Fetal Alcohol Spectrum Disorder *Promising Practices*

For Children in the Care of Alberta Children & Youth Services

Final Report

For

Alberta Centre for Child, Family & Community Research

Dorothy Badry, PhD, RSW & William Pelech, PhD, RSW

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ACKNOWLEDGEMENTS

The 2011 FASD Community of Practice Final Report reflects the efforts of five regions carrying out casework on behalf of children in care, the Ministry of Alberta Children and Youth Services, researchers and policy makers. The funding for this research project was provided by the Alberta Centre for Child, Family and Community Research. This research was carried out by a small team of researchers with collaborative support from caseworkers, supervisors, managers of five regions in Alberta (1, 6, 7, 9 & 10) and the FASD Cross Ministry Committee.

The support of the Alberta Centre for Child, Family and Community Research (ACCFCR) is deeply appreciated. The FASD Community of Practice was a collaborative effort between the University of Calgary, Faculty of Social Work, and partners working under the broad umbrella of the Alberta Ministry of Children and Youth Services working in teams and units identified below. A collaborative partnership made this work possible with all involved having a common interest in the well being of children and youth in Alberta. Dr. Dorothy Badry and Dr. William Pelech (Co-Principal Investigators) would like to thank in particular the following individuals working for the Government of Alberta: Alberta Children and Youth Services as contributors: Karen Ferguson, Assistant Deputy Minister, ACYS; Sandra Stoddard, (Former Senior Manager Innovation and Improvement Research and Innovation Branch); Denise Milne, (Senior Manager, FASD/Children's Mental Health); Larry Gazzola and Eoin Rouine (Innovation and Improvement Unit, Research and Innovation); Dude Johnson, Darla Yanchuk, Shawn Miller, Tiara Samson, and Mark Weninger (CoP Research Assistants); Caseworkers, Supervisors and Managers and Staff of Regions 1, 7, 9 and 10 of Children's and Youth Services, and the Alberta FASD-Cross Ministry Committee for all their support.

For the purposes of the data collection a comparison group was identified in the Edmonton area (Region 6) and actively participated in the project with the support of Diane Vigeant and Julie Mann who ensured linkages were made and forms collected on a regular basis, despite the challenges in doing so. The research team is deeply appreciative of the work of foster parents and caseworkers in Region 6 for their support and efforts in data collection. Other contributors included Donna Debolt, Project Manager and Lead Consultant and FASD Expert offering training and consultation throughout project; Gabrielle Daoust, MSW and Tobias Mwandala, MSW, lead research assistants with the FASD CoP for the University of Calgary, Faculty of Social Work. We also extend our thanks to a colleague, Bruce MacLaurin, Faculty of Social Work who acted in the capacity of research consultant to this project.

DEDICATION

This report is dedicated to the children and families living with the diagnosis and impact of FASD and served by Alberta Children and Youth Services. It is our hope that this research will contribute to improving their well-being.

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RESEARCH ABSTRACT FOR THE FETAL ALCOHOL SPECTRUM DISORDER COMMUNITY OF PRACTICE

PURPOSE:

This project examined the impact of *'Promising Practices'* (respite, collaboration, training, and worker contact) implemented by Alberta Children and Youth Services which were intended to address the needs of children with Fetal Alcohol Spectrum Disorder (FASD) in care. From 2009 to 2011 impacts on children, caseworkers, and foster parents were examined over 15 months in four project regions (n=98) and a comparison region (n=84). The *Promising Practices* included: a commitment to children/youth with FASD in care having permanent placements; transitional plans on record by 16th birthday; assessment for suspected cases of FASD; provision of 48 hours respite minimally per month per child/youth; collaborative support plans developed with caseworkers, foster care support workers and foster parents; minimal training of 12 hours required prior to placement and respite care; and case workers were required to meet at least once a month with caregivers. Additional supports included advanced training on FASD and the availability of expert consultation for case plan consultation and review for both caseworkers and foster parents/caregivers.

METHODS:

Implementation of the *Promising Practices* was assessed via qualitative (16 worker and foster parent focus groups) and quantitative methods (agency file reviews and participant self-reports). Practice outcomes were assessed via a quasi-experimental comparison group pretest-post-test design, using monthly self-reported child behaviour tracking forms and caregiver strain questionnaires. Outcomes included placement stability, risk behaviours, child interactions, and caregiver strain. A SharePoint site was created for this project and was accessible to participants from each region. This site served as a central point for sharing information amongst the Community of Practice. Examples include the inclusion of a news ticker on media related to FASD. There was also a restricted, password-protected area of the site for collecting research data across the regions. SharePoint was considered to be a valuable tool in keeping everyone involved in the project connected across the regions.

FINDINGS:

Placement changes declined significantly in Project Regions as compared to the Comparison Group. Increased worker contact was predictive of fewer placement changes, and Project Regions reported significantly higher worker contact than the Comparison Group. Risk behaviours trended downward in Project Regions and upward in the Comparison Group, though there were no significant changes or differences in this area. A significant finding was that positive child interactions at home were predictive of lower risk behaviours. Project Region caregivers reported higher ratings for children's home interactions and lower caregiver strain than the Comparison Group. Qualitative themes were used to illustrate and support the

quantitative findings. Themes emerging from the focus groups included: child behaviour; the relationships between child and foster parent, child and caseworker, and caseworker and foster parent; challenges of foster care; challenges in casework; training; project impact; the importance of specialized training; the value of expert case consultation/review; and the importance of both communication and teamwork.

DISCUSSION:

This research reviews the development of the FASD Community of Practice in four regions of Alberta Children and Youth Services. The focus of this project was on effectively meeting the complex needs of children with FASD in care and this research was driven by earlier, promising region emerging from the Fetal Alcohol Spectrum Disorder Practice Standards Evaluation Project (Badry, Pelech & Norman, 2005). This early research informed the current research about the importance of enhancing communication and connections between children, foster parents, and caseworkers. The results are reflective of the value and need for enhanced supports or "*Promising Practices*" in order to more effectively meet the needs of children in care with FASD. The FASD CoP project was driven by the commitment of Alberta Children and Youth Services to respond differently to the needs of children with FASD in care and their families by offering fiscal support to decrease caseloads and increase contact between caseworkers, children and their foster parents/caregivers.

EXECUTIVE SUMMARY

The FASD Community of Practice (FASD COP) represents an innovation by Alberta Children and Youth Services and the FASD Cross Ministry Partnership. This report is reflective of the research project carried out from 2009 – 2011 in five regions across Alberta. Alberta Children and Youth Services, through the FASD Cross Ministry Committee (CMC) undertook the FASD Community of Practice (CoP) project in order to bring together stakeholders (caseworkers, foster families, community agencies and partners, etc.) to improve outcomes and placement stability for children and youth in care, who are diagnosed or suspected of having FASD. The FASD-CMC partnered with the Research and Innovation Branch of the Ministry to undertake this initiative. Key components of the project included the self selection of regions into the project, development of the research project with the Faculty of Social Work, University of Calgary, and putting in place a project manager, Donna Debolt, FASD Consultant, to both oversee the initiative within the project and comparison regions.

This project was guided by a belief that the needs of children with FASD in care could be better served through the application of *Promising Practices*. In order to be included in this project children and youth were either diagnosed or suspected (based on screening and assessment) to have FASD. In cases where FASD was suspected, referrals were made for further assessment and diagnosis. These practices included: smaller caseloads for caseworkers in order to have more time available for children with FASD who have high needs; increased contact with children on the caseload resulting in more frequent visits with the child and foster parents/caregivers; a commitment to children/youth with FASD in care having permanent and stable placements; the establishment of transition plans on record (case file) by 16th birthday given the need to establish services and supports within the adult disability service system; assessment for suspected cases of FASD through both screening and assessment; the provision of 48 hours respite minimally per month per child/youth; the development of collaborative support plans developed with caseworkers, foster care support workers and foster parents; minimal training of 12 hours required prior to placement for foster parents and respite care providers. Additional supports included advanced training on FASD and the availability of expert consultation for case plan conferences/reviews for both caseworkers and foster parents/caregivers. It is important to note that within this research that the term foster parents/caregivers also include kinship and group care. The majority of children and youth within this project resided in foster homes or kinship care. Kinship care is offered/provided wherever possible to children and youth where it is possible to remain with extended family.

The FASD CoP core research team included two researchers from the Faculty of Social Work, University of Calgary (Dorothy Badry & William Pelech) in partnership with two senior managers from ACYS (Denise Milne and Sandra Stoddard). A collaborative partnership between the ministry of ACYS and the University of Calgary was essential in order to develop an effective research project whose focus was children in care. This partnership developed into a very effective research model. A leadership team was established to guide the project and met on a monthly basis for the duration of the project. The input of the leadership team was critical to informing direction in this project. Additionally, two presentations regarding this research were made to the Alberta FASD Cross Ministry Committee.

Dr. Sandra Stoddard was instrumental in developing the concept of a CoP for this project. The role of a CoP is to bring people together with peers such as caseworkers and foster parents with a common interest; which in this case was provision of the best care possible for children with FASD in care. The CoP also has a role in identifying potential outputs from leading practice models, the integration of guidelines and *Promising Practices*, gaining access to repositories of knowledge developed through collaborative disciplines in human services, identification of problems and supporting solutions, development and utilization of common tools, practices, processes, strategies and interventions. The development of common practices across regions was critical in defining what works and what does not work for children with FASD in care. The broad goal of the FASD CoP was to develop a model of excellence in best and *Promising Practices* for children and youth with FASD.

The term *Promising Practices* and the development of a Community of Practice signified a philosophical shift in child welfare caseload management. The FASD CoP was instrumental in identifying and bridging gaps in practice through a recognition that risks need to be taken to benefit children and youth with FASD who face multiple struggles in their lives and in care and live with a lifelong disability.

The broad goals of the FASD CoP included a commitment to children/youth with FASD in care having permanent placements; transitional plans on record by 16th birthday; assessment for suspected cases of FASD; provision of 48 hours respite minimally per month per child/youth; collaborative support plans developed with caseworkers, foster care support workers and foster parents; minimal training of 12 hours required prior to placement and respite care; and case workers were required to meet at least once a month with foster parents. In this report promising results of this research are profiled. The research had two major research streams.

For practical purposes both quantitative and qualitative or a mixed methodological approach was necessary in order to gather data that was not only about the experiences of children in care through monitoring and tracking, but also about the experiences with those whom the children live; namely, foster parents, and in some cases residential treatment facilities. In addition to quantitative data collection, a total of 16 focus groups across the regions took place. Focus groups were held at midterm and near the end of the project (June, 2010) in order to gather and share the experiences of foster parents/caregivers and caseworkers. The project was reliant from the beginning on caseworkers, casework supervisors, management and regional supports.

PROJECT GEOGRAPHY FOCUS GROUPS

Project Regions

- High Prairie and surrounding area (Region 10)

- Bonnyville/St. Paul/Cold Lake and surrounding area (Region 7)
- Ft. McMurray and surrounding area (Region 9)
- Lethbridge and surrounding area (Region 1)

Comparison Group

- Edmonton and surrounding area (Region 6)

REASONS FOR CONDUCTING THIS STUDY

1. It is important to conduct research on promising or best practice, as practice models for children with FASD in the care of child welfare services are not well established.
2. As guardians, caseworkers and the province are compelled to develop best practice strategies for this particular population of children who are known to have high needs, frequent placement changes, and are at risk for victimization such as physical, emotional, social (bullying) and sexual abuse without intervention.
3. Children with FASD are at risk of developing significant behavioral problems and intensive intervention and supports are required to mediate these concerns. Monitoring behavior through tracking incidence was a critical component of this research.
4. To determine the factors that can contribute to better outcomes for children in care living with the psychosocial impact of FASD.
5. Research that examines the needs of children and youth living with FASD is important to inform policy that is developed regarding their needs. This research is imperative to understanding the formula required for resource allocation and supports for children with FASD.

6. The literature is sparse on specific ways of caring for children with FASD. There exists a well-developed body of knowledge on caring for children with disabilities, but this needs to be adapted to care of children with FASD.

7. To measure the effectiveness of a Community of Practice approach. The application of the construct of a CoP to child welfare practice is new. Still, child welfare practices such as collaborative care, attention to socio-cultural issues, and responding to specific and differing needs of individuals, suggest that elements of CoP are inherent, and that a CoP should be a viable systemic response to the needs of complex populations such as children with FASD.
8. The original pilot research project (Badry, Pelech & Norman, 2005), which accompanied the implementation of these *Promising Practices* in Region 1, found significant outcomes from the project in relation to improved placement stability. This project provided an opportunity to replicate the earlier study with a larger sample size.

RESEARCH DESIGN

This project involved mixed methods including qualitative and quantitative methods. To examine the implementation of the *Promising Practices* we used qualitative methods involving focus groups and quantitative methods involving the gathering of information from agency files and caregiver. To examine the impact of the implementation of the *Promising Practices*, we utilized a quasi-experimental comparison group pretest-posttest design. In this design, the implementation of the *Promising Practices* is conceptualized as an intervention or independent variable and the behavioural outcomes will be the dependent variables.

QUANTITATIVE METHODS

Quantitative methods were utilized to examine three critical project components:

1. ***Implementation of Promising Practices*****-**examined the extent to which *Promising Practices* were implemented in the Project Regions. A non-randomized, matching sampling method was implemented in this quasi-experimental design to determine the equivalency of the Project and Comparison Regions in terms of relevant characteristics. Implementation of *Promising Practices* included requirements such as screening for FASD, child assessment and other case practice requirements.
2. ***Equivalency of Groups*****-**analyzed the equivalency of cases included in the Project and Comparison Regions. This analysis is crucial to understanding and assessing differences that arise in outcomes for each group. The more equivalent the two groups are in terms of such influential characteristics as age, placement histories, status and other factors, the greater confidence one may have in attributing that the differences that arise in outcomes are due to the impact of the interventions provided by the *Promising Practices* offered in this project.
3. ***Outcomes***-examined differences that emerged in outcome measures between the Project and Comparison regions as well as results from testing the four hypotheses stated in the original proposal. Practice outcomes were assessed via a quasi-experimental comparison group pre-test-post-test design. Data was gathered for each of these outcomes for 15 months during the implementation of the *Promising Practices*. Outcomes included placement stability, risk behaviours, child interactions, and caregiver strain. Specific outcomes measured included placement stability, risk behaviour, criminal behaviour, substance abuse, school attendance, quality of child's relationships with others at home and caregiver placement satisfaction. Outcomes were measured through use of a monthly child behavioral tracking form as well as the Caregiver Strain Questionnaire.

RESEARCH HYPOTHESES

Specific hypotheses related to the research question relating to the outcomes of implementation of the *Promising Practices* include:

1. There will be significantly lower number of placement changes, a decrease in risk behaviours for children in the project group than for those in the comparison group;
2. There will be significantly higher perceived quality of foster parent/child relationships in the project group than for foster families in the comparison group;
3. The provision of increased respite care will be associated with reduced placement disruption and risk behaviours; and,
4. Worker contact with foster homes will be positively related to quality of foster parent/child relationships.

QUALITATIVE METHODS

Focus groups are an important way to begin to understand the experiences of research participants in relation to the intervention, which in this case is the implementation of *Promising Practices* for children and youth in care with FASD. Engaging in qualitative research and analysis leads moves one through the process the experiences of individuals engaged with the research project and ultimately leads to transforming findings into units of meaning (Patton, 2002). Patton further states that no exact formula exists as each researcher will approach the analysis from their frame of knowledge, experience and engagement with the topic. It is important within qualitative research to develop understanding, to share this with others and to hold this information up for examination. Qualitative data that is triangulated or comes from several sources within the research project is stronger in that it is supported from more than one source. In this case we have integrated wherever possible both qualitative and quantitative data as a means to develop a broader understanding of the phenomenon: the experiences of caregivers, foster families/caregivers and caseworkers and ultimately children who have received the intervention; the *Promising Practices* that were implemented through the FASD Community of Practice.

In the four regions, a total of 16 focus groups were held with workers (including caseworkers and foster home support workers) and foster parents (separately) to gather information regarding their experiences with this project at the mid-point and toward the end of the project. Focus groups occurred in each region and were audio-recorded and later transcribed. Once the data was transcribed it was moved into a software program called Atlas Ti, which supports engaging in a hermeneutic analysis of the data. The process of analyzing qualitative data is very lengthy as each line of data from the transcripts must be reviewed and coded. Once coding is completed the text is then reviewed and examined in relation to themes that emerge from the data. One of the methods for developing themes is to focus deeply on codes and words that were representative of the experiences of participants. Through this process one begins to see what Patton (2002) the emergence of data that recurs on a regular basis. This review becomes an iterative process that requires moving back and forth between test, memos and transcripts in order to draw closer to the essence of the experiences of participants. A pattern begins to emerge through this sorting process and leads to the development of themes that become representative of the experience of the participants.

A qualitative analysis for themes was completed and explored the experiences of caseworkers, foster home support workers and foster parents involved with this project. Key findings from the qualitative analysis that emerged include:

1. Increased and regular contact with children by caseworkers has been viewed by foster parents as contributing to a deeper sense of being part of a team for the child or children in their home.
2. There was a clear and enhanced appreciation/understanding of the needs of foster parents by caseworkers regarding the intensive and constant needs involved in caring for children with FASD.
3. Keeping track of behavior was important and helped foster parents/caregivers to identify challenging times for the child/youth.
4. The opportunity to engage in regular training and case plan reviews has fostered better communication and assisted rural foster parents to feel less isolated.
5. Foster parents found it easier to share their struggles with caseworkers.

FOCUS GROUP QUESTIONS

1. What were some of the challenges encountered in implementing the *Promising Practices*?

2. How manageable was it to implement the *Promising Practices* including their impact on caseworker workloads and caregivers?

3. How have the *Promising Practices* affected the quality of life of children with FASD including the quality of caregiver-child relationships?

4. Which *Promising Practices* did you find particularly beneficial and why?

5. Which of the *Promising Practices* were least helpful and why?

KEY MESSAGES FROM FOCUS GROUPS

The qualitative data from the focus groups was reviewed by three members of the research team to ensure that there was consistency in the identification of codes leading to the development of themes and subsequently, the key messages presented here. Key messages are further broken down for 1) Caseworkers, 2) Casework Supervisors and 3) Foster Parents.

Key Messages

- Children and youth with FASD have ***distinct needs related to the environment*** i.e. school, home, and community.
- Children and youth with FASD require a great deal of ***support in relation to any transition in life***, i.e. change of school, change of caseworker, and change of placement.
- ***Behavioral concerns impact the child in the home, school and in the community***. Behavioral concerns must be managed on a daily basis.
- ***Establishing relationships with the child's caseworker and monthly visits supports stability*** for child/youth and foster home.
- ***The provision of respite is important.***
- ***Communication is critical*** and can occur through different means such as case contact, case consultation, phone calls, e-mails and visits.
- ***Training on FASD and expert case consultation is important.***
- The need for continuing, collaborative, competent and informed responses for children and youth in care living with FASD is a crucial construct in case management.

KEY MESSAGES AND IMPLICATIONS FOR PRACTICE FOR CASEWORKERS

Key Messages	Caseworkers (CW)
Children and youth with FASD have ***distinct needs related to the environment*** i.e. school, home, and community	Needs will differ across settings and the need exists to plan and establish consistent supports in different places. The CW in the role of guardian for supporting child/youth has a key role in providing information to the school and foster home about the needs of each child/youth.
Children and youth with FASD require a great deal of ***support in relation to any transition in life***, i.e. change of school, change of caseworker, change of placement	Caseworkers develop expert knowledge on children/youth on their caseload. Regular contact on a monthly basis supports understanding of the specific needs and to plan accordingly and develop plans to respond to crises related to change/transition. The CW can also initiate consultations with specialists in order to manage challenges/behavioral concerns related to transitions.
Behavioral concerns impact the child in the home, school and in the community. Behavioral concerns must be managed on a daily basis.	Development of behavioral management plan and crisis strategy responses to support child in foster home and school. Maintaining stable placements across environments is a critical component of behavior management. CWs require training on the neuro-developmental issues of FASD that impact behavior.
Establishing relationships with the child's caseworker and monthly visits supports stability for child/youth and foster home.	Having regular contact and home visits promotes strengthening the connection between the CW and child/youth. This contact also promotes stability in terms of the placement and supports foster parents in feeling more connected and part of the "team".
The provision of respite is important.	The provision of respite for families caring for children with FASD is important in relation to placement stability over the long term. Although the need/request for respite may vary across families the issue needs to be raised and addressed with families. As children grow older the need for respite increases and these needs to be assessed on an ongoing basis. Respite can be offered in different ways based on family need for support. It is also important to be aware of the stress related to day to day care for children with FASD and to maintain communication with the FP about identifying stress. Resources for respite will differ between families.
Communication is critical and can occur through different means such as case contact, case consultation, phone calls, e-mails and visits.	Case consultation as required helps keep the lines of communication open between everyone. Staying in contact with the child and FP helps maintain a deeper connection. Regular communication helps responding to problems and dealing with crisis situations.
Training on FASD is important.	CWs require training on the complexity of FASD as a disability. Training is critical and to the development of case planning that is responsive to the needs of children/youth with FASD. CWs need to have the opportunity to develop their professional skills related to FASD and to gain an understanding of the unique needs of children with FASD related to neurodevelopmental disorders. Training plays a critical role in supporting workers to respond more effectively to children/youth needs as well as the needs of caregivers.

