Children and Youth Who Run Away from Substitute Care: A Qualitative and Quantitative Analysis

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Abstract

Many homeless youth come from foster homes, group homes, and other forms of substitute care. For young people in the child welfare system, elopement represents a major problem as it places them at risk for a number of troubling outcomes. Three studies were undertaken examining elopement among young people living in substitute care in Canada and the United States. The first study explored strengths and needs in a sample of 5,011 children and youth housed in a variety of substitute care settings including foster homes, group homes, residential treatment centres, emergency shelters, and juvenile justice facilities. Results indicated that needs, but not strengths, predicted running among children, while both needs and strengths predicted running among adolescents. Problems with school attendance, substance abuse, and delinquency also predicted running among both children and adolescents, with the exception of young children, for whom substance abuse was not a significant predictor. The second study explored the relationship between trauma, strengths, and elopement in a sample of 2,296 adolescents living in substitute care. Sexual abuse, physical abuse, school violence, and traumatic grief/separation were found to predict elopement. In addition, family violence and community violence predicted running among younger but not older adolescents. Educational strengths predicted a lower risk of running away for all adolescents, while well-being and relationship permanence predicted a lower risk of running among younger and older adolescents, respectively. The impact of strengths on the relationship between trauma and elopement was evaluated, with results suggesting that elopement was not predicted by an interaction between strengths and trauma. The third study was qualitative in nature and explored the perspectives of youth who had run away from substitute care at least once in their lifetime. Youth provided information about their experiences as well as suggestions designed to reduce the prevalence of running away among

youth in substitute care. Findings for all three studies were discussed in relation to the literature with implications for research and prevention.

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Introduction

Background

Studies indicate that a significant proportion of homeless youth come from the child welfare system (Kennedy, 1991; Public Health Agency of Canada, 2006; Raising the Roof, 2009). In most cases, youth homelessness is a consequence of young people choosing to leave their legal place of residence without permission; within the context of child welfare, this translates into running away from placements. Among young people in substitute care, running away, also referred to in the literature as elopement or going "AWOL", has been associated with a number of troubling outcomes such as maltreatment, delinquency, and involvement in risky activities like substance use (Biehal & Wade, 1999; Kaufman & Widom, 1999; Stewart, Steiman, Cauce, Cochran, Whitbeck, & Hoyt, 2004; Tyler, Hoyt, Whitbeck, & Cauce, 2001). Further, research suggests that young people who run away from substitute care face significant hazards whether they choose to live on the streets, or return to their families or communities of origin (Courtney, Skyles, Miranda, Zinn, Howard, & Goerge, 2005). Despite a growing interest in youth homelessness (see, for example, Raising the Roof, 2009), a number of questions remain unanswered about elopement. This may make planning and decision-making difficult for child welfare workers seeking to promote the health and well-being of young people living in substitute care.

This dissertation is designed to explore the phenomenon of elopement among young people living in substitute care, also referred to as out-of-home care. Substitute care placement services are managed by child welfare agencies and consist of a number of different types of living arrangements for children and youth who have been removed from their families of origin for their own safety and protection. These include, but are not limited

to, traditional foster family care, family or relative foster care, group homes, residential treatment centres, and emergency shelters.

Although individual child welfare agencies may use differing terminology, substitute care can be conceptualized as falling into one of two groups. These groups are broadly defined as: (1) community-based settings (e.g., foster care, group homes, emergency shelters) and (2) non-community-based or institutional settings. Institutional care may refer to residential treatment centres for young people with significant behavioural and/or emotional needs, juvenile justice/corrections facilities, rehabilitative services, and emergency shelters. Ideally, settings are chosen in order to best meet the needs of the individual child or adolescent.

In spite of the efforts of child welfare workers and associated professionals to deal with the problem of elopement, research suggests that the rates of elopement among youth in substitute care remain disproportionately high. For example, data gathered from 689 homeless youth from across Canada revealed that 68% of the youth had come from foster care, group homes, or youth centres (Raising the Roof, 2009). Within the general population, research suggests that between 4-8% of all children and adolescents in the U.S. run away each year (Hammer, Finkelhor, & Sedlak, 2002; Substance Abuse and Mental Health Administration, 2004; Ringwalt, Greene, Robertson, & McPheeters, 1998; Sanchez, Waller, & Greene, 2006). Among young people living in substitute care, the proportion of youth who choose to run away is likely much higher, although at present, exact numbers are unavailable. While population-based research is lacking, findings from smaller studies conducted in the U.S. and Great Britain suggest that running away is more common among children and adolescents living in substitute care including both foster care and residential

treatment centres (Biehal & Wade, 2000; Fasulo, Cross, Mosley, & Leavey, 2002; Guest, Baker, & Storaasli, 2008).

Research suggests that most episodes of elopement are short-lived. Results of one large U.S. population-based study, for example, suggest that 19% of young people are missing for less than 24 hours and another 58% return home within 7 days (Hammer et al., 2002). Research with young people in foster care reveal similar results, with the majority of youth running for relatively short periods of time (Witherup, Vollmer, Van Camp, Goh, Borrero, & Mayfield, 2008). In spite of this, running away is often conceptualized as being a type of severe problem behaviour with serious consequences.

Conceptual Framework

Given the significant risks associated with youth homelessness, why do young people choose to leave substitute care without permission? Broadly speaking, running may represent an attempt to avoid something within the current living environment or may signify reward-seeking behaviour based on perceived rewards outside the current context. Researchers have referred to these as "push" and "pull" factors (Biehal & Wade, 2000). For example, relationships may represent a significant pull factor for children and youth who have been removed from their families and communities of origin; research suggests that many young people who run from care later report they were running to be with family (Courtney et al., 2005).

Attachment theory underlines the importance of relationships by emphasizing bonds with caregivers. Developed by Bowlby and Ainsworth (1991), attachment theory provides a conceptual framework for understanding why young people from difficult backgrounds marked by unstable, inconsistent parenting may be more likely to engage in high-risk activities. Attachment theory postulates that early relationships with caregivers provide

young people with the building blocks to form healthy relationships as adults. When a child has a consistent, responsive caregiver, he or she develops an internal working model of that caregiver as loving and dependable. Consequently, the child learns to see him or herself as loveable and worthy of support from other people. Attachment facilitates the development of basic skills required to relate to other individuals in a healthy way, as well as self-reliance and the ability to effectively regulate emotional states.

Attachment theory has special significance for children and adolescents in the child welfare system, who are more likely to come from homes characterized by abuse and neglect. Young people living in out-of-home care are particularly vulnerable to disruptions in relationships with primary caregivers as they have been removed from their families of origin for their own safety. They may also experience further disruptions once they enter the child welfare system. For instance, in one study conducted in the state of Illinois, researchers found that in the year after entry into foster care, children experienced an average of 2.1 placement changes (Zinn, DeCoursey, Goerge, & Courtney, 2006).

Research suggests that among children in foster care, quality of attachment to foster parents is associated with adjustment (Andersson, 2005; Marcus, 1991; McLaughlin, Zeanah, Fox, & Nelson, 2012; Milan & Pinderhughes, 2000). For example, Marcus (1991) found that children in foster care who had stronger emotional ties with foster parents were psychologically better adjusted and showed fewer problems with school achievement. Problems with attachment, meanwhile, have been associated with internalizing and externalizing problems among young children living in foster care (Oosterman & Schuengel, 2008). In a longitudinal study of children in foster care, Andersson (2005) found that young adults who were categorized as showing good social adjustment and well-being were more likely to have been securely attached to their mothers as young children, and were also more

likely to have continued to maintain positive relationships with their birth families. In contrast, participants who had shown attachment problems as children were more likely to show poor social adjustment and have histories of problems with school, drugs, and delinquency as young adults. The relevance of attachment to later adjustment among children and adolescents in the child welfare system has led to concerted efforts to consider attachment when making decisions about care (Mennen & O'Keefe, 2005).

With respect to elopement, Paradise (2001) argues that young people become homeless when family relationships break down. Problems with attachment can occur when individual vulnerabilities within the developing child (such as problems with attention/impulse control or learning) are paired with environmental risk in the form of unskilled, overwhelmed caregivers. In such situations, parents have difficulty providing the nurturance necessary for optimal bonding and attachment. Indeed, research shows that homeless and runaway youth are more likely to have experienced caretaking characterized by substance use, conflict, and violence (Whitbeck & Hoyt, 1999). Parenting style, especially a lack of parental responsiveness and emotional support, has been associated with youth homelessness (Tavecchio, Thomeer, & Meeus, 1999). Among incarcerated adolescent males, quality of parental attachment has been associated with running away (McGarvey et al., 2010).

Building on attachment theory, Whitbeck and Hoyt's risk-amplification developmental model emphasizes cumulative risk over time (Whitbeck & Hoyt, 1999; Whitbeck, Hoyt, & Yoder, 1999). This model posits that young people typically run from dysfunctional homes to escape from maltreatment within disorganized, volatile family environments. At the heart of these family environments are parents who are perceived by their children as having serious problems (i.e., substance abuse and/or criminal behaviour).

According to this model, parental substance abuse and criminal behaviours increase the likelihood that children will be exposed to physical and/or sexual abuse within the home. By running from home, therefore, young people may be seeking to escape these family environments characterized by factors such as poor parenting, abuse, neglect, or harsh and inconsistent discipline.

Once homeless, this model illustrates possible mechanisms by which young people are exposed to cumulative risk. Homeless youth may choose to engage in deviant subsistence strategies such as theft or prostitution in order to meet their basic needs. They may also associate with deviant peers while on the streets, and engage in dangerous behaviours such as substance abuse and unprotected sex. Each of these factors may contribute to the probability that young people may experience victimization by others while on the streets. The dangers associated with this constellation of risk are compounded by early experiences that occurred prior to running away and in their families of origin. For example, while growing up, young people may observe their parents and other adults engaging in risky behaviours which, once homeless, make them more likely to engage in such behaviours themselves, including associating with deviant peers, engaging in substance use, and participating in risky sexual behaviours.

Within this model, Whitbeck and Hoyt (1999) emphasize time spent homeless as well as association with deviant peers while on the streets, in conjunction with predisposing factors such as early maltreatment in the home. For example, research shows that young people are more likely to engage in deviant subsistence strategies depending on their family histories, how much time they have spent homeless, and how much they socialize with other youths engaging in risky behaviours. Once homeless, young people, especially females, are

more likely, through this process of cumulative risk, to develop internalizing problems such as depression and post-traumatic stress disorder (PTSD).

Another explanatory model discussed in the literature is social capital theory (Hagan & McCarthy, 1997), which seeks to explain why people become involved in deviant behaviour, including running away. Like Whitbeck and Hoyt (1999), Hagan and McCarthy (1997) argue that young people run to escape from difficult home lives. Social capital theory emphasizes the scarcity of resources or social capital, a sociological construct defined as the accumulation of skills, knowledge, and social networks. According to Hagan and McCarthy (1997), street youth are more likely to come from families with diminished social capital. From this perspective, limited social capital results in poor parenting, which drives young people to want to run from home. Once homeless, youth are less likely to acquire social capital given limited resources and opportunities, and are more likely to be involved in criminal activity rather than taking on more conventional life goals. For example, youth living in substitute care, particularly those with histories of placement instability, may be less likely to develop social and economic capital due to limited opportunities to develop social networks with family, friends, and the community (Clark et al., 2008).

Finally, this dissertation is informed by research on risk and resilience. Masten (2001) discusses resilience in terms of good outcomes in spite of serious threats to adaptation and development. Risk and resilience theories emerged from research demonstrating that certain young people thrive in spite of exposure to factors typically associated with negative outcomes, such as poverty, child abuse and neglect, and parental mental illness (Luthar, Cicchetti, & Becker, 2000; Seifer, Sameroff, Baldwin, & Baldwin, 1992; Werner & Smith, 1992). Findings from this research suggest that resilient individuals are more likely to be characterized by certain protective factors or strengths that set them apart from other

individuals who continue to struggle. These strengths allow individuals to deal more effectively with adversity (Rutter, 1987). For example, studies indicate that mentoring, meaning a close relationship with a trusted adult who serves as a confidant and positive role model, can act as a protective buffer for young people in foster care (Gilligan, 1999; Osterling & Hines, 2006).

Research on risk and resilience may have special importance for young people in the child welfare system who are more likely to have endured multiple psychosocial stressors in their lifetimes. Rutter (2000) suggests that within this population there are five groups of possible risk and protective factors in play: genetically influenced variations in vulnerability (such as emotional/behavioural, social, and educational difficulties), physical trauma (which can be prenatal, as in the case of fetal alcohol syndrome, or postnatal), preadmission psychosocial experiences (such as abuse, neglect, or family discord), experiences while living in out-of-home care (many of which parallel risk factors within families of origin), and experiences after leaving care (such as inadequate support or coping skills). Outcomes depend upon a complex interaction between risk and protective factors as well as interactions between children, their caregivers, and the environment.

In recent years, researchers investigating risk and resilience have shifted their focus away from identifying factors and toward a consideration of processes and mechanisms, emphasizing the promotion of resilience (Schofield and Beek, 2005). While the topic of resilience in the context of elopement remains largely unexplored, a growing body of literature suggests that strengths play an important role in risk behaviours (Griffin, Martinovich, Gawron, & Lyons, 2009; Lyons, Uziel-Miller, Reyes, & Sokol, 2000; Perkins & Jones, 2004).

Each of the preceding theories offers complementary perspectives on the factors that contribute to elopement. All emphasize the contribution of early life experiences to risky outcomes, which may be especially relevant to certain populations such as children and youth in the child welfare system, who have necessarily experienced a disruption in their living situation due to documented abuse and/or neglect.

Overview

This dissertation, while not designed to test a theoretical model or models, draws primarily from attachment theory and risk-amplification developmental model. Within a context of attachment and additive risk, this research seeks to explore factors that may contribute to the probability of elopement within a population of children and youth entering the child welfare system.

Three studies were conducted in the context of this dissertation in order to better understand elopement among young people in substitute care. The first study was designed to provide information about elopement within a large sample of children and youth living in out-of-home care. More specifically, the first study explored patterns of strengths and needs among young people living in a variety of substitute care settings in the state of Illinois.

The second study was designed to explore the relationship between trauma, strengths, and elopement in a sample of youth living in substitute care in the state of Illinois. This study examined both trauma and strengths independently, exploring which variables appear to have an impact on running. The impact of strengths on the relationship between trauma and elopement was also evaluated.

The third study was qualitative in nature and explored the perspectives of youth currently living in a large, central Canadian city, all of whom had first-hand experience of running from substitute care. Youth were interviewed in an urban drop-in centre, an

emergency shelter, and a supportive housing unit. They were asked to describe their experiences and to provide suggestions based on those experiences.

These three studies each provide different perspectives on an enduring issue. Although a significant proportion of homeless youth are known to come from substitute care, only a small number of studies have focused specifically on elopement within this population. Most have focused on one type of substitute care (e.g., foster care) rather than including young people from many different types of placement settings. As well, few studies on running have included children in their samples.

The frequency with which youth run away from care, as well as the significant challenges associated with youth homelessness, both indicate that research of this kind is timely and appropriate. Understanding these behaviours may represent a critical step toward addressing them. It is quite likely that elopement among young people in substitute care is, in part, related to individual characteristics and, as such, might be prevented by identifying those characteristics that predispose youth to be at a higher risk of running. However, it is also possible that running is associated with characteristics of the physical and social environments from which youth run. This duality adds to the complexity of this research, which necessitates a multi-method approach to identify factors predictive of elopement.

Study 1a

Predictors of Elopement Among Young People Living in Substitute Care

Introduction

Background

Research suggests that a disproportionate number of homeless youth come from foster homes, group homes, and other forms of substitute care (Kennedy, 1991; Public Health Agency of Canada, 2006; Raising the Roof, 2009). For child welfare organizations, elopement represents a major problem because it places young people at a greater risk for a number of troubling outcomes, including victimization, participation in high-risk activities such as substance use, and delinquency (Kaufman & Widom, 1999; Stewart et al., 2004; Tyler et al., 2001). In spite of a growing interest in pathways toward and out of youth homelessness, many questions remain unanswered about which children and youth run from substitute care and why.

Within the child welfare system, substitute care, also referred to as out-of-home care, is a form of residential placement for children and youth who must be removed from their family of origin for their own safety and protection. Substitute care may take the form of a number of different types of living arrangements. These include, but are not limited to, foster family care, kinship or relative care, group homes, and institutional care. Institutional care can refer to residential treatment for mental health problems, juvenile justice/corrections, rehabilitative services, and emergency shelters.

Different governmental child welfare departments may use differing terminology for substitute care; however, placement types can generally be divided into two groups: (1) community-based settings, such as foster care families, and (2) non-community-based settings, such as specialized residential treatment programs for significant behavioural and/or emotional difficulties.

Currently, it is unknown exactly how many young people have chosen to leave substitute care without permission. Data collected in the United States suggest that an estimated 4-8% of all children and adolescents in the general population run away each year (Hammer et al., 2002; Ringwalt et al., 1998; Sanchez et al., 2006; Substance Abuse and Mental Health Administration, 2004). In Canada, missing persons data collected by the Royal Canadian Mounted Police (RCMP) suggest that in 2007, a total of 60,582 Canadian children and youth were reported as missing to the police, the majority of whom were classified as runaways (Royal Canadian Mounted Police, 2011). While the proportion of young people reported missing represents less than 1% of the total number of Canadian children and adolescents, it is important to note that this may be an underrepresentation of the actual number of children and adolescents who run away each year in Canada, as these statistics do not take into account runaways whose caregivers did not report them missing to the police.

Research on elopement among young people in substitute care has generally involved either surveying homeless youth or examining discharge data collected by regional agencies or institutions. Findings suggest that elopement is a common occurrence among young people in substitute care (Biehal & Wade, 2000; Fasulo et al., 2002; Guest et al., 2008). For instance, a recent poll of 689 homeless youth from across Canada revealed that 68% had previously been in foster care, group homes, or youth centres, and 43% had been involved with Child Protection Services (Raising the Roof, 2009).

Risk Factors Associated with Elopement

Previous research has identified several risk factors known to be associated with elopement. Age has been identified as a demographic risk factor for running away, with adolescents showing a greater likelihood of elopement compared to children. In fact, few

studies on runaway behaviour have even included children, possibly because fewer children run away compared to adolescents (Sanchez et al., 2006). According to research funded by the U.S. Department of Justice, 68% of children and youth in the general public who ran away from home in 1999 were between the ages of 15 and 17 years, whereas children aged 7 to 11 years comprised only 4% of the sample (Hammer et al., 2002).

Findings from research with youth in foster care and residential treatment centres suggest that within these groups, age represents a significant risk factor for elopement (Baker, Wulczyn, & Dale, 2005; Courtney & Wong, 1996; Courtney et al., 2005; Eisengart, Martinovich, & Lyons, 2008; Sunseri, 2003). For example, Courtney and colleagues (2005) reported on data collected from 14,282 youth who ran away from care between 1993 and 2003, and found that nearly 90% ran for the first time after they were at least 12 years of age. Interestingly, the National Runaway Switchboard (2008) reported that children under the age of 12 represented the fastest growing group of callers to the crisis line. Calls from children increased by 172% between 2000-2007, suggesting that elopement may be on the rise within this group. There is also some indication that the rate of elopement may decrease as youth approach the age of majority; in one study of 8,933 children and youth living in residential treatment centres, researchers found that frequency of elopement peaked at 38% at age 16 and then decreased to 35% among 17-year-olds and 28% among 18-year-olds (Sunseri, 2003).

A second variable that has been identified as being associated with elopement among youth in substitute care is gender. However, results have been mixed depending on the sample under study. In many cases, researchers have reported a higher frequency of runaway behaviour among females, including both larger, population-based studies (Sanchez et al., 2006) as well as studies of youth in foster care (Courtney & Wong, 1996; Courtney & Zinn,

2009), specialized foster care (Fasulo et al., 2002), and residential treatment (Carlson, 1991; Eisengart et al., 2008; Sunseri, 2003). Other population-based studies have reported higher numbers of male runaways (Substance Abuse and Mental Health Administration, 2004; Ringwalt et al., 1998) or no significant gender differences among children and youth in the general population (Hammer et al., 2002) and in foster care (Biehal & Wade, 2000). For example, Tyler and Bersani (2008) examined data collected from 1,690 youth from the National Longitudinal Survey of Youth and reported approximately equal numbers of male and female runaways. However, when a multivariate analysis was performed on the data at 2-4 years follow-up, several variables, including being female, emerged as risk factors for runaway status. Females appear to be more likely to seek help through shelters and hotlines; in 2007, the National Runaway Switchboard reported that 75% of crisis callers were female (National Runaway Switchboard, 2008).

The link between runaway behaviour and substance use has been well-documented both among youth in the general population (De Man, 2000; Bacharach, 2006; Johnson, Whitbeck, & Hoyt, 2005) as well as among youth in foster care and residential treatment centres (Bacharach, 2006; Baker et al., 2005; Eisengart et al., 2008; Guest et al., 2008; McIntosh, Lyons, Weiner, & Jordan, 2010; Sunseri, 2003; Weiner, Abraham, & Lyons, 2001). Substance use has been shown to be both a risk factor for running away and an outcome for youth who run away from substitute care. Among homeless and runaway youth in Canada, self-reported substance use rates of 50% have been reported (Raising the Roof, 2009). It has been suggested that substance use may represent a form of maladaptive coping for homeless and runaway youth; for instance, youth may ingest stimulants in order to stay awake all night to avoid being exploited by others, or they may self-medicate to cope with problems (Raising the Roof, 2009).

Research has linked running away with problems at school including lower academic achievement, failure, and suspension both among youth in the general population (Sullivan & Knutson, 2000; Tyler & Bersani, 2008) and among youth in substitute care (English & English, 1999; McIntosh et al., 2010; Nesmith, 2006). In a study of 30 homeless and runaway youth, Paradise (2001) found that nearly all had some form of learning disability. Researchers in the province of Newfoundland found that youth who ran away from the child welfare system had more issues at school compared to non-runners (English & English, 1999). Frequent running has been associated with detachment from school among youth in care (Biehal & Wade, 1999; Raising the Roof, 2009). Sullivan and Knutson (2000) showed that children and youth with communication disabilities and mental retardation were more likely to run compared to children with other types of disabilities. However, Courtney and Zinn (2009) found that youth in substitute care were actually less likely to run if they had some form of developmental disability or cognitive delay. McIntosh and colleagues (2010), meanwhile, found that poor school attendance was associated with running away among youth in residential treatment centres.

There appears to be significant overlap between delinquency and running away. Delinquency has been found to be a risk factor for elopement (Siegel & Callesen, 1993; Tyler & Bersani, 2008), and running away increases the likelihood of being involved in delinquent activities and being arrested (Biehal & Wade, 1999; Kaufman & Widom, 1999). For example, Abbey and colleagues (1997) compared the case files of 82 males in residential treatment centres, 43 of whom had a history of running away repeatedly, and 39 who had no history of elopement. They found that habitual runners were more likely to have a history of property crime offenses. Runners were also more likely to have been perpetrators of physical abuse. Researchers have also found that homeless and runaway youth are more likely to be

arrested if they meet criteria for conduct disorder or substance abuse (Chen, Thrane, Whitbeck, & Johnson, 2006).

Placement instability has been associated with elopement from substitute care (Courtney et al., 2005; Nesmith, 2006), as has type of placement. Courtney and Zinn (2009) found that placement type was related to elopement, both for first and subsequent runs. More specifically, being placed in a relative foster home was associated with a decreased risk of elopement compared to placement in a traditional, non-relative foster home. As well, placement in non-community-based settings, such as residential treatment centres, was associated with a much higher risk of elopement. The authors also found that youth were less likely to run from juvenile justice facilities and other restrictive non-community-based settings, likely due to physical barriers preventing running.

Protective Factors Associated with Elopement

Few psychosocial strengths or protective factors have been highlighted as possibly being associated with a decreased risk of running away from substitute care. Although not directly involving children and youth in substitute care, Tyler and Bernani (2008) identified greater school engagement as being associated with a decreased likelihood of running away in a sample of youth who had been the subject of a child abuse or neglect investigation. Within this study, school engagement was a composite item consisting of 11 self-report items, including items related to how youth felt in school and how often they were disciplined in school. Skyles, Smithgall, and Howard (2007) recently conducted a qualitative research study on school engagement among youth in the child welfare system, highlighting the importance of providing the necessary support to allow young people in substitute care to achieve positive educational outcomes.

Monitoring by a parent or caregiver has been shown to be associated with a reduced risk of elopement within the general population. Longitudinal research suggests that monitoring is associated with a decrease in runaway behaviour among youth, and youth who have more positive relationships with caregivers are less likely to run (Tyler & Bersani, 2008; Tyler, Johnson, & Brownridge, 2008). Among youth in foster care, living situations with little adult supervision were associated with an increased risk of a first run (Courtney & Zinn, 2009).

The Present Study

This study was designed to provide information about elopement within a large sample of young people living in a variety of out-of-home placement settings. More specifically, this study explored predictors of running away among children and adolescents living in substitute care in the state of Illinois.

Based on findings from previous research, several hypotheses were proposed. First, it was expected that age would be positively associated with runaway risk, with older individuals showing a greater likelihood of being at a moderate or high risk of elopement. It was also hypothesized that gender would be associated with running away, with more females at risk for elopement compared to males. It was expected that the type of placement a young person was living in would be associated with running away, with participants living in non-community-based placements (such as residential treatment centres and institutions) being more likely to run away, compared to participants housed in community-based placements (such as foster homes). It was expected that strengths would be negatively associated with running away, while needs would be positively associated with running away. Finally, it was hypothesized that substance abuse, poor school attendance, and delinquency would be positively associated with risk of elopement.

Method

Setting

The present study was conducted using data routinely collected by the Illinois Department of Children and Family Services (DCFS). Illinois had an estimated population of 12,830,632 people in 2010, 24.6% of whom were under the age of 18 years (U.S. Census Bureau, 2011). In 2009, the median household income was $53,974, which is slightly higher than the median household income across the United States, which was $50,221. Also in 2009, 13.3% of residents of the state of Illinois were living below the poverty line, which is slightly lower than the U.S. national average (14.3%). Most children who enter substitute care come from families living below the poverty line. As of June 2007, there were 16,160 children in Illinois living in substitute care (Illinois Department of Children and Family Services, 2011a).

The mission of the Illinois DCFS is as follows: to protect children who are reported to be abused or neglected and to increase their families' capacity to safely care for them, to provide for the well-being of children in care, to provide appropriate, permanent families as quickly as possible for those children who cannot safely return home, to support early intervention and child abuse prevention activities, and to work in partnerships with communities to fulfill this mission (Illinois Department of Children and Family Services, 2011b). At entry into care, children and adolescents undergo a comprehensive assessment by Illinois DCFS caseworkers. Assessments are then conducted at least every 6 months thereafter, and at exit from care.

Participants

Participants were drawn from a pool of 11,988 infants, children and youth who underwent an assessment at entry into care between July 3, 2005 and May 28, 2010.

Assessments were conducted using the Child and Adolescent Needs and Strengths (CANS; Lyons, 1999; Lyons, 2009), a measure routinely utilized by the Illinois DCFS to guide decisions regarding care (see Appendix A). The CANS is described in further detail below. Only children and youth between the ages of 6 and 18 years were included in the analysis. Four participants with no specified gender were excluded from the final sample. Also excluded were children and youth for whom no information was provided about their risk of running away ($N = 185$). A small number of children and youth ($N = 68$) had undergone more than one initial CANS assessment; for those participants, secondary CANS assessments were removed from the dataset. Prior to conducting regression, the data set was screened for missing values as well as outliers. Participants for whom more than 20% of the CANS data were missing were not included in the analysis ($N = 50$).

The final sample included 5,011 children and adolescents ranging in age from 6 to 18 years, with a mean age of 11.63 years ($SD = 3.48$). Table 1 presents the demographic characteristics of the sample. There were approximately equal numbers of males and females, with females comprising 50.7% of the sample ($N = 2543$) and males comprising 49.3% of the sample ($N = 2468$). With respect to race/ethnicity, 48.2% of children and youth in the sample were African American ($N = 2413$), 44.3% were Non-Hispanic White ($N = 2218$), 5.1% were Hispanic ($N = 256$), 0.5% were Asian ($N = 24$), and 0.1% were Native American ($N = 3$). For 1.9% of participants, data regarding race/ethnicity were unavailable ($N = 97$).

The majority of participants in this sample (92.6%; $N = 4640$) were living in community-based settings, while the remaining number of children and youth (7.4%; $N = 371$) were living in non-community-based settings. Table 2 presents data on placement settings.

Table 1

Demographic Characteristics of the Sample (N = 5011)

	Frequency	Percentile
Gender		
Female	2543	50.7%
Male	2468	49.3%
Age		
6-9 years	1630	32.5%
10-12 years	1085	21.7%
13-15 years	1476	29.5%
16-18 years	820	16.4%
Ethnicity		
African American	2413	48.2%
Non-Hispanic White	2218	44.3%
Hispanic	256	5.1%
Asian	24	0.5%
Native American	3	0.1%
Not reported	97	1.9%
Total	5011	100.0%

Most participants (56.7%, *N* = 2843) were living in Parent/Relative Foster Care, a type of community-based placement where young people are housed with a relative or relatives. Fewer participants were living in Traditional Foster Care (*N* = 1148, 22.9%), where children and adolescents are placed with foster parents who are non-relatives. A small number of participants were living in other, more specialized types of foster care settings, included Special Foster Care Not Otherwise Specified (*N* = 393, 7.8%), Special Foster Care Adolescent Care (*N* = 60, 1.2%), and Special Foster Care Teen Parenting (*N* = 2, <0.1%). A total of 3.9% of the sample were between residences and living in the community at the time their received their CANS assessment (*N* = 194), the majority of whom was currently staying at emergency shelters (*N* = 182, 3.6%). Several young people fell within the category of Service Interruption Not Otherwise Specified (*N* = 11, 0.2%). Finally, one 17-year-old male participant was living independently without authorization in the community.

