioural difficulties at Time 1 were associated with lower scores in educational attainment, less positive mental health, and more frequent use of marijuana at Time 2 is not surprising. Nevertheless, these links are important. These results provide a key to gaining a broader understanding of what these behavioural difficulties are, what might underlie their expression, and how we might formulate effective interventions for reducing them. Further and more in-depth study, perhaps through strategies such as trajectory analysis or

latent class analysis, might afford greater insight into the progressive role that these and other factors might play and what their full impact might be.

In conclusion, this pilot study achieved reasonable success in meeting its two main objectives and has laid the groundwork for a larger-scale study of transitions within and from the child welfare system. A much larger sample of Crown Wards would permit sophisticated methods of constructing a much better comparison group of young people from the general population, using the CCHS-2012 and other CCHS cycles. Finally, our sobering results call for much greater investment in interventions aimed at improving the prospects of youth preparing for or undergoing key transitions. Targeted interventions intended to reduce externalising behaviours (including soft-drug use) and encouraging Crown Wards to utilize more adaptive coping strategies might prove fruitful strategies, given the results of the present study.

General Discussion, Contributions, and Implications for Future Research

In this section of the dissertation, I will focus on what the results and findings of these three studies signify regarding the larger picture of research on educational and employment outcomes for young people who are undergoing major transitions within or from the child welfare system in Canada, advances made towards the formulation of a cohesive model of risk and protective factors that can be used to predict these outcomes, and specifically, the methodological *firsts* for the field of child welfare and transition research that are the result of these three studies.

Study 1of this doctoral dissertation presented the first empirical test of a model of risk and protective factors associated with educational achievement resulting for a systematic review of the literature (O'Higgins, Sebba, & Gardner, 2014). This systematic review and subsequent empirical test in both a very large (and therefore possessing enough statistical power to detect even the smallest effect sizes from a large number of predictors) represent a step forward for the field of child welfare research. Supporting evidence for twelve of the twenty factors identified by O'Higgins revealed in the broad cross-sectional study, and for the four factors that were found to predict change in academic success over a longitudinal timeframe suggest we are on the right track.

The implementation of a sophisticated method for managing missing data in a systematic and statistically modern fashion, based on the work of Graham (2012), also represents an advance for the field. The successful application of this method to Study 1 and Study 2 will hopefully inspire other researchers to look at the issue of missing data, and frequent use of list-wise deletion or other, less-desirable, methods of imputing missing data, more seriously. Moreover, for studies utilizing large-scale samples, such as is the case with studies utilizing data

from the OnLAC project, following the method described herein would allow for an incredible increase in statistical power. This is mainly because for large-scale data collection, as noted in study 1, low levels of missing data on several variables can lead to large swaths of individuals being excluded as part of listwise deletion methods – often with unknown consequences in terms of introduced biases.

Study 2 of this doctoral dissertation presented the first application of the lag-as-moderator statistical and methodological issue to the field of child welfare longitudinal research. The OnLAC project provided a unique opportunity to test the concept that the time gap between data collection could have a strong influence on our capacity to detect differences, properly predict outcomes, and draw plausible and correct conclusions from the data collected. Results from this thorough methodological study of gap length over six years of OnLAC data were encouraging: 87.5% of the predictors tested for statistical moderation effects by the length of time between assessments were shown to be stable predictors across all gaps (i.e., no moderation by gap length effect). When three predictors where moderation effects by gap length between measurements were found, a new understanding of the mechanisms at play that determine the relationship between these predictors (namely, placement type, age, and soft drug use) and our educational outcomes was developed. Likewise, these results highlight the critical importance of taking into account the length of time between assessments, and of their variability in practice (rather than considering them to be as static as planned).

Additionally, when taken into the context of the systematic review conducted by O'Higgins, Sebba, and Gardner (2014), results from this study both broaden and deepen our understanding of what factors predict the overarching conceptual factor of educational achievement, but also in what conditions. In other words, the role of timing in longitudinal study

data collection on the strength of predictors; the role of gender is mediating some of the relationship between predictors and outcomes; and, what differential relationships might exist between similar risk and protective factors and five different methods of operationalizing the concept of educational achievement (Study 1: academic success at T1 and changes in academic success at T2; in study 2, educational attainment, educational aspirations, and NEET status).

Finally, Study 3 of the current doctoral dissertation presented the first prospective study of young people in care in Canada. Furthermore, this study is the first to examine approximate comparisons with data drawn from regional norms reflective of the specific area where these youth life. This pilot study explored what factors differed for these youth, on the cusp of major transitions within or from care, when approximately comparing them to their locally-drawn age-peers. This simple comparative exercise, particularly appropriate for a study with a small sample size, provided additional support for large studies conducted on much larger samples of youth in care, and once again, provided additional incremental validity to the model of risk and protective factor tendered by O'Higgins, Sebba, and Gardner (2014) in their systematic review.

Taken together, these three studies have made great strides towards formalizing a list of risk and protective predictors of educational outcomes (namely, academic success, educational attainment, educational aspirations, and NEET[24] status) originally selected from a systematic review that identified a range of factors found in the literature to be associated with educational outcomes for youth in care (O'Higgins, Sebba, and Gardner; 2014). From here, future research should focus on testing additional ways of operationalizing the risk and protective predictor factors, as well as the educational achievement outcomes, identified by O'Higgins, Sebba, and

[24] Not in Education, Employment, or Training

Gardner (2014), as we are on the path towards meeting that initial challenge set by Courtney, Dworsky, Cusick, Havlicek, Perez, and Keller (2007) and determining what factors predict more promising pathways to adulthood and what risk factors might predict more difficult trajectories. Additionally, continued investment by researchers in developing and implementing new statistical methods and methodological approaches, such as applying the lag-as-moderator (LAM) methods inspired by Selig (2009), implementing proper missing data management strategies as suggested by Graham (2012), as well as by authors in disseminating exemplars when these methods are successfully implemented, is recommended.

Limitations

The current doctoral dissertation has several important limitations. First, in each study, we were often restricted in our choice of how to operationalize certain conceptual frameworks, scales, or comparisons due to the nature of our instruments (e.g., the AAR interview for studies 1 and 2; the format of the questions and what questions were available in the CCHS (2012)) and the nature of secondary data use. This may have led to imperfect operationalizing of certain concepts that would be best measured using altogether different tools/scales (e.g., In study 1, suicide risk scale as the sole measure of mental health difficulties). Second, the incredibly complex and laborious process of combining the six separate waves of data spanning seven years, two revisions of the tools, and six age-specific versions for study 2 may have introduced an unknown amount of bias into the data.

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Tables

Table 1. Predictors of educational success, grouped into contextual risk, individual risk, contextual protective, and individual protective categories

	Contextual Factors	**Individual Factors**
Risk Factors *associated with lower educational outcomes*	Age of First Entry into Care Reason for Entry: Neglect School Instability Caregiver Instability Grade Retention	Exact Age (in years) Academically-related impairments Ethnic Minority Status: FNMI Ethnic Minority Status: Black Behavioural Problems Soft Drug Use Suicide Risk
Protective Factors *associated with higher educational outcomes*	Caregiver Educational Aspirations Placement Type Time with current caregiver	Individual Protective Factors Internal Developmental Assets Gender Positive Mental Health Youth Educational Aspirations

Table 2. Means (or percentages), standard deviations, Cronbach's alphas, theoretical range, and skewness statistics for study variables

	Cross-Sectional Sample (N = 3,662)					Longitudinal Subsample (n = 962)				
Variable	Mean (or %)	*SD*	Cronbach's alpha	Theoretical Range*	Skewness	Mean (or %)	*SD*	Cronbach's alpha	Theoretical Range*	Skewness
Outcome										
T1 Academic Success (*T*-score)	50	10	0.80	22 – 72	-.189	50.00	10.00	0.79	22 – 72	-.165
T2 Academic Success (*T*-score)	--	--	--	--	--	41.62	11.11	0.82	7 – 65	-.355
Contextual Risk Factors										
Age of First Entry into Care	7.99	4.14	--	0 – 17	-.019	6.17	3.33	--	0 – 17	.114
Reason for Entry: Neglect (1 = Yes; 0 = No)	61.5 %	--	--	0 – 1	-.473	71.6 %	--	--	0 – 1	--
T1 School Instability	1.94	1.16	--	0 – 4	-.053	1.75	1.12	--	0 – 4	.080
T1 Caregiver Instability †a	0.69	0.22	--	0 – 2	-.084	0.67	0.22	--	0 – 2	-.222
T1 Grade Retention (1 = Repeat; 0 = No)	15.0 %	--	--	0 – 1	1.877	12.1 %	--	--	0 – 1	--
Individual Risk Factors										
Exact Age (in years)	15.10	1.61	--	11.51 – 17.99	-.205	13.51	0.86	--	11.69 – 15.83	-.002
T1 Academically-related Impairments	1.98	1.57	0.53	0 – 9	.599	2.16	1.65	0.56	0 – 9	.505
Ethnic Minority Status: FNMI (1 = Yes; 0 = No)	17.7 %	--	--	0 – 1	1.594	19.5 %	--	--	0 – 1	--
Ethnic Minority Status: Black (1 = Yes; 0 = No)	11.2 %	--	--	0 – 1	2.441	10.4 %	--	--	0 – 1	--
T1 Behavioural Problems	12.64	7.37	0.87	0 – 40	.371	13.08	7.50	0.86	0 – 40	.351
T1 Soft Drug Use (1 = User; 0 = Non-User)	55.8 %	--	--	0 – 1	-.220	18.7 %	--	--	0 – 1	--
T1 Suicide Risk (1 = Yes; 0 = No)	19.3 %	--	--	0 – 1	1.491	13.9 %	--	--	0 – 1	--
Contextual Protective Factors										
T1 Caregiver Educational Aspirations	14.03	1.55	--	9 – 18	.495	14.16	1.61	--	9 – 18	.349
T1 Placement Type (1 = Kinship & Foster care; 0 = Group)	80.2 %	--	--	0 – 1	-1.501	86.9 %	--	--	0 – 1	--
T1 Time with current caregiver †b	1.72	0.91	--	0 – 4.12	.349	1.86	0.85	--	0 – 4.12	.004
Individual Protective Factors										
T1 Internal Developmental Assets †c	2.39	0.96	0.88	0 – 4.47	-.056	2.52	0.91	0.88	0 – 4.47	-.129
Gender (1 = Female; 0 = Male)	43.9 %	--	--	0 – 1	.246	41.3 %	--	--	0 – 1	.355
T1 Positive Mental Health †c	5.30	1.54	0.89	0 – 8.37	-.138	4.55	1.45	0.91	0 – 8.37	-.216
T1 Youth Educational Aspirations	14.18	1.75	--	9 – 18	.509	14.36	1.81	--	9 – 18	.327

Notes: T1 = Wave 10 (2010-2011); T2 = Wave 13 (2013-2014). † transformed due to significant skewness (a = log(10) transformation; b=Square root transformation; c = reflect; square root; reflect transformation). Directionality was preserved. Excluding the outcome variables, all Cronbach's alpha coefficients were calculated prior to imputation.

** As part of multiple imputation, individual data points generated in the 40 imputed datasets through the data augmentation algorithm may fall outside the theoretical range (Graham, 2012; Horton, Lipsitz, & Parzen, 2003).*

Table 3: Inter-correlation matrix for cross-sectional sample variables (N = 3,662)

	Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	T1 Academic Success	--																			
2	Age of First Entry into Care	**-.059**‡	--																		
3	Reason for Entry: Neglect (1 = Yes; 0 = No)	.027	**-.293**‡	--																	
4	T1 School Instability	**-.132**‡	**.117**‡	**-.061**‡	--																
5	T1 Caregiver Instability	**-.142**‡	**-.077**‡	**-.037***	**.440**‡	--															
6	T1 Grade Retention (1 = Repeat; 0 = No)	**-.172**‡	**.043***	.011	**.099**‡	**.069**‡	--														
7	Exact Age (in years)	**-.066**‡	**.281**‡	**-.126**‡	**.125**‡	**.086**‡	**.103**‡	--													
8	T1 Academically-related Impairments	**-.345**‡	**-.107**‡	**.049**†	.023	**.093**‡	**.118**‡	**-.066**‡	--												
9	Ethnic Minority Status: FNMI (1 = Yes; 0 = No)	**-.034***	**-.067**‡	**.050**†	.025	**.083**‡	**.048**†	**-.053**†	.001	--											
10	Ethnic Minority Status: Black (1 = Yes; 0 = No)	.005	**.042***	**-.097**‡	.004	.007	**-.048**†	.024	**-.095**‡	**-.092**‡	--										
11	T1 Behavioural Problems	**-.426**‡	-.007	**-.078**‡	**.129**‡	**.164**‡	**.114**‡	**-.062**‡	**.456**‡	.016	**-.077**‡	--									
12	T1 Soft Drug Use (1 = User; 0 = Non-User)	**-.144**‡	**.261**‡	**-.123**‡	**.176**‡	**.148**‡	**.089**‡	**.666**‡	**-.034***	.013	.012	.033	--								
13	T1 Suicide Risk (1 = Yes; 0 = No)	**-.124**‡	**.072**‡	**-.108**‡	**.097**‡	**.106**‡	**.041***	**.065**‡	**.069**‡	**.060**†	**-.038***	**.191**‡	**.107**‡	--							
14	T1 Caregiver Educational Aspirations	**.305**‡	**.052**†	-.003	**-.048**†	**-.079**‡	**-.115**‡	**-.061**‡	**-.291**‡	-.025	**.150**‡	**-.239**‡	**-.041***	**-.077**‡	--						
15	T1 Placement Type (1=Kinship/Foster care; 0=Group)	**.180**‡	**-.109**‡	**.149**‡	**-.186**‡	**-.214**‡	**-.058**†	**-.116**‡	**-.108**‡	-.013	**-.038***	**-.261**‡	**-.166**‡	**-.188**‡	**.115**‡	--					
16	T1 Time with current caregiver	**.178**‡	**-.395**‡	**.216**‡	**-.381**‡	**-.399**‡	-.023	**-.060**‡	.018	-.016	**-.038***	**-.168**‡	**-.197**‡	**-.184**‡	.008	**.323**‡	--				
17	T1 Internal Developmental Assets	**.530**‡	**-.115**‡	**.095**‡	**-.190**‡	**-.171**‡	**-.104**‡	**-.066**‡	**-.300**‡	-.018	.030	**-.523**‡	**-.194**‡	**-.176**‡	**.224**‡	**.267**‡	**.289**‡	--			
18	Gender (1 = Female; 0 = Male)	**.111**‡	**.050**†	-.010	-.019	.000	-.026	**.036***	**-.100**‡	**.038***	.010	**-.061**‡	.012	**.129**‡	**.057**‡	**.101**‡	-.017	**.130**‡	--		
19	T1 Positive Mental Health	**.304**‡	**-.109**‡	**.081**‡	**-.124**‡	**-.128**‡	**-.059**†	**-.089**‡	**-.133**‡	-.031	-.005	**-.326**‡	**-.177**‡	**-.183**‡	**.062**‡	**.203**‡	**.215**‡	**.439**‡	**-.052**†	--	
20	T1 Youth Educational Aspirations	**.301**‡	.012	-.013	-.001	**-.042***	**-.082**‡	**-.104**‡	**-.268**‡	-.032	**.094**‡	**-.172**‡	**-.068**‡	-.032	**.550**‡	**.094**‡	-.010	**.229**‡	**.108**‡	**.091**‡	--

*Notes: Bold indicates significant correlations; ‡ Correlation is significant at the .001 level (2-tailed); † Correlation is significant at the .01 level (2-tailed); * Correlation is significant at the .05 level (2-tailed); T1 = Wave 10 (2010-2011)*

Table 4: Inter-correlation matrix for longitudinal subsample variables (N = 962)

	Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	Outcome: T1 Academic Success (Wave 10)	--																				
2	Outcome: T2 Academic Success (Wave 13)	**.355**‡	--																			
3	Age of First Entry into Care	**-.073***	-.054	--																		
4	Reason for Entry: Neglect (1=Yes 0=No)	-.026	.011	**-.102**†	--																	
5	T1 School Instability	**-.104**†	**-.133**‡	**.160**‡	-.062	--																
6	T1 Caregiver Instability	**-.071***	**-.130**‡	**-.071***	-.034	**.415**‡	--															
7	T1 Grade Retention (1 = Repeat; 0 = No)	**-.151**‡	**-.103**†	-.039	.058	.040	.030	--														
8	Exact Age (in years)	.026	-.018	**.169**‡	-.003	**.075***	.011	.042	--													
9	T1 Academically-related Impairments	**-.426**‡	**-.182**‡	**-.104**†	-.022	-.005	**.071***	**.133**‡	-.044	--												
10	Ethnic Minority Status: FNMI (1 = Yes; 0 = No)	.012	-.058	-.037	.012	.021	**.109**†	-.022	.033	-.018	--											
11	Ethnic Minority Status: Black (1 = Yes; 0 = No)	.062	.057	.051	**-.081***	-.048	.019	-.044	-.011	**-.125**‡	**-.082***	--										
12	T1 Behavioural Problems	**-.460**‡	**-.242**‡	-.022	**-.084***	**.094**†	**.108**†	**.125**‡	-.041	**.513**‡	-.032	-.052	--									
13	T1 Soft Drug Use (1=User 0=Non-User)	**-.107**†	**-.159**‡	**.187**‡	-.031	**.154**‡	**.100**†	.028	**.249**‡	.009	.013	-.033	**.082***	--								
14	T1 Suicide Risk (1 = Yes; 0 = No)	-.049	-.036	**.080***	**-.075***	**.088**†	**.070***	.026	.017	.050	.051	-.021	**.125**†	.058	--							
15	T1 Caregiver Educational Aspirations	**.324**‡	**.199**‡	.020	-.000	**-.128**‡	**-.101**†	**-.139**‡	**-.084***	**-.326**‡	.012	**.177**‡	**-.250**‡	-.050	**-.083***	--						
16	T1 Placement Type (1=Kinship/Foster care; 0=Group)	**.116**‡	**.103**†	**-.086**†	**.132**‡	**-.158**‡	**-.198**‡	.032	-.054	**-.107**†	-.008	**-.082***	**-.185**‡	**-.123**‡	**-.114**†	**.126**‡	--					
17	T1 Time with current caregiver	**.137**‡	**.143**‡	**-.426**‡	**.180**‡	**-.419**‡	**-.372**‡	**.070***	-.031	.032	.005	-.012	**-.112**‡	**-.222**‡	**-.151**‡	.043	**.275**‡	--				
18	T1 Internal Developmental Assets	**.486**‡	**.325**‡	**-.118**‡	.059	**-.113**‡	**-.097**†	**-.085***	**-.094**†	**-.351**‡	.016	.047	**-.512**‡	**-.191**‡	-.070	**.229**‡	**.183**‡	**.215**‡	--			
19	Gender (1 = Female; 0 = Male)	**.120**‡	**.122**‡	-.062	**.078***	-.054	.001	**-.071***	-.011	**-.113**‡	.002	-.003	**-.078***	-.036	.049	.053	**.113**‡	**.069***	**.119**‡	--		
20	T1 Positive Mental Health	**.207**‡	**.215**‡	-.055	.030	-.069	**-.092***	-.031	-.011	**-.156**‡	.020	.001	**-.310**‡	**-.157**‡	**-.112**†	**.092***	**.158**‡	**.163**‡	**.341**‡	.000	--	
21	T1 Youth Educational Aspirations	**.309**‡	**.173**‡	.019	.009	.000	-.030	-.073	**-.081***	**-.317**‡	-.049	.059	**-.235**‡	-.016	-.032	**.488**‡	**.170**‡	-.056	**.224**‡	**.106**†	**.110**†	--

Notes: Bold indicates significant correlations

*‡ Correlation is significant at the .001 level (2-tailed); † Correlation is significant at the .01 level (2-tailed); * Correlation is significant at the .05 level (2-tailed); T1 = Wave 10 (2010-2011); T2 = Wave 13 (2013-2014)*

Table 5. Cross-Sectional Sample (N=3,662): Hierarchical regression of T1 academic success on risk (contextual & individual) and protective (contextual & individual) variables.

Outcome variable T1 Academic Success (Wave 10) Cross-Sectional regression (N = 3,662)	Step 1		Step 2		Step 3		Step 4	
Predictors	B	Standardized Beta	B	Standardized Beta	B	Standardized Beta	B	Standardized Beta
Contextual Risk Factors								
Age of First Entry into Care	**-.124**†	-.051	**-.132**‡	-.053	-.066	-.023	-.039	-.015
Reason for Entry: Neglect (1 = Yes; 0 = No)	.128	.002	-.503	-.030	**-.693***	-.040	**-.654***	-.038
T1 School Instability	**-.549**‡	-.058	**-.316***	-.033	-.160	-.012	-.057	-.007
T1 Caregiver Instability	**-4.822**‡	-.111	**-1.525***	-.035	-.092	.001	-.308	-.008
T1 Grade Retention (1 = Repeat; 0 = No)	**-4.346**‡	-.162	**-2.652**‡	-.099	**-2.416**‡	-.092	**-2.238**‡	-.084
Individual Risk Factors								
Exact Age (in years)			.037	.004	.048	.005	.015	.001
T1 Academically-related Impairments			**-1.256**‡	-.199	**-1.039**‡	-.167	**-.751**‡	-.123
Ethnic Minority Status: FNMI (1 = Yes; 0 = No)			-.621	-.046	-.582	-.064	-.478	-.059
Ethnic Minority Status: Black (1 = Yes; 0 = No)			**-1.385**†	-.026	**-1.990**‡	-.024	**-1.819**‡	-.023
T1 Behavioural Problems			**-.422**‡	-.311	**.378**‡	-.277	**-.174**‡	-.129
T1 Soft Drug Use (1 = User; 0 = Non-User)			**-2.189**‡	-.110	**-2.036**‡	-.102	**-.889***	-.044
T1 Suicide Risk (1 = Yes; 0 = No)			-.702	-.036	-.348	-.024	-.175	-.020
Contextual Protective Factors								
T1 Caregiver Educational Aspirations					**1.182**‡	.180	**.669**‡	.106
T1 Placement Type (1=Kinship/Foster care; 0=Group)					.270	.009	-.515	-.021
T1 Time with current caregiver					**1.026**‡	.100	**.436***	.043
Individual Protective Factors								
T1 Internal Developmental Assets							**3.344**‡	.314
Gender (1 = Female; 0 = Male)							**.804**†	.076
T1 Positive Mental Health							**.468**‡	.050
T1 Youth Educational Aspirations							**.588**‡	.092
ΔR^2		**.055**‡		**.197**‡		**.034**‡		**.096**‡

*Notes: * p < .05 (2-tailed); † p < .01 (2-tailed); ‡ p < .001 (2-tailed); T1 = Wave 10 (2010-2011)*

Table 6. Longitudinal subsample (N = 962): Cross-Sectional hierarchical regression of T1 academic success on risk (contextual & individual) and protective (contextual & individual) variables.

Outcome variable T1 Academic Success (Wave 10) Cross-sectional regression (N = 962)	Step 1		Step 2		Step 3		Step 4	
Predictors	B	Standardized Beta	B	Standardized Beta	B	Standardized Beta	B	Standardized Beta
Contextual Risk Factors								
Age of First Entry into Care	**-.223***	-.078	**-.318**‡	-.110	**-.221***	-.084	-.157	-.064
Reason for Entry: Neglect (1 = Yes; 0 = No)	-.690	-.022	**-1.515***	-.060	**-1.685**†	-.068	**-1.664**†	-.072
T1 School Instability	-.632	-.072	-.509	-.058	-.203	-.021	-.265	-.022
T1 Caregiver Instability	-1.996	-.040	.136	.009	1.634	.038	1.313	.029
T1 Grade Retention (1 = Repeat; 0 = No)	**-4.547**‡	-.140	**-2.315**†	-.072	**-2.092***	-.066	**-1.936***	-.066
Individual Risk Factors								
Exact Age (in years)			.492	.040	.598	.050	**.889**†	.071
T1 Academically-related Impairments			**-1.618**‡	-.268	**-.1382**‡	-.227	**-1.056**‡	-.181
Ethnic Minority Status: FNMI (1 = Yes; 0 = No)			-.195	.001	-.373	-.007	-.175	-.002
Ethnic Minority Status: Black (1 = Yes; 0 = No)			.125	.011	-.689	-.014	-.577	-.011
T1 Behavioural Problems			**-.416**‡	-.322	**-.386**‡	-.300	**-.229**‡	-.185
T1 Soft Drug Use (1 = User; 0 = Non-User)			**-1.559***	-.062	-1.368	-.050	-.748	-.032
T1 Suicide Risk (1 = Yes; 0 = No)			.478	.015	.874	.030	.537	.020
Contextual Protective Factors								
T1 Caregiver Educational Aspirations					**1.086**‡	.181	**.680**‡	.120
T1 Placement Type (1=Kinship/Foster care; 0=Group)					-.039	.008	-.834	-.016
T1 Time with current caregiver					**1.055***	.078	.752	.061
Individual Protective Factors								
T1 Internal Developmental Assets							**2.956**‡	.266
Gender (1 = Female; 0 = Male)							.640	.031
T1 Positive Mental Health							.017	-.023
T1 Youth Educational Aspirations							**.597**†	.091
ΔR^2		**.037**‡		**.263**‡		**.031**‡		**.056**‡

*Notes: * p < .05 (2-tailed); † p < .01 (2-tailed); ‡ p < .001 (2-tailed);T1 = Wave 10 (2010-2011)*

Table 7. Longitudinal subsample (N = 962): Longitudinal hierarchical regression of T2 academic success on risk (contextual & individual) and protective (contextual & individual) variables.

Outcome variable T2 Academic Success (Wave 13) Longitudinal regression (N = 962)	Step 1		Step 2		Step 3		Step 4		Step 5	
Predictors	B	Standardized Beta	B	Standardized Beta	B	Standardized Beta	B	Standardized Beta	B	Standardized Beta
T1 Academic Success (Wave 10)	**.395**‡	.366	**.371**‡	.344	**.316**‡	.296	**.296**‡	.274	**.237**‡	.230
Contextual Risk Factors										
Age of First Entry into Care			-.091	-.022	-.069	-.014	-.023	.000	.003	.010
Reason for Entry: Neglect (1 = Yes; 0 = No)			.328	.015	.169	.007	.017	.000	-.089	-.005
T1 School Instability			-.559	-.064	-.451	-.056	-.306	-.038	-.351	-.037
T1 Caregiver Instability			**-4.251***	-.082	-3.401	-.064	-2.537	-.045	-2.706	-.049
T1 Grade Retention (1 = Repeat; 0 = No)			-1.704	-.061	-1.512	-.056	-1.497	-.057	-1.397	-.058
Individual Risk Factors										
Exact Age (in years)					.106	.005	.167	.010	.335	.019
T1 Academically-related Impairments					-.051	-.022	-.028	-.009	.148	.009
Ethnic Minority Status: FNMI (1 = Yes; 0 = No)					-1.539	-.056	-1.627	-.060	-1.603	-.063
Ethnic Minority Status: Black (1 = Yes; 0 = No)					.927	.000	.610	-.009	.664	-.009
T1 Behavioural Problems					**-.123***	-.067	-.114	-.061	-.012	.007
T1 Soft Drug Use (1 = User; 0 = Non-User)					**-2.923**†	-.112	**-2.826**†	-.106	**-2.240***	-.086
T1 Suicide Risk (1 = Yes; 0 = No)					.318	.015	.552	.024	.456	.025
Contextual Protective Factors										
T1 Caregiver Educational Aspirations							**.493***	.081	.399	.070
T1 Placement Type (1=Kinship/Foster care; 0=Group)							.522	.023	-.200	-.003
T1 Time with current caregiver							.527	.044	.239	.029
Individual Protective Factors										
T1 Internal Developmental Assets									**1.675**‡	.117
Gender (1 = Female; 0 = Male)									**1.536***	.080
T1 Positive Mental Health									**.745**†	.108
T1 Youth Educational Aspirations									.183	.025
ΔR^2		**.134**‡		**.020**‡		**.019**†		**.007***		**.029**‡

*Notes: * p < .05 (2-tailed); † p < .01 (2-tailed); ‡ p < .001 (2-tailed); T1 = Wave 10 (2010-2011)*

Table 8. Conceptual Factors Linked with Concurrent Academic Success for Children in Care

Factors linked to *lower* academic success	**Factors linked to *higher* academic success**
Being neglected prior to entry into public care;	Your caregiver having higher educational aspirations;
Being held back in school;	Having the same caregiver for a longer period of time;
Having greater academically-related impairments;	Possessing more internal developmental assets;
Being part of an ethnic minority (black Canadian);	Being a girl
Having a greater number of behavioural problems,	Experiencing more positive mental health
Being a soft drug user	Having higher educational aspirations for yourself

Table 9. Conceptual Factors Linked with Changes in Academic Success for Children in Care

Factors linked to *reduced* academic success 3-years later	**Factors linked to *increased* academic success 3-years later**
Being a soft drug user	Possessing more internal developmental assets; Being a girl Experiencing more position mental health

Table 10. Means (or percentages), standard deviations, Cronbach's alphas, theoretical range, and skewness statistics for study 2 variables

	Cross-Sectional Sample (N = 512)					
Variable	Mean (or %)	*SD*	Cronbach's alpha†	Range		Skew
				Theoretical	Observed*	
Outcome						
T2 Educational Attainment	11.11	1.30	--	7 – 18	8 – 16	-.159
T2 Youth Educational Aspirations	14.24	1.55	--	11 – 18	10 – 18	.202
T2 NEET Status *(0 = Non NEET; 1 = NEET)*	20.5%	--	--	0 – 1	0 – 1	--
Control Factor						
Exact Gap Length *(between assessments)*	2.22	.93	--	1 – 5	.62 – 5.01	.525
Contextual Factors						
T1 Placement Type *(0=Group Home & All others; 1=Kinship & Foster Care)*	63.3%	--	--	0 – 1	0 – 1	--
Risk Factors						
T1 Academically-related Impairments	1.81	1.64	.559	0 – 9	-2 – 7	.593
T1 Behavioural Problems	12.41	7.23	.867	0 – 40	-4 – 32	.200
T1 Soft Drug Use Index	1.22	1.23	.787	0 – 3	-1 – 4	.301
Protective Factors						
T1 Internal Developmental Assets	12.59	5.11	.885	0 – 20	0 – 20	-.388
T1 Academic Performance	8.09	2.36	.882	0 – 12	3 – 13	-.108
T1 Exact Age	16.80	.54	--	15.00 – 17.99	15.08 – 18.02	.089
Gender *(0 = Male; 1 = Female)*	53.7%	--	--	0 - 1	0 - 1	--

Notes:
NEET = Not in education, employment, or training;
** As part of multiple imputation, individual data points generated in the 40 imputed datasets through the data augmentation algorithm may fall outside the theoretical range (Graham, 2012; Horton, Lipsitz, & Parzen, 2003). Only NEET Status was recoded into the theoretical range, as a binary dependent variable is required for logistic regression;*
† These internal consistency coefficients were calculated prior to scale formation and multiple imputation;
T1 signifies Time 1 (data taken from the first AAR available between 2006 and 2013);
T2 signifies Time 2 (data taken from the latest AAR available between 2006 and 2013).