KEY MESSAGES AND IMPLICATIONS FOR PRACTICE FOR CASEWORK SUPERVISION

Key Messages	Casework Supervision (CWS)
Children and youth with FASD have ***distinct needs related to the environment*** i.e. school, home, and community	The CW Supervisor has broad knowledge of the caseloads and can offer specific support to caseworkers in relation to case planning for children/ youth with FASD. CWS can also support referrals for child as required and provide this information to caseworkers.
Children and youth with FASD require a great deal of ***support in relation to any transition in life***, i.e. change of school, change of caseworker, change of placement	The CW Supervisor can support the reduction of changes of caseworkers/caseloads wherever possible while considering needs of children/youth with FASD, and within the context of available resources within the region.
Behavioral concerns impact the child in the home, school and in the community. Behavioral concerns must be managed on a daily basis.	The CWS can advise the caseworker on behavior management, support and advocate for resources required for the child in settings such as school or the community. The CWS has a key role in authorizing consultations as required. The CWS also has a key role in supporting training related to FASD.
Establishing relationships with the child's caseworker and monthly visits supports stability for child/youth and foster home.	The implications/challenge for the CWS is to keep caseloads manageable in order to support regular contact that fosters relationship development for child/youth and foster parents. The need for ongoing contact on a regular basis is important, but needs to be balanced in light of available resources.
The provision of respite is important.	The provision of respite services needs to be directed by CWS who is aware of the resources available for this need. The CWS and CW can evaluate this need on an ongoing basis, recognizing that the need for respite increases, particularly during adolescence. Planning for respite and dedicating resources to this area is important.
Communication is critical and can occur through different means such as case contact, case consultation, phone calls, e-mails and visits.	The CWS needs to be aware of case planning which includes contact and communication between caseworkers and children/youth. Caregivers (FPs and residential treatment facilities) need ongoing support due to the complex needs of children with FASD and this can be supported through casework supervision.
Training on FASD is important.	CWS play a key role in supporting caseworkers to attend training. CWS also develop knowledge and expertise on FASD and can be instrumental in supporting caseworkers with different interventions dependent on the needs of the child, and within the context of problems that may emerge in the foster home (placement), in relation to possible placement change, in the school system and community. CWS can also arrange for case consultations related to specific concerns on caseloads. Consultations with specialists act as a form of training in response to identified complex problems for children/youth with FASD.

KEY MESSAGES AND IMPLICATIONS FOR PRACTICE FOR FOSTER PARENTS/CAREGIVERS

Key Messages	Foster Parents (FP)/Caregivers
Children and youth with FASD have ***distinct needs related to the environment*** i.e. school, home, and community	Placement with a foster family who is aware of, and receives training about the neurobehavioral issues as part of the disability of FASD. Foster Parents have a key role in supporting consistency across environments with a focus on support, structure and stability.
Children and youth with FASD require a great deal of ***support in relation to any transition in life***, i.e. change of school, change of caseworker, change of placement	The FP is key to supporting any changes in the child's environment. The FP develops expertise on the unique needs of the child/youth in their care. The FP has a key role in relation to managing transition and can provide important information in relation to transition management. The FP requires support from the CW in managing major changes. Support and structure needs to be consistent and constant throughout the school year.
Behavioral concerns impact the child in the home, school and in the community. Behavioral concerns must be managed on a daily basis.	Documenting behavioral concerns on a regular basis helps foster parents to identify patterns or triggers and sources of stress for the child. FP awareness of behavioral concerns for children/youth and require support through training on neurodevelopmental issues related to FASD. There should be a protocol for behavior management established with the child/youths caseworker.
Establishing relationships with the child's caseworker and monthly visits supports stability for child/youth and foster home.	The FP values the relationship with the CW and having this contact on a regular basis is meaningful. The FP appreciates the CW having a stronger connection with the child through regular visits and also values working as part of a team. Regular contact also supports sharing information and debriefing problems and concerns.
The provision of respite is important.	The FP family needs to be aware of their own needs for respite and to discuss this with the CW and Foster Home Support Worker responsible for their home. The FP needs to identify concerns related to respite and if the arrangements are meeting the needs of the child/youth and foster family. It is also important to recognize that respite represents a "transition" for the child/youth and act as a trigger for behavioral concerns. Awareness that accessing respite may be a concern for child/youth helps to mediate problems. It is also important to identify these concerns to CW and Foster Home Support Worker.
Communication is critical and can occur through different means such as case contact, case consultation, phone calls, e-mails and visits.	Foster parents for children/youth with FASD need to have open lines of communication with caseworkers. Ongoing contact such as phone calls supports FPs to raise and debrief concerns and appears to play a role in averting crises such as placement breakdown.
Training on FASD is important.	Training for FPs, collaboratively with caseworkers is a highly valued activity. Collaborative training ensures that everyone involved with children/youth with FASD receive the same information and this supports a consistent response based on the child and foster home needs.

QUANTITATIVE RESEARCH: KEY FINDINGS

PART I: IMPLEMENTATION OF *PROMISING PRACTICES*

We found that considerable progress was achieved towards completion of neuro-psychological assessments for children suspected of experiencing FASD, with nearly half of these cases having completed assessments or assessments in progress.

- Over 90% of files included completed concurrent plans, with 46.2% of files documenting three reviews over the 15-month period.
- Over 80% of files for children and youth in foster care included completed Foster Care Support Plans.
- Over 80% of files for children and youth in residential care settings included completed Individualized Service Plans.
- Some of the *Promising Practices* relating to the families of children with FASD were not consistently applied across regions. A lack of clarity and consistency resulted in inconsistent application of practices relating to parental assessments and family visitation plans. However, when examining compliance for the three major pillars of the *Promising Practices* (worker contact, respite and training), significant progress was achieved towards compliance with children and youth receiving these vital supports. While not often meeting the strict interpretation of the *Promising Practices*, caregivers as well as children and youth in the Project Regions reported significantly greater worker contact and respite than those in the Comparison Regions and over 85% of caregivers completed a minimum of 12 hours of FASD-related training.

PART II: EQUIVALENCY OF GROUPS

A sample of 182 participants including 98 cases from the Project Group (Regions 1, 10, 7 and 9) and 84 from the Comparison Group (Region 6) was included in this project. Approximately, one-third of the cases in the Project sample came from Region 1, with the remaining two-thirds came from Regions 7, 9 and 10.

Overall, analysis of each matching variables yielded favorable results. While there were some noteworthy differences between groups in terms of ethnicity, years in care, legal status, and placement type at the beginning of the project, no significant differences were detected for much more potentially influential characteristics such as diagnostic classification, scores on the PBCL-36 for suspected cases, age, number of previous placements, and gender. Of the significant differences, differences in legal status may contribute to higher placement change for members of the Project Regions, as a higher proportion of children in the Project Regions were in care under various agreements.

PART III: OUTCOMES

To address the central question of the impact of the *Promising Practices* we found that:

- There was significantly higher placement stability in the Project Regions, where the *Promising Practices* were implemented than in the Comparison Region.
- Risk behaviours were negatively associated with caregiver satisfaction, and with the quality of interactions at home and school.
- Similarly, caregiver satisfaction was positively related to interactions at home and school and negatively associated with caregiver strain.
- Caregiver strain was also positively associated with respite; that is, higher caregiver strain was associated with greater provision of respite.
- Interactions at home were positively associated with interactions at school and with frequency of worker contact.
- Family contact was positively associated with placement change. The child's years in care prior to the study period appeared to be positively correlated with placement change.
- Worker contact was negatively correlated with placement change, that is, as worker contact diminished, the incidence of placement change increased.

On November 30, 2010 an FASD Community of Practice Showcase hosted by ACCFCR was held in Edmonton, Alberta to inform the community about some of the promising work being carried out around the province (http://www.research4children.com/). There were approximately 2300 participants at this day-long event, including about 300 people onsite and about 2000 people via live webinars held across Canada with a couple of participants from across the border in the USA. This was a phenomenal venue for presenting an overview of the FASD CoP from the perspectives of the caseworker, biological parent, foster parents, foster care support, researchers, Alberta Children & Youth Services, and the caseworker experience of the project. This event was started with remarks from Assistant Deputy Minister Karen Ferguson and included question and answer sessions moderated by Nancy Reynolds. Group discussions were also held as part of the afternoon with a focus on key learning, leading practice and next steps. The presentations, discussions and questions and answer sessions were interesting and enriching events as a need exists to demonstrate excellence in child welfare practice for children in care with FASD.

After the showcase, ACYS staff prepared a summary of emerging topics and themes resulting from discussions during the event. They included:

1. *Mandatory Training on FASD*
2. *Training: for Collaborative Partners and Human Service Workers*
3. *Team Approach and Collaboration*
4. *Transition to Adulthood Support*
5. *Across the Life-Span View*
6. *Aboriginal/Cultural Focus*
7. *Bio Family Involvement & Support*
8. *Increased Interaction with Caseworkers*

9. *Workload & Focused Caseload*
10. *Increased Funding for Respite and Flexible Support Services*
11. *Research and Initiatives on FASD Prevention/Early Intervention, Diagnosis and Assessment*

It is important to state that these identified topics and themes are in fact reflective of the critical issues relevant to the care of children with FASD within Alberta Children and Youth Services. All of these issues were raised within the research project and identified as concerns from the perspectives of caseworkers and foster parents/caregivers. Greater detail that illuminates many of these themes is presented within the context of this report.

DISCUSSION

There are many reasons why this research is important. A key finding that the role of the caseworker is significant in the relationship between the child, foster parent and stable outcomes. Although children with FASD in care present many challenges to the child welfare system, they also present many opportunities within the professional community to develop models of excellence and best practice to ensure meeting their physical, social, emotional and spiritual needs. Another key finding was the development of an appreciation of the complexity of caring for a child with FASD. Not only was this perspective illuminated for everyone in the project, but also a deeper understanding of what it takes to be a long-term foster parent of a child or youth with FASD in the system has emerged. There is compelling evidence both in the qualitative and quantitative data that this project had a positive impact on children, caseworkers, casework supervisors and foster parents/caregivers.

Simply stated, caseworkers that had increased and regular contact with children, positively influence child/youth and placement stability within care. The development of the FASD Community of Practice has helped to advance knowledge relating to practice for children with FASD in care.

CONTEXT OF THE RESEARCH STUDY

It is important to contextualize this research and the activities that made this project possible. Alberta Children and Youth Services, through the FASD Cross Ministry Committee (CMC) undertook the FASD Community of Practice (CoP) project in order to bring together stakeholders (caseworkers, foster families, community agencies and partners, etc.) to improve outcomes and placement stability for children and youth in care, who are diagnosed or suspected of having FASD. The FASD-CMC partnered with the Research and Innovation Branch of the Ministry to undertake this initiative. Key components of the project included the self selection of regions into the project, development of the research project with the Faculty of Social Work, University of Calgary, and putting in place a project manager, Donna Debolt, FASD Consultant, to both oversee the initiative within the project and comparison regions. A collaborative partnership was developed between the researchers and the staff from Alberta Children and Youth Services that deepened from the inception of the project to its conclusion. Partners in this collaboration included firstly, caregivers of children who were provided enhanced supports due to this project. Their lives and experiences have served as a place from which to develop new and creative ways to offer support. The detailed work of this project involved a multi-faceted approach to serving children with FASD and clearly demanded a major commitment from caseworkers, foster parents, casework supervisors and district office managers.

This project involved senior ministry staff including Assistant Deputy Minister, Karen Ferguson; the FASD Cross Ministry Committee; The Alberta Centre for Child, Family & Community Research; five project regions (1, 7,9 & 10) of Alberta Children & Youth Services, both rural and urban; and a comparison region (6). The research team held a meeting with foster parents and caseworkers in Region 6 to explain the project and answer questions about the research project. Additionally, Donna Debolt offered a training session for this region upon completion of the project. The efforts of all partners were critical to ensuring the project was carried out successfully for the duration of approximately 15 months. The role of the leadership team was to review the project on a monthly basis, to respond to questions/issues, regional concerns with support from the managers on this team, and provided a consistent feedback loop throughout the project.

If one looks at a regional map of Alberta Children & Youth Services (see Appendix 1) it is clear that the regions involved in this project reached from one end of the province to the other. The researchers made several visits to the regions over the course of this project and this instilled an appreciation of how much effort is required for a caseworker in Fort McMurray (Region10) or High Prairie (Region 9) or Cold Lake or Bonnyville (Region 7) to visit a child in a placement in Edmonton; or a worker in Region 1 visiting children placed over a vast region, particularly over the winter months. While recognizing that rural casework has its' challenges the efforts of workers to meet the requirements of the Promising Practice in relation to increased contact with children or youth in care were outstanding. At times caseworkers that were traveling a great distance to meet with a child or youth in their care would visit another child on a colleague's caseload. Team support is an important factor in rural and remote settings. In addition to regional visits, the researchers were able to present "mini-showcases" to two of the four regions – Lethbridge and High Prairie, modeled after the ACCFCR Showcase on the FASD CoP on November 30, 2010. We visited regions to share results and talk about experiences with this project held in June 2011. These return visits to the communities were events that were rich in conversation, feedback and discussion about the completion of the project. The overall sense emerging from these discussions was that participants felt they had achieved stronger expertise on FASD and acknowledged that there is a lot of creativity involved in responding to the needs of children and youth in care. The ability to identify progress was also noted through behavioral tracking and as a result of participation in this project; a stronger sense of optimism in relation to more stable futures for children and youth with FASD was expressed by foster parents/caregivers and caseworkers. This retrospective review of the FASD CoP with the regions identified concerns that the project was over and hope that the resources applied during this process would continue in the future. It is important to note that the approach to practice for children and youth with FASD in care has changed. It was clear in the post project conversations in two regions that increased awareness about FASD appeared to translate to a commitment of case management and foster home support from the vantage point of new learning's gained through the community of practice approach.

Attending provincial meetings held on the FASD CoP between researchers, caseworkers, casework supervisors and managers also took time, travel and resources in order to occur. There were two meetings held to bring regional participants together in Edmonton, Alberta to review the project, parameters and work plan. These meetings were very important in terms of providing information to the regions about the project and participating in question and answer sessions. The other key element of these meetings was developing a sense of an inter-regional community of practice across the province. Each of the regions faced challenges in carrying out this research and demonstrated commitment to the project. In this project research team members were aware of competing demands but this did not deter completion of the project. As well, face to face contact in regions with the researchers (Badry & Pelech) and the training sessions offered by Donna Debolt locally/regionally were supportive in maintaining interest and participation in the project. Some of the comments and themes emerging from training sessions are important in informing this research. For example these comments were shared in the chart below in relation to training sessions:

Every day is different!

It is hard to explain an invisible disability to others who do not know the child. You find yourself constantly educating others about the disability.

Changes are very difficult for the child. Helping child deal with change is always hard. In particular supporting their transition to adult services is hard. In particular dealing with changing relationships such as a change of workers is stressful.

Training to those who take it that makes sense and is useful.

Education on FASD is important for workers and staff at Children's Services.

It's difficult to work as a team when there are different levels of understanding of FASD, different expectations and different goals. Education of the community at large (potential employers, schools and even neighbours is important) for safety of the child or youth

REVIEW OF THE LITERATURE

WHAT IS FASD?

Children with Fetal Alcohol Spectrum Disorder (FASD) have neurological impairment related to a brain injury caused by prenatal alcohol exposure (PAE) (Streissguth, 1997). The term Fetal Alcohol Syndrome (FAS) is primarily used in literature that predates 2002 (Jones & Smith, 1973; Jones, Smith, Ulleland & Streissguth, 1973), while literature post 2001 often refers to the term FASD (Streissguth and O'Malley, 2001). The distinction between the two terms is that FAS was the first descriptive diagnosis of children who had medically identifiable disabilities related to PAE (Jones & Smith1973). Alcohol acts as a teratogen or toxin that disrupts cell development in utero and has different effects throughout the pregnancy, dependent on timing and level of exposure. Streissguth and O'Malley (2001) suggested the term FASD as a means to encapsulate the multiplicity of conditions caused by PAE, and as such, suggest there is a spectrum of affects that can lead to serious medical and social problems. We now know that prenatal alcohol exposure can contribute to a variety of disabilities including cognitive, behavioural and neurological deficits, and is broadly identified as a permanent, organic brain injury (Chudley et al**.**, 2005). Diagnostic guidelines for FASD diagnostic within Canada were published by Chudley and colleagues (2005) have served as a foundation for establishing and understanding the meaning of a diagnosis for children and families. Andrew (2010) indicates that the 4-Digit Code (Astley, 2004; Astley, 2010; Astley and Clarren, 2000), a key diagnostic tool that examines four features critical to diagnosis; growth, face [facial features], brain function and alcohol exposure is used by most clinics in Western Canada.

The vulnerability factor and challenges associated with care have been noted by a number of professionals across disciplines working with this population and researchers (Ory, 2007; Totten, 2010; Badry, 2009; Badry, Pelech & Norman,2005; Vig, Chinitz & Schulman,2005; Fuchs, Burnside, Marchenski & Mudry, 2009; Hume & Associates, 2008).There was no textbook on child welfare practice with this population in the 1980s and 1990s and no textbook approach to child welfare intervention exists at this point for the population of children in care with FASD. As such, it is critical to begin to monitor measure and report interventions such as the one outlined in this report. Children with FASD exhibit a variety of behavioural, learning, and social needs that can be intensive, requiring constant supervision and structure (Badry, 2009; Badry, Pelech & Norman, 2005; Vig, Chinitz, & Shulman, 2005). They often have histories of early exposure to trauma, often end up in permanent care of the state, and account for high costs associated with their long term care (Fuchs, et al., 2009; Fuchs, Burnside, Marchenski, & Mudry, 2009).

CHILDREN WITH FASD AND CHILD-WELFARE SYSTEMS

This research project is about applied practice methods/interventions to a population of children in the child welfare system, receiving supports from Alberta Children and Youth Services. In this study, the children receiving services are either diagnosed or suspected of having a Fetal Alcohol Spectrum Disorder (FASD). Research on fostering children and child welfare practice for children with FASD is virtually non-existent. According to Fuchs, Burnside, Marchenski and Mudry (2010), children with FASD are significantly overrepresented in care of child-welfare systems in Canada and most of those children come from Aboriginal communities (Badry, & Bradshaw, 2011; Jonson, Dennett & Littlejon, 2009; Wemigwans, 2008).

Although a lot of training and information has been publically presented on this topic, research on what works in the venues of foster care and child welfare are not well studied. A previous study and the precursor to the current research, by Badry, Pelech and Norman (2005), indicated that children with FASD respond favorably to advanced supports and children and families benefit from increased contact with caseworkers. Caseworkers benefit from reduced caseloads in order to develop stronger relationships and ties with children on their caseloads. A sense of team is fostered between foster parents and caseworkers through increased contact and everyone benefits, particularly the child who is the focus of the intervention. Key findings of the initial pilot project identified as the FASD Practice Standards were: risk behaviors decreased over time; specific training for caseworkers and foster parents are critical to develop their knowledge framework about FASD and practice interventions; caseworkers and foster parents were strongly invested in meeting the needs of children through a different approach; and life disruptions decreased such as school absences and change of placement. The concept of managed and structured care for children with FASD is crucial to meeting the needs of the child, to support the foster family and to respond to challenges related to the complex behavioral concerns associated with this disability.