Table 2

Number and Percent of Participants in Community-Based and Non-Community-Based Settings by Age Group (N = 5011)

	6-9 years	10-12 years	13-15 years	16-18 years	Total
Community-based settings					
Parent/Relative Foster Care	1068 (65.5%)	677 (62.4%)	737 (49.9%)	361 (44.0%)	2843 (56.7%)
Traditional Foster Care	423 (26.0%)	233 (21.5%)	314 (21.3%)	178 (21.7%)	1148 (22.9%)
Special Foster Care NOS	80 (4.9%)	86 (7.9%)	157 (10.6%)	70 (8.5%)	393 (7.8%)
Emergency Shelter	9 (0.6%)	19 (1.8%)	74 (5.0%)	80 (9.8%)	182 (3.6%)
Special Foster Care Adolescent Care	32 (2.0%)	14 (1.3%)	9 (0.6%)	5 (0.6%)	60 (1.2%)
Service Interruption NOS	3 (0.2%)	1 (0.1%)	0 (<0.1%)	7 (0.9%)	11 (0.2%)
Special Foster Care Teen Parenting	0 (<0.1%)	0 (<0.1%)	0 (<0.1%)	2 (0.2%)	2 (0.2%)
Unauthorized Independent Living	0 (<0.1%)	0 (<0.1%)	0 (<0.1%)	1 (0.1%)	1 (<0.1%)
Total	1615 (99.1%)	1030 (94.9%)	1291 (87.5%)	704 (85.9%)	4640 (92.6%)
Non-community-based settings					
Residential Treatment Centres	8 (0.5%)	27 (2.5%)	95 (6.4%)	58 (7.1%)	188 (3.8%)
Institutionalized	7 (0.4%)	13 (1.2%)	44 (3.0%)	44 (5.4%)	108 (2.2%)
Detention Centres	0 (<0.1%)	15 (1.4%)	45 (3.0%)	12 (1.5%)	72 (1.4%)
Special Foster Care Aggregate Care	0 (<0.1%)	0 (<0.1%)	1 (0.1%)	2 (0.2%)	3 (0.1%)
Total	15 (0.9%)	55 (5.1%)	185 (12.5%)	116 (14.1%)	371 (7.4%)
Total (all settings)	1630 (100.0%)	1085 (100.0%)	1476 (100.0%)	820 (100.0%)	5011 (100.0%)

Note: NOS = Not Otherwise Specified

A smaller proportion of children and youth (7.4%, *N* = 371) were living in non-community-based settings. These included children and youth with behavioural and/or emotional needs requiring a higher level of support and supervision, who had been placed in residential treatment centres (*N* = 188, 3.8%) and institutions (*N* = 108, 2.2%). A group of older children and youth were currently incarcerated in detention centres (*N* = 72, 1.4%). Finally, a handful of adolescents were living in Special Foster Care Aggregate Care (*N* = 3, 0.1%), a type of group home with increased supervision for young people with special needs.

Measures

The primary measure for this study was the Child and Adolescent Needs and Strengths (CANS; Lyons, 1999; Lyons, 2009), a 69-item assessment tool routinely used by the Illinois DCFS to guide decisions regarding care (see Appendix A). The CANS is designed to provide snapshot of an individual child or adolescent's level of functioning across multiple domains and contexts by highlighting the needs and strengths of young people and their families.

The CANS is a communimetric tool and thus differs from traditional psychometric measures in that it emphasizes measurement as communication. Communimetric tools are designed to be useful within human service enterprises by producing clear, unambiguous, relevant, and accessible information that can be utilized to inform interventions (Lyons, 2009). Whereas traditional psychometric theory generally views single item measures as being unreliable, necessitating some kind of combination, communimetric tools are designed to be face-valid at the item level. Further, communimetric tools are directly tied to service provision, unlike psychometric measures, where the output typically does not have an independent relationship with the construct it is designed to measure. For example, a psychometric measure

will produce a total score, which then must be interpreted or translated in order to make it clinically meaningful.

As a communimetric tool, the CANS is composed of items that have direct implications for differential action. Each item on the CANS corresponds to a need or strength that is rated along a continuum consisting of 4 action levels. For needs, action levels range from 0 (no evidence, no need for action) to 3 (indicating a need for immediate/intensive action because the need is dangerous or disabling). More specifically:

0 = No evidence – indicates a dimension where there is no evidence of any needs

1 = Watchful waiting – indicates a dimension that requires monitoring, watchful waiting, or preventive activities

2 = Action required – indicates a dimension that requires action to ensure that this identified need or risk behavior is addressed. This need is interfering with the child's individual, family or community functioning in a notable way

3 = Immediate action required – indicates a need that is dangerous or disabling, requiring immediate or intensive action

The action levels on the CANS represent a powerful means of bringing about change within human service enterprises. Unlike traditional psychometric measures, which sometimes can seem arbitrary with respect to cut-offs and require the additional step of interpretation in order to move into service delivery, the CANS makes a direct link between assessment and intervention. A score of 3 on a needs item immediately communicates to individuals involved in the care of a child or adolescent that intervention is required in this area.

There are 13 needs items on the CANS that describe a variety of problems or risk behaviours: psychosis, attention deficit/impulse control, depression, anxiety, oppositional,

conduct, substance abuse, attachment difficulties, eating disturbance, affect dysregulation, behavioural regression, somatization, and anger control. For example, one needs item on the CANS, entitled “anxiety”, describes the extent to which a child’s level of fearfulness or worry may warrant intervention. A score of 3 on this item would indicate clear evidence of a debilitating level of anxiety, making it virtually impossible for the child to function in any life domain. Another needs item, “anger control”, describes problems with a child’s ability to identify and manage his or her anger when frustrated. A score of 3 on anger control indicates a need for immediate action to address severe anger control problems. In such a situation, the child’s temper is likely associated with frequent fighting that is often physical, and others likely fear him/her.

For strengths, the continuum is reversed, with action levels ranging from 0 (a strength that could be the centerpiece of a strength-based plan) to 3 (no strength has been identified, and thus efforts at identifying and developing the strength are indicated). The following categories and action levels are used for strengths:

0 = Centerpiece strength – indicates a domain where strengths exist that can be used as a centerpiece for a strength-based plan

1 = Useful strength – indicates a domain where strengths exist, and can be included in a strength-based plan, but would require some strength-building efforts in order for them to serve as the centerpiece of a strength-based plan

2 = Strength has been identified – indicates a domain where strengths have been identified, but they require significant strength-building efforts before they can be effectively utilized

3 = No strength identified – indicates a domain in which efforts are needed in order to identify potential strengths for strength-building efforts

Strengths items on the CANS describe a variety of positive attributes at the level of the individual, the family, and the community. There are 10 strengths items in the CANS: family, interpersonal, educational, vocational, well-being, optimism, talents/interests, spiritual/religious, community life, and relationship permanence. For example, "talents/interests" refers to creative or artistic skills including art, theatre, music, or athletics. A child with a score of 0 on talents/interests shows important creative/artistic strengths, and receives a significant amount of personal benefit from activities surrounding a talent. This strength could be capitalized upon and utilized as the centerpiece for a strength-based intervention plan. A score of 3, meanwhile, would indicate that the child has no known talents, interests, or hobbies.

Another strengths item, "community life", refers to the child's level of involvement with cultural aspects of life in his or her community. A score of 0 on the community life item indicates a child with extensive, substantial, and long-term ties with the community. For example, the child may be a member of a community group (e.g., Girl or Boy Scouts) for more than one year, may be widely accepted by neighbours, may be involved in other community activities, or may be connected to others through informal networks. Having strong ties to a community represents an important asset for at-risk children and youth, and many opportunities may exist for channeling this strength within a strength-based intervention plan.

CANS items may be examined individually (e.g., to gain information about a child's school attendance) or items can be aggregated into scales. Each scale contains up to 14 items, the totals of which are added together and normalized to produce a standard score. The present analysis made use of individual CANS items as well as the Child Strengths scale (10 item sum, standardized) and the Child Behavioural/Emotional Needs scale (13 item sum, standardized).

Typically, the CANS is administered by front-line caseworkers when a child or adolescent enters the child welfare system and at 6-month intervals thereafter. Ratings apply to the past 30 days unless otherwise specified; however, some flexibility is allowed in exceptional circumstances. For instance, if a youth has been in a detention centre for the past 30 days, ratings for substance abuse may be more accurate if they are based on the 30 days immediately prior to incarceration. The CANS can be used either prospectively or retrospectively in order to inform decisions about level of care and treatment planning, as well as to measure clinical outcomes.

To ensure high, ongoing field reliability, caseworkers who complete the CANS are required to be trained and certified annually. Following a standard half-day of training, certification occurs upon successful completion of a test case vignette with a minimum reliability (intraclass correlation) of 0.70. Likewise, annual recertification requires a minimum reliability score of 0.70 in order to continue administering the CANS.

The CANS shows good predictive validity and good concurrent validity compared to another widely used measure of children's mental health, the Child and Adolescent Functional Assessment Survey (CAFAS; Lyons, Weiner, & Lyons, 2002). The CANS has also been shown to have good interrater reliability; Anderson and colleagues (2003) report that interrater reliability was 0.81 between caseworkers and researchers, and 0.85 between researchers and researchers.

At the item level, the CANS has been demonstrated to be reliable both prospectively and using field audit methods (Anderson et al., 2003). Interrater reliability for individual CANS items was found to range from 0.55 to 0.98. For substance abuse, interrater reliability was found to be 0.84 between clinicians and researchers, and 0.90 between researchers. For school functioning, interrater reliability was 0.57 between clinicians and researchers, and 0.67 between

researchers. Finally, interrater reliability for the crime/delinquency item was 0.86 between clinicians and researchers, and 0.84 between researchers.

Within the context of the current study, internal consistency for the Child Strengths scale and the Child Behavioural/Emotional Needs scale was examined using Cronbach's alpha. Each scale showed good internal consistency, with Cronbach's alphas of 0.83 for both.

Data Analysis

Data were analyzed using the SPSS statistics analysis program, version 19.0. Four logistic regression models were planned in order to identify predictors associated with runaway risk status.

The dependent variable for all four regressions, runaway risk, was derived from item 64 of the CANS entitled "runaway" which falls under the "Child Risk Behaviours" section (see Appendix A, item 64 of the CANS). This item characterizes a runaway situation as one where a child or adolescent has left his or her place of residence overnight or very late into the night. A rating of 0 on item 64 indicates that there is no known history of running away and no expressed ideation involving escaping from the present living situation. For this study, a two-level variable was created where participants were categorized as being either at (a) low risk for running, or (b) moderate to high risk for running. Low risk was defined as having no history of running and no known ideation or threats to run away (score of 0 on item 64). Moderate to high risk indicated that a child or youth had a history of running from care or had made threats to run away (score of 1, 2, or 3 on item 64).

Prior to initiating this analysis, the sample was divided into four age groups (6-9 years, 10-12 years, 13-15 years, and 16-18 years). The decision to subdivide the sample was made for several reasons, including the presence of a roughly bimodal distribution where adolescents aged

14-16 years and children aged 6 years were overrepresented in the sample. Further, results of preliminary analyses showed widely disparate results for younger compared to older individuals, much of which tended to get "washed out" when the sample was considered as a whole. This was partly due to the fact that, not unexpectedly, the risk of running was much lower for children compared to adolescents (see Table 3). For example, among children aged 6-9 years, only 3.4% (N = 55) were at a moderate/high risk of running away compared to 13.8% if children aged 10-12 (N = 150), 38.8% of youth aged 13-15 years (N = 572), and 51.1% of youth aged 16-18 years (N = 419). Therefore the decision was made to look at younger and older children and youth separately.

A variable for placement type, defined as community-based vs. non-community-based settings, was created (see Table 2 for a breakdown of placement type by age group). Only a handful of children aged 6-9 years (N = 15) and children aged 10-12 years (N = 55) were living in non-community-based settings, therefore this variable was omitted from the logistic regressions for these age groups due to insufficient variation.

Four logistic regression analyses were conducted, two with 7 predictor variables (for participants aged 6-9 and 10-12 years) and two with 8 predictor variables (for participants aged 13-15 and 16-18 years). These predictors included gender, age, placement type, strengths, needs, school attendance, substance abuse, and delinquency. Independent variables were selected for the logistic regressions based on previous research associating elopement among youth in substitute care with age, gender, school attendance, substance abuse, and delinquency. The latter three variables, namely, school attendance, substance abuse, and delinquency, were individual items on the CANS (see Appendix A: items 41, 52, and 65). Also included as predictors in the analyses were two CANS scales, Child Strengths and Child Emotional/Behavioural Needs. Prior to the

analyses, composite scores for these scales were created by summing and normalizing the constituent items for each scale, the Child Strengths scale (10 item sum, standardized) and the Child Behavioural/Emotional Needs scale (13 item sum, standardized).

Results

Runaway Risk

Compared to adolescents, children were much less likely to have a history of elopement or to exhibit ideation involving escaping from their present living situation. The majority of children aged 6-9 years (96.6%) were categorized as being at a low risk for running ($N = 1575$). Children aged 10-12 years were also more likely to be at a low risk of running (86.2%, $N = 935$). As age increased, so did risk of elopement: 61.2% of youth aged 13-15 years ($N = 904$) and 48.9% of youth aged 16-18 years ($N = 401$) were at a low of running. Table 3 presents frequencies for runaway risk for males and females across the four age groups. Chi-square tests comparing males to females showed that there were significantly fewer females than males at a moderate/high risk for running within the 10-12 year age group.

Table 3

Number of Participants in Each Runaway Risk Category by Age and Gender (N = 5011)

	6-9 years		10-12 years		13-15 years		16-18 years	
Risk of Running	Female	Male	Female	Male	Female	Male	Female	Male
Low	806	769	466	469	461	443	209	192
Moderate/High	21	34	47	103	295	277	238	181
Total *N*	827	803	513*	572*	756	720	447	373

* $p < .001$

Children Aged 6-9 Years

Among children aged 6-9 years, the 7-predictor model significantly predicted a child's placement in either the low or moderate/high risk category of running, $\chi^2(7, N = 1630) =$

112.576, $p < .001$. The Cox & Snell R Square and the Nagelkerke R Square values suggested that the model accounted for between 6.7% and 26.1% of the variance. For classification accuracy statistics (including sensitivity, specificity, positive predictive power, negative predictive power, and correct classification percentages) please refer to Table 8. Correlation matrices for each logistic regression are presented in Appendix B.

Gender, age, strengths, and substance abuse were all non-significant predictors of runaway risk (see Table 4). As mentioned previously, the actual rates of running among children aged 6-9 years were extremely low, with the majority of children at a low risk of running (N = 1575, 96.6%) compared to a small group of children at a moderate/high risk of running (N = 55, 3.4%). In spite of these caveats, needs, school attendance, and delinquency were all seen to contribute significantly to the variance, suggesting that these relationships are fairly robust. All three variables showed a positive relationship with the dependent variable, indicating that as needs, delinquency, and problems with school attendance increased, so too did the risk of running away.

Table 4

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model for Children Aged 6-9 Years (N = 1630)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	.093	.320	.084	.772	1.097	.586-2.055
Age	.156	.139	1.267	.260	1.233	.945-1.610
Strengths	.020	.029	.476	.490	1.019	.962-1.080
Needs	.216	.038	31.566	.001**	1.242	1.152-1.339
School Attendance	.436	.170	6.586	.010*	1.565	1.119-2.187
Substance Abuse	.454	.872	.271	.603	1.655	.303-9.034
Delinquency	1.301	.452	8.281	.004*	3.532	1.469-8.491

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

Children Aged 10-12 Years

Among children aged 10-12 years, the 7-predictor model significantly predicted whether a child would be in either the low or moderate/high risk category of running, $\chi^2(7, N = 1085) = 231.193$, $p < .001$. The Cox & Snell R Square and the Nagelkerke R Square values suggested that the model accounted for between 19.2% and 34.7% of the variance. For additional classification accuracy statistics, please refer to Table 8.

Compared to younger children, the model was a better fit for older children, with only gender, age, and strengths making a nonsignificant contribution to the variance (see Table 5). Children aged 10-12 years with a high needs profile were more likely to be at a moderate/high risk category for running. Similarly, children in this age group showing greater problems with school attendance, substance abuse, and delinquency were more likely to run away.

Table 5

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model for Children Aged 10-12 Years (N = 1085)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	.230	.224	1.058	.304	1.258	.812-1.950
Age	.241	.133	3.266	.071	1.273	.980-1.653
Strengths	.028	.022	1.708	.191	1.029	.986-1.074
Needs	.192	.030	41.133	.001**	1.211	1.142-1.284
School Attendance	.320	.115	7.746	.005*	1.378	1.099-1.726
Substance Abuse	.707	.246	8.285	.004*	2.027	1.253-3.280
Delinquency	.410	.147	7.746	.005*	1.507	1.129-2.012

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

Youth Aged 13-15 Years

Among youth aged 13-15 years, the 8-predictor model significantly predicted group membership, $\chi^2(8, N = 1476) = 442.135$, $p < .001$. The Cox & Snell R Square and the Nagelkerke

R Square values suggested that the model accounted for between 25.9% and 35.1% of the variance. For classification accuracy statistics, please refer to Table 8.

For this age group, every predictor was significant at the .05 or .001 level, which suggests that the model is a much better fit for youth aged 13-15 years compared to the previous two groups of children aged 6-9 and 10-12 years. The direction of the relationship for gender also indicates that for youth aged 13-15 years, being female increased the probability of falling into the moderate/high risk of running category. As well, being older also increased the risk of running. With regard to placement type, youth living in non-community-based settings were more likely to be in a higher risk category for elopement compared to youth living in community-based settings. Youth with fewer strengths were more likely to run away, as were youth with higher needs. Finally, youth with more problems with school attendance, substance abuse, and delinquency were more likely to be in a higher risk category for running.

Table 6

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model for Youth Aged 13-15 Years (N = 1476)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.336	.133	6.377	.012*	.715	.551-.928
Age	.222	.080	7.628	.006*	1.248	1.066-1.460
Placement Type	.387	.192	4.037	.045*	1.472	1.010-2.146
Strengths	.028	.014	4.291	.038*	1.029	1.002-1.057
Needs	.136	.020	45.019	.001**	1.146	1.101-1.192
School Attendance	.311	.069	20.468	.001**	1.364	1.192-1.561
Substance Abuse	.540	.098	30.029	.001**	1.716	1.414-2.081
Delinquency	.340	.092	13.785	.001**	1.405	1.174-1.681

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

Youth Aged 16-18 Years

For adolescents aged 16-18 years, the 8-predictor model significantly predicted group membership, $\chi^2(8, N = 820) = 200.718$, $p < .001$. The Cox & Snell R Square and the Nagelkerke R Square values suggested that the model accounted for between 21.7% and 29.0% of the variance. Please refer to Table 8 for classification accuracy statistics.

For this group, age was not a significant predictor. All other variables did, however, contribute to the variance in risk for running. As with younger youth, these results suggest that females aged 16-18 years are at a higher risk of running compared to males, and participants living in non-community-based settings are more likely to run compared to those living in community-based settings. As well, youth with greater needs and fewer strengths were at a higher risk of running, as were youth with poor school attendance, substance abuse, and delinquency.

Table 7

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model for Youth Aged 16-18 Years (*N = 820).*

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.609	.169	12.973	.001**	.544	.391-.758
Age	-.194	.146	1.771	.183	.824	.619-1.096
Placement Type	.796	.251	10.045	.002*	2.216	1.355-3.625
Strengths	.034	.016	4.394	.036*	1.035	1.002-1.068
Needs	.134	.025	28.205	.001**	1.143	1.088-1.201
School Attendance	.200	.080	6.232	.013*	1.221	1.044-1.428
Substance Abuse	.243	.110	4.851	.028*	1.275	1.027-1.582
Delinquency	.245	.114	4.609	.032*	1.277	1.022-1.597

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

Table 8

Classification Accuracy Statistics by Age Group (N = 5011)

Age group	Sensitivity	Specificity	Positive Predictive Power	Negative Predictive Power	Correct Classification
6-9 years	16.4%	99.8%	75.0%	97.2%	97.0%
10-12 years	31.3%	97.4%	66.2%	89.8%	88.3%
13-15 years	57.2%	84.7%	70.3%	75.8%	74.1%
16-18 years	70.4%	69.8%	70.9%	69.3%	70.1%

Note: Cut Value (CV) = 0.5

Discussion

The current study utilized retrospective clinical assessment data from a large sample of children and youth to examine predictors of elopement among young people living in substitute care. These individuals were currently living in community-based settings (e.g., traditional foster care or parent/relative foster care) and non-community-based settings (e.g., residential treatment centers, institutions, or juvenile justice facilities).

Results indicate that running was a relatively common occurrence, especially among older adolescents. As age increased, so too did the proportion of young people at a moderate or high risk of elopement (meaning they had a history of running or running ideation). Whereas only 3.4% of children aged 6-9 years were at risk for elopement, by the time youth were 16-18 years of age, over half (51.1%) were at a moderate or high risk of elopement.

Gender emerged as a predictor for some, but not all age groups. For the two adolescent groups, female participants were more likely to be at a moderate or high risk of running away. This corresponds with previous research conducted with youth in foster care and residential treatment (Carlson, 1991; Courtney & Wong, 1996; Courtney & Zinn, 2009; Eisengart et al., 2008; Fasulo et al., 2002; Sunseri, 2003). However, this finding did not apply to the younger age

groups, suggesting that gender differences in running may emerge with age and may be less relevant among children in out-of-home care. Future research comparing males and females across childhood and adolescence may be helpful in teasing apart gender-based differences in patterns of elopement.

It was hypothesized that placement type would be associated with running away, with placement in non-community-based settings (such as residential treatment centres and institutions) predicting higher risk of running away, compared to placement in community-based settings (such as foster homes). The relatively small number of children placed in non-community-based settings precluded inclusion of this variable in analyses with children aged 6-9 and 10-12 years. Among youth aged 13-15 years and youth aged 16-18 years, placement type emerged as a significant predictor. Participants living in non-community-based settings were found to be more likely to run away compared to participants housed in community-based settings. This finding is in line with previous research (Courtney & Zinn, 2009).

Within the current sample, the number of participants in certain types of non-community-based placement settings was relatively small compared to the number of participants living in traditional and family foster care. While these findings are positive in that they suggest that the Illinois DCFS is working hard to ensure that most children and youth are placed in community-based settings, within the context of the current study these differences in group size did not allow for comparison between subgroups of individuals living in various placement settings. Future research comparing different types of substitute care settings may provide important information about elopement from both community-based and non-community-based settings.

In addition to showing very different rates of running compared to adolescents, children showed differing profiles of strengths and needs. It was hypothesized that the Child Strengths

scale on the CANS would be negatively associated with running away, meaning individuals with a greater number of psychosocial strengths would be less likely to run away from substitute care. Needs, meanwhile, were expected to be positively associated with elopement, with greater needs predicting a higher risk of running away. Similarly, it was hypothesized that engagement in substance abuse, poor school attendance, and delinquency would be positively associated with risk of elopement. Interestingly, in both groups of children aged 6-9 years and 10-12 years, psychosocial strengths did not show a relationship with running, while needs did. One possibility is that a small number of high needs children are likely to engage in multiple risky behaviours, including running away from placements. It is also possible that the lack of relationship between strengths and running among children is related, in part, to the way in which strengths are measured in the CANS. Many of the strengths items in the CANS involve skills and assets that typically develop later in childhood. For example, the talents/interests item on the CANS attempts to capture participation in activities related to the cultivation of a talent or talents (e.g., athletics or music). This item may be more accessible to adolescents, who are more likely to be exposed to extra-curricular activities (such as sports, choir, or band) in later elementary school or junior high school.

While strengths did not appear to influence elopement among children, results of this study indicate that strengths seemed to play a more central role in predicting running among adolescents. For youth aged 13-15 years and 16-18 years, psychosocial strengths were inversely related to elopement, meaning youth showed a greater likelihood of running away if they had fewer strengths. Gender, placement type, strengths, needs, school attendance, substance abuse, and delinquency also all significantly predicted running for both adolescent age groups. Youth

were more likely to run if they had greater needs, fewer strengths, and more problems with school attendance, substance abuse, and delinquency.

Among the youngest participants, needs, school attendance, and delinquency were significant predictors of running. Each showed a positive relationship with the dependent variable, indicating that increased needs, delinquency, and problems with school attendance were predictive of running within this group. Children aged 6-9 years had a very similar profile to children aged 10-12 years; however, among older children, substance abuse also emerged as a significant predictor. These results suggest that within this group (children aged 10-12 years), children engaged in or suspected of engaging in substance abuse were more likely to be runners. It is possible that substance abuse did not emerge as a predictor among younger children because rates of substance abuse were extremely low in this group, with 99.0% of participants showing no evidence of substance abuse ($N = 1614$). It may also be that a relationship between substance abuse and elopement emerges in later childhood, as young people enter their "tween" years. Rates of substance abuse, although slightly higher among children aged 10-12 years, were still small, with the majority of participants in this age group (93.3%) showing no evidence of any substance abuse ($N = 1012$).

Delinquency and problems with school attendance were predictors for all four age groups, which corresponds with previous findings (McIntosh et al., 2010; Tyler & Bersani, 2008). Both may show a reciprocal relationship with elopement, meaning they may be both a cause and a consequence of elopement and of homelessness. For example, problems with education may contribute to a young person's likelihood to run, and running away in turn may affect school performance by virtue of the fact that homeless youth may be more likely to miss class and fall behind other students. Youth homelessness is known to be associated with high

rates of dropping out; one recent study, for example, reported that 62% of street youth had dropped out of school (Raising the Roof, 2009). Given the wide age range of participants within the current study, it is possible that at least among younger children, delinquency and problems with school attendance may be an antecedent of elopement and may be related to other issues at the level of the family, such as disorganized and dysfunctional families of origin.

It may be helpful for future studies to look at factors affecting adjustment over time to different types of placement settings. Because the current study was cross-sectional in nature, and only allowed for examination of entry into care, information was unavailable about how these individuals fared after weeks or months. Likewise, information about placement stability was unavailable. Given research linking placement instability to elopement (Courtney et al., 2005; Nesmith, 2006), future research looking at these factors as well as other environmental variables may be helpful.

In sum, and in spite of some similarities, these findings suggest that the profile of children who run away from substitute care appears to be very different from the profile of adolescents who run away from care. The regression model fit best for adolescents, suggesting that more research is needed to examine the predictors of elopement in children. Children who run away from out-of-home care may, for instance, be exhibiting a specific profile of significant needs, such as problems with attention/impulse control or oppositional behaviour that have a greater impact on behaviour than strengths.

To date, few studies of this size have examined the strengths and needs of children and adoelscents who run away from the substitute care. The present results confirm that both individual and environmental factors are predicting the likelihood of running in this group of young people. Development of prevention activities must therefore focus on both sets of factors

simultaneously. Understanding which children and youth are at-risk for elopement may inform the development of programs designed to address the co-factors of running (e.g., substance abuse prevention), but also to better understand the characteristics of environments that lead young people to run away. Given the risks associated with youth homelessness, especially among at-risk populations such as young people living in out-of-home care, research of this kind may have implications for future research in both an American and Canadian context. Ultimately, knowing more about elopement may enable us to better meet the needs of children and youth under the care of the state.

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Study 1b

Trauma and the Role of Strengths Among Youth Who Run Away from Substitute Care

Introduction

Background

The impact of childhood trauma on young people in the child welfare system has been the focus of much discussion in recent years. This focus on trauma has been supported by studies demonstrating a relationship between childhood exposure to trauma and a number of serious outcomes later in life (see, for example, Felitti et al., 1998). Left unaddressed, early traumatic experiences can have significant long-term consequences (Currie & Widom, 2010, Gilbert et al., 2009). This has led many child-serving systems to adopt trauma-informed systems of care, designed to provide appropriate assessment and support for children and adolescents who have experienced significant maltreatment or neglect (Griffin et al., 2011).

A number of definitions of the term "trauma" are currently in use within the literature, describing both an event as well as a reaction to an event. The DSM-IV-TR classification for post-traumatic stress disorder (PTSD) describes a situation of actual or threatened death or serious injury, or a threat to the physical integrity of self or others (American Psychiatric Association, 2000). In order to meet criteria for PTSD, individuals must experience feelings of intense fear, helplessness, or horror following direct or indirect exposure to a traumatic event. In contrast, others have defined trauma more broadly to describe an emotionally painful or distressing experience that threatens or causes harm to a child's emotional and physical well-being (National Child Traumatic Stress Network, 2012). This definition acknowledges that although some children who experience trauma may go on to develop PTSD, others may develop a range of physical, cognitive, behavioural, and emotional problems, without meeting criteria for PTSD (Felliti et al., 1998; Flaherty et al., 2006; Hussey, Chang, & Kotch, 2006; Kendler et al., 2000; Zolotor et al., 1999).

The movement toward trauma-informed models of care is seen to be particularly important within the context of children and youth living in substitute care (Griffin et al., 2011). Young people in substitute care are by definition more likely to have experienced trauma during their lifetimes, having been removed from their families due to documented situations of severe abuse and/or neglect in the home. They are placed in substitute care for their safety and protection, ideally until such time as a stable home life can be established for them, either with their families or elsewhere, or until they reach the age of majority. Typically, children and youth are placed either in traditional foster homes or with extended family in kinship (i.e., relative) foster homes. However, children and youth who have more severe trauma histories may be particularly at risk for placement in congregate settings such as group homes or residential treatment centres, because they are more likely to have developed behavioural problems as a consequence of experiencing trauma (Rivard et al., 2003; Weiner, Abraham, & Lyons, 2001).

Once removed from a family home, a sizeable number of young people choose to leave these placements without permission. This behaviour is referred to as elopement or running away. Running away is a relatively common occurrence among youth living in substitute care. Although the reasons for running may be varied, studies suggest that elopement puts young people at risk for substance abuse, prostitution, and delinquency, as well as further victimization (Kaufman & Widom, 1999; Stewart et al., 2004; Tyler et al., 2001; Whitbeck, Hoyt, & Ackley, 1997).

Researchers seeking to identify the individual characteristics that predict elopement among youth in substitute care have identified several variables such as age, gender, and substance use (Courtney & Zinn, 2009, English & English, 1999; Sunseri, 2003). As well, environmental factors such as type of placement setting have also been found to be associated

with elopement, with placement in non-community-based settings such as residential treatment centres being associated with a higher risk of elopement (Courtney & Zinn, 2009; Eisengart et al., 2008). More recently, a growing body of research has focused on trauma as a possible antecedent to elopement (Kim, Tajima, Herrenkohl, & Huang, 2009; Thompson, 2010; Tyler & Bersani, 2008).

Trauma and Elopement

The relationship between trauma and participation in high-risk behaviours has been of particular interest to researchers, child welfare workers, and associated professionals, given studies suggesting an association between engagement in high-risk behaviour and having a history of abuse or trauma (Griffin et al., 2009; Raj, Silverman, & Amaro, 2000; Riggs, Alario, & McHorney, 1990). Research suggests that the more traumatic experiences a young person has experienced, the more likely they are to engage in high-risk behaviours (Griffin et al., 2009).

Among youth in the general population, a history of adverse childhood experiences such as physical abuse, sexual abuse, or neglect, is associated with running away from home (Kaufman & Widom, 1999; Kim et al., 2009; Tyler et al., 2001; Whitbeck & Simons, 1990). For example, in a survey of 84 homeless youth, Whitbeck and Simons (1990) found that 42.5% of youth reported physical abuse, 23.6% reported sexual abuse, and 45.9% reported violence in the home as being either somewhat or very important reasons for running away. Kim and colleagues (2009) used structural equation modelling with a longitudinal sample of 416 youth to show that a history of child physical and psychological abuse predicted running away, which in turn predicted higher delinquency and victimization scores, after accounting for gender and socio-economic status. Young people may run away to escape from dysfunctional homes; in fact, the most commonly reported crisis caller problem to the National Runaway Switchboard, a 24-hour

hotline for youth across the United States, was family dynamics (National Runaway Switchboard, 2008). Neighbourhood victimization and personal victimization have also been associated with running in a longitudinal study of 1,579 youth (Tyler & Bersani, 2008).