Table 11. Inter-correlation matrix for variables in the study 2 sample (N=512)

	Variables	1	2	3	4	5	6	7	8	9	10	11	12
1	T2 Educational Attainment	--											
2	T2 Youth Educational Aspirations	**.205**‡	--										
3	T2 NEET Status *(0 = Non NEET; 1 = NEET)*	**-.220**‡	**-.182**†	--									
4	Exact Gap Length between assessments	**.263**‡	.081	.063	--								
5	T1 Placement Type	**.308**‡	**.125***	**-.167**‡	**.161**‡	--							
6	Academically-related Impairments	**-.230**‡	**-.287**‡	**.180**‡	-.054	-.017	--						
7	T1 Behavioural Problems	**-.335**‡	**-.219**‡	**.202**‡	.012	**-.231**‡	**.442**‡	--					
8	T1 Soft Drug Use Index	**-.306**‡	**-.128***	**.140**†	.024	**-.354**‡	.023	**.181**‡	--				
9	T1 Internal Developmental Assets	**.387**‡	**.219**‡	**-.230**‡	.072	**.230**‡	**-.357**‡	**-.551**‡	**-.389**‡	--			
10	T1 Academic Performance	**.366**‡	**.223**‡	**-.190**‡	.046	**.185**‡	**-.326**‡	**-.337**‡	**-.285**‡	**.486**‡	--		
11	T1 Exact Age	-.021	-.082	-.022	**-.385**‡	**-.246**‡	-.021	-.010	**.128**†	-.008	**-.144**†	--	
12	Gender *(0 = Male; 1 = Female)*	**.102***	**.138**†	-.067	.032	.025	-.080	-.050	-.062	**.130**†	**.177**‡	.032	--

Notes:
NEET = Not in Education, Employment, or Training.
Bold indicates significant correlations
‡ Correlation is significant at the .001 level (2-tailed);
† Correlation is significant at the .01 level (2-tailed);
** Correlation is significant at the .05 level (2-tailed);*
T1 signifies Time 1 (data taken from the first AAR available between 2006 and 2013);
T2 signifies Time 2 (data taken from the latest AAR available between 2006 and 2013)

Table 12. Hierarchical regression of T2 educational attainment on gap length and on T1 contextual and individual risk and protective factors

	Outcome: T2 Educational Attainment (N = 512)							
	Step 1		Step 2		Step 3		Step 4	
Predictors	B	Standardized Beta	B	Standardized Beta	B	Standardized Beta	B	Standardized Beta
Control Factor								
Gap Length	**.369**‡	.267	**.307**‡	.222	**.340**‡	.247	**.414**‡	.306
Contextual Factor								
T1 Placement Type			**.733**‡	.279	**.375**†	.130	**.426**‡	.150
Risk Factors								
Academically-related Impairments					**-.091***	-.116	-.040	-.048
T1 Behavioural Problems					**-.038**‡	-.226	**-.025***	-.162
T1 Soft Drug Use					**-.234**‡	-.243	**-.178**‡	-.196
Protective Factors								
T1 Internal Developmental Assets							.018	.065
T1 Academic Performance							**.108**‡	.194
T1 Exact Age							**.429**‡	.200
Gender *(0=Male; 1=Female)*							.046	.008
ΔR^2		**.071**‡		**.076**‡		**.148**‡		**.063**‡

Notes:
Placement Type:(1 = Foster & Kinship care; 0 = All others);
T1 signifies Time 1 (data taken from the first AAR available between 2006 and 2013);
T2 signifies Time 2 (data taken from the latest AAR available between 2006 and 2013);
*Significant results are in bold. * $p < .05$ (2-tailed); † $p < .01$ (2-tailed); ‡ $p < .001$ (2-tailed);*

Table 13. Hierarchical regression of T2 youth educational aspirations on gap length and on T1 contextual and individual risk and protective factors

	Outcome: T2 Educational Aspirations (N = 512)							
	Step 1		Step 2		Step 3		Step 4	
Predictors	B	Standardized Beta	B	Standardized Beta	B	Standardized Beta	B	Standardized Beta
Control Factor								
Gap Length	.134	.026	.103	-.001	.101	-.002	.061	-.026
Contextual Factors								
T1 Placement Type			**.363***	.164	.193	.114	.157	.100
Risk Factors								
Academically-related Impairments					**-.229**‡	-.193	**-.205**‡	-.223
T1 Behavioural Problems					-.017	-.083	-.012	-.053
T1 Soft Drug Use					-.109	-.074	-.067	-.022
Protective Factors								
T1 Internal Developmental Assets							-.008	.051
T1 Academic Performance							.044	.104
T1 Exact Age							-.132	-.039
Gender *(0=Male; 1=Female)*							**.299***	.104
ΔR^2		.001		**.026**‡		**.103**‡		**.028**†

Notes:
Placement Type: (1 = Foster & Kinship Care; 0 = All other);
T1 signifies Time 1 (data taken from the first AAR available between 2006 and 2013);
T2 signifies Time 2 (data taken from the latest AAR available between 2006 and 2013).
*Significant results are in bold. * p< .05 (2-tailed); † p< .01 (2-tailed); ‡ p< .001 (2-tailed);*

Table 14. Sequential logistic regression predicting NEET Status from gap length, contextual and individual (risk & protective) variables (N=512)

Predictors	Step 1				Step 2				Step 3				Step 4			
	B	Wald χ^2	*p*	Odds Ratio	B	Wald χ^2	*p*	Odds Ratio	B	Wald χ^2	*p*	Odds Ratio	B	Wald χ^2	*p*	Odds Ratio
Control																
Gap Length	.17	4.96	.21	1.18	.25	9.22	.06	1.29	.25	9.44	.08	1.29	.26	7.41	.10	1.30
Contextual Factors																
T1 Placement Type					-.92	22.72	**.00**	.40	-.70	14.60	**.02**	.50	-.71	14.43	**.02**	.49
Risk Factors																
Academically-related Impairments									.22	10.62	**.02**	1.25	.17	4.44	.08	1.18
T1 Behavioural Problems									.04	1.22	.08	1.04	.02	.01	.46	1.02
T1 Soft Drug Use									.16	.86	.17	1.17	.07	.06	.61	1.07
Protective Factors																
T1 Internal Developmental Assets													-.05	1.58	.16	.95
T1 Academic Performance													-.07	8.37	.32	.93
T1 Exact Age													-.12	.87	.68	.89
Gender *(0=Male; 1=Female)*													-.18	.00	.50	.84
Omnibus test of model coefficients		**χ^2 (1) = 4.919***				**χ^2 (1) = 23.215‡**				**χ^2 (3) = 20.367‡**				**χ^2 (4) = 13.675†**		

Notes:
Omnibus test of model coefficients for model as a whole χ2 (9) = 62.175, p < .001
Hosmer and Lemeshow goodness-of-fit test (χ2 (8) = 9.158 p = .329) showed good fit of model to data.
Placement Type: (1 = Foster & Kinship care; 0 = All others)
T1 signifies Time 1 (data taken from the first AAR available between 2006 and 2013);
T2 signifies Time 2 (data taken from the latest AAR available between 2006 and 2013).
*Significant results are in bold. *p< .05 (2-tailed); † p< .01 (2-tailed); ‡p< .001 (2-tailed)*

Table 15. Means (or percentages), standard deviations, and listwise *n* for study 3 variables and comparison samples from the general population in Ontario (drawn from the 2012 Canadian Community Health Survey [CCHS]), with standardized mean difference (*d*) and 95% C.I.

	Study 3 Sample			CCHS 2012 Samples			Standardized	
Variables	Mean (or %)	SD	*n*	Mean (or %)	SD	*n*	Mean Difference (*d*)	(95% C.I.)
Age *(1=20-24 age group; 0=18-19 age group)*	53.8%	--	39	73.8%	--	164	-0.49	**(-0.88, -0.09)**
Gender *(1=female; 0=male)*	71.8%	--	39	48.8%	--	164	0.54	**(0.12, 0.96)**
Ethnicity *(1=white; 0=other)*	79.5%	--	39	76.8%	--	159	0.09	(-0.39, 0.56)
In-care status at Time 2 *(1=out-of-care; 0 = in-care)*	48.7%	--	39	N/A	--	--		
Marital status *(1=single, never married; 0=married/common law)*	74.4%	--	39	92.1%	--	164	-0.77	**(-1.27, -0.26)**
Pregnant *(last 12 months, females only; 1=Yes; 0=No)*	28.6%	--	28	0.89%	--	451†	0.78	**(0.29, 1.26)**
Parenthood *(1=Yes, children; 0 =No)*	15.4%	--	39	--	--	--		
ADHD *(1=Yes; 0=No)*	28.2%	--	39	4.4%	--	894†	1.18	**(0.76, 1.61)**
Learning Disability *(1=Yes; 0=No)*	33.3%	--	39	8.9%	--	894†	0.90	**(0.51, 1.29)**
Developmental Disability *(1=Yes; 0=No)*	12.8%	--	39	N/A	--	--		
Marijuana use in the last 12 months *(1=Yes; 0=No)*	46.2%	--	39	28.6%	--	154	0.42	**(0.02, 0.82)**
Cigarette Smoker *(1=Yes; 0=No)*	38.5%	--	39	20.9%	--	163	0.48	**(0.06, 0.89)**
Tobacco use (cigarettes per day) *for daily smokers only*	15.69	8.18	13	9.04	5.58	26	1.02	**(0.31, 1.72)**
Alcohol Consumption scale	2.54	1.29	35	3.39	1.49	138	-0.59	**(-0.96, -0.21)**
Binge Drinking *(5 drinks + in one occasion)*	2.26	1.40	34	2.75	1.46	138	-0.34	(-0.72, 0.04)
Positive Mental Health scale	49.16	15.94	38	54.41	9.81	140	-0.46	**(-.082, -0.10)**
Perceived Distress Scale *(10 item scale)*	18.82	11.15	38	5.58	5.30	154	1.93	**(1.53, 2.34)**
Educational Attainment	1.90	.64	39	2.87	1.04	158	-0.99	**(-1.36, -0.63)**
Educational Aspirations	14.71	1.29	34	N/A	--	--		
In school *(1=Yes; 0=No)*	56.4%	--	39	52.2%	--	159	0.09	(-0.30, 0.48)
In employment *(1=Yes; 0=No)*	38.5%	--	39	65.0%	--	160	-0.60	**(-1.00, -0.20)**
Not in education or employment *(1 = Yes; 0 = No)*	23.1%	--	39	5.26%	--	893†	0.93	**(0.49, 1.37)**

Notes: Statistically significant differences are in bold at p < .05 (2-tailed); ADHD = Attention deficit, hyperactivity disorder
Educational Aspirations were on a 4-point scale ranging from 11=less than high school diploma to 16 = one university degree or more. Educational Attainment, for the sake of comparison with Canadian Community Health Survey (CCHS) means, was converted into a 3-point scale, ranging from "less than secondary school" to "post-secondary certificate or diploma". †These data are drawn from a Canadian Community Health Survey (CCHS) Ontario-wide sample (n=894), rather than the regional Ontario sample (n=164).

Table 16. Spearman rho correlation coefficients for selected Study 3 Time 1 variables with 12-month follow-up outcome variables.

	Time 1 Variables						
Time 2 12-Month Follow-up	T1 Age	Gender *(1=female; 0=male)*	T1 Behavioural Difficulties	T1 Internal Developmental Assets	T1 Cigarette Smoking Frequency	T1 Alcohol Use Frequency	T1 Marijuana Use Frequency
T2 Care Status *(1 = left care;0 = still in care)*	**.621**‡	-.187	-.037	-.141	.156	.099	.055
Education Outcomes							
T2 Attainment	**.600**‡	.078	**-.373***	**.295**[a]	**-.349***	-.108	-.089
T2 Aspirations	.005	.124	-.072	**.467**†	-.220	.039	.030
T2 NEET Status *(1 = NEET; 0=Non-NEET)*	.092	.208	-.070	-.088	-.034	**-.305**[a]	-.012
Mental Health Outcomes							
T2 Distress Scale	-.200	.042	.178	-.206	.086	**-.343***	.202
T2 Positive Mental Health	**.273**[a]	**-.342***	**-.481**†	.106	**-.294**[a]	.101	-.172
Soft-Drug Use Outcomes							
T2 Cigarette-Smoking Frequency	**-.316***	**-.343***	.210	-.204	**.550**‡	.005	.139
T2 Marijuana Smoking Frequency	**-.311**[a]	-.133	**.391***	-.035	**.458**†	.148	**.666**‡
T2 Alcohol Consumption Drinking Frequency	-.020	-.239	-.014	.191	-.079	.095	-.057
T2 Binge Drinking (5+ drinks)	.121	**-.302**[a]	-.185	**.339***	.141	-.134	**.349***

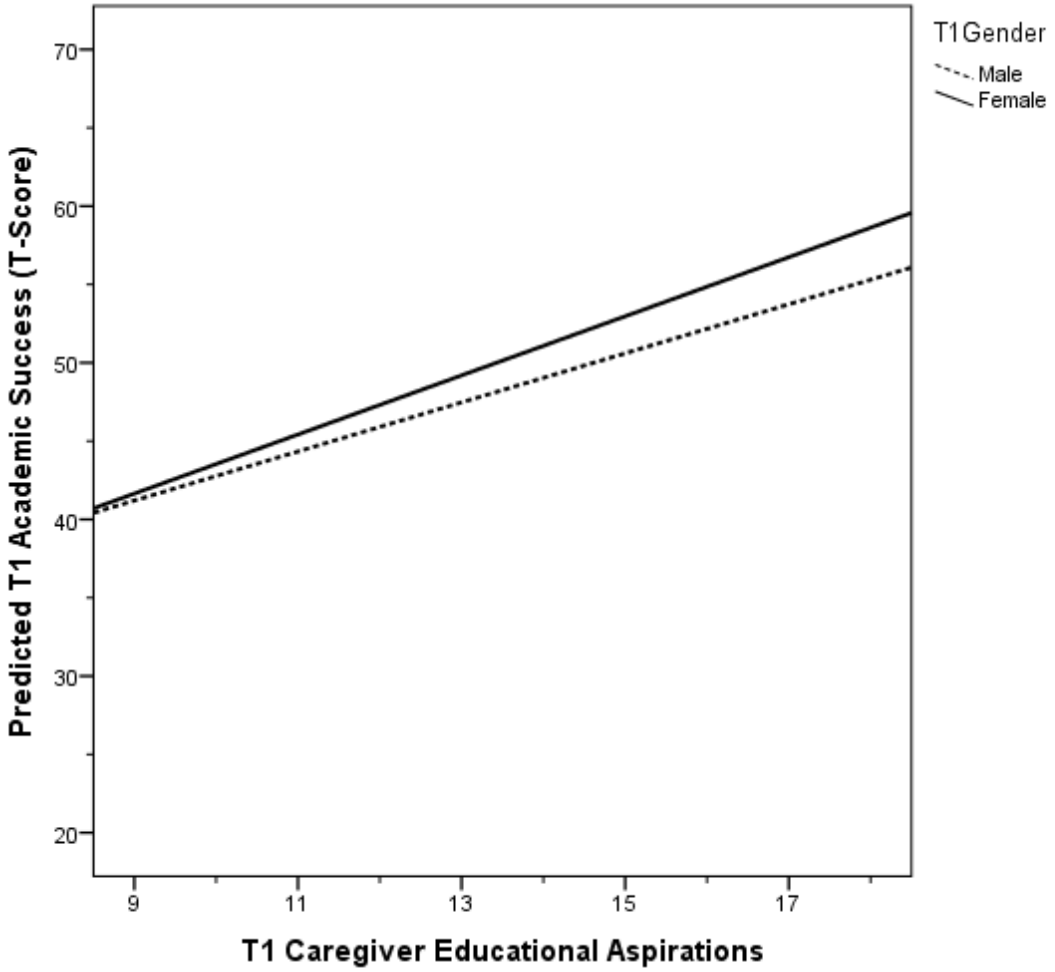
Notes:

NEET = Not in education, employment or training; T1 = Time 1; T2 = Time 2;

Significant results are in bold. [a] *p < .1 (2-tailed) *p < .05 (2-tailed); † p < .01 (2-tailed); ‡ p< .001 (2-tailed);*

Figures

Figure 1. Gender by T1 Caregiver Educational Aspirations predicting T1 Academic Success.



Notes.
T1 Caregiver Educational Aspirations units are in years of formal education.

Figure 2. Gender by T1 Placement Type predicting T1 Academic Success

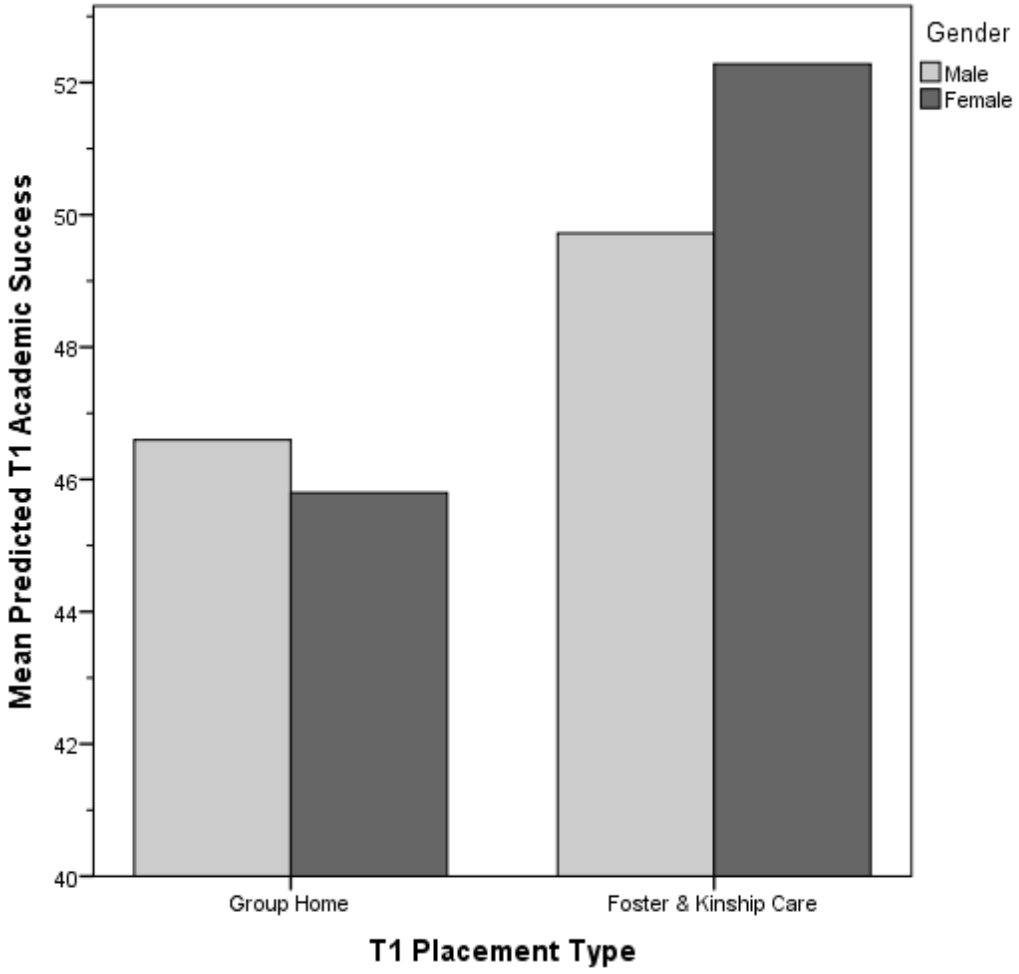


Figure 3. Histogram of Exact Gap Length in years

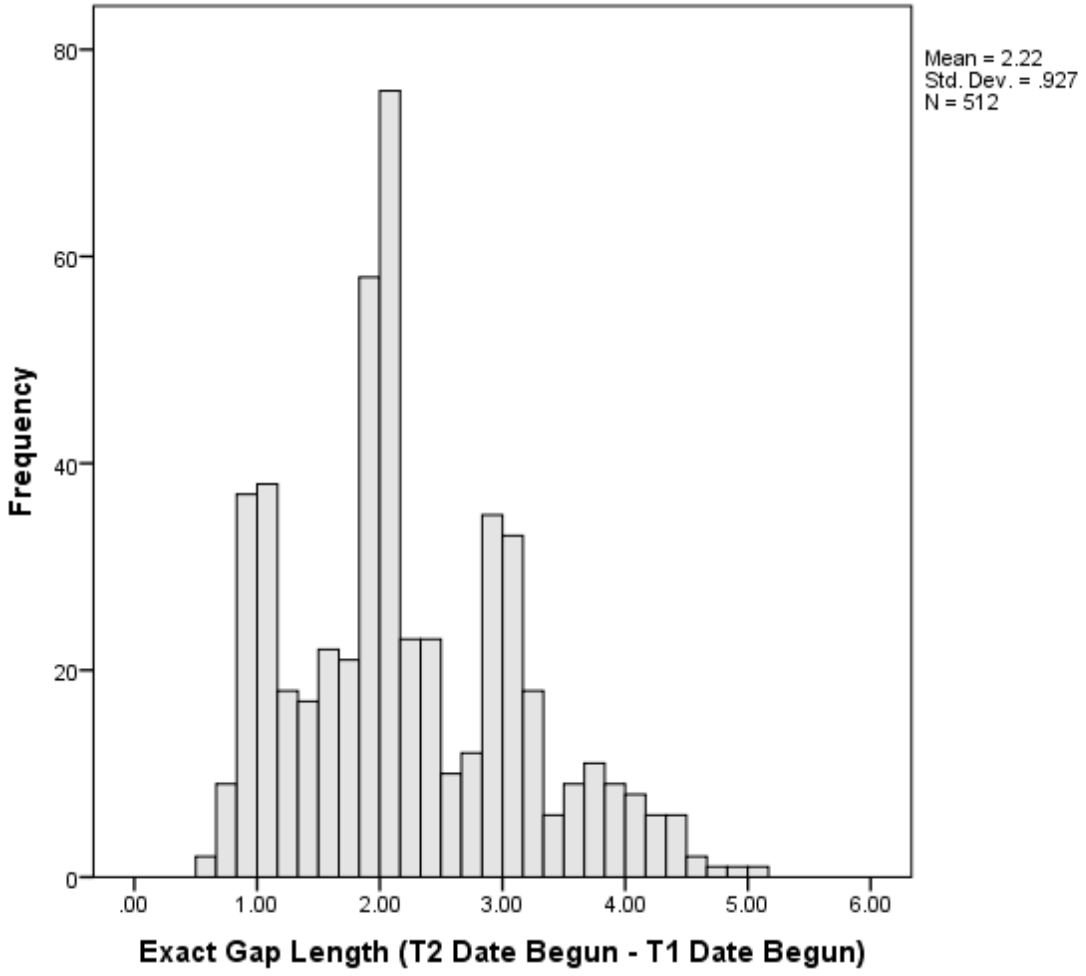
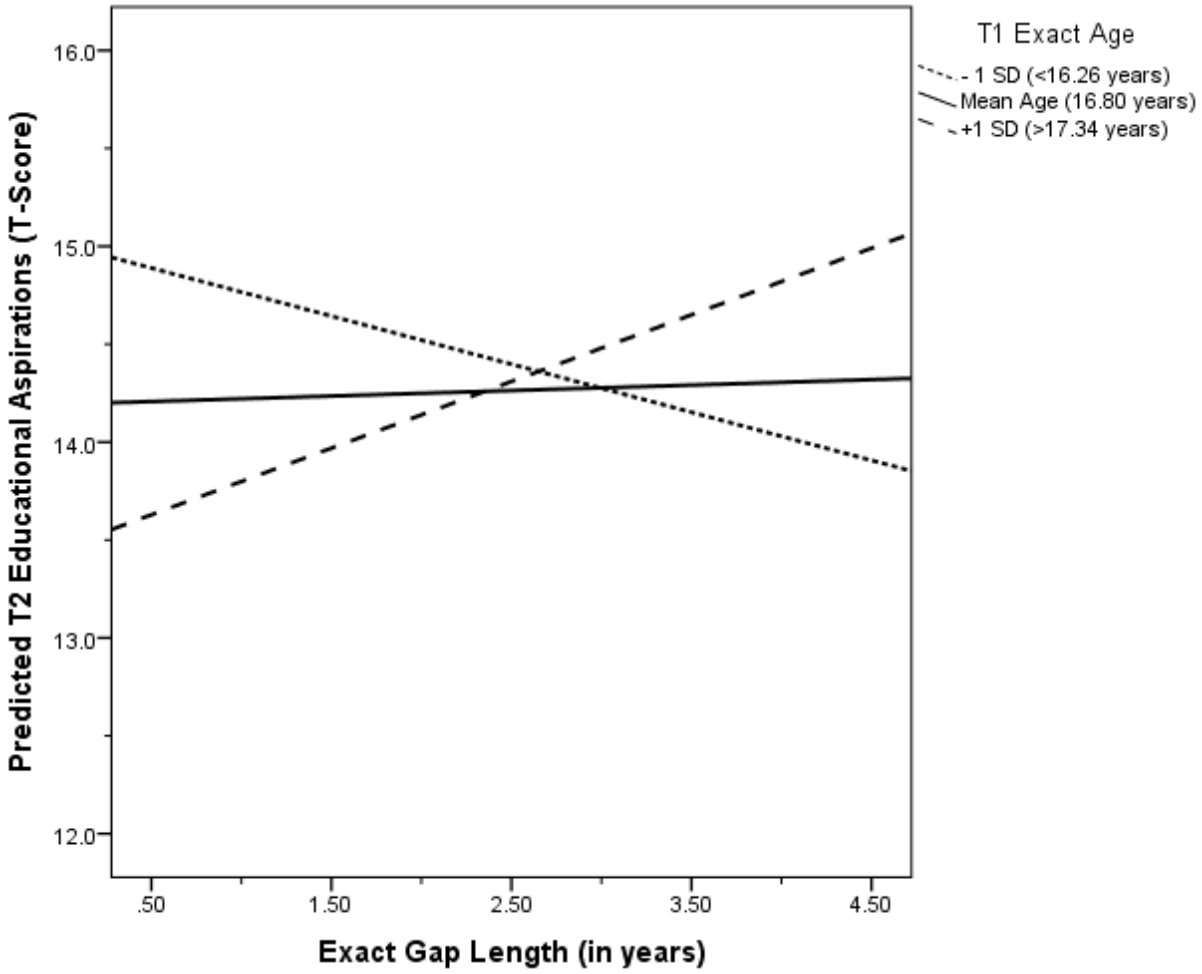
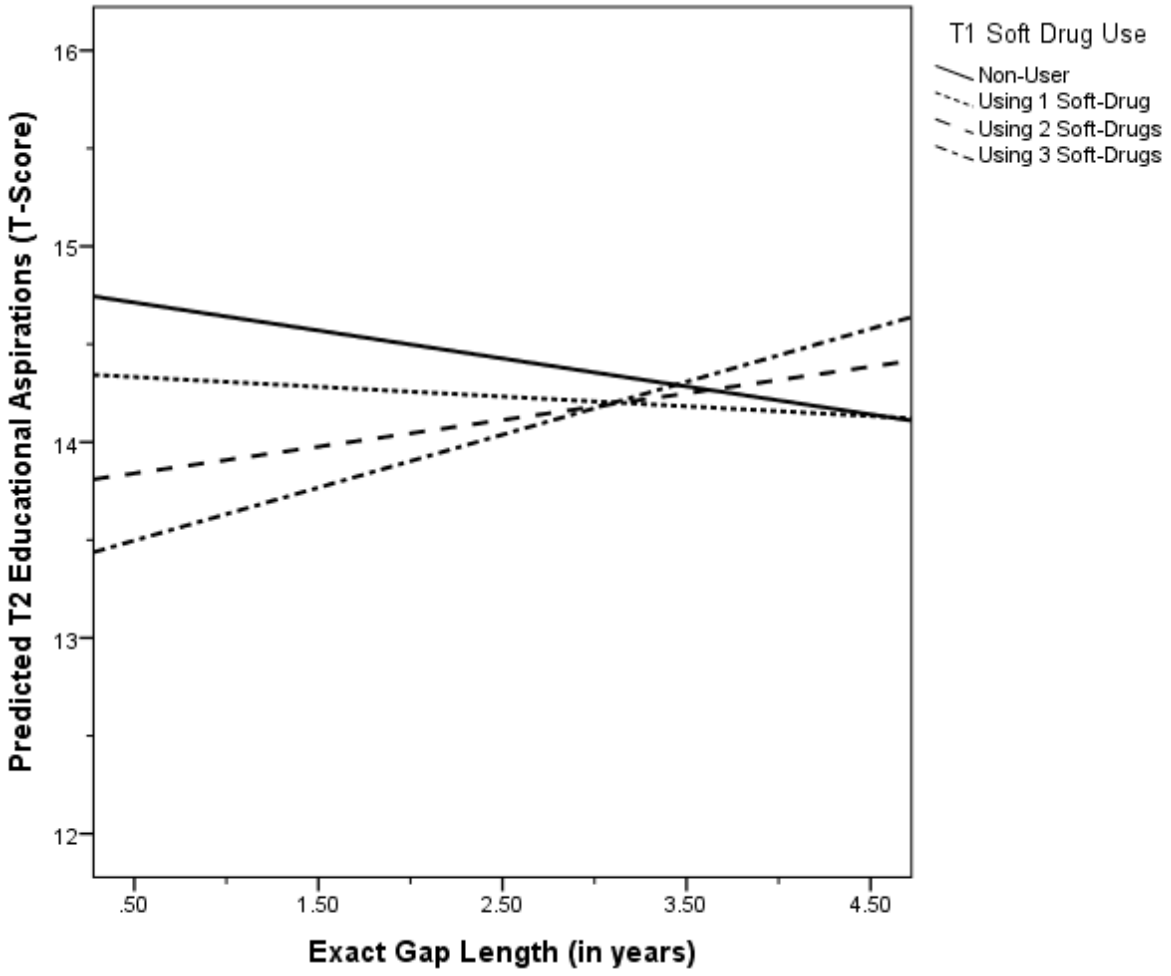