CHALLENGES

Current research shows that children with FASD in child-welfare system have complex challenges (Mattson, Schoenfeld & Riley, 1999; Rasmussen, Andrew, Zwaigenbaum, & Tough, 2008). These challenges include stress that is usually reported by caregivers living with children with such disabilities (Chan & Sigafoos, 2001; Paley, O'Connor, Frankel, & Marqaurdt, 2006). Research shows that current child-welfare interventions have failed to meet all these challenges due to lack of an integrated approach in addressing children's needs (Fuchs, Burnside, Marchenski and Mudry, 2010). Many scholars have recommended interventional models that involve multiple professional teams and community at large when addressing issues facing children affected by FASD. Currently, there is simply lack of 'team approach' or 'national consensus' when addressing these issues, for example, there are inconsistencies that exist in diagnosis of FASD (Jonson, Dennett, & Littlejon, 2009; Odersma, Simpson, Brestan, & Ward, 2000; University of Alberta Population Research Laboratory, 2009). Also, there is lack of FASD-related knowledge and training among professionals/service providers especially in the Canadian North and rural areas (Brown, 2004; Hay, 1999; Sanders & Buck, 2010).

Marcellus (2008) in a study of foster parents caring for children with prenatal alcohol exposure (PAE) identified a new theoretical framework for care issues related to both foster children and the caregivers. In caring for a child that comes into a foster family a developmental trajectory of adjustment and balance takes place for everyone in the home. Marcellus posits the following landmarks as critical in fostering:

- Immersing for the first time and finding their niche
- Rebalancing family life with each placement (regaining stability)
- Honoring limits (learned by experience)
- Experiencing an emotional double bind (attachment and letting go)
- Working the child welfare system (motivation for fostering – helping others)
- Feeling a powerless responsibility (responsibility without authority)
- Public parenting (public gaze)

Other key constructs identified by Marcellus (2008), about the work of foster care include: fostering as a social justice endeavor doing the work 24/7, and un-witnessed commitment. These are incredibly important constructs that are informative in relation to the FASD Community of Practice research project, particularly in relation to the focus groups held with foster parents. The work of Marcellus is useful in informing the FASD Community of Practice research project as echoes of the above identified constructs resonated through our own focus groups with foster parents. It is valuable to have some prior research on foster parents with the experience of caring for children with PAE in order to consider similarities and differences in emerging themes and constructs.

ADDRESSING CHALLENGES

Studies have shown that children with alcohol-related disabilities need specialized-care systems, structured environment, financial support, and good relationship with social workers/service providers and accessibility to a variety of community resources such as clinicians (Badry, 2009; Bertrand, 2009; Brown, Moraes & Mayhew, 2005; Brown, Sigvaldason & Bednar, 2005). For example, Timler and Olswang (2001) argue that when planning to implement educational services to children with alcohol-related disabilities such as FASD, teachers and other service providers must take in considerations of performances variations (e.g. academic and social behaviours) that exist in children with FASD. Public awareness and FASD training for service providers are essential in addressing FASD-related issues (Ondersma, et al, 2000; Sanders & Buck, 2010; University of Alberta Population Research Laboratory, 2009). Some researchers have found that early interventions such as receiving FASD diagnosis provide relief and validation especially to families with children suspected with FASD (Brown, 2011; Carmichael et al, 2007; Sanders & Buck, 2010). Complex issues among children with FASD can bring enormous stress on families caring for the children. Parents who engage in Respite care/relief have reported a decrease in such stress (Chan & Sigafoos, 2001).

In Canada, there not much research available relating to specific interventions needed to address needs facing children in child-welfare systems. Current research has shown that more work needs to be done across all stakeholders, in local communities, educational institutional as well as governments. One recent study, *Bound by the Clock: The Voices of Manitoba Youth with FASD Leaving Care* (Fuchs, Burnside, Reinink and Marchenski, 2010) showed that youth with FASD leaving care continued to have difficulties such as engaging in risk behaviours (e.g., inappropriate sexual behaviours, early pregnancy, criminal activities and not attending/finishing school). The study found that youth who remained in care for a longer period and had strong social network support were less likely to engage in undesirable behaviors. The majority of the youth in this study expressed fears and worries about leaving care and their future. According to the study, the youth valued emotional supports such as having close communication (feeling of belonging) with foster parents and Child Family Service agency workers more than other forms of support.

The needs of foster caregivers of children with FASD require special attention. One of the primary concerns in foster care is addressing the needs of foster caregivers. Twigg (2009) identified the following requirements for foster caregivers: need for support; need for recognition; need for addressing financial concerns; and need for training (timely, consistent and relevant to meeting needs of children). Carmichael Olson, Oti, Gelo, & Beck (2009) contended that severe gaps in knowledge and research related to family issues and stress on caregivers are a concern, but that higher quality of care giving achieves better outcomes for children with FASD. Brown and Rodger (2009) have identified needs of caregivers in the areas of gaining access to obtaining specialized professional services, supports related to the financial costs associated with fostering a child with a disability, support in relation to educational placements and services, supportive responses related to the child's behavioural concerns and issues, opportunities to engage in self-care, support dealing with multiple roles, and in working with the health care system and needs of children.

Early intervention may result in improvements. Koponen, Kalland and Autti-Rämö (2009) specifically examined the care giving environment required to meet the needs of children with FASD, and discovered that children who came into care at earlier ages (prior to age three) had fewer neuropsychological challenges than those who came into care at later ages. This suggests that early removal of children from chaotic and stressful environments and placing them in a stable care environment may have a mediating effect. This research suggests that early, long-term placement outside of homes where children with FASD are at risk for neglect, abuse, and trauma may have better outcomes in relation to social-behavioural problems.

INTRODUCTION TO RESEARCH FINDINGS

This section provides a deeper analysis of the key messages identified within the Executive Summary as they relate to the roles of caseworkers, casework supervisor and foster parents. It is important to consider how the emerging themes hold implications for all aspects of casework service delivery. It is through these consistently emerging aspects of the focus groups that led to the reporting of these findings. Key messages were further broken down and implications in relation to practice were identified. These key messages are representative of the interplay and influence of the need for children with FASD to have consistent support from all different levels of case management. As there is a lack of evidence based practice within child welfare practice for children with FASD in care it is important to identify considerations that can guide practice. One very clear theme emerging from focus groups discussions, meetings across regions and within the leadership team over two years was the importance of everyone working together with a common approach to practice. This was a driving force for this research that is directly related to growing awareness about the complex needs of children and youth with FASD. A key construct emerging is that of environment.

The child or youth's environment across different settings such as home, school and the community needs to maintain structure. This is a challenge, as the opportunity does not always exist to structure environments outside of the home. This is where communication about the needs of the child are crucial for foster parents/ caregivers with allied support from caseworkers. If a child or youth has particular needs in a school setting for example, the need exists to provide this information and also to advocate for required support. Foster parents/caregivers and caseworkers that have knowledge about FASD through training often find themselves in the position of having to explain and justify the rationale behind requesting accommodations for children and youth in their care. Efforts to maintain consistency across environments is crucial for children with FASD and this is directly related to the neurological disabilities they encounter that can make transition challenging under the best of circumstances. A child or youth with FASD requires all those involved in their life across settings to work from a common framework in order to effectively support their unique and differing needs. Novick Brown (2011) suggests there is limited evidence based research on interventions for children with FASD and has identified research that suggests both caregivers and teachers perceive children with FASD to have poor social skills in contract to their peers who do not have an FASD. Novick Brown described a study of an intervention on Children's Friendship Training (CFT; Frankel & Myatt, 2003) that occurred for both children with FASD and their caregivers. Results were promising in relation to significant improvements in social interactions as well as decreased behavioral challenges. Even more promising is the fact that these changes upon a 3-month review were being maintained. The notion that coaching caregivers is important in relation to social skill development and maintenance bears consideration. Similarly, training specific to FASD as offered to foster parents/caregivers during the FASD CoP was perceived to be important and critical for supporting children and youth in their care.

RESEARCH FINDINGS – QUANTITATIVE ANALYSIS WITH INTEGRATION OF RELEVANT QUALITATIVE FINDINGS

This section of the report contains three parts. Before comparing results obtained from Project and comparison groups, and making inferences relating to the impact of the *Promising Practices* upon behavioural outcomes, it would be prudent to examine the extent to which the

Promising Practices were actually implemented for cases in the Project Regions. Accordingly, *Part I: Implementation of Promising Practices* examines the extent to which these *Promising Practices* were implemented in the Project Regions. Similarly, as a non-randomized, matching sampling method was implemented in this quasi-experimental design, it would be important to determine the equivalency of the Project and Comparison Regions in terms of relevant characteristics. Thus, In *Part II: Equivalency of Groups,* we offer an analysis of the equivalency of cases included in the Project and Comparison Regions. Such an analysis is crucial to understanding and assessing differences that arise in outcomes for each group. The more equivalent the two groups are in terms of such influential characteristics as age, placement histories, status and other factors, the greater confidence one may have in attributing that the differences that arise in outcomes are due to the impact of the interventions provided by the *Promising Practices* offered in this project. Finally, in *Part III: Outcomes*, we examine differences that emerged in outcome measures between the Project and Comparison regions as well report the results of testing the four hypotheses stated in the original proposal. It is important to note that the term *Promising Practices* evolved from the initial work identified as the FASD Practice Standards, developed in Region 1 in 2002. The term *Promising Practices* represents a philosophical shift and indeed is reflective of the need to identify best practice for children and youth with FASD through applying different interventions.

PART I: IMPLEMENTATION OF *PROMISING PRACTICES*

Before comparing results obtained from Project and comparison groups, and making inferences relating to the impact of the *Promising Practices* upon behavioural outcomes, it would be prudent to examine the extent to which the *Promising Practices* were actually implemented for cases in the Project group. To assess of the implementation of the *Promising Practices*, a comprehensive review of all case management and foster care files was conducted for each child included in this project in Regions 1, 7, 9 & 10. Specialized checklists, tracking forms and document review forms developed in the initial pilot project in 2005 were adapted for use in this project. We will address each Promising Practice in the order that they appear in the FASD *Promising Practices* originally developed by Region 1.

PROMISING PRACTICES (FORMERLY CASE MANAGEMENT STANDARDS)

SCREENING FOR FASD

This Promising Practice required that all children with an open legal authority will be screened for prenatal alcohol exposure during the intake phase. As all cases included in the Project sites had some form of legal status and were beyond the intake phase, screening was implemented in Regions 1, 7, 9 and 10 for new intakes. The project followed the intake patterns for three regions (Region 7, Region 9 and Region 10) for a 30 day period and the intake patterns in one region (Region 1) for the duration of the project. Region 1 has a defined intake unit that was prepared to look at this work with every referral.

The outcomes were collectively gathered over a 30 day period regionally as follows:
Regions 7, 9 and 10:
Number of Intakes Screened for Issues Related to FASD: 49
Number of Intakes that Screened Positive for Prenatal Alcohol Exposure: 5
Number of Intakes that Confirmed Substance Use Disorders with Biological Mother: 24
Number of Intakes that Confirmed Developmental Delays (at intake): 9
Number of Intakes that Confirmed Behavioural Difficulties at Home: 15
Number of Intakes that Confirmed Behavioural Difficulties at School: 17

It is also important to note that in the files of 68 (69.4%) out of 98 children, prenatal exposure to alcohol was documented on the file.

CHILD ASSESSMENT

This Promising Practice required that children suspected of having prenatal exposure to alcohol would be afforded a comprehensive multifaceted assessment that covers all aspects of functioning. A multifaceted assessment was to include, where applicable, the following:

a) Family/social assessment;
b) Medical assessment/diagnosis;
c) Behavioural/cognitive/psychological/psycho-educational assessment;
d) Psychiatric assessment; and,
e) Neuro-psychological assessment

Each assessment element will be addressed below including results for each region.

FAMILY/SOCIAL ASSESSMENT

As Table 1.1 notes, family and social assessments were completed or in progress in 25.9% (24 of 93) of cases and missing or deemed not applicable in 65.6% (61 of 93) of cases.

Table 1.1: Completion of Family Assessments by Region

		Family Assessment					
Region		N/A	Missing	Incomplete	In Progress	Complete	Total
Region 1	*Count*	1	5	8	0	16	30
	% within Region	3.3%	16.7%	26.7%	.0%	53.3%	100.0%
Region 7	Count	0	27	0	0	1	28
	% within Region	.0%	96.4%	.0%	.0%	3.6%	100.0%
Region 9	Count	28	0	0	0	0	28
	% within Region	100.0%	.0%	.0%	.0%	.0%	100.0%
Region 10	Count	0	0	0	2	5	7
	% within Region	.0%	.0%	.0%	28.6%	71.4%	100.0%
Total	Count	29	32	8	2	22	93
	% within Region	31.2%	34.4%	8.6%	2.2%	23.7%	100.0%

a) Medical assessment/diagnosis

Medical assessments were completed or in progress for nearly all cases—with 67% (67 out of 100) of children having completed medical assessments.

Table 1.2: Completion of Medical Assessments by Region

		Medical Assessment				
Region		Missing	Incomplete	In Progress	Complete	Total
Region 1	Count	0	1	0	30	31
	% within Region	.0%	3.2%	.0%	96.8%	100.0%
Region 7	Count	9	0	1	18	28
	% within Region	32.1%	.0%	3.6%	64.3%	100.0%
Region 9	Count	0	0	16	12	28
	% within Region	.0%	.0%	57.1%	42.9%	100.0%
Region 10	Count	0	1	5	7	13
	% within Region	.0%	7.7%	38.5%	53.8%	100.0%
Total	Count	9	2	22	67	100
	% within Region	9.0%	2.0%	22.0%	67.0%	100.0%

b) Behavioural/cognitive/psychological/psycho-educational assessment

Of 97 children, 55.7% (54 out of 97) had completed cognitive behavioural assessments (55.7 %), while these assessments were either missing or incomplete in 28.9% (28 out of 97) of files.

Table 1.3: Completion of Behavioural & Cognitive Assessments by Region

		Cognitive Behavioural Assessment				
Region		Missing	Incomplete	In Progress	Complete	Total
Region 1	Count	3	9	0	16	28
	% within Region	10.7%	32.1%	.0%	57.1%	100.0%
Region 7	Count	15	0	1	12	28
	% within Region	53.6%	.0%	3.6%	42.9%	100.0%
	% within Cognitive Behavioural Assessment	78.9%	.0%	6.7%	22.2%	28.9%
Region 9	Count	0	0	12	15	27
	% within Region	.0%	.0%	44.4%	55.6%	100.0%
Region 10	Count	1	0	2	11	14
	% within Region	7.1%	.0%	14.3%	78.6%	100.0%
Total	Count	19	9	15	54	97
	% within Region	19.6%	9.3%	15.5%	55.7%	100.0%

c) Psychiatric assessment

The rates of completed psychiatric assessments were lower than the above assessments, with 43.2% (423 of 97) of psychiatric assessments completed or in progress. Psychiatric assessments were missing or incomplete in 56.7% (55 of 97) of cases.

Table 1.4: Completion of Psychiatric Assessments by Region

		Psychiatric Assessment				
Region		Missing	Incomplete	In Progress	Complete	Total
Region 1	Count	8	17	0	6	31
	% within Region	25.8%	54.8%	.0%	19.4%	100.0%
Region 7	Count	26	0	0	2	28
	% within Region	92.9%	.0%	.0%	7.1%	100.0%
Region 9	Count	0	0	16	11	27
	% within Region	.0%	.0%	59.3%	40.7%	100.0%
Region 10	Count	4	0	5	2	11
	% within Region	36.4%	.0%	45.5%	18.2%	100.0%
Total	Count	38	17	21	21	97
	% within Region	39.2%	17.5%	21.6%	21.6%	100.0%

d) Neuro-psychological assessment

Nearly half (48.5% or 49 of 101) of children included in this project had neuro-psychological assessments completed or in progress. Neuro-psychological assessments were missing or incomplete in 51.5% (52 of 101) of cases.

Table 1.5: Completion of Neuro-Psychological Assessments by Region

		Neuropsychological Assessment				
Region		Missing	Incomplete	In Progress	Complete	Total
Region 1	Count	7	16	0	9	32
	% within Region	21.9%	50.0%	.0%	28.1%	100.0%
Region 7	Count	26	0	0	2	28
	% within Region	92.9%	.0%	.0%	7.1%	100.0%
Region 9	Count	0	0	16	12	28
	% within Region	.0%	.0%	57.1%	42.9%	100.0%
Region 10	Count	3	0	5	5	13
	% within Region	23.1%	.0%	38.5%	38.5%	100.0%
Total	Count	36	16	21	28	101
	% within Region	35.6%	15.8%	20.8%	27.7%	100.0%

DETERMINING PARENTING ABILITY

A similar regime of assessments were also required for parents and caregivers suspected of having prenatal exposure to alcohol in order to determine their capacity and ability to parent their children, particularly if the children are FASD. This multifaceted assessment included the following:

a) Family/social assessment: historical and current functioning
b) Medical assessment
c) Parenting Assessment
d) Cognitive/Psychological/Psychiatric assessment
e) Neuropsychological Assessment

Case managers were to ensure that this assessment process is initiated within 90 days of service commencement. In terms of determining parental ability, among those case files which documented confirmed fetal exposure, 16 out of 28 (57.1%) birth parents had confirmed exposure documented on their child’s case file.

Table 1.6: Incidence of Parental Exposure by Region

		Parents Prenatal Exposure			
Region		Unknown	No	Yes	Total
Region 1	Count	0	1	13	14
	% within Region	.0%	7.1%	92.9%	100.0%
Region 7	Count	0	1	0	1
	% within Region	.0%	100.0%	.0%	100.0%
Region 10	Count	10	0	3	13
	% within Region	76.9%	.0%	23.1%	100.0%
Total	Count	10	2	16	28
	% within Region	35.7%	7.1%	57.1%	100.0%

PARENTAL ASSESSMENTS

As outlined in the *Promising Practices*, a multi-faceted parental assessment is required where applicable. Files were reviewed to determine the number of assessments that were completed.

Table 1.7: Parental Assessments by Region

		Completed Parental Assessments				
Region		Family	Medical	Cognitive	Neurological	Total
Region 1	Complete (%)	5 (45.5%)	0 (0%)	10 (83.3%)	14 (82.5%)	29 (59.2%)
	Out of	11	9	12	17	49
Region 7	Complete (%)	2 (50.0%)	2 (40.0%)	9 (69.2%)	2 (25.0%)	15 (50.0%)
	Out of	4	5	13	8	30
Region 9	Complete (%)	0	0	0	0	0
	Out of	0	0	0	0	0
Region 10	Complete (%)	0 (0%)	0 (0%)	3 (25.0%	1 (10%)	4 (10.0%)
	Out of	9	10	12	10	41
Total	Complete (%)	7 (29.2%)	2 (8.3%)	22 (59.5%)	17 (48.6%)	48 (40.0%)
	Out of	24	24	37	35	120

As noted in Table 1.7, there were mixed results in terms of completed parental assessments. In terms of overall assessments, 40% were completed with the larger proportions of completions for cognitive and neurological assessments.

CONCURRENT PLANS

a) Development & Completion

The fourth component of the FASD *Promising Practices* involved the development of individualized concurrent plans that reflect the child's/parents assessed strengths and weaknesses, recognizing the supervision and structure that children with FASD require. For children in care, Family Visitation Plans were to be reflected in the concurrent plan. Concurrent Plans were also to include evidence of the addressing of family planning issues.

Table 1.8: Completion of Overall Concurrent Plans by Region

		Concurrent Overall Plan				
Region		Not Applicable	Missing	Incomplete	Complete	Total
Region 1	Count	0	0	2	16	18
	% within Region	.0%	.0%	11.1%	88.9%	100.0%
Region 7	Count	0	4	0	24	28
	% within Region	.0%	14.3%	.0%	85.7%	100.0%
Region 9	Count	0	1	0	24	25
	% within Region	.0%	4.0%	.0%	96.0%	100.0%
Region 10	Count	1	0	0	13	14
	% within Region	7.1%	.0%	.0%	92.9%	100.0%
Total	Count	1	5	2	77	85
	% within Region	1.2%	5.9%	2.4%	90.6%	100.0%

Evidence of service plan completion was present on case files for over 90% (77 of 85) of cases. Five other elements were outlined for concurrent plan development. First, concurrent plans were to reflect the parent's assessed strengths and weaknesses in terms of the special needs of children with FASD. Of the 97 case files reviewed, approximately half (53.2%) incorporated this assessment in the concurrent plan. Perhaps indicative of the relevance or appropriateness of the two remaining criteria, nearly all concurrent plans addressed placement and permanency planning issues (90 or 92.8%), while few provided evidence of addressing of family planning issues (20 or 31.2%). Approximately half (44 or 53.7%) of the reviewed files reflected the family visitation plan in the concurrent plan.