Pathways to involvement in deviant, high-risk activities like elopement may be related, in part, to an accumulation of risk factors over time. Whitbeck and Hoyt (1999) propose a risk-amplification developmental model where running away is conceptualized as the outcome of a constellation of factors, beginning with early exposure to dysfunctional and disorganized homes, and leading to early independence and exposure to deviant peers, which in turn increases the probability that young people will participate in risky behaviours such as running away. Once homeless, youth often face significant challenges. Stewart and colleagues (2004), for example, interviewed 374 homeless youth and found that 83% had experienced physical and/or sexual victimization since leaving home. Homeless youth show disproportionately high rates of trauma as well as post-traumatic stress disorder (PTSD; Bender, Ferguson, Thompson, Komlo, & Pollio, 2010; Gwadz, Nish, Leonard, & Strauss, 2007; Stewart et al., 2004).

While the relationship between trauma, running, and homelessness appears to be bi-directional, there is also evidence that having a history of early trauma may increase the risk of further victimization while youth are on the run (Thrane, Hoyt, Whitbeck, & Yoder, 2006; Tyler et al., 2001). Thrane and colleagues (2006) suggest that this may occur because youth with a history of familial abuse are more likely to employ deviant subsistence strategies during these periods, increasing the likelihood of victimization.

Whitbeck and Hoyt's (1999) risk-amplification developmental model may be particularly relevant for children and youth in the child welfare system, as it begins with families of origin characterized by parental substance use and/or criminal behaviour. Such parenting increases the

likelihood of childhood exposure to abuse, which in turn leads young people to want to leave home. In fact, the authors found that the more abusive the family background, the earlier that children left home and the longer they stayed away.

Compared to young people in the general population, children and youth entering the child welfare system are much more likely to have experienced abuse or neglect in their lifetimes. Griffin and colleagues (2009) found that 97% of 8,131 children and adolescents living in care were suspected of having experienced at least one traumatic incident, with the majority suspected of having five or more traumatic experiences. However, only a handful of studies have explored the link between trauma and elopement among youth in substitute care, with mixed results.

Research with youth in foster care has shown that the more difficult a youth's background has been (e.g., divorce, alcoholism), the more likely they are to run from care (English & English, 1999). Courtney and Zinn (2009) found that having a history of sexual abuse decreased the likelihood of first runs by 15%, but did not affect the likelihood of subsequent runs in a sample of 14,282 children and youth who ran away from foster care system. Among 184 children and youth living in a residential treatment centres, a suspected history of sexual abuse was found to be a risk factor for running away, while a documented history of sexual abuse was not (Kashubeck, Pottebaum, & Read, 1994). The authors suggested that this finding could have been due to the fact that residents who were suspected to have suffered sexual abuse, but who had not disclosed this history, were perhaps more anxious and less trusting and therefore more likely to run away from care. Abbey, Nicholas, and Bieber (1997) examined case files of 82 adolescent males in residential treatment and found that habitual runners ($N = 43$) were more likely to have a history of physical abuse.

Sunseri (2003) examined data on 8,933 children and youth in residential treatment centres and found that having no history of physical or sexual abuse predicted discharge due to running. Eisengart and colleagues (2008), meanwhile, did not find a relationship between trauma-related symptoms and elopement in a sample of 1,927 youth who were discharged from residential treatment centres due to running away. However, the researchers highlight some issues with their primary measure, the Child Functional Assessment Rating Scale (CFARS), including the fact that individual items on the CFARS (such as the item measuring trauma-related symptoms) are substantially less reliable compared to aggregate scores.

Fasulo and colleagues (2002) looked at 147 youth in specialized treatment foster care, a type of foster care for youth with significant behavioural and/or emotional needs. They found that having a history of sexual abuse was not a significant predictor of elopment within this sample (Fasulo et al., 2002). Youth in the juvenile justice system, meanwhile, are more likely to have histories of maltreatment compared to youth in the general population (Ryan & Testa, 2005), but it is not currently known if a history of trauma is associated with runaway behaviour in this population.

Strengths and Elopement

While much of the research about trauma and elopement thus far has focused on risk, a growing body of literature suggests that psychosocial strengths play an important role in risk behaviours (Lyons, Uziel-Miller, Reyes, & Sokol, 2000; Perkins & Jones, 2004). The idea of resilience, defined as good outcomes in spite of serious threats to adaptation and development (Masten, 2001), may have particular importance for young people in the child welfare system, who are more likely to have endured multiple psychosocial stressors within their lifetimes. Resilience depends upon the presence of protective factors or strengths, which are attributes that

are known to predict better outcomes over time by promoting adaptation. For example, a positive school climate has been shown to be associated with lower rates of risky behaviour among adolescents who have experienced physical abuse (Perkins & Jones, 2004).

Within the context of trauma, strengths may impact the relationship between early adversity and later participation in risky behaviours (Griffin et al, 2009). This could explain why some individuals emerge from difficult childhoods predictive of poor outcomes and instead, go on to lead healthy, productive lives.

In an effort to better meet the needs of children and youth, many agencies and institutions have replaced older, deficit-based systems of measurement with newer behavioural health instruments such as the Child and Adolescent Needs and Strengths (CANS; Lyons, 1999; Lyons, 2009) that include functional measures of needs, strengths, trauma experiences, trauma symptoms, and risk behaviours. Unlike more traditional measures, which tend to focus almost exclusively on problems or deficits, the CANS places particular emphasis on the elucidation of protective factors or strengths. In contrast with risk factors, strengths represent personal, familial, or community-based assets that can be built upon in order to improve outcomes for children and youth. Individual strengths include, but are not limited to, individual talents, personality traits, coping skills, cognitive abilities, and social skills that have been shown to be protective. Family strengths (include parental monitoring and support) and community strengths (such as the presence of a mentor) have also been associated with positive long-term outcomes for young people.

Research shows that in general, young people living in substitute care show lower levels of strengths (Oswald et al., 2001). Strengths may have an important role to play in mitigating the

effects of early trauma. For example, a mentoring relationship with a caring adult could reduce the probability that a young person would choose to run away from substitute care.

Griffin and colleagues showed that the relationship between trauma and high-risk behaviours was moderated by strengths (Griffin et al., 2009). More specifically, the more strengths young people had, the less likely they were to engage in high-risk behaviours, with strengths having a greater moderating effect as the number of past traumatic experiences increased. It is possible that a similar relationship may exist between elopement, trauma, and strengths. As yet, however, the relationship between strengths, trauma, and elopement from substitute care remains unexplored. More specifically, it is currently unknown whether strengths moderate the association between childhood trauma and elopement.

The Present Study

To explore the relationship between trauma, strengths, and elopement among youth in substitute care, a series of analyses were conducted where traumatic experiences and strengths were examined both separately and together. Based upon previous research, several hypotheses were proposed. First, it was expected that age would be positively associated with runaway risk, with older individuals showing a greater likelihood of being at a moderate or high risk of running away. It was also hypothesized that placement type would be associated with running away, with youth in non-community-based settings more likely to be at risk for elopement. It was expected that one or more types of traumatic experiences would be associated with running away. Similarly, it was expected that one or more individual strengths items would be associated with running away. Finally, it was expected that strengths would moderate the relationship between traumatic experiences and elopement.

Method

Setting

This study was undertaken using assessment data routinely collected by the Illinois Department of Children and Family Services (DCFS). The mandate of the Illinois DCFS is to protect children who are reported to be abused or neglected and to increase their families' capacity to safely care for them, to provide for the well-being of children in care, to provide appropriate, permanent families as quickly as possible for those children who cannot safely return home, to support early intervention and child abuse prevention activities, and to work in partnerships with communities to fulfill this mission (Illinois Department of Children and Family Services, 2011a). When a child or adolescent enters the child welfare system in Illinois, he or she undergoes a CANS assessment at entry into care, every 6 months after that, and again at conclusion of services.

In recent years, the Illinois DCFS has endeavored to increase the focus on trauma and its aftermath among children and youth in the child welfare system. In 2004, a trauma-informed model of care for children and youth was implemented across the state of Illinois, including routine assessment of young people entering the child welfare system using the CANS trauma module (see Appendix A). As of June 2007, there were 16,160 children living in substitute care in the state of Illinois (Illinois Department of Children and Family Services, 2011b).

Participants

The sample group for this study was comprised of 2,296 youth aged 13 to 18 years (M = 14.89 years, SD = 1.32) who were assessed at entry into care between July 8, 2005 and May 28, 2010. The sample was 52.4% female (N = 1203) and 47.6% male (N = 1093). The majority of participants were identified as African American (N = 1152, 50.2%), followed by Non-Hispanic

White (*N* = 988, 43.0%), Hispanic (*N* = 100, 4.4%), Asian (*N* = 15, 0.7%), and Native American (*N* = 1, <0.1%). No information about race/ethnicity was available for 40 participants (1.7%). Demographic characteristics of the sample are presented in Table 1.

Table 1

Demographic Characteristics of the Sample (N = 2296)

Gender		
Female	1203	52.4%
Male	1093	47.6%
Age		
13-15 years	1476	64.3%
16-18 years	820	35.7%
Ethnicity		
African American	1152	50.2%
Non-Hispanic White	988	43.0%
Hispanic	100	4.4%
Asian	15	0.7%
Native American	1	<0.1%
Not reported	40	1.7%
Total	2296	100.0%

Most participants (86.9%) were currently housed in community-based settings (*N* = 1995) while the remaining 13.1% were living in non-community-based settings (*N* = 301). Table 2 presents data on placement settings.

Of the youth housed in community-based settings, almost half (47.8%) were living with relatives in Parent/Relative Foster Care (*N* = 1098) while another 21.4% living with non-relatives in Traditional Foster Care (*N* = 492). Other types of foster care included Special Foster Care Not Otherwise Specified (*N* = 227, 9.9%), Special Foster Care Adolescent Care (*N* = 14, 0.6%), and Special Foster Care Teen Parenting (*N* = 2, 0.1%).

Table 2

Number and Percent of Participants in Community-Based and Non-Community-Based Settings by Age Group (N = 2296)

	13-15 years	16-18 years	Total
Community-based settings			
Parent/Relative Foster Care	737 (49.9%)	361 (44.0%)	1098 (47.8%)
Traditional Foster Care	314 (21.3%)	178 (21.7%)	492 (21.4%)
Special Foster Care NOS	157 (10.6%)	70 (8.5%)	227 (9.9%)
Emergency Shelter	74 (5.0%)	80 (9.8%)	154 (6.7%)
Special Foster Care Adolescent Care	9 (0.6%)	5 (0.6%)	14 (0.6%)
Service Interruption NOS	0 (<0.1%)	7 (0.9%)	7 (0.3%)
Special Foster Care Teen Parenting	0 (<0.1%)	2 (0.2%)	2 (0.1%)
Unauthorized Independent Living	0 (<0.1%)	1 (0.1%)	1 (<0.1%)
Total	1291 (87.5%)	704 (85.9%)	1995 (86.9%)
Non-community-based settings			
Residential Treatment Centres	95 (6.4%)	58 (7.1%)	153 (6.7%)
Institutionalized	44 (3.0%)	44 (5.4%)	88 (3.8%)
Detention Centres	45 (3.0%)	12 (1.5%)	57 (2.5%)
Special Foster Care Aggregate Care	1 (0.1%)	2 (0.2%)	3 (0.1%)
Total	185 (12.5%)	116 (14.1%)	301 (13.1%)
Total (all settings)	1476 (100.0%)	820 (100.0%)	2296 (100.0%)

Note: NOS = Not Otherwise Specified

A number of youth were currently between residences and living in the community, with 154 housed in emergency shelters (6.7%). Seven participants (0.3%) fell under Service Interruption Not Otherwise Specified, while one youth, who was living in the community without permission, fell under Unauthorized Independent Living.

A total of 13.1% of participants were living in non-community-based settings ($N = 301$). Most of these individuals were in residential treatment centres ($N = 153$, 6.7%) or institutions ($N = 88$, 3.8%), both designed to provide additional support and supervision for young people with significant behavioural and/or emotional needs. A small number of adolescents were living in Special Foster Care Aggregate Care ($N = 3$, 0.1%), a specialized type of group home for youth

with special needs. Finally, a proportion of youth were currently incarcerated in detention centres (*N* = 57, 2.5%).

Measures

Information about children and youth living in substitute care was obtained from the Child and Adolescent Needs and Strengths (CANS; Lyons, 1999; Lyons, 2009). The CANS is a 69-item measure routinely utilized by Illinois DCFS caseworkers to inform decisions about level of care and treatment planning. For a detailed description of the CANS, including information about reliability and validity, please refer to Paper 1a.

The CANS contains 13 items assessing the following traumatic experiences: sexual abuse, physical abuse, emotional abuse, neglect, medical trauma, family violence, community violence, school violence, natural or manmade disasters, traumatic grief/separation, war affected, terrorism affected, and witness/victim to criminal activity (see Appendix A). Items may be considered individually or together; when combined and standardized, these 13 items form the Trauma Experiences scale. Similar to the rest of the CANS, individual items in the Trauma Experiences scale are scored along a continuum ranging from 0 to 3, with 0 indicating there is no evidence of any trauma of this type and 3 indicating there has been repeated and severe trauma with medical and physical consequences. More specifically:

0 = Indicates a dimension where there is no evidence of any trauma of this type

1 = Indicates a dimension where a single event trauma occurred or suspicion exists of trauma experiences

2 = Indicates a dimension on which the child has experienced multiple traumas

3 = Indicates a dimension describes repeated and severe trauma with medical and physical consequences

In addition to traumatic experiences, the CANS is designed to assess protective factors or psychosocial strengths. Strengths items in the CANS include a range of protective factors known to improve outcomes, operating at the level of the individual, the family, and the community. In total, there are 10 strengths items in the CANS: family, interpersonal, educational, vocational, well-being, optimism, talents/interests, spiritual/religious, community life, and relationship permanence. For each strengths items, action levels range from 0 (a strength that could be the centerpiece of a strength-based plan) to 3 (no strength has been identified, and thus efforts at identifying and developing the strength are indicated). The following categories and action levels are used for strengths:

0 = Centerpiece strength – indicates a domain where strengths exist that can be used as a centerpiece for a strength-based plan

1 = Useful strength – indicates a domain where strengths exist, and can be included in a strength-based plan, but would require some strength-building efforts in order for them to serve as the centerpiece of a strength-based plan

2 = Strength has been identified – indicates a domain where strengths have been identified, but they require significant strength-building efforts before they can be effectively utilized

3 = No strength identified – indicates a domain in which efforts are needed in order to identify potential strengths for strength-building efforts

The CANS can be used either prospectively or retrospectively in order to inform decisions about level of care and treatment planning. CANS ratings apply to the past 30 days unless otherwise specified. Flexibility with regard to the time period under consideration may vary depending on the individual child or adolescent's situation. For example, ratings for a youth

who has serious issues with substance abuse, but who has recently been hospitalized for 30 days, may be more accurate if they are based on the 30 days immediately prior to hospitalization.

CANS items may be examined individually (e.g., to gain information about a child's school attendance) or items can be aggregated into scales. Each scale contains up to 14 items, the totals of which are added together and normalized to produce a standard score. The present analysis made use of individual CANS trauma and strengths items, as well as the Child Strengths scale (10 item sum, standardized). Within the context of the current study, reliability statistics indicated good internal consistency for the Child Strengths scale, with a Cronbach's alpha of 0.83.

Data Analysis

Data were analyzed using the SPSS statistics analysis program, version 19.0. Prior to initiating analyses, the sample was divided into two age groups, 13-15 years (N = 1476, 64.3%) and 16-18 years (N = 820, 35.7%). The decision to divide the sample into age groups was made in part based on previous research (see Study 1a) suggesting substantial differences between older adolescents and younger adolescents.

Logistic regression was utilized to evaluate the relationship between trauma experiences (13 individual CANS items) and runaway risk status (low vs. moderate/high risk of running) for both age groups (13-15 years and 16-18 years). The dependent variable, runaway risk, was derived from item 64 of the CANS (see Appendix A). Using item 64, a new dichotomous variable was created whereby participants were categorized as being either at (a) low risk, or (b) moderate/high risk for running. Low risk for running was defined as having no known history of running, ideation, or threats to run away (score of 0 on item 64). Moderate to high risk status indicated that a child or youth had a history of running away from care or had made threats to

run away (score of 1, 2, or 3 on item 64). Independent variables included gender, age, placement type (referring to whether a youth was living in a community-based or non-community-based placement setting), and the 13 CANS trauma items.

Next, two logistic regressions were used to evaluate the relationship between strengths (10 individual CANS items) and risk of elopement. Logistic regressions were undertaken for each age group with runaway risk as the dependent variable. Independent variables for this set of analyses included gender, age, placement type, and each individual item comprising the Child Strengths scale.

Finally, an interactive logistic regression model was utilized to assess the moderating role of strengths in predicting risk of elopement within each age group. This time, the independent variables were gender, age, placement type, and the individual trauma and strengths variables that predicted runaway risk in the previous two sets of analyses. Interaction variables were created to explore the moderating effect of strengths on traumatic experiences. Again, the dependent variable in each of these analyses was runaway risk (low vs. moderate/high risk of running).

Results

Runaway Risk

Older youth were found to be significantly more likely to be at risk for elopement, with chi-square tests showing significant differences between the age groups with respect to runaway risk, $\chi^2(1, N = 2296) = 32.743$, $p < .001$. Whereas 61.2% ($N = 904$) of youth aged 13-15 were at a low risk for elopement (meaning they scored “0” on item 64 of the CANS, indicating they had no known history of running, ideation, or threats to run away), a smaller proportion of youth aged 16-18 years (48.9%, $N = 401$) had no known history of running, ideation, or threats to run away.

Table 3 presents the risk of running for males and females across the two age groups. Males and females showed comparable rates of risk of elopement. This was confirmed by chi-square tests comparing males to females on the runaway risk variable, which produced non-significant results.

Table 3

Runaway Risk by Age Group and Gender (N = 2296)

	13-15 years		16-18 years	
Runaway Risk	Female	Male	Female	Male
Low	461 (61.0%)	443 (61.5%)	209 (46.8%)	192 (51.5%)
Moderate/High	295 (39.0%)	277 (38.5%)	238 (53.2%)	181 (48.5%)
Total	756 (100.0%)	720 (100.0%)	447 (100.0%)	373 (100.0%)

Traumatic Experiences

Within this group of 2,296 youth, 97.9% were suspected to have had at least one type of traumatic experience in their lifetimes ($N = 2247$). On average, youth had experienced at least four different types of suspected or known traumatic experiences ($SD = 2.19$). The median number of suspected or confirmed traumatic experiences was five. Figure 1 shows the frequency of participants who obtained a score of 1, 2, or 3 for the CANS trauma items, meaning that for these children and youth, there was a reasonable suspicion of a history of trauma, or they had experienced at least one known traumatic event in their lifetimes. Table 4 presents a breakdown of these numbers by age group.

Figure 1

Frequency of Participants with Suspected or Known Traumatic Experiences (CANS Trauma Items Endorsed at Level 1, 2, or 3; N = 2296)

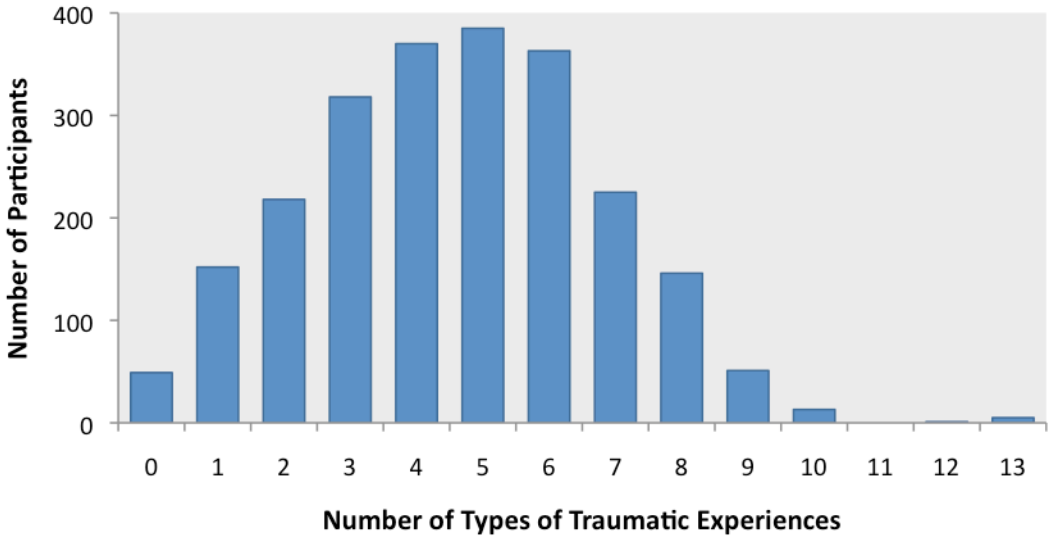

Table 4

Frequency and Percent of Participants with Suspected or Known Traumatic Experiences (CANS Trauma Items Endorsed at Level 1, 2, or 3) by Age Group (N = 2296)

	13-15 years		16-18 years		Total	
Number of items	Frequency	Percent	Frequency	Percent	Frequency	Percent
0	26	1.8%	23	2.8%	49	2.1%
1	100	6.8%	52	6.3%	152	6.6%
2	138	9.3%	80	9.8%	218	9.5%
3	224	15.2%	94	11.5%	318	13.9%
4	230	15.6%	140	17.1%	370	16.1%
5	244	16.5%	141	17.2%	385	16.8%
6	235	15.9%	128	15.6%	363	15.8%
7	149	10.1%	76	9.3%	225	9.8%
8	87	5.9%	59	7.2%	146	6.4%
9	31	2.1%	20	2.4%	51	2.2%
10	8	0.5%	5	0.6%	13	0.6%
11	0	<0.1%	0	<0.1%	0	<0.1%
12	1	0.1%	0	<0.1%	1	<0.1%
13	3	0.2%	2	0.2%	5	0.2%
Total	1476	100.0%	820	100.0%	2296	100.0%

Results for participants with a history of multiple incidents of a specific type of trauma (meaning they obtained a CANS score of 2 or 3 on at least one CANS trauma item) are presented in Figure 2 and Table 5. A substantial number of young people (85.1%) had experienced multiple incidents of trauma ($N = 1954$). On average, participants had experienced multiple incidents of at least two different types of trauma within their lifetimes ($SD = 1.83$). For a breakdown of the frequency of multiple traumatic experiences within each age group, please refer to Table 5.

Figure 2

Frequency of Participants with Multiple Traumatic Experiences (CANS Trauma Items Endorsed at Level 2 or 3; N = 2296)

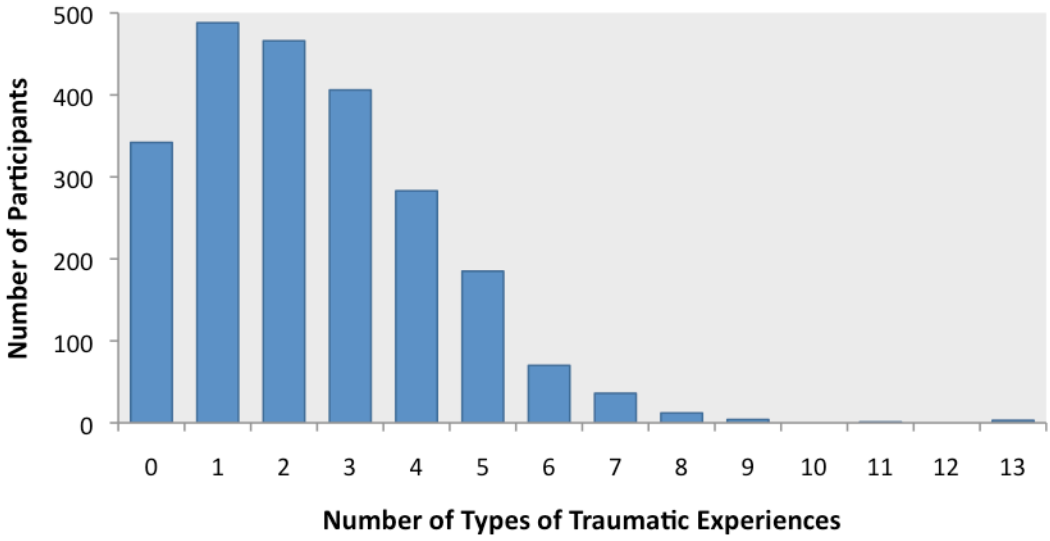

Table 5

Frequency and Percent of Participants with Multiple Traumatic Experiences (CANS Trauma Items Endorsed at Level 2 or 3) by Age Group (N = 2296)

	13-15 years		16-18 years		Total	
Number of items	Frequency	Percent	Frequency	Percent	Frequency	Percent
0	219	14.8%	123	15.0%	342	14.9%
1	306	20.7%	182	22.2%	488	21.3%
2	313	21.2%	153	18.7%	466	20.3%
3	255	17.3%	151	18.4%	406	17.7%
4	199	13.5%	84	10.2%	283	12.3%
5	103	7.0%	82	10.0%	185	8.1%
6	43	2.9%	27	3.3%	70	3.0%
7	25	1.7%	11	1.3%	36	1.6%
8	6	0.4%	6	0.7%	12	0.5%
9	4	0.3%	0	<0.1%	4	0.2%
10	0	<0.1%	0	<0.1%	0	<0.1%
11	1	0.1%	0	<0.1%	1	<0.1%
12	0	<0.1%	0	<0.1%	0	<0.1%
13	2	0.1%	1	0.1%	3	0.1%
Total	1476	100.0%	820	100.0%	2296	100.0%

Finally, frequencies and percentages for participants with histories of severe and repeated trauma are presented in Figure 3 and Table 6. Almost one third (29.3%) of participants had experienced at least one type of severe and repeated trauma with medical and physical consequences (*N* = 672). Among those young people who had histories of severe trauma, over half (64.3%) had experienced only one type of repeat trauma (*N* = 432). Within the entire sample (*N* = 2296), however, these numbers suggest that approximately one in ten youth had survived more than one type of repeated, severe trauma in their lifetime (*N* = 240).

Figure 3

Frequency of Participants with Repeated and Severe Trauma (CANS Trauma Items Endorsed at Level 3; N = 2296)

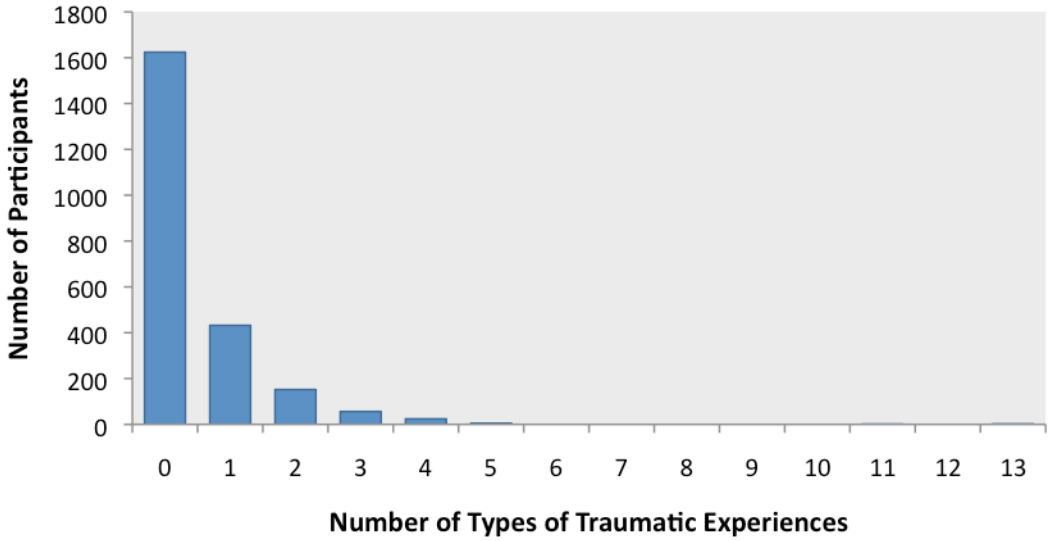

Table 6

Frequency and Percent of Participants with Repeated and Severe Trauma (CANS Trauma Items Endorsed at Level 3) by Age Group (N = 2296)

	13-15 years		16-18 years		Total	
Number of items	Frequency	Percent	Frequency	Percent	Frequency	Percent
0	1065	72.2%	559	68.2%	1624	70.7%
1	269	18.2%	163	19.9%	432	18.8%
2	85	5.8%	67	8.2%	152	6.6%
3	34	2.3%	22	2.7%	56	2.4%
4	17	1.2%	7	0.9%	24	1.0%
5	4	0.3%	1	0.1%	5	0.2%
6	0	<0.1%	0	<0.1%	0	<0.1%
7	0	<0.1%	0	<0.1%	0	<0.1%
8	0	<0.1%	0	<0.1%	0	<0.1%
9	0	<0.1%	0	<0.1%	0	<0.1%
10	0	<0.1%	0	<0.1%	0	<0.1%
11	1	0.1%	0	<0.1%	1	<0.1%
12	0	<0.1%	0	<0.1%	0	<0.1%
13	1	0.1%	1	0.1%	2	0.1%
Total	1476	100.0%	820	100.0%	2296	100.0%

Table 7 presents the 13 different types of traumatic experiences assessed by the CANS trauma module, including the number and percent of youth who had experienced each type of trauma in their lifetime. Within this sample of young people, the most common type of traumatic experience was traumatic grief/separation, with 76.7% of children and youth having a suspected or known history of traumatic grief or separation (*N* = 1762). A similar number of participants (74.5%) had a known or suspected history of neglect (*N* = 1710). The next most common type of traumatic experience was emotional abuse (*N* = 1382, 60.2%), followed by physical abuse (*N* = 1297, 56.5%) and family violence (*N* = 1289; 56.1%). Participants were least likely to have experienced trauma due to terrorism (*N* = 9, 0.4%), war (*N* = 13, 0.6%), or natural or manmade disasters (*N* = 36, 1.6%).

Table 7

Frequency of Participants with Different Types of Traumatic Experiences (N = 2296)

	CANS scores				
Traumatic Experience	0	1	2	3	1+2+3
Traumatic Grief/Separation	534	873	761	128	1762
Neglect	586	641	793	276	1710
Emotional Abuse	914	706	569	107	1382
Physical Abuse	999	523	697	77	1297
Family Violence	1007	528	616	145	1289
Sexual Abuse	1435	312	380	169	861
Witness/Victim to Criminal Activity	1524	433	282	57	772
Community Violence	1742	350	160	44	554
Medical Trauma	1912	252	100	32	384
School Violence	1831	346	112	7	465
Natural or Manmade Disasters	2260	9	14	13	36
War Affected	2283	8	2	3	13
Terrorism Affected	2287	4	1	4	9

Note: CANS scores range from 0 to 3, with 0 indicating there was no evidence of any trauma of this type, 1 indicating that a single even trauma had occurred or there was suspicion of the presence of trauma experiences, 2 indicating the participant had experienced multiple traumas, and 3 indicating the presence of repeated and severe trauma with medical and physical consequences.

Traumatic Experiences and Runaway Risk

In the first set of logistic regressions, traumatic experiences (13 individual CANS items) were entered as predictors with runaway risk (low vs. moderate/high risk of running) as the dependent variable. Also entered into the equation were gender, age, and placement type (meaning whether a youth was living in a community-based or non-community-based setting).

Youth Aged 13-15 Years. Among youth aged 13-15 years, the model significantly predicted runaway risk, meaning placement in either the low or moderate/high risk category of runaway risk, $\chi^2(16, N = 1476) = 212.424$, $p < .001$. Table 8 presents the model statistics, including betas, standard errors, Wald statistics, odds ratios, and confidence intervals.

