LOOKING AFTER CHILDREN IN YUKON

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ABSTRACT

Children raised in government care by "corporate parents" have a right to the same level of care as is expected by "good parents" in community. Looking After Children (LAC) is a research initiative that began in England for the purpose of assessing the developmental growth of children raised in care across seven developmental dimensions. In this Yukon study, all Whitehorse resident children in permanent government care from age 1-9 years were assessed using the LAC Assessment and Action Records. In addition to establishing a baseline data base of the developmental needs of children in care, the study also examined the experience of social worker and foster parent participants in using the LAC materials to help inform the ongoing development of the assessment strategy. The study also resulted in the formulation of thirty policy and practice recommendations.

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Looking After Children in Yukon occurred as an effort to improve the lives and parenting provided to many children who grow up in care in Yukon. It was also intended to assist social workers and foster parents who work so hard to provide for the children in care with a way of both documenting and tracking the progress of the children they care for. There are so many people to thank whom through their support, enthusiasm, expertise and direction, contributed to ensuring that this study occurred.

There is one young man with whom I am forever grateful. He was a child in care named Brian and it was Brian's comfort with my informal use of the LAC materials with him and the ease with which he answered my questions that actually led to the LAC in Yukon study many years later.

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CHAPTER ONE

Introduction

In 2000, there were approximately 76,000 children in Canada living in out-of-home care for their safety and protection (Farris-Manning & Zandstra, 2003). Despite an increased emphasis on family reunification[1] and prevention services, Trocmé and Chamberland (2003) recently reported at the 4th National Child Welfare Symposium held in Banff, Alberta, that child protection investigations are on the rise, the number of children in care is increasing and more and more of the children in care are First Nations. While children generally are brought into government care on grounds of abuse, neglect, and abandonment (Farris-Manning & Zandstra, 2003), a growing number of children prenatally exposed to illegal drugs, alcohol, and HIV/AIDS are being placed under government care because their specialized medical requirements extend beyond the parenting capacity of their families (Child Welfare League of America, 2003).

For the majority of children who come into contact with child welfare, the experience of being "in care" is of a temporary nature. Yet, for a significant number of children, the experience is permanent. In fact, the number of permanent guardians[2] of the government is estimated by the Adoption Council of Canada to be around 20,000 (Farris-

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[1] The reunification of children in foster care with their biological parents whenever possible, within the larger context of efforts to achieve permanent and safe living conditions for children.

[2] The concept of *parens patriae* is fundamental in any discussion of law respecting children. This term, which in Latin literally means "father of the country or government as parent" refers to a rule, derived from the English common law, empowering the monarch to act as guardian and protector of persons. Under the authority of this doctrine the court may act as a substitute benevolent parent on behalf of the state (Wharf, 1993).

Manning & Zandstra, 2003). In other words, over 20,000 Canadian children are being raised by corporate parents. In Canada, the responsibility for child welfare services lies with each of the 10 provincial and three territorial governments. Each province and territory has its own legislation that outlines the range and extent of child protection services and provides the mandate for policy and program development. In addition, Aboriginal authorities[3] are legally mandated to deliver the full range of child welfare services under the Federal First Nations Child and Family Services Program[4].

The Well-Being of Children Raised in Care

While the principles of child safety and well-being jointly form the basis of child welfare legislation across Canada, it is child safety or the protection of children that has historically been the major focus of child welfare services and research (Trocme & Chamberland, 2003). There has been extensive research on how and why children come into care (Trocme & Wolfe, 2001), their experiences while in care (Fahlberg, 1991; Francis, 2000; Klee, Soman, & Halfon, 1992; Kufeldt, Simard, & Vachon, 2000; Parker,

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[3] For the purpose of this paper, the term "Aboriginal Authorities" is used to describe both off-reserve Aboriginal Agencies such as the Vancouver Child and Family Services Society mandated in 2001 and First Nations on reserve Child and Family Caring Agencies.

[4] In 1991, a national First Nations Child and Family Services program was established by Indian Northern Affairs Canada (INAC) under the authority of Cabinet. Under this program, First Nation Child and Family Services agencies provide services for children who are registered and ordinarily resident on reserve. These agencies receive their legal mandate from their respective provincial/territorial government and function as agencies of these governments, while receiving their funding through INAC. In 1997-1998, there were 79 First Nations Child & Family Services agencies delivering services to over 70% of on-reserve children and youth across Canada, from birth to 18 years of age. None are in Yukon. For additional information see INAC's web site http://www.ainc-inac.gc.ca/pr/pub/ywtk/sgp01_e.html.

Ward, Jackson, Aldgate, & Wedge, 1991; Sawyer & Dubowitz, 1994; Stein, 1997), and the life course outcomes for children who are raised in government care (Cheung & Heath 1994; Heath, Colton, & Algate, 1994; Kufeldt et al., 2000; Simms & Halfon, 1994). However, it is only recently that the principle of child well-being and questions regarding the developmental progress of children raised in care have gained the attention of researchers in the area of child welfare.

According to Jackson (1998, p. 50), while there has been little research done on the well-being of children raised in care, there is ample evidence to suggest that "the parenting provided by local authorities [to children in care] has been grossly deficient and, unlike lower income parents, the local authority, does not lack power and resources." In a discussion paper commissioned by the National Children's Alliance of Canada to advance recommendations for future research and policy development in child welfare, Farris-Manning and Zandstra (2003) purposely pointed out in its concluding remarks that:

> ...children in care have a right to the same opportunities as children who are not in public care in order to develop into responsive, well educated, well balanced adults. The UN *Convention on the Rights of the Child [my emphasis]* ensures that they receive adequate care to facilitate their growth (UN, 1989), and child welfare policies and practices in Canada should be designed to meet those primary goals. To date, Canada does not have a national strategy concerning the provision of child protection services. The provinces, territories and First Nations have established commendable programs and strategies within their own jurisdictions, but it is evident that timely research is required to facilitate the development of

> national standards and strategies, which will ensure equal opportunities for all of Canada's children. (p.13)

In the same way as society expects "good" parents to be responsible for far more than just the safety of their children, Kufeldt and Theriault (1995, p. 362) assert that this same expectation should extend to corporate parent "To be successful the state" as corporate parent " must understand parenting and the business of raising children." Moreover, the continued protection and support given to children raised in care must be guided by scientific information that includes both the evaluation of child welfare services and intervention programs as well as the ongoing assessment of the developmental progress of children governments have responsibility over (Kufeldt & Theriault, 1995). So how do governments raise children? What are the additional challenges of corporate parents? How do corporate parents assess and monitor the progress of children under their care? These are important questions worthy of investigative consideration.

The Looking After Children Project

In 1984, researchers in England began to look closely at the question of how "looked after children" were being cared for. These efforts were the beginning of the Looking After Children (LAC) project (Parker et al., 1991). LAC is predicated on the premise that children removed from the care of their birth family by the courts deserve to have their developmental needs addressed in the same way as those of other children in the community. The LAC approach was first introduced in the United Kingdom in 1991 as a tool to monitor the developmental progress and overall well-being of children in government care. Advocates of LAC argue that birth parents, children in care themselves, social workers, and governments are all equally entitled to indications that the job of raising children is being done better than had they not come into care (Jackson, Fischer, & Ward, 1996).

In an effort to provide a means of obtaining this information, the LAC project developed a practice and research protocol called the Assessment and Action Record (AAR). The AAR was designed to assess the development of children and youth across seven developmental dimensions in which development growth occurs. These include health, education, social presentation, family and social relationships, identity, emotional and behavioral development, and self care skills. The dimensions are not exclusive of each other as they often interact and overlap and are intended to reflect the areas of growth that would be monitored naturally by adequately-resourced parents on their own children (Jackson, 1995; Ward, 1995).

The AAR was first piloted with parents of children outside of government care and proved to be an accurate reflection of the informal monitoring done by most parents (Jackson, 1995; Kufeldt et al., 2000; Parker et al., 1991; Ward, 1995). It was then piloted in England with children in care with results that were also promising (Jackson et al., 1996; Kufeldt et al., 2000). Child welfare authorities were able to assess and identify how children were progressing developmentally and determine what areas required further attention. These same studies also found that using the AAR over time actually improved the care children received by acting upon areas where needs were identified (Jackson, 1995; Jackson et al., 1996; Jones, Clark, Kufeldt, & Norman, 1998; Kufeldt et al., 2000; Parker et al., 1991; Ward, 1995). Caregivers and children in care reported that using the materials helped to identify what their needs were, where they had strengths, and what developmental areas needed attention (Jones et al., 1998; Kufeldt et al., 2000).

LAC extends the practice of providing child welfare services beyond a child protection model, which has traditionally maintained a very narrow focus on child safety, to a much broader child well-being focus that gives much more emphasis on the developmental progress of a child in care on an ongoing basis (Kufeldt & Theriault, 1995). Jackson, as cited in Kufeldt and Theriault (1995, p. 363), explains that the philosophy of LAC is based on "the established relationship between quality of parenting, children's developmental needs, and life course outcomes."

LAC has emerged into an international program with its adoption in Australia, various European countries, and Canada (Jackson et. al., 1996; Jones, Clarke, Kufeldt, & Norman, 1998; Kufeldt, et al., 2000; Owen, Jones, & Corrick, 1998; Vachon, Nadeau, Simard, & Kufeldt, 2000; Wheelaghan, Hill, Borland, Lambent, & Triseliotis, 1999; Wise, 1999).

Looking After Children in Canada

In Canada, nine of the provincial/territorial child welfare jurisdictions, including the Yukon, are involved in a national LAC Initiative. Various pilot and implementation initiatives have occurred across the country over the past seven years. In 1997, a pilot study utilizing test sites in the six eastern-most provinces in Canada including Prince Edward Island, Nova Scotia, New Brunswick, Newfoundland, Quebec and Ontario was undertaken (Kufeldt et al., 2000). In this study, Kufeldt studied the developmental progress of 263 children and youth in care using the AARs. This study also included a comparison sample of 45 non-care children and youth. Kufeldt's study, along with a parallel study implemented in Ontario, helped to inform the development of the Canadian LAC initiative (CanLAC) in fall 2001, led by the Child Welfare League of Canada. The province of British Columbia had previously obtained a separate license to implement its own LAC program. Although British Columbia developed a slightly modified version of the AARs to reflect their provincial child welfare legislation, the province is a participant in the national CanLAC initiative.

A newer "Canadianized" version of the AAR has now been designed to promote a national approach to assessing, monitoring and planning for children in care that is consistent across the country. Ongoing revisions to the AAR have incorporated standardized measures directly comparable to those of the National Longitudinal Survey of Children and Youth (NLSCY) that reports on the health and well-being of Canadian children and families (Brink & McKeller, 2000). Copyright protection and the need to purchase a license to use the materials prevent major modifications to the AAR. Some adaptations have been approved to reflect the Canadian context.

The Yukon Context

In Yukon, the developmental progress of children in care is assessed much like that of a parent in the community—that is, informally. While there are many practice procedures that are followed to address some of the developmental needs of a child in care such as yearly medicals, mandated plans of care and yearly reviews of the progress of a child in care, there are no specific method of assessing the developmental progress of a group of children in care on a formal basis.

As of March 1999, 60% of the 182 children in government care were in the permanent care and custody of the Director of Child Welfare (Child Welfare in Canada, 2000). In other words, the Director is their "parent" and is committed to either identifying adoptive families to raise them to adulthood, or raising them in long-term foster homes or residential care. However, there were only six agency adoptions of Yukon children under the Director's care in 1997, five in 1996 and two in 1994. Given this small number of finalized adoptions, being raised in government care is a very likely outcome for the majority of Yukon's children in permanent care (Department of Health and Social Services, 2000). With few opportunities for adoption and, to date, only a handful of revocations of a permanent care order (where children may be returned to their birth family), the majority of children committed to permanent care will remain in government care up to the age of majority (19 years of age in Yukon). So what is the developmental progress of Yukon children being raised in care? Do we know how these children are doing? Do we know the impacts of the child welfare interventions on the life course outcomes for the many children who grow up in care in the Yukon? To date, there have been no studies assessing the developmental status of Yukon children in care. Currently, there are no clear ways to measure whether the corporate parenting being provided to Yukon children in care has any impact on their developmental progress.

Yukon has been following the developments of LAC project informally since 1994. As a social worker directly involved with children in permanent care in Whitehorse since 1985, I began to informally experiment with the protocols as part of my case management responsibilities. In particular, I started with one child who had moved to Whitehorse at the age 16 and was assigned to my caseload. I did not know the youth very well but had to develop a plan of care with him and his relative foster parents. I reviewed the English version of the AAR for his age group and the materials provided me with a comprehensive overview and questions to ask the youth and his caregivers about how he was doing across the seven dimensions. The questions covered all of the areas that I as a parent would attend to with my own children. The questions went further than that and asked about long terms plans, goals, skills needed to learn, whether the child felt discriminated against and what the youth knew about his life experiences. Once completed, the assessment identified areas of strength for the youth and areas that needed to be attended to. Tasks to complete were then assigned to various members of the care team, including the youth. The resulting plan of care meeting went smoothly, and was very informative for me and for the caregivers, and the youth appeared to be comfortable with the questions he was asked. The questions prompted easy conversation and, through the discussion that ensued, we were able to develop a comprehensive plan of care.

I used the materials from the AARs with other children I worked with and had similar results. I also shared the AAR and the LAC philosophy of assessing and monitoring children's developmental progress with other social workers, my supervisor, foster parents and youth, receiving positive feedback from all involved. The seven dimensions of the protocols gave social workers and foster parents a consistent and thorough framework that was useful in assessing and identifying the developmental needs of children and youth as well as for developing a child's plan of care. It was this informal use that led me to propose a LAC in Yukon study.

Purpose of Research

LAC in Yukon is the first study in the Yukon designed specifically to evaluate the developmental progress of Yukon children under government care. The study had two main objectives:

1. To further the implementation of a promising, innovative approach to assessing and meeting the developmental needs of children raised in government care.
2. To model the teamwork approach required to parent a child in care by involving social workers and foster parents as collaborative partners in the research process.

Drawing upon quantitative and qualitative methods, the study examines the developmental well-being of children in permanent care along seven developmental dimensions using the Looking After Children Assessment and Action Records Version 1 (see Appendix A to view the Health dimension component of the AAR for the 5-9 year old age grouping). In addition to providing a snapshot of how these children are doing developmentally, the data obtained will provide a baseline measure to help guide future case management practices as well as inform program and policy development.

Statement of Research Question

The specific research questions to be addressed in this study are:

1. What is the current developmental status across the seven LAC developmental dimensions of Yukon children in permanent care from birth to age nine and who are residing in Whitehorse?
2. What is the experience of the social worker and foster parent participants involved in the research in regards to the perceived usefulness and appropriateness of the LAC AAR protocols for Yukon children in care?
3. Do the AARs have an impact on social worker and foster parent practice with children in care?

CHAPTER TWO

Literature Review

This chapter will include a review of the literature in relation to (a) family and parenting styles and their influence on the developmental needs of children, (b) issues of parenting children who are raised in government care, (c) the developmental needs of children in care, and (d) the Looking After Children international program designed to assess and attend to the developmental needs of children raised in government care.

Parenting and the Developmental Needs of Children

The question of whether parenting matters is well researched in the literature. While there is no single manual given to parents upon the birth of their children that shows them how to do the job correctly, and there is no guarantee that children raised in certain ways by certain family types will turn out "right", there is ample research to suggest that above all, it is the type of parenting that "determines the quality of a young child's world and shape(s) the foundations for later development" (Health Canada, 2003, p. 1).

According to ecological systems theory (recently renamed bioecological system theory), a child's development occurs through a complex interplay of many influences, which include the natural endowment of genetics and personality and the environmental conditions he or she is exposed to throughout childhood (Bronfenbrenner, 1986). The leading proponent of ecological systems theory, Urie Bronfenbrenner (2002, p. 1), says that the most immediate and earliest influence on child development "is the family, followed by the neighborhoods or community institutions such as school, religious instructions and peer group as well as the specific culture with which the family identifies." According to Bronfenbrenner, there are two environmental conditions that are necessary for human development. The first is that one or more adults must love the child unconditionally; the second is that the adults must encourage the child and spend time doing joint activities with the child in and out of the home environment.

Bronfenbrenner refers to the child as being in a nested environment. The child, who contains various systems within him or her, is at the center of the nest, surrounded by layers of individuals and groups of individuals. The child is the egg nested within the other environments, which are also nested within each other. Another way to describe it is in terms of a rock being thrown into the water: the rock in the middle is the child and the ripple effects around that rock are the other nested environments. The parents, teachers and anyone in a close relationship with the child for a substantial amount of time are in the first ripple, called the microsystem. The people in the microsystem have the most immediate effect on the child. The implications of this theory for children in government care are huge considering the large number of placements that children in care typically experience.

Loving a child and responding to his or her needs forms the basis of attachment, a critical process in human relationships that has significant impacts on the future for human beings. For Benoit (teleconference, September 17, 2002), "the role of parents as attachment figures may be the most influential role in predicting socio-emotional outcome for children." Attachment occurs when a child expresses a need, and that need is understood and attended to by responsive and nurturing caregivers. Attachment refers to characteristics of the relationship between the child and the caregiver and because children can develop attachment relationships to a neglectful and abusive caregiver, it is the quality of the attachment that is important in child welfare (Benoit, 2003). According to Allen and Marotz (1994):

> All children, whether normal, handicapped or at-risk for developmental problems, have a number of physical and psychological needs. These needs must be met if infants and children are to survive, thrive and develop to their optimum potential. Many developmental psychologists view the early years as the most critical in the entire developmental life span. Never again will the child be so totally dependent upon parents, caregivers and teachers to satisfy the basic needs of life and to provide opportunities for learning. (p. 1)

Further to the significance of family on child development outcomes, many studies suggest that parenting styles are significantly important in predicting child well being (Darling, 1999; Health Canada, 2003; Stein, 2004). According to the Canadian Institute of Child Health (2000, p. 200), "parenting is one key contributor to the mental and emotional health and well-being of children and youth."

According to Maccoby and Martin (1983), parenting style captures two important elements of parenting: parental responsiveness and parental demandingness. Parental responsiveness refers to "the extent to which parents intentionally foster individuality, self-regulation, and self-assertion by being attuned, supportive, and acquiescent to children's special needs and demands" (Baumrind, 1991, p. 62). Parental demandingness refers to "the claims parents make on children to become integrated into the family whole, by their maturity demands, supervision, disciplinary efforts and willingness to confront the child who disobeys" (Baumrind, 1991, pp. 61-62).

Baumrind's widely recognized conceptual model deals with parenting prototypes, including the concepts of authoritative, authoritarian, permissive, and rejecting/neglecting styles of parenting (Baumrind, 1966, 1968, 1989, 1991). Her work has been widely discussed and incorporated into the research of many other investigators. Building upon the work of Baumrind, Darling (1999) supported the conclusion arrived at by Baumrind that parents who exert a democratic or authoritative style of parenting, which balances realistic demands and expectations with emotional responsiveness and recognition of child autonomy, provide the most desirable child-rearing environment and have the most positive impact on a child's well-being. Likewise, Wilms study (as cited in The Health of Canada's Children, 2000):

> determined that young children whose parents employed permissive-irrational parenting styles were significantly more likely to have emotional or behavioral problems than children whose parents employed authoritarian, permissive or authoritative styles. The lowest prevalence of problems [during the pre-school years] was found among children with authoritative parents. (p.60)

In addition to providing children with structure, consistency, love, caring, and discipline, researchers have also found that the time parents spend with their children as well as the parents' own well-being plays a key role in positive child outcomes (Health Canada, 2003). According to Jackson, Fischer, and Ward (1996):

> parenting is a process which most parents learn as they go along, with help from relatives, friends, the media, health professionals and teachers. Although there are wide variations in parenting practices, there is reliable research findings which show that warmth, consistent but authoritative parenting with much praise and

> emphasis on positives achieves the best results. This knowledge…is incorporated into the Assessment and Action records. (p. 9)

Conversely, there is ample research and evidence to suggest that children raised in out-of-home care or in institutional care, without the benefit of family-based parenting, sustain lifelong effects, and some never escape those effects. During the residential school era, for example, many First Nations children were taken from their parents at the age of five and placed in residential schools (Kelm, 1998). Not only were many of these children deprived of positive parental influences, but they did not have the opportunity to learn parenting practices for fulfilling their own parenting responsibilities (Canada, 1996).

In *Restoring Dignity, Responding to Child Abuse in Institutions*, the Law Reform Commission of Canada (2000, p. 2) recognized that "residential school inflicted terrible damage not just on individuals but on families, entire communities and peoples." Similarly, a study of Romanian orphans adopted by Canadian families in the early 1990s reported that even after a significant period after adoption (5+ years), those children who had spent at least eight of their formative months in the institution without the benefit of a nurturing family environment had lower IQ scores, lower school achievement scores, greater attention difficulty, and more behavior problems than the other matched sample (Center for Family Development, 2004).

While family and parenting styles have been shown to have a large impact on child development outcomes, children's development is also influenced by their genetic make up, environment, cultural and ethnic identity, education, appearance, and life experiences (Child Welfare League of America, 1993). Understanding "normal" child development and the main domains encompassed by it, is important when working in the area of child welfare. A child's development proceeds in stages and, as the child acquires the skills of one stage, he or she can progress to the next (Allen & Marotz, 1994).

Development occurs across many domains loosely grouped into physical, emotional, social and intellectual areas (Child Welfare League of America, 1993). Although children differ in their rate of growth and development, normal development spans a broad range and each child will develop at his or her own unique pace (Allen & Marotz, 1994). Children who come into government care have experienced one or more conditions that can interfere with normal growth and development. "An environment of neglect and/or abuse during the early years contributes to later learning, behavioral, emotional and physical health problems" (Canadian Institute of Child Health, 2000, p. 66). Hence, caring for children in care requires parents, both corporate and foster, not only to have a thorough knowledge of typical child development, but also to understand the impacts of abuse on the developmental progress of a child.

The Corporate Parent: Raising Children in Government Care

Children in care present additional challenges for those responsible for their upbringing (Jackson, 1995; Jackson et al., 1996). Corporate parenting, the term coined for the job of governments who have the legal responsibility for raising children (Jackson et al., 1996), becomes a very complex task when there are numerous people responsible for the job of parenting and for ensuring that the developmental needs of children are appropriately met. When children come into care, the tasks of parenting are split up in typical bureaucratic fashion and distributed among several players; the legal tasks of parenting become the responsibility of the agency, usually delegated to a social worker, and the day–to-day parenting responsibilities are designated to an alternative caregiver or caregivers, including foster families, youth care workers, residential care staff, and treatment personnel (Fahlberg, 1991). Even after being brought into care, the division of parenting responsibilities of corporate parenting and the complexities of this task can result in no one person assuming the job of carrying out the daily monitoring of parenting which most parents do without thinking (Parker et al., 1991). Although the child still has all of the needs of a child not in care, many people are now responsible for meeting those needs. As a result, the development of partnerships among those people is essential to the task of parenting (Jackson et al., 1996).

Developmental Needs of Children Raised in Government Care

Children come into care from a variety of situations, including neglect; physical, emotional and sexual abuse; and abandonment. The Canadian Incidence Study of Reported Child Abuse and Neglect (Trocmé, MacLaurin, Fallon et al., 2001) revealed that of all substantiated cases of abuse investigations in 1998, neglect was most prevalent (40%), followed by physical abuse (31%), emotional abuse (19%) and sexual abuse (10%). The most common form of neglect was "failure of the caregiver to supervise or protect leading to physical harm" of the child (48%). Sixty-nine percent of children who were physically abused had received inappropriate punishment. Exposure to family violence (58%) was the most common cause of emotional maltreatment, while touching and fondling accounted for 68% of substantiated forms of sexual abuse (Trocmé, MacLaurin, Fallon et al., 2001). Child neglect most often involves situations that must exist over a period of time in order to be recognized or brought to the attention of a child welfare agency. Of particular concern with neglect is that " the longer the child is subjected to parental abuse and/or neglect, the more damaged he or she becomes at all levels of functioning, and the more difficult it becomes to implement an alternative permanent plan that will meet the child's needs" (MacMillan, Steinhauer, & Chappel, 2002, p. 33).

Although family-based care is the preferred placement option, the foster care system is often over-extended and under-resourced to meet the complex needs of today's children and families (Farris-Manning & Zandstra, 2003; Klee, Soman, & Halfon, 1992). Family preservation and continued efforts at reunification can mean that children enter in and out of the child welfare system, as though through a revolving door, resulting in multiple moves from home to care or within the care system greatly affecting all areas of their development. "Social stability is essential for children to develop a sense of belonging and identity as they cope with separation from their families. Some placement changes are beneficial, but multiple unplanned moves can have seriously negative short and long-term consequences for children" (Trocme, Nutter, MacLaurin, & Fallon, 1999, p. 3). A history of multiple placements is a significant contributing factor in children exhibiting "reactive attachment disorder." According to Steinhauer, Osmond, Palmer, MacMillan, and Perlman (2002):

> These children have often been exposed to years of repeated neglect, abuse and discontinuity within their own families, frequently aggravated by the cumulative effect of multiple placement breakdowns they experience in the foster care system while moving from foster home to foster home to group home to institution and back again. (p. 145)

Kufeldt et al. (2000) note that most children come into care with signs of health, emotional or behavioral problems. According to Simms and Halfon, (1994) and Kufeldt et al. (2000), children who come into foster care are likely to suffer from both acute and chronic, even severe or disabling, medical problems as well as high rates of emotional, behavioral, and developmental problems.

Research on children raised in care suggests that even after being removed from their families for their safety and well-being many children in care do not necessarily thrive. Once involved in the foster care system, the children are subjected to the unintended but negative outcomes of this intervention (Kufeldt et al, 2000). Kufeldt et al. (2000) present an extensive literature review of children growing up in care. A summary of the review suggests that children who are raised in care have higher rates of poor overall health, enter care with a history of problems in school, and experience many placement disruptions. Trocme et al. (1999, p. 2) reported that "school performance is the simplest indicator of cognitive functioning for school aged children. Research consistently shows that children receiving child welfare services are behind their peers in all aspects of cognitive development and school performance." Other researchers lend support to this view (Francis, 2000; Heath et al., 1994; Kufeldt, Simard, Tite, & Vachon 2003; Noble, 1997; Sawyer & Dubowitz, 1994; Stein, 1997). Many of these children have a poor sense of identity and low self-esteem. For many children raised in care, there is a loss of contact with the biological family including siblings and grandparents.