Table 1.9: Concurrent Plan Development by Region

Region		Reflects Parental Strengths	Reflects Family Visitation Plan	Reflects Family Planning Issues	Reflects Permanency Planning
Region 1	Count	24 (77.4%)	9 (39.1%)	0 (0%)	29 (90.6%)
	Out of	31	23	16	32
Region 7	Count	8 (80.0%)	17 (77.3%)	1 (.12.5%)	22 (91.7%)
	Out of	10	22	8	24
Region 9	Count	0 (0%)	13 (48.1%)	8 (29.6)	27 (100%)
	Out of	25	27	27	27
Region 10	Count	10 (76.9%)	5 (50.0%)	11 (84.6)	12 (85.7%)
	Out of	13	10	13	14
Total	Count	42 (53.2%)	44 (53.7%)	20 (31.2)	90 (92.8%)
	Out of	79	82	64	97

b) *Concurrent Plan Reviews*

This Promising Practice required that concurrent plans be reviewed through a formal conferencing process a minimum of twice per year. In a 15-month period, one would expect that three concurrent plan reviews would have been completed in order to meet this Promising Practice. As Table 1.10 indicates, this practice seemed to have been met in approximately half (46.2%) of the cases. In over three-quarters of the cases (77.4%) at least one concurrent plan review had been completed and 62.4% of cases had two concurrent plan reviews. As one would expect, there were a declining number of completed reviews as one moved from one to three conferences.

Table 1.10: Completion of Concurrent Plan Reviews

	Completed Conferences		
Region	1	2	3
Region 1			
N (%)	15 (53.6%)	7 (25.0%)	3 (10.7%)
Out of	28	28	28
Region 7			
N (%)	20 (80.0%)	17 (68.0%)	16 (64.0%)
Out of	25	25	25
Region 9			
N (%)	25 (92.6%)	23 (85.2%)	13 (48.1%)
Out of	27	27	27
Region 10			
N (%)	12 (92.3%)	11 (84.6%)	11 (84.6%)
Out of	13	13	13
Total			
N (%)	72 (77.4%)	58 (62.4%)	43 (46.2%)
Out of	93	93	93

HOME VISITS

This Promising Practice required that case managers prepare Family Visitation Checklists and Family Visitation Plans for all children in care prior to any visits occurring with natural family and significant others. Less than half (45 of 96 or 46.9%) of the case files reviewed included completed family visitation plans. Accordingly, a somewhat smaller proportion 43.9% (43 of 98) included completed checklists.

Table 1.11: Completion of Home Visitation Plans by Region

		Family Visitation Plan				
Region		Not Applicable	Missing	Incomplete	Complete	Total
Region 1	Count	0	6	12	8	26
	% within Region	.0%	23.1%	46.2%	30.8%	100.0%
Region 7	Count	0	7	0	21	28
	% within Region	.0%	25.0%	.0%	75.0%	100.0%
Region 9	Count	18	0	0	10	28
	% within Region	64.3%	.0%	.0%	35.7%	100.0%
Region 10	Count	8	0	0	6	14
	% within Region	57.1%	.0%	.0%	42.9%	100.0%
Total	Count	26	13	12	45	96
	% within Region	27.1%	13.5%	12.5%	46.9%	100.0%

Table 1.12: Completion of Family Visitation Checklists by Region

		Family Visitation Checklist				
Region		Not Applicable	Missing	Incomplete	Complete	Total
Region 1	Count	0	5	11	15	31
	% within Region	.0%	16.1%	35.5%	48.4%	100.0%
Region 7	Count	0	10	0	17	27
	% within Region	.0%	37.0%	.0%	63.0%	100.0%
Region 9	Count	18	0	0	10	28
	% within Region	64.3%	.0%	.0%	35.7%	100.0%
Region 10	Count	11	0	0	1	12
	% within Region	91.7%	.0%	.0%	8.3%	100.0%
Total	Count	29	15	11	43	98
	% within Region	29.6%	15.3%	11.2%	43.9%	100.0%

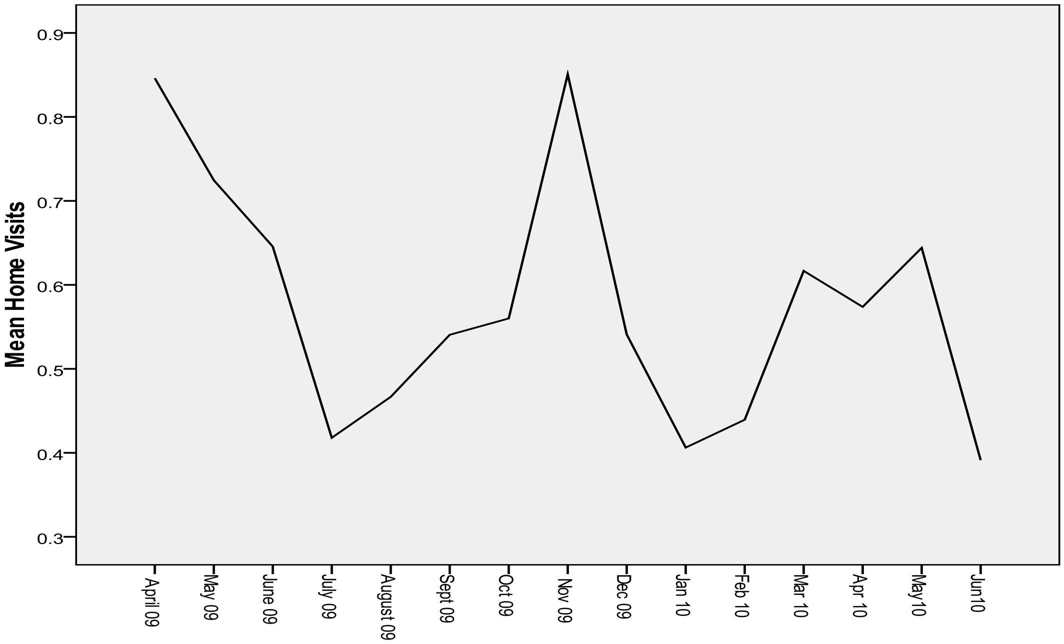
The Promising Practice required that case managers will meet face to face with children with FASD on their case loads as well as with each child's foster parents or caregivers a minimum of once per month. Case manager contacts with children and caregivers in the original pilot project were one of the major pillars of the *Promising Practices*.

Of the 103 case files in the Project regions, only 2 cases (1.9%) documented a minimum of one contact per month with the child to meet the Promising Practice. However, as Figure 1.13 indicates when one examines the mean contacts over the 15 months of the project, while mean number of contacts falls below the requirement of 1 visit per month during the implementation of the *Promising Practices*, the overall mean for this period is 5.89 contacts over 15 months with a range of 0 to 2 contacts per month.

Table 1.13: Mean Home Visits By Month

Month	Number	Range	Minimum	Maximum	Mean	Std. Deviation
April 2009	*52*	*9*	*0*	*9*	*.85*	*1.349*
May 2009	69	3	0	3	.72	.684
Jun. 2009	79	3	0	3	.65	.641
Jul. 2009	67	2	0	2	.42	.631
Aug. 2009	75	3	0	3	.47	.664
Sept. 2009	74	3	0	3	.54	.645
Oct. 2009	75	4	0	4	.56	.976
Nov. 2 009	67	6	0	6	.85	1.158
Dec. 2009	61	3	0	3	.54	.765
Jan. 2010	64	1	0	1	.41	.495
Feb. 2010	66	2	0	2	.44	.585
Mar. 2010	60	3	0	3	.62	.715
Apr. 2010	61	10	0	10	.57	1.347
May 2010	59	3	0	3	.64	.713
Jun. 2010	46	2	0	2	.39	.649

Figure 1.1: Mean Contacts with Child per Month by Region

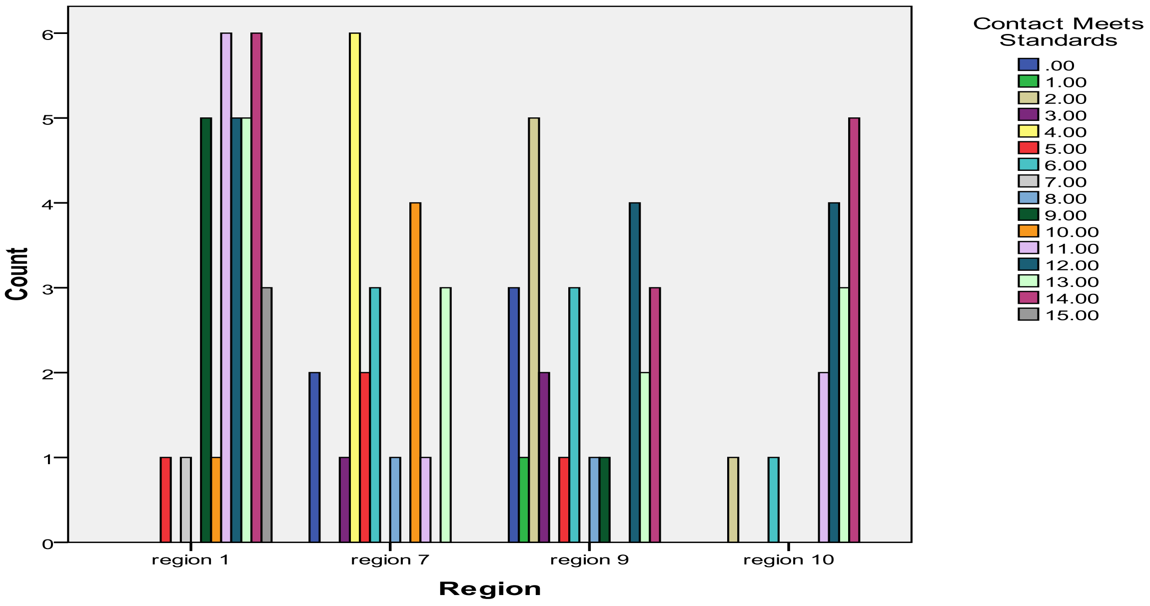


A clearer picture also emerges as one examines the distribution of monthly contacts. As Table 1.14 and Figure 1.2 illustrate, over half or 53.2% (52 out of 98) of the children in the project were visited by caseworkers at least once per month over 11 in the 15-month period from April 2009 to June 2010. Thus, while not meeting the strict interpretation of the Promising Practice, the frequency of visitations far exceeds the Ministry requirement of quarterly visits or five visits over a 15-month period.

Table 1.14: Number of Months Where Child Is Visited Once by Caseworker

Region		Contact Meets *Promising Practices*																
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total
1	Count	0	0	0	0	0	1	0	1	0	5	1	6	5	5	6	3	33
	%	.0	.0	.0	.0	.0	3.0	.0	3.0	.0	15.2	3.0	18.2	15.2	15.2	18.2	9.1	100.0
7	Count	2	0	0	1	6	2	3	0	1	0	4	1	0	3	0	0	23
	%	8.7	.0	.0	4.3	26.1	8.7	13.0	.0	4.3	.0	17.4	4.3	.0	13.0	.0	.0	100.0
9	Count	3	1	5	2	0	1	3	0	1	1	0	0	4	2	3	0	26
	%	11.5	3.8	19.2	7.7	.0	3.8	11.5	.0	3.8	3.8	.0	.0	15.4	7.7	11.5	.0	100.0
10	Count	0	0	1	0	0	0	1	0	0	0	0	2	4	3	5	0	16
	%	.0	.0	6.3	.0	.0	.0	6.3	.0	.0	.0	.0	12.5	25.0	18.8	31.3	.0	100.0
Total	Count	5	1	6	3	6	4	7	1	2	6	5	9	13	13	14	3	98
	%	5.1	1.0	6.1	3.1	6.1	4.1	7.1	1.0	2.0	6.1	5.1	9.2	13.3	13.3	14.3	3.1	100.0

Figure 1.2: Number of Months When Child Was Visited Once by Caseworker



CHILD AND FAMILY AWARENESS OF FASD

This Promising Practice was not included in this project.

PERMANENCY PLANNING

See Concurrent Plans

TRANSITIONAL PLANNING TO ADULTHOOD

The *Promising Practices* provide for planning for the transition of youth in care to adult services. The *Promising Practices* require the completion of a Transitional Checklist by the child's 16th birthday. As of the date of this report, among those youth who have reached their 16th birthday (N=16), half of these youth (N=8) had completed checklist on their files, while for the remaining 50% (N=8) of the files, the checklists were either incomplete (5 of 8) or missing (3 of 8).

Table 1.15 Completion of Transition Checklist By Region

		Transition Checklist				
Region		Not Applicable	Missing	Incomplete	Complete	Total
Region 1	Count	27	0	5	0	32
	% within Region	84.4%	.0%	15.6%	.0%	100.0%
Region 7	Count	21	2	0	3	26
	% within Region	80.8%	7.7%	.0%	11.5%	100.0%
Region 9	Count	23	1	0	4	28
	% within Region	82.1%	3.6%	.0%	14.3%	100.0%
Region 10	Count	13	0	0	1	14
	% within Region	92.9%	.0%	.0%	7.1%	100.0%
Total	Count	84	3	5	8	100
	% within Region	84.0%	3.0%	5.0%	8.0%	100.0%

PLACEMENTS

While there were 103 children tracked in the Project Regions, some experienced more than one placement during the period of April 1 to October 31 2009. Of the 103 children, 101 were placed in some type of placement resource. These children were placed in a total of 114 residential placements during this period. Children in regions 1 and 7 were placed predominantly in foster care, while children in Regions 9 and 10 a mix of foster care, kinship care and group care.

Table 1.16: Placements By Region

		Placements				
Region		Foster Care	Kinship Care	Residential	Adoptive	Total
Region 1	Count	31	0	1	0	32
	% within Region	96.9%	.0%	3.1%	.0%	
Region 7	Count	25	1	4	0	30
	% within Region	83.3%	3.3%	13.3%	.0%	
Region 9	Count	15	2	19	0	36
	% within Region	41.7%	5.6%	52.8%	.0%	
Region 10	Count	7	8	0	1	16
	% within Region	43.8%	50.0%	.0%	6.2%	
Total	Count	78	11	24	1	114

a) Kinship Care

Two *Promising Practices* were developed for placements involving kinship care. The first Promising Practice related to supports provided to each placement. Foster Care Support Workers were expected to ensure that Kinship families caring for children with FASD have support plans developed within 30 days of placement. These support plans were to include the following:

1. Training specific to understanding FASD, minimally 6 hours prior to the placement of the child;
2. Provision of respite care where appropriate;
3. Consultation and support in relation to the child placed and the impact this child has on the kinship family; and,
4. Support plans were to be reviewed on a monthly basis with the Kinship caregivers.

Of the 11 kinship care placements, eight (72.7%) were placed by Region 10. Of these placements, five (62.5%) had completed kinship care support plans on file. Two of the remaining three placements in Regions 7 and 9 had completed kinship care support plans on file. Criminal records checks and CYIM checks were completed prior to the home assessment for all (N=11) kinship care placements. Home assessments were completed and documented on all files. Evidence of FASD training for Kinship caregivers was documented on 7of 11 files (63.6%). Evidence of the provision of respite care was documented for 8 of 11 (72.7%) placements. In addition, consultation and support was evident in 9 of 11 (81.8%) placements. Finally, evidence of monthly review of kinship care support plans was present in 3 of 11 (27.3%) placements.

b) Foster Care

i. Respite Care

Along with caseworker contact, another major pillar of the *Promising Practices* is the provision of respite hours for caregivers in foster homes. The importance of this area warrants special attention. First, among the 43 cases reporting respite hours, we note that less than half (21 or 48.8%) met the strict requirement for a minimum of 48 hours of respite. However, the range (144 hours; 0 to 144 hours) and the standard deviation (39.15 hours) indicate wide variation in mean respite hours. In Region 7, 15 out of 17 cases reported 48 or more hours of respite for each month reported. Other Regions reported much smaller proportions, including 3 out of 20 in Region 1, and two out of five in Region 10. Region 9 had only one valid case with a mean of 48 hours (remaining cases were placed in contracted agency placements). All respite care placements had completed criminal records and CYIM checks on file.

Table 1.17: Mean Respite Hours Meets *Promising Practices* by Region

		Mean Respite Hours Meets Requirements		
Region		Does Not Meet Requirement	Meets Requirement	Total
Region 1	Count	17	3	20
	% within Region	85.0%	15.0%	100.0%
Region 7	Count	2	15	17
	% within Region	11.8%	88.2%	100.0%
Region 9	Count	0	1	1
	% within Region	.0%	100.0%	100.0%
Region 10	Count	3	2	5
	% within Region	60.0%	40.0%	100.0%
Total	Count	22	21	43
	% within Region	51.2%	48.8%	100.0%

In many cases the Promising Practice was not met in only one month. This pattern is evident in Figure 1.3 below which indicates the average or mean hours of respite provided for each child in foster homes over a six month period. Here, average respite hours appear to meet this requirement during the first five months of the project, though not in the sixth month. This is further supported by the overall average number of respite hours provided to Project foster homes, 51.64 hours.

Figure 1.3: Mean Respite Hours by Month

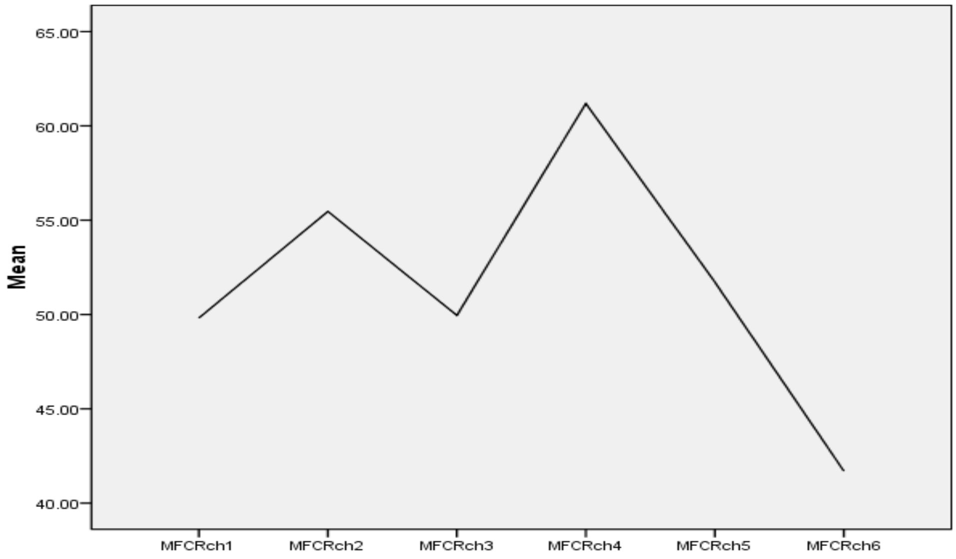
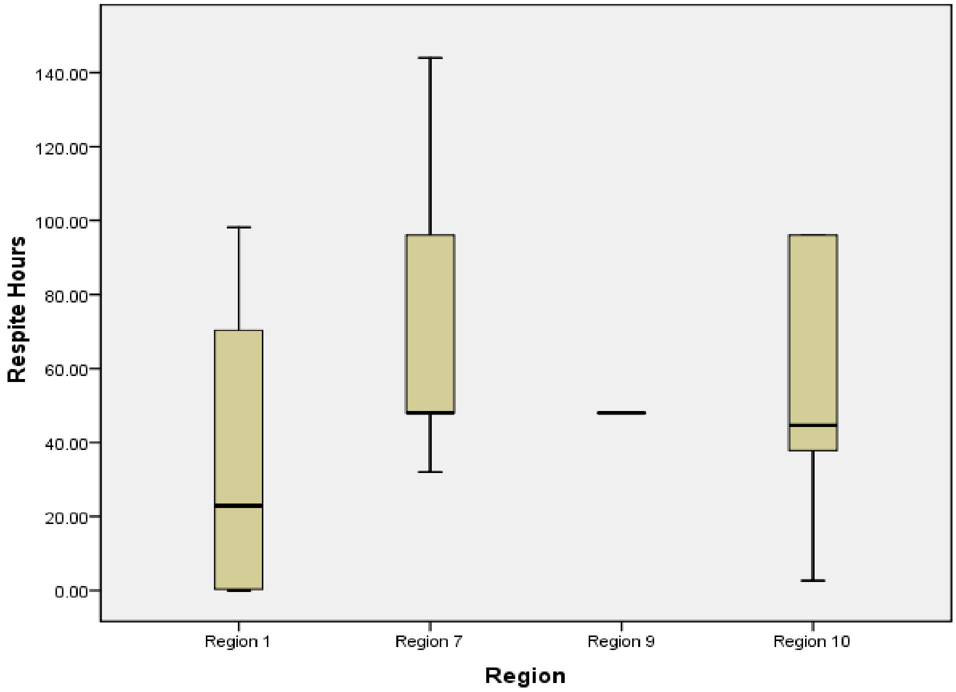


Figure 1.4: Distribution of Respite Hours by Region



ii) Support Plans

Foster Care Support Workers and Case Managers together with Foster Parents were expected to develop a support plan that describes how Foster Parents will have their support needs met. This plan was to address the following:

1. Foster Care Support contacts a minimum every two weeks, including home visits a minimum of once every month.
2. Formal and informal peer support.
3. Consultative expertise (e.g. behavioural management strategies).
4. Crisis placement response plan (relief).
5. Respite Plan.