Table 8

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Trauma and Runaway Risk Among Youth Aged 13-15 Years (N = 1476)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.039	.124	.100	.751	.962	.754-1.226
Age	.351	.073	22.954	.001**	1.421	1.231-1.641
Placement Type	.965	.176	29.982	.001**	2.625	1.858-3.707
Sexual Abuse	.147	.063	5.449	.020*	1.158	1.024-1.310
Physical Abuse	.354	.076	21.504	.001**	1.425	1.227-1.655
Emotional Abuse	.040	.078	.267	.605	1.041	.894-1.212
Neglect	-.074	.063	1.398	.237	.929	.821-1.050
Medical Trauma	.032	.103	.100	.752	1.033	.845-1.263
Family Violence	-.338	.068	24.476	.001**	.713	.624-.815
Community Violence	.261	.102	6.564	.010*	1.298	1.063-1.585
School Violence	.513	.120	18.150	.001**	1.670	1.319-2.114
Natural or Manmade Disaster	.424	.238	3.182	.074	1.529	.959-2.437
Traumatic Grief/Separation	.161	.070	5.213	.022*	1.175	1.023-1.349
War Affected	-.341	.740	.212	.645	.711	.167-3.034
Terrorism Affected	19.011	9680.404	.000	.998	1.805	–
Witness/Victim to Criminal Activity	.067	.084	.640	.424	1.069	.907-1.260

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

The Cox & Snell R Square and the Nagelkerke R Square values suggested that the model accounted for between 13.4% and 18.2% of the variance. For classification accuracy statistics (including sensitivity, specificity, positive predictive power, negative predictive power, and correct classification percentages), please refer to Table 10.

Youth Aged 16-18 Years. Among youth aged 16-18 years, the model significantly predicted runaway risk, $\chi^2(16, N = 820) = 114.373$, $p < .001$. Table 9 presents the model statistics for this age group. The Cox & Snell R Square and the Nagelkerke R Square values suggested that the model accounted for between 13.0% and 17.4% of the variance. Classification accuracy statistics are provided in Table 10.

Table 9

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Trauma and Runaway Risk Among Youth Aged 16-18 Years (N = 820)

Predictor	*β*	SE	Wald	*p*	OR	95% CI
Gender	-.178	.159	1.244	.265	.837	.612-1.144
Age	-.281	.140	4.027	.045*	.755	.573-.993
Placement Type	1.044	.241	18.719	.001**	2.841	1.770-4.559
Sexual Abuse	.229	.080	8.262	.004*	1.257	1.075-1.469
Physical Abuse	.334	.094	12.575	.001**	1.396	1.161-1.679
Emotional Abuse	.053	.098	.291	.589	1.054	.870-1.278
Neglect	.028	.082	.118	.731	1.029	.876-1.209
Medical Trauma	.060	.125	.231	.631	1.062	.831-1.358
Family Violence	-.137	.084	2.633	.105	.872	.739-1.029
Community Violence	.084	.125	.450	.502	1.088	.851-1.391
School Violence	.515	.162	10.162	.001**	1.674	1.220-2.299
Natural or Manmade Disaster	-.434	.307	1.995	.158	.648	.355-1.183
Traumatic Grief/Separation	.309	.091	11.529	.001**	1.362	1.139-1.627
War Affected	19.598	15236.599	.000	.999	3.246	–
Terrorism Affected	-.229	.773	.088	.767	.795	.175-3.616
Witness/Victim to Criminal Activity	.036	.101	.126	.723	1.037	.850-1.264

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

Table 10

Classification Accuracy Statistics for Logistic Regressions Examining Trauma and Runaway Risk by Age Group (N = 2296)

Age group	Sensitivity	Specificity	Positive Predictive Power	Negative Predictive Power	Correct Classification
13-15 years	39.2%	85.8%	63.6%	69.0%	67.8%
16-18 years	62.1%	69.6%	68.1%	63.7%	65.7%

Note: Cut Value (CV) = 0.5

Strengths and Runaway Risk

In the second set of analyses, two logistic regressions were undertaken in order to evaluate how well individual strengths items predicted runaway risk (low vs. moderate/high risk of elopement) within each age group. Independent variables were gender, age, placement type, and all 13 strengths items on the CANS.

Youth Aged 13-15 Years. Among youth aged 13-15 years, the model significantly predicted runaway risk, $\chi^2(13, N = 1476) = 221.497$, $p < .001$. Table 11 shows the model statistics for this logistic regression, including betas, standard errors, Wald statistics, odds ratios, and confidence intervals. The Cox & Snell R Square and the Nagelkerke R Square values suggested that the model accounted for between 13.9% and 18.9% of the variance in the dependent variable. For classification accuracy statistics (including sensitivity, specificity, positive predictive power, negative predictive power, and correct classification percentages), please refer to Table 13.

Table 11

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Strengths and Runaway Risk Among Youth Aged 13-15 Years (N = 1476)

Predictor	*β*	SE	Wald	*p*	OR	95% CI
Gender	-.077	.118	.420	.517	.926	.735-1.168
Age	.357	.074	23.625	.001**	1.430	1.238-1.651
Placement Type	.879	.176	25.089	.001**	2.409	1.708-3.399
Family	.123	.080	2.353	.125	1.131	.966-1.323
Interpersonal	.058	.095	.381	.537	1.060	.881-1.276
Educational	.381	.070	29.509	.001**	1.464	1.276-1.680
Vocational	-.032	.058	.298	.585	.969	.865-1.085
Well-Being	.305	.109	7.849	.005*	1.357	1.096-1.679
Optimism	.186	.096	3.733	.053	1.205	.997-.1456
Talents/Interests	-.039	.087	.204	.652	.962	.811-1.140
Spiritual/Religious	-.054	.069	.604	.437	.948	.828-1.085
Community Life	.105	.078	1.830	.176	1.111	.954-1.294
Relationship Permanence	.091	.079	1.334	.248	1.096	.938-1.280

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

Youth Aged 16-18 Years. Among older youth, the model significantly predicted runaway risk, $\chi^2(13, N = 1476) = 120.780$, $p < .001$. Model statistics, including betas, standard errors, Wald statistics, odds ratios, and confidence intervals, are presented in Table 12. The Cox & Snell R Square and the Nagelkerke R Square values suggested that the model accounted for between 13.7% and 18.3% of the variance. Additional classification accuracy statistics are provided in Table 13.

Table 12

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Strengths and Runaway Risk Among Youth Aged 16-18 Years (N = 820)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.353	.155	5.198	.023*	.703	.519-.952
Age	-.281	.143	3.883	.049*	.755	.571-.998
Placement Type	1.081	.241	20.064	.001**	2.947	1.837-4.729
Family	.060	.098	.372	.542	1.062	.875-1.288
Interpersonal	.204	.116	3.114	.078	1.226	.978-1.538
Educational	.266	.083	10.327	.001**	1.305	1.109-1.534
Vocational	.072	.079	.838	.360	1.075	.921-1.254
Well-Being	.130	.135	.933	.334	1.139	.874-1.484
Optimism	.021	.128	.027	.869	1.021	.794-1.314
Talents/Interests	.013	.112	.012	.911	1.013	.813-1.261
Spiritual/Religious	.016	.092	.030	.863	1.016	.848-1.217
Community Life	.041	.101	.162	.688	1.042	.854-1.270
Relationship Permanence	.304	.102	8.948	.003*	1.355	1.110-1.653

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

Table 13

Classification Accuracy Statistics for Logistic Regressions Examining Strengths and Runaway Risk by Age Group (N = 2296)

Age group	Sensitivity	Specificity	Positive Predictive Power	Negative Predictive Power	Correct Classification
13-15 years	44.2%	83.8%	63.4%	70.4%	68.5%
16-18 years	67.8%	63.8%	66.2%	65.5%	65.9%

Note: Cut Value (CV) = 0.5

Traumatic Experiences, Strengths, and Runaway Risk

Interactive logistic regression models were utilized to assess the possibility of strengths playing a moderating role in the relationship between trauma and elopement within each age group. First, an interactive logistic regression model examining the Child Strengths and Trauma

Experiences scales was conducted for each age group with the following predictors: age, gender, placement type, the Trauma Experiences scale (13 items, standardized), the Child Strengths scale (10 items, standardized), and a trauma-by-strengths interaction variable. The dependent variable was runaway risk (low vs. moderate/high risk of running). Next, a series of interactive logistic regressions was conducted to examine the interaction between individual trauma items and the Child Strengths scale with respect to their relationship with the dependent variable. Independent variables for this set of analyses were chosen based on findings from part one of this study. For youth aged 13-15, logistic regressions were undertaken looking at sexual abuse, physical abuse, family violence, community violence, school violence, and traumatic grief/separation. For youth aged 16-18, logistic regressions were conducted for sexual abuse, physical abuse, school violence, and traumatic grief/separation. As before, the dependent variable for both sets of analyses was runaway risk.

Youth Aged 13-15 Years. Among youth aged 13-15 years, the first model significantly predicted placement in either the low or moderate/high risk category of runaway risk, $\chi^2(6, N = 1476) = 194.814$, $p < .001$. Table 14 presents the model statistics, including betas, standard errors, Wald statistics, odds ratios, and confidence intervals. The Cox & Snell R Square and the Nagelkerke R Square values suggested that the model accounted for between 12.4% and 16.8% of the variance. For classification accuracy statistics (including sensitivity, specificity, positive predictive power, negative predictive power, and correct classification percentages), please refer to Table 16.

Table 14

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Trauma, Strengths, and Runaway Risk Among Youth Aged 13-15 Years (N = 1476)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.032	.116	.076	.783	.969	.771-1.216
Age	.382	.072	27.815	.001**	1.465	1.271-1.688
Placement Type	.917	.173	28.205	.001**	2.501	1.783-3.508
Trauma	.028	.053	.279	.597	1.028	.927-1.140
Strengths	.083	.022	14.778	.001**	1.086	1.041-1.133
Trauma X Strengths	.002	.003	.363	.547	1.002	.995-1.009

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

Six additional logistic regressions were undertaken looking at sexual abuse, physical abuse, family violence, community violence, school violence, and traumatic grief/separation among youth aged 13-15 years (see Appendix B for tables showing statistics for each model, including betas, standard errors, Wald statistics, odds ratios, and confidence intervals). Each regression included the following predictors: gender, age, placement type, the trauma item (i.e., sexual abuse, physical abuse, family violence, community violence, school violence, or traumatic grief/separation), the standardized Child Strengths scale, and an item-by-scale interaction term. The dependent variable was runaway risk (low vs. moderate/high risk of running). All six interactive logistic regression models for youth aged 13-15 years significantly predicted runaway risk. However, for every logistic regression that was conducted, only three variables significantly contributed to the variance in the dependent variable: age, placement type, and strengths. The Trauma Experiences scale (13 items, standardized), individual trauma items (sexual abuse, physical abuse, family violence, community violence, school violence, and traumatic grief/separation), and the trauma-by-strengths interaction terms did not significantly contribute to the variance in the dependent variable in any of the logistic regressions.

Youth Aged 16-18 Years. Among youth aged 16-18 years, the first model significantly predicted placement in either the low or moderate/high risk category of runaway risk, $\chi^2(6, N = 820) = 124.179$, $p < .001$. Table 15 shows the model statistics for this logistic regression. The Cox & Snell R Square and the Nagelkerke R Square values suggested that the model accounted for between 14.1% and 18.7% of the variance. Please refer to Table 16 for classification accuracy statistics.

Table 15

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Trauma, Strengths, and Runaway Risk Among Youth Aged 16-18 Years (N = 820)

Predictor	*β*	SE	Wald	*p*	OR	95% CI
Gender	-.278	.153	3.324	.068	.757	.561-1.021
Age	-.255	.139	3.363	.067	.775	.590-1.018
Placement Type	.971	.242	16.145	.001**	2.640	1.644-4.240
Trauma	.127	.064	3.965	.046*	1.135	1.002-1.286
Strengths	.095	.025	14.424	.001**	1.100	1.047-1.156
Trauma X Strengths	-.002	.004	.160	.690	.998	.990-1.006

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

Four additional logistic regressions were conducted for sexual abuse, physical abuse, school violence, and traumatic grief/separation among youth aged 16-18 years (see Appendix B for statistics for each model, including betas, standard errors, Wald statistics, odds ratios, and confidence intervals). Each regression included the following predictors: gender, age, placement type, the trauma item (i.e., sexual abuse, physical abuse, school violence, or traumatic grief/separation), the standardized Child Strengths scale, and an item-by-scale interaction term. Although the four interactive logistic models significantly predicted runaway risk, none of the interaction terms in any of the regression analyses significantly contributed to the variance in the dependent variable.

For all five logistic regressions, placement type and strengths significantly contributed to the variance in the dependent variable. Unlike youth aged 13-15 years, the Trauma Experiences scale (13 items, standardized) significantly predicted running among youth aged 16-18 years. Gender emerged as a significant predictor for two of the five regressions. Results of the final two logistic regressions indicated that the individual trauma items (school violence and traumatic grief/separation) significantly predicted running, although neither interaction term significantly contributed to the variance in the dependent variable.

Table 16

Classification Accuracy Statistics for Logistic Regressions Examining Trauma, Strengths, and Runaway Risk by Age Group (N = 2296)

Age group	Sensitivity	Specificity	Positive Predictive Power	Negative Predictive Power	Correct Classification
13-15 years	40.6%	85.2%	63.4%	69.4%	67.9%
16-18 years	65.9%	64.8%	66.2%	64.5%	65.4%

Note: Cut Value (CV) = 0.5

Discussion

In this study, a series of analyses was utilized to explore trauma and strengths in a large sample of youth entering the child welfare system. While previous research has suggested a possible link between trauma and elopement, few studies have examined the relationship between strengths and running, and to our knowledge none have explored strengths as a possible moderator in the relationship between trauma and elopement. Given the considerable risks associated with youth homelessness, research of this kind may be especially relevant for youth in the child welfare system, who are likely to have histories of abuse or neglect.

Results of this study indicate that participants did indeed show high rates of trauma, which corresponds with findings from previous studies (e.g., Griffin et al., 2009). Nearly every participant in this sample (97.9%) was suspected to have experienced trauma within their lifetime, with 85.1% having experienced multiple incidents of at least one type of trauma. The most common type of trauma experienced by youth was traumatic grief/separation, followed by neglect, followed by emotional and physical abuse. These numbers confirm that youth in the child welfare system are likely to have extensive trauma histories, known to be a risk factor for a number of troubling outcomes (Felitti et al., 1998; Griffin et al., 2009).

As hypothesized, and consistent with previous research (Courtney & Zinn, 2009; Eisengart et al., 2008; Sunseri, 2003), a greater proportion of older adolescents were identified as being at risk for elopement from out-of-home care compared to younger adolescents. Approximately half of participants aged 16 and above were at a moderate or high risk of running away, compared to 38.8% of youth aged 13-15 years. As well, placement type was consistently associated with running away, with youth in non-community-based settings showing a greater likelihood of being at risk for elopement. In other words, youth were more likely to run away if they were older and were currently housed in non-community-based settings (e.g., residential treatment centres or institutions). This corresponds with previous research suggesting that young people placed in community-based settings such as foster homes are less likely to run compared to individuals placed in non-community-based settings (Courtney & Zinn, 2009).

It was expected that one or more types of traumatic experiences would be associated with running away. Results of analyses examining the relationship between trauma and elopement suggested that four trauma items consistently predicted running within both age groups: sexual abuse, physical abuse, school violence, and traumatic grief/separation. All showed a positive

relationship with the dependent variable, indicating that as the frequency and/or severity of these forms of trauma increased, so too did the risk of elopement.

Only one strengths item, educational strengths, emerged as a significant predictor of elopement across both age groups. This corresponds with previous research indicating that youth who run from the child welfare system are more likely to have problems with school (English & English). As well, frequent absences among runaway youth may engender detachment from school over time (Biehal & Wade, 2000). Given the design of the educational strengths item of the CANS (see Appendix A, item 21), it is possible that this set of analyses has captured a group of youth who are struggling in school and lack the support necessary to succeed. This item may also be capturing those youth who are detached from school due, in part, to frequent absences associated with running. If educational strengths do indeed predict a lower risk of elopement across adolescence, there may be important opportunities for strengths building in this area. For instance, a youth may be at a lower risk of running when connected with a school system that meets his or her individual learning needs. This may include not only prompt identification of learning needs, but also regular support if necessary to help to ensure appropriate educational development as well as engagement in school life. School-based programming targeting at-risk youth may be worthy of exploration in this regard.

Given age-related differences in patterns of elopement, it is not surprising that there were differences in patterns of trauma as well as strengths between adolescents 13-15 years and 16-18 years of age. A greater number of different types of trauma seemed to influence elopement among youth aged 13-15 years. Within this group, family violence and community violence were significant predictors in addition to the previously mentioned four types of trauma (sexual abuse, physical abuse, school violence, and traumatic grief/separation). This finding suggests that

trauma experiences could be influencing elopement to a greater degree among younger adolescents compared to older adolescents. Youth aged 16-18 years, meanwhile, showed fewer trauma items that were predictive of running.

Younger and older youth also showed differences with respect to which strengths seemed to influence running. In addition to showing an association between educational strengths and elopement, youth aged 13-15 years also showed a positive relationship between well-being and running away from substitute care. Well-being refers to psychological strengths and a person's ability to enjoy positive life experiences and manage negative life experiences (see Appendix A, item 23). These results suggest that as general well-being increases, risk of running away from substitute care decreases, but only among younger adolescents.

In contrast, relationship permanence was significantly predictive of elopement among older adolescents, but not younger adolescents. The more stable relationships that adolescents had with family, friends, and community members, the less likely they were to run away from their placements. It may be that as young people age, relationship permanence begins to play a more prominent role with respect to their decision to leave substitute care without permission. Whereas many young people may have experienced problems with attachment within their families of origin (Paradise, 2001), it is also true that as young people age, they are more likely to form strong bonds with peers which may supersede or replace weaker bonds with family or foster parents. If they are meaningfully connected with others in their immediate environment, they may therefore be less likely to run away. This corresponds with research linking placement stability with reduced rates of elopement, where relationship permanence may be a consequence of young people having opportunities to form bonds with others over time (Courtney et al., 2005; Nesmith, 2006).

Results of the current analyses suggest that elopement is not predicted by an interaction between strengths and trauma. When strengths were included in the model, the value of trauma experiences in prediction disappeared, suggesting that strengths may be moderating the relationship between trauma and elopement. This corresponds with previous research suggesting that strengths moderate the relationship between trauma and participation in high-risk behaviours (Griffin et al., 2009).

Although patterns of individual strengths varied between age groups, when strengths were considered as a whole, they consistently predicted elopement across both groups. Other research has suggested that strengths may be interchangeable in their impact on well-being and high-risk behaviours (Lyons et al., 2009; Griffin et al., 2009). In other words, having strengths is important, but which specific strengths a young person has may be less important. A multi-faceted approach may therefore be warranted to build on young people's psychosocial strengths. For example, a number of evidence-based programs exist that are designed to foster good coping skills and improve mental health in young people; see, for example, SAMHSA's National Registry of Evidence-Based Programs and Practices (U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, 2011).

Given that the adolescents in this sample showed such high rates of trauma, it is possible that the short- and long-term effects of trauma on elopement are more complex within this group compared to youth in the general population. Strengths may, in fact, be affecting other variables, translating into better long-term outcomes for youth. Additionally, elopement may represent a form of self-advocacy for some youth. For instance, by running repeatedly from a particular setting, youth may eventually be moved to a different setting that better meets his or her needs. It is also possible that running represents a special type of high-risk behaviour that is influenced to

a greater degree by variables other than trauma, (e.g., age or placement type) which may play a more central role in influencing whether or not a young person will run away from care.

The current study included youth living in a broad range of placement settings, including foster care, residential treatment centres, and juvenile justice facilities. This approach was important because much of the previous research on elopement among youth in substitute care has focused exclusively on young people living in specific types of placements (e.g., foster care). By taking a more inclusive approach, this allowed for examination of youth housed in a wide range of settings at entry into care. Unfortunately, any comparison between specific types of placements such as residential treatment centres or juvenile justice facilities was impossible because so few individuals were currently housed in these settings. More information is needed about elopement within certain populations such as incarcerated youth and future research should address this issue.

Further, limitations inherent in a cross-sectional study design preclude characterization of study variables over longer periods of time. For example, previous research has shown that placement instability is associated with running (Biehal & Wade, 2000; Nesmith, 2006). It is possible that over time, depending upon their individual experiences in care, youth may become less (or more) likely to run from certain settings. In planning future studies, it may be helpful to study youth in care at different time points and with reference to their individual experiences in the child welfare system.

Although data for the current study utilized was collected in the state of Illinois, which may limit generalizability, particularly within a Canadian context, these results may be helpful for planning similar research in Canada and elsewhere. Given unique aspects of the Canadian context such as culture and climate, future research on elopement among young people in

substitute care across Canada may provide important information for child welfare workers and other professionals invested in the future of Canada's youth.

Research suggests that young people in substitute care are likely to have histories of trauma, and once they choose to run away, they place themselves at risk for experiencing further trauma while on the streets. Findings from the current study support the idea that continued efforts are needed to better understand elopement from substitute care. While this study suggests that early trauma may sometimes play a role in later elopement, results suggest that strengths may be affecting the impact traumatic experiences have on whether or not a youth chooses to run. Further research exploring the link between trauma, strengths, and runaway behaviour is both appropriate and timely and may facilitate change geared toward improving health promotion efforts among youth living in substitute care.

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Study 2

Experiences of Youth Who Run Away From Substitute Care

Introduction

Over the past two decades, there has been an upsurge of interest in youth who run from substitute care. This is likely due, in part, to the high rates of running among youth in care, as well as research highlighting the significant risks associated with running (Biehal & Wade, 1999; Biehal & Wade, 2000; Fasulo et al., 2002; Guest et al., 2008). Many young people choose to leave care without permission, sometimes referred to as elopement or going "AWOL", and for child welfare agencies, this represents a major problem, in terms of both safety issues and longer-term health and mental health outcomes for youth.

In an effort to better understand why young people run, researchers have attempted to understand what predisposes certain youth to run, especially those who run away repeatedly. A number of personal traits or features (such as age, gender, and previous history of running) have been identified as being associated with an individual youth's likelihood of running from substitute care. In additional to looking at personal characteristics, researchers have begun to turn their attention toward environmental factors, moving away from "personal pathology" explanations toward a biopsychosocial approach. Biehal and Wade (2000), for example, reported on program-level characteristics, in addition to personal characteristics, describing how 7 of the 32 group homes they studied accounted for two thirds of the total incidence of elopement. The authors noted that "the culture and regimes of children's homes were influential in inhibiting or reinforcing going missing" and suggested that factors such as low rates of absence, strong leadership, and clarity of purpose tended to be coupled with high staff motivation to negotiate boundaries with young people. In more disorganized homes with high rates of runaway behaviour, meanwhile, the authors noted "a sense of fatalism about how to challenge young people's behaviour" among staff.

More recently, Eisengart and colleagues (2008) found that program was a reliable predictor of elopement among youth in residential treatment centres. Specifically, the program accounted for nearly 10% of the variation in discharges due to runaway. While the authors found that program factors accounted for significant variation in the likelihood of discharge due to runaway, the study design did not allow for conjecture regarding which program-level factors might account for this variation. However, it appears that exploring these factors may be important since research suggests that child or family characteristics alone do not account for the variation in long-term outcomes of youth who spend time in residential treatment centres (Lyons, Terry, Martinovich, Peterson, & Bouska, 2001).

Exactly which aspects of programs or placement settings are contributing to elopement remain to be specified. One possible factor that may impact whether or not youth choose to run is the type of relationship that young people have with staff or foster parents. For example, in one study from the Netherlands, compared to non-runners, youth who ran away from foster homes perceived their family situation to be colder and were treated in a more authoritarian and cold manner by the substitute care workers (Angenent, Balthasar, & Shane, 1991). The relationship between staff and youth may, in turn, be influenced by a number of additional factors, including aspects of the work environment, compensation, and support from other staff. Concern about high employee turnover rates in the child welfare system, for example, has led to an increase in research investigating the relationship between child welfare workers and their work environment (Ellett, 2009; Shim, 2010). For instance, Shim (2010) recently showed that child welfare employees with clearer and more effective incentives and rewards for job performance showed less intention to leave their jobs compared to employees with less clear and effective incentives and rewards. Within the context of substitute care, it is possible that aspects of

organizational culture and climate could be affecting staff engagement, which in turn could impact staff relationships with youth. This, in turn, may affect how a youth experiences living in care and whether or not they choose to run.

This study represents an examination of the perspectives of young people with regard not only to individual- and family-level factors, but also to their experiences of the organizations where they were living prior to elopement. Qualitative research methods allow for access to information that may be missed using traditional data-collection techniques. This may be particularly relevant for youth living in homeless shelters, who are by definition not an easy population to access (Biehal & Wade, 1999; Courtney et al., 2005).

This study was designed both to generate theory grounded in data, as well as to inspire further systematic exploration of this phenomenon. Study methodology was therefore informed, in part, by grounded theory, which emphasizes the generation of theory from the analysis of relationships between conceptual categories that emerge from the systematic application of a specific set of analytic techniques (Glaser, 1998). Similar to grounded theory, thematic analysis, a method utilized for identifying patterns in qualitative data, was employed to guide data collection and analysis. Thematic analysis is sometimes considered to fall under the rubric of grounded theory, although others have disputed this (Braun & Clarke, 2006). Thematic analysis offers a flexible, accessible form of analysis in the absence of a detailed theoretical model. As a first step toward exploring program-level characteristics and their contribution to whether or not young people choose to run from substitute care, a thematic analytic approach was deemed appropriate to the current context of investigative research. Overarching questions guiding this study were: (1) What factors did youth identify as contributing to their decision to run from substitute care? (2) How did youth describe their experiences living in care? (3) What did youth

like and dislike about the environment of substitute care and about staff/foster parents? (4) What would have made it less likely for them to run away from substitute care? These questions were utilized as a starting point toward investigating the perspectives of homeless youth, youth staying in emergency shelters, and youth living in supportive or transitional housing who had experienced running away from substitute care.

Method

Setting

The setting for this study was downtown Ottawa, in the province of Ontario, Canada. Ottawa is a city with an estimated population of 917,550 as of year-end 2010 (City of Ottawa, 2011). The Children's Aid Society of Ottawa (CAS), a non-profit community organization funded by the Government of Ontario, handles situations in which children and adolescents are unable to remain in their family home because of abuse and/or neglect (The Children's Aid Society of Ottawa, 2011). The CAS will first attempt to place young people with extended family, and when this is not possible, "the preferred option is with foster parents" (The Children's Aid Society of Ottawa, 2011). The CAS also oversees placement in group homes and residential treatment centres in the Ottawa area.

This study involved collaboration with the Youth Services Bureau of Ottawa (YSB) who granted permission to the researchers to collect data at YSB sites. YSB is a non-profit agency that provides a range of services designed to support and empower at-risk youth and their families (Youth Services Bureau of Ottawa, 2011a). YSB receives funding from the Province of Ontario, the City of Ottawa, the United Way, and private donors. In addition to providing youth with community and housing services, YSB provides mental health services, employment services, and youth justice services in 20 locations across Ottawa. YSB community and housing

services include a Downtown Services and Drop-in, a Young Women's Shelter, and a Young Men's Shelter, as well as transitional housing and long-term housing programs. In 2009, YSB logged 18,988 visits to the Downtown Drop-in and over 20,000 individual nights of shelter (Youth Services Bureau of Ottawa, 2010b).

Sampling and Data Collection

The current sample consisted of a self-selected group of youth aged 16 to 24 years who had experienced at least one episode of running from either a foster home or a group home (N = 12). The definition of running away was relatively non-specific in order to gather information about youth's own perceptions regarding what constituted running; youth were told that running referred to leaving one's place of residence without permission from staff or foster parents.

Interviews were conducted over a two-week period in April 2011. YSB staff made the initial contact with youth, explaining that researchers were conducting a study about youth who had run away from foster care or group homes. They informed youth that those interested in participating could speak with the researchers to learn more about the study. The Principal Investigator then followed up in person with interested youth in order to ascertain whether they wanted to participate in an interview focused on their experiences before and after running away from foster care or group homes.

The majority of participants were recruited from the YSB Downtown Services and Drop-in (N = 9) while the remaining youth were interviewed at Long-term Housing (N = 2) and the Young Men's Shelter (N = 1). All 12 youth agreed to be interviewed and provided their informed consent to participate in the study. One participant declined a request to audio record the interview. The remaining 11 interviews were audio recorded and transcribed. Participants were compensated for their time with an honorarium of $5.

Interviews were between 15-30 minutes in duration. Interviews were conducted either by the Principle Investigator or a Research Assistant, a trained undergraduate student in psychology who signed a confidentiality agreement prior to study onset.

Data Coding and Analysis

Once the interviews were completed, all interview data was transcribed by the Principle Investigator and Research Assistant. Coding and analysis of the data was conducted using QDA Miner, a qualitative analysis software package (Provalis Research, 2011). First, a preliminary list of initial codes from the data was conducted using guidelines for thematic analysis developed by Braun and Clarke (2006). Next, themes were independently identified within the data linking codes as well as themes. Review and refinement of themes was conducted collaboratively between the Principle Investigator and the Research Assistant, in partnership with the Second Investigator. At the point where no new information was emerging from the data, it was determined that the process had reached saturation.

Results

Demographics

The sample was composed of 7 males and 5 females. The mean age of participants was 18.7 years, with a range of 16 to 24 years. Age of entry into care ranged from 3 to 14 years, with a mean age of 10.5 years and a modal age of 14 years. Almost all the participants (83.3%) had spent time in a group home ($N = 10$). Most (66.7%) had lived in a foster home ($N = 8$). Two participants reported having lived in a residential treatment centre (16.7%) while 3 reported having spent time in a juvenile justice facility (25.0%). Many (66.7%) reported having lived in more than one type of substitute care (e.g., foster homes as well as group homes; $N = 8$).

Youth were asked about their most recent running episode, including how long they had been living at that particular location before they ran. Most (66.7%) reported that they had run away during the first 8 weeks ($N = 8$). Almost half reported they had first run during the first 4 weeks ($N = 5$). A smaller proportion of youth (33.3%) reported that they had been living there 6 months or more before choosing to run ($N = 4$).

Youth varied widely in terms of the total number of episodes of running they had experienced in their lifetime, with a range of 1 to 50 runs. Mean number of runs for the sample was 11.3, with a median of 6.5 and a mode of 1 ($N = 12$). About a third of participants (33.3%) reported that they had run only once from care ($N = 4$). When those runners were removed from the group, the mean number of runs for the remaining participants ($N = 8$) was 16.5, with a mode of 10.

Definition of Running

Youth were asked to provide a definition of "running away". This question was designed to serve both as an "ice breaker" as well as to establish a mutually understood description of running away as the act of leaving one's place of residence without permission.

Youth answered this question in a variety of different ways. The most common response, provided by 41.7% of participants, was that running away was something that occurred when a person did not like where they were living ($N = 5$). Another three participants indicated that running away involved leaving home without obtaining consent of staff, guardians, or foster parents (25.0%) while two participants utilized the phrase "going AWOL" in response to the question (16.7%).