The literature further suggests that many children raised in care are generally not adequately prepared for adulthood (Cheung & Heath, 1994; Heath et al., 1994; Scarth, 1993). "Even when children are brought into care, assurance of physical safety can preempt efforts to ensure emotional security and attention to the child's well-being. The narrow mandate enable services to discharge young people from care into "independence when they are patently unprepared" (Kufeldt, 1999, p. 161).

Yukon Children in Care

A search for studies on how Yukon children in care were doing revealed that information is limited. A number of reviews have focused on the services to children in care, particularly in residential care (Anglin, 2001; Bilton, 1997; Child Welfare League of Canada, 2002; Pugh, 2002; Scarth & Weir, 1998). Anglin completed commissioned reports in 1989, 1993 (as cited in Pugh, 2002) and, in 2001, on the delivery of group home services in Whitehorse. Scarth and Weir (1998) also completed a report commissioned by the Department of Health and Human Resources on residential services.

The Trujillo report (cited in Pugh, 2002) was a safety audit completed on a specific contracted group home in Whitehorse. Pugh's report provides a chronological history of residential services in the Yukon for children who came into care of the government from the late 1800s to the present. Bilton (1997) reviewed five children's residential facilities in Whitehorse to determine the accessibility and adequacy of health care services. This review did not address the health progress of the children in care but rather reviewed the services that were being provided.

The most comprehensive report to date in Yukon is the Review of Services to Children in Care of the Yukon Territorial Government's Department of Health and Social Services, completed under the auspices of the Child Welfare League of Canada (CWLC, 2002). This report, a companion to the Anglin report of 2001, looked at the state of child welfare services to children in the Yukon, while the Anglin report focused on residential services. Front-line workers were invited to participate in both reviews. Informal communications with colleagues during this time period strongly indicated an overwhelming feeling of frustration, caused by unmanageable caseloads and processes that were not inclusive of the workers' experiences and expertise. The Review of Services to Children in Care concluded with 15 recommendations to government covering four main areas: workload and staffing issues, service and program supports, infra-structural supports and quality assurance. One of the recommendations made included continued efforts to support the implementation of the LAC in Yukon program.

CHAPTER THREE

Organizational Context for the Research

The Structure of Family and Children's Services

The Director of Family and Children's Services is responsible for child welfare services in Yukon. The Children's Act (last updated in 1985 and under review at the time of this study) provides the legal mandate for the protection of vulnerable children. The Director of Family and Children's Services oversees five main program areas that are intended to protect children and to ensure their developmental needs are met (Appendix B). They are Early Childhood and Prevention, Family and Children's Services, Child Placement Services, Children's Assessment and Treatment Services, and Youth Services.

At the time of this study, Yukon Family and Children's Services was undergoing another organizational change. A Manager oversaw each program area and, prior to the reorganization, provided direct supervision to front line social workers. After reorganization, team leaders/supervisors were appointed to supervise specialized areas within each program. (This reorganization did not impact on the participants' involvement in the LAC project but did have implications for the researcher in reporting structures. Initially the researcher reported directly to the Manager of Child Placement Services. After re-organization, the researcher reported to the Children's team supervisor who then reported to the Manager).

Two main program areas, Child Placement Services and Family and Children's Services, operate from the same building location (as does Child Care Services, a specialist area of Early Childhood and Prevention Program, and the Coordinator of Youth Sex Offender Treatment Services). Initially this arrangement facilitated efficient service delivery, but with expanded programs and staff resources needed, programs have outgrown their spaces and are moving to other locations. All other program areas operate from other locations within the Whitehorse area. Regional Services, whose main office is in Whitehorse and whose social workers work in the regional area offices throughout the territory, are responsible for Family and Children's Services program areas as well as Social Services and programs for seniors. The Manager of Regional Services reports to the Director of Family and Children's Services for matters within her program areas and to the Director of Social Services for the other program areas.

The services to vulnerable children and their families are provided within the Family and Children's Services branch and are specific to each program area. Early Childhood and Prevention programs encompass child care services (day care) and Healthy Families services. Healthy Families work with children and families who present situations requiring support to meet the needs of their children. Children receiving these services are in the care of their parents. Family and Children Services programs include three areas of services; Intake, Family Service and Family Support/Counseling.

Family and Children's Services is the name of the Branch that includes all five programs areas previously identified led by the Director, and is also the name of a specific program area led by a Manager. The Family Services team works with families and children in temporary care and are an area of specialty within Family and Children's Services program area (refer to the organizational chart in Appendix B). Children who receive services from the Family and Children's Services program area are either in the care of their parents, or in the temporary care and custody of the Director. The third program area is Child Placement services, which specializes in Adoption services, Foster

Care, and a Children in Care team. Children receiving services within this program area are in the permanent care and custody of the Director, with one exception. When a child who is in temporary care and custody in the region outside of Whitehorse, moves into Whitehorse, away from parents, a social worker from the Children in Care team assumes responsibility for the child while the regional social worker works with the family. If the family also moved into Whitehorse with the child, the child and the family would be assigned to a Family Services team social worker.

Pressure from the Media/Significance of the Research

During the time this study was being proposed, in 2000 and 2001, Family and Children's Services in Yukon was experiencing some organizational adjustments that included taking direct control over the day to day management, supervision and staffing of previously contracted out group home services. This shift in program reorganization drew reaction from the community. A private contractor and her consulting psychologist, whose contract with Family and Children's Services to provide group home services was not renewed, brought to the media questions regarding the care of the children being raised by the government (Webster, 2001a, 2001b). During this same period of time, the media was reporting the details of a trial involving a young adult, who was charged and subsequently convicted of a brutal rape, exposing a traumatic childhood history that included being raised in government care (Regina v Jacob, 2002).

Perceptions that emerged in the media from members of the Yukon community suggested that children in care, particularly those children living in group homes, were receiving less than adequate care to meet their developmental needs (Regina v Jacob, 2002; Webster, 2001a, 2001b). It was also reported that for some Yukon children, growing up in care has prepared them for a lifetime of institutional care and an ongoing dependency on government social services (Regina v Jacob, 2002).

These were difficult claims to defend in light of the fact that, at the time, Yukon did not have a method to assess the developmental progress of children in care. Consequently, the implementation of the LAC Assessment and Action Records offered a credible way to obtain information about the developmental progress of individual children.

Background to the LAC in Yukon study

Designed as both a practice protocol as well as a research tool, information obtained using the AARs is intended to be used in two ways. First, using the AARs as a practice protocol offers social workers and foster parents a standardized format for assessing a child's well-being. At present, such a format does not exist in Yukon. Information gained from other LAC projects suggests that use of the AARs resulted in an improvement in the quality of care for children raised by governments. Second, by aggregating the data, Yukon child welfare staff and management can gain a big picture view of how well (or not) this group of Yukon children in care are doing developmentally across the seven dimensions to be assessed. Other than demographic statistics on children in care, this information is not currently available in Yukon. The interpretations of research findings can lead to important policy decisions, service adjustments, and changes to front line practice all geared to improve the experiences of children being raised in government care.

In light of the national initiative and the promising implications of implementing the LAC materials with children in care, the Yukon Director of Family and Children's

Services endorsed the LAC in Yukon project and signed a data sharing agreement between her and the researcher (Appendix C).

The Challenges of LAC

Prior to designing the LAC in Yukon study, the researcher undertook a review of other LAC projects. An advisory committee comprised of representatives from all social work teams within Family and Children's Services, as well as representatives from youth in care, foster parents and residential services provided consultative input into the research design. In consultation with the LAC advisory committee, the design of the project attempted to incorporate the following challenges identified in the other international projects:

The Philosophical Shift

Historically, social work practice has been grounded in the practice of "keeping kids safe." However, LAC purports that once children have been brought into care, those responsible for their care must go beyond keeping children safe and parent them as well as other reasonably-resourced parents in the community would. LAC is a model of practice that focuses so entirely on the well-being of the child that attention is also given to needs beyond child protection. This requires a philosophical shift, not only from front line social workers but also from all levels of government (Kufeldt et al., 2000). The LAC protocols provide a framework to assess the developmental needs of children and to identify needs that are not being met. It also supports and guides strength-based practice where the focus is on identifying and developing the child's strengths. For some social workers and for many foster parents, this has been their practice framework. The philosophical shift has already occurred.

The Time Commitment

The LAC Assessment and Action Records are lengthy documents each comprising about 60 pages of questions. This is a frightening sight for social workers that already feel overwhelmed with the administrative demands of their caseloads. Having people accept the program can be difficult and the LAC pilots that have occurred have noted this. Even being supportive of the LAC philosophy does not necessarily translate into eager participation in completing the assessments. Acceptance seems to be more likely when workers' participation is voluntary and when workers experience positive reactions from the children with whom they work. When using the materials as they are intended, the process is meant to be a collaborative one with social workers, foster parents and others all working towards meeting the developmental needs of the children for whom they are responsible. Support from supervisors and managers in recognizing the amount of work and time required is crucial to workers viewing the materials and their use as helpful.

Training

In the pilot projects that took place in England, Canada, and Australia, training was identified as an important component of the design of a study and subsequent implementation of the LAC materials (Jackson et al., 1996; Kufeldt et al., 2000; Wise, 1999). Training needed to occur across all levels of agency personnel including social workers, supervisors and management. Furthermore, training must be extended to caregivers and youth in care. In addition to providing all the background information to the project, training identifies the importance of acceptance and support for the project at all levels within the agency.

Duplication of Information

Social workers already express being overwhelmed with the amount of paperwork that is required to meet policy expectations. Some of the information gathered using the AARs would duplicate information already being collected. For the Yukon study, social workers were to be prepared to expect this and to provide feedback on what paperwork could be eliminated when using the LAC materials. Social workers working in the Children's team had already been introduced to the seven developmental dimensions from the Assessment and Action Records and had incorporated this format for the completion of yearly plans of care.

CHAPTER FOUR

Research Design

This chapter describes the research design of this workplace-based study. According to Patton (1990, p. 150), "purpose is the controlling force in research. Decisions about design, measurement, analysis, and reporting all flow from purpose." For Riessman (1994), the main deciding factor when approaching research is to plan a method of inquiry that fits, not only the purpose but also the problem statement, the research context, and objectives of the research question. Additionally, when trying to conduct research in the workplace, Maluccio and Fein (1994, p. 337) propose that workplace-based research in child welfare settings should be carried out with "excitement, exhilaration and the desire to improve the lives of vulnerable children", and the practice of social workers. According to Maluccio and Fein (1994), research in a child welfare setting:

> more often than not can be accurately described as uninspiring, frustrating, time consuming and inconsequential. In particular, the attempt to apply rigor and order and coherence to the research enterprise in the hurly-burly of the practice setting is a search for tidiness in an untidy world. But if one can live with the lack of tidiness and appreciate the benefits of immersion in the clutter, the process of doing research holds potential for excitement, for having impact on service delivery, for clarifying ones ideas, for learning and for discovery. (p. 337)

Maluccio and Fein (1994) also identify coping strategies that are necessary for doing research in a practice setting:

> building and maintaining rapport, being sensitive to the political context, showing respect for the competing demands and pressures faced by the agency, gaining trust, demonstrating technical competence, and involving the agency actively in the research process. (p. 337)

Similarly, Shaffer and Stebbins (as cited in Maluccio & Fein, 1994) advocate that:

> conducting research…in a child welfare agency…requires knowledge not only of quantitative and qualitative methodology but also an appreciation of the organizations characteristics, especially the demands and challenges with which it must deal with on a day-today basis. (p. 338)

Therefore, as a researcher with over twenty some years of social work expertise and experience working with children in care, the opportunity to have some real world effect on the lives of children in care and on improving the way social workers and foster parents are able to work with children in care presented itself in the Looking After Children in Yukon study.

Evaluation Research Design

The overall aim of the LAC in Yukon evaluation research study is to enhance the developmental outcomes for children raised in government care. As such, it is a form of applied research—intended to have some real-world effect, not only for Yukon children being raised in government care, but also have implications for social workers and foster parents in the way they attend to the developmental needs of children in their care. The generic goal of most evaluations is to provide useful feedback to a variety of audiences including sponsors, donors, client-groups, administrators, staff, and other relevant constituencies (Trochim, 2001). The goal of LAC in Yukon is to provide information useful at several levels of child welfare service delivery. At the direct service level, information obtained regarding the developmental progress of children in care could be invaluable to help guide the case management decision-making processes for individual children in care. At a practice level, the collaborative approach modeled through the LAC philosophy and information gathering process of the AARs could enhance the way social workers and foster parents work together to parent children in care. At a policy level, information from the aggregated AARs could be useful to managers and policy makers in planning services. In order to obtain this wealth of information, the researcher employed a variety of methods to obtain the data that included the AARs research and practice tool, a survey, a focus group and unstructured interviews with participants.

Mixed-Method Approach

The idea of combining research methods is not new (LeCompte & Preissle, 1993; Reinharz, 1992; Trochim, 2001). Consequently one can find a considerable amount of writing about the integration of qualitative and quantitative methods (Bryman, 1988; Cresswell, 1994; Denzin 1978; Flick 1992; Trochim, 2001), ranging from rather abstract and general methodological considerations to practical guidelines for mixing methods and models in one research design. A mixed-method approach is also considered a form of triangulation (Denzin & Lincoln, 1998). Mixing methods can help delineate overlapping but distinct aspects of a phenomenon, elaborate one set of findings with data from another, expand potential findings, and discover paradoxes and contradictions between results based on different methods (Greene & Caracelli, 1997). These varied purposes for mixing methods serve, in turn, to shape the manner in which they are combined. For example, some mixed-method inquiries have a dominant approach (qualitative or quantitative) and a less dominant approach that is used in a supplemental fashion (Creswell, 1994).

The focus of this inquiry was well suited for a mixed-method approach in that the AARs are designed to obtain both quantitative and qualitative data. The quantitative data consisted of descriptive studies on the children's developmental progress within seven developmental domains and the qualitative data provides additional information to help explain the quantitative results.

Various authors have reported that by combining quantitative and qualitative methods, the strengths of each can be brought together in the same research project (Bryman, 2003a, Bryman, 2003b; Maluccio & Fein 1994; Morgan, 1998). Morgan (1998, p. 365) states that "health researchers are particularly likely to try and connect the strengths of different methods to address the complexity of their research topics—especially when a project goals include both pure research and applied uses in practice setting." When conducting research in the field of child welfare, Maluccio and Fein (1994, p. 344) support the use of a combined methodology suggesting that "only the qualitative approach in our interview experience alerted us to the richness hidden in the quantitative data." Equally, Morgan (1998, p. 370) argues that "qualitative methods typically provide interpretive resources for understanding the results from the quantitative research."

A Collaborative Action Research Context

Collaboration has long been a watchword in applied research. Collaboration is synonymous with teamwork, group effort, relationship and cooperation. Collaboration ultimately implies working together, in a partnership, toward some common goal. It goes beyond cooperation in accessing subjects or discussing research implications. It implies some sense of shared conception, decision-making, and implementation. It also includes data analysis and interpretation and dissemination of findings done in collaboration.

According to Bray, Lee, Smith, and Yorks (2000), research may be defined as collaborative if a collaborative process was employed in any of these stages of research; the more stages in which collaboration can be accomplished, however, the more potential benefits accrue. Sagor (1992) suggests that collaborative research often results in better programs and more relevant findings compared to cases when research is conducted either by a researcher alone without community input or by an agency alone without the collaboration of a researcher.

For the purpose of this study, research was conceived, planned and conducted in collaboration between the principle researcher, agency social workers and administrators, and foster care providers. An advisory committee was established to oversee the process, design and implementation of the project. Teams working with children in care were invited to identify members who would sit on the committee and represent their interests. In addition to social workers, other committee members included representatives of Children's residential services, youth in care, and the Yukon Foster Family Association. The committee also served to disseminate ongoing information and updates across the Branch to staff not directly involved as participants. Once the data was summarized into descriptive statistics, the social workers and foster parents participants were invited to provide their interpretation of the findings through verbal and written feedback to the researcher during group presentations.

Sampling

The study used an inclusive sampling based on purposeful criterion-based sampling (Maxwell, 1996; Patton, 1990). This strategy was chosen for both the children in care sample and the sample selection of social worker and foster parent participants.

Children in care sample

The following factors were considered in determining the type and size of the children in care sample:

- Because of the amount of time that is required to complete an AAR, a decision was made to limit the sample size to approximately 25 children in permanent care.
- The workload issue of social workers and time limitations of foster parents were also major considerations in the decision to maintain the sample size below 25 children.
- LAC protocols require that children over the age of 10 be included in the assessment process. This would require training in completing the AARs. There were many logistical problems and questions surrounding the training issue. As a result, a decision was made to include only children under the age of ten in the sample population.

In view of these important considerations, a decision was made to assess **all** children in permanent care from birth to age 9. This age grouping of 23 children met the criteria proposed for the sample. The decision to assess children under the age of 10 also eliminated the need to provide training to the sample group in completing a self assessment ARR. This should not imply that children under ten years old are not able or should not be included in the gathering of the data. It simply means that for the purposes of this study, and in the interests of time, and training needs, children were not directly involved in providing the data. The numbers and age groupings of the children selected are highlighted in the Table 4.1.

Table 4.1

Number of Yukon Children in Care by age groups, legal status, and social work team September 1, 2001

Age groups	0-1	1-2	3-4	5-9	10-14	15+	total
FAMILY SERVICE TEAM							
Temporary Care	X*	X	X	X	X	X	X
CHILDREN'S TEAM							
Temporary Care	1	1	1	1	0	1	5
Permanent Care	**0**	**4**	**7**	**12**	28	26	77
REGIONAL TEAM							
Temporary Care	X	X	X	X	X	X	X
Permanent Care	X	X	X	X	X	X	X

**Note.* Data are deemed confidential and not necessary for the purposes of this report at this time.

The sample population was approved by the advisory committee and viewed as an appropriate sample by the various service teams. The Children's team was identified as the most appropriate team to take the lead in the implementation of the project. As principle researcher, I am a member of the Children's team.

Social worker participant sample

At the time of the study, the Children's team was comprised of seven social workers (including the researcher) as well as one social work student. The birth-9 year age grouping of children in permanent care spanned all seven caseloads. Each worker had from 1 to 7 children involved in the project requiring an assessment. In order to balance the number of assessments to be completed amongst all of the team members, the social work student assisted two of the social workers in the completion of several assessments, and one social worker assisted another social worker complete one assessment on one child who had previously been on her caseload.

Foster parent participant sample

It was identified through a file review that 14 foster parents were involved in providing out-of-home-care for the sample group of 23 children. All 14 sets of foster parents agreed to participate in the study and to complete an ARR on their respective foster children included in the study.

Data collection

Children in Care

Using the age specific AARs, data was gathered on the developmental progress of this group of children in permanent care. The AARs for the 23 children involved in the project were completed over a period of 4 months between October 1, 2001 and January 30, 2002. The original proposed completion date was extended from December 31 to January 30 at the request of the social work team due to time restraints. After completion of the AAR, the social worker forwarded the original to the researcher. The researcher copied the record, returning the original to the social worker for individual case planning. Original AARs are filed on the child's case file. Any identifying information from the copied record was removed to ensure confidentiality of the participants.

The Assessment Action Records

The AARs were the instruments used to collect the data on the children in care. The first Canadian adaptation of the records was used for the Yukon study. As the records are under copyright, permission was obtained from the Canadian Looking After Children project (CanLAC) to use the records in the Yukon study[5].

The AARs were designed to assess all areas of development that would be monitored informally by a "reasonable parent" (Ward, 1995). Although originally designed as a research tool, the AARs have undergone and continue to undergo revisions to reflect the needs of researchers, governments, practitioners, parents, fosters parents, children in care as well as trends in current child care research (Ward, 1995, 1998). In Canada, Flynn and Biro (1998) assessed the test-retest reliability and convergent validity of single items from the AAR. Results of their study showed both high and low reliability and validity measures for different AAR items. What has followed is a newer Canadianized version of the AAR that incorporates many standardized measures from the National Longitudinal Survey of Children and Youth (Flynn, Ghazal, Moshenko, & Westlake, 2001).

The comprehensive records cover seven developmental dimensions: health, education, identity, social presentation, family and social relationships, emotional and behavioral development and self care skills. There are six versions of the records corresponding to the differing stages of psychosocial development for children from birth to age 18. The age bands are under 1, 1-2, 3-4, 5-9, 10-14 and 15+. For the Yukon study, only the AAR's for the age bands 1-2, 3-4 and 5-9 was used. Each dimension in the

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[5] Revisions to the records are continuing and, in Canada, a new "Canadianized" version is being piloted on a national basis (Flynn et al 2001). Since the Yukon study, questions in the newest version have been modified to correspond to those in the National Longitudinal Study for Children and Youth, the first longitudinal study of children and youth in Canada allowing for comparisons of outcomes for children in care with those not in care (Brink, 2000).

record begins with a statement reflecting the aims of a parent for a child within that age group for that dimension. The assessment questions are to be answered by the child's primary caregiver and the child's social worker, ideally at the same time. Questions in each dimension attempt to determine the child's current development as well as the degree to which the child has been given the opportunity to achieve the specific objectives of the dimension. When further action is needed to meet an objective, the respondents are asked to identify who will take the action. If no further action is needed, respondents are then asked to provide an explanation. Each dimension concludes with summary questions that ask the respondents to consult on whether the objectives for that dimension have been met. The final question of the dimension asks the degree to which the respondents agree or not with the assessment. If there is disagreement, the AAR provides space to identify who disagrees and why.

The format of the records provides both quantitative data and qualitative data. The quantitative data are intended to provide the descriptive information on the developmental progress of the child for the seven dimensions assessed. The opportunity to provide explanations and greater understanding of the quantitative data is provided through open-ended questions. The degree to which each developmental objective has been met is summarized in the record. Each AAR asks approximately three hundred questions, too many to list here, but some of the descriptive measures include:

- the degree to which the child is normally well, thriving and protected against common accidents
- incidence of health conditions
- the child's current educational performance

- whether the child has an identified learning disability
- number of school changes the child has experienced
- whether the child has a life book
- whether the child has a positive view of himself (as determined by the respondents)
- the number of caregivers the child has had since birth
- the amount of family contact and an assessment of the quality of the contact
- whether the child has an identified emotional and/or behavioral problem, and if so, whether the problem was being addressed.
- specific information on the acquisition of self-care skills for the child's developmental level

The reader is referred to Appendix A to review the questions in the Health dimension of the AAR for children in the 5-9 year old age grouping.

Training Session

A one-day training session was provided to social workers, the social work student and foster parent participants who were to be directly involved in the collection of data. In order to provide ongoing support to foster parents, foster care staff participated in this joint training with the foster parents.

The Experience of the Research Participants

In order to understand the experience of the participants on the use of the LAC materials, and to obtain their opinions on the future of the LAC project in Yukon, social workers and foster parents were asked to provide feedback in several different ways:

1. Social worker participants participated in a survey and focus group at the mid point data collection stage of the study.
2. Foster parent participants completed the same survey given to social worker participants following the data collection stage of the study.
3. Social worker and foster parent participants were also invited to provide both verbal and written feedback into the interpretations of the findings at the conclusion of the data collection period and preliminary analysis. Participant feedback is included in the discussion of the findings.

Social worker participant mid-point survey/focus group

A combined survey and focus group was used to gather information from the social worker participants on their experiences in using the AARs at the mid-point of the data collection stage. This combined method was developed around the needs of the team. An exploration of the best ways to obtain information from the team indicated that the combination of a survey and focus group would work best for everyone for many reasons. The use of this combined method provided the social workers the opportunity to respond to the survey only, participate in the focus group only or provide input to both. Despite heavy caseload demands and branch involvement in two major service reviews, four of the social workers participants participated in both the focus group, which offered them an opportunity to discuss the study as a group, and also completed the survey. The questions used in the focus group were based on an instrument developed for a similar study completed earlier in eastern Canada (Kufeldt et al., 2000). A copy of the social worker focus group questions can be found in Appendix D. Data obtained from both methods was considered as a whole in the analysis.

Page one of the survey asked both quantitative and qualitative questions; the first one soliciting a description of the experience of using the materials on a scale that ranged from 'very positive to very negative'. Social workers were asked how many sessions/ hours it had taken to complete a record, whether they felt the time they spent was worthwhile, whether they had learned anything new, then to describe any new learning, and the number of people consulted in completing the records. Page two of the survey asked three qualitative questions describing the strengths/positives of using the materials, the least helpful/weaknesses of using the materials, and what changes workers would like to see. These final three questions were the same questions asked, and then discussed, in the focus group.

Prior to beginning the focus group, the researcher reviewed participant informed consents and confirmed their understanding or need for further clarification. A participant information sheet was provided and reviewed with the group (Appendix F) and signed consent was requested (Appendix G). The researcher then presented a short overview of the proposed focus group and the outline of questions to be posed. The first question was then asked, "What were the most helpful aspects in using the materials. Their strengths or positives?" Responses were elicited from as many members who wanted to speak. The researcher asked questions of the participants for clarification, intentional pauses were allowed to occur without filling in order to allow time for further responses, and probing questions were asked when additional information was needed. Participants also spoke amongst each other. This process continued with the second question and then the third question. Once enough information was gathered, the workers were asked if they could help summarize and identify what they felt were key points. A very brief summary of information was given from four other pilot projects to further explain what I was asking for. This was followed by a discussion of each of the questions and a determination of the 'loudest' points.

During the focus group, the researcher wrote short notes on flip chart paper to gather the responses. Once the recorder was turned off, a discussion ensued and several additional comments were obtained with verbal permission of the participants. At the conclusion of the group, the tape was professionally transcribed. The surveys were collected (5 by the end of the day, one the following day and the 7th two weeks later). The focus group was planned to go for 25-30 minutes and it ended at 25.8 minutes.