Figure 4. Exact Gap Length by T1 Exact Age predicting T2 Educational Aspirations



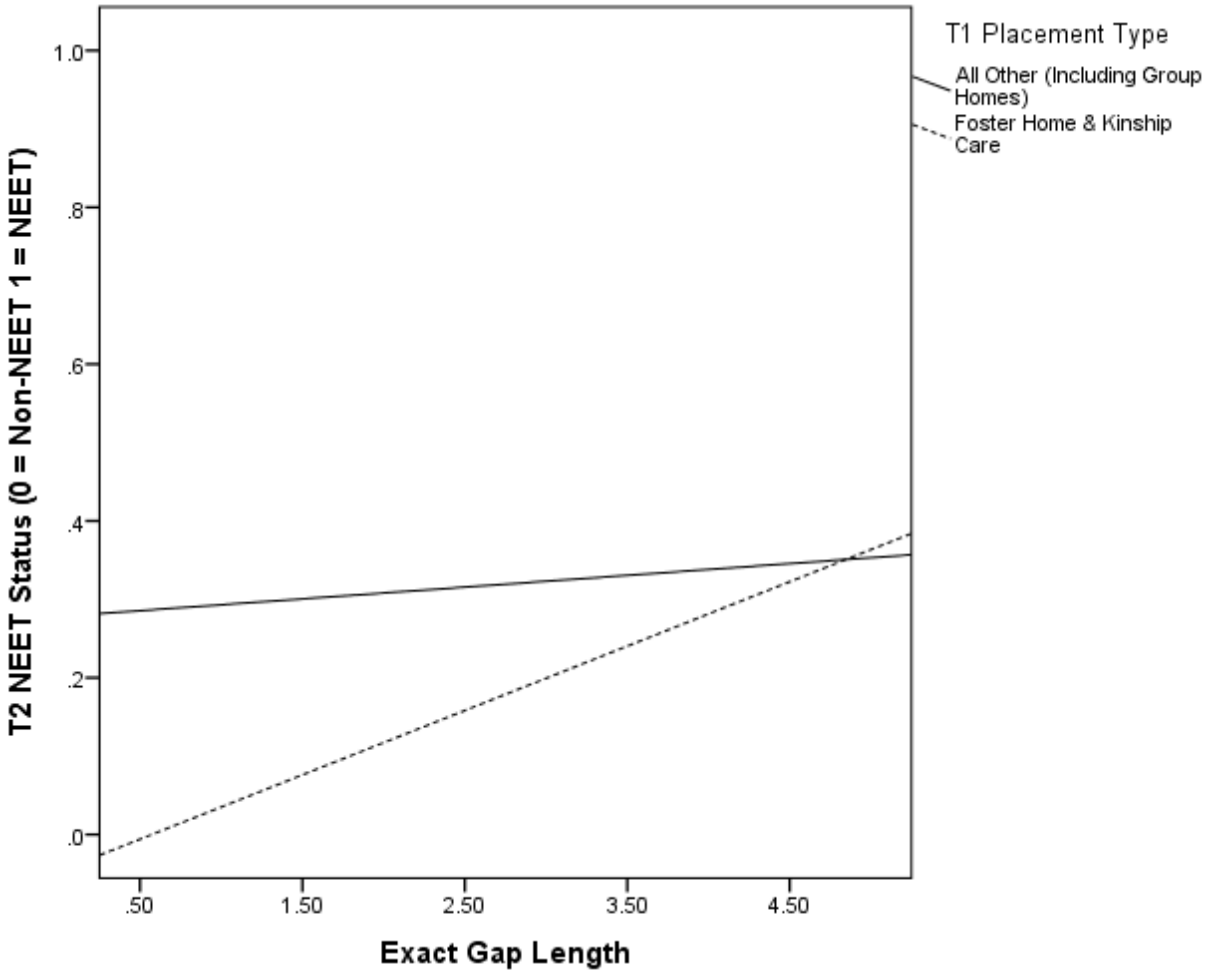
Notes: T1 signifies Time 1 (data taken from the first AAR available between 2006 and 2010); T2 signifies Time 2 (data taken from the latest AAR available between 2006 and 2010).

Figure 5. Exact Gap Length by T1 Soft Drug Use predicting T2 Educational Aspirations



Notes: T1 signifies Time 1 (data taken from the first AAR available between 2006 and 2010); T2 signifies Time 2 (data taken from the latest AAR available between 2006 and 2010).

Figure 6. Exact Gap Length by T1 Placement Type predicting T2 NEET Status



Notes: T1 signifies Time 1 (data taken from the first AAR available between 2006 and 2010); T2 signifies Time 2 (data taken from the latest AAR available between 2006 and 2010).

NEET = Not in Education, Employment, or Training

Appendices

Appendix A - Multiple Imputation Using NORM 2.03, MI Automate, and SPSS 21/22

Prepared by Nicholas Tessier (2014)

N.B. all page references refer to John W. Graham's 2012 book entitled "Missing Data – Analysis and Design". This book is available online for free through most university libraries.

NORM 2.03, MI Automate, and both User Guides can be downloaded here:
http://methodology.psu.edu/pubs/books/missing#soft

Both NORM and MI Automate come in self-extracting .ZIP files. Be sure to place them in a folder where you will remember where they are (such as in a folder on your desktop) – as these files do not necessarily create Start menu links).

Preparing your SPSS file

1. In SPSS, select only those variables that will be included in your imputation model
    a. These variables typically include all variables that will be included in your analysis (e.g., linear regression), as well as additional variables that will be used to "boost" both independent and dependent variables in your analysis model. These "booster" variables should be highly correlated with the IV/DV they are boosting.
    b. You can use the "save as…" function in SPSS (under the "file" menu) to do this.
        i. On the right-hand side of the "save as…" window, click the button labeled "Variables…" .
        ii. In this new window, select only those variables that will be in your imputation model and analysis model (you might also include ID number to ensure proper imputation).
        iii. Click "Ok".
        iv. Give this new file a name that is easily identifiable as the analysis model & click "save".
2. Create any interaction terms (if any)
3. Recode SYSMIS (“.” In SPSS) into "-99" for ALL variables, including interactions.
4. Ensure that your file is sorted in an appropriate way (e.g., In ascending order by ID number). *This is to allow for easy comparison should any difficulties arise in the imputation process.*

Converting your SPSS file to that it can be read by NORM

This procedure is described in Graham, p. 75.

5. Create a new folder specifically for each imputation (e.g., "Model 1 – Educational Attainment") – *this is important as NORM will generate several files for each imputation and may overwrite previous imputation files if they are in the same folder.*
6.
7. Saving your data as a *.dat file
    a. Select the "Save as…" function in SPSS (under the "file" menu).
    b. Make sure you are in the correct, newly-created folder (from Step 5)
    c. In the "File Name:" cell, write a short, one-word descriptive name (less than 8 characters) (e.g., "EdAttain" for "education attainment").
    d. In the "Save as type:" cell, select "Tab delimited (*.dat)"
    e. In the "Encoding:" cell, select "Local Encoding"

f. Uncheck/deselect the option "Write variable names to spreadsheet"
g. Click "Save".

8. Create a *.nam file *(Graham, p. 76)*
    a. Open Notepad *(This program is typically found in the Windows Start Menu, in the Accessories folder)*
    b. Write out a shortened version of each variable name on each line. Each name must be shorter than 8 characters. It is extremely important that the order of the variables be identical to those in the data.

    Here is an example:

Original variable names in SPSS	New variable names in Notepad
ID	ID
Gender	Gender
T1_Age	T1age
T1_Educational_Attainment	T1EdAttain
T2_Educational_Attainment	T2EdAttain
T1_Developmental_Assets	T1DevAss
T2_Developmental_Assets	T2DevAss
T1_Soft_Drug_Use	T1Drugs
T2_Soft_Drug_Use	T2Drugs

    c. Under the "file" menu, select "Save as…"
    d. Make sure you are in the same folder as the *.dat file (from Step 5 & 6.b)
    e. In the "File Name:" cell, enter the same name as the *.dat file in step 5 with a *.nam extension (e.g., "EdAttain.nam").
    f. Select "ANSI" in the "Encoding:" cell (the third button from the bottom right)
    g. Click "Save".

Running NORM

This procedure is described in Graham, p. 76.

9. Open NORM
    a. In the "file" menu, select "New Session"
    b. Select the previously created *.dat file (from Step 6)

10. Verifying your variables
    a. NORM should open to the "Data file" tab, under the "Data" tab.
        i. Ensure that the number of variables and No. of cases is correct.
        ii. Ensure that the "Missing value code =" is "-99"
    b. Click on the "Variables" tab.
        i. Under the "Name" column, verify that your variable names are all correct & distinguishable from each other.
        ii. Under the "In model" column, deselect any variables (*by double-clicking the left mouse button)* that were included in the data file, but will not be part of your imputation model and analysis model (e.g., ID).
        iii. If any transformations need to be done and have not been previously done in SPSS, you can select these in the "transformations" column. Note that these will not be applied to any interaction terms. (Graham, p. 77).

iv. Under the "Rounding Column", set any rounding parameters (such as integer for categorical variables). Note that Graham suggests leaving rounding to a minimum, as this adds a small amount of additional random error variance. (Graham, P.77).

c. Click on the "Summarize" tab and Click "Run"
   i. Verify your data (Graham, p.78-80).
   ii. Generally, you want to verify that the number of missing data points/% missing accurately reflects what you expect from what you know of your data.
   iii. Review the "Matrix of Missingness Patterns". Hopefully, there are many complete cases (i.e., with all 1s) and no completely empty cases (i.e., with all 0s). Graham believes that it is not good form to include these blank cases. See Graham p.79.

11. Running the EM Algorithm
   a. Select the "EM Algorithm" tab and click on the "Computing" button at the bottom.
      i. Max Iterations should be = 1000 and "Maximum-likelihood estimate" should be selected. Click "Ok". (*For additional scenarios & details, see Graham pp.81-86.*)
      ii. Click "Run" on the "EM Algorithm" tab at the top right.
   b. Review the EM Output (Graham, pp. 82-85)
      i. The top part of the EM output file contains basic information about the dataset, any transformations, means, and SDs.
      ii. The second part reflects the "iteration history" for the observed data loglikelihood function. Scan the values quickly – they should change monotonically.
      iii. When this is the case, the number of iterations should be reasonably low (<1000).
      iv. Write down the number of iterations, as this value will be used later. (You also want to write "EM converged normally in XXX iterations" in any paper).
      v. Any surprises here are discussed in Graham p.85
      vi. The last part of the EM Output contains the ML parameter estimates (means, SDs, etc.). Graham believes that these are the best point estimates for these parameters and, if reported in any paper, should be taken from this output (Graham, p. 85).

12. Imputing from (EM) Parameters
   a. Select the "Impute from parameters" tab & Click "Run"
   b. This will yield the *_0.imp data file (see p.87). This file can be used for data quality analyses such as coefficient alpha or exploratory factor analysis. *It should not, however, be used for any hypothesis testing.*
   c. Graham describes what to do if this step fails on p. 87.

13. Data Augmentation (and Imputation) [Graham, p.88]
   a. Select the "Data Augmentation" tab.
   b. Click on the "Series" button (at the bottom, far right).
      i. Select "Save all parameters at every *k*th cycle, where *k*=1).
      ii. Click "OK"
   c. Click on the "Imputation" button (at the bottom, middle).
      i. Select "Impute at every *k*th iteration".

ii. In the "k = " cell, enter the number of iterations it took for EM to converge (from Step 10.b.iv)
iii. Click "OK"
iv. If you do not trust your data, see Graham p.88 for more details.

d. Click on the "Computing" button (at the bottom, far left).
i. Ensure that "Standard noninformative prior" is selected (if using Ridge Prior earlier, see Graham p.88)
ii. In the "No. of iterations" cell, enter the value of *k* from Step 10.b.iv multiplied by how many imputations you wish to create (Graham suggests 40 imputations. Thus, if EM converged after 30 iterations, the number entered in this cell would be equal to 40 X 30 = 1200). This means that after every *k* data augmentation steps (i.e., every 30 DA steps), NORM will write out an imputed dataset. Each will be sequentially labelled *_1.imp, *_2.imp, etc.. until 40 imputed datasets are created.
iii. "Click OK"

e. Click "Run" (top right). *(If you've excluded a variable from your imputation (i.e., ID Number), you may get a warning that you are including excluded variables in your dataset, click "ok".)*
i. This may take a few minutes, depending on the number of variables included in your model and the power of your computer.
ii. Once it is complete, you will have 40 imputed files in the folder we created earlier.

14. Data Augmentation Diagnostics
a. This step checks the diagnostic plots to verify: "(a) that the number of DA steps between imputed data sets was sufficient, and (b) that the imputation solution was 'acceptable,' and not 'pathological'" (cited from Graham, p. 89).
b. Under the "Series" menu, select "Open"
i. Click on the "da.prs" file (*in the correct folder*) and select "Open".
ii. Under the "Series" menu, select "plot" and "means"
iii. Page through each graph to check the following :
1. The top plot is the "series" plot for each parameter. Acceptability in these plots means that they generally look like a rectangle (the values should not "wander" up or down too much).
2. The bottom plot is the sample autocorrelation function (the correlation of the parameter from one step of DA with the same parameter at 5, 10, 20, 50, 100 steps removed). The red lines indicate significance. Falling within these lines (mostly below this red line) after a few steps indicates non-significant correlations (indicating random draws). <u>This is what you want.</u>
3. Graham p. 90-93 includes sample plots and interpretations for acceptable, unclear, and pathological plots – as well as what to do in each case.
iv. Under the "Series" menu, select "plot" and "covariances" – repeat the above checks for each graph.

15. MI Automate

MI Automate is a java-based program that will take all 40 imputed datasets created by NORM and combine them into one dataset. It will also generate an SPSS syntax file facilitating the importation of the data into SPSS. For more details, see Graham pp.95-98.

a. Run the "MI Automate" program by double-clicking on "MIAutomate.exe". N.B. *We will be proceeding from top to bottom **BEFORE** clicking on "Run".*
b. For Input Dataset, click on "Browse". Locate the folder containing the data and imputed files and select the **original** *.dat file (e.g., EdAttain.dat). Click "Ok"
c. Check the box for "Variable names file available?"
d. For No. of Imputations, enter "40" (or the number of imputations you selected in Step 12.d.ii)
e. Click on the "Select first file" button and select the first imputed file (typically, *_1.imp [e.g., EdAttain_1.imp]). Click "Ok".
(VERY IMPORTANT: DO NOT SELECT *_0.imp as your first file!)
f. For "Syntax Choice:" select "SPSS 17-20".
g. Click on the "Run" button.

16. Once MI Automate is done (this may take a few seconds), the program will ask you if you wish to launch SPSS. Click on "Yes".
    a. SPSS should now be open, as well as the Syntax editor with SPSS1.sps already opened.
    b. *N.B. Verify that all your variables are listed in the syntax. MI Automate sometimes omits certain variables. If they are not all present, manually enter them **in the same order as the *.nam** file, and write "[space]f16.8" after each variable name, where 16 is the column width and 8 is the decimals spaces desired.*
    c. In the "Run" menu, click on "All".
    d. Save this new SPSS file under a different name that clearly indicates that this contains imputed data. All 40 datasets should now be merged and a new variable should be added at the beginning (_imputation).

17. You may now repeat steps 14 & 15 for the *_0.imp file – this file contains 1 imputed dataset that was created using the EM algorithm prior to data augmentation. As note earlier, this is the file from which you will draw your parameter estimates, such as standardized βs for multiple regression or Wald's for logistic binary regression. It is not to be used for hypothesis testing, as it will underestimate error terms (Graham, 2012). The statistical tests must always be conducted using the pooled results from *m* imputed datasets.
    a. For Input Dataset, click on "Browse". Locate the folder containing the data and imputed files and select the **original** *.dat file (e.g., EdAttain.dat). Click "Ok"
    b. Check the box for "Variable names file available?"
    c. For No. of Imputations, enter "1"
    d. Click on the "Select first file" button and select the first imputed file (typically, *_0.imp [e.g., EdAttain_1.imp]). Click "Ok".
    e. For "Syntax Choice:" select "SPSS 17-20".
    f. Click on the "Run" button.
    g. Now repeat step 15 for this dataset, and save it as "Imputed dataset - File 0".

Appendix B1. Cross-Sectional and Longitudinal Imputation Models, Missing Cases, And EM Convergence Iterations for Study 1 variables

Variables	Cross-sectional sample (N = 3,662) Number missing (%)	Longitudinal subsample (*n* = 962) Number missing (%)
Dependent variable components for T1 Academic Success		
T1 Performance matches ability [a]	46 (1.3%)	13 (1.35%)
T1 New skills are being acquired [a]	47 (1.3%)	12 (1.25%)
T1 Reading achievement [b]	185 (5.1%)	33 (3.43%)
T1 Math achievement [b]	175 (4.8%)	27 (2.81%)
T1 Overall school achievement [b]	199 (5.43%)	40 (4.16%)
T1 Youth is ahead or behind cohort [a]	357 (9.75%)	102 (10.60%)
T1 Youth's view of school work [c]	338 (9.23%)	79 (8.21%)
Dependent variable components for T2 Academic Success		
T2 Performance matches ability [a]		
T2 New skills are being acquired [a]	--	12 (1.25%)
T2 Reading achievement [b]	--	12 (1.25%)
T2 Math achievement [b]	--	100 (10.40%)
T2 Overall school achievement [b]	--	103 (10.71%)
T2 Youth is ahead or behind [a]	--	116 (12.06%)
T2 Youth's view of school work [c]	--	102 (10.60%)
	--	117 (12.16%)
Independent Variables		
T1 Exact Age	0 (0.00%)	0 (0.00%)
Gender	0 (0.00%)	0 (0.00%)
T1 Placement Type	82 (2.24%)	0 (0.00%)
Minority Ethnicity: FNMI	264 (7.21%)	49 (5.09%)
Minority Ethnicity: Black	264 (7.21%)	52 (5.41%)
Age of first entry into care	0 (0.00%)	0 (0.00%)
Reason for Entry in care: Neglect	0 (0.00%)	0 (0.00%)
T1 Academically-related impairments	236 (6.44%)	48 (4.99%)
T1 Behavioural Problems	263 (7.18%)	61 (6.34%)
T1 Internal Developmental Assets	472 (12.89%)	113 (11.75%)
T1 Positive Mental Health Scale	880 (24.03%)	251 (26.09%)
T1 Time with Current Caregiver	141 (3.85%)	32 (3.33%)
T1 Caregiver Instability	206 (5.63%)	47 (4.89%)
T1 Youth Educational Aspirations	814 (22.23%)	221 (22.97%)
T1 Caregiver Educational Aspirations	395 (10.79%)	87 (9.04%)
T1 School Instability	164 (4.48%)	46 (4.78%)
T1 Grade Retention	264 (7.21%)	43 (4.47%)
T1 Soft Drug Use	326 (8.90%)	66 (6.86%)
T1 Suicide Risk	482 (13.16%)	112 (11.64%)

Appendix B2. Cross-Sectional and Longitudinal Imputation Models, Missing Cases, And EM Convergence Iterations for Study 1 variables (continued)

Variables	Cross-sectional sample (N = 3,662) Number missing (%)	Longitudinal subsample (*n* = 962) Number missing (%)
Interaction variables		
Gender X Exact Age	0 (0.00%)	0 (0.00%)
Gender X Placement Type	265 (7.24%)	53 (5.51%)
Gender X Minority Ethnicity: FNMI	104 (2.84%)	15 (1.56%)
Gender X Minority Ethnicity: Black	104 (2.84%)	16 (1.66%)
Gender X Age of first entry into care	0 (0.00%)	0 (0.00%)
Gender X Reason for entry: Neglect	0 (0.00%)	0 (0.00%)
Gender X Academically-related impairments	90 (2.46%)	15 (1.56%)
Gender X Behavioural Problems	118 (3.22%)	23 (2.39%)
Gender X Internal Developmental Assets	674 (18.41%)	162 (16.84%)
Gender X Positive Mental Health	388 (10.60%)	104 (10.81%)
Gender X Time with Current Caregiver	57 (1.56%)	9 (0.94%)
Gender X Caregiver Instability	87 (2.38%)	20 (2.08%)
Gender X Youth Educational Aspirations	329 (8.98%)	82 (8.52%)
Gender X Caregiver Educational Aspirations	169 (4.61%)	28 (2.91%)
Gender X School Instability	70 (1.91%)	20 (2.08%)
Gender X Grade Retention	113 (3.09%)	12 (1.25%)
Gender X Soft Drug Use	135 (3.69%)	19 (1.98%)
Gender X Suicide Risk	202 (5.52%)	45 (4.68%)
Expectation Maximization (EM) algorithm iterations until normal convergence	17	31

Notes:
T1 signifies Time 1 (Wave 10; 2010-2011) data;
T2 signifies T2 (Wave 13; 2013-2014) data.
No cases were missing all variables.
a = Data source is the Child Welfare Worker;
b = Data source is the Caregiver;
c = Data source is the Young person.

Appendix C1. Source OnLAC AAR waves for merged T1 and T2 data (N=512)

T1 AAR source year (from OnLAC)	T2 AAR source year (from OnLAC)	Approximate gap length (in years)	N	%
Wave 6	Wave 7	1	14	2.7
Wave 6	Wave 8	2	17	3.3
Wave 6	Wave 9	3	10	2.0
Wave 6	Wave 10	4	6	1.2
Wave 6	Wave 11	5	1	0.2
Wave 7	Wave 8	1	20	3.9
Wave 7	Wave 9	2	26	5.1
Wave 7	Wave 10	3	18	3.5
Wave 7	Wave 11	4	14	2.7
Wave 7	Wave 12	5	4	0.8
Wave 8	Wave 9	1	25	4.9
Wave 8	Wave 10	2	41	8.0
Wave 8	Wave 11	3	48	9.4
Wave 8	Wave 12	4	32	6.3
Wave 9	Wave 10	1	11	2.1
Wave 9	Wave 11	2	29	5.7
Wave 9	Wave 12	3	44	8.6
Wave 10	Wave 11	1	31	6.1
Wave 10	Wave 12	2	104	20.3
Wave 11	Wave 12	1	17	3.3

Appendix C2. Total number of cases and percentage of total sample by approximate gap length (N=512)

Approximate Gap Length (in years)	N	%
1	118	23.0
2	217	42.4
3	120	23.4
4	52	10.2
5	5	1.0

Notes:
Approximate Gap Length represents the numeric difference between waves (i.e. Wave 10 – Wave 9 = 1).
The variable "Exact Gap Length" was calculated separately and not used in determining from which OnLAC project waves Time 1 and Time 2 data were drawn.

Appendix D. Multiple Imputation Model, Missing Cases, and EM Normal Convergence Iteration for Study 2 variables

Variables	N = 512 Number Missing (%)
Dependent variables	
T2 Educational Attainment	60 (11.72%)
T2 Youth Educational Aspirations	103 (20.12%)
T2 NEET Status*	87 (16.99%)
Independent Variables	
Control Factor	
Exact Gap Length	0 (0.00%)
Contextual Factor	
T1 Placement Type	3 (0.59%)
Individual Risk Factors	
T1 Behavioural Problems	88 (17.19%)
T1 Soft Drug Use	56 (10.94%)
Academically-related impairments	41 (8.01%)
Individual Protective Factors	
T1 Exact Age	0 (0.00%)
Gender	0 (0.00%)
T1 Internal Developmental Assets	81 (15.82%)
T1 Academic Performance	117 (22.85%)
Interaction Terms	
Exact Gap Length X T1 Placement Type	3 (0.59%)
Exact Gap Length X T1 Behavioural Problems	88 (17.19%)
Exact Gap Length X Soft Drug Use	56 (10.94%)
Exact Gap Length X Academically-related impairments	41 (8.01%)
Exact Gap Length X T1 Exact Age	0 (0.00%)
Exact Gap Length X Gender	0 (0.00%)
Exact Gap Length X T1 Internal Developmental Assets	81 (15.82%)
Exact Gap Length X T1 Academic Performance	117 (22.85%)
Expectation Maximization (EM) algorithm iterations needed until normal convergence	30

Notes:

** NEET = Not in Education, Employment, or Training.*

T1 signifies Time 1 (data taken from the first AAR available between 2006 and 2013);

T2 signifies Time 2 (data taken from the latest AAR available between 2006 and 2013).

No cases were missing all variables.

Appendix E. OnLAC AAR (AAR-C2-2010) for ages 16-17

Notes:

This appendix contains the OnLAC AAR-C2-2010 shrunk to 89% of the original page size.

Other versions of the AAR were also used and are available upon request, these include:

AAR-C2-2006 for ages 12-15

AAR-C2-2006 for ages 16-17

AAR-C2-2006 for ages 18+

AAR-C2-2010 for ages 12-15

AAR-C2-2010 for ages 18+

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

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

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

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

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

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

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

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

PLEASE DO NOT:

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

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

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

Main language of AAR conversation:
☐ English ☐ French ☐ First Nations or Inuit language ☐ Other

The AAR is written in:
☒ English ☐ French

Age-group of this AAR is:
☐ 18-21 years ☐ 12-15 years ☐ 5-9 years ☐ 1-2 years
☒ 16-17 years ☐ 10-11 years ☐ 3-4 years ☐ 0-11 months

Province or territory of young person's placement:
☐ Alberta ☐ Northwest Territories ☐ Québec
☐ British Columbia ☐ Nova Scotia ☐ Saskatchewan
☐ Manitoba ☐ Nunavut ☐ Yukon
☐ New Brunswick ☐ Ontario ☐ Other
☐ Newfoundland and Labrador ☐ Prince Edward Island

Province or territory with legal guardianship of the young person (if different from province or territory of young person's placement):
☐ Alberta ☐ Northwest Territories ☐ Prince Edward Island
☐ British Columbia ☐ Nova Scotia ☐ Québec
☐ Manitoba ☐ Nunavut ☐ Saskatchewan
☐ New Brunswick ☐ Ontario ☐ Yukon
☐ Newfoundland and Labrador

BACKGROUND INFORMATION

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

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

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

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

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

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

- ☐ Kinship in care
- ☐ Foster home operated by child welfare organization
- ☐ Group home operated by child welfare organization
- ☐ Foster home - outside purchased care
- ☐ Group home - outside purchased care
- ☐ Children's mental health residential facility
- ☐ Hospital
- ☐ Customary care (in the case of aboriginal children)
- ☐ Other
- ☐ Psychiatric facility
- ☐ With birth parent(s)
- ☐ Adoption probation
- ☐ With relatives (not in foster care)
- ☐ Whereabouts unknown or unapproved
- ☐ Independent living
- ☐ Shelter
- ☐ Custody/Detention facility

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

- ☐ Regular foster care
- ☐ Specialized foster care
- ☐ Treatment foster care
- ☐ Other foster care

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

☐ Males only ☐ Females only ☐ Both genders

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

☐ Yes ☐ No

BG3A: 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 499,999
- ☐ Urban, population 30,000 to 99,999
- ☐ Urban, population < 30,000
- ☐ Northern remote area
- ☐ Rural area
- ☐ First Nations reserve

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

☐☐☐☐☐☐

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

☐☐ **Years**

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

- ☐ Temporary care agreement
- ☐ Interim care and custody
- ☐ Customary care
- ☐ Society ward
- ☐ Crown ward, with access
- ☐ Crown ward
- ☐ Extended care and maintenance
- ☐ Other

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

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

☐ Yes ☐ No ☐ Don't know

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

☐ Yes ☐ No ☐ Don't know

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

☐ Status ☐ Non-Status ☐ Bill C-31 ☐ Eligible but not registered ☐ Don't know

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

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

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

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

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

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

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

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

☐ **Other**

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

☐☐ **Years** ☐☐ **Months (If less than one year.)**

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

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

☐ Yes ☐ No

BG11B: If yes, please describe:

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2. INFORMATION ON THE CURRENT PLACEMENT SETTING.

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

☐☐ **Total number of children or youths not in care**

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

☐☐ **Total number of children or youths in care besides young person**

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

☐☐ **Total number of siblings**

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

BG15: Child welfare worker's gender:

☐ Male ☐ Female

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

☐ Less than 1 year ☐ 1-3 years ☐ 4-9 years ☐ 10 years and over

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

☐ Less than 1 year ☐ 1-3 years ☐ 4-9 years ☐ 10 years and over

BG18: The child welfare worker's team is:

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

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

☐ A FNMI team

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

☐ Yes ☐ No

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

☐ Less than a high school diploma
☐ High school 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 level
☐ Bachelor degree
☐ University certificate or diploma above bachelor level
☐ Master's degree
☐ Doctoral degree

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

- ☐ Social work
- ☐ Child & youth care
- ☐ Native Studies
- ☐ Other

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

- ☐ Yes
- ☐ No

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

- ☐ Not applicable, this is my first AAR
- ☐ Sometimes
- ☐ Very often
- ☐ Almost never

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

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

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

BG25: Main respondent's gender:

- ☐ Male
- ☐ Female

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

- ☐ Less than 1 year
- ☐ 1-3 years
- ☐ 4-9 years
- ☐ 10 years and over

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

- ☐ English
- ☐ French
- ☐ First Nations or Inuit language
- ☐ Other

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

- ☐ No religion or spiritual affiliation
- ☐ Anglican
- ☐ Baptist
- ☐ Buddhist
- ☐ Eastern Orthodox
- ☐ FNMI (traditional)
- ☐ FNMI (other)
- ☐ Mormon
- ☐ Hindu
- ☐ Islam (Muslim)
- ☐ Jehovah's Witness
- ☐ Jewish
- ☐ Lutheran
- ☐ Mennonite
- ☐ Pentecostal
- ☐ Presbyterian
- ☐ Roman Catholic
- ☐ United Church
- ☐ Sikh
- ☐ Other

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

☐ The same ☐ Similar ☐ Neither the same nor similar

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

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

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

☐ Yes ☐ No

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

☐ Daily ☐ Occasionally ☐ Not at all

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

☐ Yes ☐ No

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

☐ PRIDE pre-service (Parenting Resources for Information, Development & Education program)

☐ Agency-specific program (i.e., PRIDE in-service)

☐ Foster parenting techniques (training offered by a CEGEP or college)

☐ Other program

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

BG35: What is the model of the group home?