These support plans are to be completed 30 days from the placement of the first child within the home and updated as children are admitted and discharged. Among the 42 cases involving foster care placements, 22 (81.0%) case files contained completed foster care support plans.

Table 1.18: Completion of Foster Care Support Plans By Region

		FC Support Plan Completion			
Region		Missing	Incomplete	Complete	Total
Region 1	Count	1	2	16	19
	% within Region	5.3%	10.5%	84.2%	
Region 7	Count	4	0	18	22
	% within Region	18.2%	.0%	81.8%	
Region 9	Count	1	0	0	1
	% within Region	100.0%	.0%	.0%	
Total	Count	6	2	34	42
	% within Region	14.3%	4.8%	81.0%	4.8%

Table 1.19: Foster Care Support Plan

HV – Home Visit CM-Case Manager

Region		Collaboration with CM	Bi Wkly Contact	Monthly HV	Peer Support	Consultation With Expert	Crisis Plan	Respite Plan
Region1	Count	11	7	11	14	13	15	0
	%	(100%)	(100%)	(100%)	(93.3%)	(86.7%)	(100%)	(0%)
	Out of	11	7	11	15	15	15	15
Region 7	Count	23	16	22	17	17	6	0
	%	(100%)	(66.7%)	(75.0%)	(70.8%)	(70.8%)	(25.0%)	(.0%)
	Out of	23	24	24	24	24	24	7
Region 9	Count	2	2	2	3	1	1	0
	%	(100%)	(66.7%)	(66.7%)	(100%)	(100%)	(50%)	(.0%)
	Out of	2	3	3	3	1	2	1
Region 10	Count	7	4	1	6	7	3	2
	%	(100%)	(57.1%)	(14.3%)	(100%)	(100%)	(60.0%)	(66.7%)
Total	**Count**	**40**	**24**	**32**	**40**	**38**	**25**	**3**
	%	**(93%)**	**(58.5%)**	**(71.1%)**	**(83.3%)**	**(80.9%)**	**(54.3%)**	**(16.7%)**
	Out of	**43**	**41**	**45**	**48**	**47**	**46**	**12**

As noted in the Promising Practice above, a number of other criteria were identified concerning the completion of foster care support plans. These include collaboration with case managers, bi-weekly contact with foster homes and monthly foster home visits, as well as provision of peer support, consultative expertise, crisis placement response plan and a respite plan. In addition, the *Promising Practices* required updating of the plan as children are admitted or discharged, an annual plan review, and filing of the plan in the case management file. Table 1.19 provides an overview of the file review for each of the above criteria. It is noteworthy is that all support plans provide evidence of collaboration with caseworkers and approximately 80% of support plans provide evidence of peer support and consultative expertise. Over 70% provide evidence of monthly home visits and nearly 60% (58.5%) provide evidence of bi-weekly contact. While over half (54.3%) include a crisis plan, very few document a respite plan. However, as noted above, respite is clearly being provided to caregivers.

iii) Residential Care

The *Promising Practices* also outline requirements for children placed in residential care facilities. These include requirements relating to admission to residential resources, specifically the provision of a full comprehensive assessment and an Individualized Service Plan (ISP). Information from two regions (7 and 9) provided information relating to residential care. Region 9 reported that assessments were provided on or before admission in 10 of 13 placements (83.3%) and ISPs were completed in 16 of 16 (100%) placements.

Table 1.20: Criteria for Individual Service Plan's by Region

Residential Care Individual Service Plan Reflects

Region		Need for Learning	FASD Assessment	Need for Supervision	Task & Progress	Family Visitation Plan
Region7	Count	2	1	1	1	2
	%	(50.0%)	(0%)	(25.0%)	(25%)	(50%)
	Out of	4	4	4	4	4
Region 9	Count	16	6	16	16	12
	%	(100%)	(37.5%)	(100%)	(100%)	(75%)
	Out of	16	16	16	16	4
Total	**Count**	**18**	**7**	**17**	**17**	**14**
	%	**(90.0%)**	**(35%)**	**(85.0%)**	**(85.0%)**	**(70%)**
	Out of	**20**	**20**	**20**	**20**	**20**

In addition, the *Promising Practices* outline specific criteria for ISPs, including requirements for the ISP's to reflect the need for interactive learning, FASD assessment recommendations, provision of individualized supervision, ways to identify tasks and signs of achievement and, where appropriate, family visitation plans. Based upon reporting from the two regions, 90% of the ISPs reflected the child's need for interactive learning, and 80% of the ISPs reflected the need for individualized supervision and identification of progress and task achievement. As this review reflects on the first half of this project, it is understandable that there are lower proportions of completed assessments and family visitation plans placed on file.

iv) Adoptive Services/Private Guardianship

Finally, the *Promising Practices* provide for the development of a support plan and FASD training for adoptive families. There was only one adoptive placement on file, in Region 10. The support plan for this placement had been completed.

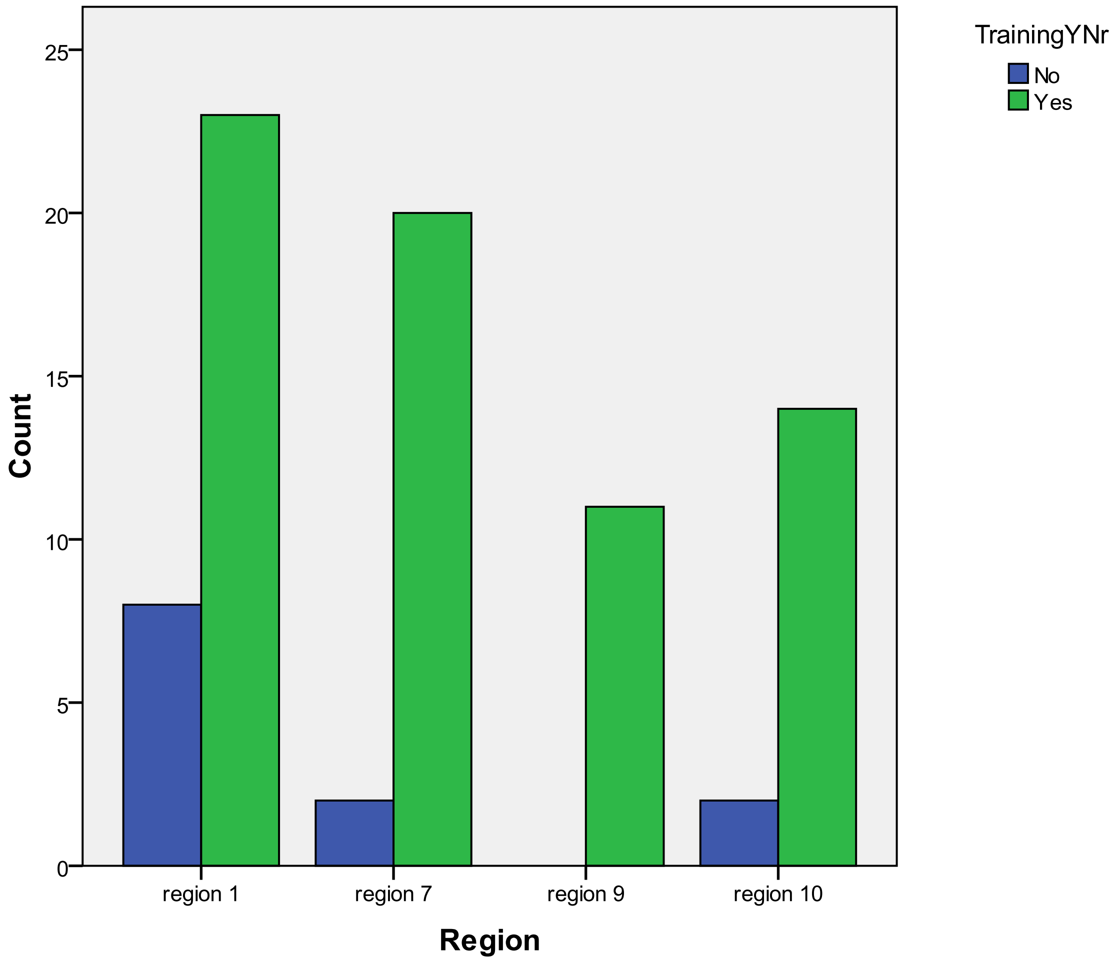
v) Provision of FASD Training

The *Promising Practices* also provided for a minimum of 12 hours of FASD-specific training for caregivers. As noted in Table 1.21 below, 85% of caregivers in the Project Regions completed the requisite FASD training. While the proportion of caregivers completing training in Region 1 is lower than in other regions, it is also important to note that, given the piloting of the *Promising Practices* in the Region in 2003 to 2005, some of these caregivers may have already have completed training prior to involvement in the current project.

Table 1.21: Completion of FASD Training By Region

Region		Training YNr		
		No	Yes	Total
Region 1	Count	8	23	31
	% within Region	25.8%	74.2%	100.0%
Region 7	Count	2	20	22
	% within Region	9.1%	90.9%	100.0%
Region 9	Count	0	11	11
	% within Region	.0%	100.0%	100.0%
Region 10	Count	2	14	16
	% within Region	12.5%	87.5%	100.0%
Total	Count	12	68	80
	% within Region	15.0%	85.0%	100.0%

Figure 1.5: Completion of FASD Training By Region



A QUALITATIVE LENS ON FASD SPECIFIC TRAINING

Within the focus groups both caseworkers and foster parents/caregivers consistently and repeatedly mentioned the importance and value of training. Training included caseworkers and foster parents in the same sessions. Taking part in this activity together facilitated deeper connections and common understandings of the needs of children and youth with FASD. From a philosophical perspective having all members of the "team" together on behalf of the child/youth enhanced the development and growth of a community of practice. Further documentation of the importance and value of training is included in the latter section of this report.

PART II: EQUIVALENCY OF GROUPS

In 2008, members of the Project Leadership Team met to discuss the design of an evaluation project. A quasi-experimental matched comparison group design was adopted for the purposes of this inquiry. Attempts were made create comparable groups based on gender, age, diagnostic class, years in care, ethnicity, legal status (i.e. PGO, TGO, etc), and type of placement. It is important to note that while Project sites recruited participants and began collecting data in April 2009, the comparison group completed recruitment in late Fall 2009. Accordingly, as of October 31st, 2009 total of 101 cases were included in the Project Group (originally there were 103, with attrition occurring over time) while 128 cases were selected for inclusion with the Comparison Group. While the implementation of the *Promising Practices* was to span a 15-month period, it is important to note that children entered the Project from April 1st to June 1st 2009. Recruitment of participants in Region 6 was challenging. While approximately 43 participants agreed to participate in the fall of 2009, not all participated fully, leading to the implementation of alternate data collection methods and supports were offered to the research assistant in order to increase participation in the comparison group. To this end, cases were identified which offered detailed records of risk behaviours. As demonstrated below, there appeared to considerable similarities between the Project (Regions 1, 7, 9 and 10) and Comparison (Region 6) groups.

PARTICIPANTS BY REGION

As Table 2.1 indicates, there is a reasonably balanced sample of 182 participants including 98 cases from the Project Group (Regions 1, 10, 7 and 9) and 84 from the Comparison Group (Region 6). Approximately, one-third of the cases in the Project sample came from Region 1, with the remaining two-thirds came from Regions 7, 9 and 10. It is important to note that attrition reduced the numbers of participants in the project, which began with 229 participants. Ultimately, the inclusion of any caregiver for data analysis in the project depended upon his or her submission of completed data collection forms.

Table 2.1: Children Included in Project by Region – as at June 30, 2010

Group		Region 1	Region 6	Region 7	Region 9	Region 10	Total
Project Regions	Count	33	0	23	26	16	98
	% Group	33.7%	.0%	23.5%	26.5%	16.3%	100%
Comparison Region	Count	0	84	0	0	0	84
	% Group	.0%	100.0%	.0%	.0%	.0%	100.0%
Total	Count	33	84	23	26	16	182
	% Total	18.1%	46.2%	12.6%	14.3%	8.8%	100.0%

DIAGNOSTIC CLASSIFICATION BY GROUP

An important matching criterion is the diagnostic classification of children included in the study. Table 2.2 indicates diagnoses applied to members of the Project and Comparison Groups as of June 30, 2010. There is a slightly higher proportion of children with a diagnosis in the Comparison Region, though analysis revealed no significant differences between the Project and Comparison Groups with respect to diagnostic class $\chi^2(1, N = 169) = .31, p = .58$.

Table 2.2 Diagnostic Class by Group

		Diagnosis		
Group		Diagnosed	Suspected	Total
Project Regions	Count	35	62	97
	% within Groups	36.1%	63.9%	100.0%
Comparison Region	Count	29	43	72
	% within Groups	40.3%	59.7%	100.0%
Total	Count	64	105	169
	% within Groups	37.9%	62.1%	100.0%

A QUALITATIVE LENS ON DIAGNOSIS

In focus groups with caregivers and caseworkers, certain themes related to diagnosis were raised and explored. Participants briefly discussed the benefits of diagnosis, the assessment process, and biological family reactions to diagnosis. With respect to the benefits of diagnosis, it was stated that formal FASD diagnosis opens up access to supports, services, and resources within the community and the educational system – which would not be accessible without the diagnosis. As one caseworker stated,

> *CW: Once they have that diagnosis, FASD, once they have that they can get help at school.*

Another diagnosis-related issue explored by foster parents and caseworkers was that of assessment, focusing on assessment wait times and funding, which may affect or be associated with the diagnosis process. As one focus group participant stated,

> *We find that's a real struggle too is getting assessments done. There are just not the funds available through the system, so, you know, we've gone, we had one set up. We were supposed to go and then the [funds were not available].*

This quote reflects a significant issue, with respect not only to frustrations with wait times or a lack of funding, and in relation to the potential effects on children waiting to be assessed. As stated above, FASD diagnosis (and other assessments or diagnoses) can determine access to gaining required supports and services. As assessment or diagnostic processes are postponed due to funding or other factors, so too is access to valuable services.

In one focus group, the issue of family resistance or defensiveness to the reality of FASD (ascertained by diagnosis) was explored. As one caseworker explains,

> *CW: For so long they feel blamed for the child having issues, 'We are a bad parent' – I'm not saying that, but that's what they hear, if they have FASD themselves.*

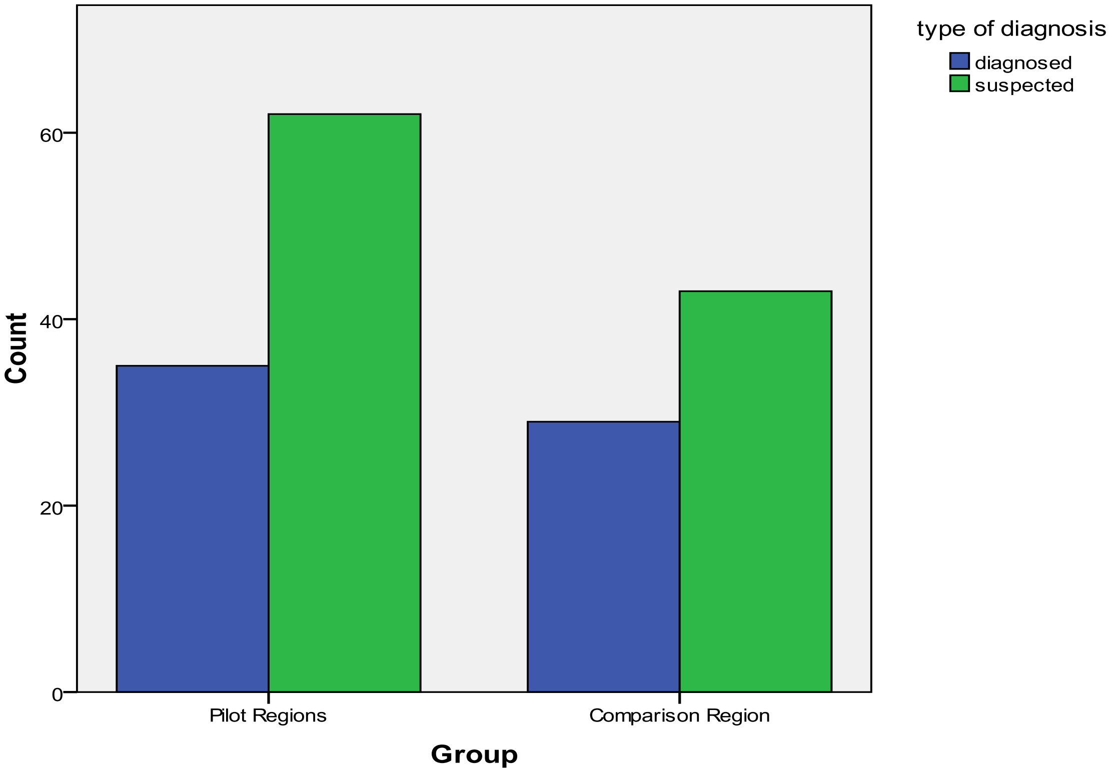
This is an important issue to identify within the context of the research. The idea that a biological family acknowledges the information regarding alcohol use during pregnancy is a concern that must be mediated through casework. The question raised as a researcher relates to roles and opportunities related to talking about such a sensitive issue. What protocols exist in terms of how this discussion takes place with families? This raises an area for further discussion and research.

Another caseworker discusses similar challenges:

> *CW: Sometimes family not open to FASD or suspected FASD… It's probably because the family is so dysfunctional themselves and have FASD – they are not understanding, very defensive, 'No, I did not drink, my child does not have FASD'… Now we are saying the child is showing behaviours consistent with that and they become defensive… I was just simply trying to explain the extra level of support needed by youth and trying to use polite language and I got back, 'She is not stupid.' Well, I didn't say she was stupid. If you are trying to label someone with FASD the label of family understanding is that they are [disabled] or stupid so you can't talk about it with her, it's like a pejorative term and it's difficult… If they get caught up the language is demeaning and hurtful, it's difficult…*

This quote, in addition to addressing the reaction of biological parents to a child's FASD diagnosis, also raises the issue of language associated with FASD. While this issue may not have been explored in depth, it is important to note the potentially demeaning or hurtful connotations of certain language used in discussions about FASD and diagnosis. There is no doubt that significant tensions exist in relation to diagnosis because a diagnosis of FASD is a much larger and often traumatic experience for families. When children come into care foster parents often bring concerns to the attention of the caseworker related to the potential of FASD based on their observations of the child in the home. The training offered to caseworkers and foster parents supports a particular level of competence in understanding the needs of children with FASD and their families.

Figure 2.1: Diagnostic Class by Sites



SUSPECTED CASES

An important aspect in confirming the validity of the research findings and the equivalency of groups was the administration of the PBCL-36 (Streissguth, Bookstein, Barr, Press & Sampson, 1998). The PBCL-36 was administered to all cases lacking a diagnosis (and suspected of experiencing FASD). Completion of the PBCL-36 by 66 caregivers found a comparable mean to score to several studies conducted by Streissguth et al., where the mean score for their reference sample of 472 children, adolescents and young adults with confirmed FAS/ARND (Fetal Alcohol Syndrome/Alcohol Related Neurodevelopmental Disorder) diagnoses was 20.3. Since higher scores are associated with increased with increased likelihood of FAS/ARND, preliminary findings based on this instrument are favourable in that we found a mean score of 20.8 for children included in this study. However, as noted in Table 2.3 below, the PBCL-36 was completed by only 62.9% (66 out of 105 cases) of all caregivers with children suspected of FASD.

Very preliminary comparisons between groups found one significant difference in the subscales (Personal Manner *t* = -2.23; *p* =.03). Comparison of the total score between groups detected a slightly higher score for the Project Regions, though this difference did not reach statistical significance (*t* = -.13; *p* =.90).