Ethical considerations

Two weeks prior to the focus group, the researcher met with the social work team to discuss ethical issues including obtaining free and informed consent, principles of workplace based research, the choice to not participate, to participate only in the focus group, or to only complete the survey. The combination of roles of the researcher was discussed. In addition to being a colleague of the participants, the researcher was also the coordinator of the LAC in Yukon study. The researcher acknowledged a potential for bias and conflict of interest and invited comments for discussion. There were none. A discussion of the recording practice and transcribing of the focus group was further clarified as well. After the discussion, workers were asked again about their interest, availability and understanding of their participation.

Strengths and limitations of focus group methods

According to Dick (1998) focus groups as a research methodology is particularly suited to preliminary research such as gathering information on the experiences of social workers in the use of this new practice tool. Stewart & Shamdasani (1991, p. 15) recommend a focus group method when “generating impressions of new programs” and “when diagnosing potential problems with new programs.” It is a strong, hardy and robust method that is useful to an inexperienced researcher. Focus groups can be organized quickly, can provide rich information in a short period of time (as opposed to individual interviews of the same number) and can include many people. Focus group participants can also help the researcher in the preliminary analysis and interpretation of the information. This collaborative approach was especially suited to this research when many social workers may already feel excluded from decisions that affect them.

When used in combination with other methodologies (such as the quantitative/ qualitative surveys used here), focus groups can provide a deeper understanding, and richness of the information given. The direct interactions between the researcher and the participants allow for further explanations, opportunities to clarify and a better understanding of what is being said. Observations of body language, eye contact, tone of voice and openness in discussion during the focus group, all provide the researcher additional cues about what is being said. Focus groups are a flexible and adaptable method of research study.

Although there are many advantages of using a focus group, they also lend themselves to some limitations as a methodology. Grouping people together to talk can present the opportunity for stronger, opinionated voices to dominate and quiet voices may not get heard. This can skew results if one person speaks more and provides more input. This can also lead to some participants going along with the dominant opinion, wanting to appear as part of the group. While this study did not see any dominating opinions, the focus group may have limited some of the participation of less vocal members.

Stewart & Shamdasani (1991) point out that live participants as opposed to only seeing responses on a survey can tend to be viewed with more credibility and their responses seem to have more weight. I was aware of this fact and made a conscious attempt not to give more weight to verbal responses.

The design of the focus group questions can also limit the information obtained by being too specific. In this case, the focus group was given three questions that specifically asked for strengths, weaknesses and suggestions for change. By asking these specific questions, this researcher may have narrowed the focus enough to miss some broader concerns that may have been exposed with more general questions such as those asked in the survey. The questions about how many sessions and how many hours it took to complete the assessments were also unclear for most participants. Some workers who had not yet completed an assessment and others who had completed more than one, found the question confusing.

A final disadvantage of a focus group lies with the researcher and how her biases can provide cues to the participants about a more desirable answer or a confirmation that an answer is good or bad. During the focus group, this researcher did ask some leading questions and at least on one occasion offered an answer. The sample of participants used for this survey/ focus group limits the results to this population.

Foster parent participant survey

Foster parents completed a survey similar to that of the social workers describing their experiences in using the LAC materials. The survey was mailed out to all fourteen foster parents who had participated in completing one or more AARs on a child in the study. The survey was mailed out six weeks after the final date for completion of the AARs. A cover letter thanked the participants for their involvement in completing the AARs and inviting them to provide their candid feedback on their experiences in using the LAC materials (see Appendix H). A follow up phone call was made to all fourteen participants to remind them about completing the survey. After completing the survey, the participants were asked to return it to the researcher in the enclosed, self-addressed and stamped envelope.

The survey (see Appendix E) was comprised of 13 questions, 10 being identical to the questions asked of the social workers. The three additional questions asked of the foster parents included (a) what effect, if any, did the LAC materials have on their relationships with specified people, (b) whether there were any additions they would like to see and (c), whether there was anything they wanted deleted.

Strengths and limitations of survey methods

Mail surveys are a potentially inexpensive and flexible method of obtaining information from a large number of respondents. They allow respondents to answer and return their survey at their relative convenience and can be completed in their own homes.

The limitations of surveys as a data gathering method include poor or low rates of return. Poor rates of return can result from people not willing to participate, forgetting to complete their survey or losing their survey. Although response rates can range from 0 percent to 100 percent, Neuman (2000, p. 267) suggests that "most researchers consider anything below 50 percent to be poor and over 90 percent as excellent." In this study, the 14 foster parent participants were asked to complete a mail-in survey. Six of the 14 mailed out surveys were completed and returned to the researcher.

In addition, the possibility of biased phrasing of questions and the possibility of excluding those who may have language or literacy problems can limit the useful of surveys as research methods. Completing a pilot test of the survey beforehand can reduce some limitations. Although no pilot test was completed for this study, the survey was a modification of the instrument used in the LAC in Canada study (Kufeldt et al., 2000).

Data Analysis

Analysis of the Quantitative Data from the Assessment and Action Records

The copied AARs were forwarded to Dr. Louise Legault at the University of Ottawa for data entry, the preparation of a database, and the completion of a confidential report to the researcher of the frequencies of participant responses to individual questions in the AARs (Legault & Flynn, 2002)[6]. The database was provided back to the researcher in both Excel and SPSS software formats. As Yukon government uses SAS and Excel software but not SPSS, Excel formatting was used to generate the figures. Due to the amount of data that was obtained, quantitative data were organized using descriptive statistics. Univariate analysis (describing individual variables), the collapsing of response

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[6] Permission to use the AARs, which are under copyright, was obtained through Dr Kathleen Kufeldt principal researcher. At the time that the Yukon data was obtained, the CWLC had assumed responsibility for this national initiative and provided support to the Yukon study through data entry into an already created database.

categories and the use of subgroup descriptions to compare age groups were methods used to present the data in a manageable and understandable form. The term ‘missing data” is used when a question was left blank and no response was received.

Analysis of the Qualitative Data from Assessment and Action Records

The qualitative responses to questions in the AARs were provided back to the researcher in verbatim form. Individual responses were included in the discussion of the findings and when appropriate, same and similar responses were grouped according to general themes and used to provide additional explanations and clarification of the quantitative data.

Social Worker Participant Survey/Focus Group

The survey contained both quantitative and qualitative information. The quantitative information was aggregated and the qualitative information was grouped according to general themes. Responses to the three identical qualitative questions posed in both the survey and then discussed in the focus group were combined for the analysis.

A review of the focus group findings began by first reading through the transcript of the focus group. I reviewed the participant’s responses to get a feel of the information and to compare what I was reading to what I had heard during the focus group. The written word is clearly very different than the spoken word. When reading, the focus is on the words whereas, in the group setting, some of the words are upstaged by visual and auditory information coming in at the same time. The information available from the surveys, transcript and flip chart notes was then combined with the focus group data into one summary. The researcher read through all of the data many times to get a general sense of the information obtained. Ideas and patterns of responses were identified in the margins of the summary. Similar or like responses were then grouped into general categories with the researcher recording written comments on emerging themes.

The three questions asked during the focus group allowed for an initial grouping of responses on the flip charts according to strengths, weaknesses and then suggestions for change on the use of the LAC materials. Using those categories, a thematic analysis looked for general themes in the responses that could be grouped together. The themes that emerged were consistent with the challenges expressed during the other pilot projects and will be discussed in the findings as well as underlying issues that contributed to those challenges that were revealed.

Foster Parent Participant Survey

The qualitative analysis of the foster parent survey responses was completed using the same methods as those used for the social worker survey. The responses were reviewed initially for completeness and to provide the researcher with an overview of the information. Using a blank survey, quantitative data was aggregated and exact responses from each of the individual questions was recorded and summarized. Researcher comments regarding emerging themes were documented.

Feedback to Participants/Input from Participants

Once all of the data for the LAC project was collected and analyzed, the researcher prepared a summary of the information for presentations back to the participants. Social workers, foster care workers, supervisors and foster parents were then invited to participate in the presentation of the descriptive data that was provided from the AARs and by the participants through the focus group and survey. Participants were again provided with an information sheet outlining their rights as research participants

(Appendix I), and their written consent to participate and to use any verbal or written feedback was requested (Appendix J). The researcher recorded comments from the participants when they were made about the data. Social work participants were also invited to provide written feedback on the data. The feedback obtained from the participants is incorporated in the discussion of the findings.

Overall Ethical Considerations

LAC in Yukon is a workplace-based research study that combined the roles of researcher, social worker and participant. It was important that the research be conducted in an ethical and collaborative way with the intention of not only learning about the developmental status of children in care but also creating an empowering environment for the participants. The Director, as the legal guardian of Yukon children in permanent care, provided approval for the study. Social workers completed the AARs with foster parents caring for the children in care. The AARs, now an international protocol, received ethics board approval through Memorial University for its use in the first Canadian pilot project. Dr. Kathleen Kufeldt, principal researcher provided approval for this researcher to use the protocols for the LAC in Yukon study. Permission from Dr. Louise Legault who provided the data base under the auspices of CanLAC, was deemed to not be required as ownership of the database was already co-owned by the Yukon government and provided to the researcher through a data sharing agreement (see Appendix B).

All children involved in this research project were under the age of 10 and were purposely not directly involved in the collection of the information. Once the AARs were completed, the identifying information was removed for the data aggregation and analysis to protect the confidentiality of the child in care and the participants completing the assessments. Consents were obtained from social workers that agreed to participate in a focus group that was tape recorded for analysis. Feedback on the results and interpretations of the data was shared back to all of the participants. The participants were invited to offer their own interpretations of the findings through group discussions, and for the social work team through a written report that was circulated to them. The research component in the collection of the interpretations was explained to the participants and a second consent to participate was sought. Looking After Children in Yukon was approved through the University of Northern British Columbia research ethics board. Only non-identifying information will be used in the reports and the thesis.

CHAPTER FIVE

Research Findings

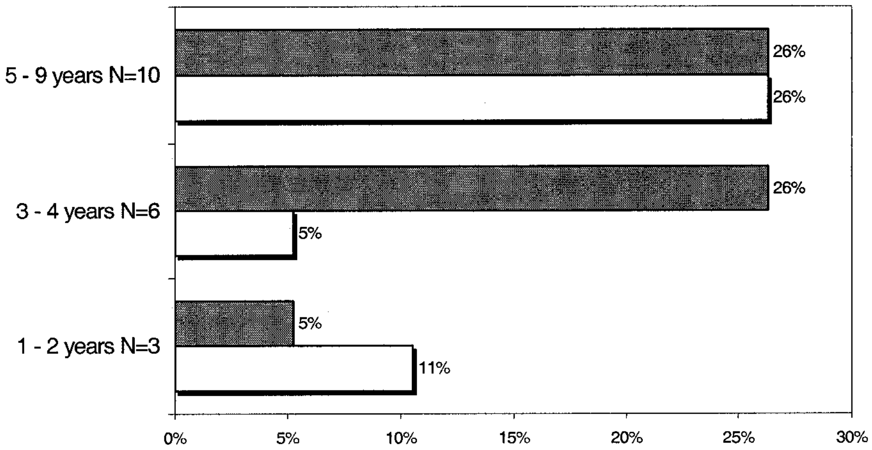
In this chapter, the researcher reports on the research findings of the AARs on children in care. The descriptive data is presented in detail to ensure that all of the baseline data obtained is provided. Should LAC in Yukon develop into a longitudinal study of this group of children raised in permanent care, this data could be very useful in allowing for direct comparisons to subsequent assessment data. Following the findings on the children in care, I discuss the results of the combined focus group and survey of the social worker participants and then on the responses to the foster parent survey.

Children in Care Research Findings

All of the children in the study were in permanent care, living in a foster home in Whitehorse and were between the ages of 1 and 9 years old as of October 1, 2001. Although 23 were identified for assessment, two children moved out of the Whitehorse area shortly after the study began and two assessment records were not returned to the researcher. As illustrated in Figure 5.1 below, 19 children were included in the assessment results. From this total, there were 3 children in the 1-2 age grouping; 6 children in the 3-4-age grouping; and 10 children from 5-9 years of age. Slightly more than half of the children (58%) were boys.

Figure 5.1

Socio-demographic characteristics of children in care (age 1-9)



	1 - 2 years N=3	3 - 4 years N=6	5 - 9 years N=10
▨ male N= 11	5%	26%	26%
☐ female N=8	11%	5%	26%

The Dimensions

There were children from three different age groupings in the study and a slightly different AAR was completed reflecting the differing developmental stages for each age group. When a specific question is asked that was not asked of all of the age groupings, the number or sample size is less than 19 children and this will be noted.

Health

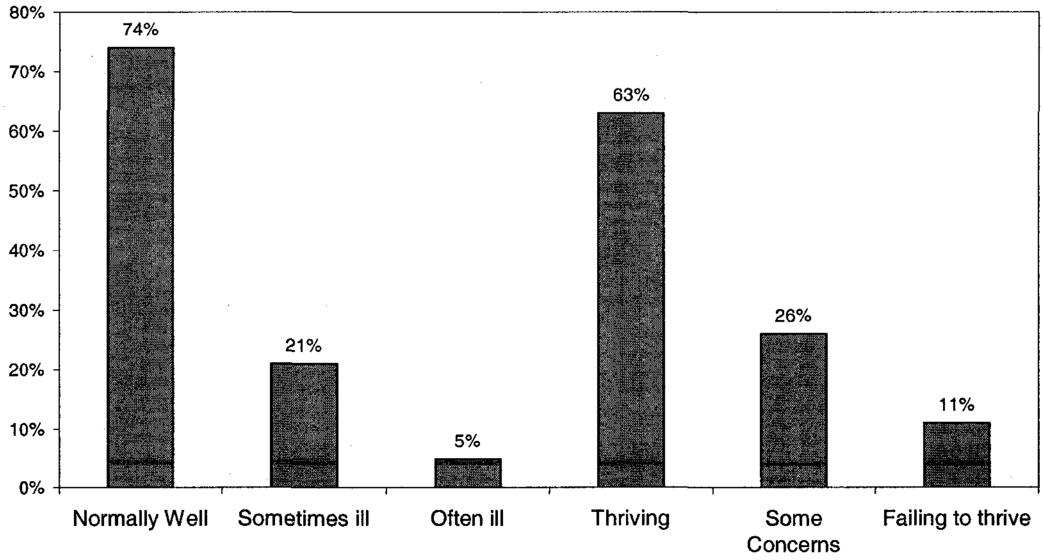
The Health dimension covers the areas of the child's early medical history recording, medical exam, hearing, language development, sight, growth, immunizations, dental, health conditions, development, illnesses/injuries, diet, eating habits, exercise, household safety issues, adult supervision. Children in care tend to come into care with poorer health perhaps as a result of poor prenatal care or childhood neglect. The questions in this dimension are intended to assess the degree to which:

- The child is normally well
- The child is thriving
- All preventative health measures are being taken
- All ongoing health conditions and disabilities are being dealt with
- The child is reasonably protected against common accidents

As illustrated in Figure 5.2 below, the majority of children from 1-9 years old enjoy good health with 74% (14/19) described as doing "normally well". For the remaining children, 26% (5/19) were identified as "sometimes" or "often ill". The percentage of children described as "thriving" was less with 63.2% (12/19) of the children described as thriving, 26 % (5/19) indicated that there were some concerns and 10.5% (2/19) were seen as failing to thrive.

Figure 5.2

Percentages of children normally well/thriving (age 1-9)



All children in permanent care are required to have yearly medicals to monitor their overall health and to identify and respond to any medical concerns promptly. The yearly medical also provides hearing and optical screenings and can identify the need for a further referral for a hearing or optical assessment. Children who are under 5 years of age and not in school are expected to have a yearly dental check up and children of school age are seen through the school dental programs. Children who have ongoing medical, dental, optical or hearing conditions would be monitored on a more frequent basis.

Eighty-four percent (16/19) of the children reported to have had their annual medicals within the past 12 months. All of the respondents noted that the medical exam either had no recommendations or when recommendations had been made, all had been carried out to date. Some of the recommendations included maintenance of medication therapy, having a hearing assessment, taking vitamins, having a flu vaccine and referral for optical exams.

A hearing assessment can be requested by the parent, foster parent, social worker or teacher in addition to the physician if there are concerns about a child's hearing. Eighty-four percent (16/19) indicated no concerns about a child's hearing while 15.8% (3/19) reported that they had concerns. For the question whether the child has had a hearing test, 15.8% (3/19) responded that the child had, and 84% (16/19) of possible responses were not completed.

Seventy-four percent (14/19) of the children assessed had no vision concerns while 26% (5/19) had sight concerns. Seventy-four percent (14/19) of the children had vision tests, while for 26% (5/19) of the children, the caregiver/social worker either did not know when the last vision test was or did not respond to the question. Two of the nineteen children were being monitored for possible testing at a later date. Sixteen percent of the children (3/19) need to wear glasses with 2 of the 3 wearing them sometimes (at school and for reading). Sixty-three percent (12/19) of the children do not need glasses; while for 21% (4/19) of the children the data was missing.

Sixty-six percent (2/3) of the children aged 1-2 brushed their teeth regularly. For the children aged 3-9 years old, 69% (11/16) had been to the dentist with 50% of them (8/16) having gone within the past 6 months. Two of the children between 3 and 9 years of age (12.5%) had not been to a dentist; for 2 of the children (12.5%) neither the social worker nor foster parent knew if the child had been to the dentist and one answer was missing. Recommended treatments resulting from dental assessments included regular check-ups, fillings, teeth removal; teeth straightening and other. All of the children from 1-9 years old had immunizations that were up to date.

The question "child is achieving developmental milestones" was asked in the health dimension for the 1-2 year old age group. For the three children aged 1-2 years, there were no concerns with one child who was achieving normal milestones; for one child there were some concerns and for the third child the caregiver/social worker had serious concerns about the child's development. All three children are attending the Child Development Center. Developmental progress for the children aged 3-9 is covered in the education dimension.

For 78.9% (15/19) of all of the children, there are no concerns with the child's height or weight; for 16% (3/19), there are some concerns (but not specified), and for one child there was no response recorded. Consistent with the yearly medical, 70-80% of the children from age 5 to 9 years had been weighed and measured within the past year.

Ninety five percent (18/19) of the children from aged 1-9 years old were being taught speech as their primary method of communication. Six of the nineteen children (32%) were also being taught another form of communication (American Sign Language or other).

Of the 19 children in the study, over half of the children, 58% (11/19) aged 1-9 years old are diagnosed with unspecified health conditions and health professionals are monitoring all of them. Twenty-one percent (4/19) have a physical condition. For the children aged 3-9 years old, the question was asked whether the child had been given information about their ongoing health condition. Twenty-five percent of the children (4/16) aged 3-9 had been talked to about their condition while half of the children (8/16) had not. The remaining 4/16 did not provide a response.

Just over a quarter of the children 26% (5/19) were being seen by a specialist, while 53% (10/19) were not and 21% (4/19) did not respond. Fifty-eight percent (11/19) of the children had no illnesses or injuries in the past year while 42% (8/19) had experienced illness or injury. However, because the question was double-barreled ("illness or injury"), it is not possible to distinguish between illness and injury using the quantitative data alone. The qualitative data provided for this question lists specific illness. The illnesses listed are: heart surgery, respiratory distress, bronchial pneumonia, foot and mouth disease, flu, cold, ear infection, chest infection, asthma, minor cuts and bruises, strep throat, nose bleeds, tonsils and adenoids.

Thirty-two percent (6/19) of the children have some dietary needs identified as sensitivities to milk and other foods, problems with swallowing which require special preparation of food, and calorie rich food supplements. All of the children from age 3-9

(16/16) have a healthy diet according to their foster parent and social worker. Ninety-five percent (18/19) of the children walk or play outside on a daily basis. One response was missing.

Numerous questions were asked in this health dimension concerning household safety issues and practices of the foster parents. Use of child equipment was queried such as cribs, strollers, stair gates, car seats and smoke alarms. Seat belts and car seats were used 100% of the time. Responses to the summary question "are the children reasonably protected against common accidents" indicated that 100% were rated as having a safe environment. The responses to individual questions regarding household safety were ambiguous and therefore responses were mixed.

Education

The educational development needs of children from ages 1 through 9 years vary greatly and the objectives of this education dimension are varied for each of the age groupings. The general areas covered in the education dimension include: a child's exploration of his environment; motor and social development; school readiness; types of school program; attendance; grade levels; assessments of child's school performance; school changes; special needs; learning difficulties; literacy skills; special skills; and involvement in activities outside of school. The following questions are intended to assess the educational objectives:

- The child is being encouraged to develop to his potential
- Developmental delays or learning difficulties are recognized promptly and being addressed
- The child has an education program that meets his needs

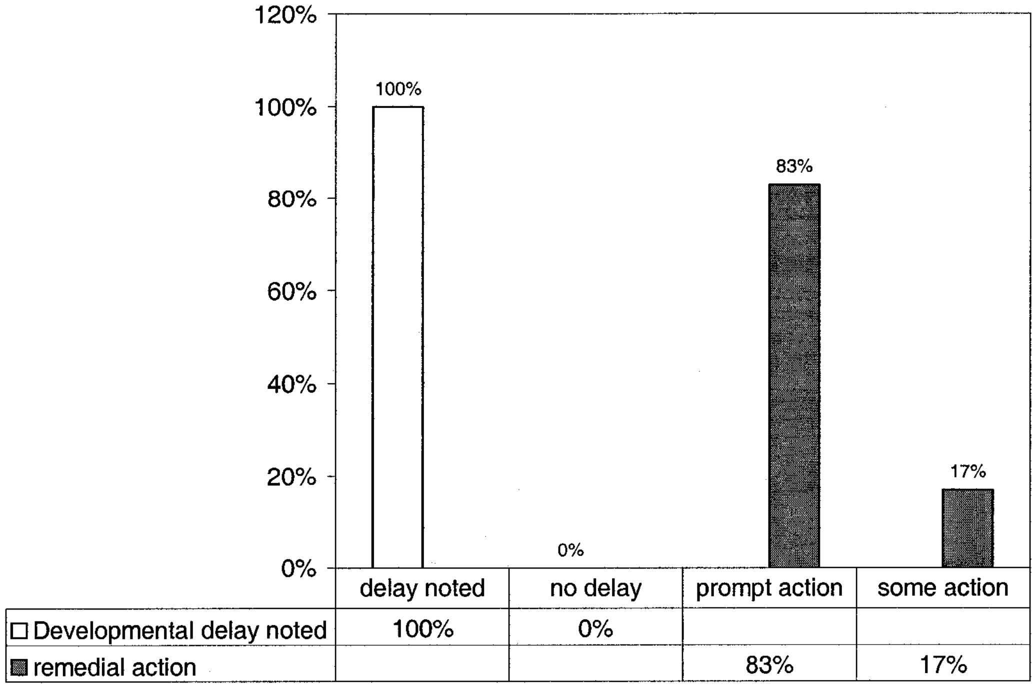
- The child has the opportunity to participate in activities both in and out of school
- The child has the opportunity to develop skills in areas he is interested in
- Efforts are being made to see that the child is happy at school.

All of the children (3/3) from ages 1-2 (100%) are fully encouraged to explore their environments. They are also given the opportunities to play with crayons, boxes and containers, toys, playthings, water (1-4 yr. old), sand, dough, construction toys and play make believe (ages 3-4). All of the children are played with and talked to by their foster parents.

For the 3-4 year olds, as shown below in Figure 5.3, respondents were asked if a developmental delay had been noted. In answering this question, respondents could check four different responses to this question that included "yes", "no", "currently being assessed" or "don't know". In addition, a sidebar provided that a "child has a developmental delay if s/he finds it difficult to carry out tasks that most children of the same age can do easily". Developmental delays are noted in all of the children in the 3-4 age group (6/6 or 100%). Four of the 6 children (67%) aged 3-4 also had speech that was difficult to understand outside of the immediate family. For all of the children, remedial action was being taken.

Figure 5.3

Developmental delays/remedial action (age 3-4)

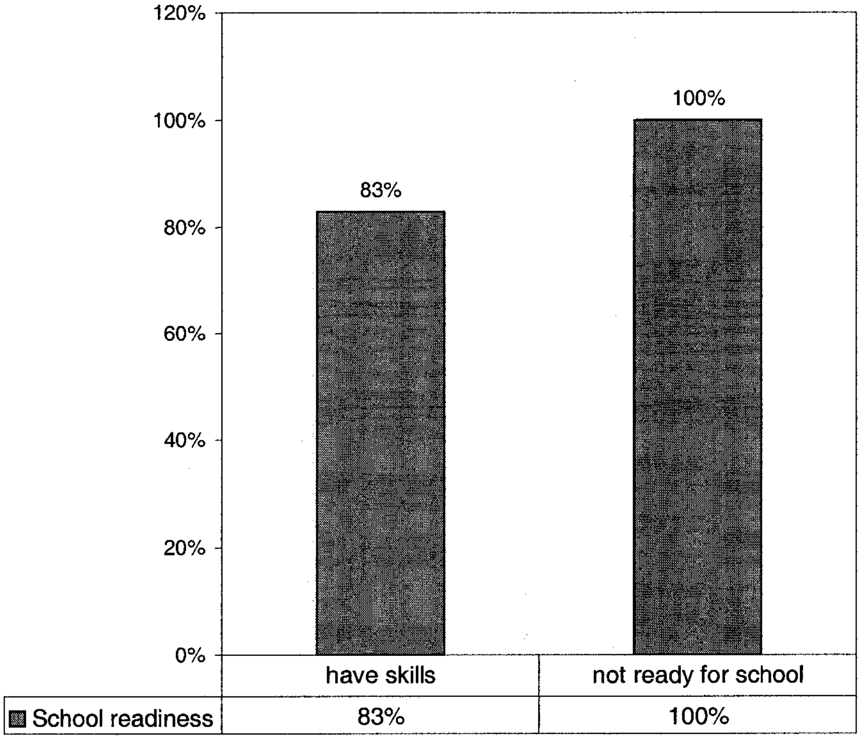


	delay noted	no delay	prompt action	some action
☐ Developmental delay noted	100%	0%		
▨ remedial action			83%	17%

In terms of school readiness skills, 5 of 6 children (83.3%) aged 3-4 could count; recognize letters or words; distinguish colors, sizes and shapes. All of them could follow simple instructions. Despite having these skills, none of the children aged 3-4 was deemed to be ready for school by their assessors (see Figure 5.4) and no explanations for this were requested in the AAR.