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

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

☐ Other

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

☐ Not applicable ☐ A team of group home workers ☐ A key group home worker

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

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

☐ No **(IF NO, PLEASE GO SECTION 6 - question BG42)**

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

BG42: HEIGHT: How tall is ...?

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

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

☐☐☐ **Pounds OR** ☐☐☐ **Kilograms**

BG44: FNMI YOUNG PEOPLE (If not an FNMI young person, go to question BG46): When did ... last see a Traditional Healer?

☐ Less than a year ago ☐ More than a year ago ☐ Never **(Go to question BG46)**

BG45: Has everything the Healer recommended been done?

☐ Yes ☐ No ☐ Uncertain ☐ No recommendation(s)

BG46: MEDICAL EXAM: When did ... last have a medical exam?

☐ Less than a year ago ☐ More than a year ago ☐ Never had one **(Go to question BG48)**

BG47: Has everything the doctor recommended been done?

☐ Yes ☐ No ☐ Uncertain ☐ No recommendation(s)

BG48: DENTAL EXAM: When did ... last visit the dentist?

☐ Less than a year ago ☐ More than a year ago ☐ Never **(Go to question BG50)**

BG49: Have all treatments the dentist recommended been carried out?

☐ Yes ☐ No ☐ Uncertain ☐ No recommendation(s)

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BG50: Is ... taking any psychotropic and/or behaviour altering medication(s) prescribed by a physician (e.g., Ritalin, tranquilizers, anti-convulsants, etc.)?

☐ Yes ☐ No **(Go to question BG52)** ☐ Uncertain

BG51: If ... is taking psychotropic and/or behaviour altering medication(s) prescribed by a physician, is this being monitored by an appropriate health care professional?

☐ Yes ☐ No ☐ Uncertain

BG52: HOSPITALIZATIONS: In the past 12 months, was ... ever an overnight patient in the hospital?

☐ Yes ☐ No

BG53: IMMUNIZATIONS: Are all of ...'s immunizations up-to-date?

☐ Yes ☐ No

BG54: LONG-TERM CONDITIONS: In this question "long-term conditions" refer to conditions that have lasted or are expected to last 6 months or more and have been diagnosed by a health professional. Does ... have any of the following long-term conditions? **(Mark all that apply.)**

☐ None	☐ Fetal alcohol spectrum disorder
☐ Food or digestive allergies	☐ Cerebral palsy
☐ Respiratory allergies such as hay fever	☐ Kidney condition or disease
☐ Any other allergies	☐ Blood disorder (i.e., Von Willebrand, hemophilia, etc.)
☐ Asthma	☐ Developmental disability
☐ Bronchitis	☐ Learning disability
☐ Heart condition or disease	☐ Attention deficit disorder
☐ Epilepsy	☐ Emotional, psychological, or nervous difficulties
☐ Diabetes	☐ Any other long-term condition

BG55: HEALTH SERVICES RECEIVED BY THE YOUNG PERSON DURING THE LAST 12 MONTHS:
For each of the service providers listed, please indicate whether ... has received services from such a provider during **the last 12 months.**

1. Family physician ☐ Yes ☐ No	**6. Dentist** ☐ Yes ☐ No	**11. Speech therapist** ☐ Yes ☐ No
2. Pediatrician ☐ Yes ☐ No	**7. Orthodontist** ☐ Yes ☐ No	**12. Physiotherapist** ☐ Yes ☐ No
3. Ophthalmologist ☐ Yes ☐ No	**8. FNMI Traditional Healer** ☐ Yes ☐ No	**13. Occupational therapist** ☐ Yes ☐ No
4. Other MD ☐ Yes ☐ No	**9. Optometrist** ☐ Yes ☐ No	**14. Nurse practitioner** ☐ Yes ☐ No
5. Nurse ☐ Yes ☐ No	**10. Audiologist** ☐ Yes ☐ No	**15. Other health service provider** ☐ Yes ☐ No

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7. BACKGROUND INFORMATION RELATING TO THE YOUNG PERSON'S EDUCATION

BG56: TYPE OF SCHOOL: What type of school is ... (i.e., the young person in care) currently enrolled in? (Or, if this conversation takes place during the summer, what type of school was ... enrolled in during the last school year?)

- ☐ Not currently in school **(Go to question BG58)**
- ☐ Public school
- ☐ Catholic school (publicly funded)
- ☐ Private school
- ☐ FNMI school
- ☐ Taught in an institution (e.g., hospital, young offender facility, child welfare facility)
- ☐ Taught at home (home schooling)
- ☐ Post-secondary
- ☐ Other

BG57: In what language is ... mainly taught?

☐ English ☐ French ☐ First Nations or Inuit language ☐ Other

BG58: What is the highest grade that ... has completed?

- ☐ Grade 8 (Secondaire II in QC)
- ☐ Grade 9 (Secondaire III in QC)
- ☐ Grade 10 (Secondaire IV in QC)
- ☐ Grade 11 (Secondaire V in QC)
- ☐ Grade 12 (Ontario Secondary School Diploma)
- ☐ Grade 12 (Ontario Certificate of Accomplishment)
- ☐ First year of post-secondary
- ☐ Other

BG59: Has ... repeated a grade at school (including kindergarten)?

☐ Yes ☐ No

BG60: CHANGES IN SCHOOLS: Other than the natural progression through the school system, how many times (if any) has ... changed schools since birth?

- ☐ No changes in school (other than natural progression through the school system)
- ☐ 1 or 2 changes
- ☐ 3 or 4 changes
- ☐ 5-7 changes
- ☐ 8 or more changes

LEVEL OF DIFFICULTY: The next few questions concern levels of difficulty of different subjects that may be offered at the school currently or last attended by the young person in care. The terms used may not be the same as those used in your community. The **advanced/enriched** level includes courses targeting those with stronger abilities/performance in their grade and allows them to progress more rapidly. The **general** level includes courses targeting those with average abilities/performance and allows students to progress normally. The **basic** level includes courses targeting students with lower abilities/school performance and allows them to accomplish different educational or occupational plans. For each of the following subjects, please indicate the level at which the young person in care is enrolled (or was enrolled during the last year that he/she was enrolled in school):

BG61: Reading and other language arts (spelling, grammar, composition)?

☐ Advanced/Enriched ☐ General ☐ Basic ☐ Does not take it

BG62: Mathematics?

☐ Advanced/Enriched ☐ General ☐ Basic ☐ Does not take it

BG63: Science?

☐ Advanced/Enriched ☐ General ☐ Basic ☐ Does not take it

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BG64: EDUCATIONAL AND RECREATIONAL SERVICES RECEIVED BY THE YOUNG PERSON DURING THE LAST 12 MONTHS: Has ... received services from the following providers in the **last 12 months**?

	Yes	No
1. Teacher (regular class)	☐	☐
2. Teacher (special education)	☐	☐
3. Teacher's aide	☐	☐
4. Educational tutor	☐	☐
5. Other educational or recreational service provider	☐	☐
6. Paid recreation/sports instructor or coach	☐	☐
7. Volunteer (unpaid) recreation/sports instructor or coach	☐	☐
8. Volunteer/paid driver	☐	☐
9. Summer camp staff	☐	☐
10. FNMI Traditional Elder or Cultural Teacher	☐	☐
11. FNMI cultural recreational service provider	☐	☐

8. BACKGROUND INFORMATION RELATING TO THE YOUNG PERSON'S FAMILY AND SOCIAL RELATIONSHIPS

BG65: How long has ... been living with his/her current caregiver? **(If less than one year indicate months.)**

☐☐ **Years** ☐☐ **Months (If less than one year.)**

BG66: Is there a permanency plan for ...?

☐ Yes ☐ Uncertain ☐ No

BG67: The permanency plan for the young person is to:

☐ Remain in current placement ☐ Status change to legal custody ☐ Move to adult services

☐ Move to adoption ☐ Move to customary care ☐ Discharge from care

☐ Move to kinship ☐ Move to independent living ☐ Other

☐ Permanency plan is not yet determined

BG68: Is it the caregiver's intention to have this young person in the current placement into adulthood?

☐ Yes ☐ No ☐ Uncertain

BG69: How many changes in main caregivers has ... experienced since birth? **(A main caregiver is a person who has acted in that capacity for one month or more. If care was shared by two or more people, select only one of these people as a main caregivers for that period.) Try to give an estimate of the number, even if you are not certain.**

☐☐ **Changes in main caregiver(s) (write in total number)**

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BG70: CHANGES IN PLACE OF RESIDENCE: How many times in ...'s life has he/she moved, that is, changed his/her **usual** place of residence? **(Write in the number of times.)**

☐☐ No. of times (00 = none; 01 = once; 02 = twice; etc.)

BG71: CONTACT WITH BIRTH FAMILY: What main type of contact does ... have with his/her birth family (i.e. birth mother, birth father, siblings he/she is not living with, extended birth family)?

☐ At least once a month
☐ Less than once a month
☐ Telephone or letter contact only
☐ No contact at all
☐ Crown ward, with no access
☐ Deceased

BG72: If ... is not living with all of his/her sibling(s), is ... receiving all necessary assistance to remain in contact with his/her sibling(s)?

☐ Yes ☐ No ☐ Not applicable

BG73: Is ... receiving all necessary assistance to remain in contact with his/her birth family?

☐ Yes ☐ No ☐ Not applicable

BG74: PREVIOUS CAREGIVERS: What main type of contact does ... have with his/her previous caregivers?

☐ At least once a month
☐ Less than once a month
☐ Telephone or letter contact only
☐ No contact at all
☐ Has not had any previous foster parents or other adult caregivers

BG75: Is ... receiving all necessary assistance to remain in contact with his/her previous supportive caregiver(s)?

☐ Yes ☐ No ☐ Not applicable

BG76: PLACEMENT SETTING(S) IN WHICH THE YOUNG PERSON HAS LIVED DURING THE LAST 12 MONTHS: Please indicate whether the young person has lived in one or more of the following placement settings during the last 12 months.

1. Foster care ☐ Yes ☐ No

2. Group home ☐ Yes ☐ No

3. Residential treatment ☐ Yes ☐ No

4. Independent living ☐ Yes ☐ No

5. Respite/relief home (young person leaves foster home) ☐ Yes ☐ No

6. Hospital ☐ Yes ☐ No

7. Custody/detention facility ☐ Yes ☐ No

8. Kinship in care ☐ Yes ☐ No

9. Customary care home ☐ Yes ☐ No

10. Other residential placement setting ☐ Yes ☐ No

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BG77: SERVICES RECEIVED BY THE YOUNG PERSON DURING THE LAST 12 MONTHS:
For each of the service providers listed please indicate whether ... has received services from such a provider in the **last 12 months**.

1. Child welfare worker ☐ Yes ☐ No	**5. Police officer** ☐ Yes ☐ No	**9. FNMI Traditional Healer** ☐ Yes ☐ No
2. Social worker (not from child welfare agency) ☐ Yes ☐ No	**6. Child access worker** ☐ Yes ☐ No	**10. FNMI Cultural Teacher** ☐ Yes ☐ No
3. Child & youth care worker ☐ Yes ☐ No	**7. Probation Officer** ☐ Yes ☐ No	**11. Volunteer Driver** ☐ Yes ☐ No
4. Lawyer ☐ Yes ☐ No	**8. Adoption worker** ☐ Yes ☐ No	**12. Other child welfare service provider** ☐ Yes ☐ No

9. BACKGROUND INFORMATION RELATING TO THE YOUNG PERSON'S EMOTIONAL AND BEHAVIOURAL DEVELOPMENT

BG78: MENTAL HEALTH SERVICES RECEIVED BY THE YOUNG PERSON DURING THE LAST 12 MONTHS: For each of the service providers listed please indicate whether ... has received services from such a provider during the **last 12 months**.

1. Psychiatrist ☐ Yes ☐ No	**3. Psychologist/counsellor** ☐ Yes ☐ No
2.Other mental health service provider ☐ Yes ☐ No	

BG79: ADVERSITIES: Which of the following family-related adversities has ... experienced in the last year? **(Mark all that apply).**

☐ Death of his/her birth or step parent	☐ Abuse of drugs or alcohol by his/her birth or step father
☐ Death of his/her brother or sister	☐ Violence between his/her birth or step parents
☐ Death of his/her relative or close friend	☐ His/her birth or step mother spent time in jail
☐ Divorce or separation of his/her birth or step parents	☐ His/her birth or step father spent time in jail
☐ Serious physical illness of his/her birth or step mother	☐ Severe poverty
☐ Serious physical illness of his/her birth or step father	☐ Physical abuse
☐ Serious psychiatric disturbance of his/her birth or step mother	☐ Sexual abuse
☐ Serious psychiatric disturbance of his/her birth or step father	☐ Emotional abuse
☐ Abuse of drugs or alcohol by his/her birth or step mother	☐ Neglect

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BG80: ADVERSITIES: Which of the following self-related adversities has ... experienced in the last year? **(Mark all that apply.)**

- ☐ A change in caregivers because of ...'s behaviour problems
- ☐ Serious arguments with his/her birth or step parents
- ☐ Ran away from home multiple times
- ☐ Skipping school (truancy)
- ☐ Became pregnant
- ☐ Suspension from school (temporary or not)
- ☐ Spent time in a detention centre
- ☐ Failed a grade and was held back
- ☐ Received treatment for substance abuse
- ☐ Was beaten up by school mates
- ☐ Was hopitalized for depression
- ☐ Changed schools for reasons other than planned progress through the school system

Looking After Children AAR-C2-2010 - Assessment and Action Record (16-17 yrs)

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The main principles and values of Looking After Children:

1. The welfare of the young person is paramount.
2. Agencies should aim for standards equivalent to those of a well informed parent with adequate resources.
3. Agencies require a formal system to plan and record what good parents do daily.
4. Agencies with care and responsibility of young people must work in partnership with birth parents, current caregivers, and relevant other professionals.
5. Young people must be consulted and listened to as soon as they are old enough.
6. Each young person is an individual with unique needs.
7. A young person with a disability is firstly a young person who has additional needs.
8. Access should only happen if it is meaningful and beneficial to the young person and doesn't prevent the permanency of placement.
9. Young people have a right to keep in touch with their birth family's cultural traditions.
10. LAC's aim is to promote both well-being and success, and not just to prevent harm.
11. Young people in care may have needs which are more difficult to meet than their peers, but outcome targets should not be set at a lower standard than those for their equals; child welfare workers should act on behalf of the young person to organize resources.
12. LAC focuses on daily experiences that improve young people's prospects for adult life.
13. LAC is a youth-centred developmental way of working and not a bureaucratic system.
14. Assessments should take account of the perspectives of all those involved, paying particular attention to the young person's interests and feelings.
15. Positive action will improve a young person's health and educational performance.
16. Achievable objectives should be collaborated on for all developmental dimensions.
17. All plans of care make it clear who is responsible for what and by when.
18. Positive work is possible even in less than ideal circumstances.

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

These prompts are meant to help the child welfare worker and the caregiver(s) to answer the various questions posed during the AAR conversation.

Index of AAR developmental dimensions

Health

Education

Identity

Family and social relationships

Social presentation

Emotional and behavioural development

Self-care skills


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Looking After Children AAR-C2-2010 - Health dimension (16-17 yrs) 1

DEVELOPMENTAL DIMENSION 1: HEALTH

This dimension is about the health of the young person and the help he/she is getting to be and remain well. The questions in this section are designed to make sure that the young person is getting all necessary preventive medical care, including immunizations, that any health problems or disabilities are being properly treated, and that he/she is learning to keep in shape. This section also asks questions about things that affect the young person's health such as diet and safety issues.

Note to the child welfare worker: *Please use the right-hand page for each item on which you judge that further action needs to be taken during the coming year.* ***For each such item, note the action to be taken, the person responsible, and the target date, for inclusion in the updated individualized Plan of Care.***

During the AAR conversation, the **YOUNG PERSON** is to answer the following section with assistance, as needed.

H1: GENERAL HEALTH: In general, would you say your health is:
☐ Excellent? ☐ Very good? ☐ Good? ☐ Fair? ☐ Poor?

H2: Do you have problems with any of the following activities? **(Mark all that apply.)**
☐ Seeing ☐ Speaking ☐ Climbing ☐ Using hands and fingers
☐ Hearing ☐ Walking ☐ Bending ☐ No problems

H3: Are you receiving all the help and resources you require to treat the above health conditions/problems?
☐ None identified ☐ Yes ☐ No

Young people sometimes experience health problems that may or may not be related to stress and may affect other areas in their life. Your answers to the following questions will help build a picture of your general health.

During the past 6 months, how often have you had or felt the following?

H4: Headache
☐ Seldom/never ☐ About once a month ☐ About once a week ☐ More than once a week ☐ Most days

H5: Stomachache
☐ Seldom/never ☐ About once a month ☐ About once a week ☐ More than once a week ☐ Most days

H6: Backache
☐ Seldom/never ☐ About once a month ☐ About once a week ☐ More than once a week ☐ Most days

H7: Difficulties in getting to sleep
☐ Seldom/never ☐ About once a month ☐ About once a week ☐ More than once a week ☐ Most days

H8: PAIN AND DISCOMFORT: Are you usually free of pain or discomfort?
☐ Yes ☐ No

H9: MEMORY: How would you describe your usual ability to remember things? **(Mark one only.)**
☐ Able to remember most things ☐ Very forgetful
☐ Somewhat forgetful ☐ Unable to remember anything at all

H10: THINKING: How would you describe your usual ability to think and solve day-to-day problems? **(Mark one only.)**
☐ Able to think clearly and solve problems ☐ Having a great deal of difficulty
☐ Having a little difficulty ☐ Unable to think or solve problems
☐ Having some difficulty

H11: CAR SAFETY: How often do you use a seat belt when you ride in a car?
☐ Always ☐ Often ☐ Sometimes ☐ Seldom or never ☐ Usually there is no seatbelt where I sit

Looking After Children AAR-C2-2010 - Health dimension (16-17 yrs) 1a

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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).

DIMENSION 1: HEALTH

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

In Looking After Children, health is identified as a key dimension of young peoples' 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 young people's upbringing and development.

One key task of parents is safeguarding and promoting their young people's health. The Looking After Children approach aims to facilitate this important parental task of keeping young people healthy when their care is shared by a number of people.

The young person's doctor will need to know any problems he/she is having. His/her child welfare worker should check that illnesses, accidents, hospital stays, and operations have been noted in the Plan of Care.


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Looking After Children **AAR-C2-2010 - Health dimension (16-17 yrs)** **2**

H12: Are you aware of the laws pertaining to cellular phone usage while driving?

☐ Yes ☐ No

H13: BICYCLE SAFETY: How often do you wear a helmet when you ride your bicycle?

☐ Always ☐ Often ☐ Sometimes ☐ Seldom or never ☐ I do not ride a bicycle

H14: Are you taking precautions to minimize your exposure to the sun (i.e., wearing sunblock)?

☐ Yes ☐ No

***Note to the young person*:** The following questions will help build a picture of your overall health.

H15: DISABILITY: Do you have any long-term conditions or health problems which prevent or limit your participation in school, at play, in sports, or in any other activity for a young person of your age?

☐ Yes ☐ No **(Go to question H17)**

H16: SPECIAL HELP OR EQUIPMENT: Do you have all the special help or equipment you may need for any long-term conditions or disabilities you may have?

☐ Yes ☐ No ☐ No special help or equipment needed

H17: SERIOUS INJURIES: The following questions refer to injuries, such as a broken bone, bad cut or burn, head injury, poisoning, or a sprained ankle, which occurred in the past 12 months, and were serious enough to require medical attention by a doctor, nurse, or dentist. In the past 12 months were you injured?

☐ Yes ☐ No **(Go to question H19)**

H18: For the most serious injury, what type of injury did you have? **(Mark one only.)**

☐ Not applicable - no serious injuries	☐ Sprain or strain	☐ Dental injury
☐ Broken or fractured bones	☐ Multiple injuries	☐ Poisoning by substance or liquid
☐ Burn or scald	☐ Cut, scrape, or bruise	☐ Internal injury
☐ Dislocation	☐ Concussion	☐ Other

H19: DIET: Do you have a special diet for health, weight-control, religious, or cultural reasons?

☐ Yes ☐ No

H20: DIETARY ASSISTANCE: Are you receiving all the help you require to maintain a healthy daily diet, whether special or not?

☐ Yes ☐ No

H21: BREAKFAST: During a school week (Monday to Friday), how many days do you normally eat breakfast?

☐ Never ☐ 1 or 2 days a week ☐ Most school days

H22: WEIGHT: Would you say you are...:

☐ Not trying to do anything about your weight? ☐ Trying to lose weight?

☐ Trying to stay the same weight? ☐ Trying to gain weight?

H23: MEDICATIONS: Are you taking any medication(s)?

☐ Yes ☐ No **(Go to question H25)**

H24: Do you have all the information you need about the medication(s) and why you need to take it/them?

☐ Yes ☐ No

H25: PUBERTY: Do you have any questions related to body changes (e.g., acne, menstruation, voice, hair growth)?

☐ Yes ☐ No

H26: Are you getting all the information you need with questions you may have related to body changes?

☐ Yes ☐ 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).

Young people need to be given information and opportunities to talk about any disability they may have. Caregivers may also need advice and/or support. Literature and information about support groups both for young people and/or their caregivers can be obtained from organizations which exist to promote understanding of specific conditions (e.g., Canadian Diabetes Association). Various organizations provide opportunities for young people with medical conditions to take part in activities together. Parks and Recreation Departments may run specialized programs.

Financial assistance for medication, treatments, or special equipment not covered by the provincial health plan is also offered by some organizations (e.g., Multiple Sclerosis Society; Trillium Foundation).

It is important that young people in care have a diet that relates to their ethnic background and culture in order to remain familiar with the customs and daily practices of their birth family.

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H27: FNMI YOUNG PEOPLE: Are you getting guidance from a FNMI Traditional Elder or Cultural Teacher as you are entering into this new stage of life?

☐ Yes ☐ No ☐ Not Applicable

H28: SEXUALITY: Do you have any questions related to sexuality? (i.e., sexual relations, contraception, pregnancy, HIV, and other sexually transmitted diseases?)

☐ Yes ☐ No ☐ Not sure

H29: Are you receiving all the information you need with questions related to sexuality?

☐ Yes ☐ No

H30: CIGARETTES: Do you smoke cigarettes (or use other tobacco products)?

☐ Not at all **(Go to question H32)** ☐ Have tried it ☐ Occasionally ☐ Daily

H31: Are you getting all the help you need to quit smoking?

☐ Yes ☐ No ☐ I smoke but I do not want to quit

How many of your close friends do the following:

	None	A Few	Most	All
H32: Smoke cigarettes?	☐	☐	☐	☐
H33: Drink alcohol?	☐	☐	☐	☐
H34: Break the law by stealing, hurting someone, or damaging property?	☐	☐	☐	☐
H35: Have tried marijuana?	☐	☐	☐	☐
H36: Have tried drugs other than marijuana?	☐	☐	☐	☐

H37: ALCOHOL: Which of the following best describes your experience with drinking alcohol **in the past 12 months**?

☐ Not at all **(Go to question H39)** ☐ Have tried it ☐ Occasionally ☐ Daily

H38: Are you getting all the help you need to quit drinking alcohol?

☐ Yes ☐ No ☐ I drink but I do not want to stop

H39: DRUGS: Have you ever used drugs?

☐ Yes **(Go to H40)** ☐ No **(Go to H46)**

Questions regarding the young person's experiences with the following drugs are to be asked only if it pertains to this young person. ***Which of the following best describes your experience with the following drugs during the past 12 months:***

	Not at all	Tried it	Occasionally	Daily
H40: Marijuana and cannabis products (also known as a joint, pot, grass, or hash):	☐	☐	☐	☐
H41: Drugs like crack, cocaine, heroin, speed, or ecstacy, etc.:	☐	☐	☐	☐
H42: Glue, gasoline, hair spray, or other solvents:	☐	☐	☐	☐
H43: Drugs without a prescription or advice from a doctor (e.g., downers, uppers, tranquilizers, Ritalin, etc.):	☐	☐	☐	☐
H44: Hallucinogens like LSD/acid, magic mushrooms:	☐	☐	☐	☐

H45: Are you getting all the help you need to quit using drugs?

☐ Yes ☐ No ☐ I use drugs, but I do not want to quit

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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).

Accurate factual knowledge about puberty, sex, and contraception, as well as discussion about the part sex plays in relationships, are important to all young people who are developing into adulthood. If you want more information in confidence, you can talk to your doctor or child weflare worker.

Young people 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.

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 also ask to see a male or female doctor to talk about these health issues or for your healthcare.

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During the AAR conversation, the **CHILD WELFARE WORKER** is to answer the following section based on the information obtained on the entire developmental dimension of health.

ATTAINMENT OF HEALTH OBJECTIVES OF THE CHILD WELFARE SYSTEM

H46: Objective 1: The young person is normally well.
(**Note:** "Unwell" here means ill enough to be in bed or take some time off school.)

- ☐ 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)

H47: Objective 2: The young person's weight is within normal limits for his/her height.

- ☐ Within normal limits
- ☐ Slightly overweight
- ☐ Seriously overweight
- ☐ Slightly underweight
- ☐ Seriously underweight

H48: Objective 3: All necessary preventive health measures, including immunizations, are being taken.

☐ All ☐ Most ☐ A few ☐ None

H49: Objective 4: All necessary attention, including support and monitoring of medication for the young person, is being provided.

- ☐ Not on medication
- ☐ Is receiving appropriate attention
- ☐ Is receiving some attention
- ☐ Needs attention

H50: Objective 5: All ongoing health conditions and disabilities are being dealt with.

- ☐ No health condition or disability
- ☐ All being adequately dealt with
- ☐ Some being adequately dealt with
- ☐ Needs attention

H51: Objective 6: The young person 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 right hand page.*

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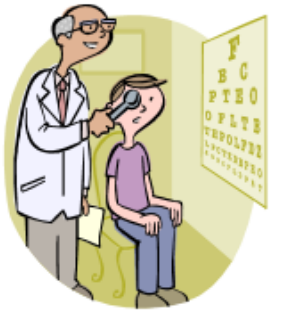
The space below allows the child welfare worker to prepare a draft of the Plan of Care (goals/objectives, work required, target date, and persons responsible for taking further action).



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.

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.

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DEVELOPMENTAL DIMENSION 2: EDUCATION

This dimension is about the young person's experiences at school. The questions in this section are designed to find out if the young person is getting the help he/she needs to make sure that he/she does as well at school as possible and that his/her education is being properly planned. The questions are also meant to find out if the young person has opportunities to learn special skills and to take part in a wide range of activities both in and out of school.

During the AAR conversation, the **CAREGIVER** is to answer the following section with assistance, as needed.

E1: GRADE: What grade is ... in?

- ☐ Not currently enrolled in school
- ☐ Grade 9 (Secondaire III in QC)
- ☐ Grade 10 (Secondaire IV in QC)
- ☐ Grade 11 (Secondaire V in QC)
- ☐ Grade 12
- ☐ Ungraded (i.e., special education)
- ☐ Apprenticeship
- ☐ College of Applied Arts and Techonolgy
- ☐ CEGEP
- ☐ Private career college
- ☐ University
- ☐ Other

E2: Does ... have possible learning-related difficulties?

☐ Yes ☐ No

E3: LEARNING-RELATED DIFFICULTIES: Has ... been assessed for possible learning-related difficulties (e.g., attention-deficit and hyperactivity disorder [ADHD]; learning disability; unsatisfactory progress; fetal alcohol spectrum disorder)?

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

E4: Has ... been identified by Identification Placement Review Committee (IPRC) as exceptional?

☐ Yes ☐ No **(Go to question E6A)**

E5: If yes, check applicable area(s) of identification **(if MULTIPLE check all that apply)**:

☐ Behaviour ☐ Communication ☐ Intellectual ☐ Physical

E6A: Does the young person have an Individual Education Plan (IEP)?

☐ Yes ☐ No **(Go to question E7)**

E6B: Is the Individual Education Plan being satisfactorily implemented?

☐ Yes ☐ No ☐ Uncertain

E7: Does ... receive special/resource help at school because of a physical, emotional, behavioural, or some other learning-related difficulty that limits the kind or amount of school work he/she can do?

☐ Yes ☐ No ☐ On a waitlist ☐ Not attending school

E8: TRANSPORTATION: Does ... have ready access to transportation (including any special equipment or assistive devices that may be needed) for getting to and from school?

☐ Yes ☐ No ☐ Not applicable

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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).

DIMENSION 2: EDUCATION

This dimension is about the young person'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.

A review of the young person's educational needs should be undertaken regularly to assess his/her academic progress. This is even more important if he/she is experiencing some academic difficulties.

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SCHOOL PERFORMANCE:
Based on your knowledge of ...'s school work, including his/her report cards, how is he/she doing in the following areas at school this year (or, during the last school year he/she was enrolled in school)?

	Very well or well	Average	Poorly or very poorly	Does not take it
E9: Reading and other language arts (spelling, grammar, composition)?	☐	☐	☐	☐
E10: Mathematics?	☐	☐	☐	☐
E11: Science?	☐	☐	☐	☐
E12: Overall?	☐	☐	☐	

E13: Overall, in comparison to his/her age group, is ...

☐ Ahead by one or more grade levels ☐ At grade level ☐ Behind by one or more grade levels

E14: If currently attending high school in **grade 9 or 10**, the majority of courses taken are in the following stream:

☐ Not applicable ☐ Academic (University-bound) ☐ Other (e.g., Special education)
☐ Specialist High Skills Major ☐ Applied (College-bound)

E15: If currently attending high school in **grade 11 or 12**, the majority of courses taken are in the following stream:

☐ Not applicable ☐ Applied (College-bound) ☐ Specialist High Skills Major
☐ Academic (University-bound) ☐ Work place ☐ Other (e.g., Special education)

E16: Overall, what is ...'s average mark this year (or what was it during the last school year or the last year he/she was in school)?