Table 2.3: Comparison of PBCL-36 by Group

	Group	N	Mean	Std. Deviation	Std. Error
Communication	Project Regions	43	4.36	2.69	.42
	Comparison Region	23	4.69	2.42	.50
Personal Manner	Project Regions	43	3.15*	1.46	.23
	Comparison Region	23	2.30	1.42	.29
Emotion	Project Regions	43	1.37	.87	.13
	Comparison Region	23	1.65	.71	.14
Motor Skills	Project Regions	43	1.00	.89	.13
	Comparison Region	23	1.00	.90	.18
Academic Work	Project Regions	43	2.13	1.08	.16
	Comparison Region	23	2.14	1.23	.32
Social Skills	Project Regions	43	6.55	3.41	.52
	Comparison Region	23	5.60	2.16	.45
Bodily Function	Project Regions	43	2.41	1.36	.20
	Comparison Region	23	2.60	1.11	.23
Total	Project Regions	43	20.86	9.88	1.60
	Comparison Region	23	20.57	6.06	1.61

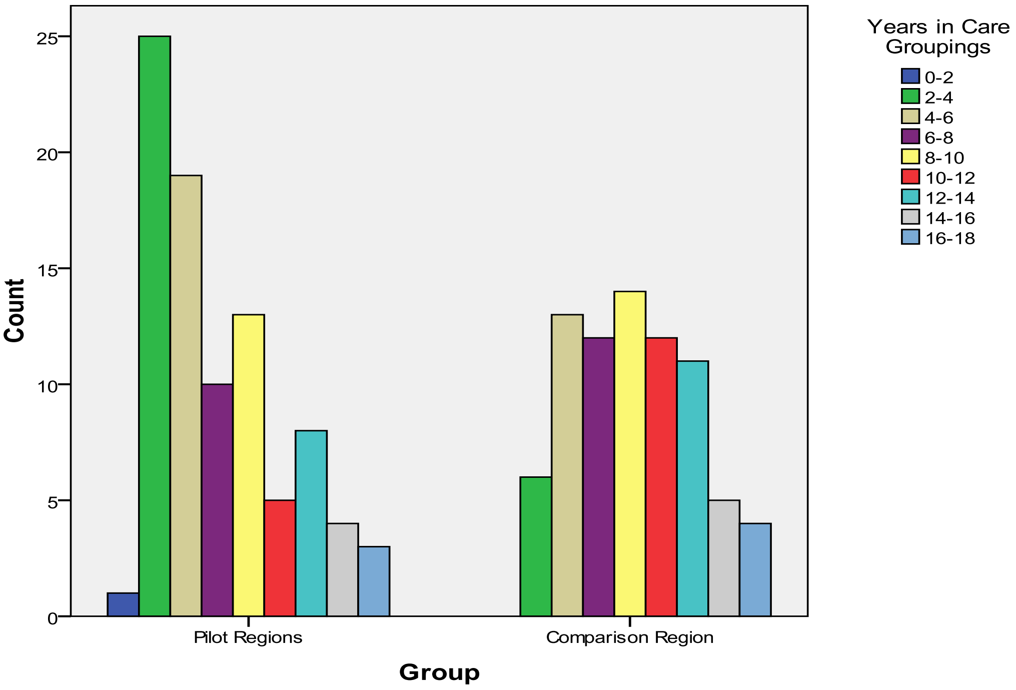
*p <.05

AGE, YEARS IN CARE & PREVIOUS PLACEMENTS

Another important matching criterion is the age of children included in the project. Analysis of age as of April 1, 2009 for each child revealed that the mean age for children included in the Project Regions was 11.8 years (*N* = 98, *SD* = 3.6 years). Mean age for children included in the Comparison group was slightly higher, at 11.9 years (*N* = 78, *SD* = 3.6 years). This difference was not statistically significant (*t* = -.18; *p* =.88).

As for years in care, a notable discrepancy emerged in the findings. While one would normally expect a positive correlation between age and years in care, despite there being no significant difference in ages between groups, children in the Comparison group (*M* = 8.69 years, *SD* =3.83) have been in care for a significantly (*t* = -3.24, p=.001) longer duration than those in the Project group (*M* = 6.72, *SD* = 3.97). Figure 2.2 depicts the distribution of children by age groupings for the Project and Comparison regions. As indicated by the positively skewed distribution, the Project Regions display much higher proportions of children in the younger age grouping than do the Comparison Region.

Figure 2.2: Years in Care by Group



While children in the Comparison group had spent significantly more time in care than children in the Project group, this difference did not translate into significantly more placements. Children in the Comparison group (*M* = 7.54, *SD* = 6.89) had experienced a slightly higher though non-significant average number of placements that those in those in the Project group (*M* = 7.33, *SD* = 7.50).

Table 2.4: Age, Years in Care and Previous Placements By Group

	Group	N	Mean	Std. Deviation	Std. Error Mean
Age	Project Regions	98	11.82	3.64	.36
	Comparison Region	78	11.90	3.60	.40
Years in Care	Project Regions	88	6.72	3.97	.42
	Comparison Region	77	8.69	3.83	.43
Total Placements	Project Regions	64	7.33	7.50	.93
	Comparison Region	71	7.54	6.89	.81

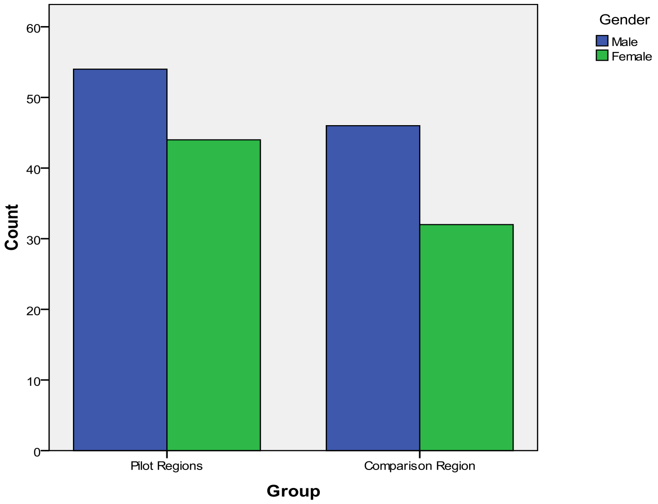
GENDER

Table 2.5 and Figure 2.3 illustrate similarities in the Project and Comparison Groups with respect to gender composition. Consistent with general population trends for those diagnosed with FASD, more male children were included in the samples of both groups. Chi square analysis revealed no significant differences between the Project and Comparison Groups with respect to gender [χ^2 (1, *N = 176*) = .27, *p* = .61].

Table 2.5: Gender by Group

Group		Gender		
		Male	Female	Total
Project Regions	Count	54	44	98
	% within Group	55.1%	44.9%	100.0%
Comparison Region	Count	46	32	78
	% within Group	59.0%	41.0%	100.0%
Total	Count	100	76	176
	% within Group	56.8%	43.2%	100.0%

Figure 2.3: Gender by Group



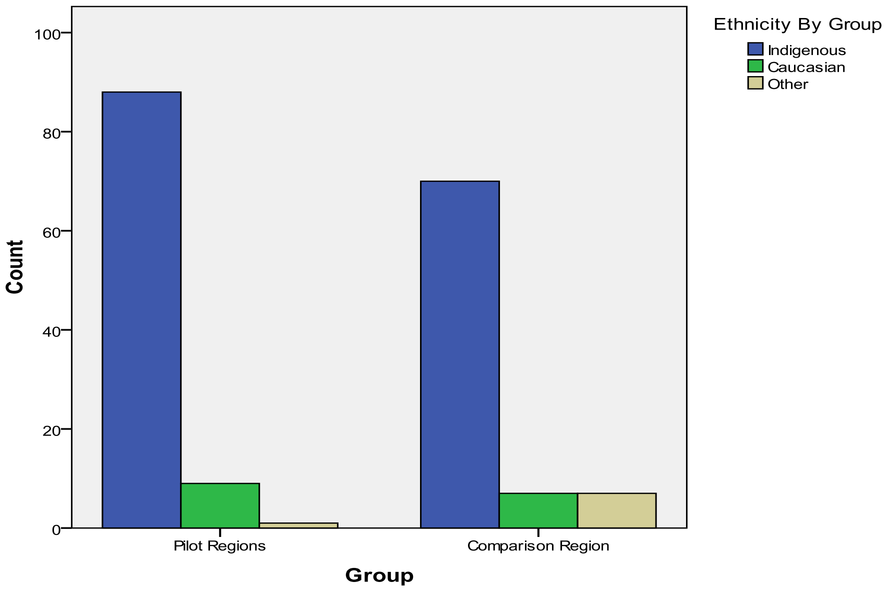
ETHNICITY

Table 2.6 and Figure 2.4 indicate that both groups included a substantially larger proportion of Indigenous children, compared to children of other ethnicities. Analysis of ethnicity revealed some differences between the groups, which approached significance. A non-significant difference was detected χ^2 (2, *N = 165*) = 5.75, *p* =.056 in relation to the proportion of Indigenous children in the Project Regions (89.8%) when compared to the Comparison Region (83.3%). There were also a higher proportion of children from other ethnic origins in the Comparison Region than in the Project Regions.

Table 2.6: Ethnicity by Group

Group		Ethnicity			Total
		Indigenous	Caucasian	Other	
Project Regions	Count	88	9	1	98
	% within Group	89.8%	9.2%	1.0%	100.0%
Comparison Region	Count	70	7	7	84
	% within Group	83.3%	8.3%	8.3%	100.0%
Total	Count	158	16	8	182
	% within Group	86.8%	8.8%	4.4%	100.0%

Figure 2.4: Ethnicity by Group



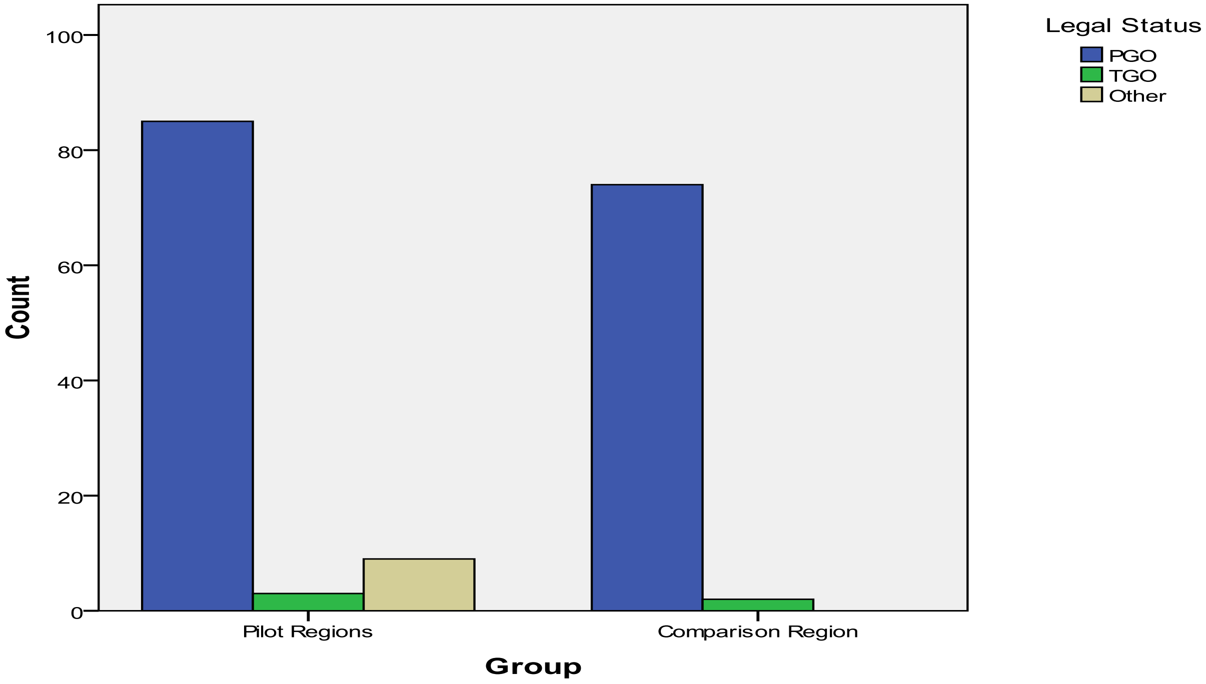
LEGAL STATUS

As Table 2.7 and Figure 2.5 indicate, both groups were quite similar in that a large majority of children were in care under PGO status. A significant difference [χ^2 (2, *N = 173*) = 7.52, *p* =.023] arose due to the number of children under "Other" status in the Project Regions. The Project Regions reported that a number of children were in care as a result of various agreements, and this difference could contribute to higher placement changes in the Project Regions group.

Table 2.7: Legal Status by Group

		Legal Status			
Group		PGO	TGO	Other	Total
Project Regions	Count	85	3	9	97
	% within Groups	87.6%	3.1%	9.3%	100.0%
Comparison Region	Count	74	2	0	76
	% within Groups	97.4%	2.6%	.0%	100.0%
Total	Count	159	5	9	173
	% within Groups	91.9%	2.9%	5.2%	100.0%

Figure 2.5: Legal Status by Group



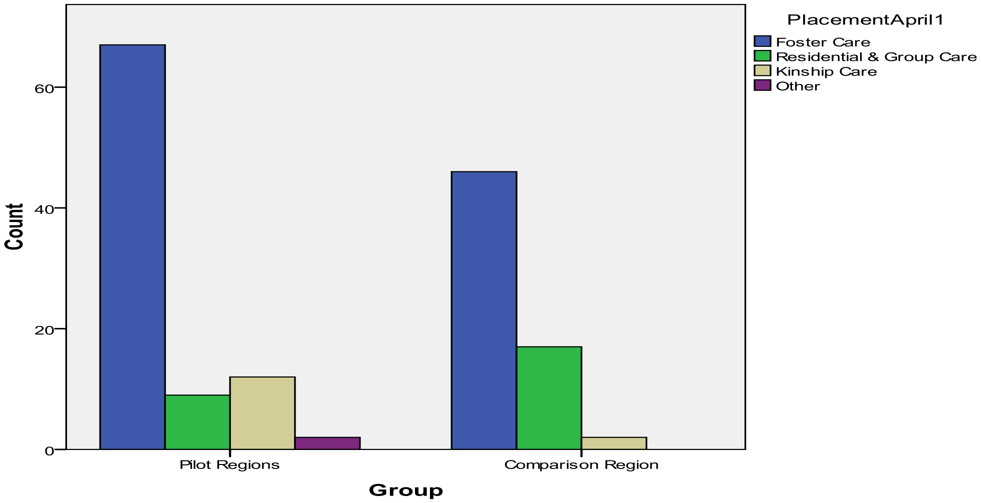
PLACEMENT TYPE

Finally, the groups were compared in terms of the types of placements in which children were residing at the beginning of the Project on April 1st, 2009. As noted in Table 2.8 and Figure 2.6, a large majority of children in both groups were placed in foster homes at the beginning of the study. Given Region 10's emphasis on kinship care, the Project Regions also had a much higher proportion of children in kinship care placements. On the other hand, challenges in participation rates in the Comparison Region, led to the recruitment of higher proportions of children in Residential and Group care placements. These differences lead to overall significant statistical differences between the groups in terms of the types of placements [χ^2 (4, *N = 155*) = 11.78, *p* =.008].

Table 2.8: Placement Type by Group

Region		Placement at April 1				Total
		Foster Care	Residential & Group Care	Kinship Care	Other	
Project Regions	Count	67	9	12	2	90
	% within Group	74.4%	10.0%	13.3%	2.2%	100.0%
Comparison Region	Count	46	17	2	0	65
	% within Group	70.8%	26.2%	3.1%	.0%	100.0%
Total	Count	113	26	14	2	155
	% within Group	72.9%	16.8%	9.0%	1.3%	100.0%

Figure 2.6: Placement Type by Group



OTHER DISABILITIES

Files were also reviewed to determine if children included in the study experienced other disabilities in addition to FASD. No significant differences were found between groups in terms of the presence of concurrent disabilities [χ^2 (1, *N = 182*) = .043, *p* =.84]. As Table 2.9 indicates, approximately half of the children in each group were found to experience other disabilities.

Table 2.9: Presence of Other Disabilities by Group

Region		Other Disabilities		
		No	Yes	Total
Project Regions	Count	51	47	98
	% within Group	52.0%	48.0%	100.0%
Comparison Region	Count	45	39	84
	% within Group	53.6%	46.4%	100.0%
Total	Count	96	86	182
	% within Group	52.7%	47.3%	100.0%

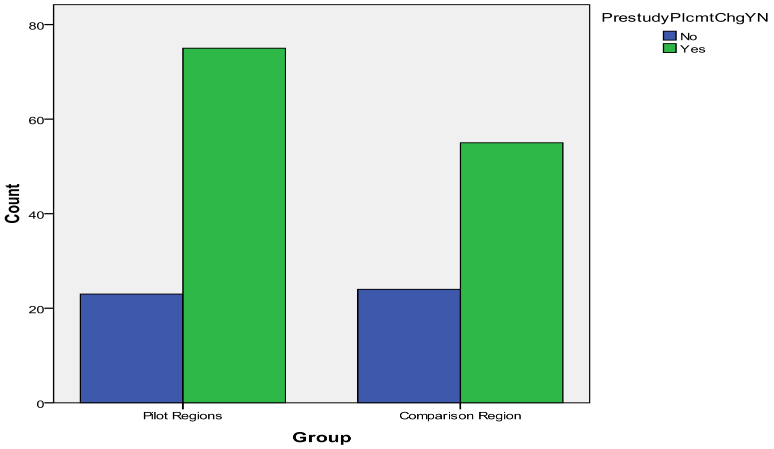
PLACEMENT STABILITY

Baseline data was gathered in relation to the number of placement changes that children had experienced since coming into care. As Table 2.10 and Figure 2.7 indicate, the majority of children in both the Project and Comparison Groups had experienced placement change since coming into care. While the proportion in the Project Regions was somewhat higher than in the Comparison Region, this difference was not significant [χ^2 (1, *N = 177*) = 1.07, *p* =.30].

Table 2.10: Occurrence of Pre-Study Placement Change by Group

Group		Pre-Study Placements		
		No	Yes	Total
Project Regions	Count	23	75	98
	% within Group	23.5%	76.5%	100.0%
Comparison Region	Count	24	55	79
	% within Group	30.4%	69.6%	100.0%
Total	Count	47	130	177
	% within Group	26.6%	73.4%	100.0%

Figure 2.7: Occurrence of Pre-Study Placement Changes by Group



Overall Group Equivalency

Overall, analysis of each matching variables yielded favourable results. While there were some noteworthy differences between groups in terms of ethnicity, years in care, legal status, and placement type at the beginning of the project, no significant differences were detected for much more potentially influential characteristics such as diagnostic classification, scores on the PBCL-36 for suspected cases, age, number of previous placements, and gender. Of the significant differences, differences in legal status may contribute to higher placement change for members of the Project Regions, as a higher proportion of children in the Project Regions were in care under various agreements.

A QUALITATIVE LENS ON PLACEMENT ISSUES AND STABILITY

Some focus group discussion points were related to placement issues, including length of time in care and number of placements. Specifically, caseworkers and caregivers made statements regarding a child or youth entering care and placement stability.

As one foster parent explained, the age at which children enter care (and, therefore, the length of time they spend in care) influences their experience in care, as it affects the development of relationships with caregivers. This foster parent states that,

> *FP: I found with my girls, because they have come into care so late, making this their actual family is really difficult… They show up on my doorstep when they're 14 or 15. So you have them for a very short window of time and their connection is still to their biological family… What we [hope as foster parents is to] make you [the youth] safer in relationships than you were when you came into care.*

It may be more challenging to build relationships with children who are older when first entering care. As such, the focus of the care giving relationship might shift to life skills support.