Figure 5.4

School readiness/skills (age 3-4)



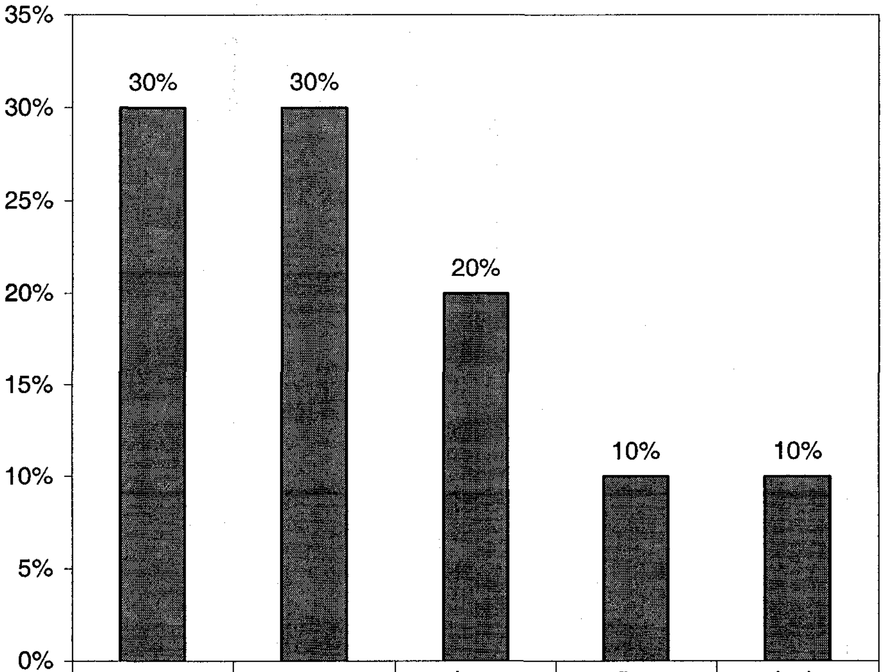
For the children in the 3-9 age group (N=16), seventy-five percent (12/16) of respondents felt the children were receiving an education appropriate to their needs; while 2 of the children (12.5%) are currently being assessed with no specifics provided on the nature of the assessment. For the 2 remaining children (12.5%), there were no responses given. The children were involved in a variety of learning situations including regular school; regular school with help; special classes, nursery school and playgroups.

Sixty percent (6/10) of the children in the 5-9 age group were identified by their social worker and /or foster parent as having a learning difficulty. A learning difficulty is defined in a sidebar as a child who "finds it much harder to learn than most children of the same age or if s/he has a disability which makes it difficult to use the normal educational facilities".

The number of school changes was noteworthy for several of the children from aged 5-9 (see Figure 5.5). Responses to the question of how many school changes the child has experienced since age 5 were: no school change for 30% (3/10) of the children; 1 school change for 30% of the children; 3 school changes for 20% of the children and 5 school changes had occurred for 10% (1/10) of this age grouping.

Figure 5.5

School changes for (age 5-9)



	none	one	three	five	missing
▇ percentage of school changes	30%	30%	20%	10%	10%

Sixty percent (6/10) of the 5-9 years olds had perfect attendance at school; 20% (2/10) had 7-15 days of absence and 20% (2/10) were missing data. One of the children was missing a lot of school because of difficulties with transportation. Grade levels were not recorded consistently so school performance data cannot be presented. Nine of the 10 foster parents for the children aged 5-9 years old felt the children were doing as well as they could in school. For 6 of the 10 children, the foster parent helped them with their homework; 2 of the children did not have homework and for 2 of the children the data was missing. For the question, "who discusses the child's progress with the teacher?", some responses indicated there was more than one person doing this for the child. Social workers discussed the child's progress with the teacher for half of the children (5/10) and it was the foster parents for 7 of the 10 children. For one child, the birth parent also spoke to the teacher.

The literacy skills of children were assessed and, for the children ages 1-4 years (N=9), all of the children were either read to, shown picture books or told stories daily or up to several times a week. For children aged 3-9 (N=16), half of them borrow books from the library weekly while 12.5% (2/16) borrow them monthly. Unfortunately 37.5%, (6/16) either borrowed less than once a month or the respondent did not know. Over 80% (13/16) of the children aged 3-9 years owned 10 or more books.

The question "The child has the opportunity to participate in activities both in and out of school" was asked only of the 5-9 year olds and 9 out of 10 of the children have participated in activities out of school. There was quite a range of activities that the children participated in including golf, swimming, summer camps, therapeutic horse riding, skating, soccer, native language, cooking, biking, hiking, gymnastics and kareoke.

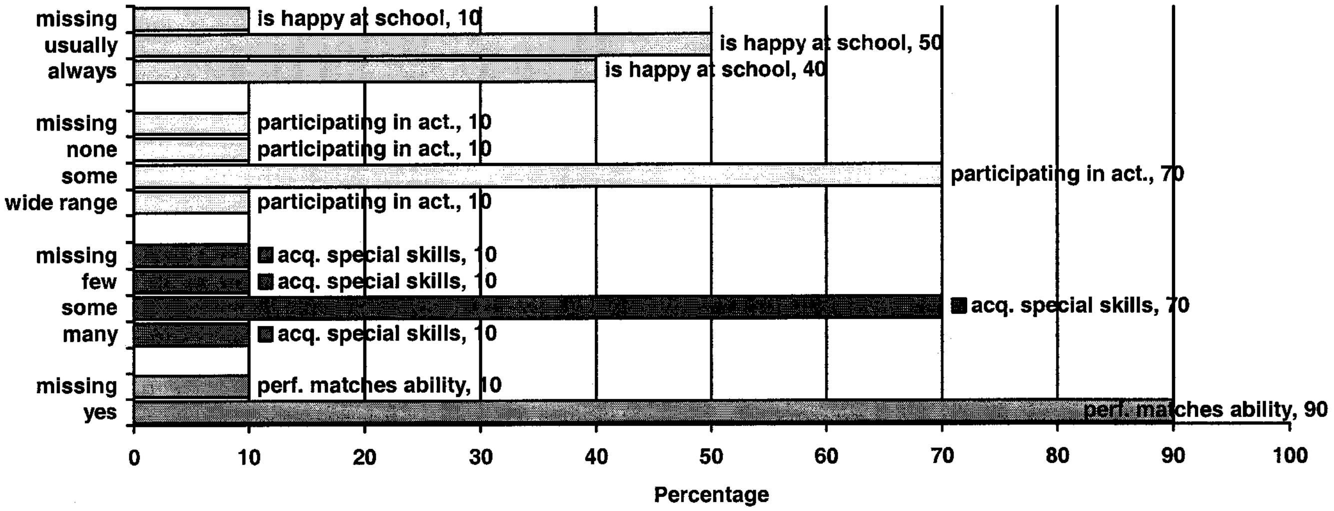
For the children aged 5-9 years old, 8/10 of them can swim and ride a bicycle while 2/10 of them are learning to do both. Seven of the 10 children have other special skills; 1 does not and for 2 children the data was missing.

The questions in the summary section of the educational objectives were as follows: For the children aged 1-2, 67% (2/3) have physical skills that are progressing normally. Sixty-seven percent (6/9) of the children age 1-4 are usually inquisitive and eager to learn. Communication skills is an area of concern for this combined grouping (ages 1-4 years with N= 9) with 33% (3/9) showing serious concern and an additional 11% (1/9) showing some cause for concern. Forty-four percent (4/9) were showing good or satisfactory progress in their communication skills. In the area of concentration, the children aged 3-4 were split with half of the children able to concentrate (3/6) and half of the children (3/6) having poor concentration.

Overall, the 10 children aged 5-9 appear to be doing well in meeting their educational objectives at this time (see Figure 5.6). Educational performance matches ability for 90% of the children; 80% are acquiring many and some special skills; 80% are participating in many and some activities in and out of school; and 90% are always or usually happy at school.

Figure 5.6

Summary of Educational objectives (age 5-9)



Identity

As with the health and education dimensions, children in care are vulnerable to difficulties with the formation of their identity due to the factors that being raised in care present. Separation from their birth and extended families often leads to loss of contact, which also can mean the loss of important family history and heritage (Kufeldt et al., 2000). Areas explored in this dimension include:

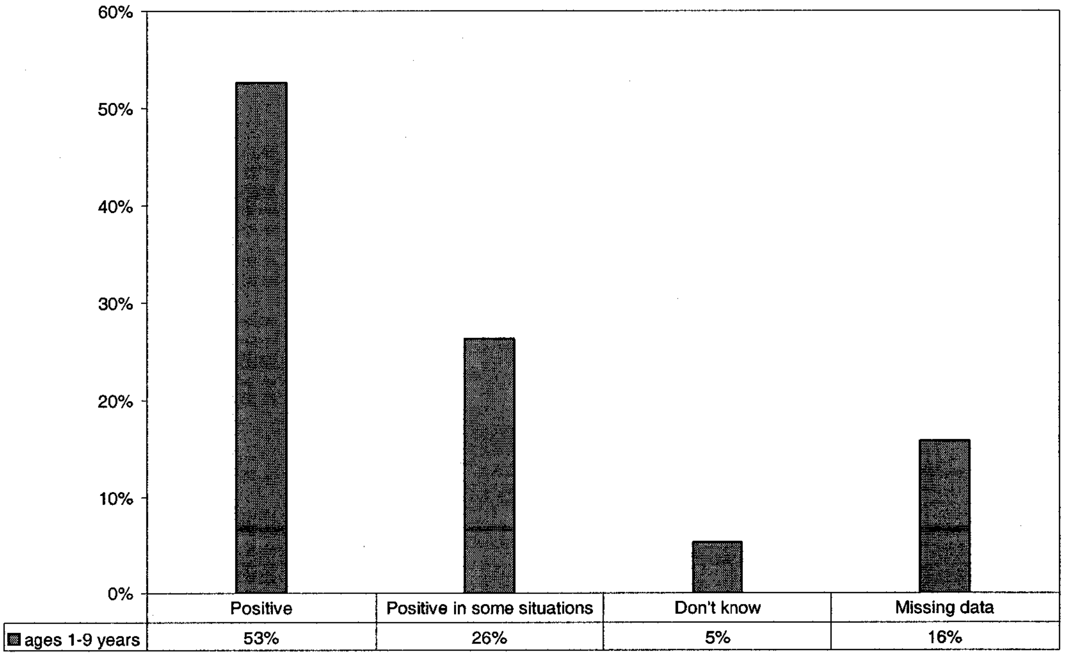
- Personal identity and self-view
- Understanding of current life situation
- Relationship to family, foster family and others
- Life books
- Social interactions
- Religion
- Ethnic identity

- Role models

Development of ones identity is a life long process that begins at birth (Kufeldt et al., 2000; Tizard, 1996). In the area of personal identity, all of the children aged 1-2 (3/3) can recognize their own names and 56% (5/9) of the children aged 1-4 know their gender. Sixty-seven percent (4/6) of the 3-4 year old can give their full names, while 33% (2/6) cannot. Half (5/10) of the 5-9 year olds can give their full name, address and birthday, while the other half cannot. Eighty percent (8/10) of the children 5-9 years old were assessed by the participants as being able to state three things that they are good at. Overall Figure 5.7 shows that 53 % (10/19) of the children had a positive view of self and 26 % (5/19) were somewhat positive.

Figure 5.7

The child has a positive view of herself and her abilities (age 1-9)

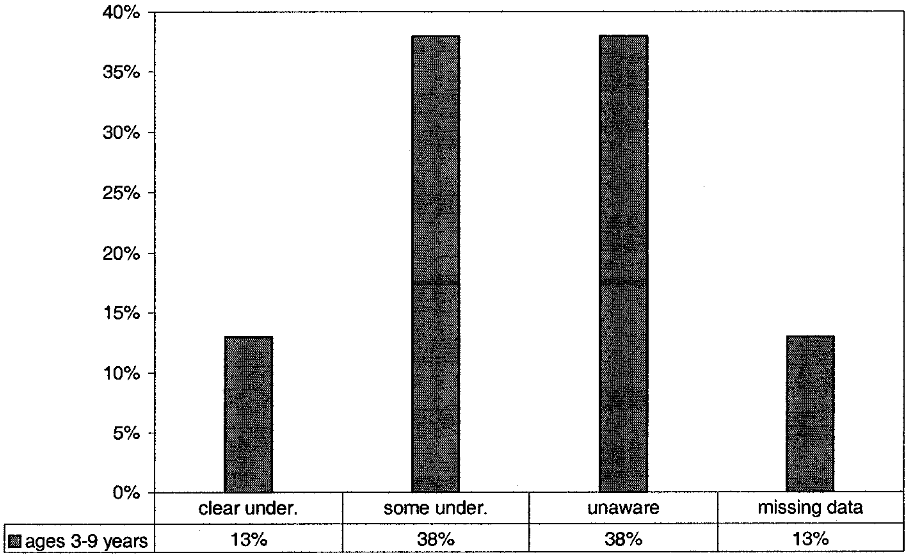


The experience of feeling loved and perceived as worthwhile plays an important part in one's beginning identity formation in childhood (Triseliotis as cited in Kufeldt et al., 2000, p.39). Responses to AAR questions indicate that foster parents are praising the children often (95%, 18/19), with the remaining 5% (1/19) data missing. The foster parents are interested in the child's activities (9/10; 1 missing) and are promptly responding to the child's needs (100%).

Children who understand their history and can separate themselves from their parents' lack of responsibility in caring for them, are more likely to show better outcomes than those who can not (Silva-Wayne, 1995). Of the children aged 3-9, 46% (7/16), have been told why they are living with foster parents; 38% (6/16) have not been told why; 13% (2/16) are not sure if the child has been told why and, for 6% of the children (1/16), the data was missing. In responding to the summary question of whether the child has an understanding of their current situation, the following data was obtained:

Figure 5.8

The child has an understanding of his current situation (age 3-9)



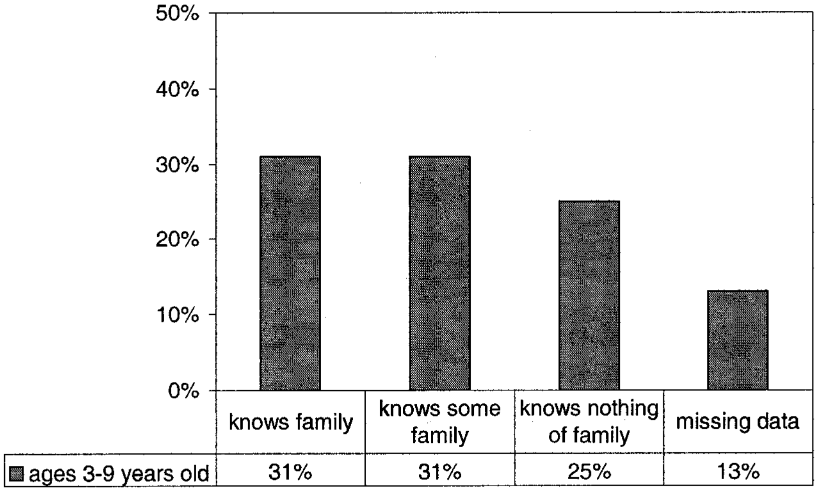
The importance of Lifebooks (memory books that record people and events in a child's life) for children in care has become more and more significant as we better understand the impacts of growing up in care (Child Welfare League of America, 1993; Fahlberg, 1991). Change of placements, different caregivers, and school changes all contribute to the loss of important information and experiences for a child in care. Lifebooks help children understand their past and can provide a visual memory of experiences and people that otherwise may be forgotten. Ninety percent of all of the children in this study (17/19) have Lifebooks, albums or mementos being saved for them while 10% do not. For children aged 3-9 years old, 6% (1/16) could name all or most of their birth family. Almost 70% (11/16) of the children could name a few members and 25% (4/16) of the children could not name any members of their birth family.

In the summary section for identity, respondents are asked if the child has knowledge of his family of origin. As shown in Figure 5.9, 31 % of the children (5/16) knew their family; 31% (5/16) knew something about their family; 25% (4/16) knew nothing about their family and for 12.5% (2/16) there were no responses recorded. For all of the children aged 1-9 years old, 74% (14/19) of their foster parents are open about the child's relationship with the birth family; 10% (2/19) are not open; 10% (2/19) make 'some concealment" and, for 5% (1/19), the data for this question was missing. The same question is asked of the birth family from the perspectives of the social worker/foster parent. In responding to the question, "are the birth parents open about their relationship" with the child, 10% (2/19) of the birth parents were deemed to be open about the relationship; 37% (7/19) were not open; 5% were thought to make some concealment;

16% responded that they didn't know; and for 32% the data for this question was missing.

Figure 5.9

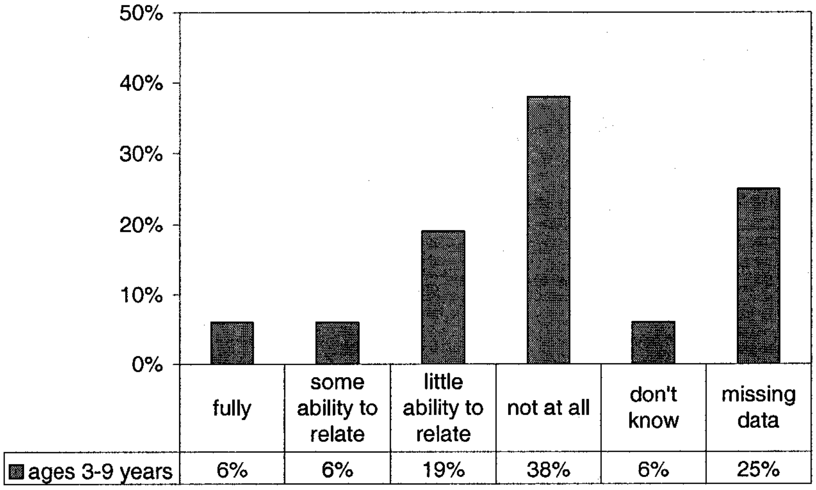
The child has knowledge of her family of origin (age 1-9)



Almost 80% (15/19) of the foster families for all of the children aged 1-9 speak the same language as the child. When asked whether the language spoken was the same as the birth family, 58% (11/19) of the responses were missing; 5% (1/19) didn't know; for 10% (2/19) the response was not at all; and 26% (5/19) spoke the same language as the birth family fluently. In terms of religion of the foster family and birth family, the question was asked only of the 5-9 year old age grouping. Ten percent of the foster families (1/10) share the same religion as the birth family; 20% do not; 60% didn't know and 10% (or 1/10) of the data was missing. Seventy-four percent of the foster families (14/19) have made some or serious efforts to ensure toys and books reflect the racial and ethnic background of the child. Twenty-one percent (4/19) had made little or no effort. The remaining 5% were missing data. Thirty-one percent (6/19) of the children live with foster parents of the same or similar racial/ethnic background as the child; 53% (10/19) do not and, for 16% (3/19) of the children, the data was missing. All of the children except one (where the data was missing) have contacts with other children of the same ethnic background. In answering a summary question of whether the child can relate to his/her racial ethnic background for the age group 3 to 9, participants provided the following responses as displayed in Figure 5.10. Although 25% (4/16) of possible responses were from missing data, it is noteworthy that more than half of the remaining children (57%, 9/16), were assessed as having little or no ability to relate to his/her racial/ethnic background.

Figure 5.10

The child can relate to her racial/ethnic background (age 3-9)



	fully	some ability to relate	little ability to relate	not at all	don't know	missing data
▨ ages 3-9 years	6%	6%	19%	38%	6%	25%

Family and social relationships

Questions in this section cover the child's contacts and relationships with the foster family, birth family and with their peers. Continuity of relationships and issues of separation are included here. The objectives of this dimension are that:

- The child has had continuity of care
- The child is definitely attached to one foster parent

- The child's contact with their birth family strengthens his relationship with them
- The child has a stable relationship with at least one adult over a number of years
- The child is liked by adults and other young people

Foster parents/social workers were asked to state the number of people who have acted as the child's main caregiver since infancy. Although infancy is not quantified, the responses are highlighted in Table 5.1.

Table 5-1

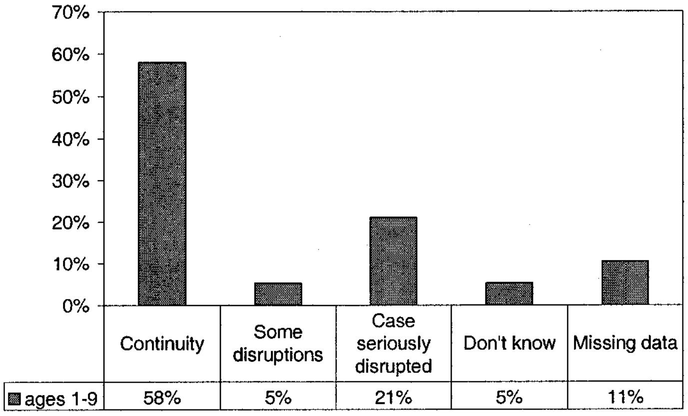
Number of caregivers since infancy

# of care givers	1	2	3	4	5	7	12	unsure	missing data
# of responses (N=19)	1	2	1	3	2	1	1	4	4
%	5.3	10.5	5.3	15.8	10.5	5.3	5.3	21.1	21.1

Continuity of care is difficult to determine from the data, as 21% (4/19) of the responses were unsure of how many caregivers a child has had and another 21% (4/19) of the data were missing. It is concerning to see that 37% (7/19 responses) of children aged 1-9 years old had 4 or more caregivers since infancy. The responses to the summary question for this objective (see Figure 5.11) were: 58% of the children did have continuity of care (11/19); while 5 % (1/19) were showing some disruptions and 21% (4/19) had serious disruptions of care. For 16% of the children, the response was don't know (1/19) or the data was missing (2/19).

Figure 5.11

The child has continuity of care (age 1-9)

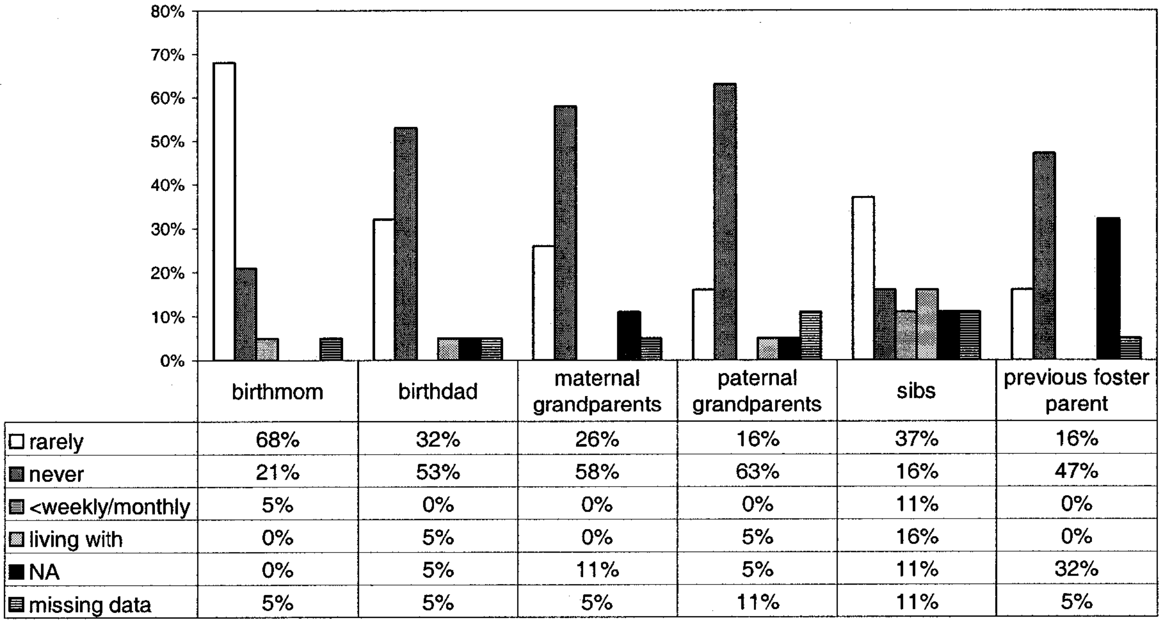


	Continuity	Some disruptions	Case seriously disrupted	Don't know	Missing data
▨ ages 1-9	58%	5%	21%	5%	11%

Respondents were asked to rate how frequently the child is in touch with various birth family members and previous foster parents. As shown in Figure 5.12, most of the responses were in the rarely and never categories.

Figure 5-12

Child has continuing contacts with family (age 1-9)

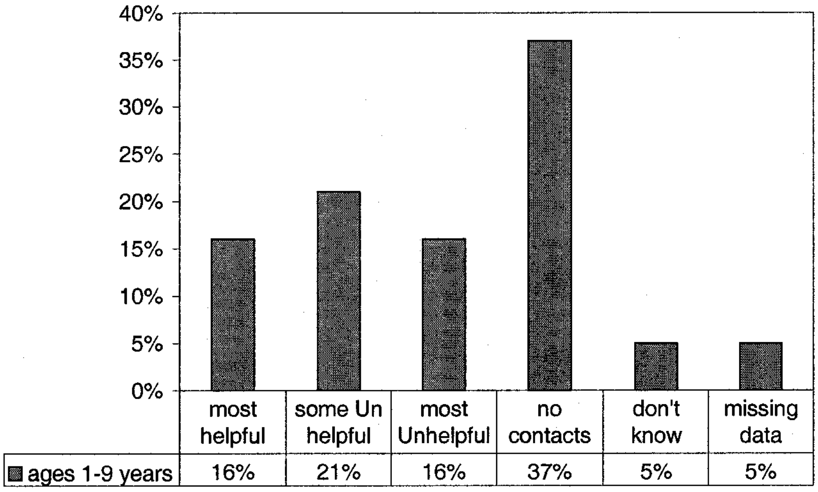


	birthmom	birthdad	maternal grandparents	paternal grandparents	sibs	previous foster parent
□ rarely	68%	32%	26%	16%	37%	16%
▨ never	21%	53%	58%	63%	16%	47%
▨ <weekly/monthly	5%	0%	0%	0%	11%	0%
▨ living with	0%	5%	0%	5%	16%	0%
■ NA	0%	5%	11%	5%	11%	32%
▨ missing data	5%	5%	5%	11%	11%	5%

When asked whether the contact with birth family strengthens the child's relationship with them, only 16% (3/19) thought the contact was helpful (see Figure 5.13). Thirty-seven percent (7/19) thought some or most of the contact was unhelpful for the child, while 37% (7/19) of the children had no contact with their birth family. Five percent (1/19) responded "don't know" while the remaining 5% (1/19) was missing data.