☐ Level 4 (80-100%, A- to A+) ☐ Level 3 (70-79%, B- to B+) ☐ Level 2 (60-69%, C- to C+)
☐ Level 1 (50-59%, D- to D+) ☐ R (0-49%) ☐ Not applicable, ungraded

E17: CAREGIVER'S EXPECTATIONS: How important is it to you that ... have good grades in school?

☐ Very important ☐ Important ☐ Somewhat important ☐ Not important at all

E18: How far do you hope ... will go in school?

☐ Secondary or high school graduation ☐ A university degree
☐ Apprenticeship program ☐ More than one university degree
☐ CEGEP ☐ I don't know
☐ College of Applied Arts and Technology ☐ Other
☐ Private career college

E19: EDUCATIONAL SUPPORT: Does ... have an RESP or Canada Learning Bond?

☐ Yes ☐ No ☐ Uncertain

E20: Will any of the following factors prevent ... from completing his/her education or going to post-secondary education? **(Mark all that apply.)**

☐ None of the following factors will prevent him/her from doing so ☐ Health reasons or disability
☐ His/her financial situation ☐ He/she is not interested enough
☐ No programs available close to home ☐ Other reason(s)
☐ He/she won't have the requirements

Looking After Children AAR-C2-2010 - Education dimension (16-17 yrs) 6a

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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).

Literacy is 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.

Research findings have shown that the conditions necessary for youths to learn successfully are a ready supply of suitable reading material and the close attention of an adult.

These findings underline the importance that 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.

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E21: How often do you and ... talk about his or her plans for the future?

☐ Daily ☐ One or more times a week ☐ One or more times a month ☐ Less than once a month or rarely

E22: ABSENCES FROM SCHOOL: How many days, if any, was ... absent from school during the last 12 months?

☐ 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

E23: What were the **main reasons** for... being absent from school? **(Mark all that apply.)**

☐ Illness
☐ Appointments with doctor or dentist
☐ Appointments with mental health professional
☐ Meeting with social worker or child welfare worker
☐ Transportation issue
☐ Access visits
☐ Family vacation
☐ Completing AAR/plan of care
☐ Attending FNMI ceremonies
☐ Problem with the teacher
☐ Problem with weather
☐ Problem with children/youths at school
☐ Fear of school
☐ Supension
☐ Court appearance
☐ Other

E24: 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

During the AAR conversation, the **YOUNG PERSON** is to answer the following section with assistance, as needed.

Note to the young person: The following section is about your experience of school during the current year (or during the last year you were enrolled in school).

E25: SCHOOL: How do you feel about school?

☐ 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

E26: How well do you think you are doing in your school work?

☐ Well or very well ☐ Average ☐ Poorly or very poorly

	Yes	No
E27: Do you have access to a computer at home?	☐	☐
E28: Do you have access to the internet at home?	☐	☐
E29: Do you understand the importance of internet safety?	☐	☐
E30: Does you have access to a cellular phone?	☐	☐
E31: Do you understand the importance of appropriate cellular phone use?	☐	☐

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AAR - Education dimension (16-17 yrs) 7a

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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).

A Registered Education Savings Plan (RESP) is a special type of account designed to help people save for their child's post-secondary education at university, college or trade school. RESPs can be opened on behalf of a child by their biological parents, foster parents, family members and, as of July 2005, a child welfare agency.

To help people save for the post-secondary education of their children, the Government has introduced two financial supports: the Canada Learning Bond and Canada Education Savings Grant. These financial supports can only be accessed if a child has an RESP opened on their behalf.

The Canada Learning Bond is an initial $500 payment deposited into an RESP for children who were born on or after 1 January, 2004 and who qualify to receive the National Child Benefit (NCB) supplement or the Children's Special Allowance (CSA). This payment may be followed by subsequent, annual installments of $100 for each year the child remains entitled to receive the NCB supplement or CSA. No outside contributions need to be paid into an RESP for an eligible child to receive the Canada Learning Bond.

The Canada Education Savings Grant has been available since 1998 and is available to all children under the age of 17, including children in care, regardless of when they were born. It is a matching grant on any funds which have been deposited into the child's RESP account.

As of July 2005, children in care who receive the CSA are automatically eligible for a 40% matching grant on the first $500 saved in their RESP each year. On savings over $500 and up to $2000, a 20% matching grant is available.

There is no limit to the number of RESPs a child can have opened on their behalf, although only one RESP can receive the Canada Learning Bond.

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LEVEL OF IMPORTANCE: ***How important is it to you to do the following in school?***

	Very important	Somewhat important	Not important
E32: Make friends	☐	☐	☐
E33: Get good grades	☐	☐	☐
E34: Participate in extra-curricular activities	☐	☐	☐
E35: Learn new things	☐	☐	☐
E36: Always show up for class on time	☐	☐	☐
E37: Express your opinion in class	☐	☐	☐
E38: Take part in student council or other similar groups	☐	☐	☐
E39: Hand in assignments on time	☐	☐	☐

E40: Have you started the volunteer hours required by the school curriculum?

☐ Yes ☐ No ☐ Not required ☐ Not applicable

E41: Have you received a high school diploma or its equivalent?

☐ Yes ☐ No, but I plan on doing so ☐ No, and I do not plan on doing so

ACTIVITIES: ***In the last 12 months, how often have you:***

	4 or more times a week	1 to 3 times a week	Less than once a week	Never
E42: Played sports or done physical activities without a coach or an instructor (e.g., biking, skate boarding, etc.)?	☐	☐	☐	☐
E43: Played sports with a coach or instructor, other than for gym class (e.g., swimming lessons, baseball, hockey, etc.)?	☐	☐	☐	☐
E44: Taken part in dance, gymnastics, karate, traditional dance, or other groups or lessons, other than in gym class?	☐	☐	☐	☐
E45: Taken part in art, drama, or music groups (including traditional drumming), clubs or lessons, outside of class?	☐	☐	☐	☐
E46: Taken part in clubs or groups such as Guides or Scouts, 4-H club, community, church, or other religious or cultural groups?	☐	☐	☐	☐
E47: Done a hobby or craft (drawing, model building, traditional hunting, trapping, etc.)?	☐	☐	☐	☐

SCHOOL SUBJECTS: ***How do you like the following subjects:***

	I like it a lot	I like it a little	I don't like it very much	I hate it	I don't take it
E48: Math	☐	☐	☐	☐	☐
E49: English	☐	☐	☐	☐	☐
E50: French	☐	☐	☐	☐	☐
E51: Science	☐	☐	☐	☐	☐
E52: Gym/Phys. Ed.	☐	☐	☐	☐	☐
E53: Arts (art, music, drama)	☐	☐	☐	☐	☐

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11402

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).

Unplanned changes are other than those that everyone experiences (e.g., grade 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. 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.

Suspensions disrupt young people's learning, their social relationships, and school-based activities. It also puts them at higher risk of offending and of drug and alcohol misuse. The child welfare worker or the caregiver need to make arrangements to permit continued learning and participation in important activities.

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TEACHERS: ***The next statements are about teachers and homework during the current year at school (or during the last year that you were enrolled in school).***

	All the time	Most of the time	Some of the time	Rarely	Never
E54: In general, how often do your teachers treat you fairly?	☐	☐	☐	☐	☐
E55: How often do your teachers provide extra help if you need it?	☐	☐	☐	☐	☐
E56: When your teachers give you homework, do you do it?	☐	☐	☐	☐	☐
E57: How often do your caregivers check your homework or provide help with homework?	☐	☐	☐	☐	☐

E58: How often do you talk to a teacher outside of class about class matters?

☐ Daily ☐ A few times a month ☐ Less than once a month
☐ A few times a week ☐ Once a month ☐ Rarely
☐ Once a week

E59: How often do you talk to a teacher outside of class about social matters?

☐ Daily ☐ A few times a month ☐ Less than once a month
☐ A few times a week ☐ Once a month ☐ Rarely
☐ Once a week

E60: SCHOOL PERFORMANCE: In the last 2 years, have you repeated a grade?

☐ Yes ☐ No

E61: In the last 2 years, have you failed a course at school? **(Mark all that apply)**

☐ No, I have not failed any courses in the last 2 years ☐ Yes, I failed French
☐ Yes, I failed Math ☐ Yes, I failed Science
☐ Yes, I failed English ☐ Yes, I failed another type of course

E62: CAREGIVER'S ACADEMIC SUPPORT: How often were your caregivers ready to help you if you had problems at school?

☐ All or most of the time ☐ Some of the time ☐ Rarely or never ☐ No problems at school

E63: My caregivers encourage me to do well at school.

☐ All or most of the time ☐ Some of the time ☐ Rarely or never

E64: How often do you feel that your caregivers expect too much from you with regard to your performance at school?

☐ All of the time ☐ Some of the time ☐ Never
☐ Most of the time ☐ Rarely

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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).

School is a place where young people acquire social and leisure skills, making and keeping friends, negotiating agreements, and relating to a variety of adults.

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E65: CHANGE IN SCHOOLS: For your most recent change in schools (even if it happened more than 2 years ago), what is/are the main reason(s) for changing? **(Mark all that apply.)**

- ☐ Regular progression through school system
- ☐ You wanted a specific program
- ☐ You changed your place of residence (e.g., you or your foster family moved, etc.)
- ☐ Your marks were too low or you were not progressing well in your previous school
- ☐ You were not getting along with others in your previous school
- ☐ Other

E66: MY ASPIRATION: How far do you hope to go in school? I hope to complete:

- ☐ Secondary or high school graduation
- ☐ Apprenticeship program
- ☐ CEGEP
- ☐ College of Applied Arts and Technology
- ☐ Private career college
- ☐ A university degree
- ☐ More than one university degree
- ☐ I don't know
- ☐ Other

FAIR TREATMENT: ***During the past 12 months have you personally been treated unfairly because of:***

	Yes	No	I don't know
E67: Your sex/gender?	☐	☐	☐
E68: Your race, skin colour, or ethnic group?	☐	☐	☐
E69: Your religion?	☐	☐	☐
E70: Another reason?	☐	☐	☐

SCHOOL SAFETY:
For each of the following statements, choose the answer that best describes how you feel.

	Most or all of the time	Some of the time	Rarely or never
E71: I feel safe at school.	☐	☐	☐
E72: I feel safe on my way **to** and **from** school.	☐	☐	☐
E73: Other young people say mean things to me at school.	☐	☐	☐
E74: I am bullied at school.	☐	☐	☐
E75: I feel my culture is respected at school.	☐	☐	☐
E76: I am bullied on my way **to** and **from** school.	☐	☐	☐

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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).

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.

Given these long term positive outcomes, caring adults need to recognise and affirm school achievement (academic, sporting, and creative) if it is to be sustained. One way to affirm the importance of academic achievement is to encourage the young person in care to set realistic yet ambitious educational goals. Significant adults also need to support and help the young person not to lose sight of his/her goals during his/her life experiences in the child welfare system.

If a young person 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? As a good parent, the job of the child welfare worker is to explain to the young person the necessary steps along the way, do everything possible to help, and encourage and build on his/her aspirations and talents.

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During the AAR conversation, the **CHILD WELFARE WORKER** is to answer the following section based on the information obtained on the entire developmental dimension of education.

ATTAINMENT OF GENERAL EDUCATION OBJECTIVES OF THE CHILD WELFARE SYSTEM

E77: Objective 1: The young person's educational performance matches his/her ability.

☐ Performance matches ability ☐ Performance somewhat below ability ☐ Performance seriously below ability

E78: Objective 2: The young person is acquiring special skills and interests.

☐ Many ☐ Some ☐ Few ☐ None

E79: Objective 3: Adequate attention is being given to planning the young person'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.*

Looking After Children AAR-C2-2010 - Education dimension (16-17 yrs) 11a

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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).

School is also where sometimes difficult situations arise such as bullying. Bullying can be threats, teasing, taunting, social isolation, and/or hitting. If you are being bullied at school talk to your teacher or child welfare worker. Some school have a policy on anti-racism, bullying, and sexual abuse. Your teacher or child welfare worker should be able to tell you about this.

Knowledge of the kind and amount of educational services received by the young person is very important to help all concerned gain a better clinical understanding of the relationship between services received and positive developmental outcomes.

This knowledge will also help the child welfare worker, the caregivers, and the young person review past accomplishments and determine what other services or actions need to be taken to further promote positive schooling experiences and successes.

Education plays a central role in determining the quality of adult life. School success enhances self-esteem and can offer a channel of escape from disadvantage. Open and regular communication between student, school, child welfare worker, and caregivers is an important means of supporting the young person's continued academic progress.

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DEVELOPMENTAL DIMENSION 3: IDENTITY

This dimension is about the identity of the young person. The questions in this section are designed to make sure that the young person knows something about his/her birth family and his/her culture, understands and accepts the reasons why he/she is in care, and is being helped to feel increasingly confident about himself/herself and about the way he/she makes decisions.

During the AAR conversation, the **YOUNG PERSON** is to answer this section with assistance, as needed. If you were **adopted** and have had no contact with your birth family since then, questions in this section apply to your adoptive family or your birth family.

ID1: Would you like to find out more about your birth family?

☐ Yes ☐ Uncertain ☐ No

ID2: BEING IN CARE: Would you like more information about why you are in care?

☐ Yes ☐ Uncertain ☐ No

ID3: Would you like any assistance dealing with questions about your birth family, where you live, or why you are in care?

☐ Yes ☐ No ☐ No assistance required

ID4: LIFE BOOK: Do you have a personal album, containing photographs and mementos about people and events that were important to you?

☐ Yes ☐ No

ID5: RELIGION(S) / SPIRITUAL AFFILIATION(S): What, if any, is your religion or spiritual affiliation(s)? **(Mark no more than two.)**

☐ No religion	☐ FMNI (traditional)	☐ Jewish	☐ Presbyterian
☐ Anglican	☐ FNMI (other)	☐ Lutheran	☐ Roman Catholic
☐ Baptist	☐ Hindu	☐ Mennonite	☐ United Church
☐ Buddhist	☐ Islam (Muslim)	☐ Mormon	☐ Sikh
☐ Eastern Orthodox	☐ Jehovah's Witnesses	☐ Pentecostal	☐ Other

ID7: Do you have enough opportunities to practice your religion (including religious services, festivals and holidays, prayers, clothing, diet, fasting, traditional sweat lodge, pow wow, drumming,etc.)?

☐ No religious or spiritual affiliation ☐ Yes ☐ No

ID8: Other than on special occasions (such as weddings or funerals), how often did you voluntarily attend religious services or meetings in the past 12 months?

☐ About once a week ☐ About once a month ☐ 3 or 4 times ☐ Once ☐ Never

ID9: FIRST LANGUAGE: What is the language that you first learned at home in childhood and can still understand? (If you can no longer understand the first language learned, choose the second language learned.) **(Mark all that apply.)**

☐ English ☐ French ☐ First Nations or Inuit language ☐ Other

ID10: Overall, do you have enough opportunities to speak your own first language (at home, at school, with friends, etc.)?

☐ Yes ☐ 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).

DIMENSION 3: IDENTITY

This dimension is about the identity of the young person 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.

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 this information.

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ID11: ETHNICITY: To which ethnic or cultural group(s) did your ancestors belong? (For example: French, British, Chinese) **(Mark all that apply.)**

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

ID12: Overall, do you have enough opportunities to meet people from your own ethnic or cultural background (including, for First Nations young people, people from your own band or community)?

☐ Yes ☐ No

ID13: Overall, do you have enough opportunities to learn about traditions, customs, ceremonies, or events related to your ethnic or cultural background?

☐ Yes ☐ No

ID14: Overall, do you have enough opportunities to participate in traditions, customs, ceremonies, or events related to your ethnic or cultural background?

☐ Yes ☐ No

NOTE TO THE CHILD WELFARE WORKER: *While it is essential for those who are providing child welfare services in ethnically diverse communities to consider the unique traditions and heritage of all cultures, the Child and Family Services Act emphasizes the importance of paying particular attention to the provision of services to FNMI young people.*

FNMI YOUNG PEOPLE : IF you are a *First Nations, Métis, or Inuit young person*, **THEN** please answer questions ID15 to ID21. **If not, go to question ID22.**

ID15: If your ancestors were members of a First Nation, to which band, community, or nation did they belong?

_____

_____

ID16: Do you visit or meet with people from your own FNMI community?

☐ Often ☐ Sometimes ☐ Rarely/Never

ID17: Do you learn about traditional teachings, customs, or ceremonies?

☐ Often ☐ Sometimes ☐ Rarely/Never

ID18: Do you participate in your own FNMI community events, activities, traditional meals/foods, and ceremonies?

☐ Often ☐ Sometimes ☐ Rarely/Never

ID19: How often do you speak your own First Nations or Inuit language?

☐ Often ☐ Sometimes ☐ Rarely/Never ☐ Don't know my First Nations or Inuit language

ID20: Do you have a personal connection with an Elder, Healer, and/or Cultural Teacher?

☐ Yes ☐ No

Looking After Children AAR-C2-2010 - Identity dimension (16-17 yrs) 13a

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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).

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ID21: Do you have a native Spirit Name?
☐ Yes ☐ No ☐ Not yet ☐ Don't know

ABOUT ME:
For each of the following statements, choose the answer that best describes how you feel.

	Most of the time/Always	Sometimes	Rarely/Never
ID22: I have a lot to be proud of.	☐	☐	☐
ID23: I can do things as well as most people.	☐	☐	☐
ID24: I am as good as most other people.	☐	☐	☐
ID25: Other people think I am a good person.	☐	☐	☐
ID26: When I do something, I do it well.	☐	☐	☐
ID27: A lot of things about me are good.	☐	☐	☐

QUESTIONS ABOUT YOUR GOALS: The six sentences below describe how young people think about themselves and how they do things in general. Read each sentence carefully. For each sentence, please think about how you are in most situations. Choose the answer that describes **YOU** the best. **There are no right or wrong answers.**

	Most of the time	Often	Sometimes	Never
ID28: I think I am doing pretty well.	☐	☐	☐	☐
ID29: I can think of many ways to get the things in life that are most important to me.	☐	☐	☐	☐
ID30: I am doing just as well as other kids my age.	☐	☐	☐	☐
ID31: When I have a problem, I can come up with lots of ways to solve it.	☐	☐	☐	☐
ID32: I think the things I have done in the past will help me in the future.	☐	☐	☐	☐
ID33: Even when others want to quit, I know that I can find ways to solve the problem.	☐	☐	☐	☐

HOW YOU DEAL WITH PROBLEMS: Sometimes young people have problems or feel upset about things. When this happens, they may do different things to solve the problem or to make themselves feel better. For each item, choose the answer that best describes how often you do this to solve your problems or make yourself feel better. **There are no right or wrong answers.** Just indicate how often **YOU** do each thing.

When I have a problem:	Most of the time	Often	Sometimes	Never
ID34: I do things to make my problem better.	☐	☐	☐	☐
ID35: I think about different ways of solving my problem.	☐	☐	☐	☐
ID36: I take action to improve the situation.	☐	☐	☐	☐
ID37: I try to learn more about what is causing my problem.	☐	☐	☐	☐

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"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.

A young person 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.

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.

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Note: This is meant to be a discussion with the young person. He/she has the coice as to whether or not he/she would like to disclose.

Now we're going to talk about sexual orientation and gender identity, which is part of who we are. Sexual orientation refers to gay, lesbian, bisexual, and heterosexual. Gender identity refers to whether you identify yourself as a boy, a girl, or both (including two-spirit for First Nations young people).

ID38: Do you have any questions or want further information about sexual orientation or gender identity?

☐ Yes ☐ No

During the AAR conversation, the **CHILD WELFARE WORKER** is to answer the following section based on the information obtained on the entire developmental dimension of identity.

ATTAINMENT OF GENERAL IDENTITY OBJECTIVES OF THE CHILD WELFARE SYSTEM

ID39: Objective 1: The young person has knowledge of his/her family of origin.

☐ Clear knowledge ☐ Some knowledge ☐ Little or no knowledge

ID40: Objective 2: The young person identifies with and is proud of his/her racial or ethnic background.

☐ To a great extent ☐ To some extent ☐ To little or no extent

ID41: Objective 3: The young person has a good level of self-esteem.

☐ High self-esteem ☐ Moderate self-esteem ☐ Low self-esteem

ID42: Objective 4: The young person has a clear understanding of his/her current situation.

☐ Clear understanding ☐ Some understanding ☐ Little or no understanding

Note to the child welfare worker: *If anyone disagrees with these answers to the Identity objectives, please note the details on the opposite page.*

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One important dimension of resilience *is the presence of hope. Hope is an overall perception that we will be able to overcome barriers to meet our goals. Young people who are hopeful can imagine and embrace goals associated with success. Furthermore, young people who are hopeful envision different ways to achieve the goals they set and show remarkable determination in attaining their goals when barriers are encountered.*

People respond differently to stressful situations, often using several coping strategies. Research has shown that young people's coping efforts to diminish the effects of negative events have important implications for their mental health (Ayers et al., 1996). Studies have determined that active coping strategies are often associated with greater well-being.

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DEVELOPMENTAL DIMENSION 4: FAMILY AND SOCIAL RELATIONSHIPS

This dimension is about the young person's relationship with friends, family, and others. The questions in this section are meant to find out if he/she has a close relationship with a parent or someone who acts as his/her parent, if he/she has a home where he/she is welcomed, and if he/she knows an adult who will help out if something goes wrong.

During the AAR conversation, the **CAREGIVER** is to answer the following section with assistance, as needed.

F1: What is the permanency plan for ...? **(Please specify.)**

F2: CURRENT FRIENDSHIPS: About how many days a week does ... do things with friends outside of school hours?

☐ Never ☐ 1 day a week ☐ 2-3 days a week ☐ 4-5 days a week ☐ 6-7 days a week

SHARED ACTIVITIES: ***How often do you do the following activities with the young person?***

	Every day	3-6 days per week	1-2 days per week	1-2 times per month	Rarely or never
F3: How often do you eat together?	☐	☐	☐	☐	☐
F4: How often do you have a discussion together?	☐	☐	☐	☐	☐
F5: How often do you have a family outing/ entertainment together?	☐	☐	☐	☐	☐
F6: How often do you participate in activities, ceremonies, practices, etc. that are culturally relevant to the young person?	☐	☐	☐	☐	☐

	Always	Often	Sometimes	Almost never	Never
F7: You let ... know when he/she is doing a good job with something.	☐	☐	☐	☐	☐
F8: You warn ... that you will discipline him/her and then do not actually discipline him/her.	☐	☐	☐	☐	☐
F9: ... fails to leave a note or to let you know where he/she is going.	☐	☐	☐	☐	☐
F10: ... talks you out of being disciplined after he/she has done something wrong.	☐	☐	☐	☐	☐
F11: ... stays out in the evening past the time he/she is supposed to be home.	☐	☐	☐	☐	☐
F12: You compliment ... when he/she does something well.	☐	☐	☐	☐	☐
F13: You praise ... if he/she behaves well.	☐	☐	☐	☐	☐
F14: ... is out with friends you don't know.	☐	☐	☐	☐	☐
F15: You let ... out of a discipline consequence early (like lift restrictions earlier than you originally said).	☐	☐	☐	☐	☐

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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).

DIMENSION 4: FAMILY AND SOCIAL RELATIONSHIPS

This dimension is about the young person's relationships with friends, family, and others. The questions ask about his/her relationships with caregivers, contacts with members of his/her birth family, ability to get along well with adults or other young people, and whether he/she has any close friends.

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 young person, appropriate guidance, and limit-setting - achieves the best results.

Family activities: *If young people 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.*

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During the AAR conversation, the **YOUNG PERSON** is to answer the following sections with assistance, as needed.

Note to the young person: This section is about your relationships with friends, family, and others. The questions ask about your relationship with your caregiver(s), your contacts with members of your birth family, your ability to get along well with adults and other young people, and whether you have any close friends.

The next few questions have to do with friends. ***Would you say:***

F16: I have many friends.

☐ True or mostly true ☐ Sometimes true/Sometimes false ☐ False or mostly false

F17: I get along easily with others my age.

☐ True or mostly true ☐ Sometimes true/Sometimes false ☐ False or mostly false

In this next section, by "close friends", we mean the people that you trust and confide in. They are friends that you see or hang out with at school or outside of school.

F18: How many close friends do you have?

☐☐ Number of close friends ☐ None

F19: Other than your close friends, do you have anyone else in particular you can talk to about yourself or your problems?

☐ Yes **(Go to question F20)** ☐ No **(Go to question F21)**

F20: If you have someone else or other people you can talk to, what is their relationship to you? **(Mark every person that you feel you can talk to about yourself or your problems.)**

☐ Foster mother	☐ Elder	☐ Birth parent's partner
☐ Foster father	☐ Cultural Teacher	☐ Teacher
☐ Birth mother	☐ Healer	☐ Child welfare worker
☐ Birth father	☐ First Nation, Métis, or Inuit community member	☐ Sitter or baby sitter
☐ Brother	☐ Foster sibling(s)	☐ Other (e.g., family doctor, etc.)
☐ Sister	☐ A friend of the family or a friend's parent	
☐ Grandparents	☐ Boyfriend or girlfriend	
☐ Other relative	☐ Coach or leader (e.g., Scout, Guide, or religious leader)	

F21: If you don't have anyone like this, would you like to be put in touch with someone who could give you support when you need it?

☐ Yes ☐ Not sure ☐ No

Thinking of your caregiver(s):

Caregiver 1 Gender: ☐ Male ☐ Female

	A great deal	Some	Very little
F22: How well do you feel he/she understands you?	☐	☐	☐
F23: How much fairness do you receive from him/her?	☐	☐	☐
F24: How much affection do you receive from him/her?	☐	☐	☐

F25: Overall, how would you describe your relationship with him/her?

☐ Very close ☐ Somewhat close ☐ Not very close

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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).

Friends: *While there are some exceptions, young people who remain in touch with relatives and enjoy a stable social network, usually fare better than those who drift apart from home and neighbourhood.*

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Caregiver 2 Gender: ☐ Male ☐ Female

	A great deal	Some	Very little
F26: How well do you feel he/she understands you?	☐	☐	☐
F27: How much fairness do you receive from him/her?	☐	☐	☐
F28: How much affection do you receive from him/her?	☐	☐	☐

E29: Overall, how would you describe your relationship with him/her?

☐ Very close ☐ Somewhat close ☐ Not very close

F30: How well do you feel your caregivers support your cultural needs.

☐ A great deal ☐ Some ☐ Very little

F31: How often do your caregivers participate in your cultural ceremonies, traditions, and events?

☐ Very often ☐ Sometimes ☐ Never ☐ Not applicable

	Always	Often	Sometimes	Almost never	Never
F32: Your caregiver tells you that you are doing a good job.	☐	☐	☐	☐	☐
F33: Your caregiver warns you that he/she will discipline you and then does not do it.	☐	☐	☐	☐	☐
F34: You fail to leave a note or let your caregiver know where you are going.	☐	☐	☐	☐	☐
F35: You talk your caregiver out of disciplining you after you have done something wrong.	☐	☐	☐	☐	☐
F36: You stay out in the evening past the time you are supposed to be home.	☐	☐	☐	☐	☐
F37: Your caregiver compliments you when you have done something well.	☐	☐	☐	☐	☐
F38: Your caregiver praises you for behaving well.	☐	☐	☐	☐	☐
F39: Your caregiver does not know the friends you are with.	☐	☐	☐	☐	☐
F40: Your caregiver lets you out of a discipline consequence early (like lift restrictions earlier than he/she originally said).	☐	☐	☐	☐	☐

CURRENT PLACEMENT: The next few questions have to do with your current living situation.

Would you say that:	A great deal	Some	Very little
F41: You like living here?	☐	☐	☐
F42: You feel safe living in this home?	☐	☐	☐
F43: You would be pleased if you were to live here for a long time?	☐	☐	☐
F44: You are satisfied with the amount of privacy you have here?	☐	☐	☐
F45: You have a good relationship with other people with whom you are living?	☐	☐	☐
F46: Overall, you are satisfied with your current living situation here?	☐	☐	☐

Looking After Children AAR-C2-2010 - Family and social relationships (16-17 yrs) 18a

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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).

Getting along with caregivers: *Research in the 1970s raised questions about the state's ability to parent and highlighted drift and instability for young people away from home. Given the significant risk within substitute care of placement change or disruption (and associated negative consequences which can last well into adulthood) all sources of potential continuity - parents, relatives, schools, and friends - need to be nurtured wherever possible.*

Studies that have examined young people's satisfaction with their out-of-home placements found that generally young people report being satisfied with their current placement. However, these same young people make numerous valid suggestions for improvement.

F47: What improvements, if any, in your current living situation would you like to see happen in the coming year?
Specify:

During the AAR conversation, the **CHILD WELFARE WORKER** is to complete the following section based on the information obtained on the entire developmental dimension of family and social relationships.

ATTAINMENT OF GENERAL SOCIAL AND FAMILY RELATIONSHIP OBJECTIVES OF THE CHILD WELFARE SYSTEM:

F48: Objective 1: The young person has had continuity of care.
- ☐ Much continuity of care (i.e., no change of placement in the last 12 months)
- ☐ Some disruptions (i.e., one change of placement in the last 12 months)
- ☐ Serious disruptions (i.e., two or more changes of placement in the last 12 months)

F49: Objective 2: The young person is definitely attached to at least one caregiver.
- ☐ Definitely attached ☐ Some attachment ☐ Little or no attachment

F50: Objective 3: The young person's contact with his/her birth family strengthens his/her relationship with them.
- ☐ Most contacts are helpful ☐ Most contacts are unhelpful ☐ No contacts

F51: Objective 4: The young person has a strong sense of belonging in his/her cultural identity through his/her family and social relationships..
- ☐ A great deal ☐ Some ☐ Very little

F52: Objective 5: The young person has had a stable relationship with at least one adult over a number of years.
- ☐ Stable relationship throughout life
- ☐ Fairly long-term relationship (i.e., more than 3 years)
- ☐ Short-term relationship (i.e., 1-3 years)
- ☐ No stable relationship

F53: Objective 6: The young person 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

F54: Objective 7: The young person is able to make friendships with others of the same age.
- ☐ Several friends ☐ Some friends ☐ Few friends ☐ No friends

F55: Objective 8: All feasible action is being taken to create or maintain a permanent placement for him/her.
- ☐ Yes ☐ No

Note to the child welfare worker: *If anyone disagrees with these answers to the Family and Social Relationships objectives, please note the details on the opposite page.*

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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 Assessment and Action Record was designed to provide young people with an opportunity to voice their recommendations about care within a hopefully safe forum. Young people placed in out-of-home care need to be aware that their feelings and suggestions are being taken into account and that steps can be taken to make their current home care placement a positive experience. It is through a shared dialogue between the young person and the adults responsible for his/her care that placement breakdowns may be prevented.