Some participants seemed to take the question literally and used it as an opportunity to describe how they themselves had run away, suggesting that the question itself could have been

worded in a more transparent manner. For example, one participant provided the following response to the question: *"You hide, you never stay in the same place too long."* Another youth answered the question by describing why she felt a person might choose to run:

> *"Runaway is when you no longer want to be part of who you're with, if you want to change yourself, um, the people you associate with, and just, I don't know, tired of following other people's footsteps, and other people being in charge, and just, I don't know, want to take power of your own life, I guess." [Female, age 17]*

When she was asked the follow-up question: "Where would you draw the line?" she listed several reasons why she ran away from her group home:

> *"When I was in foster care, considering the stuff that has happened in my life… I had no freedom whatsoever. My windows, they had barbells on all their side. When I took a shower or a bath, um, they're on all the doors. I wasn't allowed leaving the house, my friends had to come there. School, I'd be picked up. My phone calls had to be on speaker. They had to read my mail. I had no communication with the rest of my family when I was there. Just, I couldn't even use razors. They wouldn't let me, because I used to cut and everything. I had no freedom whatsoever. I was completely trapped. I felt like I was in jail." [Female, age 17]*

Several youth indicated specific time frames after which time leaving a place of residence would be labeled running away. Three participants indicated that an absence of 24 hours or more would constitute running away (25.0%), while two suggested that running involved no contact for two or more days (16.7%). One participant suggested that leaving should be considered running away after a week or two. Additionally, the point was made that the rules of what constituted an act of running away typically vary depending on location; after one night with no

contact, a foster home might label a youth a runaway, whereas at home, a youth could be gone for two weeks before parents reported his/her absence to the authorities.

A quarter of the sample ($N = 3$), meanwhile, argued that timing was less relevant. Rather, these participants indicated that the circumstances of the episode and the seriousness of the youth's intent were key. For instance, one participant explained: *"I would say that you were a runaway if you decided to leave that day, even if you were gone for like 24 hours, you've still run away."* Another participant emphasized intent by describing a situation she would not consider running away, explaining that a youth who *"…just run away for, like, 2 hours to their friend's house, and then they come back"* would not constitute running away.

Why Did Youth Run From Substitute Care?

Youth were asked a general, open-ended question about why they thought young people might choose to run away from substitute care. Depending on their own histories (i.e., where they had been placed, including locations from which they had run as well as locations where they had chosen not to run), youth were then questioned about their time in foster care, group homes, residential treatment centres, or juvenile justice facilities. They reported both personal reasons for running away as well as their own observations and opinions regarding why other young people living in substitute care would choose to run. Many of the issues raised by youth came up repeatedly during the interviews, particularly when youth were asked what they liked and disliked about living in substitute care. Although they were asked about all the places where they had lived, most of the comments and suggestions provided by youth were related to their experiences living in foster homes and group homes. For youth who had lived in multiple settings, many commented that they had difficulty remembering details about specific locations

(i.e., when providing comments, they sometimes had trouble pinpointing whether they were referring to a group home or residential treatment centre).

The most commonly cited reason that youth provided for choosing to run from substitute care was that they disliked the rules and restrictions. Nearly every participant (N = 10; 83.3%) directly cited rules and restrictions as playing a central role in their decision to run. As one participant explained:

> *"They don't like the rules… there's a lot of restrictions in group homes. Big time. Some people don't like… yeah, mainly it's the rules. That's why I ran away." [Female, aged 17]*

Comments and complaints about rules and restrictions were associated in large part with living in group homes, although some youth mentioned issues they had with rules in foster homes and residential treatment centres. Youth perceived many of the rules to be unreasonable or excessive. For example, one youth, who estimated that he had run away approximately 50 times, explained:

> *"Having people on your back, every second of the day, telling you what to do. Telling you that you can't do this, can't do that. I'm 16 and I can't even go outside for, like, over 3 hours. And I gotta call when I get here, I gotta call when I get there, and they, like, even drive by to see if I'm actually where I say I am. You know, I can't have that. I need my freedom." [Male, aged 17]*

This participant, who had lived in a series of group homes, juvenile justice facilities, and a residential treatment centre, emphasized his need to be in control of his own life, as did other youth, who expressed a desire to make their own decisions.

The word "freedom" was utilized by half of all participants (N = 6), both to describe their experiences living in care as well as to explain their reasons for leaving. Other participants used words liked "trapped" and "suffocated" to describe their feelings. Four participants (25.0%) used

the word "jail" to describe their perceptions of group homes and foster care. Youth provided a number of illustrative examples, including limits on socializing outside the home, staff monitoring phone calls and internet use, and locks on doors and windows.

Some youth expressed awareness of how their own adjustment to living in substitute care had been difficult because of their prior experiences. In these cases, youth talked about how their families of origin had provided little in the way of structure and limits. For example, one female commented: *"Living at home, there wasn't a lot of rules… but going into the group home, they have a lot of rules and boundaries, and they're very strict."* This same participant later commented that she learned about the importance of rules through her experiences living at her group home. Older participants were more likely to comment on the benefits of having structure and limits on behaviour. For example, one participant insisted that: *"Nobody likes rules, but see, rules are good for future life"*.

Other youth reported that they felt personally targeted by staff, explaining that additional restrictions were implemented for some individuals, but not others. One female commented that she felt staff *"pinpointed... like if you had trouble in the house before, if something happens, they automatically blame the person that did it before"*. This participant felt as if she were treated differently from other residents in her group home with respect to the rules and restrictions on her behaviour. Consequently, she said, she found living there intolerable and capitalized on every opportunity to run.

Restrictions on socializing were particularly salient for youth. For example, youth reported not being allowed to visit friends or socialize with other youth outside the home, except under specific circumstances or with supervision. Youth reported they sometimes chose to run in order to connect with their peers. They explained that they wanted to socialize outside the home

and *"let loose"* but were unable to do so within what they felt was an overly restrictive environment.

Related to the idea of socializing with peers was the possibility of engaging in substance abuse, which was alluded to, but generally not discussed directly. Only one participant, who had been on the run from the age of 13 to 17, was candid about wanting to party and use drugs:

> *Why would you want to be in a place where you're told what to do? Everybody wants to be out with their friends, having a good time. Usually it's drugs or alcohol. They want to go out, they want to get f***** up. They don't want to be home by 9:00 pm. If you're doing drugs, you don't care. If you don't do drugs, you're probably going home. It's drugs and alcohol. You're not sober and running away. [Male, age 20]*

Youth also talked about running away as a means to connect with or spend time with family. One participant, who had a history of running from both group homes and foster homes, talked about her decision to run from what she described as her favorite foster home because of the fact that she had located her birth mother in another province and wanted to meet her. Another participant described feeling like an outsider within a foster home *"because it's not your real family and they try to be your real family. And I find if you don't take them as, like, your real family, then they neglect you, they don't like you"*. This particular youth also described running away to stay with her mother.

Finally, youth talked about the atmosphere of the home as contributing to their decision to run. Living in substitute care was described as being stressful and tense. One male, aged 16, described his experience living in a group home as follows: *"I didn't like the atmosphere… it was full of tension. I can remember it to this day. It was full of tension."* Another youth who ran several times from her group home explained:

"Too many crisises [sic]. I didn't want to deal with them… they would happen probably two or three times a week. Let's say suicide attempts, or someone was cutting, or people would start fighting with other people, so the police would get called, or they'd run away and then the police would get called. It was just, it was really stressful." [Female, age 24]

How Did Foster Parents and Staff Try To Prevent Running?

Youth were asked about the ways in which foster parents or group home staff tried to prevent running. Answers to this question tended to fall into one of two categories: either attempts to prevent running, or rewards/incentives for not running. There were a few youth (*N* = 2, 16.7%) who reported that they could not recall any specific way that staff/foster parents attempted to prevent running. In all cases, however, additional prompting revealed some strategies used to prevent running, although youth were quick to point out that once they had decided to run, there was little staff or foster parents could do to stop them.

The majority of youth (58.3%) cited prevention (defined here as anything staff used to prevent running) as a key set of strategies routinely utilized to keep youth from running from substitute care (*N* = 7). Prevention strategies ranged from threats to the use of restraints. One quarter of participants (*N* = 4) recalled having shoes locked up to prevent running; youth most commonly described staff/foster parents locking up shoes although shoelaces, outerwear (e.g., winter jackets), and other clothes were also mentioned.

Several youth mentioned the use of threats to prevent running. Threats described by youth involved the possible removal of privileges. For example, youth described being told that if she ran again, then: *"you won't get to go out for your walks"*. Threats were sometimes tied to "points" or "star levels" systems used by staff/foster parents in an effort to promote good behaviour. Youth were questioned about these points/stars/levels and what emerged was a

description of type of behavioural management strategy where youth entered the home at the lowest level and had to work to improve their standing and gain access to privileges. Use of these systems appeared to be limited to group homes; however, it is possible that residential treatment centres and even some foster homes also utilized such strategies.

Youth recalled being threatened by staff about losing privileges related to these point/star/level systems. They unanimously perceived these systems to be overtly punitive. For example, one female participant noted:

> *"They would threaten you, like: 'if you do run, next time it's going to be worse, like, this is gonna happen, you won't get your points, you won't be able to go out for your walks'. They try and scare you, which is why people run away longer, 'cause they don't want to go back and face that." [Female, age 19]*

Because point/star/level systems were described in more detail when youth were asked about what they disliked about substitute care, their perceptions regarding the use of these systems is discussed below.

Participants also described a number of preventive measures designed to limit movement ($N = 4$; 25.0%) These included limits on socializing outside the home and additional supervision in public places. For instance, one participant described being required to hold hands with group home staff in a shopping mall, something she described with disdain, later referring to the practice as being "babied". The same participant talked about how a fellow resident was confined to his room on a regular basis, indicating that it upset her that: *"…this one kid was never out of his room. He wasn't allowed out of his room. He had to eat in his room and everything."* Youth indicated that for some residents, particularly repeat runners, staff/foster parents utilized increased supervision to prevent running. This included monitoring

communication (e.g., phone calls, email) as well as increased one-on-one supervision of youth at a high risk of running.

One quarter of youth also described aspects of the physical environment designed to limit the movement of residents and prevent running (N = 4). These included locks on bathroom doors, locks on bedroom doors at night, and locks on bedroom windows. Most expressed frustration with these measures, although one participant described with some pride how he had taught himself, at the age of 13, how to open the locks on his bedroom window without triggering alarms, thus enabling him to abscond at night without being detected.

The use of restraints to prevent running was brought up by two male participants (16.7%), both of whom implied that they had experienced this first-hand. In such cases, one youth explained staff would *"just tackle you and hold you down for however long it takes"*. Other youth spontaneously mentioned that they had never personally experienced the use of restraints, but were aware they were utilized in some contexts.

Finally, youth reported the use of rewards or incentives to encourage individuals not to run away. These mainly included gifts and money. Rewards and incentives were perceived by some youth to be successful, while others did not respond as positively to rewards. One participant, who discussed the use of rewards/incentives in relation to her decision to run, explained that although she had appreciated the perks (such as a new cell phone, cameras, and a laptop) she had run anyway in order to be with family. She reported:

> *"They bribed me with money, buy me anything I want. And that's where I finally discovered that money doesn't buy happiness." [Female, age 19]*

Another youth, who had run three times from his group home, described how he decided not to run for a period of time because of rewards/incentives:

"At one point, they decided to try giving incentives and that basically completely stopped me. Like, they gave me raises on my allowance, and that was cool... yeah, it worked really well" [Male, aged 16]

What Did Youth Like About Substitute Care?

Youth were asked about what they liked about living in foster care, group homes, residential treatment centres, and juvenile justice facilities. Half of the participants (50.0%) reported that there was nothing they liked about living in substitute care (N = 6). Of those who initially answered "nothing", additional questioning led half (N = 3) to provide at least one thing they liked about living in care.

Youth most commonly talked about relationships with staff and foster parents. More than half of all participants (58.3%) discussed positive relationships with staff and foster parents as being important to them during the time they lived in substitute care. Although youth were asked about both staff and foster parents, the majority spoke about staff. Many described an emotional connection or bond they felt with a particular staff member who seemed to genuinely care about them.

What exactly was it about the way staff related to youth? Many participants seemed to have difficulty describing the specific set of behaviours staff exhibited that showed youth they cared. For instance, one participant was asked to describe what he liked about a particular staff member: *"Nice. Not like an a******. Not 'do this, do that'. Like, you're a person, I'm going to treat you like a person"*. In the words of another participant, youth could tell which staff cared by: *"Just, like, how they talk. Like, some of them will sit there and talk to you for a half hour just about everything, about life."*

Several youth brought up one-on-one time where youth could spend time alone with staff. Activities included going to movies, playing videogames together, going to Tim Horton's for a hot chocolate, or simply talking a walk together. One participant, who had talked about how she found the group home environment to be very stressful, explained: *"One-on-one time gives them something to look forward to once a week… it's just you and the staff, and that's it, outside the home."* These types of activities, however infrequent, seemed to make a huge difference to youth. Many spoke of maintaining relationships with staff years after leaving substitute care.

When it came to the specific behaviours staff were showing youth, above and beyond spending one-on-one time talking with youth, a few key aspects of social interaction emerged from these discussions. The ability of staff to listen without jumping to conclusions was noted by a few youth as being important. In the words of one participant:

> *"They actually, like, listen when [youth] talked. They're not just talking by the book, like 'you have to do this, and I'm really not going to listen to what you have to say about it, or what you're going through right now.'" [Male, age 17]*

Connected to the idea of listening was the idea of empathy. Youth spoke positively about staff members who showed empathy, meaning staff would take into account their individual circumstances rather than treating youth like a number. One participant said that he appreciated when staff members were able to *"put themselves in your shoes"*. Other youth talked about being encouraged by staff and foster parents. One participant used the phrase *"unconditional care"* several times, explaining that she had had a very positive experience in her first group home, which was now unfortunately closed. She explained:

> *"It's really all about unconditional care and support. Like, a lot of teens… who have been through stuff, and are now in the system, they can read people like a book. And they can tell if*

you're honest if and you truly care, or if you're in it for the money, or if you're just faking it or doing something like that. So I think you have to be really genuine if you want to be a foster parent or if you want to work in a group home. 'Cause in a sense, you're their parent, you're their guardian. So you need someone to look up to, someone who's not going to let them down, because more than likely they've been let down. So it's just to keep checking on the kids and genuinely caring and having their best interest." [Female, age 20]

Youth also raised the issue of staff and foster parents treating youth equally. It was important to youth, for instance, that they be treated in the same way as other foster children as well as biological children in the home. One participant, who had lived in the same foster home for over 10 years, talked about the importance of being treated equally. This participant was the least frequent runner of the sample and reported having run from home only once or twice, for the day. He attributed his low rate of running to the fact that he liked his foster home and did not want to be *"bounced from home to home"*.

"My foster family didn't treat one person unfairly and other people fairly. They basically, if [there was something] that you really want, you buy with your own money, then you get a job. Even their biological son, my foster parents didn't even buy his cell phone for him. He had to buy it, he has to pay his own contract." [Male, aged 20]

For this participant, it meant a great deal to him that his foster family brought him on vacations. He reported having met other foster children who were left behind on vacation while the family and biological children travelled together, and he said he felt fortunate to have been placed in a family where everyone was treated equally.

Routine and consistency were another aspect of substitute care that some youth appreciated. Youth talked about liking the routine of living in substitute care, knowing what to

expect and when to expect it. For example, one participant explained: *"The only thing I liked was, like, everything was in order, and things were organized. Routine, like the same thing every day."* Related to the idea of consistency, youth reported being appreciative of rules and restrictions that they perceived to be reasonable. For example, one youth talked about having a curfew that allowed her some freedom of movement, linking her decision not to run with her foster father's implementation of what she perceived to be reasonable limits on her freedom:

> *"He changed a couple of things to see if I'd actually stay. I had freedom… weekdays I had to be home at 7 for supper, Saturdays I didn't have to come home until 10:30… he drove me where I had to go, he picked me up. If I didn't want to be picked up, he let me take the bus." [Female, aged 17]*

Another participant, who emphasized the importance of reasonable, but consistent rules and restrictions, talked about how she herself had initially struggled against the rules of her group home. A frequent runner, she talked about *"testing the waters"* to see whether staff would tolerate her behaviour, or whether she would be *"handed off to another group home"*. She described her experience as follows:

> *"They had rules, which I later discovered was very important… they never gave up on me. It was like they cared about me, whereas my parents at home would just let me do whatever I wanted, so it's a big change." [Female, age 20]*

Aspects of the physical environment of substitute care that appealed to youth included having space of their own or having their own room, which necessarily translated into having more privacy. One participant noted that her foster family's financial security was something she appreciated. Three participants (25.0%) were very enthusiastic about the food provided to them

in their foster homes and group homes. They talked about how nice it was to have home cooked meals by a staff member or foster parent who was particularly talented in this area.

Youth who had spend time in juvenile justice facilities had few positive things to say about these forms of substitute care; however, one participant mentioned that he much preferred being incarcerated to living in a group home because there were many more youths his own age in the juvenile justice facility. In his group home, meanwhile, a smaller group of youth lived in close quarters, typically in a rural setting. If they did not get along, he explained, life could be difficult. He reported feeling as though he had more in common with the other males in his juvenile justice facility, because: *"they're there for something stupid they did, and I don't know, they're rebellious too, but it could be anybody, you know?"*

In addition to these positive aspects of substitute care, youth also spontaneously provided positive feedback about the Youth Services Bureau (YSB) and its services. Many were currently living in YSB housing and were particularly happy about how they were treated by staff. Several implied a mutual respect between YSB staff and youth that they appreciated in the context of the services they were receiving.

What Did Youth Not Like About Substitute Care?

Youth were asked what they did not like about living in substitute care. Some of their responses, which had emerged earlier in the interview when they were asked about reasons for running, were revisited at this juncture. A number of new complaints were also raised by youth.

Again, rules and restrictions figured heavily within people's responses, with 8 of the 12 youth (66.7%) mentioning rules and restrictions they found to be excessive or overly punitive in nature. As before, most of the comments that were made about rules related to life in group homes although some youth talked about rules and restrictions in foster care. Youth reported

being uncomfortable with rules around almost every aspect of life in group homes, including eating, sleeping, coming and going, bathing, and socializing both with other residents and outside the home.

A common complaint related to rules around food and eating. Youth talked about how food was locked away between meals, which they found difficult, especially if they were not used to the food being served at mealtime.

> *"Food was locked away. You weren't allowed to snack on stuff. Just, like, little things like that, that people are used to having. Like, if you're coming from a home where you can just open your fridge, be, like, 'okay, I'm hungry, so I want a snack'... like, all those little restrictions make people rebel, because it's stuff that they just, like, had all the time, you know?" [Female aged 19]*

In some cases, this was taken to an extreme. One participant described how while staying at a temporary foster home, he was allotted one small glass of water each meal, with nothing to drink between meals. He described how he sometimes drank water from the sink in the bathroom because he was so thirsty.

Rules around bedtime seemed especially strict at certain group homes, with one youth reporting that at 16 years of age, she and the other girls in her group home were required to go to their rooms at 7:00 pm, with lights out at 8:00 pm. Rules about entering and exiting the home could also be stringent. One participant reported undergoing physical searches every time she came or went from the home, something she disliked a great deal.

In addition to rules governing basic functions and amenities, youth reported the presence of many additional rules that they found difficult to deal with. Again, these occurred mainly, but

not exclusively, within group homes. These included rules governing who could spend time in what section of the house, swearing, television use, games, and noise levels. For instance:

> *"You can't even turn on the TV without the staff there, like, you can't have it on a certain channel, or you can't play with the Nintendo 64. We had a Nintendo 64, and it was like once a month we got to play the Nintendo 64. So it was just stupid things like that would get people going." [Female, age 19]*

The same youth commented that many of the rules seemed, in her opinion, to be designed to set youth up for failure. Youth who had lived in more than one type of substitute care were particularly critical of homes where rules and restrictions seemed excessive and seemed to lack any logical basis that youth could readily understand. For example, one participant said:

> *"I understand there's a reason why there's restrictions in group homes, because it's not supposed to be… a vacation going there. Like, it's not supposed to be super awesome, and you're not supposed to like, super love group homes or anything. But it's not supposed to feel like you're in a detention centre." [Female, age 19]*

Youth also had a number of comments about staff. Implementation of the rules by staff was perceived by some youth to be overly controlling to the point of *"power tripping"*. Youth referred to certain staff members as *"rude"* and many felt that staff *"weren't there to help you, it was more like, to make your life miserable"*.

> *"They try and control you way too much. Like, I was a smoker and I had a pack of smokes, and they told me to be honest. So told them, yeah, I smoke. And then she takes the whole pack and she crushes it up right in front of me. And I'm like: you told me to be honest, and then you crush it in front of me." [Female, age 19]*

Youth talked about how you could tell which staff cared versus those who were *"just there for the money"*. Participants were particularly critical of staff who seemed to treat youth differently from each other, or showed favouritism. Some felt unfairly labeled by staff and foster parents. Others felt excluded from the family and treated differently from biological children. For example, one participant talked about how it hurt being left behind while the rest of the family, including the biological children of her foster parents, went on vacation. She described feeling like an outside in her foster home: *"It was like their family, and the foster kid."* Another participant described how her foster family treated her like a maid, expecting her to do all the housework while the other family members were left alone. She explained:

> *"There was so many other people there, I don't understand how come we couldn't split up the work. But it was always me doing everything. Like they used me as Cinderella, their little maid." [Female, age 24]*

When it came to discussing the use of physical force, few participants reported having experienced this themselves, and those who did so tended to be vague in their descriptions (e.g., talking about a generic "you" rather than talking about personal experiences). One participant, who denied having been restrained herself, noted that *"a lot of times, they are really quick at doing restraints instead of trying to talk to you."* This participant was highly critical of the use of physical force in group homes and, like other youth, felt that staff were often quick to act without first asking questions.

One quarter of youth ($N = 4$) brought up the issue of point/star/level systems implemented in their group homes. As mentioned previously under reasons youth chose to run, these point/star/level systems were unanimously panned by participants. When questioned about how these systems functioned, youth described having to earn points in order to obtain basic

privileges. Upon entry to the home, youth explained, they were placed at the lowest level and had to work to earn the right to certain privileges. Privileges listed by youth were varied and included things like receiving a weekly allowance or having the right to go for a short walk outside in the evening, as well as more basic privileges like having an alarm clock and a pillow. While these systems appeared at first glance to represent a form of behaviour modification, based on the descriptions that youth provided, these systems seemed to be much more punitive than traditional models of behaviour modification, which tend to emphasize rewards rather than punishments. One participant explained:

> *"If you do something wrong, you're all the way back to level one. And you just work up, um, the levels to be able to go outside and be a teenager. Instead, they pretty much coop you up inside with a group of let's say 8 other females or males." [Female, age 24]*

For many youth, having a 30-minute walk in the evening was particularly important to them, and the prospect of having to work hard to earn it was frustrating. They also reported feeling like they were being punished from the moment they stepped into the group home. One participant described her experiences with the system as follows:

> *"It was like a self-esteem killer. You start off so low, and you have to work so hard to get up there, and it's like they would, they would use it against you. They'd be like: 'yeah, you want to do that? Fine, I'm going to take that star away from you. Now you're not going to get this much allowance this week or something.' And it's just like a big game to them. And I hated that point system so much 'cause it was almost like, oh, how would you say it? It's like you, especially with people who already have low-esteem or something, it's like you're put under other people." [Female, aged 19]*

Another youth, who talked about how she had never managed to make it past "level 3", said: *"It doesn't give you a chance. It's a fail-fail system."*

Discussions about punishment flowed naturally from many of the discussions about these point/star/level systems. Youth had thoughts to share about the types of punishments administered mainly in group homes, but also in other types of substitute care. In particular, the practice of withholding food as punishment was brought up as being intensely frustrating for youth. For example, one participant talked about staff punished the whole group home one day by withholding hotdog buns. For youth, the link between their behaviour and staff withholding food was far from salient, and these types of punishments instead were perceived as an act of aggression.

Another type of punishment discussed by youth was the "Quiet Room". One participant talked about being sent to the Quiet Room when she was upset. She explained:

> *"Say you were crisising [sic] or you were being loud or obnoxious, or being rude to the staff, they put you in the Quiet Room and give you a half hour and say, okay, go to the Quiet Room, like kick and scream. 'Cause it was, like, metal walls and stuff. So the only thing you can hurt is yourself. But I hated that Quiet Room so much." [Female, age 19]*

This participant talked about how staff were quick to send youth to the Quiet Room rather than asking them about what was bothering them, or making an effort to understand why they were upset. She argued that from her perspective, it seemed as though youth were being punished for showing emotion.

The idea was raised by youth that an overly restrictive environment might actually inadvertently encourage poor behaviour rather than reduce it. One female, who had lived in group homes, explained:

"Some of the restrictions they had were kind of ridiculous… it's like, if you put so many restrictions on somebody, eventually they're going to want to be rebellious 'cause… they don't have any sort of freedom. So if you take their shoes away, they're going to be like 'yeah, well, I'll leave without my shoes'. Like, I don't even think there was one time I did AWOL with my shoes. Like, I'd just be, like: 'Yeah? Eff you guys, I'm going to leave without my shoes. Like, screw you all.' And just, like, it made people rebel more, with so many restrictions." [Female, aged 19]

Beyond the rules and restrictions, youth had several other comments to make about substitute care. One participant brought up experiences with homophobia in group homes and foster care. This youth, who identified as gay, described how a foster parent had brought her to church against her wishes. There, she was made to sit up at the front of the church. She described undergoing some kind of religious ritual involving water, which she believed had occurred because the people there thought she *"was obsessed with satan or something like that, because I was gay."*

Aspects of the physical environment that youth reported disliking included the location of the residence (many homes were situated in rural settings), which meant early wake-ups, long bus rides to and from school, and limited opportunities for socializing outside the home. Rural locations appeared to reduce running for some youth, especially in the winter. For other youth, living in a rural location seemed to increase their stress level, thereby increasing the probability of running.

Youth also had comments about the rooms they slept in, describing Spartan settings that did not feel at all home-like. For example, one participant, when asked what she did not like about living in her group home, said:

"Maybe the rooms. Like, you get an alarm clock, and if you lose your points, they take it away. You get, like, no blanket, pretty much, no pillow. So you're supposed to feel at home, they tell you to, but they give you nothing. You're only allowed like, two outfits in your room, in case you were trying to run." [Female, age 19]

Other youth complained of crowding, again mainly in group homes. Youth talked about sleeping three or four to a room, which limited privacy and increased the likelihood of friction between residents. Youth also talked about age discrepancies between residents as being a source of frustration. For example, one participant described sharing a room with an infant, while another talked about being the oldest person in her group home where the other four residents were under the age of 12.

The stressful nature of living in an environment with so many youth was emphasized by participants. References to "crisising" were made by several youth, who talked about how there was always drama in the home because one youth or more were having meltdowns.

Finally, one quarter of youth (25.0%) reported that they had no complaints about living in at least one particular type of substitute care. Out of those people, three went on to provide complaints about at least one other types of substitute care where they had lived. For example, one participant reported that he loved his foster family, but had serious problems with a "respite" foster care home where he and his foster siblings were routinely sent to live for weekends or weeks at a time in order to give his foster parents "a break". This participant indicated that at these homes, the foster parents were, in his opinion, quite negligent toward youth. He expressed pride in the fact that he reported these issues to his Children's Aid Society (CAS) case worker, although he expressed disappointment that nothing seemed to change.

What Recommendations Did Youth Provide For Reducing Running?

Youth provided a number of recommendations to reduce the probability that young people would run from substitute care. Half of all participants (N = 6) initially had difficulty providing recommendations; however, with additional questions, all but one were able to provide some ideas for how to reduce running among youth in substitute care. For example, one participant indicated that he had liked his foster home and did not feel any improvements were needed. However, this same participant later had several comments to make about respite care, a short-term form of foster care mentioned above. One participant also had no ideas to offer to improve substitute care, other than jokingly suggesting that he might have stayed at his group home had there been "more parties".

Reasonable limits. Nearly every participant (N = 8; 66.7%) suggested revisions to existing rules and restrictions. Several acknowledged that group homes varied a great deal with respect to how they were managed, indicating that some group homes provided reasonable boundaries with clear and consistent implementation while others seemed excessively regimented. Some examples were provided over the course of the interviews (such as age-appropriate curfews, allowing youth to access food between meals), but youth seemed most uncomfortable with the sheer volume of rules and restrictions they were required to follow in their new homes. Youth also emphasized the importance of clear communication of the reasons for consequences, as well as how to avoid punishments, as a means to reduce frustration. Overall, youth supported a revision of what they perceived to be an overly restrictive environment, explaining that this was important so that youth *"don't feel like they're being punished by being in group homes"*.

Revisit point/star/level systems. Youth sent a clear message regarding point/star/level systems, which they perceived as being overly punitive from day one. These systems, likely implemented as a means to motivate positive behaviours, seemed to have the opposite effect on youth. Youth reported that upon entry into the home, they began at the lowest level and had to work their way up. In other words, rather than beginning with the assumption that their behaviour and intentions were essentially positive, youth felt they were symbolically and literally required to prove themselves to staff as being worthy of trust. While some participants acknowledged the importance of having rules in the home to keep youth safe, in general youth reported finding these point/star/level systems to be both frustrating and demeaning. If, indeed, these systems were designed to function as forms of behaviour modification, it may be helpful to revisit how they are being implemented in group homes and other types of substitute care.

Don't withhold basics to punish. Related to the idea of reasonable limits was the idea that staff/foster parents should not withhold basic amenities to punish youth. Youth reported feeling upset and angry during incidents where food and basic comforts (e.g., pillows, alarm clocks) were taken away as punishment. The link between their behaviour and these punishments did not seem to be salient for youth; instead, they were more likely to characterize staff as vindictive and uncaring.

Rewards for good behaviour. Youth talked about how rewards could be helpful for encouraging good behaviour such as not running away or going AWOL for a period of time. For example, one youth indicated that raises on his allowance had motivated him to stop running for a period of time. Positive reinforcement may be particularly important for young people under the care of the child welfare system, who may perceive the environment of substitute care to be excessively punitive.

Relationships with staff/foster parents. Youth indicated that not only did relationships with specific staff/foster parents made a huge difference to their overall experience of living in care, but they also reduced the likelihood of running. Youth emphasized the importance of one-on-one time with staff, both because it allowed them some individual attention and because it gave them a break from being in the home. The frequency with which this one-on-one attention occurred did not seem to be especially important, with some youth describing spending only a few minutes each week with a staff member, nor did the type of activity the two engaged in. Rather, youth felt it was important for staff and youth to *"talk, hang out with, anything really."*

Youth reported feeling most connected with staff who expressed genuine, unconditional care and support through simple acts like listening, asking youth how they were doing, and spending time with them. This was particularly important to youth in times of crisis, when youth were feeling upset and emotional. They emphasized the importance of talking with youth and listening to what they had to say rather than *"jumping right into restraints"*.

Improved screening of staff. A number of comments were made by youth throughout the interviews about the motivations of staff, namely, that youth believed themselves to be well able to differentiate between staff who were there because they cared versus staff who were simply there *"just there for the money"*. Additional questioning revealed that youth felt some staff seemed less willing to get to know individual youth and were quick to restrain rather than reason with them in times of crisis.