Figure 5.13

Child's contact with birth family strengthens their relationship (age 1-9)



	most helpful	some Un helpful	most Unhelpful	no contacts	don't know	missing data
▩ ages 1-9 years	16%	21%	16%	37%	5%	5%

For ninety-five percent of the children, the closeness of the attachments to the families they live with were rated as very well or quite well. In addition to their foster parents, 80% (8/10) of the children aged 1-4 years had an attachment to another adult. Twenty-one percent (4/19) of the children have difficulty being separated from their foster parents; while 26% (5/19) did not have any difficulty with the separation. More than half (10/19) of the data was missing for this question.

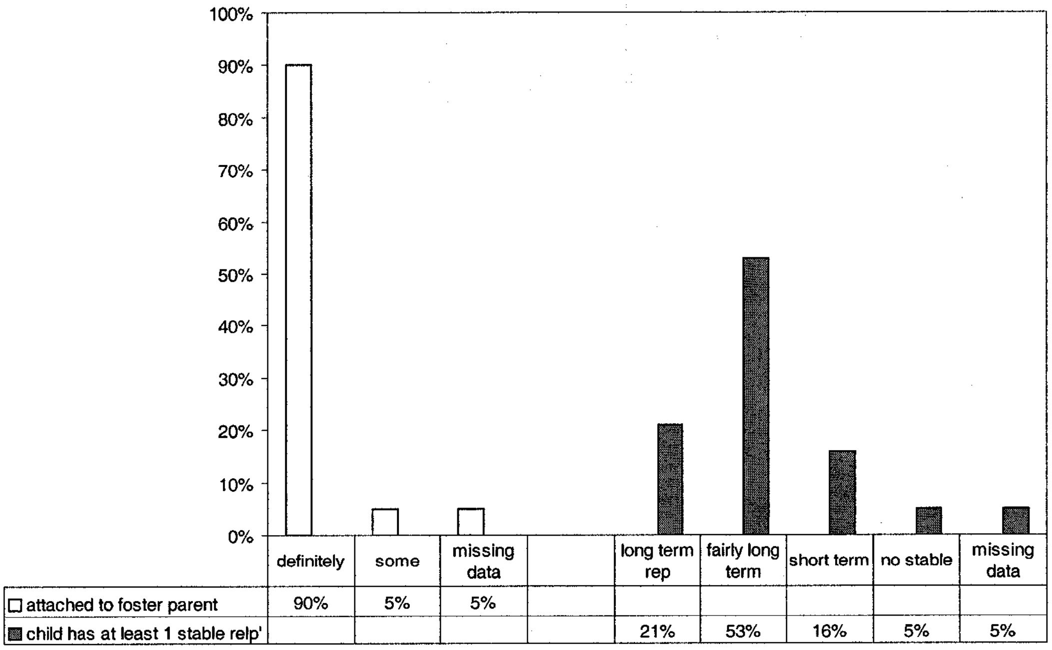
Some indications of a stable relationship can be seen through expressions of mutual affection and attachment. For 84% (16/19) of the children, the foster parents show them physical affection often and sometimes for 5.3% (1/19). For the remaining children

(2/19), the data was missing. As illustrated in Figure 5.14, ninety percent of the children (17/19) were described as definitely attached to at least one of their foster parents; 5.3% (1/19) show some attachment and data was missing for one child (5%).

The percentage of children rated as having a long term or fairly long-term (greater than two years) relationship with at least one adult was high at 74% (14/19). Sixteen percent (3/19) have a stable but short-term relationship (short term being between one and two years); and one child (5%) has no stable relationship. Data was missing in one case.

Figure 5.14

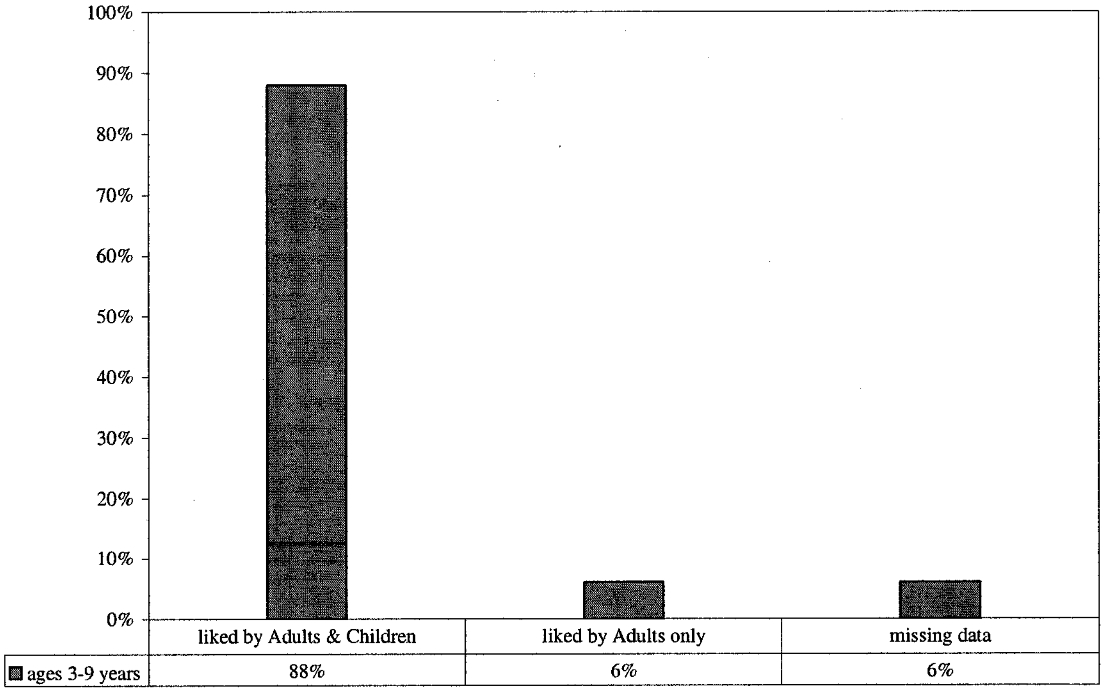
The child is definitely attached to one foster parent/has a stable relationship with one adult (age 1-9)



All of the children aged 1-4 in the study are encouraged to play with other children either frequently (78%, 7/9) or sometime (22%, 2/9). Sixty percent (6/10) of the children aged 5-9 are encouraged to see friends outside of school, while 30 % (3/10) are rarely or never encouraged to do this. For 10% (1/10), the data was missing. For 60% (6/10) of the children aged 5-9, long-term friendships with other children (greater than 6 months) include those within the care system. For 90% (9/10) of the children, their long-term friendships include children outside of the care system. As illustrated in Figure 5.15, 88 % (14/16) of children between 3-9 years old are usually liked by both adults and children, while 6% (1/16) are usually liked by adults only. For one child, the data was missing.

Figure 5.15

The child is liked by other adults and young people (age 3-9)



Social presentation

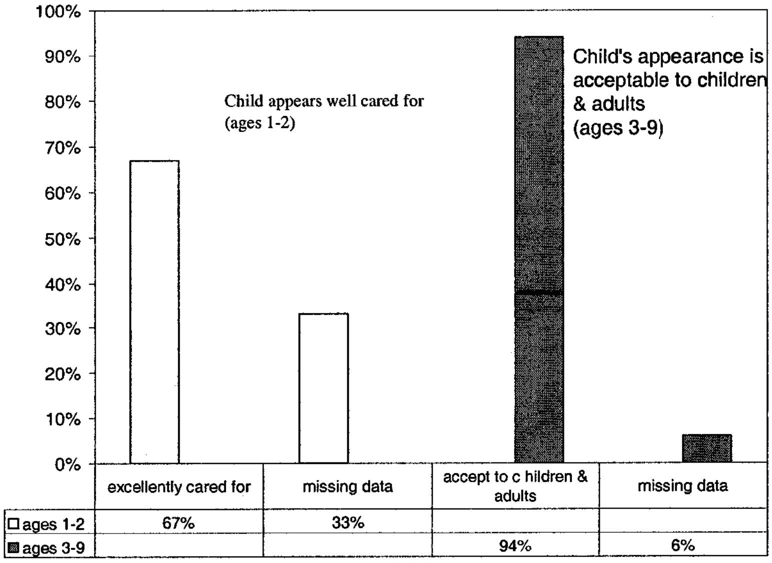
Questions in this dimension are designed to find out whether the child appears to be well cared for and that the child is learning behavior (manners etc) that is acceptable to others in a variety of social situations. Objectives of this dimension are to assess whether:

- The child appears well cared for
- The child's appearance is acceptable to other children and adults
- The child's behavior is acceptable to other children and adults

Responses to questions regarding diaper changes, bathing and hair washing for the children aged 1-2 indicated that the children were being well-cared for (see Figure 5.16). Sixty-seven percent (2/3) of the children aged 1-2 were receiving excellent care and the remaining 33% (1/3) there was no response to this question. For the children aged 3-9 years old, 94 % (15/16) had appearance that was acceptable to both children and other adults with the remaining 6% (1/16) missing data.

Figure 5.16

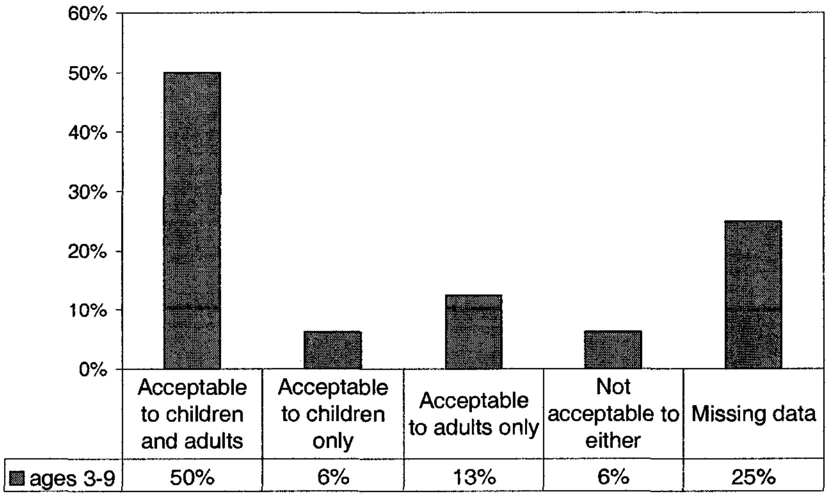
The child appears well-cared for/has acceptable appearance (age 1-2 and 3-9)



For the children aged 3-9, the question was asked whether the child says please, thank you and excuse me. Over 80% of the children were rated as using manners usually (81%, 13/16), while 13% (2/16) used them sometimes. Six percent of the data was missing (1/16). For the 10 children in the 5-9 age group, 50% (5/10) of them could adjust their behavior and conversation to a wide range of situations; 30% (3/10) could not do this all the time. For 10% (1/10) the answer was not known and for the remaining 10% (1/10) the data was missing. Overall, 50% (8/16) of the children (Figure 5.17), aged 3-9 were rated as having behavior that was acceptable to both adults and children; 13% (2/16) were acceptable to adults only; 6% (1/16) were acceptable to children only; 6% were acceptable for neither and for 25% (4/16) of the respondents the data for this question was missing. Forty percent (4/10) of the 5-9 year olds could communicate easily, while 50% (5/10) had some difficulty with communication. Ten percent (1/10) of the data for this question was missing.

Figure 5.17

The child's behavior is acceptable to others (age 3-9)



Emotional and behavioral development

This sections covers the areas of emotional and behavioral development and includes almost 50 questions around the child's behaviors with others; his concentration, anxieties and worries, use of professional services; and past abuses including bullying. Objectives of this dimension are the same for all three-age groupings:

- The child is free of serious emotional and behavioral problems
- The child is receiving effective treatment for all persistent problems

Ninety percent (17/19) of the children from 1-9 years old enjoy physical affection and will go to their foster parents when needing reassurance. All of the infants aged 1-2 (3/3) display content behaviors and are not described as fretful, irritable or crying persistently.

Concerning behaviors are presented in the negative and respondents are asked to describe a child's behaviors according to a Likert response scale. Response choices to the presented behavior ranged from "definitely like the child" to "quite like the child" to "a bit like the child" to "not at all like the child". For many of the questions, the majority of the respondents replied "not at all like the child". Examples of this are as follows.

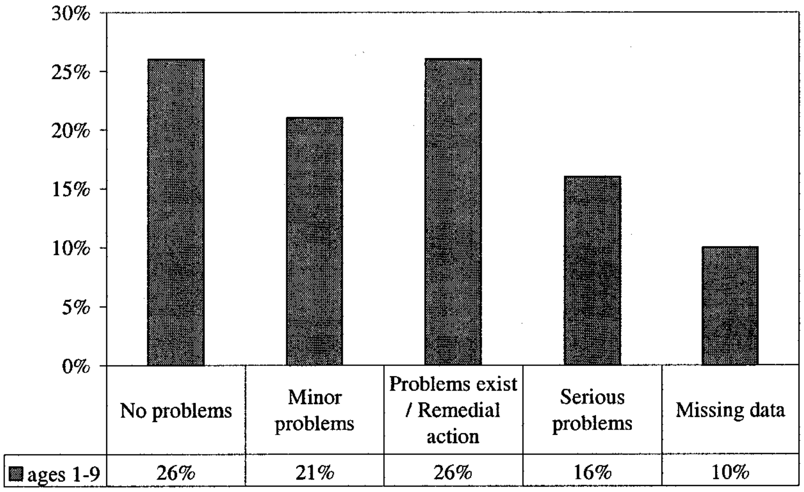
For the children aged 5-9 years, 70% (7/10) do not wet or soil themselves. For the children 3-9 years, 63% (10/16) do not display sadness or unhappiness; 63% (10/16) do not seem worried or anxious while 88% (14/16) don't complain of aches or pains. For all of the children aged 1-9 years, 63% (12/19) are not frightened of particular things and 79% (15/19) do not display self-injurious behaviors.

There were mixed responses for questions concerning concentration and behaviors where 44% (7/16) of the children aged 3-9 years were assessed as having difficulties with concentrating; 56 % (9/16) rush into things and 63% (10/16) find it difficult to settle to tasks. Forty-four percent (7/16) of the children aged 3-9 are destructive or steal things, while an equal percentage do not. The remaining 12% (2/16) of respondents did not answer this question.

In response to the summary question of whether the child was free of serious emotional and behavioral problems as illustrated in Figure 5.18, 26% (5/19) had no problems; 21% (4/19) had minor problems; 26% (5/19) have problems which require remedial action; 16% (3/19) were described as having serious problems and for the remaining 10% (2/19) the data was missing.

Figure 5.18

The child is free of serious emotional and behavioral problems (age 1-9)

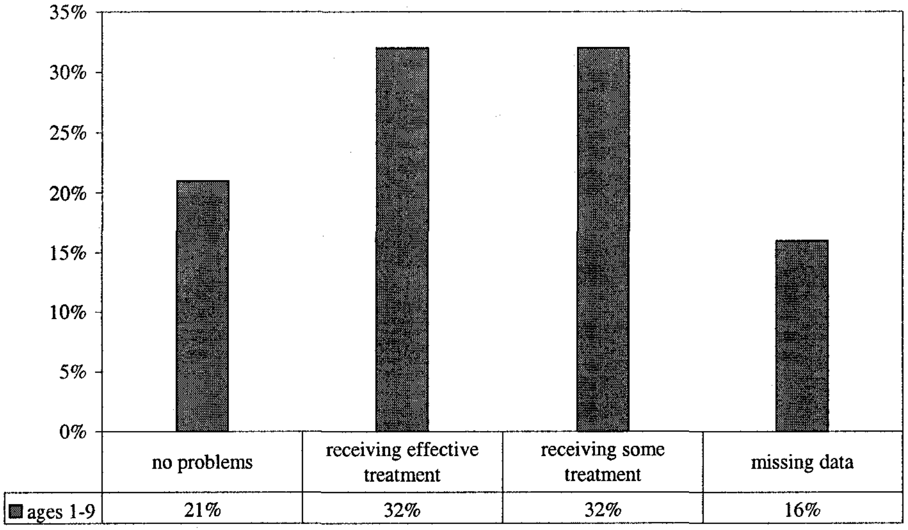


For 14 of the 19 children aged 1-9 years old, a variety of mental health professionals have been utilized in the past including a clinical psychologist, a educational psychologist, family therapist, a counselor and others but not specified. Seventy-four percent (14/19) of the children were not seeing a mental health professional at this time. Forty-two percent (8/19) of the children did not have emotional or behavioral difficulties that required help; 53% (10/19) were getting help from their foster parents; 5% (1/19) from their social worker and 11% (2/19) from other people. In this case, the percentages summed to greater than 100 as in some situations more than one person was helping or supporting the child.

In response to the summary question of whether the child was receiving effective treatment for all persistent problems (see Figure 5.19), for 21% (4/19) of the children the question did not apply; 32% (6/19) were receiving effective treatment; 32% were receiving some treatment and the data was missing for 3 children.

Figure 5.19

The child is receiving effective treatment for all persistent problems (age 1-9)



Self-care skills

This section covers self-care, developing independence, and safety skills appropriate to the developmental age group of the child. Objectives of this dimension are:

- The child is being encouraged to develop early self-care skills

- The child is learning simple self-care skills for coping with early independence:
- The child is learning to care for himself at a level appropriate to his age and ability with some supervision

Children in the 1-2 aged grouping were assessed in the areas of toileting, feeding and dressing skills. All of the children were learning to feed themselves with a spoon, while 67% (3/3) of them either could or were learning to put on their shoes and coats. One third (33%, 1/3) of the children were learning to control their bladders and bowels.

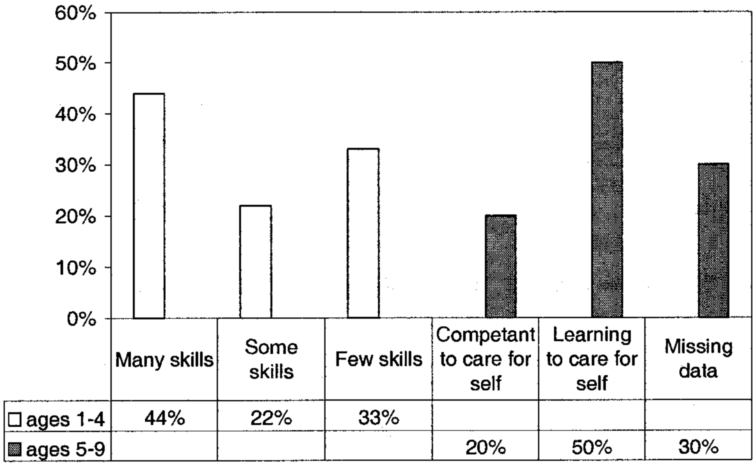
For the 3-4 year olds, the self-care skills assessed included toiletting alone, washing and drying hands, blowing own nose, dressing and undressing self, using a knife and fork, helping to tidy playthings and being able to recognize their own belongings. Consistently for all of the skills, over 80% (5/6) of the children in this age group could do the skill alone, with help or were learning to do it.

For the 5-9 year olds, self-care skills showed higher percentages of children who could do the skill, could accomplish the skill with help or were learning. This question included the skills of brushing teeth, bathing and washing themselves and getting a drink or snack. For the early independence skills, the results were mixed with 80% (8/10) or more of the children able or learning to do dishes, cross quiet roads safely and avoid common hazards. Percentages dropped to 40 % (4/10) for those able or learning to answer the telephone; 50% (5/10) who could make or were learning to make an emergency call, and 50% (5/10) who could or were learning to handle small amounts of money.

In summarizing (see Figure 5.20) a child's self care skills, the social worker and foster parent were asked to assess whether "the child (age 1-4) is being encouraged to develop early self care skills and whether the child is learning simple self care skills for coping with early independence." For the children ages 5-9, participants were asked to assess whether "the child is learning to care for him/herself at a level appropriate to his age and ability with some supervision."

Figure 5.20

Summary of Self –Care Skills (age 1-4 and 5-9)



Data on Research Participants

The data analysis on research participants is presented in two parts beginning with social worker participants followed by foster parent participants. All of the participants were invited to attend a one-day training workshop in preparation for the completion of the AARs. All seven social worker participants and eight of fourteen foster parents attended the training. Both social workers and foster parents who had attended the training were also permitted to use the AARs with other youth in their care, who were not included in the study, but with whom the participants felt using the AARs would be helpful.

Social worker participant survey and focus group

All seven social workers took part in the survey and focus group. Completed surveys were received from all seven social workers. Beginning with the survey component, the overall experience of using the LAC materials by social workers ranged from 3 social workers reporting a “somewhat positive” experience, 2 reporting a “mixed reactions”, 1 reporting a “very positive” experience and the seventh social worker checking off “very positive”, but noting that she actually felt somewhere between “very positive” and “somewhat positive”. No one indicated that the experience had been negative.

The second question in the written survey asked about how many sessions/ hours it had taken to complete a record and whether social workers felt the time spent was worthwhile. The question was asked in three parts. The first part of the question asks, “How many sessions did it take to complete the records”. The seven responses ranged from 1-6 sessions with two responses indicating they were not finished yet and one response reporting that it had taken 6 sessions and 8 hours so far as they were working with a youth (who was not part of the study). The second part of the question asks, “how many hours did it take overall”. For this question, response ranged from 2-8 hours per assessment with two social workers noting they had not yet completed one assessment, and for social workers who had completed more than one assessment comments included:

- “Varies, as it includes time spent by foster parent preparing for the meeting”
- “I expect that the questions will promote longer discussion with foster parents and with teenagers as I improve with the tool.”

All but one social worker found the investment of time worthwhile, with only one social worker having mixed feelings about the time invested. Social workers identified positive impacts on their relationships with the youth, and the amount of information about the child that they were able to obtain as reasons why they felt the time investment was worthwhile. Comments made by the social workers about the investment of time being worthwhile included:

- "Absolutely! In my opinion the time strengthened my relationship with the boy. It also promoted discussion that may not have occurred without specific questions"
- "Yes but I wish I had more time to do the questionnaire. I felt rushed in completing the form"
- "It has been very worthwhile. The 2-¼ hours have been intense. Lots of information and questions. The time has provided opportunities to explore [foster parents] views and feelings about the situation of her foster child".

All seven workers felt they had learned something new and some of their comments on what they learned were:

- "how thorough an LAC assessment can be"
- "the importance of rapport was emphasized when working with people"
- "the prepared questions helped to stimulate discussion"
- "getting to know more about the youth; their interests and activities; the child's achievements;"

One worker also commented that she now understood the new formatting for the child's "plan of care[7]" and how it matched with the LAC assessments. According to the social workers, most of the assessments had been completed with the social worker and foster parents. One social worker consulted with a medical doctor and previous social worker in the completion of the child's assessment.

The three questions designed for the focus group were provided to all participants prior to the group interview. Two workers who were unable to attend the focus group gave their input to the focus group questions in writing. Four of the five workers who attended the focus group gave written responses to the three questions as well as their verbal responses during the group.

Themes of the social worker participant combined survey/focus group

The following responses include information collected and analyzed from the written surveys, the transcript of the focus group and the flip chart summary recorded during the focus group. Workers identified strengths of using the LAC materials to be:

- the collaboration that occurred with the foster parent in working together with the worker and sometimes the child, to complete the assessment. Workers felt they got to know both the needs of the child better and the work of the caregiver.
- the transference of the information easily to the child's plan of care document and the easy identification of what tasks needed to be attended to and what had already been taken care of.

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[7] As will be discussed in Chapter 7, one of the policy changes that occurred during the study was the re-formatting of mandatory yearly plans of care for all children in care to reflect the seven dimensions assessed in the AARs.

- the increased knowledge and understanding of the needs of the child that developed through the AAR process for both the social workers and, in their opinions, for the foster parent.
- the questions asked in the assessment were good in that they were thorough, kept people on track; they were open ended, new, and led to discussions.

Workers identified the areas of weakness in using the LAC materials to be:

- the amount of time required in completing the assessments.

This was further sub-categorized into the time it took to go through the materials with the foster parent and the time it took to coordinate the numerous sessions required with the foster parent. The amount of time was further increased when working with a foster parent who had not attended the training, and when a child/youth was included in the assessment.

- the difficulties workers and foster parents had in fitting their responses into the ranges that were offered in the AAR. Much of the time they wrote the specific answer in the margin of the AAR because they were not able to figure out what to say.
- the importance of training for all participants. Social workers identified a considerable difference in completing the documents depending on whether the foster parent had attended the training or not. Lack of training placed greater demand on the social workers in having them provide some training to the foster parents.
- Social workers further expressed comments about their inexperience with using the tool, which meant they were reading the questions and which felt awkward.

- Having to record the responses of the foster parent seemed to depersonalize the process.

Other comments in this area included;

- “hard to stay focused on the questions with other things to do”
- “cumbersome to write everything down”
- “felt intrusive with an untrained foster parent; felt I was a nuisance”

During the focus group session, there were many more areas of weakness identified than there were strengths identified in using the LAC materials. Visually the areas of strength took up half a page of flip chart paper, while areas of weakness took up one full page and part of a second.

For the question on suggestions for change, social workers in the focus group identified four ideas. It should be noted that time had run out and this area did not get adequate time for exploration. As well, there was not time to do an initial summary with the social workers on what they thought were their priorities in terms of these four suggestions. They are listed here in no particular order:

- Training is necessary for all users of the LAC materials and has a positive impact on the use of the materials and the process of gathering the information
- Formatting of the assessments should indicate the summary from the year before for comparative purposes.
- There needs to be a place to list any medical or physical diagnoses up front.
- The distribution of the assessments to be completed should be fairly distributed across a team.