Looking After Children AAR-C2-2010 - Social presentation (16-17 yrs) 20

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DEVELOPMENTAL DIMENSION 5: SOCIAL PRESENTATION

This dimension is about making sure that the young person is being helped to understand what sort of impression he/she makes on other people and how he/she needs to adapt to different situations.

During the AAR conversation, the **CAREGIVER** is to answer the following section with assistance, as needed.

	Always	Often	Sometimes	Never/rarely
P1: Does ... keep himself/herself clean (i.e., body, hair, teeth)?	☐	☐	☐	☐
P2: Does ... take adequate care of his/her skin?	☐	☐	☐	☐
P3: Overall, does ...'s personal appearance give people the impression that he/she takes care of himself/herself properly?	☐	☐	☐	☐
P4: Does ... wear suitable clothes (e.g., at school, home, or parties, etc.)?	☐	☐	☐	☐
P5: Can people understand what he/she is saying?	☐	☐	☐	☐
P6: Is ... polite with friends and adults?	☐	☐	☐	☐

During the AAR conversation, the **YOUNG PERSON** is to answer the following section.

	True	Mostly true	Sometimes true/ sometimes false	Mostly false	False
P7: I like the way I look:	☐	☐	☐	☐	☐
P8: I like the way I dress:	☐	☐	☐	☐	☐

During the AAR conversation, the **CHILD WELFARE WORKER** is to answer the following section based on the information obtained on the entire developmental dimension of social presentation.

ATTAINMENT OF SOCIAL PRESENTATION OBJECTIVES OF THE CHILD WELFARE SYSTEM:

P9: Objective 1: The young person's appearance is acceptable to young people and adults.

☐ Usually acceptable to young people and adults ☐ Usually acceptable to adults only

☐ Usually acceptable to young people only ☐ Usually not acceptable to either young people or adults

P10: Objective 2: The young person's manners are acceptable to young people and adults.

☐ Usually acceptable to young people and adults ☐ Usually acceptable to adults only

☐ Usually acceptable to young people only ☐ Usually not acceptable to either young people or adults

P11: Objective 3: The young person can communicate easily with others.

☐ Very easily ☐ Easily ☐ With some difficulty ☐ With great difficulty

P12: Objective 4: The young person has a positive physical self-image.

☐ Good physical self-image ☐ Fair physical self-image ☐ Poor physical self-image

Note to the child welfare worker: *If anyone disagrees with these answers to the Social Presentation objectives, please note the details on the opposite page.*

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DIMENSION 5: SOCIAL PRESENTATION

Social presentation can be viewed as a combination of modes of dress and of communication.

A reasonable corporate parent will be as concerned about social presentation as about every other aspect of a young person's development.

Physical appearance affects how young people, especially adolescents, feel about themselves. They may also be stigmatized or unemployable because of unattractive appearance, unlikeable personal habits, or inappropriate social behaviours.

Looking After Children AAR-C2-2010 - Emotional & behavioural development (16-17 yrs) 21

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DEVELOPMENTAL DIMENSION 6: EMOTIONAL AND BEHAVIOURAL DEVELOPMENT

This dimension is designed to assess how the young person in care has been feeling and how this may have affected the way he/she behaves.

During the AAR conversation, the **YOUNG PERSON** is to answer the following section with assistance, as needed.

During the past MONTH, how often did you feel:	Every day	Almost every day	2 or 3 times a week	About once a week	Once or twice a month	Never
B1: happy	☐	☐	☐	☐	☐	☐
B2: interested in life	☐	☐	☐	☐	☐	☐
B3: satisfied	☐	☐	☐	☐	☐	☐
B4: that you had something important to contribute to society	☐	☐	☐	☐	☐	☐
B5: that you belonged to a community (like a social group, your school, or your neighbourhood)	☐	☐	☐	☐	☐	☐
B6: that our society is becoming a better place for people like you	☐	☐	☐	☐	☐	☐
B7: that people are basically good	☐	☐	☐	☐	☐	☐
B8: that the way our society works made sense to you	☐	☐	☐	☐	☐	☐
B9: that you liked most parts of your personality	☐	☐	☐	☐	☐	☐
B10: good at managing the responsiblities of your daily life	☐	☐	☐	☐	☐	☐
B11: that you had warm and trusting relationships with other children/youth	☐	☐	☐	☐	☐	☐
B12: that you had experiences that challenged you to grow and become a better person	☐	☐	☐	☐	☐	☐
B13: confident to think or express your own ideas and opinions	☐	☐	☐	☐	☐	☐
B14: that your life has a sense of direction or meaning to it	☐	☐	☐	☐	☐	☐

Now, we have a few questions to ask **you** (i.e., the **YOUNG PERSON**) about suicide. Some of them might be hard for you to answer, but please answer them as well as you can. If you feel you need support, please talk to your caregiver, your child welfare worker, your family doctor, your FNMI Traditional Healer, an Elder, or Cultural Teacher.

B15: Has anyone in your school or someone else you know ever committed suicide?

☐ Yes, within the last year ☐ Yes, more than a year ago ☐ No, never ☐ I don't know

B16: During the past 12 months have you ever attempted to hurt yourself?

☐ Yes ☐ No

B17: During the past 12 months, did you seriously consider attempting suicide?

☐ Yes ☐ No

B18: If you attempted suicide during the past 12 months, did you have to be treated by a doctor, nurse, or other health professional (for a physical injury or counseling)?

☐ I did not attempt suicide within the past 12 months ☐ Yes ☐ No

Looking After Children AAR-C2-2010 - Emotion and behavioural devel. (16-17 yrs) 21a

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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).

DIMENSION 6: EMOTIONAL AND BEHAVIOURAL DEVELOPMENT

This dimension is designed to draw attention to how the young person in care has been feeling and how this has affected the way he/she behaves.

Emotional and behavioural problems in adolescence are quite common, but only a small number of young people will need the help of a specialist. However, young people in care are somewhat more likely than others to have some problems of this kind because they have often had more stressful life experiences. It is important to consider whether the feelings or behaviours that trouble young people or their caregivers would benefit from specialized assessment and help. Certain types of disorders (e.g., post traumatic stress disorder, anorexia nervosa, bulimia, obsessive compulsive disorders, depression, or suicide attempts) need specific types of help. Any self-harm behaviour should always be treated seriously and appropriate help sought.

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During the AAR conversation, the **CAREGIVER** is to answer the following section.

B19: STRENGTHS AND DIFFICULTIES QUESTIONNAIRE: For each item, please mark the box for Not True, Somewhat True or True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behaviour over the last six months or this school year.

	True	Somewhat true	Not True
1. Considerate of other people's feelings.	☐	☐	☐
2. Restless, overactive, cannot stay still for long.	☐	☐	☐
3. Often complains of headaches, stomachaches, or sickness.	☐	☐	☐
4. Shares readily with other youth, for example books, games, food.	☐	☐	☐
5. Often loses temper.	☐	☐	☐
6. Would rather be alone than with other youth.	☐	☐	☐
7. Generally well behaved, usually does what adults request.	☐	☐	☐
8. Many worries or often seems worried.	☐	☐	☐
9. Helpful if someone is hurt, upset, or feeling ill.	☐	☐	☐
10. Constantly fidgeting or squirming.	☐	☐	☐
11. Has at least one good friend.	☐	☐	☐
12. Often fights with other youth or bullies them.	☐	☐	☐
13. Often unhappy, depressed, or tearful.	☐	☐	☐
14. Generally liked by other youth.	☐	☐	☐
15. Easily distracted, concentration wanders.	☐	☐	☐
16. Nervous in new situations, easily loses confidence.	☐	☐	☐
17. Kind to younger children.	☐	☐	☐
18. Often lies or cheats.	☐	☐	☐
19. Picked on or bullied by other youth.	☐	☐	☐
20. Often offers to help others (parents, teachers, youth).	☐	☐	☐
21. Thinks things out before acting.	☐	☐	☐
22. Steals from home, school, or elsewhere.	☐	☐	☐
23. Gets along better with adults than with other youth.	☐	☐	☐
24. Many fears, easily scared.	☐	☐	☐
25. Good attention span, sees work through to the end.	☐	☐	☐

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Looking After Children AAR-C2-2010 - Emotional and behavioural devel. (16-17 yrs) 22a

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).

Sometimes people who have been physically or sexually harmed by others respond by hurting other people. If you are frightened you might do this, tell someone you trust, as it is possible to arrange some help for you.

You can get further confidential advice from Kids Help Phone at 1-800-668-6868.

The Canadianized Assessment and Action Record includes many standardized measures of young people's behaviour included in the National Longitudinal Survey of Children and Youth. Using the Assessment and Action Record on a yearly basis allows the child welfare worker, the caregiver and the young person to assess the progress of the young person in care over time and compare the development of youths in care with that of their age peers in the general population.

Looking After Children AAR-C2-2010 - Emotional & behavioural development (16-17 yrs) 23

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During the AAR conversation, the **YOUNG PERSON** is to answer the following section with assistance, as needed.

B20: ADVERSE LIFE EXPERIENCES: Would you like to discuss any events or situations that caused you, or continue to cause you, a great amount of worry or unhappiness? **Specify:**

B21: POSITIVE LIFE EXPERIENCES: Which of the following positive experiences have you had during the last year? **(Mark as many as apply.)**

- ☐ I have caregivers who care about me.
- ☐ I have had someone in my life who really listens to me.
- ☐ I have had enough stability in my living arrangements.
- ☐ I have been included in my caregivers' family activities and outings.
- ☐ I have enjoyed the fact that my caregivers have spent time with me.
- ☐ I have felt trusted by my caregivers.
- ☐ I have had a strong relationship with a supportive adult other than my caregiver.
- ☐ I have had a say in things that affect my life.
- ☐ I have had a comforting sense of routine in my life (for example, supper time, bed time, etc.).
- ☐ I have made new friends at school or elsewhere.
- ☐ I have kept in touch with friends who live elsewhere.
- ☐ I have had good contact with my birth mother (if applicable).
- ☐ I have had good contact with my birth father (if applicable).
- ☐ I have had good contact with my birth sibling(s) (if applicable).
- ☐ I have enjoyed participating in a school or community club, or sports team.
- ☐ I have gone to a fun summer or weekend camp.
- ☐ I have gone on a trip.
- ☐ I have received a medal, trophy, or certificate (for example, sports, music, scouts, guides, etc.).
- ☐ I have had good grades in school.
- ☐ I have enjoyed school.
- ☐ I have had good teachers at school.
- ☐ I have learned a new skill (for example, guitar, hobby, language, etc.).
- ☐ I have enjoyed participating in cultural ceremonies, activities, or other cultural events.

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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).

Resilience is about successful adaptation, positive functioning, and competence development in the face of adversity or risk.

The most striking conclusion arising from the research on resilience is that the extraordinary recovery power of young people comes from basic human protective systems. These systems include attachment and close relationships, spirituality, motivation to learn and develop new skills, community and family.

The list of positive events reflect the various life experiences identified by young people in care that have contributed to their positive development. Among the many types of positive life events reported by young people, the main themes involved close interpersonal relationships (for example, reunited with an older brother), being part of activities and events (for example, going on a trip with the foster or biological family) and the in-care experience (for example, having a longterm stable foster home) (Legault & Moffat, 2006).

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B22: POSITIVE LIFE EXPERIENCES: What are the most positive life experiences you have had during the last 12 months? **Specify:**

During the AAR conversation, the **CHILD WELFARE WORKER** is to answer the following section based on the information obtained on the entire developmental dimension of emotional and behavioural development.

ATTAINMENT OF EMOTIONAL AND BEHAVIOURAL DEVELOPMENT OBJECTIVES OF CHILD WELFARE SYSTEM:

B23: Objective 1: The young person displays behaviours appropriate to his/her age in a range of situations.

- ☐ Always
- ☐ Sometimes
- ☐ Most of the time
- ☐ Infrequently

B24: Objective 2: The young person displays emotional reactions appropriate for his/her age in a range of situations.

- ☐ Always
- ☐ Sometimes
- ☐ Most of the time
- ☐ Infrequently

B25: Objective 3: The young person is free of serious emotional and behavioural problems.

- ☐ No problems
- ☐ Problems exist that need remedial action
- ☐ Minor problems
- ☐ Serious problems exist which need specialized assistance

B26: Objective 4: The young person is receiving effective treatment for all persistent problems.

- ☐ Does not need treatment
- ☐ Is receiving some treatment
- ☐ Is receiving effective treatment
- ☐ Is not receiving effective treatment

Note to the child welfare worker: *If anyone disagrees with these answers to the Emotional and Behavioural objectives, please note the details on the opposite page.*

Looking After Children AAR-C2-2010 - Emotional and behavioural devel. (16-17 yrs) 24a

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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).

B21

☐

A single positive experience such as the impact of a sports coach, foster parent, or teacher can redirect a child towards positive development.

Moreover, as noted by author Tony Newman (2002, p. 17), "[a] key protective factor for children who have experienced severe adversities is the ability to recognize any benefits that may have accrued, rather than focusing solely on negative effects, and using these insights as a platform for affirmation and growth".

Practitioners must pay close attention to these events, also known as turning points, in order to improve planning and promote positive development. All these experiences have the potential of raising self-esteem, exposing young people to new opportunities for positive growth, and favoring a chain of protective thinking.

Adopting a resilience focus is a positive approach which identifies an individual's strengths in regards to his experiences and builds positive life events for young people in care while empowering them.

The Assessment and Action Record from the Looking After Children approach is a particularly promising vehicle for improving child protection practice because it adopts a resilience framework to assess needs, identify resilience promoting processes, and identify resilience-focused interventions.

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DEVELOPMENTAL DIMENSION 7: SELF-CARE SKILLS & TRANSITION TO YOUNG ADULTHOOD

The questions in this dimension are designed to find out whether the young person is learning to care for himself/herself at a level appropriate to his/her age, whether s/he is gaining the experience of volunteer or paid work, and whether s/he is getting prepared to make the transition to young adulthood.

This section is to be answered by the **YOUNG PERSON** with assistance, as needed.

LIFE SKILLS:

Do you know how to:	Yes	No	Not Applicable
S1: Research information?	☐	☐	☐
S2: Give a presentation?	☐	☐	☐
S3: Meet project deadlines?	☐	☐	☐
S4: Work with other people on projects?	☐	☐	☐
S5: Lead others in a project or task?	☐	☐	☐
S6: Write a report, essay, or business letter?	☐	☐	☐
S7: Talk with people you don't know at all?	☐	☐	☐
S8: Help others with their concerns or problems?	☐	☐	☐
S9: Search for a suitable apartment?	☐	☐	☐
S10: Negotiate a lease for an apartment?	☐	☐	☐
S11: Apply for a passport, expired health card, social insurance card, birth certificate, etc.?	☐	☐	☐
S12: Apply for post-secondary education/training (i.e., college, university, trade school)?	☐	☐	☐
S13: Prepare a meal?	☐	☐	☐
S14: Use the vacuum cleaner?	☐	☐	☐
S15: Use the washer and the dryer?	☐	☐	☐
S16: Manage your time (i.e., get up on time, be ready for school/work, etc.)?	☐	☐	☐
S17: Undertake simple first aid?	☐	☐	☐
S18: Utilize public transportation?	☐	☐	☐

Do you have:	Yes	No
S19: A valid driver's license?	☐	☐
S20: A valid health card?	☐	☐
S21: A valid social insurance card?	☐	☐
S22: A valid birth certificate?	☐	☐
S23: A valid passport?	☐	☐

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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).

DIMENSION 7: SELF-CARE SKILLS AND TRANSITION TO YOUNG ADULTHOOD

The questions in this dimension are designed to find out if the young person 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.

If some of the life skills enumerated on the left page have yet to be learned, it is important that the young person be given the opportunity to practice and acquire these skills.

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FINANCIAL LITERACY: At age 18, young people are eligible to access savings from the Ontario Child Benefit equivalent savings program. In order to access these fungs, young people must demonstrate certain financial literacy competencies.

Do you:

	Yes	No	Not Applicable
S24: Save money for things you want to buy?	☐	☐	☐
S25: Use a bank machine?	☐	☐	☐
S26: Use a bank account?	☐	☐	☐
S27: Know how to write a resumé or a summary of your job qualifications?	☐	☐	☐
S28: Know how to prepare yourself for a job interview?	☐	☐	☐
S29: Know how to find out what kinds of jobs are available for people your age?	☐	☐	☐
S30: Know how to find information on different types of jobs you may be interested in when you have completed your post-secondary education?	☐	☐	☐
S31: Know how to prepare a budget?	☐	☐	☐
S32: Know how to keep track of what you earn and spend in a month?	☐	☐	☐
S33: Know about the requirement to file a tax return?	☐	☐	☐
S34: Understand interest paid on credit cards, loans, and other debts?	☐	☐	☐
S35: Know about different types of investments (i.e., RRSP, GIC, mutual fund, Canada Savings Bond, etc.)?	☐	☐	☐
S36: Know how to access various funds available to you (i.e., RESP, OCBe, OSAP, Victim's Compensation, etc.)?	☐	☐	☐
S37: Understand terms of contracts, including fine print (i.e., cellular phone, internet, cable, rental agreements, etc.)?	☐	☐	☐

S38: Have you developed a budget based on your monthly income and monthly expenses?

☐ Yes ☐ No ☐ Not Applicable

COMMUNITY INVOLVEMENT: The following questions ask about your community involvement.
In the past 12 months, have you volunteered or helped without pay (excluding chores around the house) by:

	Yes	No
S39: Supporting a cause (such as a food bank, environmental group, political group, etc.)?	☐	☐
S40: Fundraising (for example, for a charity)?	☐	☐
S41: Helping in your community (for example, hospital volunteering, work in a community organization, or coaching)?	☐	☐
S42: Helping neighbours or relatives (for example, cutting grass, babysitting, or shovelling snow)?	☐	☐
S43: Doing another volunteer activity?	☐	☐

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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).

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S44: During the past 12 months, how often have you volunteered or helped without pay?

☐ Everyday ☐ A few times a month ☐ Less than once a month

☐ A few times a week ☐ Once a month ☐ Never

☐ Once a week

EMPLOYMENT: The next questions are about jobs or employment. These questions are about all types of work, paid or unpaid, full-time or part-time.

S45: Did you work at a job or business for pay at any time in the past 12 months (for example, at a store or a restaurant)?

☐ Yes ☐ No

S46: Did you do any odd jobs (or jobs on the side) for pay (for example, babysitting, mowing a neighbour's lawn, or delivering flyers)?

☐ Yes ☐ No

S47: Did you do any work as part of a co-op program or work placement organized by your school in the past 12 months?

☐ Yes ☐ No

S48: How many weeks did you work in the past 12 months?

☐☐ **No. of total weeks**

Thinking about all of the jobs you have had during the last 12 months, how many hours did you usually work per week?

S49: When you were in school:

☐☐ **Hours per week**

S50: When you were not in school (for example, during the summer):

☐☐ **Hours per week**

S51: Do you have a job at the present time?

☐ Yes ☐ No

S52: If you have a job at present, how many hours a week do you usually work?

☐☐ **Hours per week** ☐ I do not have a job at the present time

S53: If you have a job at the present time, does working cause you to do less school work than you would like?

☐ Not applicable - I do not have a job at present, or I am not in school ☐ Yes, somewhat less

☐ Yes, a great deal less ☐ No, not at all less

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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).

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S54: Considering all aspects of the paid or unpaid jobs you have had in the **last 12 MONTHS**, would you say you were:

- ☐ Very satisfied?
- ☐ Satisfied?
- ☐ Dissatisfied?
- ☐ Very dissatisfied?
- ☐ Not applicable - I haven't had any paid or unpaid jobs in the past 12 months

S55: Have you done any of the following things to find out about future careers or work? **(Mark all that apply.)**

- ☐ Talked to a guidance counsellor at school?
- ☐ Talked to someone working in a job you might like?
- ☐ Talked to a FNMI Elder or Cultural Teacher or other Community member?
- ☐ Completed a questionnaire to find out about your interests and abilities?
- ☐ Read information about different types of work or careers?
- ☐ Attended an organized visit to a workplace?
- ☐ Taken a school course where you spent time with an employer (such as a co-op program)?
- ☐ Attended a presentation by people working in different types of jobs?
- ☐ Volunteered in an area you are interested in?
- ☐ None of the above?

S56: CAREER GOALS: What kind of career or work would you be most interested in having when you are about 30 years old?

S57: What is the minimum level of education you think is needed for this type of work?

- ☐ Less than high school graduation
- ☐ High school diploma or graduation equivalency
- ☐ Trade/vocational certificate
- ☐ College diploma
- ☐ Don't know
- ☐ Private career college diploma
- ☐ CEGEP certificate
- ☐ One university degree (for example, Bachelor's)
- ☐ More than one university degree (Master's, PhD, more than 1 Bachelor's)

S58: During the past 12 months, what was your total income (before deductions) from all sources (including income from odd jobs, income from employers, an allowance from the Children's Aid Society, money from your family or caregivers, or any income from other sources)?

- ☐ Less than $1000
- ☐ $1000 to $2499
- ☐ $2500 to $4999
- ☐ $5000 to $7499
- ☐ $7500 to $9999
- ☐ $10000 to $14999
- ☐ $15000 to $19999
- ☐ $20000 to $24999
- ☐ $25000 to $29999
- ☐ $30000 to $34999
- ☐ $35000 to $39999
- ☐ $40000 or more

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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).

Daily living programs are specifically designed for young people with disabilities. They cover areas such as independent living skills, mobility skills, personal care skills, and continence management.

S59: Is there anything standing in your way of going as far in school as you WOULD LIKE to go? **(Mark up to 3 answers.)**

- ☐ No **(Go to question S60)**
- ☐ Your financial situation (for example, you would need to work or it would cost too much)
- ☐ You are not interested enough or lack the necessary motivation
- ☐ You would like to stay close to home
- ☐ It would take too long
- ☐ You would like to work (for pay)
- ☐ You need to care for your own children
- ☐ Your health
- ☐ You are not sure what you would like to do later on in life
- ☐ Other

S60: Each month, how much of the money that you receive (from all sources) do you save?

☐ None ☐ Less than half ☐ About half ☐ More than half ☐ Almost all

S61: Of the money that you save, is some of it for your education after high school?

☐ I don't save any ☐ Yes ☐ No

S62: DAILY LIVING PROGRAM: Are you following a formal daily living program that teaches independent living skills?

☐ Yes ☐ No

S63: Are you receiving all the assistance you need to learn to live independently?

☐ Yes ☐ No

S64: What kind of help do you need most, at the present time, to prepare to live independently?

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).

Looking After Children AAR-C2-2010 - Self-care skills & transition to adulthood (16-17 yrs) 30

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During the AAR conversation, the **CAREGIVER** is to answer the following section.

S65: I help... maintain a budget of his/her expenses and income.

☐ Always or often ☐ Sometimes ☐ Rarely or Never

S66: I help ... to answer his/her questions about money management.

☐ Always or often ☐ Sometimes ☐ Rarely or Never

S67: I am involved in helping ... prepare for his/her transition to independent living.

☐ Always or often ☐ Sometimes ☐ Rarely or Never

S68: I talk to ... about his/her financial planning for the future.

☐ Always or often ☐ Sometimes ☐ Rarely or Never

During the AAR conversation the **CHILD WELFARE WORKER** is to answer the following section based on the information obtained on the entire developmental dimension of self-care skills.

ATTAINMENT OF SELF-CARE OBJECTIVES OF THE CHILD WELFARE SYSTEM:

S69: Objective 1: The young person is learning to care for himself/herself at a level appropriate to his/her age and ability when given the necessary resources and support.

☐ Already competent ☐ Learning to care for himself/herself ☐ Not learning to care for himself/herself

S70: Objective 2: The young person is learning money management skills?

☐ Already competent ☐ Learning money management skills ☐ Not learning money management skills

S71: Objective 3: The young person has a Learning Plan to build financial literacy skills?

☐ Has a plan and it is implemented ☐ No action

☐ A plan is under development ☐ Not applicable

Note to the child welfare worker: *If anyone disagrees with these answers to the Self-Care Skills objectives, please note the details on the opposite page.*

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Looking After Children AAR-C2-2010 - Self-care skills & trans. to adulthood (16-17 yrs) 30a

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).

Looking After Children AAR-C2-2010 - Asset profile (16-17 yrs) 31

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The **CHILD WELFARE WORKER** is to answer the following section based on the information obtained from the entire Assessment and Action Record. **"Yes" should only be answered if you are very certain that the young person truly possesses the asset.**

SUMMARY PROFILE OF YOUNG PERSON'S ASSETS. The Search Institute has identified the following assets as building blocks that help young people grow up healthy, caring, and responsible.

Asset Category, Name, and Definition:

SUPPORT	Yes	Uncertain	No
A1: ***Caregiver support:*** Caregivers provide high levels of love and support.	☐	☐	☐
A2: ***Positive communication:*** Young person and caregivers communicate positively, and young person is willing to seek advice and counsel from caregivers.	☐	☐	☐
A3: ***Other adult relationships:*** Young person receives support from other adults besides caregivers.	☐	☐	☐
A4: ***Caring neighbourhood:*** Young person experiences caring neighbours.	☐	☐	☐
A5: ***Caring school environment:*** School provides a caring, encouraging environment.	☐	☐	☐
A6: ***Caregiver involvement:*** Caregivers are actively involved in helping young person succeed in school.	☐	☐	☐

EMPOWERMENT	Yes	Uncertain	No
A7: ***Community values youth:*** Young person perceives that adults in the community value youth.	☐	☐	☐
A8: ***Youth as resources:*** Young person is given useful roles in the community.	☐	☐	☐
A9: ***Service to others:*** Young person serves others in the community on a regular basis.	☐	☐	☐
A10: ***Safety:*** Young person feels safe at home, school, and in neighbourhood.	☐	☐	☐

BOUNDARIES AND EXPECTATIONS	Yes	Uncertain	No
A11: ***Caregiver boundaries:*** Caregivers have clear rules and consequences and monitor the young person's whereabouts.	☐	☐	☐
A12: ***School boundaries:*** School provides clear rules and consequences.	☐	☐	☐
A13: ***Neighbourhood boundaries:*** Neighbours take responsibility for monitoring the young person's behaviour.	☐	☐	☐
A14: ***Adult role models:*** Caregivers and other adults model positive, responsible behaviour.	☐	☐	☐
A15: ***Positive peer observations:*** Young person's best friends model responsible behaviour.	☐	☐	☐
A16: ***High expectations:*** Both caregivers and teachers encourage young person to do well.	☐	☐	☐

CONSTRUCTIVE USE OF TIME	Yes	Uncertain	No
A17: ***Creative activities:*** Young person spends time regularly in lessons or practice in music, theater, or other arts.	☐	☐	☐
A18: ***Youth programs:*** Young person spends time regularly in sports, clubs, or organizations at school and/or in the community.	☐	☐	☐
A19: ***Religious or spiritual community:*** Young person spends time regularly in religious or spiritual activities.	☐	☐	☐
A20: ***Time at home:*** Young person is out with friends "with nothing special to do" two or fewer nights per week.	☐	☐	☐

Looking After Children AAR-C2-2010 - Asset Profile (16-17 yrs) 31a

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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).

Resilience: *Research findings have shown that young people who demonstrate resilience utilize various personal characteristics (e.g., cognitive capabilities and personality traits) and available resources (e.g., adult mentors and prosocial organizations) to foster their positive development (Masten & Reed, 2002). These young people use what they are provided with to make some sense of their lives.*

In other words, resilience goes beyond simple adaptation to include resources found in ***basic human adaptational systems*** *(e.g., attachment relationships and parenting systems; pleasure-in-mastery and motivational systems; self-regulation of emotion, arousal, and behaviour; families; formal educational and community systems; cultural belief systems; and religious organizations; Masten & Reed, 2002, p. 82).*

Within each of these systems are numerous protective factors identified in past research such as nurturing parents (Luthar & Zelazo, 2003; Masten, 2001), self-esteem (Cicchetti & Rogosch, 1997; Cicchetti et al., 1993), and access to good schools (Masten & Reed, 2002).

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COMMITMENT TO LEARNING	Yes	Uncertain	No
A21: ***Achievement motivation:*** Young person is motivated to do well in school.	☐	☐	☐
A22: ***School engagement:*** Young person is actively engaged in learning.	☐	☐	☐
A23: ***Homework:*** Young person reports doing homework regularly.	☐	☐	☐
A24: ***Bonding to school:*** Young person cares about his/her school.	☐	☐	☐
A25: ***Reading for pleasure:*** Young person reads for pleasure regularly.	☐	☐	☐

POSITIVE VALUES	Yes	Uncertain	No
A26: ***Caring:*** Young person places high value on helping other people.	☐	☐	☐
A27: ***Equality and social justice:*** Young person places high value on promoting equality and reducing hunger and poverty.	☐	☐	☐
A28: ***Integrity:*** Young person acts on convictions and stands up for his/her beliefs.	☐	☐	☐
A29: ***Honesty:*** Young person "tells the truth even when it is not easy".	☐	☐	☐
A30: ***Responsiblity:*** Young person accepts and takes personal responsibility.	☐	☐	☐
A31: ***Restraint:*** Young person believes it is important not to be sexually active or to use alcohol or other drugs.	☐	☐	☐

SOCIAL COMPETENCIES	Yes	Uncertain	No
A32: ***Planning and decision making:*** Young person knows how to plan ahead and make choices.	☐	☐	☐
A33: ***Interpersonal competence:*** Young person has empathy, sensitivity, and friendship skills.	☐	☐	☐
A34: ***Cultural competence:*** Young person has knowledge and comfort with people of different cultural, racial, and/or ethnic backgrounds.	☐	☐	☐
A35: ***Resistance skills:*** Young person can resist negative peer pressure and dangerous situations.	☐	☐	☐
A36: ***Peaceful conflict resolution:*** Young person seeks to resolve conflict nonviolently.	☐	☐	☐

POSITIVE IDENTITY	Yes	Uncertain	No
A37: ***Personal power:*** Young person feels that he/she has control over "things that happen to me".	☐	☐	☐
A38: ***Self-esteem:*** Young person reports having high self-esteem.	☐	☐	☐
A39: ***Sense of purpose:*** Young person reports that "my life has a purpose".	☐	☐	☐
A40: ***Positive view of personal future:*** Young person is optimistic about personal future.	☐	☐	☐

Looking After Children AAR-C2-2010 - Asset Profile (16-17 yrs) 32a

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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).