Youth suggested that better screening of staff for employment in group homes was needed. One suggestion made by youth was that this could include a greater focus on educational background, with the assumption this may have an impact on their orientation toward youth. For example, one participant talked about the positive, youth-oriented approach of staff who were

concurrently working toward degrees or diplomas in child and youth studies or social work. Youth suggested that staff seeking careers in corrections, for example, could be less focused on communication and more focused on correcting poor behaviour. Youth suggested that good staff are *"people who are willing to get involved with the child instead of just being staff"*.

Equal treatment. Youth expressed positive feelings about staff/foster parents who made an effort to ensure everyone in the home was treated the same way. This point was made by youth both about tangible (i.e., *"if one person got to have this, we all got it"*) and non-tangible features of life in substitute care. For example, one participant spoke at length about how stigmatized she felt moving from a group home to a foster home; whereas in the group home, she felt respected, within her new foster family, she felt as though she was always the outsider because her foster family treated her differently from their biological children. This participant emphasized the importance of educating foster families:

> *"Just make sure that you include them. And if, like, [foster parents] have their own children, to really, like, educate them and you know, make sure that the other kids include them too, and don't treat them differently, and don't label them as, like, "oh, foster kid". You know what I mean? Like, just treat them like they're another part of your family. Anything you do. Like I know at my foster home, like, they would take trips with their kids, without me and the other foster kid. You know what I mean? And it's like, why would you do that? Like why don't you just include them?" [Female, age 20]*

More preparation before placement. Youth suggested that having more information beforehand might help prepare staff/foster parents as well as youth for living together. Youth suggested that for staff/foster parents, knowing more about an individual youth's history might help them to make an informed decision about whether or not they feel equipped to deal with

that youth's specific set of needs. Similarly, if youth had more information about staff or foster parents as well as the home prior to actually moving in, this might reduce the probability of future running. One participant raised the idea of arranging a meeting prior to actually moving a youth into a residence:

> *"It's awkward being in a new home with people you don't know. Do they know me? Do they not know me? Do they think I'm weird? It's just, you don't know what to expect. So I think it's good to meet and figure out whether or not they are a good match." [Female, age 24]*

Greater interaction with birth families. Some youth reported having run away from substitute care to be with family. These youth emphasized the importance of maintaining regular contact with their families. (Obviously this would apply only to situations where there is no legally mandated separation precluding any kind of contact between family members.) Youth described cases in which they were allowed to communicate with parents with staff supervision; however, in practice it appears that this occurred on an infrequent basis. They argued that more contact (e.g., being allowed visits with parents in their group homes, or being allowed to use the phone to call home) would have made a huge difference to them.

A related idea was the notion of staff/foster parents respecting families of origin. Youth reported hearing negative comments about their birth families, which upset them a great deal. For example, one participant reported that her foster parents would routinely "badmouth" her birth mother:

> *"My mom's a drug user, and she's been to rehab and stuff. They were saying that if I lived at home, I'd be just like my mother. And the way I'm going, I'm going to be just like my mother." [Female, age 17]*

She emphasized feeling like an outsider during her time in foster care mainly for this reason. Now living in supportive housing, this participant explained that she now has a good relationship with her mother. She suggested that youth would be less likely to run, and would be more likely to develop better relationships with foster parents, if foster parents would *"not talk down about our families all the time."*

Improve policies regarding how crises are dealt with. Youth emphasized how stressful they found substitute care, alluding to frequent crises and meltdowns in the home. The suggestion was made that the manner in which these crises were dealt with could be improved. One participant indicated that perhaps it would be better if crises be kept private as much as possible, in order to avoid affecting other members of the home. She explained:

> *"If there's a suicide attempt, they don't need to make it known to everybody. They can do what they need to do, but not involve all the other, let's say, 7 girls that are there. Make it private so we don't need to deal with the extra stress and stuff. 'Cause usually when one person crisises [sic], or has a crisis, everybody else does as well. 'Cause it's like, it's not just our crisis, it's everybody's. Because we're all there and we're all experiencing the same thing, like we're all seeing it and we're there, and we don't want to see it. You know, the police getting called every day or every other day, that's really stressful, especially on a teenager." [Female, age 24]*

Fewer youth per home. Related to the idea of multiple crises in the home was the idea of overcrowding. Youth reported that many group homes were, in their experience, overcrowded. They described sharing bedrooms with several other youth and pointed to a lack of privacy as contributing to their overall stress level. Some acknowledged that financial considerations contributed to decisions to house many youth in one home, saying: *"it's just about the money"*.

The point was made that the stress level inside group homes increased with the addition of each new resident. One participant described crowding in the following manner: *"[With 3 to a room], you don't have the space if you need to calm down, if you need to cry… so you might react in a different way."* Youth suggested that having a greater degree of privacy in the home would have influenced their decision to run.

"More like a home." Finally, youth suggested that staff/foster parents work to make substitute care feel more like a home, *"not, like, just a spot where they throw all the unwanted kids".* When asked to explain what they meant, a number of suggestions were made, many of which have been discussed above. One was to house fewer youths together (discussed above). One participant suggested that family meals were important so that everyone could regularly enjoy a good meal together. Youth also suggested that other youth might enjoy *"better munchies".* As mentioned previously, good food appeared to be a major benefit for some youth.

Also revisited was the idea of encouraging staff to show genuine, unconditional care and support for youth. Over the course of the interviews, several youth referred to staff at the YSB as being respectful of their choices. This corresponded with observations of the physical environment at the Downtown Services and Drop-in, where basic amenities such as food, clothing, showers, and health care were available to youth in a "self-serve" fashion.

Discussion

The present study examined the perspectives of young people who had experienced at least one episode of running from substitute care, including foster homes, group homes, residential treatment centres, or juvenile justice facilities. Youth were asked about their own histories and experiences living in care, which included discussions about both individual and program-level features of substitute care. They provided a wealth of information based on their

own understanding of and familiarity with substitute care, describing a range of experiences in relation to their own histories of running. Youth also provided suggestions for improvements designed to reduce the incidence and prevalence of running among their peers.

There were many lessons learned throughout this process, including the importance of paying special attention to the wording of questions, particularly the first "ice-breaker" question. The importance of keeping language simple and concrete was driven home by the variety of different answers that were provided to this question. Happily, these discussions did appear to function adequately as an ice-breaker and set the stage for the remaining questions.

Youth expressed strong feelings about the rules and restrictions of substitute care at many different points during the interviews. Almost universally, the rules associated with substitute care were described as being excessive and unreasonable. Few youth linked the presence of rules to efforts to ensure the safety or security of residents. Youth were much more likely to perceive the implementation and enforcement of rules as arbitrary and representing some kind of personally targeted attack. Within this context, elopement was seen as a means to secure a sense of personal freedom.

One possibility is that the perceptions of youth were shaped, in part, by the contrast between their experiences growing up in their families of origin and the more organized and regimented environment of substitute care, where housing large groups of youth necessitates the implementation of at least some rules to ensure the safety and comfort of residents living in close quarters with each other. That being said, youth described a range of rules and restrictions that varied between homes, and, in some cases, did indeed seem to be excessive and almost punitive in nature.

Youth also sent a clear message regarding point/star/level systems, which they perceived as representing a complex and confusing form of punishment. Based on descriptions provided by youth, these systems appear to be a form of behaviour modification. However, without knowing more about them, it is impossible to be certain how behavioural contingencies were set up and enforced. If, indeed, these systems are forms of behaviour modification, it may be helpful to revisit how they are being implemented within group homes and other forms of substitute care. Behaviour modification systems can be very effective; however, implementation is often challenging and a system designed to be rewarding can easily become one that feels, to youth, to be quite the opposite, particularly if upon entry into the home, they have to work hard to obtain basic privileges. The issue of how behaviour modification systems are actually being implemented in substitute care settings (e.g., within a given setting, does the literature support the actual proportion of positive versus negative reinforcement currently in use by staff or foster parents) may be worth exploring further in future research.

The importance of relationships between youth and staff/foster parents was emphasized by youth at key points in the interviews, including when they were asked to provide suggestions for reducing elopement among their peers. For example, one-to-one time outside the home was highlighted as being key both to connecting with staff and reducing the stress associated with being in the group home. Youth spoke positively about staff who were empathetic, who treated youth equally, and who were unconditional in their care. Research has shown that a mentoring relationship between an adult and a young person can be a powerful tool for promoting resilience in many populations, including youth in foster care (Gilligan, 1999; Osterling & Hines, 2006).

Youth also suggested that elopement could be reduced if group home staff underwent better screening to ensure their qualifications and motivations were suited to a substitute care

environment. This corresponds with previous research, where social worker assessments of foster parents were associated with a lower risk of elopement (Nesmith, 2006).

Similarly, youth suggested that perhaps if youth and foster parents had more preparation before an actual move, including some basic information about the youth's history, this would prevent running. It is possible that this suggestion speaks to the stress of moving into an unknown home with strangers. While the feasibility of these ideas may be limited given the possibility of emergencies requiring that youth be moved quickly, the idea that more preparation may reduce anxiety could be an important one. Additional research into the specific practices of child welfare agencies regarding how young people are prepared for moves may provide information that could be used to reduce the probability of elopement.

The environment of substitute care was described by many youth as being crowded and stressful. Examples that were provided by youth included the ways in which crises were managed by staff, including the use of physical force or restraints. Youth advocated for other youth, explaining that from their perspective, some staff were often quick to act without first asking questions and allowing youth the time and space to calm down. They also indicated that having physical space to call their own was important for them when living in an environment with so many other youth. Youth suggested that it might be helpful to avoid living situations where multiple youth were housed in one bedroom. They also described the physical environment of substitute care as being the opposite of home-like, indicating that substitute care should feel "more like a home" rather than a form of punishment. They cited things like good home-cooked meals and caring relationships with staff/foster parents as examples of positive experiences that contributed to feeling at home in substitute care.

Finally, there seemed to be a tremendous amount of variation between different substitute care settings with respect to both environmental factors as well as culture. In some group homes, for instance, youth reported being crowded into a bedroom with multiple roommates while in others, youth had a bedroom to themselves. The implementation of rules and restrictions also seemed to vary a great deal depending on the group home. In some homes, staff seemed to genuinely empathize with youth, while in others, youth reported feeling targeted and misunderstood.

Future Directions for Research

In this study, participants from multiple types of substitute care settings were included in the sample, including group homes, foster homes, residential treatment centres, and juvenile justice facilities. Because there are comparatively fewer children and youth placed in residential treatment centres and juvenile justice facilities, it is not surprising that most of the comments and suggestions that were provided by youth related to their experiences in foster care and group homes. While the inclusion of multiple types of substitute care in the context of this study allowed the researchers to cast a broad net and avoid excluding any youth, it may have meant that some detail was lost about these individual types of substitute care. It may therefore be worthwhile in future to look specifically at the experiences of youth living in group homes, foster care, residential treatment centres, and juvenile justice facilities.

Similarly, this study involved a range of age groups, including both younger youth, who had recently left substitute care and older youth who had the benefit of several years of living independently in supportive housing. While this approach provided valuable information, the inclusion of older youth may have affected the results since memories of past experiences are generally less salient and more subject to error compared to memories of recent events. On the

other hand, some younger participants seemed to have difficulty recalling relatively recent details about life in substitute care. It is possible that the passage of time allowed for consolidation of experiences, offering additional clarity to older participants and allowing them to reflect on their time in substitute care.

As well, this study represented a first step into looking at some of the program-level factors that may contribute to a youth's decision to run from substitute care. Questions were designed to be open-ended in order to allow youth to recall the information that was most salient to them. This represented both an advantage and a weakness of the study, since many youth had trouble remembering details about their experiences living in substitute care. It is possible, for instance, that because of subsequent events in their lives, certain aspects of their experiences were emphasized while others were largely overlooked. More specific questions about environmental or program-level factors may be helpful in future research. For example, many of the youth interviewed in the context of this study reported that their group homes had been located in rural settings. The decision to situate group homes in rural locations may be based, in part, on research showing higher rates of elopement among youth living in urban rather than suburban or rural settings (Sanchez et al., 2006). Situating group homes in rural locations may, however, have unintended consequences such as isolating youth from family and friends; for example, Kashubeck and colleagues (1994) found that youth who ran from residential treatment were more likely to be living more than 100 miles from home. It may be helpful to explore this issue further in future studies.

It may also be important to look at other sources of information regarding the contribution of environmental factors to whether or not youth decide to run. For example, staff and foster parents could represent an invaluable resource, providing information about their

experiences in foster homes, group homes, residential treatment centres, and juvenile justice facilities. Given the importance youth placed on relationships with staff, it would be important to explore aspects of the working environment that might contribute to worker engagement. The challenges, successes, and limitations they may face in working with youth could shed light on this issue.

Without a doubt, the transition from living at home to living in substitute care can be very stressful for youth. Many young people choose to run from care and in doing so, place themselves at an increased risk for a number of harmful outcomes. The present findings suggest that the perspectives of youth who have run from substitute care may be helpful in determining how to better meet their needs. In addition, these results indicate that some changes may be warranted in order to better serve youth in substitute care. Future research examining possible avenues for change may be warranted, with the goal reducing elopement among youth in substitute care.

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General Discussion

The three studies that comprise this dissertation were designed to provide information about elopement among children and youth under the care of the child welfare system. These young people were living in a variety of substitute care settings, including foster homes, group homes, residential treatment centres, and juvenile justice facilities. A conceptual framework for this research was provided by several theories, most notably attachment theory and Whitbeck & Hoyt's (1999) risk-amplification developmental model, where elopement was assumed to be the result of an accumulation of risk factors beginning with problematic early relationships with caregivers. As well, this dissertation explored the contribution of psychosocial needs and strengths to running, with an emphasis on protective factors in the context of early traumatic experiences. Though often overlooked, strengths, in addition to needs, are important considerations both in terms of immediate and long-term risk, as well as with respect to planning interventions designed to reduce risk and improve outcomes.

Across these three studies, results suggest that the set of factors that determine whether or not a child will choose to run from out-of-home care is likely to be different from the factors that determine whether an adolescent will choose to run away. The first and second studies, both of which explored predictors of elopement within a large sample of young people living in substitute care, revealed differences in patterns of elopement between younger participants and older participants, with older participants showing a greater likelihood of being at a moderate or high risk of running away. Previous research has shown age-related differences in rates of running away (Baker et al., 2005; Courtney et al., 2005; Eisengart et al., 2008; Sunseri, 2003) although very little research has been done looking at predictors of elopement among children.

Because the first study in this dissertation included participants ranging in age from 6 to 18 years, results allowed for an examination of similarities and differences between children and adolescents with respect to patterns of predictors of elopement from substitute care. Approximately half of all adolescents were at a moderate to high risk of running, and elopement within this group appeared to be influenced by both needs and strengths. In contrast, among children, running was a relatively rare occurrence. Further, those children flagged as being at a moderate to high risk of running appeared to be influenced by constellations of needs, but not strengths. This meant that the set of predictors chosen for the logistic regression model for the first study was much better able to predict running among youth compared to children. This may be due, in part, to the fact that the predictors for Study 1a were chosen based on previous findings, and until now, much of the current literature has focused on adolescents. These results suggest that other unknown factors may be affecting elopement among children.

One possibility for the differences noted between children and adolescents may relate to attachment processes underlying observed effects. In Study 1a, the group of children identified as being at risk for running away may be coming from much more disorganized and dysfunctional backgrounds. Early experiences among these children may have resulted in problems with attachment, which are known to be correlated with psychological adjustment both in childhood and later in life (Andersson, 2005; Marcus, 1991). With respect to participation in high-risk behaviours such as running away, previous research suggests that the more abuse a child experiences within his or her family of origin, the earlier the age they leave home, and the longer they stay away from home (Whitbeck & Hoyt, 1999). Whereas among many individuals, early attachment problems may contribute to runaway behaviour through an accumulation of risk leading to elopement typically during adolescence, it is possible that more severe trauma is

linked with running away at a much earlier age. While this dissertation did not directly assess a possible link between attachment, early experiences, and elopement among children, future research designed to explore this issue may be warranted.

It is also possible that children who run away from substitute care are typified by a high needs profile, including internalizing and/or externalizing problems. From an attachment perspective, this could be due not only to disorganized and dysfunctional parenting, but also to individual vulnerability factors, with both interacting to produce problems with attachment. Paradise (2001), for example, discusses the interplay between children with high needs and parents who are overwhelmed and lack the skills to adequately meet their children's attachment needs. Research shows that young children in foster care who exhibit attachment problems are more likely to also exhibit internalizing and externalizing problems (Oosterman & Schuengel, 2008). Future studies may examine which child and caregiver needs are central to this effect in order, not only to highlight children who might possibly choose to run away, but also to plan interventions for chronic runners.

The finding that children and adolescents showed differing patterns of predictors of elopement may serve as a reminder that prevention efforts must always be designed and implemented with development in mind. However, since the actual number of children who were at a moderate to high risk of running was relatively small, and a substantial proportion of the variance was unaccounted for by the model, further research will be needed in order to develop a model that is better able to predict running in children. If, in fact, needs play a more important role in whether a child chooses to run, then this population may be better served by strategies designed to identify and reduce risk factors, whereas strengths-building strategies designed to reduce running might be more appropriate for adolescents.

The relationship between strengths and running appears to be a complex one. Results of the first study indicated that having strengths predicted a reduction in runaway risk for adolescents, while the second study showed that only a few key individual strengths were predicting elopement, with differences between older and younger adolescents. When strengths were considered in sum, they seemed to moderate the impact of traumatic experiences on elopement, effectively downgrading the effect of traumatic experiences on running. This corresponds with previous research suggesting that strengths moderate the relationship between trauma and participation in high-risk behaviours (Griffin et al., 2009).

From the perspective of a risk-amplification developmental model, where risk accumulates over time due to interactions between multiple factors, it is possible that protective factors reduce the strength of association between those factors that cumulatively lead to increased risk. For example, having community, family, and spiritual/religious strengths may cumulatively lessen the likelihood that young people associate exclusively with deviant peers. A child or adolescent who is involved with organized, community-based activities such as Girl or Boy Scouts, who is connected in a meaningful way to their foster family, and who is also connected to a religious community, may benefit from these associations in a way that mitigates the impact of other, more unhealthy relationships. When faced with challenges, they may, for instance, be more likely to turn to their foster parents or individuals in the community, rather than turning to deviant peers for support. Consequently, they may, through exposure to these groups of people, acquire healthier coping skills instead of exposing themselves to further risk through their relationships with deviant peers, who might encourage, for instance, substance use as a means to cope with stressors.

One particular strength that was highlighted across studies was education. In Study 1b, educational strengths, which refer to the fit between the individual and the school system with regard to his or her learning needs, were found to predict a reduced risk of elopement among youth. The importance of factors related to education and the school environment was also highlighted with respect to trauma, where school violence was found to be a significant predictor of elopement among adolescents. As well, poor school attendance predicted elopement across age groups in Study 1a. These findings correspond with previous research suggesting a link between issues with education and running away from substitute care (Biehal & Wade, 1999; English & English, 1999) as well as research linking a positive school climate with lower rates of participation in risky behaviour among adolescents who have experienced abuse (Perkins & Jones, 2004).

It is possible that running and homelessness may place young people at a disadvantage by resulting in missed educational opportunities. In Canada, for example, research suggests that over half of street youth had dropped out of school (Raising the Roof, 2009). Homelessness may significantly impact progress through school, particularly for individuals who are dealing with learning or attentional difficulties. Problems with learning or attention may also predate elopement. Such difficulties, when not properly addressed, may lead to detachment from school, making young people more likely to run away. For example, Paradise (2001) conducted research with 30 homeless youth and found that almost all had a learning disability of some kind. Findings such as these provide support for additional exploration of the role of strength-building in education, as well as the need to find systematic ways to engage young people at school, with the goal of reducing rates of elopement (Skyles et al., 2007). This could include school-based programs addressing both learning needs (such as tutoring) as well as building prosocial

relationships with other students and with the community (such as clubs built on a common interest).

A second strength that emerged in Study 1b, specifically among older youth, was relationship permanence. Relationship permanence predicted lower risk of running away among adolescents aged 16-18 years. In Study 2, relationships were also highlighted by youth during interviews, where it was suggested that close relationships with caregivers reduced the likelihood of running. This corresponds with the literature on attachment and youth homelessness, where the quality of attachment with caregivers has been shown to be related to elopement (McGarvey et al., 2010; Whitbeck & Hoyt, 1999). Close relationships typically take time to develop, which may explain why relationship permanence was found to predict a decrease in elopement among older adolescents. In practice, this may mean that youth are less likely to run from substitute care if they have formed stable relationships with people they care about.

Related to the idea of relationship permanence is placement stability. Research has linked elopement from substitute care with a history of placement instability (Courtney et al., 2005; Nesmith, 2006). While the dataset for this research did not allow for exploration of placement stability, it is possible that the mechanism for this association may be related, in part, to difficulties establishing relationships with others due to frequent moves. Clark and colleagues (2008) suggest that social capital theory provides a framework for understanding the impact of frequent placement changes on youth in substitute care in terms of missed opportunities for the development of social networks. They argue that one way to reduce runaway behaviour would be to help youth to identify, with assistance, their preferred living situations, with the goal of stabilizing them within these settings.

In keeping with this emphasis on relationships, findings from Study 2 revealed that youth were particularly positive about foster parents or staff who were empathetic and supportive. Previous research has highlighted the positive effect that caregiver sensitivity can have on children in foster care (Oosterman & Schuengel, 2008). In contrast, participants had difficulty with caregiving they perceived to be typified by strict rules and harsh punishment. One aspect of substitute care that was discussed at length in Study 2 was the number of rules and restrictions implemented in group homes. Youth seemed particularly unhappy with the high level of monitoring in substitute care, citing examples of staff monitoring their communications via telephone or internet, limitations on socializing outside the home, and limitations on movement within the home (e.g., locks on bedroom doors).

Research suggests that monitoring by a parent or caregiver is known to be associated with a decreased probability of running (Tyler & Bersani, 2008; Tyler et al., 2008). For example, Tyler, Johnson, and Brownridge (2008), who found that positive parenting predicted lower rates of elopement, suggest that adolescents who experience appropriate levels of monitoring and who feel close to their caregivers may be less likely to run because they feel cared about. Further, they may be more likely to communicate with their caregivers when troubles arise, rather than using running as a coping mechanism. As well, research suggests that living situations with little adult supervision are associated with an increased risk of a first run among youth in foster care (Courtney & Zinn, 2009). However, results of Study 2 suggest that in the context of substitute care, too much monitoring may actually have the opposite effect. Youth reported feeling rebellious about monitoring that they perceived to be excessive. Although they recognized that monitoring was designed to prevent elopement, most insisted that in spite of the efforts of their caregivers, there was little that foster parents or staff could do to keep them from running. In

contrast, youth indicated that they were less likely to run when they felt they had some privacy and a reasonable amount of freedom. It may be that there is an "ideal" amount of monitoring that allows youth to feel protected and cared for without feeling suffocated.

Given these findings, it may be worthwhile to explore the possibility of developing interventions targeting the relationship between youth and caregivers in order to reduce elopement among young people in substitute care. Kumpfer and Alvarado (2003) argue that interventions focused on building family strengths may be beneficial in the prevention of youth problem behaviours; in particular, they suggest that the research supports positive parent-child relationships, positive discipline methods, monitoring and supervision, and communication of prosocial and healthy family values and expectations as all being protective factors. A similar approach to strengths-building may be helpful within a substitute care context for staff and foster parents seeking to reduce running and other problem behaviours.

An important aspect of relationship-building may involve ensuring staff and foster parents are adequately supported. Research indicates that the extent to which foster parents feel supported has an impact on youth in foster care (Leon, Ragsdale, Miller, & Spacarelli, 2005). Results from Study 2 suggest that youth believe themselves to be capable of differentiating between staff who are there because they care about youth, compared to those who are *"just there for the money"*. Insufficient support leading to worker burnout among staff might be one reason youth experience some staff in this manner. It may be helpful to systematically examine the extent to which staff as well as foster parents currently feel supported. For example, an examination of the use of behavioural management strategies (i.e., point/star/level systems) within group homes may provide valuable information that could be utilized to support staff. Additional training and ongoing support in the implementation and maintenance of these systems

may be warranted. Workshops focused on the basics of behavioural modification, for instance, could enable group home staff to better implement systems designed to motivate positive behaviours in a more effective manner.

Relationship-building efforts may involve researching and utilizing new technologies. Advances in technology, including the proliferation of relatively inexpensive cellular phones as well as widespread internet access, have changed the way young people socialize and maintain relationships. In particular, social networking websites such as Facebook allow youth to maintain connections with a virtual community regardless of their physical location. The small amount of research that has been conducted in this area suggests that over 96% of homeless youth are regularly using the internet (Rice, Monro, Barman-Adhikari, & Young, 2010). This corresponded with observations made during qualitative data collection at the YSB Downtown Services and Drop-in, where youth were provided with access to new computers with unlimited internet access. Over the two weeks that interviews were conducted, youth were observed to be using the computers on an almost constant basis. It is possible that youth are using the internet to maintain relationships as well as to form new ones. The interplay between elopement, youth homelessness, and new technologies, including social networking, is worthy of exploration in future studies.

The connection between relationships and technology among homeless and runaway youth has yet to be explored in depth. However, it is clear that technology offers new possibilities with respect to practice and policy. For instance, Clark and colleagues (2008) describe a program where cellular phones are provided to youth living in out-of-home care in order to encourage communication between young people and staff, particularly if youth decide to run. The authors explain that this program allows trained staff receiving the calls to guide

youth from afar, as well as to express statements of caring, empathy, or concern. The phones also indirectly serve as an instructive tool for youth regarding norms around obtaining consent from caregivers to leave their homes, as well as regularly reporting their whereabouts to caregivers.

Findings from research such as this dissertation provide support for additional exploration of the role of strength-building with the goal of reducing elopement among youth in substitute care. While these three studies allowed for the examination of multiple variables in relation to elopement, there are nonetheless several limitations to this research that must be acknowledged. First, the data for studies 1a and 1b were collected in the state of Illinois, which may limit generalizability within a Canadian context. Accessing datasets of this size can be challenging in regions where centralized data storage has yet to be implemented. However, these results may be helpful for informing similar research projects conducted within a Canadian context. This should include sampling youth in the child welfare system in both official languages.

A second limitation of this research involves the lack of data on placement stability. As mentioned previously, information about participants' histories of placement in substitute care was unavailable. Given research linking placement instability to elopement (Courtney et al., 2005; Nesmith, 2006), it will be important for future research to examine this variable. Similarly, a longitudinal study design may allow for the exploration of how young people adjust to life in substitute care over the weeks or months following entry into care.

Further exploration of environmental variables associated with substitute care may be helpful. For instance, several youth discussed a lack of space within group homes as contributing to their decision to run away. Variables relating to caregivers themselves should also be explored. For instance, factors such as workload, support, compensation, and relationships with

other staff may all be important in influencing willingness to *"get involved with the child instead of just being staff"*.

Future studies of this kind should also include information about lesbian, gay, bisexual, transgendered, and transsexual (LGBTT) youth. Despite being known to be overrepresented in shelters (Whitbeck, Chen, Hoyt, Tylor, & Johnson, 2004), LGBTT youth have largely been overlooked in the literature, perhaps in part because measurement of these variables can be challenging due to social stigma. This lack of data is concerning given that homeless youth who self-identify as gay, lesbian, bisexual, or questioning show higher rates of depression, suicidal ideation, injection drug use, and victimization, both before they become homeless and afterwards, compared to their heterosexual counterparts (Noell & Ochs, 2001; Whitbeck et al., 2004). Future research should include looking at gender identity and sexual identity.

For some individuals, elopement may represent a form of self-advocacy, taken in response to living conditions perceived to be untenable. For others, it may represent an impulsive decision. In either case, the unfortunate reality is that running can have serious consequences for young people both in the short- and long-term. If, indeed, changes need to be made to the way in which substitute care is run, then more research is needed to inform these changes. Knowing more about children and adolescents who run away from substitute care may ultimately provide important information, which could be used to inform our systems of care with the goal of better serving the needs of young people in the child welfare system.

References (Introduction and Discussion)

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Appendix A

Measures

Child and Adolescent Needs and Strengths (CANS)

(Items 1-41 and 46-69 from CANS Comprehensive Assessment for Illinois Department of Children and Family Services Manual)

CHILD AND ADOLESCENT NEEDS AND STRENGTHS

TRAUMA EXPERIENCES

These ratings are made based on lifetime exposure of trauma.

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

0 indicates a dimension where there is no evidence of any trauma of this type.
1 indicates a dimension where a single even trauma occurred or suspicion exists of trauma experiences.
2 indicates a dimension on which the child has experienced multiple traumas.
3 indicates a dimension describes repeated and severe trauma with medical and physical consequences.

1. SEXUAL ABUSE

This rating describes child's experience of sexual abuse or the impact of the abuse on child's functioning.

0 There is no evidence that child has experienced sexual abuse.

1 Child has experienced single incident sexual abuse with no penetration.

2 Child has experienced multiple incidents of sexual abuse without penetration or a single incident of penetration.

3 Child has experienced severe, chronic sexual abuse that could include penetration or associated physical injury.

2. PHYSICAL ABUSE

This rating describes the degree of severity of the child physical abuse.

0 There is no evidence that child has experienced physical abuse.

1 There is a suspicion that child has experienced physical abuse but no confirming evidence. Spanking without physical harm or intention to commit harm also qualifies.

2 Child has experienced a moderate level of physical abuse and/or repeated forms of physical punishment (e.g., hitting, punching).

3 Child has experienced severe and repeated physical abuse with intent to do harm and that causes sufficient physical harm to necessitate hospital treatment.

3. EMOTIONAL ABUSE

This rating describes the degree of severity of emotional abuse, including verbal and nonverbal forms.

0 There is no evidence that child has experienced emotional abuse.

1 Child has experienced mild emotional abuse. For instance, child may experience some insults or is occasionally referred to in a derogatory manner by caregivers.

2 Child has experienced moderate degree of emotional abuse. For instance, child may be consistently denied emotional attention from caregivers, insulted or humiliated on an ongoing basis, or intentionally isolated from others.

3 Child has experienced significant emotional abuse over an extended period of time (at least one year). For instance, child is completely ignored by caregivers, or threatened/terrorized by others.

4. NEGLECT

This rating describes the degree of severity of neglect.

0 There is no evidence that child has experienced neglect.

1 Child has experienced minor or occasional neglect. Child may have been left at home alone with no adult supervision or there may be occasional failure to provide adequate supervision of child.

2 Child has experienced a moderate level of neglect. This may include occasional unintended failure to provide adequate food, shelter, or clothing with corrective action.

3 Child has experienced a severe level of neglect, including prolonged absences by adults, without minimal supervision, and failure to provide basic necessities of life on a regular basis.

5. MEDICAL TRAUMA

This rating describes the degree of severity of medical trauma.

0 There is no evidence that child has experienced any medical trauma.

1 Child has experienced mild medical trauma, including minor surgery (e.g., stitches, bone setting).

2 Child has experienced moderate medical trauma, including major surgery or injuries requiring hospitalization.

3 Child has experienced life threatening medical trauma.

6. WITNESS TO FAMILY VIOLENCE

This rating describes the degree of severity of exposure to family violence.