Written responses from the social workers provided the following suggestions for change:

- The time required setting up meetings with the foster parent, and then to complete the assessment needs to be understood and given recognition by the employer. The time requirements are increased when people are just getting to know one another and when the caregiver does not have the LAC training.
- It would be preferable to shorten the number of questions to be answered because of the time required to complete the assessment
- There should be an understanding that, over time, implementation will improve with practice and experience in using the materials.
- The importance of training for all involved in using the materials was emphasized.
- There should be a computerized format for the assessments

The following information was revealed at the conclusion of the focus group after the tape was turned off. Social workers said that they wanted the employer to recognize the amount of time required completing the assessments. They were feeling rushed to have the assessments completed by the desired time. Social workers indicated that they sometimes felt silly and unskilled when they were working through the documents with foster parents. This was most concerning to them when working with an untrained foster parent because not only did the social worker have to provide some training and explanation, but the social worker was still learning to use the tool themselves. This put them in a position where they sometimes felt like a nuisance.

Foster parent participant survey

Fourteen foster parents participated in the study and each foster parent received a follow up evaluation questionnaire to complete by mail at the conclusion of the data-gathering phase. Six out of 14 (42.8%) mailed questionnaires were returned by the requested date. All foster parents received a follow up phone call or message encouraging them to complete the assessment if they had not already done so. The response rate of 42.8% would be considered poor according to Neuman (2000).

All of the six foster parents who responded to the survey felt the experience of using the LAC materials was positive (3/6) or somewhat positive (3/6). Foster parents wrote that the amount of time needed to complete the materials ranged from 3- 15 hours and the number of sessions ranged from 1 to more than 6. All six of the foster parent respondents indicated that the time invested was worthwhile. One foster parent provided the following further comment to the question of the AAR being worthwhile:

- "Yes if the information is used and kept as a means of tracking the development of a child: no if the information is destroyed or covered up to hide accountability."

Half of the foster parents (3/6) learned something new by doing the assessment. One foster parent provided the following comment on what was learned:

- "The [department] has a very inadequate system of tracking children almost to the point of neglect and negligence. The history of this child both before care [and] while in care was very vague. Foster parent input was critical to being able to complete the information requested."

Many of the foster parents stated that they had completed some or much of the assessments on their own. One foster parent indicated they had completed one AAR completely on their own. Two of the foster parents had also consulted with a doctor to complete the AAR.

Foster parents were also asked to comment on whether completing the AARs had any effect on relationships with specific people. Foster parents were asked to check any effects using the following Likert scale: very positive, fairly positive, no effect, fairly negative, and very negative. One foster parent indicated that the effect on the relationship with the social worker was “very positive”. Three foster parents indicated that there were fairly positive effects on relationships with the young person, the social worker and with the health care worker. The remaining 16 responses were checked as having no effect on any relationships from five of the six foster parents.

Foster parents were asked to identify what was the most helpful aspect of using the materials. Their responses included the following

- “Having so much information in such a form will be so helpful and if the child moves. And, having the opinions and or perceptions of someone else to questions”
- “Keeping this fresh”
- “Knowing the department was making some attempt at trying to improve the care they provide for children in care”
- “Will be good for child to review at some time in the future”
- “Keep up my own records”
- “[Information] all in one book. I hope we get to continue this”

Foster parents were next asked to indicate what they thought was the least helpful. Two responses were left blank; three of the responses indicated that the social worker either did not participate or was not very involved due to time restraints, and one foster parent wrote the following comment regarding the training:

- “a complete waste of time especially when $$$ were not offered to compensate peoples time”

Responses to the question requesting suggestions for change included 2 left blank, one responding with a question mark-?; one response indicating “none” and the following comment from one foster parent again regarding the training;

- “training for social workers only-foster parents have better things to do like parenting. Asking [foster parents] to give up a Saturday was an insult-no special training was required to answer the questions or justify the reasons for doing it”

One foster parent commented that she would like to see training offered after the LAC assessments were competed. Comments on what should be deleted included “ a lot of repetitious questions” and “no further actions needed” questions as “they were very unnecessary”. One additional comment was included at the end of the survey with the foster parent writing:

- “this [survey] should have come out sooner while this was still fresh. This information gives the [social worker] a more personal look at the child they represent. It will give older child input into their life and a way to start a hard conversation.”

CHAPTER SIX

Discussion of Research Findings

The LAC philosophy and corresponding practice materials attempt to mimic as closely as possible the good parenting practices of a reasonably resourced parent in the community. The AARs provide corporate parents with a guideline of what parents need to pay attention to in order to meet the developmental needs of their children and hopefully prepare children to become healthy adults. As noted in the review of the literature, the seven developmental dimensions assessed are not exclusive of each other. Experiences and events in any child's life can impact them across many of the developmental dimensions. Although there are never any guarantees for any parent, there is strong research that links certain practices of parenting with more positive outcomes for children. For children in care, the unintended negative realities of growing up in care can affect a child across all of these seven dimensions. Placement moves, having many people responsible for their care, the stigma of being in foster care and loss of contacts with others are some of the unfortunate conditions that can exacerbate the life situation for an already vulnerable child.

On an individual child basis, the LAC materials provide a structured practice protocol designed to first assess a child's current developmental needs and then plan for how those developmental needs of the child will be attended to. When the assessments are completed on a group of children and the data aggregated, information can be obtained that can identify where possible program or practice changes can be made to enhance the care for all of the children. In addition to a general overall discussion of the themes that emerged through the aggregation of the data, direct comments from the study participants on their interpretations of the data will be presented.

The Well Being of Children Raised in Care

Health Status of Children in Care

The information obtained under this area of investigation confirmed the previous research that purports that the majority of children who come into care arrive with poor health and pre-existing health conditions. Almost 80% of the children in this study were found to have health conditions and disabilities that require special attention.

- "With some [children in care] it was very clear when the child came into care that some of these medical conditions cleared up and improved dramatically. This speaks to the exceptional care by foster parents." (SW)
- "usually [child in care's] health clear up after 6 months to a year in care." (SW)

The children in our study are having their yearly medicals completed, and for most, regular vision, hearing and optical assessments. For all of the children, their immunizations were up to date. That is consistent with high immunization rates for all infants and young children in Canada. However, according to the Canadian Institute of Child Health (2000, p. 58), "this relatively new form of safety for children requires constant vigilance to maintain and must not be taken for granted." For the children aged 1-4, the foster parents are dealing with children with heart conditions, respiratory problems, ongoing flus, colds, ear and chest infections. For the children aged 5-9, the conditions requiring medication therapy were more prevalent as were emotional and behavioral issues.

Many of the children in the study also had special dietary needs including low tolerance or sensitivities to dairy products requiring limited consumption, other food sensitivities, and some children required special management of their food due to choking and difficulties with swallowing. Overall three quarters of the children were generally healthy.

It appeared that for this group of children there is a need to recognize and understand that many will have health conditions that will require attention well beyond that of a typical child.

- "I am worried that children [in care] who are reported as unwell may give the impression that health needs are unmet when actually some of the more serious conditions might be the reason the children are actually in care." (SW)

Given the greater health needs of this population of children, the importance of regular and ongoing medical check ups is highlighted. Foster parents in this study want to see 100% of medicals done.

Furthermore, ensuring that the child has a consistent doctor who has knowledge of the child's medical history and the importance of maintaining and obtaining good medical records are also highlighted (Butler & Payne, 1997; Klee, Soman & Halfon, 1992; Simms & Halfon, 1994).

Issues regarding the safety of a child's environment revealed misleading data. Although the summary data indicated that 100% of the children were residing in a safe environment, further scrutiny of the individual safety questions revealed ambiguous responses. Take for example the following question and the responses provided:

1. Have the child's foster parents taken steps to ensure that all medicines, cleaning fluids and poisonous substances are locked in a cupboard with key removed?
   Response: (N=19): Yes=15, No=4

Does this mean that medicines and other substances are not locked away but are nonetheless put in an inaccessible location? Or does this mean that in 4 instances these substances are accessible to the children? Further scrutiny of foster parents would be required to determine what is meant by the responses.

According to the Canadian Institute of Child Health (2000, p. 74), the leading cause of death for Canadian children aged 1-4 is from injuries and poisoning, and for children aged 5-9, from external causes of injury (p. 106). Although infants in Canada rarely die from injuries, the injuries they do experience are most likely to occur in the home environment (Canadian Institute of Child Health, 2000, p. 46). Injuries and poisoning are all potentially preventable. However, less than one-fifth of Canadian parents viewed childhood injuries as "very or completely preventable" (Canadian Institute of Child Health, 2000, p. 68). Yukon children in foster care need to reside in home environments that make efforts to ensure all injury prevention safety measures are taken. These efforts include age-appropriate supervision as well as modifications to the home environment such as baby gates, locked medicine cabinets and approved child beds designed to prevent accidental injuries. In addition, continuing education and information regarding child safety issues needs to be provided to both the caregivers and social workers of children in care.

Education Status of Children in Care

A child's education is a high priority for parents who understand the longer-term implications of education and it impacts on future quality of life issues. The school system with its multiple academic, social, and recreational opportunities can be an area of constancy for children whose lives are disrupted and chaotic. Staying in school and participating in one activity outside of school are documented to be two strong protective factors that can promote resiliency in children (Gilligan, 2000). Children in care are often further disadvantaged in their schooling when there are many placement moves, which often results in a school move as well. Changing schools means a loss of familiarity to ones teacher and friends as well as loss of educational information. During the time it takes to adjust to these changes, children cannot focus on their learning. For the school-aged children in our study, only 3 of the 10 had had no school moves. Sixty percent of the children had between 1 and 5 school moves and all of the children are under 10 years old!

- "...how many of the school changes occurred prior to coming into care and also how many occurred post permanent wardship. We may not only want to know how the children are doing, but also how they are doing in comparison since they have entered care." (SW)

For Whitehorse children in permanent care, developmental delays are noted in all of the children in the 3-4-age grouping and those many of the same children have speech difficulties. For the 5-9 age group, 6 of the 10 children (60%) were identified as having learning difficulties. School programs appeared to be quite specialized with many of the children of school age involved in a variety of learning situations. The majority of respondents felt the children were receiving appropriate educational programming for their needs. However, there were areas of identified need:

- "Important that the transition between CDC, [Child Development Center], and kindergarten for our special needs children be smooth. [Foster parents] often frustrated as their children have immediate access to [occupational and physiotherapists and speech-language pathologists] in CDC, then move into the education system where they may have to wait up to a year for an assessment." (SW)

- "Need more specialists to identify FAE/FAS in younger children sooner if possible instead of waiting when [child in care] gets into school." (SW)
- "School system needs to be more aware of the FAS/FAE problem in Yukon." (SW)

The children were also involved in a wide variety of additional activities outside of school.

- "It's important to engage the kids in a sport/activity that they love to do young so that it may follow them up past 9 years old [and] through to the teenage years." (SW)

Social workers and foster parents need to ensure that a child's education program and opportunities to participate in activities outside of school continue to be highlighted and are given a high priority in caring for Yukon children in care. "Participation in sports, recreation and the arts may contribute to the resiliency of children and protect against psychosocial problems" (Canadian Institute of Child Health 2000, p. 90). However, according to one social worker in this study:

- "It is difficult to find appropriate help or programming for children with a mild or less severe delay. I find gaps in the system and it can be very frustrating for social workers and foster parents." (SW)

General comments from foster parents regarding data from this dimension were:

- "Wow" (FP)
- "New foster parents need to know this information" (FP)

- "we want actual diagnoses and reason for [child's] delay." (FP)

Identity Status of Children in Care

Children in care are prone to difficulties with identity formation (Kufeldt et al., 2000). Inconsistent, neglectful or abusive early parenting contributes to a child coming into care with a poor sense of self. Once in care, placement moves, loss of contacts with birth family, loss of information about one's past, and the possibly of competing loyalties between birth families and foster families can all exacerbate the already complicated task of figuring out who one is and how one fits into the world.

For our children in care, almost 80% of the children were assessed as having a positive view of themselves, although only half of the children seemed to have some or a clear understanding of their current life situation. Comments from social workers include:

- "Unless a child learns about the forces which shaped him, the history of his people, their values and customs, their language, he will never really know himself or his potential as a human being. National Indian Brotherhood 1972." (SW)
- "Workers have to remember to continue to go back to this as children get older. Understanding why they are in care at the different developmental stages is so important." (SW)

Almost all of the children have Lifebooks being prepared for them, which was very positive given the time requirements of this task.

- "Workers and foster parents should work closer together on [children in care] lifebooks. Lifebooks are very important to the [child in care] when growing up in a foster home." (SW)

Areas for further scrutiny would include the child's knowledge of their family of origin and whether the child can relate to their racial/ethnic background. The data indicated that the numbers of children with knowledge of family was low, as was the ability to relate to their cultural background. However, given the ages of the sample, the developmental delays, and the amount of contacts with birth family (discussed in Family and Social Relationships dimension), the low percentages may be better understood. Comments from social workers included:

- "Children especially First Nations children in care should be told who they are related to." (SW)
- "More work needs to be done teaching the First Nations children in care about their clan systems and how this system works." (SW)

Family and Social Relationships Status of Children in Care

Relationships, their importance, their quality, and their continuity are all areas highlighted in the questions in this dimension. For children in care, their relationship to their family of origin is disrupted and for many children a replacement family can never quite take its place (Jackson, 1998). The complex task of developing relationships is again much more complicated for children in care who are vulnerable to placement moves and loss of continuity of care.

For the Yukon children in permanent care in this sample, continuity of caregivers is an area that raises concerns given that 37% (7 of 11 known responses) of the children aged 1-9 had had 4 or more primary caregivers since infancy. Respondents felt that only just over half of the children had continuity of care, while 26% were deemed to have some (5%) or serious (21%) disruptions. Unfortunately, 16% of the data was either missing or not known for this question. One social worker commented:

- "We need to ensure our [children in care] have fewer foster homes. History shows [children in care] bounce around a lot from foster home to foster home."

What the data does suggest is that serious attention must be paid to the stability of the child's present placement and the need to monitor, support and promote an attachment process with a caregiver.

Foster parents and social workers reported promising information on the assessed attachments of their foster children with 95% of the children being definitely or somewhat attached to the foster parents. For almost 75% of the children, the relationship was described as long term or greater than two years in length. "A healthy bond with a caring adult, particularly a parent, is an important building block of resiliency and, as such, can have a lasting positive impact on children's health and well-being over the long-term" (Canadian Institute of Child Health, 2000, p. 215). For the social workers:

- "Relationships with caregiver needs to be well documented." (SW)
- "We need to put a lot of effort and time into this area. Work to keep relationships going." (SW)

However, when it came to maintaining contacts with previous foster parents, the data indicated that over 60% of the children rarely or never had that contact. A foster parent commented that:

- "We want the department to support us with continuing visits [for children in care] with past foster parents." (FP)

Relationships with birth families are an area that also requires a closer look to understand the data that was provided. When asked how often the children were in contact with various members of their birth family, the responses were primarily reported as “rarely in contact” or “never”. Only 16% of the respondents felt the contact was helpful. This seems like a really low percentage. However, the data does not provide explanations to fully clarify why, when birth family knowledge and contact is deemed important for children in care, our children do not seem to have a lot of contacts or knowledge of their family of origin.

- “It appears that contact with family will be an issue we will have to deal with—access to birth family does not seem to be cut and dry when birth family are involved.” SW
- “[Permanent wards] should at least know their family tree if there is no family contact.” SW

Sometimes the lack of contact results from the withdrawal of the birth family after a permanent care order. Another contributing factor may be the age of these children and the significant number of developmental delays making explaining and understanding of their life situation more difficult and complex. In addition, one social worker questioned whether the child’s legal status impacted on this data when she wrote:

- “I believe the data about children’s contact with birth family members (i.e. rare) needs to be compared on the basis of legal status as this study was limited to children in permanent care where reunification is no longer a goal.” (SW)

In terms of peer relationships for children in care, one social worker made the following two comments:

- “Often our children tend to have limited social contact with other children that are not [children in care] except for in school.” (SW)

- “We must actively involve our kids in normalized activities to encourage healthy social development.” (SW)

Social Presentation Status of Children in Care

We live in a world where judgments about us are made by the way we look, the way we speak and the way we act in social situations. Children in care are often stigmatized because they are in care and this makes them already different from other children. The way a child is dressed and is taken care of can translate into perceptions of being cared about. The questions in this dimension relating to a child’s appearance are asked differently in each developmental age grouping. For the majority of children where there was data, the respondents stated that the children were either excellently cared for (67% aged 1-2) or their appearance was acceptable (94% ages 3-9). The remaining percentages were all from missing data. As a practicing social worker, the Assessment and Action records drew my attention to the need to ask questions about the child’s appearance and these questions should also be asked of teachers and others who are in contact with the child. Even more so than typical children, children in care are at risk of standing out in the crowd simply by being in care. Ensuring that their physical appearance (i.e., clothing and personal hygiene) does not stigmatize them any further is important. Appropriate clothing and the purchase of hygiene products are basic supports that can be provided for children in care.

Half of the children had social behavior that was seen as acceptable to both other adults and children. However, half of the children aged 5-9 had some difficulty communicating with others.

- “50% appears a bit high. We need to work on communication problems.” SW

In addition to the comments made regarding the data, one social worker wrote the following recommendations:

- "That the use of this tool continues as the child gets older" (SW)
- "Continuation of [this LAC] project" (SW)
- "Good work" (SW)

Emotional and Behavioral Development Status of Children in Care

The well researched situation of being separated from ones birth family as a result of abuse or neglect, and then being subjected to many of the unintended but negative aspects of the foster care system, places children in care at a high risk for developing emotional and behavioral problems.

According to the Canadian Institute or Child Health (2000, p. 209), "abuse is a profoundly important determinant of mental health and well-being...Further, the impact of child abuse is long lasting and pervasive, negatively affecting many aspects of the child's life." The consequences of child abuse include emotional and behavioral problems. The objectives of assessing this dimension were to determine the extent of children suffering from emotional and/or behavioral problems and then to determine if, when there were identified problems, the child was receiving help.

For the children in our sample aged 1-9, 63% had emotional and behavioral problems ranging from minor to serious. Given the reported number of caregivers, developmental delays, health conditions and school changes, this does not seem too surprising. Many of specific emotional and behavioral difficulties noted included problems with concentration, impulsivity and difficulty settling to tasks, many of which are symptoms of children with alcohol related birth defects. The study did not attempt to determine the extent to which this sample of children had a specific diagnosis of FAE/FAS (now referred to as FASD, fetal alcohol spectrum disorder). Foster parents noted that they would like to have children in care assessed for FASD.

Many mental health professionals have been utilized (including psychologists, therapists and counselors) to treat identified emotional and behavioral problems. Sixty-four percent of the children were identified as receiving effective treatment for an identified problem.

- "There has been noticeable changes as foster parents now pay attention to areas addressed in this project. Community resources to meet need is used appropriately. Definite and positive changes seen." (SW)

Self-care Skills Status of Children in Care

Preparing children for eventual independence is a process that begins very early in life. It is important for children to learn how to care for themselves to the best of their abilities. Beginning with dressing, feeding and toileting skills, children within the developmental age grouping of 1- 9 years old can progress to taking care of their belongings and helping out with family tasks. Results from the project indicated that children were making progress in all age groupings and for most skills. What was most helpful through this dimension was identifying the specific self-care skills that a child should be accomplishing for their developmental level. The assessment allowed for a comparison of the child to a typical child of that developmental level. For some children, the checklist identified areas of advancement and accomplishment as well as areas that the foster parent may not yet have addressed with the child (i.e., answering the phone). In light of the number of children in this study with developmental delays, this dimension also identified which specific skills the child was behind in and brought to light in a practical way the implications of developmental delays on day-to-day life of the child and foster parent.

Looking After Children as an Effective Assessment Tool to Track Developmental Outcomes for Children Raised in Government Care

Both the social workers and the foster parents liked the LAC materials and its philosophy of focusing on a child's overall well being. The foster parents showed eager participation in the project and were anxious to have feedback of the results. Despite the amount of time required to complete the assessments, 83% of the assessments were completed. However, the collaboration between foster parents and social workers that LAC promotes did not occur to the extent that it was intended. This is likely a direct reflection of the current workloads of the social workers working with the children in permanent care and not an indication of disinterest. It should also be considered that, at the same time as this project was being undertaken, there were also two additional service reviews being conducted within the Branch that required the time and attention of all Branch staff. It is hoped that with feedback from the project, all the participants will see the value of the LAC materials to their practice and, when given a manageable workload, the LAC materials will enhance their work with children in care.

Social Workers

A review of the findings provided what initially seemed to be opposing views. On one hand, workers were reporting in the survey that they felt generally positive about their experiences in using the LAC materials. Yet, during the focus group, they listed far more areas of weakness than areas of strengths in using the materials. The information seemed contradictory until I was able to take a closer look at what workers were saying. Some of the revelation came from the information provided after the tape was turned off in the focus group. It was as if workers were then able to reveal what some of the underlying issues that affected them were, while using the LAC materials. What has also become clear is that workplace-based research cannot operate in isolation from other activities that workers are exposed to during the same time period and that these other events impact on their experiences reported.

The main points expressed by the workers were similar to those issues presented as challenges for the other pilot projects completed in England, Canada and in Australia (Jackson, 1995; Jones et al., 1998; Kufeldt et al., 2000; Wise, 1999). First, the philosophical shift required to change ones practice from a "keeping children safe" focus to a "developmental model of parenting" focus does not appear to have been met with any resistance from this group of social workers. Workers liked the shift in focus and felt that they had already begun focussing on the child's overall wellbeing when working with children in permanent care. The training did provide them with a clearer understanding of their roles and responsibilities when attending to the child's overall wellbeing. Workers talked about the thoroughness of the assessments, the important information about the child that they learned from the process, the more intimate day-to-day information they obtained that helped them to understand the child's life better and the knowledge of the child's achievements. This developmental model identifies the child's areas of strength and needs and identified what areas required attention. Using the seven dimensions allowed for all developmental areas to be addressed for all children. Working with the foster parent in completing the assessment allowed the workers to engage in an ongoing exchange and sharing of information with the foster care providers.

The positive impacts on the relationships with both the foster parents and with the child that occurred during the assessment process was commented upon many times. This collaborative approach helped to identify to the workers the work that foster parents were doing to meet the needs of the child. The philosophical shift that the LAC materials requires may not really be much different for this team of social workers who are responsible for the care of children whose birth families' rights have been terminated. Working with children in permanent care demands more than just keeping children safe. Social workers in this team are already accustomed to doing assessments and comprehensive reviews with children. Workers commented that the LAC materials helped to provide a framework for setting up a child's plan of care and the format of the seven dimensions offered a consistent way of assessing children for the whole team.

The second challenge found in the other pilot projects and echoed in this research was the whole element of time and what the implications of time were for the workers. This appeared to be the 'loudest' issue that came out of this research and further exploration revealed the underlying concerns. Workers were concerned with both the amount of time it took to set up the appointments with the foster parents to work on the assessments and the time it actually took to go through the questions. The time to set up appointments was not recorded so the extent of this impact on workers' time cannot be quantified. Workers identified it to be a considerable problem for them.

In addition, the time requirements needed to complete an assessment were a problem as workers indicated it was taking between 2 hours and 8 hours to finish. Those taking 2 hours indicated that the foster parents had taken some time beforehand preparing for the meeting. After saying that they were concerned with all the time taken, workers then indicated that for most of them the time taken was worthwhile. What was this mixed message really saying? Workers said that taking the time was not the problem. It was the need for supervisors and managers to understand the time needed to complete the assessment with the foster parent and to understand that, with heavy caseload demands, this put a lot of pressure on workers in addition to what was already expected of them.

Although some workers were given some assistance from the student and some assessments were distributed more equitably amongst the team of workers, nothing had been taken away in terms of caseload responsibilities in order to use the LAC materials. Workers questioned whether supervisors and management understood the practical casework requirements that came with the philosophical shift of caring for children beyond keeping them safe. Although the materials were found to be useful, the time it took placed an added burden for workers who already felt overwhelmed. It was difficult to feel enthusiastic about an added burden no matter how good the materials may be. Workers seem to be suggesting that a lack of recognition and understanding about their current caseload demands was evident when they were being asked to do more work without other demands being lessened.

The third challenge identified in the pilot projects, and also seen with this team of social workers, was the importance of training to the development of the project. All social workers attended the training for the pilot project, as did all of the foster home support workers including their supervisor. In addition, the social work student was trained as well as eight of the fourteen foster parents. Training had been offered on two different days, one a weekday and one a Saturday, to accommodate everyone but still some foster parents did not attend. When working with a trained foster parent, who understood the philosophy behind the practice protocols and their part in completion of the materials, there was a mutual "awkwardness" with using the new materials [researcher's word].

Overall, workers felt that both they and the foster parent understood the learning process needed and that the study was intended to be a practice and trial run for using the materials. However, when working with a foster parent who had not received the training workers described themselves as feeling "silly, like I was nuisance". Reading the questions directly from the assessments felt awkward and sometimes intrusive. Workers explained these feelings as bringing question to their professional credibility, particularly in the eyes of the foster parents. Workers who were collaborating with a foster parent who had received the training on the use of the materials also found that the sessions went quicker than with those foster parents that did not have the background to the project.

The duplication of information was a concern expressed in this research as it was in other pilot projects. In this case, workers were advised to expect this duplication and to provide input into what they felt was being duplicated and what could be replaced if using the LAC materials. The experiences of this team of social workers did identify that some of the information was repetitive. This did not present as a big issue for this team at this time. Workers were pleased with the ease that the assessment material transferred into the child's plan of care and both followed the seven developmental dimensions.

The 'loudest' and 'biggest' point that emerged throughout this study was workers feelings of dis-empowerment that was displayed throughout their current practice and the

LAC project gave them an opportunity to express it. Workers described many issues of concern in using the LAC materials but what appeared to emerge as the underlying issue was this feeling of exclusion. Their interest in doing the mid-pilot evaluation indicated a desire to provide input. They were eager to be participants in this research and wanted to provide information on their experiences. Workers want to make a difference and have valuable information to contribute. Workers have continually felt that decisions were been made for them and without their input and it has impacted greatly not only on the work that they do but in their feelings of credibility, value and roles as social workers.