The issue of placement stability/instability was explored during focus group discussions. The issue of planned placement moves versus unplanned placement disruptions was discussed. Focus group participants focused primarily on planned placement changes, as opposed to unplanned moves (and reasons for placement disruptions). As one caseworker explains,

> *CW: The movement of a lot of my kids was to find permanency. I'd say 50% of my kids then moved because I moved them [to find permanent homes]. I purposely moved them because of that.*
>
> *CW: These kids that we've had through the project, I don't think we had a single instance of a move of a child due to frustration [by foster parent] where the child had to be moved because of that. We did have some moves. I can think of a few that ended up moving because of some issues. But it wasn't a 'kids' issue. We had a number of kids that were moved because of case plans [related to permanency].*

According to at least one foster parent, the focus and emphasis on placement stability seems to have increased in association with this project (which may, in part, explain caseworkers' focus on planned placement moves and placement changes intended to find permanency). This foster parent states that,

> *FP: Our boys, since the project started, it seems like it's been a concerted effort to keep them there and not move them.*

One broad reason for placement disruption was identified during focus group discussions. As one caseworker states, project training has enabled a greater understanding of caregiver burden, and recognition of the "normalcy" of caregivers reaching the "end of their rope". This statement was made in the context of a discussion about placement moves, and the caseworker raised the issue of emergency placements (versus general respite placements). As one caseworker explains,

> *CW: This project can help deal with a pattern from the past. We haven't answered the needs of a foster parent well when all hell has broken loose, they're mad at the system, and the child goes into group care and it's unfortunate. This project says, let's interview [connect/intervene with foster parents] before it gets to that point.*

This quote identifies one factor that may increase the number of unplanned placement moves for certain children such as children with more challenging behaviours. It sheds light on one target area, which could decrease placement disruptions: early intervention and caregiver support, prior to crisis escalation. As one focus group participant stated,

> *[Workers] said, 'Okay, I guess we need to get these kids out of there', and did exactly that. It became a move rather than getting the kids out there to respite.*

As a number of focus group participants stated, if caregivers are provided with increased supports before a situation reaches the point of a crisis requiring a placement change, placement breakdown might be prevented.

PART THREE: OUTCOMES

As stated in the original project proposal, it was believed that the implementation of the *Promising Practices* would result in better outcomes for children impacted by FASD. This raises the central question of this inquiry: Did the enhanced services, supports and resources, provided through the *Promising Practices* result in better outcomes for children who experience FASD? If they do, then one may be ethically and morally compelled to ensure that they are provided to all children with FASD. If they do not, then one may be ethically and morally constrained from re-directing resources that have proven effective for other clients for use in such a project. It is crucial to note at this time, that while the results of this inquiry will add to our understanding of potentially helpful interventions with this population, the sample size and other limitations of the design will not allow us to conclusively answer this question. Further multi-site research involving much larger numbers of clients is greatly needed in this area, as is greater access to diagnostic clinics for those who may be affected by FASD. A further discussion of methodological limitations will be offered in the final part of this section.

To address the central question of efficacy, this section of the evaluation report summarizes measurement of three major outcomes that were outlined in the Project Proposal. These include residential placement stability, quality of relationships with caregivers and teachers, and risk behaviours. As this study spanned a period of one year, it was not possible to examine longer-term outcomes. Indeed, one year has proven to be a somewhat short period of time in which to examine placement stability.

In this section of the evaluation report, we will provide a summary of the research design and methods used to gather data related to outcomes. In the results section, a descriptive summary of outcomes for both the Project and Comparison groups will be presented. Where practical, some statistical analysis of changes over time and differences between groups will be offered. We will also attempt to examine which interventions provided for in the *Promising Practices* may be predictive of outcomes for children. Finally, we will offer a brief summary of the findings and limitations of the inquiry.

In spring 2008, members of the COP Leadership Team and researchers from the Faculty of Social Work at the University of Calgary met to discuss the design of an evaluation project. At that time, four regions (Regions 1, 7, 9 and 10) had volunteered to implement *Promising Practices* for children suspected of or diagnosed with FASD. Region 6 had volunteered to serve as a comparison group. As noted above, to promote greater comparability, school age children were selected for both the Project and Comparison groups. Attempts were also made create comparable groups based on gender, age, diagnostic class, and legal status (i.e., PGO, TGO, etc). Thus, a quasi-experimental matched comparison group design was adopted for the purposes of this inquiry. A total of 33 cases were included in the Project Group while 30 cases were selected for inclusion in the Comparison Group. While the implementation of the *Promising Practices* was to span a 15-month period, it is important to note that children entered the Project from April 1st to June 1st 2009. Similarly, children entered the Comparison group from July to October 2009.

One of the challenges with longitudinal studies is the potential for missing data and attrition of subjects over the course of a long data collection regime. Such was the case with this study. Participants were asked to complete data report forms monthly over a 15-month period. In some cases, far less than 15 months of data was ultimately gathered. For our purposes here, cases in which 12 months of data were collected for a particular child were included for analysis. To reduce attrition, particularly in those instances where one or two months of data is missing, we have collapsed monthly data into quarterly means for analysis purposes.

Several categories of outcome variables will be described including: (1) risk behaviour including occurrences of unauthorized absences (AWOLs), substance abuse, criminal behaviour, inappropriate sexual behaviour, and acting out; (2) school related behaviour including school absences, contacts by school and ratings of the quality of interactions at school; (3) child contact with their families (4) caregiver-related variables including ratings of interactions at home as well as caregiver strain and placement satisfaction; and (5) supports provided to the home including respite as well as contact by caseworker and foster home worker personnel.

RISK BEHAVIOUR

UNAUTHORIZED ABSENCES

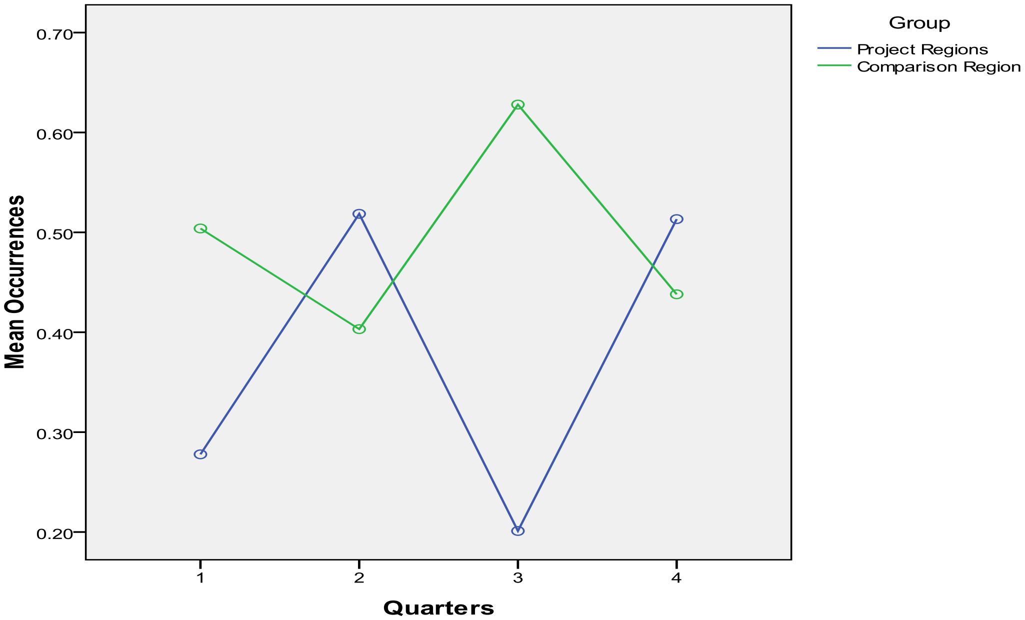
Patterns of unauthorized absences varied dramatically between the Project and Comparison regions. It is noteworthy that patterns of unauthorized absences fluctuated over time in the Project Regions with noticeable increases in the second quarter during summer months and then falling off in the fall. Indeed the overall mean occurrences of unauthorized absences were considerably lower in the Project Regions (*M* = .378, *SD* =.240) than in the Comparison Region (*M* =.493, *SD* =.291). Overall main effect between groups was not significant [*F* (1,105)=2.278, *p*=.259)] nor was there significant change evident over time [*F*(2.338, 245.514) =1.611, *p* =.197)].

Table 3.1 Quarterly Incidence of Unauthorized Absences by Group

Group	Mean	Std. Deviation	N

Quarter 1	Project Regions	.278	1.191	63
	Comparison Region	.504	1.172	43
	Total	.370	1.183	106
Quarter 2	Project Regions	.519	3.778	63
	Comparison Region	.403	1.432	43
	Total	.472	3.042	106
Quarter 3	Project Regions	.201	1.070	63
	Comparison Region	.628	2.379	43
	Total	.374	1.727	106
Quarter 4	Project Regions	.513	3.057	63
	Comparison Region	.438	1.932	43
	Total	.483	2.648	106

Figure 3.1: Quarterly Incidence of Unauthorized Absences by Group



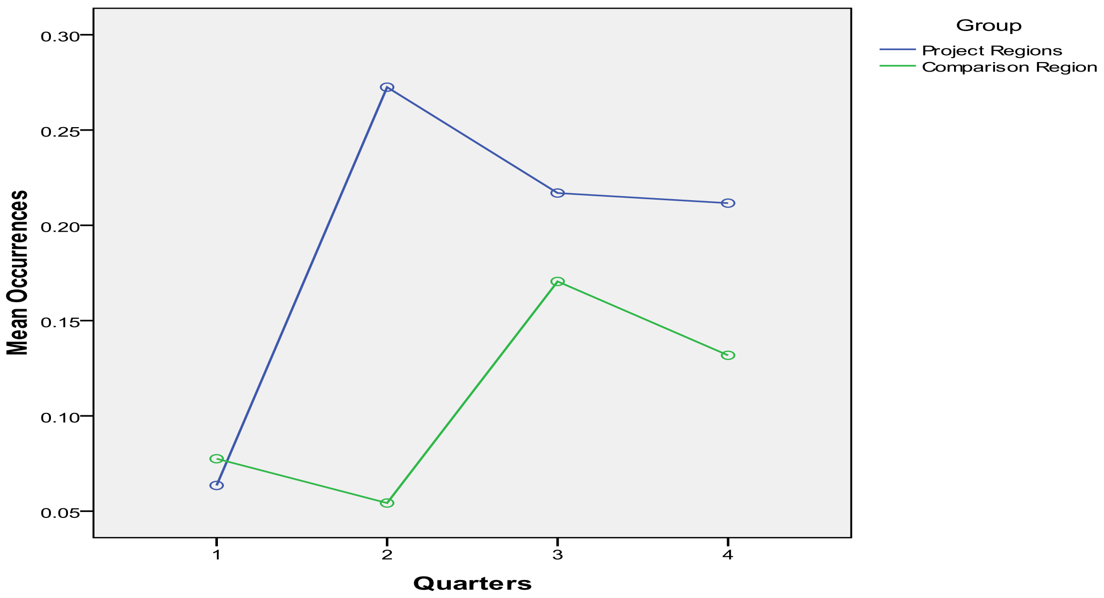
SUBSTANCE ABUSE

Incidences of reported substance abuse were rarer than for unauthorized absences. The pattern of mean incidences of substance abuse was quite variable and did not show a clear trend. Unlike unauthorized absences, mean incidences of substance abuse were higher in the Project Regions (*M* =.191, *SD* =.075) than in the Comparison Region (*M* =.109, *SD* =.091) over this time period. Overall main effect between groups was not significant [*F*(1,104)=.487, p=.487)] nor was there significant change evident over time [*F*(1.434, 149.177)=.360, *p* =.627)].

Table 3.2: Quarterly Incidence of Substance Abuse by Group

Group		Mean	Std. Deviation	N
Quarter 1	Project Regions	.064	.348	63
	Comparison Region	.078	.459	43
	Total	.069	.395	106
Quarter 2	Project Regions	.273	1.954	63
	Comparison Region	.054	.192	43
	Total	.184	1.510	106
Quarter 3	Project Regions	.217	.874	63
	Comparison Region	.171	.579	43
	Total	.198	.765	106
Quarter 4	Project Regions	.212	.784	63
	Comparison Region	.132	.472	43
	Total	.179	.673	106

Figure 3.2: Quarterly Incidence of Substance Abuse by Group



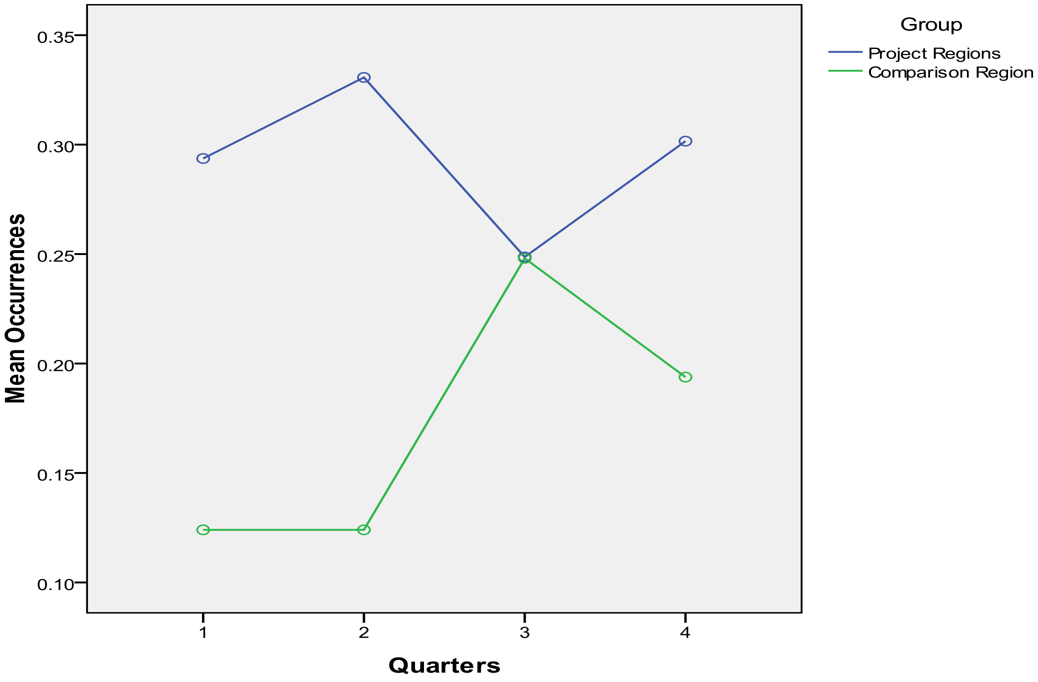
CRIMINAL BEHAVIOUR

Overall mean incidences of criminal behaviour in the Project Regions were higher (*M* =.294, *SD* = .100) than those reported in the Comparison Region (*M* =.172, SD =.121). However, there were no significant differences between the groups *F*(1,104)=.397, *p* =.441; nor was there significant changes over time [*F*(1.58, 312) =.583, *p* =.521].

Table 3.3: Quarterly Incidence of Criminal Behaviour by Group

Group		Mean	Std. Deviation	N
Quarter 1	Project Regions	.294	1.137	63
	Comparison Region	.124	.263	43
	Total	.225	.893	106
Quarter 2	Project Regions	.331	1.441	63
	Comparison Region	.124	.364	43
	Total	.247	1.136	106
Quarter 3	Project Regions	.249	.982	63
	Comparison Region	.248	.569	43
	Total	.248	.836	106
Quarter 4	Project Regions	.302	1.102	63
	Comparison Region	.194	.371	43
	Total	.258	.880	106

Figure 3.3: Quarterly Incidence of Criminal Behaviour by Groups



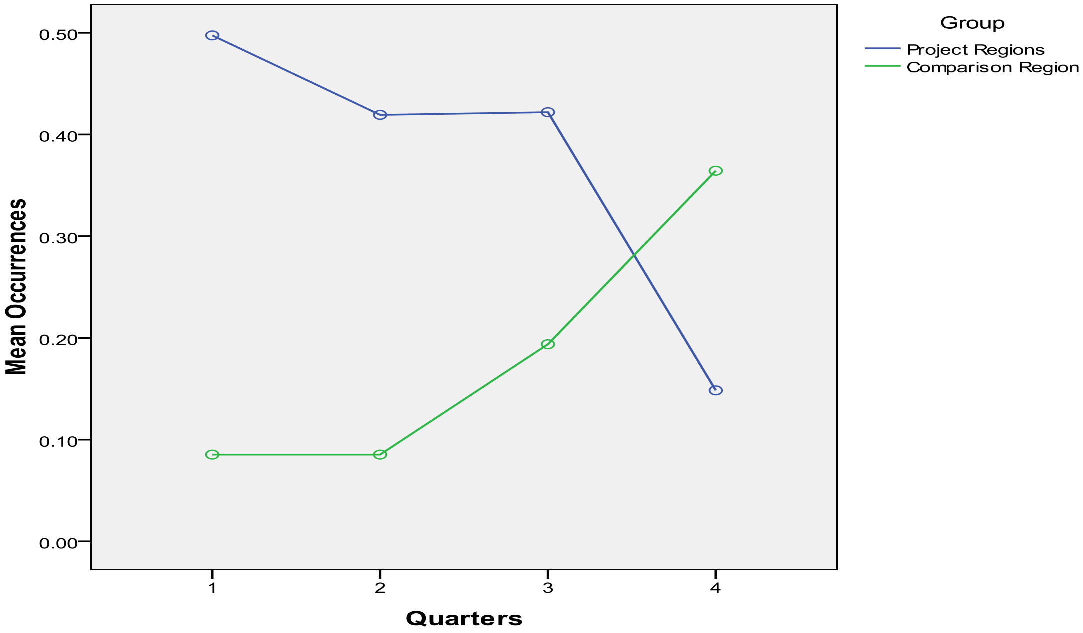
INAPPROPRIATE SEXUAL BEHAVIOUR

Reported incidences of inappropriate sexual behaviour during this period demonstrated a clear pattern of decline in the Project Regions, with an increase Comparison Region over this period. Mean reported incidences of inappropriate sexual behaviour were substantially higher in the Project Regions (*M* =.372, *SD* =.092) than in the Comparison Region (*M* =.182, *SD* = .113). Given the higher yet declining incidence in the Project Regions there was no significant difference between group effect [*F*(1, 105)=1.690, p=.196)], nor was there a significant change over time [*F*(2.350, 246.44)=.2.153, *p* =.109)].

Table 3.4: Quarterly Incidence of Inappropriate Sexual Behaviour by Group

Group		Mean	Std. Deviation	N
Quarter 1	Project Regions	.497	1.316	64
	Comparison Region	.085	.219	43
	Total	.332	1.044	107
Quarter 2	Project Regions	.419	1.755	64
	Comparison Region	.085	.300	43
	Total	.285	1.376	107
Quarter 3	Project Regions	.422	1.489	64
	Comparison Region	.194	.444	43
	Total	.330	1.187	107
Quarter 4	Project Regions	.148	.752	64
	Comparison Region	.364	.894	43
	Total	.235	.815	107

Figure3.4: Quarterly Incidence of Inappropriate Sexual Behaviour by Group



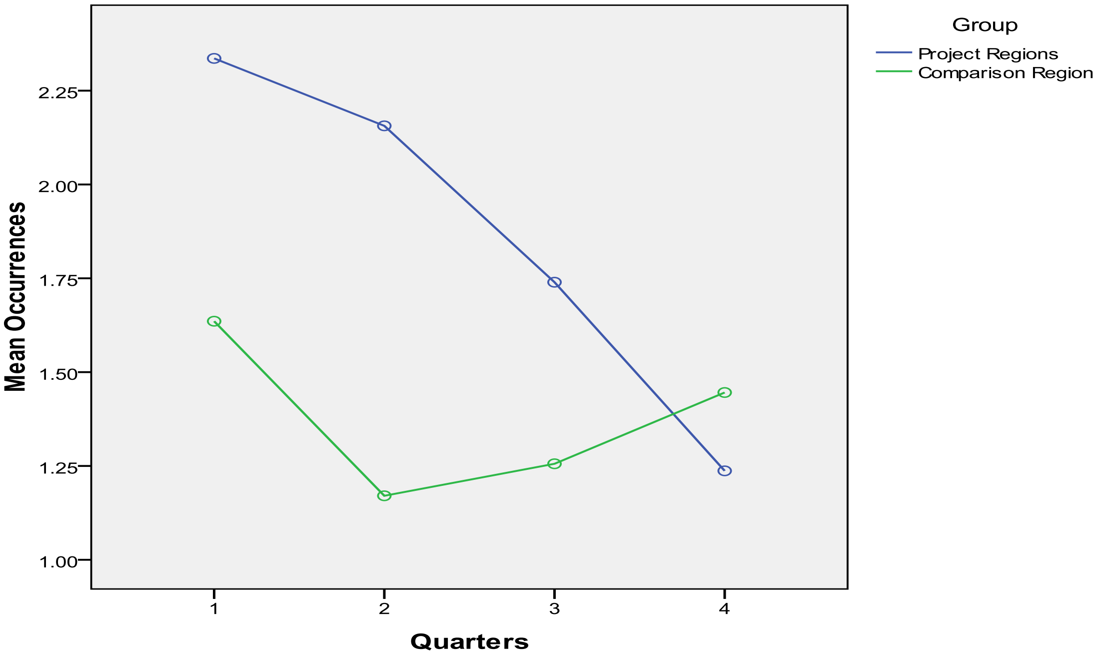
PHYSICALLY ACTING OUT

Perhaps the risk behaviour most applicable to all children across age groups is acting out behaviour. Consequently, it may also be the most likely to be sensitive to changes in the social supports provided in the home. As will be noted below, the magnitude of reported incidences for both groups is much larger than for any of the above mentioned risk behaviours. While the mean incidence of acting out behaviour in the Project Regions (*M* =1.867, SD =.274) was higher than in the Comparison Region (*M* =1.377, *SD* =.334). Figure 3.5 displays a general trend of decreasing acting out behaviour in the Project Regions and an increasing trend in acting out behaviour in the Comparison Region. No significant differences were detected between groups [*F*(1,105)=1.288, *p* =.259] or over time [F(2.338, 245.514) =1.611, *p*=.274].