Basic human adaptational systems (defined on the preceding page) play a central role in the development and presence of assets characterizing young people who demonstrate resilience. Interestingly, these systems are also well established resources associated with well-being and development in general (i.e., under low adversity conditions).

Research findings consistently show the most crucial asset for a young person is to have a strong bond with a competent and caring adult (who need not be the biological parent). For a caring and competent adult, "[r]aising children…is vastly more than fixing what is wrong with them. It is about identifying and nurturing their strongest qualities, what they own and are best at, and helping them find niches in which they can best live out these strengths" (Seligman & Csikszentmihalyi, 2000, p. 6).

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ATTAINMENT OF THE GOALS OF LOOKING AFTER CHILDREN: Overall, in working with this particular young person and his/her caregivers, how successful do you think you have been up to now in attaining the following goals of Looking After Children? **(Please answer each item as honestly and frankly as possible.)**

	Very successful	Somewhat successful	Not very successful
T1: Helping the young person develop his/her potential to a maximum rather than a minimum level.	☐	☐	☐
T2: Focussing on the young person's successes, not just on his/her problems.	☐	☐	☐
T3: Planning according to the young person's individualized needs.	☐	☐	☐
T4: Believing your work with the young person can bring about positive change, even in less than ideal circumstances.	☐	☐	☐
T5: Achieving ambitious but feasible objectives in all major areas of the young person's development.	☐	☐	☐
T6: Helping the young person to develop a positive cultural identity and feeling of cultural safety.	☐	☐	☐

COMPLETION OF THE AAR:

Q1: How many conversations did it take to complete this AAR (including the Background Information Section)?

☐ 1 session ☐ 2 sessions ☐ 3 sessions ☐ 4 or more sessions

Q2: Total time to complete the AAR (including the Background Information section)?

☐☐ hours and ☐☐ minutes

Q3: Total time that the young person participated in completing the AAR?

☐☐ hours and ☐☐ minutes

Q4: Who took part in the AAR conversation? **(Mark as many as apply.)**

- ☐ Child welfare worker
- ☐ One foster parent
- ☐ Two foster parents
- ☐ FNMI Band or Community representative
- ☐ Family worker
- ☐ One adult caregiver other than a foster parent
- ☐ Two adult caregivers other than a foster parent
- ☐ One birth parent
- ☐ Two birth parents
- ☐ Other

Q5: The young person for whom the AAR is being completed:

- ☐ Participated in the entire AAR conversation
- ☐ Participated in only part of the AAR conversation
- ☐ Participated in only part of the AAR conversation because of refusal
- ☐ Participated in only part of the AAR conversation because of lack of capacity
- ☐ Participated in none of the AAR conversation because of refusal
- ☐ Participated in none of the AAR conversation because of lack of capacity

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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).

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*


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Q6: If a FNMI Band or Community representative, Elder, or Cultural Teacher took part in the AAR conversations, was he/she familiar with the Looking After Children approach?

☐ Yes ☐ No ☐ Uncertain ☐ Not applicable

Q7: The AAR is intended to be completed in face-to-face conversations, unless for some reason this is impossible. How was this AAR conversation being completed? **(Mark as many as apply.)**

☐ In a face-to-face conversation conducted by the child welfare worker

☐ In a face-to-face conversation conducted by the child welfare worker in conjunction with a member of ...'s FNMI community

☐ In a telephone conversation conducted by the child welfare worker

☐ Through self-administration by the caregiver

☐ Through self-administration by the young person

☐ Other

Thank you for your participation!

Looking After Children AAR-C2-2010 - Assessment and Action Record (16-17 yrs) 34a

11402

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).

25576

The AAR-C2-2010 is the 2010 version of the second Canadian adaption of the Assessment and Action Record from the Looking After Children international initiative. The authors of this new version are Robert Flynn and Meagan Miller (Centre for Research on Educational and Community Services [CRECS], University of Ottawa), Lynn Desjardins and Hayat Ghazal (Ottawa Children's Aid Society [CAS]), and Louise Legault (Social Research and Demonstration Corporation, Ottawa).

The authors were assisted by an AAR Revision Subcommittee of the Caring for Children and Youth Council. The members of this committee were: Lynn Desjardins, Chair; Sarah Bell (Ontario Ministry of Children and Youth Services), Francoise Crosby (CAS of Stormont, Dundas and Glengarry), Sharon Evans (Ontario Association of Children's Aid Societies [OACAS]), Robert Flynn and Meagan Miller (CRECS, University of Ottawa), Doreen Haveman (Toronto Catholic CAS), Myra Hurst (OACAS), Amélie Lesieur (Prescott-Russell Services to Children and Adults), and Marlyn Wall (Ottawa CAS) .

Special thanks to those who contributed to the AAR C2-2010 including but not limited to: Cam Agowissa and Yvonne Lunham (Simcoe CAS), Dawna Lee Chartrand (Sudbury-Manitoulin CAS), Sylvie Demers (Prescott-Russell Services to Children and Adults), Christian Hackbusch (Ottawa CAS), Mary Hutchings, (Toronto CAS), Niagara Family and Children's Services Staff, Gabe Minor (Ontario Ministry of Children and Youth Services), Andréanne Laframboise (CRECS, University of Ottawa), and OnLAC Lead Hands focus groups.

The French translation of this latest 2010 version was completed by Marie-Pierre Paquet (CRECS, University of Ottawa). Formatting in TeleForm was carried out by Meagan Miller (CRECS, University of Ottawa).

The AAR-C2-2010 was revised from the previous version of the second Canadian adaptation (i.e., the AAR C2-2006) prepared by Robert Flynn, Hayat Ghazal and Louise Legault from CRECS, University of Ottawa.

Many individuals from a large range of organizations contributed to earlier versions of the second Canadian adaption including: Beverly Byrne, Eric Plante, Suzie Leroux, Francine Groulx and Raymond Lemay (Prescott Russell Services to Children and Adults), Wendy James, Peter Dudding, Shannon Bala and Victoria Norgaard (Child Welfare League of Canada), Shaye Moffat (CRECS, University of Ottawa) Daniel Moore (Grey CAS and Ontario Ministry of Children and Youth Services), Sandy Moshenko, Liane Westlake, Gail Vandermeulen and Susan Petrick (OACAS).

The final product is the responsibility of the authors alone.

Ottawa, May 2011

Appendix F. Phase II Questionnaire from the Eastern Ontario Consortium Study

Transitions in child welfare project - 12-Month follow-up interview schedule
Flynn, Beaupré, Tessier (2013)

[BEGIN AUDIO RECORDING]

You are invited to continue your participation in the study, *Transitions of Crown Wards in Child Welfare.* This study is being carried out by Professor Robert Flynn, Mr. Nicholas Tessier, and Mr. Joël Beaupré, at the University of Ottawa. This project is funded by the Children's Aid Society of the United Counties of Stormont, Dundas and Glengarry, the Children's Aid Society of Ottawa, Family and Children Services County of Renfrew, and Valoris for Children and Adults of Prescott-Russell. The purpose of the project is to enable the four agencies to help Crown Wards make the most successful transitions possible.

You are receiving this letter because you agreed last year, during the initial (year-1) interview, to being contacted to see whether or not you wished to continue your participation in the *Transitions of Crown Wards in Child Welfare* study. The research team at the University of Ottawa will be contacting you in the near future to ask you if you are interested in participating in the second (year-2) phone interview. This second interview will be similar in nature to the one you participated in last year. The interview will last approximately 1 hour. Some questions during the interview may be of a sensitive nature. If at any moment you feel uncomfortable in answering, you may to refuse to answer.

The year-2 interview will be carried out by telephone. As was the case last year, you will be paid $60.00 (Can.) for participating in this interview, as payment for your time. At the end of the interview, you will be able to decide whether you agree to being contacted in a year's time, in 2014-2015, to be invited to take part in a third (year-3) interview, for which you would also be paid $60.00 (Can.), for your time.

The researchers will put what they learn about youths together with what they learn about other youths, so no one will be able to tell which answers came from whom. Also, when the researchers tell other people about their research, they will not use any names, so no one will be able to know whom we are talking about.

If you choose not to continue your participation in the study, no one will be mad at you, and you will experience no negative consequences. Also, if you choose to be in the study now but change your mind later, you will be able to do so.

If you decide to continue your participation in the study, you will be contacted and interviewed by the research team. At the beginning of the interview, you will be asked to confirm your decision to participate. This confirmation will be recorded by the research team to document your agreement to participate.

If you have any questions about the study, or if you decide later that you want to withdraw from the study, you can contact the project coordinator, Joël Beaupré, by phone at 1-855-227-1125 or, by email, at Transitions@uottawa.ca.

If you have any questions with regards to the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, tel.: (613) 562-5387 or ethics@uottawa.ca.

Do you have any questions?

"Would you like to continue your participation in this study? If so, please say the following:"

"My name is _____ and I would like to continue my participation in the Transitions from Care study."

[END AUDIO RECORDING]

Thank you for your continued participation in the Transitions in child welfare project. You will recall that we interviewed you about one year ago in _____. (insert month and year of previous interview) This was shortly before or after you underwent an important transition either by moving out on your own, by starting post-secondary education, by returning to your birth family, or else by aging out of care. Your answers to our questions last year, along with those of many other young men and women, were included in a report that has been submitted to decision-makers who are responsible for improving programs to help young adults like yourself. For the interview today, your ongoing cooperation and careful answers to my questions would be greatly appreciated; your answers will give us an accurate picture of your experiences during the last 12 months.

GENERAL INFORMATION

1. What is your gender?
   - ☐ Male
   - ☐ Female
   - ☐ Other: _____ *(specify)*
   - ☐ Refused

2. How old are you now?
   Age in years_____
   - ☐ Don't know
   - ☐ Refused

3. You may belong to one or more racial or cultural groups on the following list. Are you...?
   - ☐ White
   - ☐ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
   - ☐ Chinese
   - ☐ Black
   - ☐ Filipino
   - ☐ Latin American
   - ☐ Arab
   - ☐ Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian, etc. .)
   - ☐ West Asian (e.g., Iranian, Afghan, etc.)
   - ☐ Korean
   - ☐ Japanese
   - ☐ Other – (Specify :_____)
   - ☐ Native
   - ☐ Metis
   - ☐ Don't know

- ☐ Refused

4. How many brothers, including half-brothers and step-brothers do you have?
   Number of birth brothers _____
   Number of step brothers _____
   Number of half brothers _____
   Number of foster brothers _____
   - ☐ No brothers
   - ☐ Don't know
   - ☐ Refused
5. How many sisters, including half-sisters and step-sisters do you have?
   Number of birth sisters _____
   Number of step sisters _____
   Number of half sisters _____
   Number of foster sisters _____
   - ☐ No sisters
   - ☐ Don't know
   - ☐ Refused

6. Do you have the following: *(Check all that apply)*
   - ☐ A valid driver's license
   - ☐ A valid health card
   - ☐ A valid social insurance card
   - ☐ A valid birth certificate
   - ☐ A valid passport
   - ☐ Don't know
   - ☐ Refused

CARE STATUS

Now I want to ask you some questions about your care status?

7. Are you now (today) still in care (including Extended Care and Maintenance-ECM)?
   - ☐ Yes, still in care, but not in ECM
   - ☐ Yes, still in care, in ECM
   - ☐ No, I left care entirely (since when _____ (year) _____ (month) _____ (day) How many years of age was the youth when leaving care (see first year data)?_____
   - ☐ Don't know
   - ☐ Refused
     a. If **YES**, how many times, during the past year, did you have face-to-face visits with your child welfare worker? *Write in their response:* _____ *(probe for whole numbers).*
     b. If **YES**, how many times, during the past year, did you have any *other* kind of contact with your child welfare worker (not face-to-face; e.g., email, telephone, text message, etc.)?
     Write in their response: _____ *(probe for whole numbers).*
     c. If **NO**, how did you leave care? *(check all that apply)*
        - ☐ You left because you were discharged(aging out of care (18))
        - ☐ You left because you were discharged(aging out of ECM (21))
        - ☐ You were discharged but stayed with the foster or kinship care family that you were living with before leaving care
        - ☐ You left of your own accord before aging out
        - ☐ Other – (Specify :_____)
        - ☐ Don't know
        - ☐ Refused

LIVING SITUATION

Now I would like to ask you some questions about the places that you have lived since we last talked with you.

8. In what kind of living arrangement are you currently in?
   - ☐ Respondent's own room in motel, hotel, sro (single room occupancy)
   - ☐ Home of respondent's partner (boyfriend/girlfriend/spouse)
   - ☐ Home of respondent's relative
   - ☐ Home of respondent's friend
   - ☐ Respondent's own apartment, or room in private dwelling
   - ☐ Respondent's own house
   - ☐ Hospital, treatment program, or detox
   - ☐ Jail or prison
   - ☐ Respondent was homeless
   - ☐ Home of former foster parent (not a relative)
   - ☐ Adoptive home
   - ☐ Other – (Specify :_____)
   - ☐ Foster home with relatives (Kinship)
   - ☐ Foster home without relatives
   - ☐ Group home
   - ☐ Residential treatment facility
   - ☐ Family of origin
   - ☐ Don't know
   - ☐ Refused
     a. For how many months have you been in this arrangement?
        Number of months_____
        - ☐ Don't know
        - ☐ Refused

9. With whom are you living with?
   - ☐ Nobody
   - ☐ Birth Mother
   - ☐ Birth Father
   - ☐ Step Mother
   - ☐ Step Father
   - ☐ Adoptive Mother
   - ☐ Adoptive Father
   - ☐ Grandmother
   - ☐ Grandfather
   - ☐ Partner
   - ☐ Friends : If so, prompt how many _____
   - ☐ Sibling(s) : If so, prompt how many _____
   - ☐ Other: Specify _____
   - ☐ Don't know
   - ☐ Refused

10. Total number of people in household is? _____ *(ask participant if this is correct?)*

11. Are you still living in the same place that you were living when we last interviewed you?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know
    - ☐ Refused
    a. If **NO**, how many different places have you lived since we last interviewed you?
        - ☐ Number of different places_____
        - ☐ Don't know
        - ☐ Refused
    b. If **NO**, I would like to ask you about all the places where you have lived since the last time we talked to you on ___MONTH___DAY____YEAR. Please start with the first place you lived after leaving the care system, and then go on to the second place, then the third place, etc. "Lived" means that you had no other place to stay, i.e. you were NOT just visiting.
    (NOTE: Using the classification system listed below, note the type of place lived for the following successive transitions. Note the type of place lived with the corresponding number):
    ____Type of the FIRST place where young person lived after leaving care system
    ____Type of the SECOND place (if applicable)
    ____Type of the THIRD place (if applicable)
    ____Type of the FOURTH place (if applicable)
    ____Type of the FIFTH place (if applicable)
    ____Type of the SIXTH OR MORE FREQUENT place(s) (if applicable)

Types of possible living arrangements

1. Respondent's own room in motel, hotel, sro (single room occupancy)
2. Home of respondent's partner (boyfriend/girlfriend/spouse)
3. Home of respondent's relative
4. Home of respondent's friend
5. Respondent's own apartment, house or room in private dwelling
6. Hospital, treatment program, or detox
7. Jail or prison
8. Respondent was homeless
9. Home of former foster parent (not a relative)
10. Adoptive home
11. Other – (Specify :_____)
12. Respondent's own house
13. Foster home with relatives (Kinship)
14. Foster home without relatives
15. Group home
16. Residential treatment facility
17. Family of origin
18. Don't know
19. Refused

12. Since we last talked, have you ever been homeless for one night or longer; that is: you slept in a place where people weren't meant to sleep, or slept in a homeless shelter, or didn't have a regular residence in which to sleep?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know
    - ☐ Refused
        a. If **YES**, how many separate times have you found yourself homeless for one or more nights since leaving the care of the child welfare system?
            - ☐ Number of times homeless _____
            - ☐ Longest number of consecutive days homeless _____
            - ☐ Don't know
            - ☐ Refused

MARITAL STATUS

Now I would like to ask you a few questions about your close relationships with others.

13. What is your current marital status; this includes common law, being married, etc.?
    - ☐ Married
    - ☐ Living common-law
    - ☐ Widowed
    - ☐ Separated
    - ☐ Divorced
    - ☐ Single, never been married
    - ☐ Don’t know
    - ☐ Refused

14. Since we last talked with you, has there been any change in your marital (conjugal) status, that is have you had any changes in serious relationships?
    - ☐ Yes
    - ☐ No
    - ☐ Don’t Know
    - ☐ Refused
        a. If **YES**, what type of change?

Type of change 1? _____

Type of change 2? _____

Type of change 3+? _____

15. How important is it for you to be married (today, or someday): very important, somewhat important, not very important or not at all important?
    - ☐ Very important
    - ☐ Somewhat important
    - ☐ Not very important
    - ☐ Not at all important
    - ☐ Don't know
    - ☐ Refused

PARENTHOOD & FAMILY LIFE

Now I would like to ask you some questions about parenthood and family life.

16. Since the last time we spoke with you, have you been pregnant or made someone pregnant?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

17. Do you have any children?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

    a. If **YES**, how many?

    Write in their response: _____ (probe for whole numbers).

    b. If **YES,** are they in your custody

    - ☐ Yes How many_____
    - ☐ No How many_____
    - ☐ Don't Know
    - ☐ Refused

EDUCATION

Now I would like to ask you some questions about the education that you have had.

18. What is the highest certificate, diploma or degree that you have completed?
    - ☐ Less than high school diploma or its equivalent
    - ☐ High school diploma or a high school equivalency certificate
    - ☐ Trade Certificate or Diploma
    - ☐ College, cegep or other non-university certificate or diploma (other than trades certificates or diplomas)
    - ☐ University certificate or diploma below the bachelor's level
    - ☐ Bachelor's degree (e.g. B.A., B.Sc., LL.B.)
    - ☐ University certificate, diploma or degree above the bachelor's level
    - ☐ Don't know
    - ☐ Refused
        a. If **HIGHER THAN HIGH SCHOOL,** ask: what is the specific program in which you graduated? (*Note as much detail as possible)*

Educational classification code (CIP):_____

Socio-economic index code (SEI):_____

19. Have you ever received (or will you receive) a <u>certificate or license</u> that enables you (or will enable you) to practice a trade or profession?
    - ☐ Yes, I have received a certificate or license
    - ☐ Yes, I will receive a certificate or license
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
        a. If **YES**, what type of certificate or license _____

20. Are you currently attending a school, college, cegep or university?
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

a. If **YES**, are you enrolled as…?
- ☐ A full-time student
- ☐ A part-time student
- ☐ Both full-time and part-time student
- ☐ Don't know
- ☐ Refused

b. **If **YES**, what type of school are you in?
- ☐ Elementary (primary) School
- ☐ High school
- ☐ Trade school
- ☐ College, cegep or other non-university (other than trades)
- ☐ University below the bachelor's level
- ☐ Bachelor's degree (e.g. B.A., B.Sc., LL.B.)
- ☐ University above the bachelor's level
- ☐ Don't know

c. **If **YES**, in the last grading period, what has been your average grade overall?
- ☐ Level 4 - 80-100% (A- & A+)
- ☐ Level 3 - 70-79% (B- & B+)
- ☐ Level 2 - 60-69% (C- & C+)
- ☐ Level 1 - 50-59% (D- to D+)
- ☐ R – 0-49% (F)
- ☐ Not applicable; Ungraded
- ☐ Don't know
- ☐ Refused

d. If **YES,** what is the specific program in which you are currently studying? (*Note as much detail as possible)*

Educational classification code (CIP):_____

Socio-economic index code (SEI):_____

e. If **YES,** were you in this same program last year?
- ☐ Yes
- ☐ No
- ☐ Was not in school last year
- ☐ Don't Know
- ☐ Refused

21. Have you received any other education that could be counted towards a degree, certificate, diploma or degree from an educational institution?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know
    - ☐ Refused

22. Are you currently in any training program, co-op program, or apprenticeship that is related to school or work?
    - ☐ Yes, training
    - ☐ Yes, Co-op
    - ☐ Yes, apprenticeship
    - ☐ Yes, other: _____ *(specify)*
    - ☐ No training currently
    - ☐ Don't know
    - ☐ Refused

23. If you could go as far as you wanted in school, how far would you go?
    - ☐ Less than high school diploma or its equivalent
    - ☐ High school diploma or a high school equivalency certificate
    - ☐ Trade Certificate or Diploma
    - ☐ College, cegep or other non-university certificate or diploma (other than trades certificates or diplomas)
    - ☐ University certificate or diploma below the bachelor's level
    - ☐ Bachelor's degree (e.g. B.A., B.Sc., LL.B.)
    - ☐ University certificate, diploma or degree above the bachelor's level
    - ☐ Don't know
    - ☐ Refused

24. How far do you think you will actually go in school?
    - ☐ Less than high school diploma or its equivalent
    - ☐ High school diploma or a high school equivalency certificate
    - ☐ Trade Certificate or Diploma
    - ☐ College, cegep or other non-university certificate or diploma (other than trades certificates or diplomas)
    - ☐ University certificate or diploma below the bachelor's level
    - ☐ Bachelor's degree (e.g. B.A., B.Sc., LL.B.)
    - ☐ University certificate, diploma or degree above the bachelor's level
    - ☐ Don't know
    - ☐ Refused

25. Does a long-term physical condition or mental condition or health problem, reduce the amount or the kind of activity you can or could do at school?
    - ☐ Sometimes
    - ☐ Often
    - ☐ Never
    - ☐ Does not attend school
    - ☐ Don't Know
    - ☐ Refused

HEALTH

Now, I'd like to ask you about your health.

26. In general, would you say your health is excellent, very good, good, fair, or poor?
    - ☐ Excellent
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor
    - ☐ Don't know
    - ☐ Refused

27. Compared to one year ago, how would you say your health is now? Is it...?
    - ☐ Much better now than 1 year ago
    - ☐ Somewhat better now (than 1 year ago)
    - ☐ About the same as 1 year ago
    - ☐ Somewhat worse now (than 1 year ago)
    - ☐ Much worse now (than 1 year ago)
    - ☐ Don't know
    - ☐ Refused

28. Thinking about the amount of stress in your life, would you say that most days are...?
    - ☐ Not at all stressful
    - ☐ Not very stressful
    - ☐ A bit stressful
    - ☐ Quite a bit stressful
    - ☐ Extremely stressful
    - ☐ Don't know
    - ☐ Refused

29. Since we last talked with you, have you seen a doctor or been to a health clinic for a routine check-up?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

30. Do you have a regular medical doctor?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
        a. If **NO,** why do you not have a regular medical doctor?
        - ☐ No medical doctors available in the area
        - ☐ Medical doctors in the area are not taking new patients
        - ☐ Have not tried to contact one
        - ☐ Had a medical doctor who left or retired
        - ☐ Other – (Specify: _____)
        - ☐ Don't Know
        - ☐ Refused

31. How often do you usually have a general physical check-up?
    - ☐ More than once a year
    - ☐ Once a year
    - ☐ Once every 2 years
    - ☐ Once every 3 years
    - ☐ Less than once every 3 years
    - ☐ No regular pattern
    - ☐ Don't Know
    - ☐ Refused
        a. If **LESS THAN ONCE EVERY 3 YEARS**, what are the reasons that you have not had a general physical check-up in the past 3 years?
        - ☐ Have not gotten around to it
        - ☐ Respondent - did not think it was necessary
        - ☐ Doctor - did not think it was necessary
        - ☐ Personal or family responsibilities
        - ☐ Not available - at time required
        - ☐ Not available - at all in the area
        - ☐ Waiting time was too long
        - ☐ Transportation - problems
        - ☐ Language - problem
        - ☐ Cost
        - ☐ Did not know where to go / uninformed
        - ☐ Fear (e.g., painful, embarrassing, find something wrong)
        - ☐ Unable to leave the house because of a health problem
        - ☐ Other – (Specify:_____)
        - ☐ Don't Know
        - ☐ Refused

32. Since we last talked with you, have you seen a doctor or been to a health clinic for any physical health problem or disability?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
33. Thinking of the most recent time you saw a doctor, what was the type of care that was needed?
    - ☐ Treatment of - a physical health problem
    - ☐ Treatment of - an emotional or mental health problem
    - ☐ A regular check-up (including regular pre-natal care)

- ☐ Care of an injury
- ☐ Other – (Specify :_____)
- ☐ Don't Know
- ☐ Refused

34. Where did you try to get the service you were seeking?
    - ☐ Doctor's office
    - ☐ Community health centre / CLSC
    - ☐ Walk-in clinic
    - ☐ Appointment clinic
    - ☐ Hospital - emergency room
    - ☐ Hospital - outpatient clinic
    - ☐ Other – (Specify :_____)
    - ☐ Don't Know
    - ☐ Refused

35. Since we last talked with you, were there times when you were unable to get medical care when you thought you needed it?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know
    - ☐ Refused

    a. Thinking of the most recent time, why didn't you get care?
    - ☐ Not available - in the area
    - ☐ Not available - at time required (e.g. doctor on holidays, inconvenient hours)
    - ☐ Waiting time too long
    - ☐ Felt would be inadequate
    - ☐ Cost
    - ☐ Too busy
    - ☐ Didn't get around to it / didn't bother
    - ☐ Decided not to seek care
    - ☐ Doctor - didn't think it was necessary
    - ☐ Other – (Specify :_____)
    - ☐ Don't know
    - ☐ Refused

36. Since we last talked with you, have you been to the dentist?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

37. Do you usually visit the dentist *(list all options)*:
    - ☐ More than once a year for check-ups?
    - ☐ About once a year for check-ups?
    - ☐ Less than once a year for check-ups?
    - ☐ Only for emergency care?
    - ☐ Don't know
    - ☐ Refused

38. Do you have insurance that covers all or part of your dental expenses?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know
    - ☐ Refused
        a. If **YES**, who is it provided from?
        - ☐ A government-sponsored plan
        - ☐ An employer-sponsored plan
        - ☐ A private plan
        - ☐ College/university/other academic institution
        - ☐ Paid for by your CAS
        - ☐ Don't know
        - ☐ Refused

39. Since we last talked with you, were there times when you were unable to get dental care when you needed it?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
        a. If **YES**, thinking of the most recent time, why didn't you get care?
        - ☐ Not available - in the area
        - ☐ Not available - at time required (e.g. doctor on holidays, inconvenient hours)
        - ☐ Waiting time too long
        - ☐ Felt would be inadequate
        - ☐ Cost
        - ☐ Too busy
        - ☐ Didn't get around to it / didn't bother
        - ☐ Decided not to seek care
        - ☐ Doctor - didn't think it was necessary
        - ☐ Other – (Specify :_____)
        - ☐ Don't Know
        - ☐ Refused

40. Do you have insurance that covers all or part of the cost of your prescription medications?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
        a. Is it...?
        - ☐ A government-sponsored plan
        - ☐ An employer-sponsored plan
        - ☐ A private plan
        - ☐ College/university/other academic institution
        - ☐ Paid for by your CAS
        - ☐ Don't Know
        - ☐ Refused

41. Do you have insurance that covers all or part of the costs of eye glasses or contact lenses?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
        a. Is it...?
        - ☐ A government-sponsored plan
        - ☐ An employer-sponsored plan
        - ☐ A private plan
        - ☐ College/university/other academic institution
        - ☐ Paid for by your CAS
        - ☐ Don't Know
        - ☐ Refused

42. How would you describe your <u>usual</u> ability to remember things? *(list options)*
    - ☐ Able to remember most things
    - ☐ Somewhat forgetful
    - ☐ Very forgetful
    - ☐ Unable to remember anything at all
    - ☐ Don't know
    - ☐ Refused

43. How would you describe your <u>usual</u> ability to think and solve day-to-day problems? *(list options)*
    - ☐ Able to think clearly and solve problems
    - ☐ Having a little difficulty
    - ☐ Having some difficulty
    - ☐ Have a great deal of difficulty
    - ☐ Unable to think or solve problems
    - ☐ Don't know
    - ☐ Refused

44. In general, how would you rate your ability to handle unexpected and difficult problems, for example, a family or personal crisis? Would you say your ability is:
    - ☐ Excellent
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor
    - ☐ Don't know
    - ☐ Refused

45. In general, how would you rate your ability to handle the day-to-day demands in your life, for example, handling work, family and volunteer responsibilities? Would you say your ability is:
    - ☐ Excellent
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor
    - ☐ Don't know
    - ☐ Refused

46. Thinking about stress in your day-to-day life, what would you say is the most important thing contributing to feelings of stress you may have?
    - ☐ Time pressures / not enough time
    - ☐ Own physical health problem or condition
    - ☐ Own emotional or mental health problem or condition
    - ☐ Financial situation (e.g., not enough money, debt)
    - ☐ Own work situation (e.g., hours of work, working conditions)
    - ☐ School
    - ☐ Employment status (e.g., unemployment)
    - ☐ Caring for - own children
    - ☐ Caring for - others
    - ☐ Other personal or family responsibilities
    - ☐ Personal relationships
    - ☐ Discrimination
    - ☐ Personal and family's safety
    - ☐ Health of family members
    - ☐ Other - Specify _____
    - ☐ Nothing
    - ☐ Don't know
    - ☐ Refused

47. Do you have any of the following long-term conditions? (a long-term condition refers to a condition that has lasted or is expected to last 6 months or more and has been diagnosed by a health professional) *(check all that apply)*
    - ☐ Developmental disability
    - ☐ Learning disability
    - ☐ Attention deficit disorder
    - ☐ No, none of these conditions
    - ☐ Don't Know
    - ☐ Refused

48. In the past year, have you received any medication for your emotions?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

49. In the past year, have you stopped taking any prescribed medication?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
        a. If so why? _____

50. In the past 12 months, have you seen or talked to a health professional about your emotional or mental health?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
        a. If **YES**, how many times (in the past 12 months)?
           Number of times_____
        b. If **YES**, whom did you see or talk to?
            - ☐ Family doctor or general practitioner
            - ☐ Psychiatrist
            - ☐ Psychologist
            - ☐ Nurse
            - ☐ Social worker or counsellor
            - ☐ Other – Specify _____
            - ☐ Don't Know
            - ☐ Refused

51. In the past year, have you attended a drug abuse or alcohol abuse treatment program?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

52. Since we last talked with you, have you spent one or more nights in a psychiatric hospital or any other mental health facility?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

53. In your lifetime, have you smoked a total of 100 or more cigarettes (about 4 packs)?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

54. Have you ever smoked cigarettes daily?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
        a. If **YES**, at what age did you begin to smoke cigarettes daily?
        Age in years: _____
        - ☐ Don't Know
        - ☐ Refused

55. At the present time, do you smoke cigarettes daily, occasionally or not at all?
    - ☐ Daily
    - ☐ Occasionally
    - ☐ Not at all
    - ☐ Don't Know
    - ☐ Refused
        a. If **DAILY**, how many cigarettes do you smoke each day now?
        Number of cigarettes: _____

ALCOHOL CONSUMPTION

Now, some questions about your alcohol consumption.
When we use the word 'drink' it means:
- One bottle or can of beer or a glass of draft
- One glass of wine or a wine cooler
- One drink or cocktail with 1 and a 1/2 ounces of liquor.