Foster Parents

As noted previously, foster parents were eager participants in completing the AARs for the children in their care. All of the nineteen assessments had the participation of the children's foster parent and this was not the case with all of the children's social workers. Foster parents were not as eager to attend the one day training for participants with only 8 of the fourteen foster parents attending one of the two sessions that were offered. One of the comments from a foster parent did identify the responsibility of parenting to be a barrier to attending training on a weekend. As well, only 6 foster parents responded to the mailed out survey despite follow up calls. As noted by the one foster parent the survey was mailed out 6 weeks after the final collection of the completed AARs. For some foster parents, it may have been several months since they completed an AAR and the information about their experiences was no longer fresh or clear in their minds. As well at the time of this mail out survey, the foster care team had also asked foster parents to respondent to a survey about foster care services from the department. Although coincidental that the two surveys were sent out at the same time, this oversight may have impacted on the response rate to the LAC study. Only 6 foster parents attended a presentation where the data from the study was shared and their interpretations of the feedback was solicited. Another noteworthy item was that all fourteen participating foster parents were foster moms and there were no foster dads who assisted in completing the AARs, attended training or attended the presentation.

Foster parents described the LAC materials as useful and were particularly pleased with how the AARs reflected on the job of parenting that they were doing. One foster parent's comment that the AAR could not be completed without her input was particularly significant to this social worker. The truth to her comment came through clearly when I attempted to get started on one of child's AAR before meeting with the foster parent. I did not get very far. Foster parents are an invaluable resource to the child welfare system and it appears that their knowledge and skills may be under-utilized. Several foster parents commented that they completed all or most of the AAR on their own without the child's social worker. This is not the intent of the LAC philosophy that is to promote a teamwork approach to parenting children in care. It must be recognized that foster parents hold a wealth of important information about children in care and that this information is invaluable for the social worker and for the child's history. Foster parents need to be seen as equal and competent members of the corporate parenting team. Foster parents in Yukon who participated in the study would like to see Looking After Children continue. Comments from foster parents were:

- "[LAC] should continue so children can see these reports when older and are aware of the care given to them growing up."(FP)
- "I would like to see it [LAC] continue with or without extra help." (FP)

CHAPTER SEVEN

Practice and Policy Implications and Recommendations

Looking After Children was first introduced to Yukon child welfare staff in September 2000 when this researcher embarked on what was to become a four year project to get the word out about this exciting and new international initiative. Informal use of the AARs, as well as following the national and international progress of LAC, garnered interest amongst staff and management. Although discussions about LAC had been occurring at the management and front line levels of service, the real impetus for the LAC began when the researcher, as a member of the Children's team, drafted a redesign of the plan of care format to use with children in permanent care. As a result of this, the LAC in Yukon initiative began and even before the completion of the study there were several policy and practice implications that already had impacts on service delivery for children in care.

Impacts of Looking After Children in Yukon Study Thus Far

Plans of Care

Social workers are responsible for ensuring that each child in care has a written plan and this is mandated in policy. For children in permanent care, a plan is developed yearly and reviewed minimally every 6 months and more often if significant changes warrant additional reviews. Although a plan of care format existed, the areas to be covered were vague. Formats for plan of care meetings were as varied as the social workers that led them. The re-designed plan of care was modeled on the LAC seven dimensions of child's development. In addition to the seven dimensions, the goals of each dimension were included as guidelines for areas to cover within the dimension. Use of the draft plan of care amongst the Children's team proved to be a practical and informative method for social workers in developing mandated plans of care. The format of this plan of care provided an agenda for plan of care meetings that outlined all of the areas to be covered. Social workers found the plans of care to be thorough and practical in that they identified specific tasks within each dimension that were to be attended to, asked who was going to attend to them and requested time frames for completing the tasks. As well, plans could be hand written and signed off right at the plan of care meeting and copies distributed to all team members. Modifications to the plan of care format were made as social workers practiced using them. The re-designed plan of care was soon being used across the branch and during the time of the LAC in Yukon study was incorporated into policy.

Recommendation # 1:

Although the LAC plan of care is now incorporated into policy, training on their use did not occur across the branch. It is important that all social workers receive training on the philosophical basis of the seven dimensions and that includes parenting practices and resiliency factors. LAC training should also be incorporated into the departments CORE professional development plan.

The Philosophical Shift in Practice

Understanding the dual mandate of child welfare services and the need to place emphasis on the well being of children in care provides a foundation for all social work practice with children in care. Training in the LAC initiative, its theoretical underpinnings in developmental, expectancy and resiliency theories outlines the importance of attending to all seven dimensions of child development. As well, understanding how to divide up the complexities of tasks of parenting a child in care amongst all team members, and working in a collaborative way, is essential to good social work and foster parent practice. Understanding the roles and responsibilities of each of the team members and the needs of the child that have to be attended to helps to clarify how to get things done. For those involved in the LAC study, training provided this clarification and participants in the study recommended that this training be provided to all social workers and foster parents working with children care.

Recommendation # 2:

Training occurs throughout the branch on the philosophical underpinnings of the LAC initiative. This training should be incorporated into the branch CORE training mandatory for all social work staff. Ideally training would occur jointly with social workers and foster parents.

Factors Associated with Resiliency

LAC identified in its teaching a number of negative implications of growing up in care and a number of protective factors that seem to contribute to better outcomes for children. This information led to an informal tracking of specific factors for children on the permanent care team. Social workers began documenting the number of placement moves, the number of school moves and the number of caregivers a child has had. This information is now documented in the child's yearly review recording, discussed at the yearly plan of care and tracked on an individual child basis. In addition, discussions among team members about the positive implications of keeping a child in the same school, assisting them to stay in school and tracking children's involvement in activities outside of school is occurring. An "activity" sheet was initiated that looked at the activities that children in the permanent care team were involved in and, for those children where no activity was identified, encouraging the child to get involved in one. One of the highlights of the activity sheet was that many children in permanent care were involved in a wide variety of activities and a great many of them were very successful. This information was provided to the Minister of Health and Social Services as a good news story.

Recommendation # 3:

Continue to track the number of placements, school moves and number of caregivers for children in care and ensure this information is recorded in child's yearly review recording and discussed at each yearly plan of care meeting.

Recommendation # 4:

Ensure that every child in care in involved in at least one extra curricular activity outside of school.

Future ideas for use of Looking After Children in Yukon

The seven dimensions of the LAC materials has been valuable in providing social workers with a framework for their practice.

Recommendation # 5:

Re-design the needs assessment for children in care to reflect the seven dimensions of LAC or consider using the AARs instead of the needs assessments and determine the corresponding foster care rates based on the outcome of the AARs.

Recommendation # 6:

Re-design the yearly review recording for children in care to include the seven dimensions of LAC and incorporate this into policy. During the LAC in Yukon study, this social worker, with permission from the Assistant Director, informally re-designed plans of care using the LAC dimensions for children on my caseload. It is only a matter of reformatting the headings. Information from the yearly plan of care meeting, which already follows the LAC plan of care format with the seven dimensions, allows for easy inputting of information into the review recording.

The Children In Care and the Assessment and Action Records

Recommendations below are being made based on the aggregated information obtained for the AARs with the children in care in this study

The Health Dimension

Recommendation # 7:

Recognize that children often come into care with poorer health than typical children. Poor health requires vigilant monitoring, assessing and accessing of health care services.

Recommendation # 8:

Health care needs to be documented on the child's file to be accessible to all. Updated information needs to be included in all yearly review recordings.

Recommendation # 9:

All efforts need to be made to ensure that a child in care has a consistent doctor and preferably the same doctor that works with the child's family. In Yukon, the small population can accommodate this.

Recommendation # 10:

Yearly medical be completed on all children in care as per departmental policy.

Recommendation # 11:

Yearly medicals need to include height, weight and percentiles information, as well as vision, hearing and dental screenings. This information should also be sought through a thorough medical when a child first comes into care.

Recommendation # 12:

Immunizations continue to be given high priority and documented on the child's yearly review recording.

Recommendation # 13:

Encourage social worker, foster parents and health care providers to talk to the children about any ongoing health conditions.

Recommendation # 14:

The area of household safety requires further scrutiny and attention. Initially the findings of this study should be discussed with social workers and foster parents and supervisors to provide information on the prevention of injuries for children in care. Also provide statistical information on the prevalence of childhood injuries and accidents and their prevention.

The Education Dimension

Recommendation # 15:

The prevalence of developmental delays in all of the children in the 3-4 year old age grouping is concerning as is the rate of learning difficulties for children aged 5-9 in this study. This aggregated information should be of concern to not only Family and Children's Services but also to the Department of Education. This information needs to be shared and programs planned accordingly.

Recommendation # 16:

Assessment of all children in care who display suspected symptoms of FASD must occur. Such a diagnosis helps to provide explanation for not only developmental delays but also for behaviors. Appropriate programming can be developed when the needs of the children are understood.

Recommendation # 17:

The number of school changes that some children in this study have experienced is extremely concerning. Vigilant monitoring as well as exploring creative alternatives to school changes needs to occur on an individual child basis. Yukon is a small enough community to support a child's school placement. Regular consultations with social workers of children in care, foster parents and school officials to better deal with this negative implication of child welfare service needs to occur.

Recommendation # 18:

Social workers need to involve themselves in discussions with the child's teacher. Inclusion of the child's birth family in these discussions, as appropriate, is also recommended.

Recommendation # 19:

Track involvement of children in extra curricular activities and make involvement in extra curricular activities an expectation for every child in care.

The Identity Dimension

Recommendation # 20:

Children in care need to understand why they are in care and this information needs to be reviewed regularly. Social workers and foster parents need to provide this information to the children. Involvement of birth family in these discussions and responsibility is recommended as appropriate.

Recommendation # 21:

Continue preparing and using Lifebooks for children. Supervisors need to understand the importance of this activity and the time commitments for both the foster parent and the social worker.

Recommendation # 22:

Children in care need to know who their birth family is and their birth family history. Greater emphasis needs to be put into activities (such as Lifebooks and genograms) and simple discussions that provide that information for the child.

The Family and Social Relationships Dimension

Recommendation # 23:

The issue of continuity of care for children in this study is very concerning. Missing information needs to be obtained and recorded on the child's yearly review recording. Tracking the number of caregivers for each child and aggregating the information is crucial to understanding its importance and implications for children in care.

Recommendation # 24:

Children need to have a relationship with at least one person who is crazy about them. Social workers and foster parents need to recognize that connecting children in care to lifelong relationships is crucial to meetings the basic needs of a child in care. A primary responsibility of those who care for children is to ensure this occurs prior to a child leaving care.

Recommendation # 25:

Children in care need help in maintaining relationships with members of their birth family, and with previous caregivers. The importance of these relationships needs to be recognized and their continued contact supported.

The Social Presentation Dimension

Recommendation # 26:

Recognition by social workers and foster parents of the importance of a child's appearance and a child's behaviors in social settings. Social workers and foster parents need to help children learn appropriate behaviors in various social situations.

The Emotional and Behavioral Development Dimension

Recommendation # 27:

Many children in this study were assessed with difficulties associated with concentration, impulsiveness and problems settling to tasks. Follow up should occur on recommendations for children to be assessed for FASD.

The Self-care Skills Dimension

Recommendation # 28:

Children in care need to develop skills that will lead them towards independence. Ongoing assessment of their development and progress using the LAC AARs is recommended.

The Experiences of the participants

The Social Workers

Recommendation # 29:

Recognition of the time required practicing good parenting. This includes ongoing implementation of the Looking After Children philosophy and materials.

The Foster Parents

Recommendation # 30:

Recognition of the foster parents knowledge about the day to day care needs of the child and the importance of foster parents as equal team members.

Summary

Looking After Children in Yukon began as a workplace based study intended to work towards improving the developmental outcomes for children raised in government care. As a social worker working with children in care for over twenty years, LAC in Yukon presented an innovative yet practical approach to the complex task of corporate parenting. Children in care have the same developmental needs as other children in the community. But they also have many complexities including multiple caregivers, placement and school moves and additional needs resulting from experiencing abuse and neglect. Trying to provide a model of parenting that mimics the 'good parenting" expected of parents in the community is an enormous task for a bureaucratic organization. Sorting out what parenting needs to be done for the children, and who is going to do it is a difficult task for most two-parent families. Those difficulties become exponential when governments, with many social workers, foster parents, birth families and other caregivers are all involved in the parenting decisions for a child raised in government care. Using the seven dimensions of the LAC AARs, a comprehensive assessment and then action plan was developed for a child, similar to what most parents do regularly with their own child. The information obtained from the nineteen assessments completed provided a wealth of information of the developmental progress of this group of children. Specifically, we know that the children in Yukon in this study came into care with poor health and pre-existing health conditions. We know now that caring for these children will place greater demands on the foster parents with whom they are placed. We also know that 12 of the eldest children in the study have developmental delays and /or learning difficulties. This is extremely important information for the Yukon Department of Education to be aware of so that appropriate planning can occur to anticipate and prepare for the educational needs of these children. Each of the dimensions assessed revealed new information for individual children and, when the information is aggregated, it provided insights into how practice and policy could be implemented to assist in better meeting the needs of this group of children growing up in permanent care. The potential for program and policy changes, as indicated in the thirty recommendations made, is great and the information is there for the taking. Social workers and foster parents reported a desire to continue with the program and its positive impacts on the lives of children in care.

LAC in Yukon was designed with the potential to become a longitudinal study. A follow up study on this same group of children, now from 0 to age 12, and include other children now in permanent care in Whitehorse could be useful in providing information on how these children are progressing. Although the sample group would not be exactly the same, aggregated data on how the children are faring within each dimension could be useful in assessing whether any changes have occurred. By using the newer version of the AAR's which provides a direct comparison to the National Longitudinal Survey of Children and Youth, information obtained in this follow up study on Yukon children in care could be compared to other children growing up in Canada. This information could provide Family and Children's' Services with some evidence of the impact of the corporate parenting they are providing to Yukon children in care.

Should a follow up study be proposed I would recommend a number of changes be made to the design and implementation of the research study. Firstly, recognition of the time required of the social workers in completing the AARs with children in care, setting up appointments with the foster parents involved and attending a training session. By raising the age to 12 years old, the children being assessed need to be included in completing the assessments. As the questions in the AAR's are designed to promote discussion, including the child in the assessment will require more time to complete the records. Social workers need to be provided with relief from some of their casework responsibilities to enable them to participate in the training and assessments.

Secondly foster parents need to be recognized as equal participants in the study and in the completion of the assessments. In this study some foster parents indicated that they had completed assessments on their own. The intent of the LAC philosophy is to work collaboratively and it is the team work approach required to complete the AAR's that promotes discussion and the sharing of the responsibility in caring for children in care. Participants need to understand this and ensure that they complete the records together.

And finally, LAC in Yukon study was just the beginning. Yukon Family and Children's Services needs to embrace the LAC materials and philosophy for the sake of the children growing up in government care.

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Appendix A

Looking After Children Assessment and Action record: Version 1

Health section for age group 5-9 years

Reference number: ______________________________

LOOKING AFTER CHILDREN

Assessment and Action Record

Age Five to Nine Years

Child's name: ______________________________

Gender: ______________________________

Date of birth : __ __ __ __ __ __
Day Month Year

Current placement (eg. foster parents, residential unit)

____

This assessment was coordinated by:

Name: ______________________________

Position: ______________________________

Agency: ______________________________

Approved by:

Supervisor: ______________________________

Date: ______________________________

Date begun: __ __ __ __ __ __ __ __
Day Month Year

Date completed: __ __ __ __ __ __ __ __
Day Month Year

How to get the best from the Assessment and Action Records

Note to social workers, foster parents and other profesionals: The Assessment and Action Records are designed to help you assess children's progress, monitor the quality of the care they are receiving and make plans for improvements across seven developmental dimensions. Each dimension is identified throughout the series by its own symbol:

HEALTH

EDUCATION

IDENTITY

FAMILY AND SOCIAL RELATIONSHIPS

SOCIAL PRESENTATION

EMOTIONAL AND BEHAVIOURAL DEVELOPMENT

SELF-CARE SKILLS

Except where otherwise indicated, all the questions are relevant for all children.

Do:

- Think about who is the best person to complete the Record with the child or young person. This should be someone s/he knows well and trusts. Older children may like to choose whom they want to do it with.
- Try to have conversations about the topics raised by the Record rather than question and answer sessions. Feel free to use a form of speaking which is familiar and comfortable for you and the person you are working with.
- Plan ahead and read through each section before you complete it with the child: some of the questions ask about sensitive issues which you may need to think about in advance.
- Talk to significant others.
- Fill in the Assessment of Objectives at the end of each section. These are intended to provide a means of comparing how a child has changed from one assessment to another.
- Make plans for future work and write down details on the summary sheet as you go along.
- Aim to make the sessions enjoyable for all concerned.
- Use you own judgement and discuss issues more fully when you find the Sections do not include details which are important.

Don't:

- Try to complete it all in one sitting.
- Panic if there are gaps. Be prepared to find out the information or plan action for the future
- Say to the child that you are doing "it" because "they" have told you it has to be done.
- Try to complete the Record without involving the child.

HEALTH

NB Factual information should be written on the Essential Information Record or the front of the file or health report.

The questions in this section are designed to make sure that all preventive health measures are being taken, that all health issues, problems or disabilities are being monitored and treated, that the child is reasonably protected against common accidents and that, as far as possible, s/he is well.

Please give details if the child has a health condition or disability:

____

H1

Child welfare agencies should arrange regular medical examinations for all children and young people in their care. The purpose of the examination is to pick up health problems that can be treated and often cured while the child is in care. Efforts should be made to combine statutory medicals with regular medical examinations undertaken as part of the preventive health service for all children. Whenever possible, arrangements should be made for children to attend the same clinic/doctor on each occasion.

When did the child last have a statutory medical or check-up?

___ Less than a year ago ___ A year ago or more

___ Never had one ___ Don't know

by whom: ______________________

date: ______________________

What recommendations were made?

____

____

____

Have all recommendations been carried out?

___ No medical ___ No recommendations

___ All ___ Some

___ None ___ Don't know

Who will take further action if needed?

___ No further action needed because:

____

___Further action needed but not possible or appropriate at present because:

____

____

Further action will be taken by:

___ Parent(s) ___ Foster parent(s) ___ Social worker

___ Residential worker ___ Public health nurse

___Other (please specify): ______________________

H2

A significant proportion of children will have some hearing difficulty. Hearing losses may be temporary or permanent. Temporary hearing losses are usually caused by conditions like 'glue ear' and occur in the early years. Such hearing losses fluctuate and may be mild or moderate in degree, but they can cause major problems for children at school. Permanent hearing losses vary from mild through to severe and profound. Children with severe hearing loss may have major communication difficulties. If there is any concern about a child's ability to hear, or if there are physical signs such as persistently discharging ears, it is important to get medical advice. Early recognition, diagnosis and treatment with specialist support if required, are essential for children's future development.

The doctor will need to know about any problems or treatment s/he is having. The social woker should check that details have been noted on the Essential Information Record.

Are there any concerns about the child's hearing?	___Yes ___No ___Don't know
Has s/he been prescribed a hearing aid?	___Yes ___No ___ Don't know
Does s/he use it?	___ Not applicable: no hearing aid ___ Don't know ___ Always ___ Sometimes (please say why) ___ Never (please say why)
When did s/he last have a hearing test?	___ Less than 6 months ago ___6 months ago or more ___ Never had one ___ Don't know
Who will take further action if needed?	___ No further action needed because: ___Further action needed but not possible or appropriate at present because: Further action will be taken by: ___ Parent(s) ___ Foster parent(s) ___ Social worker ___ Residential worker ___ Public health nurse ___Other (please specify): ___

H3

If the child has communication difficulties please complete this question; otherwise, go to H4

The doctor will need to know about any problems or treatment s/he is having. The social worker should check that details have been noted on the Essential Information Record.

Sign language is used by people with severe hearing impairments and is recognized as a language in its own right. Bliss symbolics is a visual form of communication. It consists of a board with pictures to represent certain verbs and nouns for the child or young person to point to manually or with an aid. This facilitates communication for children and young people with severe disabilities or health conditions.

Which method of communication does the child prefer to use?	___ Speech ___ American Sign Language (ASL) ___ English Sign Language (Nova Scotia) ___ Bliss symbolics ___ Other (please specify) ___________
What help is s/he getting (eg. speech therapy) to develop communication and language skills?	___________ ___________
Does difficulty in communicating make the child feel frustrated?	___ Often ___ Sometimes ___ Never
How does s/he show this to others?	___________ ___________ ___________
Who will take further action if needed?	___ No further action needed because: ___________ ___Further action needed but not possible or appropriate at present because: ___________ Further action will be taken by: ___ Parent(s) ___ Foster parent(s) ___ Social worker ___ Residential worker ___ Public health nurse ___Other (please specify): ___________

H4

If the child has difficulty reading what is written on the blackboard at school or if s/he get headaches while watching television, it is a good idea to get his/her eyes tested even if s/he have never needed glasses. If the child does wear glasses , his/her eyes should be tested by an eye specialist every six months.

The doctor will need to know about any problems or treatment s/he is having. The social woker should check that details have been noted on the Essential Information Record.

Are there any concerns about the child's sight?	___ Yes ___ No ___ Don't know
Does the child need glasses?	___ Yes ___ No ___ Don't know
Does s/he wear them?	___ Not applicable: no glasses ___ Always ___ Sometimes (please say why) ________________________________ ___ Never (please say why) ________________________________ ___ Don't know
When did the child last have an eye examination?	___ Less than 6 months ago ___ 6 months ago or more ___ Never had one ___ Don't know
Who will take further action if needed?	___ No further action needed because: ________________________________ ___Further action needed but not possible or appropriate at present because: ________________________________ Further action will be taken by: ___ Parent(s) ___ Foster parent(s) ___ Social worker ___ Residential worker ___ Public health nurse ___Other (please specify): ________________

H5

What is the child's height?	___ ___ ___ metres or ____ feet/inches ___ Don't know
When was s/he last measured?	___ Less than 6 months ago ___ 6 months ago or more ___ Don't know
What is the child's weight?	___ ___ ___ kilograms or ____ pounds(lbs.) ___ Don't know
When was the child last weighed ?	___ Less than 6 months ago ___ 6 months ago or more ___ Don't know
Is the child's height or weight a cause for concern?	___ No concerns ***If no concerns, go to H6*** → ___ Some concerns ___ Serious concerns ___ Don't know
If so, who is monitoring it?	___ Foster parent(s) ___Family physician ___Paediatrician ___ Other (please specify:) ______________________________
Who will take further action if needed?	___ No further action needed because: ______________________________ ___Further action needed but not possible or appropriate at present because: ______________________________ Further action will be taken by: ___ Parent(s) ___ Foster parent(s) ___ Social worker ___ Residential worker ___ Public health nurse ___Other (please specify): ______________________________

H6

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

The social worker should check that all immunizations have been noted on the Essential Information Record. If there is no record of what the child has had, it may be necessary for the doctor to check through health records so that the information can be recorded by the child welfare agency. This is important because if the child has a change of doctors, it can take a while for health records to catch up and the information may be urgently needed.

Are all routine immunizations up-to-date?	___ Yes ___ No ___ Don't know
If you don't know, who will check immunization records?	___ Parent(s) ___ Foster parent(s) ___ Social worker ___ Residential worker ___ Public health nurse ___Other (please specify): ______________________
Who will take further action if needed?	___ No further action needed because: ______________________ ___Further action needed but not possible or appropriate at present because: ______________________ Further action will be taken by: ___ Parent(s) ___ Foster parent(s) ___ Social worker ___ Residential worker ___ Public health nurse ___Other (please specify): ______________________

H7

When did the child last visit a dentist?	___ Less than 6 months ago ___ 6 months ago or more ___ Never seen one ___ Don't know name: ______________________ date: ______________________
What treatment did s/he recommend?	___ Dentist not seen ___ No treatment, just a check-up ___ Filling(s) ___ Treatment to straighten teeth ___ Teeth removed because (eg. decayed, not enough room) (please specify) ______________________ ___ Other (eg. Fluoride treatment) (please specify) ______________________
Has all treatment been carried out?	___ Not applicable: dentist not seen ___ Not applicable: no treatment recommended ___ All ___ Some ___ None ___ Don't know
Who will take further action if needed?	___ No further action needed because: ______________________ ___Further action needed but not possible or appropriate at present because: ______________________ Further action will be taken by: ___ Parent(s) ___ Foster parent(s) ___ Social worker ___ Residential worker ___ Public health nurse ___Other (please specify): ______________________

H8

The doctor will need to know about any problems or treatment the child is having. The social woker should check that details have been noted on the child's Essential Information Record .

Has the child been diagnosed as having any ongoing health conditions (eg. diabetes, asthma, allergies or epilepsy)?	___ Yes ___ No ___ Currently being assessed ___ Don't know
If so, are these being monitored or treated by health professionals?	___ No health conditions ___ Yes ___ No ___ Don't know
Does the child have any physical conditions (eg. squint, hare lip, cerebral palsy)?	___ Yes ___ No ___ Currently being assessed ___ Don't know
If so, are these being treated?	___ No physical conditions ___ Yes ___ No ___ Don't know

Please answer this question if the child has an ongoing health condition or disability; otherwise go to H9 ➡

Children need to be given information and opportunities to talk about any health condition or disability they may have. Parent(s) and foster parent(s) may also need advice and/or support. Literature and information about support groups can be obtained from organizations which exist to promote the understanding of specific conditions (eg. Canadian Diabetic Association). Various organizations also exist which give children with medical conditions opportunities to take part in activities together. For example there are swimming lessons for children with disabilities.

The doctor will need to know about any problems or treatment s/he is having. The social worker should check that details have been noted on the Essential Information Record.

Has information been given to and discussed with:

the child? __ Yes __ No __ Don't know

the foster parent(s)? __ Yes __ No __ Don't know

Have there been any changes in the child's condition over the last six months?

those noted by health professionals:

____

____

those noted by the child or foster parent(s):

____

____

Please describe any changes in the child's treatment over the last six months and say how these have affected him/her:

____

____

____

Is the child being seen by a specialist? __ Yes __ No __ Don't know

Who will take further action if needed?