0 There is no evidence that child has witnessed family violence.

1 Child has witnessed one episode of family violence.

2 Child has witnessed repeated episodes of family violence but no significant injuries (i.e. requiring emergency medical attention) have been witnessed.

3 Child has witnessed repeated and severe episode of family violence or has had to intervene in episodes of family violence. Significant injuries have occurred and have been witnessed by the child as a direct result of the violence.

7. COMMUNITY VIOLENCE

This rating describes the degree of severity of exposure to community violence.

0 There is no evidence that child has witnessed or experienced violence in the community.

1 Child has witnessed occasional fighting or other forms of violence in the community. Child has not been directly impacted by the community violence (e.g., violence not directed at self, family, or friends) and exposure has been limited.

2 Child has witnessed the significant injury of others in his/her community, or has had friends/family members injured as a result of violence or criminal activity in the community, or is the direct victim of violence/criminal activity that was not life threatening, or has witnessed/experienced chronic or ongoing community violence.

3 Child has witnessed or experienced the death of another person in his/her community as a result of violence, or is the direct victim of violence/criminal activity in the community that was life threatening, or has experienced chronic/ongoing impact as a result of community violence (e.g., family member injured and no longer able to work).

8. SCHOOL VIOLENCE

This rating describes the degree of severity of exposure to school violence.

0 There is no evidence that child has witnessed violence in the school setting.

1 Child has witnessed occasional fighting or other forms of violence in the school setting. Child has not been directly impacted by the violence (e.g., violence not directed at self or close friends) and exposure has been limited.

2 Child has witnessed the significant injury of others in his/her school setting, or has had friends injured as a result of violence or criminal activity in the school setting, or has directly experienced violence in he school setting leading to minor injury, or has witnessed ongoing/chronic violence in the school setting.

3 Child has witnessed the death of another person in his/her school setting, or has had friends who were seriously injured as a result of violence or criminal activity in the school setting, or has directly experienced violence in the school setting leading to significant injury or lasting impact.

9. NATURAL OR MANMADE DISASTERS

This rating describes the degree of severity of exposure to either natural or man-made disasters.

0 There is no evidence that child has been exposed to natural or man-made disasters.

1 Child has been exposed to disasters second hand (i.e., on television, hearing others discuss disasters). This would include second hand exposure to natural disasters such as a fire or earthquake or man-made disaster, including car accident, plane crashes, or bombings.

2 Child has been directly exposed to a disaster or witnessed the impact of a disaster on a family or friend. For instance, a child may observe a caregiver who has been injured in a car accident or fire or watch his neighbor's house burn down.

3 Child has been directly exposed to a disaster that caused significant harm or death to a loved one or there is an ongoing impact or life disruption due to the disaster (e.g., house burns down, caregiver loses job).

10. TRAUMATIC GRIEF/SEPARATION

This rating describes the level of traumatic grief due to death or loss or separation from significant caregivers.

0 There is no evidence that child has experienced traumatic grief or separation from significant caregivers.

1 Child is experiencing some level of traumatic grief due to death or loss of a significant person or distress from caregiver separation in a manner that is appropriate given the recent nature of loss or separation.

2 Child is experiencing a moderate level of traumatic grief or difficulties with separation in a manner that impairs function in certain but not all areas. This could include withdrawal or isolation from others.

3 Child is experiencing significant traumatic grief or separation reactions. Child exhibits impaired functioning across several areas (e.g., interpersonal relationships, school) for a significant period of time following the loss or separation.

11. WAR AFFECTED

This rating describes the degree of severity of exposure to war, political violence, or torture. Violence or trauma related to terrorism is not included here.

0 There is no evidence that child has been exposed to war, political violence, or torture.

1 Child did not live in war-affected region or refugee camp, but family was affected by war. Family members directly related to the child may have been exposed to war, political violence, or torture; family may have been forcibly displaced due to the war, or both. This does not include children who have lost one or both parents during the war.

2 Child has been affected by war or political violence. He or she may have witnessed others being injured in the war, may have family members who were hurt or killed in the war, and may have lived in an area where bombings or fighting took place. Child may have lost one or both parents during the war or one or both parents may be so physically or psychologically disabled from war so that they are not able to provide adequate caretaking of child. Child may have spent extended amount of time in refugee camp.

3 Child has experienced the direct affects of war. Child may have feared for their own life during war due to bombings, shelling, very near to them. They may have been directly injured, tortured or kidnapped. Some may have served as soldiers, guerrillas or other combatants in their home countries.

12. TERRORISM AFFECTED

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

0 There is no evidence that child has been affected by terrorism or terrorist activities.

1 Child's community has experienced an act of terrorism, but the child was not directly impacted by the violence (e.g., child lives close enough to site of terrorism that they may have visited before or child recognized the location when seen on TV, but child's family and neighborhood infrastructure was not directly affected). Exposure has been limited to pictures on television.

2 Child has been affected by terrorism within his/her community, but did not directly witness the attack. Child may live near the area where attack occurred and be accustomed to visiting regularly in the past, infrastructure of child's daily life may be disrupted due to attack (e.g., utilities or school), and child may see signs of the attack in neighborhood (e.g., destroyed building). Child may know people who were injured in the attack.

3 Child has witnessed the death of another person in a terrorist attack, or has had friends or family members seriously injured as a result of terrorism, or has directly been injured by terrorism leading to significant injury or lasting impact.

13. WITNESS/VICTIM TO CRIMINAL ACTIVITY

This rating describes the degree of severity of exposure to criminal activity.

0 There is no evidence that child has been victimized or witnessed significant criminal activity.

1 Child is a witness of significant criminal activity.

2 Child is a direct victim of criminal activity or witnessed the victimization of a family or friend.

3 Child is a victim of criminal activity that was life threatening or caused significant physical harm or child witnessed the death of a loved one.

TRAUMATIC STRESS SYMPTOMS

These ratings describe a range of reactions that children and adolescents may exhibit to any of a variety of traumatic experiences from child abuse and neglect to community violence to disasters.

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

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

14. ADJUSTMENT TO TRAUMA

This item covers the youth's reaction to any of a variety of traumatic experiences -- such as emotional, physical, or sexual abuse, separation from family members, witnessing violence, or the victimization or murder of family members or close friends. This dimension covers both adjustment disorders and posttraumatic stress disorder from the DSM-IV.

0 Child has not experienced any significant trauma or has adjusted well to traumatic experiences.

1 Child has some mild adjustment problems to trauma. Child may have an adjustment disorder or other reaction that might ease with the passage of time. Or, child may be recovering from a more extreme reaction to a traumatic experience.

2 Child has marked adjustment problems associated with traumatic experiences. Child may have nightmares or other notable symptoms of adjustment difficulties.

3 Child has post-traumatic stress difficulties as a result of traumatic experience. Symptoms may include intrusive thoughts, hyper-vigilance, constant anxiety, and other common symptoms of Post Traumatic Stress Disorder (PTSD).

15. REEXPERIENCING

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

0 This rating is given to a child with no evidence of intrusive symptoms.

1 This rating is given to a child with some problems with intrusions, including occasional nightmares about traumatic events.

2 This rating is given to a child with moderate difficulties with intrusive symptoms. This child may have more recurrent frightening dreams with or without recognizable content or recurrent distressing thoughts, images, perceptions or memories of traumatic events. This child may exhibit trauma-specific reenactments through repetitive play with themes of trauma or intense physiological reactions at exposure to traumatic cues.

3 This rating is given to a child with severe intrusive symptoms. This child may exhibit trauma-specific reenactments that include sexually or physically traumatizing other children or sexual play with adults. This child may also exhibit persistent flashbacks, illusions or hallucinations that make it difficult for the child to function.

16. AVOIDANCE

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

0 This rating is given to a child with no evidence of avoidance symptoms.

1 This rating is given to a child who exhibits some problems with avoidance. This child may exhibit one primary avoidant symptom, including efforts to try and avoid thoughts, feelings or conversations associated with the trauma.

2 This rating is given to a child with moderate symptoms of avoidance. In addition to avoiding thoughts or feelings associated with the trauma, the child may also avoid activities, places, or people that arouse recollections of the trauma.

3 This rating is given to a child who exhibits significant or multiple avoidant symptoms. This child may avoid thoughts and feelings as well as situations and people associated with the trauma and have an inability to recall important aspects of the trauma.

17. NUMBING

These symptoms include numbing responses that are part of the DSM-IV criteria for PTSD. These responses are not present before the trauma.

0 This rating is given to a child with no evidence of numbing responses.

1 This rating is given to a child who exhibits some problems with numbing. This child may have a restricted range of affect or an inability to express or experience certain emotions (e.g., anger or sadness).

2 This rating is given to a child with moderate difficulties with numbing responses. This child may have a blunted or flat emotional state or have difficulty experiencing intense emotions or feel consistently detached or estranged form others following the traumatic experience.

3 This rating is given to a child with significant numbing responses or multiple symptoms of numbing. This child may have a markedly diminished interest or participation in significant activities and a sense of a foreshortened future.

18. DISSOCIATION

Symptoms included in this dimension are daydreaming, spacing or blanking out, forgetfulness, emotional numbing, fragmentation, detachment, and rapid changes in personality often associated with traumatic experiences. This dimension may be used to rate dissociative disorders (e.g., Dissociative Disorder NOS, Dissociative Identity Disorder) but can also exist when other diagnoses are primary (e.g., PTSD, depression).

0 This rating is given to a child with no evidence of dissociation.

1 This rating is given to a child with minor dissociative problems, including some emotional numbing, avoidance or detachment, and some difficulty with forgetfulness, daydreaming, spacing or blanking out.

2 This rating is given to a child with a moderate level of dissociation. This can include amnesia for traumatic experiences or inconsistent memory for trauma (e.g., remembers in one context but not another), more persistent or perplexing difficulties with forgetfulness (e.g., loses things easily, forgets basic information), frequent daydreaming or trance-like behavior, depersonalization and/or derealization. This rating would be used for someone who meets criteria for Dissociative Disorder Not Otherwise Specified or another diagnosis that is specified "with dissociative features."

3 This rating is given to a child with severe dissociative disturbance. This can include significant memory difficulties associated with trauma that also impede day to day functioning. Child is frequently forgetful or confused about things he/she should know about (e.g., no memory for activities or whereabouts of previous day or hours). Child shows rapid changes in personality or evidence of alternate personalities. Child who meets criteria for Dissociative Identity Disorder or a more severe level of Dissociative Disorder NOS would be rated here.

CHILD STRENGTHS

For **Child Strengths**, the following categories and action levels are used:

0 indicates a domain where strengths exist that can be used as a centerpiece for a strength-based plan.
1 indicates a domain where strengths exist but require some strength building efforts in order for them to serve as a focus of a strength-based plan.
2 indicates a domain where strengths have been identified but that they require significant strength building efforts before they can be effectively utilized in as a focus of a strength-based plan.
3 indicates a domain in which efforts are needed in order to identify potential strengths for strength building efforts.

19. FAMILY

Family refers to all biological or adoptive relatives with whom the child or youth remains in contact along with other individuals in relationships with these relatives.

0 Significant family strengths. This level indicates a family with much love and mutual respect for each other. Family members are central in each other's lives. Child is fully included in family activities.

1 Moderate level of family strengths. This level indicates a loving family with generally good communication and ability to enjoy each other's company. There may be some problems between family members. Child is generally included.

2 Mild level of family strengths. Family is able to communicate and participate in each other's lives; however, family members may not be able to provide significant emotional or concrete support for each other. Child is often not included in family activities.

3 This level indicates a child with no known family strengths. Child is not included in normal family activities.

20. INTERPERSONAL

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

0 Significant interpersonal strengths. Child is seen as well liked by others and has significant ability to form and maintain positive relationships with both peers and adults. Individual has multiple close friends and is friendly with others.

1 Moderate level of interpersonal strengths. Child has formed positive interpersonal relationships with peers and/or other non-caregivers. Child may have one friend, if that friendship is a healthy ‘best friendship model.

2 Mild level of interpersonal strengths. Child has some social skills that facilitate positive relationships with peers and adults but may not have any current relationships, but has a history of making and maintaining healthy friendships with others.

3 This level indicates a child with no known interpersonal strengths. Child currently does not have any friends nor has he/she had any friends in the past. Child does not have positive relationships with adults.

21. EDUCATIONAL

This rating refers to the strengths of the school system and may or may not reflect any specific educational skills possessed by the child or youth.

0 This level indicates a child who is in school and is involved with an educational plan that appears to exceed expectations. School works exceptionally well with family and caregivers to create a special learning environment. A child in a mainstream educational system who does not require an individual plan would be rated here.

1 This level indicates a child who is in school and has a plan that appears to be effective. School works fairly well with family and caregivers to ensure appropriate educational development.

2 This level indicates a child who is in school but has a plan that does not appear to be effective.

3 This level indicates a child who is either not in school or is in a school setting that does not further his/her education.

22. VOCATIONAL

Generally this rating is reserved for adolescents and is not applicable for children 12 years and under. Computer skills would be rated here.

0 This level indicates an adolescent with vocational skills who is currently working in a natural environment.

1 This level indicates an adolescent with pre-vocational and some vocational skills but limited work experience.

2 This level indicates an adolescent with some pre-vocational skills. This also may indicate a child or youth with a clear vocational preference.

3 This level indicates an adolescent with no known or identifiable vocational or pre-vocational skills and no expression of any future vocational preferences.

23. WELL-BEING

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

0 This level indicates a child with exceptional psychological strengths. Both coping and savoring skills are well developed.

1 This level indicates a child with good psychological strengths. The person has solid coping skills for managing distress or solid savoring skills for enjoying pleasurable events.

2 This level indicates a child with limited psychological strengths. For example, a person with very low self-esteem would be rated here.

3 This level indicates a child with no known or identifiable psychological strengths. This may be due to intellectual impairment or serious psychiatric disorders.

24. OPTIMISM

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

0 Child has a strong and stable optimistic outlook on his/her life. Child is future oriented.

1 Child is generally optimistic. Child is likely able to articulate some positive future vision.

2 Child has difficulties maintaining a positive view of him/herself and his/her life. Child may vary from overly optimistic to overly pessimistic.

3 Child has difficulties seeing any positives about him/herself or his/her life.

25. TALENTS/INTERESTS

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

0 This level indicates a child with significant creative/artistic strengths. A child/youth who receives a significant amount of personal benefit from activities surrounding a talent would be rated here.

1 This level indicates a child with a notable talent. For example, a youth who is involved in athletics or plays a musical instrument, etc. would be rated here.

2 This level indicates a child who has expressed interest in developing a specific talent or talents even if they have not developed that talent to date.

3 This level indicates a child with no known talents, interests, or hobbies.

26. SPIRITUAL/RELIGIOUS

This rating should be based on the child or adolescent's and their family's involvement in spiritual or religious beliefs and activities.

0 This level indicates a child with strong moral and spiritual strengths. Child may be very involved in a religious community or may have strongly held spiritual or religious beliefs that can sustain or comfort him/her in difficult times.

1 This level indicates a child with some moral and spiritual strengths. Child may be involved in a religious community.

2 This level indicates a child with few spiritual or religious strengths. Child may have little contact with religious institutions.

3 This level indicates a child with no known spiritual or religious involvement.

27. COMMUNITY LIFE

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

0 This level indicates a child with extensive and substantial, long-term ties with the community. For example, individual may be a member of a community group (e.g., Girl or Boy Scouts, etc.) for more than one year, may be widely accepted by neighbors, or involved in other community activities, informal networks, etc.

1 This level indicates a child with significant community ties although they may be relatively short term (e.g., past year).

2 This level indicates a child with limited ties and/or supports from the community.

3 This level indicates a child with no known ties or supports from the community.

28. RELATIONSHIP PERMANENCE

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

0 This level indicates a child who has very stable relationships. Family members, friends, and community have been stable for most of his/her life and are likely to remain so in the foreseeable future. Child is involved with both parents.

1 This level indicates a child who has had stable relationships but there is some concern about instability in the near future (one year) due to transitions, illness, or age. A child who has a stable relationship with only one parent may be rated here.

2 This level indicates a child who has had at least one stable relationship over his/her lifetime but has experienced other instability through factors such as divorce, moving, removal from home, and death.

3 This level indicates a child who does not have any stability in relationships.

LIFE DOMAIN FUNCTIONING

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

0 indicates a life domain in which the child is excelling. This is an area of considerable strength.
1 indicates a life domain in which the child is doing OK. This is an area of potential strength.
2 indicates a life domain in which the child is having problems. Help is needed to improve functioning into an area of strength.
3 indicates a life domain in which the child is having significant problems. Intensive help is needed to improve functioning into an area of strength.

29. FAMILY

Family ideally should be defined by the child; however, in the absence of this knowledge consider biological relatives and their significant others with whom the child still has contact as the definition of family.

0 Child is doing well in relationships with family members.

1 Child is doing adequately in relationships with family members although some problems may exist. For example, some family members may have some problems in their relationships with child.

2 Child is having moderate problems with parents, siblings and/or other family members. Frequent arguing, difficulties in maintaining any positive relationship may be observed.

3 Child is having severe problems with parents, siblings, and/or other family members. This would include problems of domestic violence, constant arguing, etc.

30. LIVING SITUATION

This item refers to how the child is functioning in their current living arrangement which could be a relative, a temporary foster home, shelter, etc.

0 No evidence of problem with functioning in current living environment.

1 Mild problems with functioning in current living situation. Caregivers concerned about child's behavior in living situation.

2 Moderate to severe problems with functioning in current living situation. Child has difficulties maintaining his/her behavior in this setting creating significant problems for others in the residence.

3 Profound problems with functioning in current living situation. Child is at immediate risk of being removed from living situation due to his/her behaviors.

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

0 Child is on a healthy social development pathway.

1 Child is having some minor problems with his/her social functioning.

2 Child is having some moderate problems with his/her social functioning.

3 Child is experiencing severe disruptions in his/her social functioning.

32. DEVELOPMENTAL/INTELLECTUAL
This rating describes the child's development as compared to standard developmental milestones such as talking, walking, toileting, cooperative play, etc.

0 No evidence of developmental problems or mental retardation.

1 Evidence of a mild developmental delay or low IQ (70 to 85)

2 Evidence of a pervasive developmental disorder, including Autism, Tourette's, Down's syndrome or other significant developmental delay or child's has mild mental retardation (50 to 69).

3 Severe developmental disorder or IQ below 50.

33. RECREATIONAL
This item is intended to reflect the child access to and use of leisure time activities.

0 Child has and enjoys positive recreation activities on an ongoing basis.

1 Child is doing adequately with recreational activities although some problems may exist.

2 Child is having moderate problems with recreational activities. Child may experience some problems with effective use of leisure time.

3 Child has no access to or interest in recreational activities. Child has significant difficulties making use of leisure time.

34. JOB FUNCTIONING
This item is intended to describe functioning in vocational settings. If a child or youth is not working, rate a '3'.

0 Child is gainfully employed in a job and performing well.

1 Child is gainfully employed but may have some difficulties at work.

2 Child works intermittently for money (e.g., babysitting) or child has job history but is currently not working.

3 Child has no job history.

NA Not applicable based on child's age.

35. LEGAL
This item involves only the child's (not the families') involvement with the legal system.

0 Child has no known legal difficulties.

1 Child has a history of legal problems but currently is not involved with the legal system.

2 Child has some legal problems and is currently involved in the legal system.

3 Child has serious current or pending legal difficulties that place him/her at risk for a court ordered out of home placement

36. MEDICAL
This item refers to the child's health.

0 Child is healthy.

1 Child has some medical problems that require medical treatment.

2 Child has chronic illness that requires ongoing medical intervention.

3 Child has life threatening illness or medical condition.

37. PHYSICAL
This item describes any physical limitations the child may experience due to health or other factors.

0 Child has no physical limitations.

1 Child has some physical condition that places mild limitations on activities. Conditions such as impaired hearing or vision would be rated here. Rate here, treatable medical conditions that result in physical limitations (e.g., asthma).

2 Child has physical condition that notably impacts activities. Sensory disorders such as blindness, deafness, or significant motor difficulties would be rated here.

3 Child has severe physical limitations due to multiple physical conditions.

38. SEXUAL DEVELOPMENT
This rating describes issues around sexual development, including developmentally inappropriate sexual behavior and problematic sexual behavior. Sexual orientation or gender identity issues could be rated here if they are leading to difficulties.

0 No evidence of any problems with sexual development.

1 Mild to moderate problems with sexual development. May include concerns about sexual identity or anxiety about the reactions of others.

2 Significant problems with sexual development. May include multiple older partners or high-risk sexual behavior.

3 Profound problems with sexual development. This level would include prostitution, very frequent risky sexual behavior, or sexual aggression.

39. SCHOOL BEHAVIOR

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

0 No evidence of behavior problems at school or day care. Child is behaving well.

1 Mild problems with school behavioral problems. May be related to either relationships with teachers or peers. A single detention might be rated here.

2 Child is having moderate behavioral difficulties at school. He/she is disruptive and may receive sanctions, including suspensions or multiple detentions.

3 Child is having severe problems with behavior in school. He/she is frequently or severely disruptive. School placement may be in jeopardy due to behavior.

NA Not applicable for children five years and younger

40. SCHOOL ACHIEVEMENT

This item describes academic achievement and functioning.

0 Child is doing well in school.

1 Child is doing adequately in school, although some problem with achievement exists.

2 Child is having moderate problems with school achievement. He/she may be failing some subjects.

3 Child is having severe achievement problems. He/she may be failing most subjects or is more than one year behind same age peers in school achievement.

NA Not applicable for children five years and younger

41. SCHOOL ATTENDANCE

If school is not in session, rate the last 30 days when school was in session.

0 No evidence of attendance problems. Child attends regularly.

1 Child has some problems attending school, although he/she generally goes to school. He/she may miss up to one day per week on average. Or, he/she may have mad moderate to severe problems in the past six months but has been attending school regularly in the past month.

2 Child is having problems with school attendance. He/she is missing at least two days per week on average.

3 Child is generally truant or refusing to go to school.

CHILD BEHAVIORAL/EMOTIONAL NEEDS

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

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

46. PSYCHOSIS

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

0 This rating indicates a child with no evidence of thought disturbances. Both thought processes and content are within normal range.

1 This rating indicates a child with evidence of mild disruption in thought processes or content. The child may be somewhat tangential in speech or evidence somewhat illogical thinking (age inappropriate). This also includes children with a history of hallucinations but none currently. The category would be used for children who are subthreshold for one of the DSM diagnoses listed above.

2 This rating indicates a child with evidence of moderate disturbance in thought processes or content. The child may be somewhat delusional or have brief or intermittent hallucinations. The child's speech may be at times quite tangential or illogical. This level would be used for children who meet the diagnostic criteria for one of the disorders listed above.

3 This rating indicates a child with severe psychotic disorder. The child frequently is experiencing symptoms of psychosis and frequently has no reality assessment. There is evidence of ongoing delusions or hallucinations or both. Command hallucinations would be coded here. This level is used for extreme cases of the diagnoses listed above.

47. ATTENTION DEFICIT/IMPULSE CONTROL

Symptoms of Attention Deficit and Hyperactivity Disorder and Impulse Control Disorder would be rated here. Inattention/distractibility not related to opposition would also be rated here.

0 This rating is used to indicate a child with no evidence of attention/hyperactivity problems.

1 This rating is used to indicate a child with evidence of mild problems with attention/hyperactivity or impulse control problems. Child may have some difficulties staying on task for an age appropriate time period.

2 This rating is used to indicate a child with moderate symptoms attention/hyperactivity or impulse control problems. A child who meets DSM-IV diagnostic criteria for ADHD would be rated here.

3 This rating is used to indicate a child with severe impairment of attention or dangerous impulse control problems. Frequent impulsive behavior is observed or noted that carries considerable safety risk (e.g., running into the street, dangerous driving or bike riding). A child with profound symptoms of ADHD would be rated here.

48. DEPRESSION

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

0 This rating is given to a child with no emotional problems. No evidence of depression.

1 This rating is given to a child with mild emotional problems. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to gross avoidance behavior.

2 This rating is given to a child with a moderate level of emotional disturbance. This could include major, depression, or school avoidance. Any diagnosis of depression would be coded here. This level is used to rate children who meet the criteria for an affective disorder listed above.

3 This rating is given to a child with a severe level of depression. This would include a child who stays at home or in bed all day due to depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. Disabling forms of depressive diagnoses would be coded here. This level is used to indicate an extreme case of one of the disorders listed above.

49. ANXIETY

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

0 No evidence of any anxiety or fearfulness.

1 History or suspicion of anxiety problems or mild to moderate anxiety associated with a recent negative life event. This level is used to rate either a mild phobia or anxiety problem or a sub-threshold level of symptoms for the other listed disorders.

2 Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered significantly in child's ability to function in at least one life domain.

3 Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any life domain

50. OPPOSITIONAL BEHAVIOR (Compliance with authority)

This item is intended to capture how the child relates to authority. Oppositional behavior is different from conduct disorder in that the emphasis of the behavior is on non-compliance to authority rather than on seriously breaking social rules, norms, and laws.

0 This rating indicates that the child/adolescent is generally compliant.

1 This rating indicates that the child/adolescent has mild problems with compliance to some rules or adult instructions. Child may occasionally talk back to teacher, parent/caregiver may be letters or calls from school.

2 This rating indicates that the child/adolescent has moderate problems with compliance to rules or adult instructions. A child who meets the criteria for Oppositional Defiant Disorder in DSM-IV would be rated here.

3 This rating indicates that the child/adolescent has severe problems with compliance to rules or adult instructions. A child rated at this level would be a severe case of Oppositional Defiant Disorder. They would be virtually always noncompliant. Child repeatedly ignores authority.

51. CONDUCT

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

0 This rating indicates a child with no evidence of behavior disorder.

1 This rating indicates a child with a mild level of conduct problems. The child may have some difficulties in school and home behavior. Problems are recognizable but not notably deviant for age, sex, and community. This might include occasional truancy, repeated severe lying, or petty theft from family.

2 This rating indicates a child with a moderate level of conduct disorder. This could include episodes of planned aggressive or other anti-social behavior. A child rated at this level should meet the criteria for a diagnosis of Conduct Disorder.

3 This rating indicates a child with a severe Conduct Disorder. This could include frequent episodes of unprovoked, planned aggressive or other anti-social behavior.

52. SUBSTANCE ABUSE

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

0 This rating is for a child who has no substance use difficulties at the present time. If the person is in recovery for greater than 1 year, they should be coded here, although this is unlikely for a child or adolescent.

1 This rating is for a child with mild substance use problems that might occasionally present problems of living for the person (intoxication, loss of money, reduced school performance, parental concern). This rating would be used for someone early in recovery (less than 1 year) who is currently abstinent for at least 30 days.

2 This rating is for a child with a moderate substance abuse problem that both requires treatment and interacts with and exacerbates the psychiatric illness. Substance abuse problems consistently interfere with the ability to function optimally but do not completely preclude functioning in an unstructured setting.

3 This rating is for a child with a severe substance dependence condition that presents a significant complication to the coordination of care (e.g., need for detoxification) of the individual. A substance-exposed infant who demonstrates symptoms of substance dependence would be rated here.

53. ATTACHMENT DIFFICULTIES

This item should be rated within the context of the child's significant parental or caregiver relationships.

0 No evidence of attachment problems. Caregiver-child relationship is characterized by mutual satisfaction of needs and child's development of a sense of security and trust. Caregiver appears able to respond to child cues in a consistent, appropriate manner, and child seeks age-appropriate contact with caregiver for both nurturing and safety needs.

1 Mild problems with attachment. There is some evidence of insecurity in the child-caregiver relationship. Caregiver may at times have difficulty accurately reading child bids for attention and nurturance; may be inconsistent in response; or may be occasionally intrusive. Child may have mild problems with separation (e.g., anxious/clingy behaviors in the absence of obvious cues of danger) or may avoid contact with caregiver in age-inappropriate way. Child may have minor difficulties with appropriate physical/emotional boundaries with others.

2 Moderate problems with attachment. Attachment relationship is marked by sufficient difficulty as to require intervention. Caregiver may consistently misinterpret child cues, act in an overly intrusive way, or ignore/avoid child bids for attention/nurturance. Child may have ongoing difficulties with separation, may consistently avoid contact with caregivers, and may have ongoing difficulties with physical or emotional boundaries with others.

3 Severe problems with attachment. Child is unable to form attachment relationships with others (e.g., chronic dismissive/avoidant/detached behavior in care giving relationships) OR child presents with diffuse emotional/physical boundaries leading to indiscriminate attachment with others. Child is considered at ongoing risk due to the nature of his/her attachment behaviors. A child who meets the criteria for an Attachment Disorder in DSM-IV would be rated here. Child may have experienced significant early separation from or loss of caregiver, or have experienced chronic inadequate care from early caregivers, or child may have individual vulnerabilities (e.g., mental health, developmental disabilities) that interfere with the formation of positive attachment relationships.

54. EATING DISTURBANCES

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

0 This rating is for a child with no evidence of eating disturbances.

1 This rating is for a child with a mild level of eating disturbance. This could include some preoccupation with weight, calorie intake, or body size or type when of normal weight or below weight. This could also include some binge eating patterns.

2 This rating is for a child with a moderate level of eating disturbance. This could include a more intense preoccupation with weight gain or becoming fat when underweight, restrictive eating habits or excessive exercising in order to maintain below normal weight, and/or emaciated body appearance. This level could also include more notable binge eating episodes that are followed by compensatory behaviors in order to prevent weight gain (e.g., vomiting, use of laxatives, excessive exercising). This child may meet criteria for a DSM-IV Eating Disorder (Anorexia or Bulimia Nervosa).

3 This rating is for a child with a more severe form of eating disturbance. This could include significantly low weight where hospitalization is required or excessive binge-purge behaviors (at least once per day).

55. AFFECT DYSREGULATION

These symptoms include difficulties modulating or expressing emotions, intense fear or helplessness, difficulties regulating sleep/wake cycle, and inability to fully engage in activities.

0 This rating is given to a child with no difficulties regulating emotional responses. Emotional responses are appropriate to the situation.

1 This rating is given to a child with some minor difficulties with affect regulation. This child could have some difficulty tolerating intense emotions and become somewhat jumpy or irritable, in response to emotionally charged stimuli or more watchful or hypervigilant in general. This child may have some difficulty sustaining involvement in activities for any length of time.

2 This rating is given to a child with moderate problems with affect regulation. This child may be unable to modulate emotional responses. This child may exhibit marked shifts in emotional responses (e.g., from sadness to irritability to anxiety) or have contained emotions with a tendency to lose control of emotions at various points (e.g., normally restricted affect punctuated by outbursts of anger or sadness). This child may also exhibit persistent anxiety, intense fear or helplessness, or lethargy/loss of motivation.

3 This rating is given to a child with severe problems with highly dysregulated affect. This child may have more rapid shifts in mood and an inability to modulate emotional responses (feeling out of control of their emotions). This child may also exhibit tightly contained emotions with intense outbursts under stress. Alternately, this child may be characterized by extreme lethargy, loss of motivation or drive, and no ability to concentrate or sustain engagement in activities (i.e., emotionally “shut down”).

NA Not applicable due to child’s age. See section for children 0 to 5 years old.