56. During the past 12 months, have you had a drink of beer, wine, liquor or any other alcoholic beverage?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

    a. If **YES,** how often did you drink alcoholic beverages?
    - ☐ Less than once a month
    - ☐ Once a month
    - ☐ 2 to 3 times a month
    - ☐ Once a week
    - ☐ 2 to 3 times a week
    - ☐ 4 to 6 times a week
    - ☐ Every day
    - ☐ Don't Know
    - ☐ Refused

    b. If **YES,** how often in the past 12 months have you had 5 or more drinks on one occasion?
    - ☐ Never
    - ☐ Less than once a month
    - ☐ Once a month
    - ☐ 2 to 3 times a month
    - ☐ Once a week
    - ☐ More than once a week
    - ☐ Don't Know
    - ☐ Refused

    c. If **YES**, thinking back over the past week, did you have a drink of beer, wine, liquor or any other alcoholic beverage?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

DRUG USE

I am going to ask some questions about drug use. Again, I would like to remind you that everything you say will remain strictly confidential.

57. Have you ever used or tried marijuana, cannabis or hashish?
    - ☐ Yes, just once
    - ☐ Yes, more than once
    - ☐ No
    - ☐ Don't Know
    - ☐ Refuse
        a. If **YES**, have you used it in the past 12 months?
        - ☐ Yes
        - ☐ No
        - ☐ Don't Know
        - ☐ Refused
            i. If **YES,** how often (did you use marijuana, cannabis or hashish in the past 12 months)?
            - ☐ Less than once a month
            - ☐ 1 to 3 times a month
            - ☐ Once a week
            - ☐ More than once a week
            - ☐ Every day
            - ☐ Don't Know
            - ☐ Refused

58. Have you ever used or tried cocaine or crack?
    - ☐ Yes, just once
    - ☐ Yes, more than once
    - ☐ No
    - ☐ Don't Know
    - ☐ Refuse
        a. If **YES**, have you used it in the past 12 months?
        - ☐ Yes
        - ☐ No
        - ☐ Don't Know
        - ☐ Refused
            i. If **YES**, how often (did you use cocaine or crack in the past 12 months)?
            - ☐ Less than once a month
            - ☐ 1 to 3 times a month
            - ☐ Once a week
            - ☐ More than once a week
            - ☐ Every day
            - ☐ Don't Know
            - ☐ Refused

59. Have you ever used or tried speed (amphetamines)?
    - ☐ Yes, just once
    - ☐ Yes, more than once
    - ☐ No
    - ☐ Don't Know
    - ☐ Refuse
        a. If **YES**, have you used it in the past 12 months?
        - ☐ Yes
        - ☐ No
        - ☐ Don't Know
        - ☐ Refused
            i. If **YES**, how often (did you use speed (amphetamines) in the past 12 months)?
            - ☐ Less than once a month
            - ☐ 1 to 3 times a month
            - ☐ Once a week
            - ☐ More than once a week
            - ☐ Every day
            - ☐ Don't Know
            - ☐ Refused

60. Have you ever used or tried ecstasy (MDMA) or other similar drugs?
    - ☐ Yes, just once
    - ☐ Yes, more than once
    - ☐ No
    - ☐ Don't Know
    - ☐ Refuse
        a. If **YES**, have you used it in the past 12 months?
        - ☐ Yes
        - ☐ No
        - ☐ Don't Know
        - ☐ Refused
            i. If **YES**, how often (did you use ecstasy or other similar drugs in the past 12 months)?
            - ☐ Less than once a month
            - ☐ 1 to 3 times a month
            - ☐ Once a week
            - ☐ More than once a week
            - ☐ Every day
            - ☐ Don't Know
            - ☐ Refused

61. Have you ever used or tried hallucinogens, PCP, Psilocybin (Mushrooms) or LSD (acid)?
    - ☐ Yes, just once
    - ☐ Yes, more than once
    - ☐ No
    - ☐ Don't Know
    - ☐ Refuse
        a. If **YES**, have you used it in the past 12 months?
        - ☐ Yes
        - ☐ No
        - ☐ Don't Know
        - ☐ Refused
            i. If **YES**, how often (did you use hallucinogens, PCP or LSD in the past 12 months)?
            - ☐ Less than once a month
            - ☐ 1 to 3 times a month
            - ☐ Once a week
            - ☐ More than once a week
            - ☐ Every day
            - ☐ Don't Know
            - ☐ Refused

STRESS

The next part of the questionnaire deals with different kinds of stress. Although the questions may seem repetitive, they are related to various aspects of a person's physical, emotional and mental health.

I'd like to ask you about some things that may have happened in the past 12 months. Some of these experiences happen to most people at one time or another, while some happen to only a few.

62. In the past 12 months, were you beaten up or physically attacked?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

63. In the past 12 months, did you have a major financial crisis?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

64. In the past 12 months, did you fail school or a training program?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

65. Did you receive welfare anytime in the past 12 months?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

66. Did you ever spend 2 weeks or more in the hospital as a child or teenager?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

EMPLOYMENT

Now I would like to ask you some questions about any jobs you may have now, or have had in the past.

67. Have you worked at a job or business at any time in the past 12 months?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
        a. If **YES,** would you say that most days at work were...?
        - ☐ Not at all stressful
        - ☐ Not very stressful
        - ☐ A bit stressful
        - ☐ Quite a bit stressful
        - ☐ Extremely stressful
        - ☐ Don't Know
        - ☐ Refused

68. Does a long-term physical condition or mental condition or health problem, reduce the amount or the kind of activity you can do, or could do at work?
    - ☐ Sometimes
    - ☐ Often
    - ☐ Never
    - ☐ Does not work at a job
    - ☐ Don't Know
    - ☐ Refused

The next questions concern your activities in the last 7 days.

69. Last week, did you work at a job or a business? Please include part-time jobs, seasonal work, contract work, self-employment, baby-sitting and any other paid work, regardless of the number of hours worked.
    - ☐ Yes
    - ☐ Yes, more than one
    - ☐ No
    - ☐ Permanently unable to work
    - ☐ Don't Know
    - ☐ Refused

SECTION FOR PARTICIPANTS WHO ARE CURRENTLY IN PAID EMPLOYMENT
(IF NOT WORKING, GO TO NEXT SECTION)

If person currently holds more than one job, report on the job for which the number of hours worked per week is the greatest.

The next questions are about your current job or business.

70. Are you an employee or self-employed?
    - ☐ Employee
    - ☐ Self-employed
    - ☐ Working in a family business without pay
    - ☐ Don't Know
    - ☐ Refused

71. What is the name of your business or for whom do you currently work (For example: name of business, government department or agency, or person)?

    _____
    - ☐ Don't Know
    - ☐ Refused

72. What kind of business, industry or service is this? (For example: cardboard box manufacturing, road maintenance, retail shoe store, secondary school, dairy farm, municipal government)

    _____
    - ☐ Don't Know
    - ☐ Refused

73. What kind of work are you doing? (For example: babysitting in own home, factory worker, forestry technician)

    _____
    - ☐ Don't Know
    - ☐ Refused

74. How long have you been working for this or these employers (in months)? _____

75. What are your most important activities or duties? (For example: caring for children, stamp press machine operator, forest examiner)

    _____

- ☐ Don't Know
- ☐ Refused

76. National occupational classification (NOC): _____

77. Socio-economic index code (SEI): _____

78. How satisfied are you with this job, on the whole?
    - ☐ Extremely satisfied
    - ☐ Satisfied
    - ☐ Neither satisfied nor dissatisfied
    - ☐ Dissatisfied
    - ☐ Extremely dissatisfied
    - ☐ Don't know
    - ☐ Refused

79. About how many hours a week do you usually work at your job or business? If you usually work extra hours, paid or unpaid, please include these hours.
    Number of hours:_____
    a. If **WORKING LESS THAN 30 HOURS**, do you want to work a full-time work week of 30 hours or more per week?
        - ☐ Yes
        - ☐ No
        - ☐ Don't Know
        - ☐ Refused

80. In the past three months, have you been absent from work because of any reason related to your physical or mental health?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

81. Which benefits, if any, would it be possible for you to receive as part of your job? (*Check all that apply)*
    - ☐ Life insurance that would cover your death for reasons not connected with your job
    - ☐ Dental benefits
    - ☐ Pension
    - ☐ Paid maternity or paternity leave
    - ☐ A flexible work schedule
    - ☐ Tuition reimbursement for certain types of schooling
    - ☐ Company-provided or subsidized childcare
    - ☐ Employee Stock Ownership Plan(s)
    - ☐ Other_____
    - ☐ None
    - ☐ Don't Know
    - ☐ Refused

82. In this job, are you eligible for any paid vacation or sick days?
    - ☐ Yes, paid sick days
    - ☐ Yes, paid vacation days
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

83. What is your hourly or weekly pay (including tips, commission, or any other extras, but before any deductions for income tax or other reasons)? $_____
    (Note: Enter dollar amount in dollars and cents. (e.g. $5.50)
    - ☐ Reported in hourly units
    - ☐ Reported in weekly units (each week)
    - ☐ Reported in bi-weekly units (every two weeks)
    - ☐ Don't know
    - ☐ Refused

END OF WORKING SECTION

ASK ONLY IF PERSON IS NOT CURRENTLY WORKING IN PAID EMPLOYMENT

84. In the past 4 weeks, did you do anything to find work?
    - ☐ Yes
    - ☐ No
    - ☐ Disabled & unable to work
    - ☐ Unable to work for some other reason
    - ☐ Don't Know
    - ☐ Refused

85. Do you currently want a job, either full or part time?
- ☐ Yes - full-time (30+ hrs/wk)
- ☐ Yes – part-time (less than 30 hrs/wk)
- ☐ Maybe - it depends
- ☐ No
- ☐ Disabled & unable to work
- ☐ Unable to work for some other reason
- ☐ Don't know
- ☐ Refused

86. What was the main reason you were not working LAST WEEK?
- ☐ On layoff (temporary or indefinite)
- ☐ Slack work/business conditions
- ☐ Waiting for new job to begin
- ☐ Own illness/injury/medical problems
- ☐ Child care problems
- ☐ Other family/personal obligation
- ☐ Maternity or paternity leave
- ☐ Labor dispute
- ☐ Weather affected job
- ☐ School/training/apprenticeship
- ☐ Other (specify: _____)
- ☐ No job
- ☐ Don't know
- ☐ Refused

END OF NOT WORKING SECTION

CRIMINAL JUSTICE SYSTEM INVOLVEMENT

I would now like to ask you questions about your involvement with the justice system.

87. Have you ever been arrested?
- ☐ Yes
- ☐ No
- ☐ Don’t Know
- ☐ Refused
    a. If **YES,** what kind of crime were you arrested for allegedly committing: a crime of violence which includes rape, sexual assault, robbery, aggravated assault, or verbal threats; purse-snatching or pocket-picking; or a property crime which includes burglary, theft, or motor vehicle theft?
    - ☐ Crime of violence
    - ☐ Purse-snatching or pocket-picking
    - ☐ Property crime
    - ☐ Other specify : _____
    - ☐ Don’t Know
    - ☐ Refused

88. Have you been arrested since we last talked with you?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
        a. If **YES,** what kind of crime were you arrested for allegedly committing: a crime of violence which includes rape, sexual assault, robbery, aggravated assault, or verbal threats; purse-snatching or pocket-picking; or a property crime which includes burglary, theft, or motor vehicle theft?
        - ☐ Crime of violence
        - ☐ Purse-snatching or pocket-picking
        - ☐ Property crime
        - ☐ Other specify :_____
        - ☐ Don't Know
        - ☐ Refused

89. Have you been convicted of a crime since we last talked with you?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
        a. If **YES**, what kind of crime were you convicted of committing?
        - ☐ Crime of violence
        - ☐ Purse-snatching or pocket-picking
        - ☐ Property crime
        - ☐ Other specify :_____
        - ☐ Don't Know
        - ☐ Refused

90. Have you spent one night or more in jail, prison, juvenile hall, or another correctional facility since we last talked with you?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused
        a. If **YES,** for what kind of crime did you last spend time incarcerated?
        - ☐ Crime of violence
        - ☐ Purse-snatching or pocket-picking
        - ☐ Property crime
        - ☐ Other specify :_____
        - ☐ Don't Know
        - ☐ Refused

FINANCIAL INFORMATION

91. Thinking about your total personal income, from which of the following sources did you receive any income in the past 12 months?
    - ☐ Wages and salaries
    - ☐ Income from self-employment
    - ☐ Dividends and interest (e.g., on bonds, savings)
    - ☐ Employment insurance
    - ☐ Worker's compensation
    - ☐ Benefits from Canada or Quebec Pension Plan
    - ☐ Job related retirement pensions, superannuation and annuities
    - ☐ RRSP/RRIF (Registered Retirement Savings Plan/Registered Retirement Income Fund)
    - ☐ Old Age Security and Guaranteed Income Supplement
    - ☐ Provincial or municipal social assistance or welfare
    - ☐ Child Tax Benefit
    - ☐ Child support
    - ☐ Alimony
    - ☐ Other (e.g., rental income, scholarships)
    - ☐ None
    - ☐ Your Children's Aid Society
    - ☐ Student grants or loans
    - ☐ Don't Know
    - ☐ Refused

92. What is your total monthly income from all sources at the present time, including tips, commission, CAS payments or student grants or loans but before any deductions for income taxes, etc.? (If you are not certain, please make your best estimate.) $_____

93. Was there ever a time during the past 12 months when you could not pay your rent or mortgage because you did not have enough money?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

94. Were you evicted from your apartment or house at any time during the past 12 months because you did not have enough money to pay the rent or mortgage?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

95. Was there ever a time during the past 12 months when you could not pay a utility bill because you did not have enough money? (By utility bill, I mean a bill for gas, electricity, water, telephone and/or Internet/cable service.)
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know
    - ☐ Refused

FOOD SECURITY

The following questions are about the food situation for your household in the past 12 months.

96. Please tell me if any of the following happened to you during the past 12 months: Did you (or any of the other adults in your household) (CHECK AS MANY AS APPLY):
    - ☐ Eat less than you felt you should because there wasn't enough money to buy food?
    - ☐ Hungry but didn't eat because you couldn't afford enough food?
    - ☐ Lost weight because you didn't have enough money for food?
    - ☐ Ever not eat for a whole day because there wasn't enough money for food?
    - ☐ Ever get food or borrow money for food from friends or relatives?
    - ☐ Ever put off paying a bill so that you would have money to buy food?
    - ☐ Ever get emergency food from a church, food pantry, or food bank?
    - ☐ Ever eat any meals at a soup kitchen or community meal program?
    - ☐ Ever cut the size of your meals or skip meals because there was not enough money for food?

RELATIONSHIP WITH BIRTH PARENTS

97. During the past year, how often did you see (or visit with) your birth mother?
    - ☐ Never (if never, prompt why:_____)
    - ☐ Rarely (1-3 times)
    - ☐ Less than once a month (4-10 times)
    - ☐ About once a month (11-14 times)
    - ☐ Often (15+)
    - ☐ Daily
    - ☐ Not applicable (e.g., birth mother is deceased)
    - ☐ Other_____
    - ☐ Don't Know
    - ☐ Refused
        a. If participant visits with birth mother ask: in general, would you say that you feel very close, somewhat close, not very close, or not at all close to your birth mother these days?
            - ☐ Very close
            - ☐ Somewhat close
            - ☐ Not very close
            - ☐ Not at all close
            - ☐ Don't know
            - ☐ Refused

98. During the past year, how often did you see (or visit with) your birth father?
    - ☐ Never (if never, prompt why:_____)
    - ☐ Rarely (1-3 times)
    - ☐ Less than once a month (4-10 times)
    - ☐ About once a month (11-14 times)
    - ☐ Often (15+)
    - ☐ Daily
    - ☐ Not applicable (e.g., birth father is deceased)
    - ☐ Other_____
    - ☐ Don't Know
    - ☐ Refused
        a. If participant visits with birth father ask: in general, would you say that you feel very close, somewhat close, not very close, or not at all close to your birth father these days?
            - ☐ Very close
            - ☐ Somewhat close
            - ☐ Not very close
            - ☐ Not at all close
            - ☐ Don't know
            - ☐ Refused

ASK ONLY IF PARTICIPANT VISITS WITH ONE OR BOTH PARENTS

99. During the past year, do you feel that, overall, the amount you have seen your birth parents was too little, just about enough, or too much?
    - ☐ Too Little
    - ☐ Just about enough
    - ☐ Too much
    - ☐ Don't know
    - ☐ Refused

POSITIVE MENTAL HEALTH TOOL

ADULT MHC-SF (AGES 18 OR OLDER)

The following questions are about how you have been feeling during the past month. Please answer what best represents how often you have experienced or felt the following. The following options are possible answers : Everyday, almost every day, about 2 or 3 times a week, about once a week, once or twice, never.

During the past month, how often did you feel …	NEVER	ONCE OR TWICE	ABOUT ONCE A WEEK	ABOUT 2 OR 3 TIMES A WEEK	ALMOST EVERY [illegible]	EVERY DAY
MHC-SF						
1. happy	☐	☐	☐	☐	☐	☐
2. interested in life	☐	☐	☐	☐	☐	☐
3. satisfied with life	☐	☐	☐	☐	☐	☐
4. that you had something important to contribute to society	☐	☐	☐	☐	☐	☐
5. that you belonged to a community (like a social group, or your neighborhood your city, your school)	☐	☐	☐	☐	☐	☐
6. that our society is becoming a better place for people like you.	☐	☐	☐	☐	☐	☐
7. that people are basically good	☐	☐	☐	☐	☐	☐
8. that the way our society works makes sense to you	☐	☐	☐	☐	☐	☐
9. that you liked most parts of your personality	☐	☐	☐	☐	☐	☐
10. good at managing the responsibilities of your daily life	☐	☐	☐	☐	☐	☐
11. that you had warm and trusting relationships with others	☐	☐	☐	☐	☐	☐
12. that you had experiences that challenged you to grow and become a better person	☐	☐	☐	☐	☐	☐
13. confident to think or express your own ideas and opinions	☐	☐	☐	☐	☐	☐
14. that your life has a sense of direction or meaning to it	☐	☐	☐	☐	☐	☐

We are now going to ask you questions about your social support networks.

For the next questions please answer none of the time, a little of the time, some of the time, most of the time, or all of the time, depending on how you feel about each situation.

#	Question MOS Social support scale	NONE OF THE TIME	A LITTLE OF THE TIME	SOME OF THE TIME	MOST OF THE TIME	ALL OF THE TIME
1	How often do you feel that there is someone to help you if you were confined to bed.	☐	☐	☐	☐	☐
2	How often do you feel that there is someone you can count on to listen to you when you need to talk.	☐	☐	☐	☐	☐
3	How often do you feel that there is someone to give you good advice about a crisis.	☐	☐	☐	☐	☐
4	How often do you feel that there is someone to take you to the doctor if you needed it.	☐	☐	☐	☐	☐
5	How often do you feel that there is someone who shows you love and affection?	☐	☐	☐	☐	☐
6	How often do you feel that there is someone to have a good time with?	☐	☐	☐	☐	☐
7	How often do you feel that there is someone to give you information to help you understand a situation?	☐	☐	☐	☐	☐
8	How often do you feel that there is someone to confide in or talk to about yourself or your problems?	☐	☐	☐	☐	☐
9	How often do you feel that there is someone who hugs you?	☐	☐	☐	☐	☐
10	How often do you feel that there is someone to get together with for relaxation?	☐	☐	☐	☐	☐
11	How often do you feel that there is someone to prepare your meals if you were unable to do it yourself?	☐	☐	☐	☐	☐
12	How often do you feel that there is someone whose advice you really want?	☐	☐	☐	☐	☐
13	How often do you feel that there is someone to do things with to help you get your mind off things?	☐	☐	☐	☐	☐
14	How often do you feel that there is someone to help with daily chores if you were sick?	☐	☐	☐	☐	☐
15	How often do you feel that there is someone to share your most private worries and fears with?	☐	☐	☐	☐	☐
16	How often do you feel that there is someone to turn to for suggestions about how to deal with a personal problem?	☐	☐	☐	☐	☐
17	How often do you feel that there is someone to do something enjoyable with?	☐	☐	☐	☐	☐
18	How often do you feel that there is someone who understands your problems?	☐	☐	☐	☐	☐
19	How often do you feel that there is someone to love and make you feel wanted?	☐	☐	☐	☐	☐

The next questions are about your current relationships with friends, family members, co-workers, community members, and so on. Please indicate to what extent each statement describes your current relationships with other people.

Please tell me if you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree.

#	Question	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE OR	AGREE	STRONGLY AGREE
	Social Provisions Scale					
1	There are people I can depend on to help me if I really need it.	☐	☐	☐	☐	☐
2	There are people who enjoy the same social activities I do.	☐	☐	☐	☐	☐
3	I have close relationships that provide me with a sense of emotional security and wellbeing.	☐	☐	☐	☐	☐
4	There is someone I could talk to about important decisions in my life.	☐	☐	☐	☐	☐
5	I have relationships where my competence and skill are recognized.	☐	☐	☐	☐	☐
6	There is a trustworthy person I could turn to for advice if I were having problems.	☐	☐	☐	☐	☐
7	I feel part of a group of people who share my attitudes and beliefs.	☐	☐	☐	☐	☐
8	I feel a strong emotional bond with at least one other person.	☐	☐	☐	☐	☐
9	There are people who admire my talents and abilities.	☐	☐	☐	☐	☐
10	There are people I can count on in an emergency.	☐	☐	☐	☐	☐
Self-esteem						
1	You feel that you have a number of good qualities.	☐	☐	☐	☐	☐
2	You feel that you're a person of worth at least equal to others.	☐	☐	☐	☐	☐
3	You are able to do things as well as most other people.	☐	☐	☐	☐	☐
4	You take a positive attitude toward yourself.	☐	☐	☐	☐	☐
5	On the whole you are satisfied with yourself.	☐	☐	☐	☐	☐
6	All in all, you're inclined to feel you're a failure.	☐	☐	☐	☐	☐
Mastery						
1	You have little control over the things that happen to you.	☐	☐	☐	☐	☐
2	There is really no way you can solve some of the problems you have.	☐	☐	☐	☐	☐
3	There is little you can do to change many of the important things in your life.	☐	☐	☐	☐	☐
4	You often feel helpless in dealing with problems of life.	☐	☐	☐	☐	☐
5	Sometimes you feel that you are being pushed around in life.	☐	☐	☐	☐	☐
6	What happens to you in the future mostly depends on you.	☐	☐	☐	☐	☐
7	You can do just about anything you really set your mind to.	☐	☐	☐	☐	☐

100. About how many close friends and close relatives do you have, that is, people you feel at ease with and can talk to about what is on your mind?

Number of close friends or relatives_____

The following questions deal with feelings you may have had during the past month.
Please answer which frequency best represents how you have felt : all of the time, most of the time, some of the time, a little of the time, none of the time.

#	During the past month, about how often did you feel:	NONE OF THE TIME	A LITTLE OF THE TIME	SOME OF THE TIME	MOST OF THE TIME	ALL OF THE TIME
	Distress					

1	...tired out for no good reason?	☐	☐	☐	☐	☐
2	...nervous?	☐	☐	☐	☐	☐
3	...so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
4	...hopeless?	☐	☐	☐	☐	☐
5	...restless or fidgety?	☐	☐	☐	☐	☐
6	...so restless you could not sit still?	☐	☐	☐	☐	☐
7	...sad or depressed?	☐	☐	☐	☐	☐
8	...so depressed that nothing could cheer you up?	☐	☐	☐	☐	☐
9	...that everything was an effort?	☐	☐	☐	☐	☐
10	...worthless?	☐	☐	☐	☐	☐

101. During the past month, how much did these feelings usually interfere with your life or activities?
- ☐ A lot
- ☐ Somewhat
- ☐ A little
- ☐ Don't know
- ☐ Refused

SPIRITUALITY

I now have a few questions about spiritual values in your life.

102. Do spiritual values play an important role in your life?
- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Refused

103. To what extent do your spiritual values help you to find meaning in your life?
- ☐ A lot
- ☐ Some
- ☐ A little
- ☐ Not at all
- ☐ Don't know
- ☐ Refused

104. To what extent do your spiritual values give you the strength to face everyday difficulties?
- ☐ A lot
- ☐ Some
- ☐ A little
- ☐ Not at all
- ☐ Don't know
- ☐ Refused

105. To what extent do your spiritual values help you to understand the difficulties of life?
- ☐ A lot
- ☐ Some
- ☐ A little
- ☐ Not at all
- ☐ Don't know
- ☐ Refused

SATISFACTION WITH LIFE

Now I'd like to ask about your satisfaction with various aspects of your life. For each question, please tell me whether you are very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, or very dissatisfied.

#	How satisfied are you with: Satisfaction with life	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
1	...your job or main activity?	☐	☐	☐	☐	☐
2	...your leisure activities?	☐	☐	☐	☐	☐
3	...your financial situation?	☐	☐	☐	☐	☐
4	... yourself?	☐	☐	☐	☐	☐
5	... the way your body looks?	☐	☐	☐	☐	☐
6	... your relationships with family members?	☐	☐	☐	☐	☐
7	... your relationships with friends?	☐	☐	☐	☐	☐
8	... your housing?	☐	☐	☐	☐	☐
9	... your neighbourhood?	☐	☐	☐	☐	☐

RETROSPECTIVE

106. Looking back over the last 12 months, since our last interview, what is the best thing that has happened to you?

☐ Don't know
☐ Refused

107. Again, looking back over the last 12 months, since our last interview, what has been the most difficult thing you have had to deal with?

☐ Don't know
☐ Refused

108. We would like to contact you in about a year from now for another interview similar to this one. You would be paid $60.00 for your time. Would you like us to contact you next year to see whether you want to continue your participation in this study?
☐ Yes
☐ No

If the answer to question 70 is "no", please go to the end of the interview and ask for the address to which the Crown Ward's cheque should be sent. If the participant answers "yes", continue with the following section on future contact information.

FUTURE CONTACT INFORMATION

"Here are the last few questions of the interview."

"Now I would like to ask you some questions that will help us to contact you in the future when we interview you again for Phase III. Please remember that we will only use the information that you give us in order to find you. We will **not** be asking any of these people for any other information about you. Also, please remember that what you have told me is **confidential** and that we will not be sharing any of your answers to today's questions with any of these other people."

(Note: If the respondent does not have the information below available during the interview, you can offer to call them back within a day or two to get this information. Set up a specific call back day and time, as needed.)

109. Do you have a nickname or other name that you are commonly known by?
- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Refused
  a. If **YES**, What is it? _____ *(specify)*

110. If participant is still in contact with birth mother, ask if there has been any change in her contact information?
- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Refused
  a. If any changes, please specify?

(specify)

- ☐ Don't Know
- ☐ Refused

111. If participant is still in contact with birth father, ask if there has been any change in his contact information?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Refused

a. If any changes, please specify?

(specify)

- ☐ Don't Know
- ☐ Refused

IF ANY BROTHERS OR SISTERS

112. Since we last talked did any of your brothers and sisters contact information change (Please note all changes, if any)?

(specify)

- ☐ Don't Know
- ☐ Refused

113. Are you still in contact with your most recent caregivers? If so, can you tell us there contact information? Caregivers' name (e.g., foster parents, group home staff, etc.)?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Refused
  a. If **YES**, could you tell me their full names, addresses, email addresses, and telephone numbers, if you have them?

(specify)

- ☐ Don't Know
- ☐ Refused

114. Is there an adult relative or relatives, other than your parents, that you have seen often in the last year?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Refused
  a. If Yes, could you tell me their full names, addresses, email addresses, and telephone numbers, if you have them?

(specify)

- ☐ Don't Know
- ☐ Refused

115. Could you tell me the full names, addresses, email addresses, and telephone numbers of three of your best friends?

(specify)		

☐ Don't Know
☐ Refused

116. Since the last time we talked, did your email address or addresses, Facebook name, Twitter account change?

☐ Yes
☐ No
☐ Don't Know
☐ Refused

a. If **YES,** note changes.

(specify)

☐ Don't Know
☐ Refused

117. What is your current address and phone number (residential and cell phone)?

(specify)

☐ Don't Know
☐ Refused

118. Are you planning to move in the next year?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Refused

a. If **YES,** please specifi the new address and phone number.

(specify)

- ☐ Don't Know
- ☐ Refused

119. Is there any other way you can think of that would be good for us to be able to contact you?

(specify)

- ☐ Don't Know
- ☐ Refused

120. Do you intend to join the Canadian armed forces or the Canadian reserves?

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Refused

a. If **YES**, which branch of the armed forces or reserves do you intend to join?

- ☐ Army
- ☐ Navy
- ☐ Air force
- ☐ Coast guard
- ☐ Reserves: _____ *(specify which branch)*
- ☐ Other: _____ *(specify)*
- ☐ Don't know
- ☐ Refused

ASK ONLY IF PARTICIPANT IS STILL IN CARE

[BEGIN AUDIO RECORDING]

121. And finally, if you are still in contact with your child welfare worker is it OK if we ask him/her for any names and addresses of any other contact people so that we can contact them in order to find you a year from now? We will only be contacting this person in order to get information to find you. We will **not** be asking them any questions about you or sharing your answers to this questionnaire with them.

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Refused

[END AUDIO RECORDING]

"THIS IS THE END OF THE SURVEY."

Can you give us an address to send you the $60 cheque for this interview?

Thanks for your help and patience! We look forward to speaking with you again in about one year!