__ No further action needed because:

____

__Further action needed but not possible or appropriate at present because:

____

Further action will be taken by:

__ Parent(s) __ Foster parent(s) __ Social worker

__ Residential worker __ Public health nurse

__Other (please specify): ______________________________

H9

If at all possible, it is important that a parent or familiar adult stay with the child throughout a hospital admission. This greatly reduces the potential negative effects of a hospital stay for a child, as well as assisting his/her recovery. The doctor will need to know about any problems or treatment the child is having. The social worker should check that significant illnesses, injuries, accidents, hospital stays and operations have been noted on the child's Essential Information Record.

Has the child had any illnesses, injuries or accidents in the last year?

__ No ***If no, go to H10*** ➡

__ Yes __ Don't know

If yes, please give brief details and say who was consulted or how these were dealt with:

Illness	**Treated by**
eg. Flu	Foster parents
Ear infection	Family physician
Cut knee	Hospital casualty
____________	____________
____________	____________
____________	____________
____________	____________

Who will take further action if needed?

__ No further action needed because:

____

__Further action needed but not possible or appropriate at present because:

____

Further action will be taken by:

__ Parent(s) __ Foster parent(s) __ Social worker

__ Residential worker __ Public health nurse

__Other (please specify): ____________________

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

H10

Does the child have any special dietary needs for health, food allergies, religious or cultural reasons (eg. high fibre, prescribed diet, food cut up or pureed, kosher, vegetarian)?

___ Yes ___ No ___ Don't know

If no, go to H11 ➧

If yes, please say what these are:

Please say if there are difficulties in keeping to this diet (eg. too expensive, not provided by foster parent(s), the child does not like it or has difficulties eating):

If s/he is on this diet for health reasons, what is its effect (eg. desired effect, irregular bowel movements, hyper-activity)?

Who will take further action if needed?

___ No further action needed because:

___Further action needed but not possible or appropriate at present because:

Further action will be taken by:

___ Parent(s) ___ Foster parent(s) ___ Social worker

___ Residential worker ___ Public health nurse

___Other (please specify): ______________________

H11

A small number of children are allergic to nuts, eggs or shellfish and must never be given food containing them.

How often has the child had the following to eat or drink <u>in the last week</u>?	Everyday	Most days	On one or two days	Not at all	Don't know
Fruits (including fresh fruit juices)	___	___	___	___	___
Vegetables and salads	___	___	___	___	___
Milk/yogurt	___	___	___	___	___
Carbohydrates					
Rice	___	___	___	___	___
Pasta (eg. spaghetti, macaroni)	___	___	___	___	___
Breads (including pita bread, wholewheat bread)	___	___	___	___	___
Potatoes (including fries)	___	___	___	___	___
Cereal and grains (eg. oats, breakfast cereal, bulgur wheat, couscous)	___	___	___	___	___
Proteins					
Meat	___	___	___	___	___
Fish	___	___	___	___	___
Eggs	___	___	___	___	___
Cheese	___	___	___	___	___
Legumes (eg. baked beans, lentils)	___	___	___	___	___
Nuts	___	___	___	___	___
Snack foods and drinks					
Chips	___	___	___	___	___
Cookies/Cake	___	___	___	___	___
Candy	___	___	___	___	___
Pop, fizzy drinks	___	___	___	___	___

Does the foster parent think this is a healthy diet for a child of this age?

___ Yes ___ No ___ Doubtful

___ Don't know

Who will take further action if needed?

___ No further action needed because:

____

___Further action needed but not possible or appropriate at present because:

____

Further action will be taken by:

___ *Parent(s)* ___ *Foster parent(s)* ___ *Social worker*

___ Residential worker ___ Public health nurse

___Other (please specify): ______________________________

H12

	How often does the child go·for walks or play outside?	___ Daily ___ Several times a week ___ About once a week ___ Less than once a week ___ Don't know
	Who will take further action if needed?	___ No further action needed because: ___ ___Further action needed but not possible or appropriate at present because: ___ Further action will be taken by: ___ Parent(s) ___ Foster parent(s) ___ Social worker ___ Residential worker ___ Public health nurse ___Other (please specify): ___
The social worker should check that the name and phone number of any adviser and details of specialized equipment have been noted on the child's Essential Information Record.	If the child has a medical condition (eg. arthritis or asthma) that affects his/her ability to exercise, is anyone giving advice about this?	___ Not applicable: no medical condition/ability to exercise not affected ***If not applicable, go to H13*** ➧ ___ Physiotherapist ___ Occupational therapist ___Leisure centre staff ___ No-one ___ Don't know ___ Other (please specify)___
	Does the child need special help or equipment for exercise?	___ Yes ___ No ___ Don't know
	Who will take further action if needed?	___ No further action needed because: ___ ___Further action needed but not possible or appropriate at present because: ___ Further action will be taken by: ___ Parent(s) ___ Foster parent(s) ___ Social worker ___ Residential worker ___ Public health nurse ___Other (please specify): ___

H13

Do the foster parent(s) have all the following :	
safety covers for electrical sockets?	___ Yes, and always use them ___ Yes, and rarely use them ___ No
smoke alarm?	___ Yes, and always use it ___ Yes and rarely use it ___ No
Who will take further action if needed?	___ No further action needed because: ______ ___Further action needed but not possible or appropriate at present because: ______ Further action will be taken by: ___ Parent(s) ___ Foster parent(s) ___ Social worker ___ Residential worker ___ Public health nurse ___Other (please specify): ______

H14

Have the child's foster parent(s) taken the steps to ensure that:	
fireplaces are adequately protected by guards?	___ Not necessary, no fireplace ___ Yes ___ No
all medicines, cleaning fluids and poisonous substances are locked in a cupboard with the key removed?	___ Yes ___ No
the child learns and uses the rules of traffic?	___ Yes ___ No
the child has a car seat and/or wears a seat belt when travelling by car?	___ Yes ___ No
the child is aware of self-protection measures (eg. not accepting candy from strangers)?	___Yes ___ No
Who will take further action if needed?	___ No further action needed because: ___Further action needed but not possible or appropriate at present because: Further action will be taken by: ___ Parent(s) ___ Foster parent(s) ___ Social worker ___ Residential worker ___ Public health nurse ___Other (please specify): ___________________

H15

A 'responsible person' is an adult who would be regarded as trustworthy and capable of taking adequate care of a child of this age.	Is the child under the supervision of a responsible person at all times?	___ Yes ___ No ___ Don't know
	Who will take further action if needed?	___ No further action needed because: ___Further action needed but not possible or appropriate at present because: Further action will be taken by: ___ Parent(s) ___ Foster parent(s) ___ Social worker ___ Residential worker ___ Public health nurse ___Other (please specify): ___________________

Please record details about plans for further action and target dates in the summary at the back of this Record.

The remaining space has been left blank for notes and observations.	

ASSESSMENT OF OBJECTIVES: HEALTH

The following section should be filled in by the social worker in consultation with all those people responsible for the child's care. There is a space at the end to record disagreements. After this has been done, look at the previous Assessment and Action Record to see how the child has changed. Please read the notes in the margin before you tick any boxes. How far have the following objectives been met?

1 Unwell for 1 week or less in the last 6 months; *2 Unwell between 8 and 14 days in the last 6 months;* *3 Unwell between 15 and 28 days in the last 6 months:* *4 Unwell for more than 28 days in the last 6 months.* *"Unwell" means ill enough to be in bed or take some time off school.*	Objective 1: The child is normally well:	__ Normally well [1] __ Sometimes ill [2] __ Often ill [3] __ Frequently ill [4] __ I don't know
1 Satisfactory growth and development; *2 Serious concerns about the rate of growth and/or development*	Objective 2: The child is thriving:	__ Thriving [1] __ Some concerns about the rate of growth and/or development __ Failing to thrive [2] __ Don't know
	Objective 3: All preventive health measures, including appropriate immunizations, are being taken:	__ All __ Most __ Few __ None __ Don't know
	Objective 4: All ongoing health conditions and disabilities are being dealt with:	__ No health condition or disability __ All being adequately dealt with __ Some being adequately dealt with __ None being adequately dealt with __ Don't know
1 Foster parent(s) are aware of common hazards and take adequate precautions; *2 Foster parent(s) take some precautions against hazards but safety could be improved;* *3 The child is at serious risk of accidental injury.*	Objective 5: The child is reasonably protected against common accidents:	__ Safe environment [1] __ Some protection [2] __ Inadequate protection [3] __ Don't know

Views on the assessment of health objectives 1-5

	Agree(s) fully	Agree(s) partially	Disagree(s)	Not consulted
Child	____	____	____	____
Parent(s)	____	____	____	____
Foster parent(s)	____	____	____	____
Residential worker	____	____	____	____
Social worker	____	____	____	____
Public health nurse	____	____	____	____
Other (specify)	____	____	____	____

If you do not agree, please give further details. Say who disagrees and why:

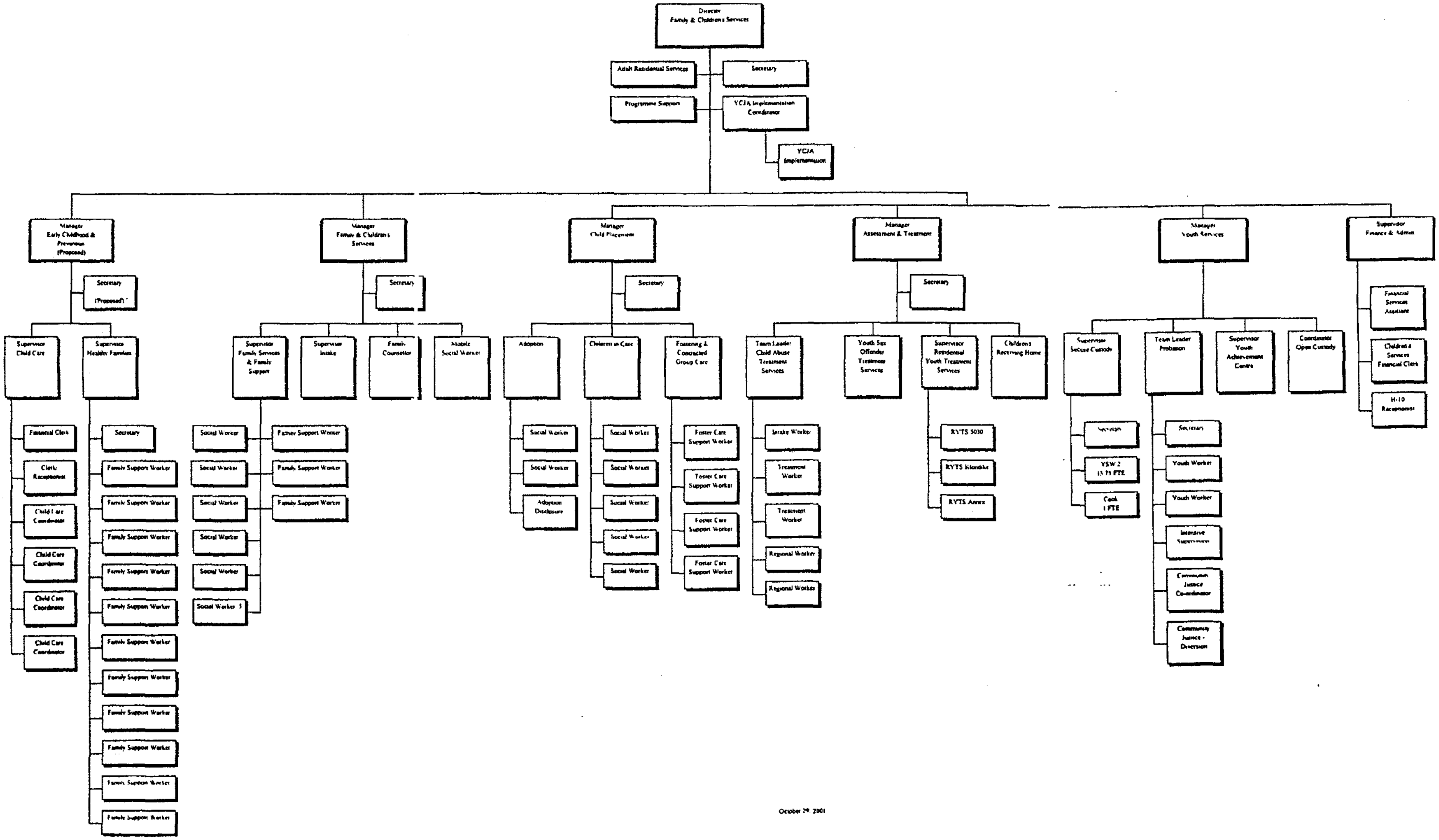
Section completed: __ __ __ __ __ __ __ __
Day Month Year

Appendix B

Organizational structure of Family and Children's Services

October 2001

Appendix B: Family and Children's Services organizational Chart



October 29, 2001

Appendix C

Data sharing agreement between the Director of Family and Children's services and Researcher

Health and Social Services and Brenda Dion
Agreement for
Disclosure of Information for Research to Meet Requirements for MSc degree.

BETWEEN

Brenda Dion

AND

Anne Westcott, Director, Family and Children's Services

WHERAS Brenda Dion is an employee of the Family and Children's Services Branch and is engaged in research for her Master's degree on Branch services in the area of Looking After Children, and the Director is in agreement with research on the implementation of Looking After Children in Yukon,

This agreement will allow for the disclosure of information for research purposes.

THE PARTIES AGREE AS FOLLOWS:

1. DEFINITIONS

Child welfare: The statutory services provided to children and families intended to protect children from harm or neglect. This includes a variety of intervention and supports services ranging from prevention to placement of children in safe environments such as foster care.

Child in permanent care: children who are ordered to the permanent legal care and custody of the Director of Family and Children's Services in Yukon, who acts as their legal guardian or children who are ordered to the permanent care and custody of another provincial or territorial child welfare designate and are residing in Yukon and are under the supervision of the Director of Family and Children's Services.

Looking After Children: An innovative approach to providing care for children who are looked after by governments; first developed in England and is now an International initiative. The Canadian project is called CanLac.

Looking After Children in Yukon: The name of the pilot project using the Looking After Children materials with Yukon children in care.

Assessment and Action Records: the assessment materials developed by the Looking After Children National project (CanLac), to assess and monitor the developmental progress of children in care across seven dimensions; health, education, identity, social presentation, family and social relationships, emotional and behavioral development and self-care skills.

2. PURPOSE OF THE DATA SHARING

The purpose of this data sharing activity is to allow for research by Brenda Dion to meet the requirements of her Master's degree and to further the implementation of Looking After Children in Yukon..

3. CONFIDENTIAL INFORMATION TO BE SHARED WITHIN THE DATA BASE

The Family and Children's Services Branch will allow access to the following information:

(a) Information regarding past and present services and programs offered by Family and Children's Services.
(b) Information about children in care provided indirectly through file information, social workers, foster parents. .
(c) Statistical Information generated by Family and Children's Services; including number of children in care, dates of birth, placement information, and genders; adoption statistics.
(d) Information collected through the use of the Looking After Children Assessment and Action Records and the subsequent data base (non-identifying information), that is generated.
(e) Permission to use information generated through the Looking After Children project; specifically information from the questionnaire sent to foster parent participants.
(f) Permission to use the report to the Director prepared by Brenda Dion in November 2002 summarizing Phase one of the Looking After Children in Yukon pilot project.
(g) Agreement by Brenda Dion to share her thesis report with the Director of Family and Children's Services.

4. USE OF CONFIDENTIAL INFORMATION

Brenda Dion will use only ***non-identifying data*** for the following purposes:

- Provision of summary statistics
- Research
- Reports resulting from research
- Presentations resulting from research
- Completion of a Master's Thesis on the Looking After Children in Yukon project

Brenda Dion will not use confidential information provided under this Agreement for any purpose other than that set out in the Agreement and as outlined in Access to Information and Protection of Privacy Act.

5. NOTICE REQUIREMENT

This consent will be submitted whenever there is a formal request for information for research purposes.

6. METHOD OF SHARING DATA

Information required for research under this agreement may include the following;

1. Review of files held by the Director of Family and Children's Services and use of non-identifying information from those files.
2. Statistics generated with information available to the Director of Family and Children's Services.
3. Information regarding programs and services provided by the Director of Family and Children's Services.
4. Information about those involved with services currently and in the past, in order to track trends and changes and evaluation services and programs.
5. Information about program suitability, efficiency.
6. Preparation of a Phase one summary presentation for participants and to gather input from the participants on interpretations of the data.

7. ACCURACY AND SECURITY OF THE CONFIDENTIAL INFORMATION

- Ensure control is maintained over physical access to the data

- Copies of printed information will be kept in secure areas.

- No identifying information will leave the Family and Children's Services premises.

8. DURATION OF DATA SHARING AND RETENTION OF CONFIDENTIAL INFORMATION

This Agreement shall commence on November 20, 2001 and will terminate on June 30, 2005.

9. TERMINATION OF THE DATA SHARING ACTIVITY

In the event of the termination of this Agreement, confidential information obtained by Brenda Dion under this Agreement shall be returned to the Family and Children's Services Branch.

10. AMENDING PROCEDURES

This Agreement may be amended by the written agreement of the parties herein.

11. CHANGES THAT AFFECT THE AGREEMENT

The parties undertake to give one another written notice of any changes in legislation, regulations or policies respecting those parties and programs that are likely to affect this Agreement.

Signed on behalf of the Family and Children's Services Branch.

January 13/03
Date

Anne Westcott
Director,
Family and Children's Services

January 8, 2003.
Date

Brenda Dion
Social Worker,
Family and Children's Services

Appendix D

Social worker survey/focus group questions

Evaluation of *Looking After Children* experience.

Generally how was the experience of using the *Looking After Children* materials for you?

Very positive	☐
Somewhat positive	☐
Mixed reactions	☐
Somewhat negative	☐
Very negative	☐
Other comments?	☐

How many sessions did it take to complete the records?

About how many hours did it take overall?

In your opinion, was this investment of time worthwhile?

Did you learn anything new?

If so, can you say what some of these things were?

How many people were consulted in order to complete the records, and who were they?

FOCUS GROUP QUESTIONS

What were the most helpful aspects of using the materials? *the strengths/positives*

What were the least helpful? *the weaknesses/difficulties*

What would be your suggestions for change?

Thank you for your help

Appendix E

Foster parent survey

Evaluation of *Looking After Children* experience.

Generally how was the experience of using the *Looking After Children* materials for you?

Very positive	☐
Somewhat positive	☐
Mixed reactions	☐
Somewhat negative	☐
Very negative	☐
Other comments?	☐

How many sessions were you involved in?

About how many hours of your time did it take overall?

In your opinion, was this investment of time worthwhile?

Did you learn anything new?

If so, can you say what some of these things were?

How many people were consulted in order to complete the records, and who were they?

What effect, if any, did going through the *Looking After Children* materials have on your relationship with the following people? (Please place a tick in the box that applies)

	Very positive	Fairly positive	No effect	Fairly negative	Very negative
Young person					
Young person's own parents					
Social worker					
Teacher					
Health care worker					
Other (please identify)					

What was the most helpful aspect of using the materials?
(You may identify more than one thing if you wish)

What was the least helpful?
(You may identify more than one thing if you wish)

Do you have any suggestions for change?

Are there any additions you would like to see?

Is there anything that you think should be deleted?

Please use the back of the page if there is anything else that you would like to tell us.

Thank you for your help!

Appendix F

PARTICIPANT INFORMATION SHEET

HHSC 703-3 RESEARCH PROJECT

This is a qualitative research study into The Experiences of Social Workers in the use of the Looking After Children materials in Yukon.

Brenda Dion, a graduate student in the joint Yukon College/UNBC master's program, is carrying it out.

This research project will assist the student in practicing a qualitative research method, and gather information relevant to the research topic. The research will gather information on your experiences in using the 'Looking After Children" materials through your responses on a questionnaire and participation in a focus group.

Your participation in the focus group will be tape recorded and transcribed. You will have the opportunity to review a copy of the transcript.

Your rights as a research participant:

You may change your mind about participating at any time, you can refuse to answer individual questions, and it is your choice. Your decision not answer specific questions or to withdraw entirely will not affect your services or standing in any way.

Your answers are important to understanding this issue. Information obtained through the focus group will be used for the research but not in a way that will reveal who said what, without that individuals' written permission. Other people will read what is used from the focus group but no one else (other than the focus group participants) will read the actual transcript from the focus group. The transcript from the focus group will be kept in a locked cabinet for the duration of the research project (minimum five years).

This research will help provide information specific to social workers experiences in using the 'Looking After Children" materials. The information obtained will be used as part of the evaluation of the "Looking After Children" in Yukon pilot project

It also will help us make arguments for those improvements at the national level. If you would like feedback from the results of this research or a copy of the final report I write, please let me know.

If you have any questions, or think of other information you would like me to have, please call me at

If something happens that you don't like and you think something should be done please feel free to call Dr. Theresa Healy at UNBC, at . She will be happy to respond to your ideas.

Appendix G

LOOKING AFTER CHILDREN IN YUKON

Interview
CONSENT FORM

Interview #: __________

1. I understand that Brenda Dion is conducting a study for "HHSC 703-3 Qualitative Research Methodology"; a UNBC/Yukon College Graduate Seminar Course delivered at the Yukon College, and is interviewing a number of persons with respect to their experiences with using the "Looking After Children" materials.

2. This consent is given on the understanding that Brenda Dion, the Yukon College and the University of Northern British Columbia shall use their best efforts to ensure that my identity is not revealed, whether directly or indirectly, unless I have signed paragraph 5.

3. I understand and agree that the information I have given to Brenda Dion in our interview(s) or focus group of Tuesday November 13, 2001 may be:

   (a) Recorded and reproduced;

   (b) Used by Brenda Dion in the production of a research paper;

   (c) May be stored as part of the archives of U.N.B.C. or the Yukon College and made available to researchers for study, reproduction and recording.

   (d) Used in a published work by Brenda Dion, the Yukon College or U.N.B.C.

4. I hereby waive any claim against Brenda Dion, the Yukon College, U.N.B.C.; their employees, directors, officers, agents and publishers with respect to the use of said information, provided it is used in accordance with this agreement. I do this freely and with full knowledge of the legal consequences of this consent.

Name: ____________________ **Date:** ____________________

Signed: ____________________ **Witness:** ____________________

5. I hereby give my further consent to the use of my name, and/or details about my life, which may directly or indirectly reveal my identity.

Date: ____________________

Signed: ____________________ **Witness:** ____________________

(Copy to records, copy to interviewee)

Appendix H

March 1, 2002

Dear ________________

RE: LOOKING AFTER CHILDREN IN YUKON PILOT PROJECT

Thank you so much for your involvement in the Looking After Children Pilot project. The completed Assessment and Action records are now being prepared for data collection and analysis. It is hoped that by taking a close look at the information obtained through the records we will have a better understanding of how our children in care are doing.

As part of the pilot, it is important to hear from participants about their experiences in using the Looking After Children materials. Your candid feedback will help to guide the future of how Yukon wants to proceed with this material. Enclosed is a short questionnaire that I hope you will complete and return to me before March 30, 2002, in the self-addressed envelope. You may sign your completed questionnaire if you like, otherwise your responses will be completely confidential.

If you have any questions about the questionnaire or the Looking After Children project please contact me at or via email at

Thank you

Brenda Dion

Appendix I

PARTICIPANT INFORMATION SHEET

Looking After Children in Yukon Research/Pilot project

This is a quantitative/qualitative joint research and pilot project study of the developmental progress of children in permanent care and custody of the Director of Family and Children's Services using the Looking After Children materials.

Brenda Dion, a graduate student in the joint Yukon College/UNBC master's program, is carrying it out.

This portion of the research project will assist Brenda Dion in gathering further information on the interpretation of the quantitative /qualitative data you assisted in providing.

Your verbal participation in the group presentation will be recorded in writing and your written feedback will be requested in the accompanying feedback worksheets.

Your rights as a research participant.

You may change your mind about participating at any time, you can refuse to answer individual questions, and it is your choice. Your decision not answer specific questions or to withdraw entirely will not affect your standing in any way.

Your answers are important to understanding this issue. Your information will be used but not in a way that will reveal who you are. Other people will read what is used of your words but you will not be identified. This research is being gathered with the intention of improving the services and resources for children in care. It is hoped that the information from the pilot project will help us make arguments for those improvements at the national level. If you would like a copy, or the opportunity to review a copy of the final report I write, please let me know.

If you have any questions, or think of other information you would like me to have, please call me at (

If something happens that you don't like and you think something should be done please feel free to call Dr. Bryan Hartman at UNBC, at

Appendix J

LOOKING AFTER CHILDREN IN YUKON

CONSENT FORM re Data from Pilot project 2001

1. I understand that Brenda Dion is conducting a Pilot project of the Looking After Children materials in Yukon. The project is in partial fulfillment of her Masters' Degree in Community Health

2. This consent is given on the understanding that Brenda Dion, the Yukon College and the University of Northern British Columbia shall use their best efforts to ensure that my identity is not revealed, whether directly or indirectly, unless I have signed paragraph 6.

3. I understand and agree that the information I have given to Brenda Dion during the presentation of the pilot project report and collected in the written feedback from the worksheets, will be

   (a) Used by Brenda Dion in the production of a thesis paper

   (b) Used by Brenda Dion in a paper or presentation to the Director of Family and Children's Services, Government of Yukon.

   (c) May be stored as part of the archives of U.N.B.C. or the Yukon College and made available to researchers for study, reproduction and recording.

   (d) Used in a published work by Brenda Dion, the Yukon College or U.N.B.C.

4. I hereby waive any claim against Brenda Dion, the Yukon College, U.N.B.C.; their employees, directors, officers, agents and publishers with respect to the use of said information, provided it is used in accordance with this agreement. I do this freely and with full knowledge of the legal consequences of this consent.

5. I am fully aware that my participation in this phase of the pilot project is voluntary and that I can withdraw at any time.

Name: ______________________ Date: ______________________________

Signed: _____________________ Witness: ___________________________

6. I hereby give my further consent to the use of my name, and/or details about my life, which may directly or indirectly reveal my identity.

Date: ___________________________

Signed: _____________________ Witness: ___________________________