56. BEHAVIORAL REGRESSIONS

These ratings are used to describe shifts in previously adaptive functioning evidenced in regressions in behaviors or physiological functioning.

0 This rating is given to a child with no evidence of behavioral regression.

1 This rating is given to a child with some regressions in age-level of behavior (e.g., thumb sucking, whining when age inappropriate).

2 This rating is given to a child with moderate regressions in age-level of behavior including loss of ability to engage with peers, stopping play or exploration in environment that was previously evident, or occasional bedwetting.

3 This rating is given to a child with more significant regressions in behaviors in an earlier age as demonstrated by changes in speech or loss of bowel or bladder control.

57. SOMATIZATION

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

0 This rating is for a child with no evidence of somatic symptoms.

1 This rating indicates a child with a mild level of somatic problems. This could include occasional headaches, stomach problems (nausea, vomiting), joint, limb or chest pain without medical cause.

2 This rating indicates a child with a moderate level of somatic problems or the presence of conversion symptoms. This could include more persistent physical symptoms without a medical cause or the presence of several different physical symptoms (e.g., stomach problems, headaches, backaches). This child may meet criteria for a somatoform disorder. Additionally, the child could manifest any conversion symptoms here (e.g., pseudoseizures, paralysis).

3 This rating indicates a child with severe somatic symptoms causing significant disturbance in school or social functioning. This could include significant and varied symptomatic disturbance without medical cause.

58. ANGER CONTROL

This item captures the youth's ability to identify and manage their anger when frustrated.

0 This rating indicates a child with no evidence of any significant anger control problems.

1 This rating indicates a child with some problems with controlling anger. He/she may sometimes become verbally aggressive when frustrated. Peers and family members are aware of and may attempt to avoid stimulating angry outbursts.

2 This rating indicates a child with moderate anger control problems. His/her temper has gotten him/her in significant trouble with peers, family, and/or school. This level may be associated with some physical violence. Others are likely quite aware of anger potential.

3 This rating indicates a child with severe anger control problems. His/her temper is likely associated with frequent fighting that is often physical. Others likely fear him/her.

NA Not applicable due to child's age.

CHILD RISK BEHAVIORS

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

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

59. SUICIDE RISK

This rating describes both suicidal and significant self-injurious behavior. A rating of 2 or 3 would indicate the need for a safety plan.

0 Child has no evidence or history of suicidal or self-injurious behaviors.

1 History of suicidal or self-injurious behaviors or significant ideation but no self-injurious behavior during the past 30 days.

2 Recent, (last 30 days) but not acute (today) suicidal ideation or gesture. Self-injurious in the past 30 days (including today) without suicidal ideation or intent.

3 Current suicidal ideation and intent in the past 24 hours.

60. SELF-MUTILATION

This rating includes repetitive physically harmful behavior that generally serves a self-soothing functioning with the child.

0 No evidence of any forms of self-mutilation (e.g., cutting, burning, face slapping, head banging)

1 History of self-mutilation but none evident in the past 30 days.

2 Engaged in self-mutilation that does not require medical attention.

3 Engaged in self-mutilation that requires medical attention.

61. OTHER SELF HARM

This rating includes reckless and dangerous behaviors that while not intended to harm self or others, place the child or others at some jeopardy. Suicidal or self-mutilative behavior is NOT rated here.

0 No evidence of behaviors that place the child at risk of physical harm.

1 History of behavior other than suicide or self-mutilation that places child at risk of physical harm. This includes reckless and risk-taking behavior that may endanger child.

2 Engaged in behavior other than suicide or self-mutilation that places him/her in danger of physical harm. This includes reckless behavior or intentional risk-taking behavior.

3 Engaged in behavior other than suicide or self-mutilation that places him/her at immediate risk of death. This includes reckless behavior or intentional risk-taking behavior.

62. DANGER TO OTHERS

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

0 Child has no evidence or history of aggressive behaviors or significant verbal aggression towards others (including people and animals).

1 History of aggressive behavior or verbal aggression towards others but no aggression during the past 30 days. History of fire setting (not in past year) would be rated here.

2 Occasional or moderate level of aggression towards others including aggression during the past 30 days or more recent verbal aggression.

3 Frequent or dangerous (significant harm) level of aggression to others. Child or youth is an immediate risk to others.

63. SEXUAL AGGRESSION

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

0 No evidence of problems with sexual behavior in the past year.

1 Mild problems of sexually abusive behavior. For example, occasional inappropriate sexually aggressive/harassing language or behavior.

2 Moderate problems with sexually abusive behavior, For example, frequent inappropriate sexual behavior. Frequent disrobing would be rated here only if it was sexually provocative. Frequent inappropriate touching would be rated here.

3 Severe problems with sexually abusive behavior. This would include the rape or sexual abuse of another person involving sexual penetration.

64. RUNAWAY

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

0 This rating is for a child with no history of running away and no ideation involving escaping from the present living situation.

1 This rating is for a child with no recent history or running away but who has expressed ideation about escaping present living situation or treatment. Child may have threatened running away on one or more occasions or have a history (lifetime) of running away but not in the past year.

2 This rating is for a child who has run away from home once or run away from one treatment setting within the past year. Also rated here is a child who has run away to home (parental or relative) in the past year.

3 This rating is for a child who has (1) run away from home and/or treatment settings within the last 7 days or (2) run away from home and/or treatment setting twice or more overnight during the past 30 days. Destination is not a return to home of parent or relative.

65. DELINQUENCY

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

0 Child shows no evidence or has no history of criminal or delinquent behavior.

1 History of criminal or delinquent behavior but none in the past 30 days. Status offenses in the past 30 days would be rated here.

2 Moderate level of criminal activity including a high likelihood of crimes committed in the past 30 days. Examples include vandalism, shoplifting, etc.

3 Serious level of criminal or delinquent activity in the past 30 days. Examples would include car theft, residential burglary, gang involvement, etc.

66. JUDGMENT

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

0 No evidence of problems with judgment or poor decision making that result in harm.

1 History of problems with judgment in which the child makes decisions that are in some way harmful. For example, a child who has a history of hanging out with other children who shoplift.

2 Problems with judgment in which the child makes decisions that are in some way harmful to his/her development and/or well-being.

3 Problems with judgment that place the child at risk of significant physical harm.

67. FIRE SETTING

This item refers to behavior involving the intentional setting of fires that might be dangerous to the child or others. This does not include the use of candles or incense or matches to smoke.

0 No evidence or history of fire setting behavior

1 History or fire-setting but not in past six months

2 Recent fire setting behavior (in past six months) but not of the type that has endangered the lives of others (e.g., playing with matches) OR repeated fire setting behavior over a period of at least two years even if not in the past six months.

3 Acute threat of fire setting. Set fire that endangered the lives of others (e.g., attempting to burn down a house).

68. SOCIAL BEHAVIOR

This rating describes obnoxious social behaviors that a child engages in to intentionally force adults to sanction him/her. This item should reflect problematic social behaviors (socially unacceptable behavior for the culture and community in which he/she lives) that put the child at some risk sanctions (e.g., not excessive shyness).

0 Child shows no evidence of problematic social behaviors.

1 Mild level of problematic social behaviors. This might include occasionally inappropriate social behavior that forces adults to sanction the child. Infrequent inappropriate comments to strangers or unusual behavior in social settings might be included at this level.

2 Moderate level of problematic social behaviors. Social behavior is causing problems in the child's life. Child may be intentionally getting in trouble in school or at home.

3 Severe level of problematic social behaviors. This would be indicated by frequent seriously inappropriate social behavior that force adults to seriously and/or repeatedly sanction the child. Social behaviors are sufficiently severe that they place the child at risk of significant sanctions (e.g., expulsion, removal from the community).

69. SEXUALLY REACTIVE BEHAVIORS

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

0 No evidence of problems with sexually reactive behaviors or high-risk sexual behaviors.

1 Some evidence of sexually reactive behavior. Child may exhibit occasional inappropriate sexual language or behavior, flirts when age-inappropriate, or engages in unprotected sex with single partner. This behavior does not place child at great risk. A history of sexually provocative behavior would be rated here.

2 Moderate problems with sexually reactive behavior that place child at some risk. Child may exhibit more frequent sexually provocative behaviors in a manner that impairs functioning, engage in promiscuous sexual behaviors or have unprotected sex with multiple partners.

3 Significant problems with sexually reactive behaviors. Child exhibits sexual behaviors that place child or others at immediate risk.

Study 2: Questionnaire

Thank you for answering a few questions about yourself. If you are not sure of an answer, it is okay to guess.

1. Name: _____ 2. Age: _____

3. I am: ❒ male ❒ female

4. My first language (the language I spoke growing up) is:

- ❒ English
- ❒ French
- ❒ Other: _____

5. Have you ever lived in:

- ❒ A foster home
- ❒ A group home
- ❒ A residential treatment center
- ❒ A juvenile justice facility
- ❒ Other (please explain): _____

6. The last time you ran away, where were you living? _____

7. How long were you living there before you ran? _____

8. Was this the first time you have run away from there? ❒ Yes ❒ No

9. How many times did you run away from there? _____

10. How old were you when you started living in care? _____

11. How many times have you run away in total? (If you are unsure, please guess.) _____

Thank you!

Study 2: Interview

Note: Brackets represent optional probes that may be utilized to get more information.

Introduction: Thank you for agreeing to participate in this study. This research represents part of a larger study on youth living in foster homes, group homes, residential treatment centres, and juvenile justice facilities. We're interested in hearing from youth about their experiences.

1. Nowadays we hear a lot about runaways in the news, on TV, and in movies. How would you define the word "runaway"? (How long would a person have to be away without permission before you'd call it "running away"?)

2. Where were you living before you ran away? If you've run away more than once, tell me about the last (most recent) place first. (If it's easier to tell it the other way around, starting with the first place you lived, then start there.)

3. Why do you think young people run away from foster care/residential treatment/etc.? (Why did you run?)

4. What kinds of things did staff or foster parents do to prevent you from running away?

5. What did you like about the place? About staff/foster parents?

6. What did you not like about the place? About staff/foster parents?

7. What do you think would have kept you from running away?

8. What would you change about the place where you were living (before you ran away)? (What do you think would make kids want to stay?)

Appendix B

Additional Tables

Correlation Matrices for Study 1a

Table 1

Study 1a Correlation Matrix for Children Aged 6-9 Years (N = 1630)

Variable	1	2	3	4	5	6	7
1. Gender	–	-.036	-.047	-.099	-.078	-.031	-.056
2. Age	-.036	–	-.039	.056	.110	.067	-.162
3. Strengths	-.047	-.039	–	-.371	-.143	.012	-.122
4. Needs	-.099	.056	-.371	–	-.070	-.101	-.145
5. School Attendance	-.078	.110	-.143	-.070	–	.101	-.014
6. Substance Abuse	-.031	.067	.012	-.101	.101	–	-.223
7. Delinquency	-.056	-.162	-.122	-.145	-.014	-.223	–

Table 2

Study 1a Correlation Matrix for Children Aged 10-12 years (N = 1085)

Variable	1	2	3	4	5	6	7
1. Gender	–	.100	.075	-.129	-.003	.028	-.207
2. Age	.100	–	.055	.004	-.047	-.079	-.176
3. Strengths	.075	.055	–	-.411	-.127	-.010	-.087
4. Needs	-.129	.004	-.411	–	-.048	-.135	-.220
5. School Attendance	-.003	-.047	-.127	-.048	–	-.049	-.100
6. Substance Abuse	.028	-.079	-.010	-.135	-.049	–	-.109
7. Delinquency	-.207	-.176	-.087	-.220	-.100	-.109	–

Table 3

Study 1a Correlation Matrix for Youth Aged 13-15 years (N = 1476)

Variable	1	2	3	4	5	6	7	8
1. Gender	–	.093	-.015	-.009	.013	.018	.009	-.283
2. Age	.093	–	.017	.057	.030	-.057	-.140	.003
3. Placement Type	-.015	.017	–	-.073	-.123	.022	-.022	-.080
4. Strengths	-.009	.057	-.073	–	-.400	-.178	.078	.009
5. Needs	.013	.030	-.123	-.400	–	.032	-.201	-.238
6. School Attendance	.018	-.057	.022	-.178	.032	–	-.140	-.108
7. Substance Abuse	.009	-.140	-.022	.078	-.201	-.140	–	-.235
8. Delinquency	-.283	.003	-.080	.009	-.238	-.108	-.235	–

Table 4

Study 1a Correlation Matrix for Youth Aged 16-18 years (N = 820)

Variable	1	2	3	4	5	6	7	8
1. Gender	–	-.002	-.065	.021	-.061	.032	-.074	-.237
2. Age	-.002	–	-.063	-.030	-.019	.022	-.045	.053
3. Placement Type	-.065	-.063	–	-.033	-.093	.044	.017	-.040
4. Strengths	.021	-.030	-.033	–	-.373	-.282	.121	-.071
5. Needs	-.061	-.019	-.093	-.373	–	.030	-.292	-.206
6. School Attendance	.032	.022	.044	-.282	.030	–	-.229	-.081
7. Substance Abuse	-.074	-.045	.017	.121	-.292	-.229	–	-.175
8. Delinquency	-.237	.053	-.040	-.071	-.206	-.081	-.175	–

Correlation Matrices for Study 1b

Table 5

Study 1b Correlation Matrix of Trauma Items for Youth Aged 13-15 Years (N = 1476)

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	–	.098	-.062	.305	-.080	.041	-.020	-.022	.047	-.074	-.040	.001	.027	.050	.000	.027
2	.098	–	.043	.009	.025	.019	-.007	-.032	.024	-.013	.011	-.031	-.027	-.021	.000	.037
3	-.062	.043	–	-.006	-.020	.036	-.011	.008	.052	-.032	-.034	-.005	-.063	.019	.000	-.001
4	.305	.009	-.006	–	-.060	-.134	.034	-.013	.005	.010	.035	.023	-.040	.063	.000	-.075
5	-.080	.025	-.020	-.060	–	-.468	.069	-.033	-.249	-.006	-.030	-.004	-.013	-.031	.000	.023
6	.041	.019	.036	-.134	-.468	–	-.151	-.026	-.121	.048	-.008	-.025	-.050	-.021	.000	.029
7	-.020	-.007	-.011	.034	.069	-.151	–	-.092	-.110	-.044	-.031	.032	-.160	-.026	.000	-.100
8	-.022	-.032	.008	-.013	-.033	-.026	-.092	–	.005	-.059	.009	-.073	-.049	-.018	.000	-.010
9	.047	.024	.052	.005	-.249	-.121	-.110	.005	–	-.018	-.051	-.056	.005	.036	.000	-.218
10	-.074	-.013	-.032	.010	-.006	.048	-.044	-.059	-.018	–	-.394	-.002	-.047	.009	.000	-.291
11	-.040	.011	-.034	.035	-.030	-.008	-.031	.009	-.051	-.394	–	.020	-.060	.018	.000	-.009
12	.001	-.031	-.005	.023	-.004	-.025	.032	-.073	-.056	-.002	.020	–	.003	.007	.000	-.023
13	.027	-.027	-.063	-.040	-.013	-.050	-.160	-.049	.005	-.047	-.060	.003	–	-.030	.000	-.039
14	.050	-.021	.019	.063	-.031	-.021	-.026	-.018	.036	.009	.018	.007	-.030	–	.000	.024
15	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	–	.000
16	.027	.037	-.001	-.075	.023	.029	-.100	-.010	-.218	-.291	-.009	-.023	-.039	.024	.000	–

Variables: (1) Gender (2) Age (3) Placement Type (4) Sexual Abuse (5) Physical Abuse (6) Emotional Abuse (7) Neglect (8) Medical Trauma (9) Witness to Family Violence (10) Community Violence (11) School Violence (12) Natural or Manmade Disasters (13) Traumatic Grief/Separation (14) War Affected (15) Terrorism Affected (16) Witness/Victim to Criminal Activity

Table 6

Study 1b Correlation Matrix of Trauma Items for Youth Aged 16-18 Years (N = 820)

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	–	.007	-.067	.241	-.029	.107	-.096	-.058	.003	-.074	-.018	.032	-.014	.000	-.028	-.005
2	.007	–	-.037	-.003	-.080	.041	-.088	-.076	.105	.001	.028	.035	-.040	.000	-.025	-.018
3	-.067	-.037	–	-.002	.001	.002	.005	-.042	-.020	-.015	.003	-.073	-.049	.000	.030	-.077
4	.241	-.003	-.002	–	-.022	-.082	.040	-.036	.019	.043	-.001	-.022	.020	.000	.018	-.144
5	-.029	-.080	.001	-.022	–	-.395	.050	-.041	-.228	.030	-.030	-.038	.040	.000	.028	-.047
6	.107	.041	.002	-.082	-.395	–	-.174	.020	-.078	.020	-.006	-.017	-.093	.000	-.009	-.014
7	-.096	-.088	.005	.040	.050	-.174	–	-.013	-.099	-.067	-.053	-.006	-.171	.000	.071	-.104
8	-.058	-.076	-.042	-.036	-.041	.020	-.013	–	.052	-.067	-.085	-.023	-.080	.000	.005	-.075
9	.003	.105	-.020	.019	-.228	-.078	-.099	.052	–	-.006	-.064	.003	-.057	.000	.039	-.143
10	-.074	.001	-.015	.043	.030	.020	-.067	-.067	-.006	–	-.361	.015	-.050	.000	.048	-.277
11	-.018	.028	.003	-.001	-.030	-.006	-.053	-.085	-.064	-.361	–	.014	-.022	.000	-.003	.062
12	.032	.035	-.073	-.022	-.038	-.017	-.006	-.023	.003	.015	.014	–	-.022	.000	-.051	-.016
13	-.014	-.040	-.049	.020	.040	-.093	-.171	-.080	-.057	-.050	-.022	-.022	–	.000	-.016	-.032
14	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	–	.000	.000
15	-.028	-.025	.030	.018	.028	-.009	.071	.005	.039	.048	-.003	-.051	-.016	.000	–	-.139
16	-.005	-.018	-.077	-.144	-.047	-.014	-.104	-.075	-.143	-.277	.062	-.016	-.032	.000	-.139	–

Variables: (1) Gender (2) Age (3) Placement Type (4) Sexual Abuse (5) Physical Abuse (6) Emotional Abuse (7) Neglect (8) Medical Trauma (9) Witness to Family Violence (10) Community Violence (11) School Violence (12) Natural or Manmade Disasters (13) Traumatic Grief/Separation (14) War Affected (15) Terrorism Affected (16) Witness/Victim to Criminal Activity

Table 7

Study 1b Correlation Matrix of Strengths Items for Youth Aged 13-15 Years (N = 1476)

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Gender	–	.096	-.051	.083	-.091	-.076	.001	.036	.038	.030	-.039	-.045	.030
2. Age	.096	–	.022	-.019	.036	.004	.080	-.019	.029	-.001	-.004	-.013	-.011
3. Placement Type	-.051	.022	–	.049	-.084	-.041	-.072	-.033	.036	.011	.021	-.075	-.004
4. Family	.083	-.019	.049	–	-.096	-.025	-.013	-.022	-.041	.038	-.033	-.001	-.343
5. Interpersonal	-.091	.036	-.084	-.096	–	-.109	-.047	-.323	-.185	-.065	.085	-.116	-.002
6. Educational	-.076	.004	-.041	-.025	-.109	–	-.023	-.059	-.002	-.094	-.097	-.042	-.007
7. Vocational	.001	.080	-.072	-.013	-.047	-.023	–	-.016	-.037	-.089	-.136	.016	.052
8. Well-being	.036	-.019	-.033	-.022	-.323	-.059	-.016	–	-.344	-.088	.003	-.054	-.138
9. Optimism	.038	.029	.036	-.041	-.185	-.002	-.037	-.344	–	-.215	-.127	-.002	.019
10. Talents/ Interests	.030	-.001	.011	.038	-.065	-.094	-.089	-.088	-.215	–	-.144	-.269	.002
11. Spiritual/ Religious	-.039	-.004	.021	-.033	.085	-.097	-.136	.003	-.127	-.144	–	-.331	-.095
12. Community Life	-.045	-.013	-.075	-.001	-.116	-.042	.016	-.054	-.002	-.269	-.331	–	-.149
13. Relationship Permanence	.030	-.011	-.004	-.343	-.002	-.007	.052	-.138	.019	.002	-.095	-.149	–

Table 8

Study 1b Correlation Matrix of Strengths Items for Youth Aged 16-18 Years (N = 820)

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Gender	–	-.014	-.091	.045	-.043	-.118	-.033	.093	-.065	.064	-.030	.017	-.076
2. Age	-.014	–	-.042	.058	-.017	-.038	.099	-.043	.093	-.096	.073	-.055	-.108
3. Placement Type	-.091	-.042	–	-.010	-.018	-.001	.059	-.015	-.082	-.005	.059	-.058	.052
4. Family	.045	.058	-.010	–	-.075	-.030	-.030	-.118	.030	.050	-.012	-.016	-.338
5. Interpersonal	-.043	-.017	-.018	-.075	–	-.059	-.040	-.315	-.191	-.022	.022	-.048	-.054
6. Educational	-.118	-.038	-.001	-.030	-.059	–	-.168	-.082	.008	-.083	-.028	-.088	-.016
7. Vocational	-.033	.099	.059	-.030	-.040	-.168	–	-.048	-.136	-.104	-.083	.012	.006
8. Well-being	.093	-.043	-.015	-.118	-.315	-.082	-.048	–	-.364	-.032	-.070	-.094	-.048
9. Optimism	-.065	.093	-.082	.030	-.191	.008	-.136	-.364	–	-.210	-.050	-.018	.001
10. Talents/ Interests	.064	-.096	-.005	.050	-.022	-.083	-.104	-.032	-.210	–	-.228	-.250	-.043
11. Spiritual/ Religious	-.030	.073	.059	-.012	.022	-.028	-.083	-.070	-.050	-.228	–	-.323	-.033
12. Community Life	.017	-.055	-.058	-.016	-.048	-.088	.012	-.094	-.018	-.250	-.323	–	-.131
13. Relationship Permanence	-.076	-.108	.052	-.338	-.054	-.016	.006	-.048	.001	-.043	-.033	-.131	–

Additional Tables for Study 1b

Youth Aged 13-15 Years

Table 9

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Strengths, Sexual Abuse, and Runaway Risk Among Youth Aged 13-15 Years (N = 1476)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	.018	.122	.021	.884	1.018	.801-1.293
Age	.379	.072	27.470	.001**	1.460	1.267-1.682
Placement Type	.914	.172	28.150	.001**	2.495	1.780-3.497
Strengths	.103	.013	60.072	.001**	1.108	1.080-1.138
Sexual Abuse	.154	.170	.820	.365	1.167	.836-1.628
Strengths X Sexual Abuse	-.002	.011	.024	.876	.998	.977-1.020

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

Table 10

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Strengths, Physical Abuse, and Runaway Risk Among Youth Aged 13-15 Years (N = 1476)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.071	.116	.369	.543	.932	.742-1.170
Age	.388	.073	28.481	.001**	1.475	1.279-1.701
Placement Type	.924	.173	28.536	.001**	2.518	1.795-3.534
Strengths	.101	.016	40.752	.001**	1.106	1.072-1.141
Physical Abuse	.293	.173	2.874	.090	1.341	.955-1.882
Strengths X Physical Abuse	-.002	.012	.031	.860	.998	.976-1.021

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

Table 11

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Strengths, Family Violence, and Runaway Risk Among Youth Aged 13-15 Years (N = 1476)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.083	.116	.516	.473	.920	.733-1.155
Age	.368	.072	25.776	.001**	1.444	1.253-1.665
Placement Type	.871	.173	25.370	.001**	2.389	1.702-3.352
Strengths	.110	.015	51.414	.001**	1.116	1.083-1.150
Family Violence	-.166	.166	.997	.318	.847	.612-1.173
Strengths X Family Violence	-.001	.011	.007	.933	.999	.978-1.021

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

Table 12

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Strengths, Community Violence, and Runaway Risk Among Youth Aged 13-15 Years (N = 1476)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.106	.116	.836	.361	.899	.716-1.129
Age	.375	.073	26.771	.001**	1.455	1.263-1.678
Placement Type	.874	.173	25.444	.001**	2.398	1.707-3.368
Strengths	.095	.012	60.805	.001**	1.100	1.074-1.126
Community Violence	.235	.292	.648	.421	1.265	.714-2.244
Strengths X Community Violence	.006	.018	.127	.722	1.006	.972-1.042

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

Table 13

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Strengths, School Violence, and Runaway Risk Among Youth Aged 13-15 Years (N = 1476)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.115	.117	.966	.326	.892	.710-1.121
Age	.378	.073	26.988	.001**	1.460	1.266-1.684
Placement Type	.864	.175	24.511	.001**	2.373	1.685-3.340
Strengths	.088	.012	54.679	.001**	1.092	1.067-1.118
School Violence	-.005	.366	.000	.989	.995	.486-2.039
Strengths X School Violence	.035	.023	2.321	.128	1.036	.990-1.083

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

Table 14

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Strengths, Traumatic Grief/Separation, and Runaway Risk Among Youth Aged 13-15 Years (N = 1476)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.057	.115	.246	.620	.944	.753-1.184
Age	.375	.072	26.941	.001**	1.455	1.263-1.676
Placement Type	.904	.172	27.588	.001**	2.470	1.763-3.462
Strengths	.113	.018	37.917	.001**	1.120	1.080-1.161
Traumatic Grief/Separation	.232	.188	1.519	.218	1.261	.872-1.822
Strengths X Traumatic Grief/Separation	-.010	.012	.655	.418	.990	.967-1.014

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

Youth Aged 16-18 Years

Table 15

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Strengths, Sexual Abuse, and Runaway Risk Among Youth Aged 16-18 Years (N = 820)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.191	.157	1.491	.222	.826	.607-1.123
Age	-.237	.138	2.932	.087	.789	.602-1.035
Placement Type	1.048	.238	19.316	.001**	2.851	1.787-4.550
Strengths	.095	.016	35.923	.001**	1.099	1.066-1.134
Sexual Abuse	.065	.204	.101	.751	1.067	.716-1.591
Strengths X Sexual Abuse	.012	.014	.729	.393	1.012	.985-1.040

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

Table 16

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Strengths, Physical Abuse, and Runaway Risk Among Youth Aged 16-18 Years (N = 820)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.283	.152	3.432	.064	.754	.559-1.017
Age	-.256	.139	3.404	.065	.774	.590-1.016
Placement Type	1.018	.241	17.868	.001**	2.769	1.727-4.440
Strengths	.090	.017	26.955	.001**	1.094	1.058-1.132
Physical Abuse	.160	.209	.585	.444	1.174	.779-1.769
Strengths X Physical Abuse	.011	.014	.619	.432	1.011	.983-1.041

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

Table 17

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Strengths, School Violence, and Runaway Risk Among Youth Aged 16-18 Years (N = 820)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.340	.153	4.935	.026*	.712	.527-.961
Age	-.236	.139	2.877	.090	.790	.602-1.037
Placement Type	1.040	.241	18.688	.001**	2.828	1.765-4.532
Strengths	.107	.015	53.890	.001**	1.113	1.082-1.145
School Violence	1.180	.395	8.899	.003*	3.254	1.499-7.063
Strengths X School Violence	-.045	.024	3.381	.066	.956	.912-1.003

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

Table 18

Betas, Standard Errors (SE), Wald Statistics, Odds Ratios (OR), and Confidence Intervals (CI) for Variables in the Predictive Model Examining Strengths, Traumatic Grief/Separation, and Runaway Risk Among Youth Aged 16-18 Years (N = 820)

Predictor	*ß*	SE	Wald	*p*	OR	95% CI
Gender	-.304	.152	4.021	.045*	.738	.548-.993
Age	-.255	.138	3.435	.064	.775	.591-1.015
Placement Type	1.044	.240	18.973	.001**	2.842	1.776-4.546
Strengths	.114	.022	26.780	.001**	1.121	1.074-1.171
Traumatic Grief/Separation	.420	.211	3.941	.047*	1.522	1.005-2.303
Strengths X Traumatic Grief/Separation	-.015	.014	1.028	.311	.985	.958-1.014

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

Appendix C

Consent Form

INFORMED CONSENT STATEMENT

Title of the study: Experiences of Homeless Youth Who Run Away From Care

Principal Investigators: Andrea Byrne, M.A., Ph.D. Candidate
John Lyons, Ph.D., C.Psych.

Invitation to Participate: You are being asked to be part of a research study. The information in this consent form explains what this study is about, including the risks and benefits of participating, and how your information will be handled. Please read it carefully and feel free to ask any questions that you might have.

What is the study about?

The purpose of this study is to explore the experiences of youth who have run away from substitute care (meaning foster homes, group homes, residential treatment centres, or juvenile justice facilities). We would like to know more about the experiences of youth before and after running away from care.

What is my role in the study?

For this study, we are asking you to complete a short questionnaire and participate in an interview. The interview should take around 15-30 minutes. Before the interview, we will ask you to complete a questionnaire that will take around 5 minutes to complete. During the interview, you will be asked about your experiences before and after running away from care. You do not have to answer every question. Your interview will be audiotaped and transcribed (typed up). To thank you for your time, you will be offered $5. If you have any questions before, during, or after, please feel free to ask.

Why should I participate?

Your opinions are very important. Although this study does not offer any direct benefit to you, we hope that studies like this one will help us to better understand why youth run away from care.

Are there any risks to my participating?

It is possible that some questions may make you feel uncomfortable, but please remember that you do not have to answer all the questions if you do not want to. You may feel upset talking about some of your past experiences however you are free to decide if you want to talk. You can end your participation in the study at any time without having to explain. Your answers will be kept private and confidential by the researchers.

How will my information be handled?

Your information will be kept **strictly confidential** within the limits of the law. In reporting results, your answers will be combined with those of all the other people we interview. If something you say in the interview is used, it will be reported in such a way that no one will be able to identify you.

We will maintain the privacy of your answers by never using your name in reports written based on this study. Audio files and transcripts will be password protected and kept in a secure location in a locked office at the University of Ottawa. Only members of the research team will have access to the data. As an additional safety measure, the consent forms will be stored separately from collected data.

By law, we must break confidentiality under the following conditions: if a participant discloses that they intend to harm themselves or others, or they disclose that they or someone they know under the age of 16 is currently being abused. In this case, the investigator(s) will be required to disclose this information to the Children's Aid Society and provide the participant with access to help. In addition, there will be a service provider available at all times during the sessions (either in person or by phone) should any participant need to follow up with any issues following the interview.

Do I have to participate?

No. You do not have to participate. Participating in this study is ***voluntary***. You may refuse to answer any question. You may end your participation at any time. If you choose to withdraw, it will not affect the services you are receiving.

Who do I contact if I have questions about my rights as a participant in this study?

If you have any questions, you can contact the study investigators: Andrea Byrne or Dr. John Lyons at [contact information]. If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa at [contact information].

Informed Consent

Name of participant: _____

I have read all the information provided above. I voluntarily agree to participate in this study. I understand that this interview will be audio taped. I am aware that I can withdraw my consent at any time without penalty. I have received one copy of this consent form, which I may keep. The study investigators will keep the other copy.

Signature of participant: _____ Date: _____

Signature of investigator: _____ Date: _____

Signature of witness: _____ Date: _____