Table 3.5: Quarterly Incidence of Physical Acting-Out Behaviour by Group

Group		Mean	Std. Deviation	N
Quarter 1	Project Regions	2.336	2.880	64
	Comparison Region	1.636	2.897	43
	Total	2.055	2.894	107
Quarter 2	Project Regions	2.156	3.585	64
	Comparison Region	1.171	2.189	43
	Total	1.760	3.126	107
Quarter 3	Project Regions	1.740	2.481	64
	Comparison Region	1.256	3.276	43
	Total	1.545	2.822	107
Quarter 4	Project Regions	1.237	2.169	64
	Comparison Region	1.446	2.668	43
	Total	1.321	2.372	107

Figure 3.5: Quarterly Incidence of Physical Acting-Out Behaviour by Group



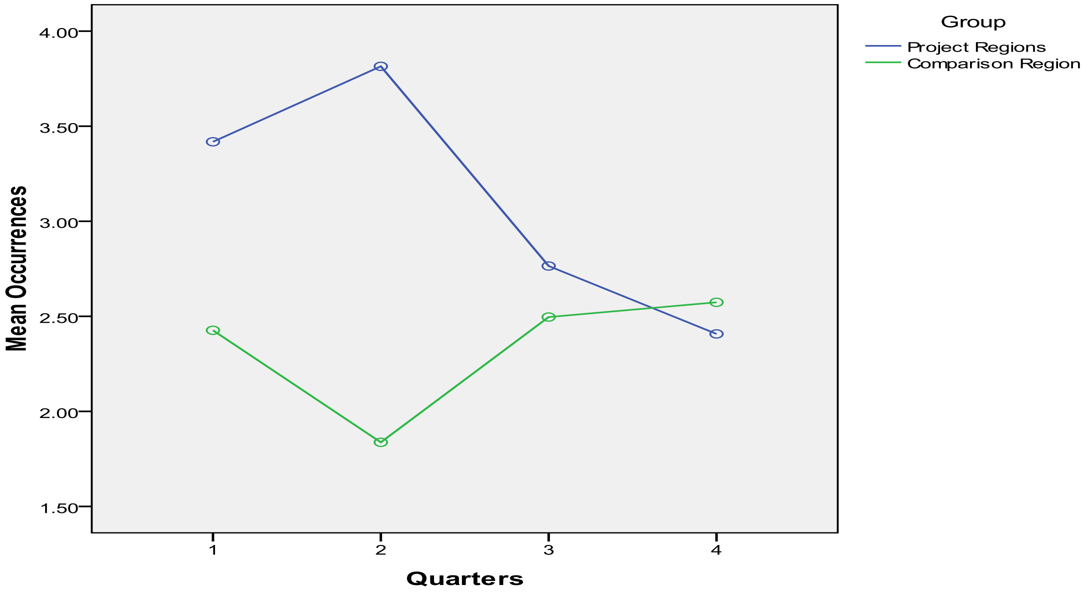
ALL RISK BEHAVIOUR

Overall, when combining all reported risk behaviour (including unauthorized absences, inappropriate sexual behaviour, criminal behaviour, substance abuse, and physical acting out); we note that reported incidences of risk behaviour for the Project Regions, while higher initially (*M* = 3.101, *SD* =.515) than the Comparison Group (*M* =2.333, *SD* =.623), trended downward during this period, while those for the Comparison Group trended higher. However, there were no significant differences arising between groups [*F*(1,104)=.903, *p* =.344] nor significant changes over time [*F*(1.918, 199.513)=1.630. *p* = .205].

Table 3.6: Incidence of All Risk Behaviours by Month by Group

	Group	Mean	Std. Deviation	N
Quarter 1	Project Regions	3.418	4.303	63
	Comparison Region	2.426	3.592	43
	Total	3.016	4.041	106
Quarter 2	Project Regions	3.815	9.586	63
	Comparison Region	1.832	2.813	43
	Total	3.013	7.641	106
Quarter 3	Project Regions	2.765	3.667	63
	Comparison Region	2.496	4.357	43
	Total	2.656	3.944	106
Quarter 4	Project Regions	2.407	4.411	63
	Comparison Region	2.574	3.332	43
	Total	2.475	3.992	106

Figure 3.6: Incidence of All Risk Behaviours by Month by Group



PREDICTING RISK BEHAVIOUR

We examined the relationship between mean risk behaviour and predictor variables including interactions at home and school, respite, worker contact, and perceived social support. Regression analysis found that only interactions at home were predictive of risk behaviour (*t* = -2.27, *p* =.028), with risk behaviour declining as interactions at home improve.

Table 3.7: Predicting Risk Behaviour

	Unstandardized Coefficients		Standardized Coefficients		
Model	B	Std. Error	Beta	t	Sig.
(Constant)	7.188	2.355		3.052	.004
MInteractHome	-1.306	.574	-.315	-2.273	.028

a. *Dependent Variable: MAllRiskBehvr*

A QUALITATIVE LENS ON BEHAVIORAL CONCERNS FOR CHILDREN AND YOUTH WITH FASD IN CARE

In the focus group discussions there was a major focus on risk behaviors, with attention paid primarily to general behavior issues, rather than the specific risk behaviors identified on the project's behavior tracking sheets (AWOLs, drug or alcohol use, criminal behavior, sexual behavior, or physical acting out).

A number of participants (both foster parents and caseworkers) discussed the need to reframe the way that challenging behaviors are viewed. As one foster parent states,

> *FP: It can be a bit challenging in that aspect, that they tend to forget, but at the same time when I used to be frustrated about thinking he was doing this on purpose, you know, saying that I forget... I used to get really frustrated about it, now I just treat it like, 'Okay, I guess he did forget'.*

One of the challenging behaviors associated with FASD is the issue that memory can be a serious problem. As a result of participation in training a deeper understanding of the complexity of the neurological disabilities associated with this diagnosis seemed to mediate some of the challenges that foster parents and caseworkers experience with children and youth. The need to repeat information, reiterate expectations for children and youth with FASD was identified as an important part of practice. Having a better understanding why memory problems occur, supported those involved with the child or youth to engage and communicate more effectively. What may appear as inappropriate or overly challenging behavior to some people may be considered good behavior in the context of a particular child with FASD. This was explained by one caseworker, who states that,

> *CW: To that foster parent, 'Oh, that's just who they are, that's just how they behave.' So they don't bat an eye at it. So if somebody who doesn't understand that came in, they would say, 'Oh no, this is way out of whack', but for somebody who understands this they'd say, 'No, this is, this child's doing pretty good'. If you understood what was going on here, the child's doing okay.*

As part of the act of reframing the way in which a child's behavior is viewed, the potential factors behind the behavior ought to be considered. As one caseworker explains, a child's behaviors may be due to a variety of reasons, such as a lack of supervision or placement transitions:

> *CW: They suspended him [at school] – after we told them he just had a placement breakdown, he just moved to a new foster home, expect behavior problems, you know maybe don't have him in class, put him in [activities]... they punished him for having a completely normal response under the circumstances...*

One focus group participant talked about the need to frame behaviors in different ways, using different language depending on the context (for example, home versus school). This may shift the way that people perceive a child's behavior and the way in which they respond to that behavior:

<u>Behaviour tracking process:</u> Focus group participants discussed their perceptions of the behaviour tracking process required by this project. Many participants viewed this as an important and valuable process. It seems that the primary perceived benefit of the tracking process was that foster parents were able to identify trends or patterns in child behaviours when looking at a completed monthly tracking sheet. As one foster parents states:

> **FP: It was kind of nice actually in a lot of ways because it's on one sheet and you could see the whole month in one sheet so you could almost graph it right there and see, okay, there were the low points. Whether it has actually has to do with something else, some of the behaviours, some of the occurrences...*

As a result of the behaviour tracking process, foster parents could also identify stressors, particularly those related to transitions and this increased awareness acted to support interventions. In other words, this deeper awareness has led foster parents and caregivers to anticipate problems and respond accordingly. By identifying potential connections or triggers, for example, they might be able to intervene before a crisis occurs:

> *FP: Every time these kids had a visit with their [bio-family], then their behaviours on the tracking form escalate, escalate, then it stopped, then it was settled back down. They were really, really good for two weeks and it was really easy to tell what was causing it.*

It is important for children in care to maintain contact with biological family wherever possible and considerable efforts were made to ensure these visits occur. However, visits and even the use of respite care were identified in the focus groups as a *transition* for the child or youth. Knowing that transitions are challenging for children with FASD this creates an awareness that stress occurs, can influence behavior and responsive interventions can be implemented to support the child when this occurs.

A participant who was a caregiver within a residential care facility explained that, via behaviour tracking sheets, foster parents could identify escalating behaviours or periods of time during which a child was struggling. This enabled the residential care staff to intervene earlier, before the point of crisis. It allowed (and encouraged) them to take a closer look at the child's behaviours over an extended period of time.

<u>Foster Parent Fears:</u> Discussions about behavior issues (and reporting behavior issues) were occasionally related to statements made by foster parents regarding a fear of being judged, a fear of being considered a "bad" parent, or a fear of having children removed from their care. Some felt that child behaviors might be perceived as illustrating a lack of "control" over a child. As one foster parent explains:

> *FP: When the child is having temper tantrums and throwing objects and people are walking by saying what is wrong with that child, what is wrong with that parent, and you're sitting there …You don't want to be judged as not able to do my job...*

> *FP: I think a lot of times, a lot of us as foster parents sometimes put on the tough skin and say there's not problems but, 'cause we know if we say there is a problem, there's a good chance the kids are going to get moved.*

These caregiver sentiments were acknowledged or echoed by some caseworkers during focus group discussions:

> *CW: But still, new and older foster parents, it's just that fear that if they exactly how bad things are, then it won't be 'Oh, here's all the help in the world,' it will be 'Oh, we better move this kid'.*

These quotes reflect an important issue, in the context of general care and in the context of this project. Fears about the perceived danger of reporting child risk behaviors may have limited caregivers' behavior tracking documentation.

<u>It is important to manage the environment for a child/youth with FASD and thus manage risks.</u> Potential strategies for coping with or addressing the behavior concerns and controlling risks were also discussed. One focus group participant described an example of one such strategy, emphasizing the need to avoid making the child feel different and to take measures not to set the child up for "failure" (engagement in risk behaviors):

> *One young guy who put everything in his pocket, and she [caseworker] said, sew the pockets shut… and it is learning these approaches, try and make [the] child never feel different. I know she will steal, so don't set her up.*

In addition to child-specific or behavior-specific strategies, much broader structural strategies were also suggested. For example, the role of placement stability in mediating risk behaviours was emphasized. As one caseworker explains,

> *CW: If they don't move around a lot and they find that permanent connection… then you obviously, ah, reduce your risk of the secondary conditions, right? The drug addiction, the loss and grief and the criminal activities and the early pregnancies and future FASD kids and all this other stuff. So finding a connection in a community, around people that are going to support them long term…*

This quote reflects the need to be proactive in addressing risk behaviors – to take step to prevent them from occurring in the first place. This may be done in the context of longer-term or broader decisions and efforts (such as placement stability). It may also be done by paying attention to contextual or environmental factors or to patterns in behavior and the identification of triggers (as discussed in relation to behavior tracking forms).

SUPPORTS

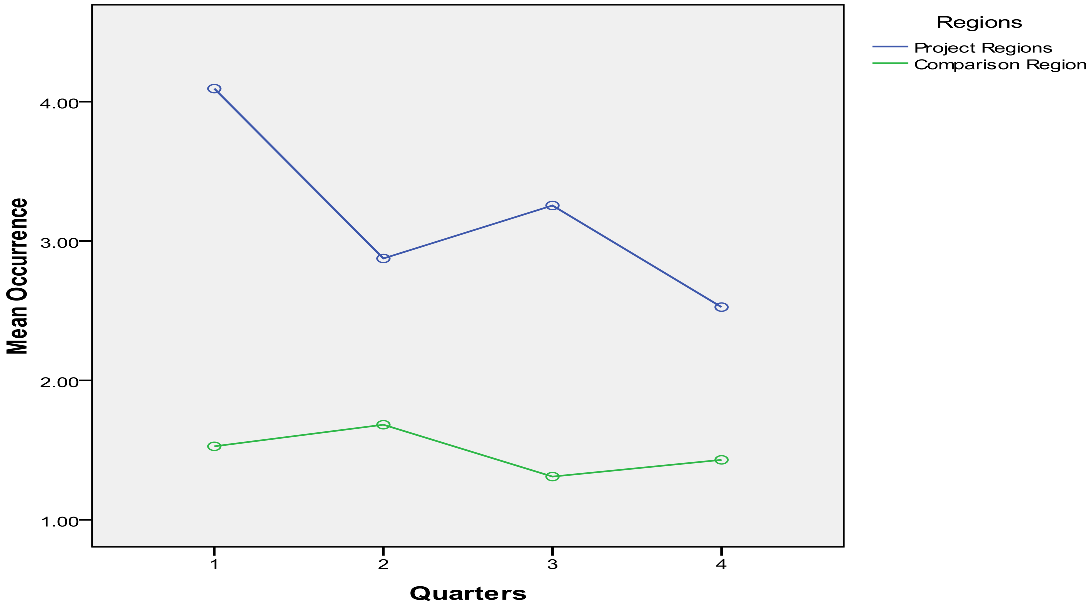
WORKER CONTACT

Indicative of application of the promising practice of enhanced worker contact and support, a clear difference arose in patterns of worker contact over the period reported here. There was a substantially higher level of monthly worker contact reported (*M* = 3.67, *SD* =.35) by caregivers in the Project Regions than in the Comparison Group (*M* =1.4, *SD* =.37). This difference is clearly evident in Figure 3.7 and was detected between groups [*F*(1,64)=19.64, *p* =.000] with no significant differences over time [*F*(5.06, 323.74)=1.38, *p* =.23].

Table 3.8: Contact by All Workers by Month by Group

Region		Mean	Std. Deviation	N
Quarter 1	Project Regions	4.094	3.308	64
	Comparison Region	1.527	2.410	43
	Total	3.062	3.225	107
Quarter 2	Project Regions	2.875	2.647	64
	Comparison Region	1.682	2.853	43
	Total	2.396	2.781	107
Quarter 3	Project Regions	3.255	3.176	64
	Comparison Region	1.310	1.781	43
	Total	2.474	2.858	107
Quarter 4	Project Regions	2.526	2.133	64
	Comparison Region	1.430	1.901	43
	Total	2.086	2.104	107

Figure 3.7: Contact by All Workers by Month by Group



A QUALITATIVE LENS ON WORKER CONTACT

Worker contact was a central point of focus group discussion on the part of both foster parents and caseworkers. They explored issues of caseworker support and home visits, examining both benefits and challenges associated with (increased) worker contact, as well as factors influencing worker contact.

<u>Benefits of worker contact:</u> Project *Promising Practices* required increased worker contact with families (monthly visits). Increased worker contact enabled caseworkers or social workers to get to know the children on their caseload and to build connections with foster parents. The development of these relationships is of central importance in supporting families and children in care. A number of foster parents described positive relationships with their caseworkers, and seemed to value the enhanced relationship and support. One foster parent described an appreciation of a caseworker's enthusiasm and efforts to get to know the family.

Many caseworkers expressed the ways in which increased worker contacts (required by *Promising Practices*) enables to development of enhanced connections with children in care. As one worker states,

> *CW: I like the project practices, they make us look at our practice and keep us accountable to when these kids are in foster home, to actually keeping that connection to [foster home] and not just dropping them off and seeing them every few months... it keeps us accountable to saying, 'Is this working?', or 'How are the kids really doing?'*

Increased contact between caseworkers and children in care, in addition to enhancing relationships, may also enhance a child's understanding of the role of the worker. As one foster parent explains,

> *FP: She [worker] is supposed to support them, you know what I mean? Like, that's her job. That's why the meetings are more important, because the more she meets them and they meet her, then they start realizing whose role is what. You know, there didn't even know she was there for them. She [child] just thought me and her [worker] were friends.*

Increased worker contact also enables the development of relationships between caseworkers and foster parents. As one caseworker explains,

> *CW: In terms of the relationship building, M and I really hardly knew each other before. I mean, we knew each other to see each other but that's really about it. I think through this we really did get to know each other a little bit. I think we work quite well together at this point... when that relationship is there, you really do work with each other, much more so.*

Caseworkers and foster parents explained that, in addition to relationship-building, monthly visits enable an enhanced understanding of the experience of families and children. Workers were able to see interactions and events unfold in front of them, rather than reading a written report of hearing it over the telephone. This allows for a more immediate and in-depth understanding:

> *CW: I think if you're having the monthly contact then you're far more in tune with everything that's going on, so then you're able to maybe pinpoint things that otherwise may have taken a few more visits or months to focus.*
>
> *FP: The home visits... she was able to, our social worker was able to appreciate that there's a lot more challenges with the kids than what she sees in her case file.*

Focus group participants stated that, as workers gain an enhanced understanding of the family experience, they may be better able to comprehend caregiver decisions and come to trust caregiver judgment. As one foster parent explained, this recognition of the validity of caregiver decisions is an empowering experience for the caregiver, who feels as though his or her decisions and judgment are respected and supported by the caseworker.

Challenges associated with worker contact: While they are general perceived as valuable, the increased number of (monthly) visits required by the *Promising Practices* served a challenge to some workers. For example, some workers might be unsure about what to do during these visits or felt as though they were interrupting or intruding on the family:

> *CW: I have foster parents who do feel it is intrusive, don't want me there every month. Oh yeah, I'll do it but they don't, don't hand in paperwork, are resistant, [they] don't like more visits.*

> *CW: Sometimes when I'd go, I'd be like, 'I don't understand why I'm here'. Like, I understanding that's what the project's calling for, but there's nothing to talk about. So we'd sit and we'd have a coffee... I always felt like, 'Oh God I'm interrupting how busy they are' and 'I'm here every month talking about nothing but they know I have to be here'...*

However, the same caseworker explained that after a number of monthly visits, the value of the visits became more apparent:

> *CW: It wasn't, 'Oh, hi social worker' anymore, it was 'Hi V'. It was, you know, they actually knew my name. I was there for four weeks. I think that helped just being there...*

A case manager expressed similar thoughts concerning monthly visits, stating that while some foster parents may initially have questioned the value of the project and the monthly visits, being provided with monthly opportunities for debriefing were of great value and served as a starting point for the development of more supportive relationships.

Some caseworkers discussed issues that might impede the establishment of relationships with caregivers during worker visits. One worker stated that worker visits were dominated by the project paperwork (behavior tracking forms were the central focus on the visits). Another worker stated that, which they are extremely important, interactions with the children in a home during monthly visits might limit time spent with caregivers:

> *CW: It's great that you know what, we can meet with our kids and we can have a conversation and feel like we know what's going on but again, I think sometimes that's lost and we really should be having as much or more focus with the parents. They're the ones that deal with them 24/7. I mean all relationship is important but I think sometimes we forget about the importance of the caregiver.*

This sentiment was echoed by a foster parent, who states that,

> *FP: My experience is that it's not that they [caseworker] know [my spouse] and any better than they did before, but it's that they know the kids better.*

Factors influencing worker contact: Foster parents and caseworkers identified a number of factors influencing caseworker contact (including adherence to *Promising Practices*), such as issues with caseload management, changing caseloads, changing case planning, staff turnover, and other caseworker constraints. The primary factor influencing worker contact appeared to be staff turnover, or changes in caseworkers. As foster parents explain,

> *FP: [Children] develop relationships with worker, and the worker does not have to, if the worker is around for a while you don't always have to ask the child to explain everything, you just kind of know, so when a new worker comes on board it starts all over again.*

> **FP: Getting a new worker who has dreams and aspirations [for child], [who is] not familiar with child and changes case plan to suit their vision for the child and that's*

> *where frustration comes in for caregivers... a lot of new workers do not have training from the get go.*

These quotes address the issue of staff turnover and the need for a child to start over with a worker, but take this notion a bit further in terms of identifying the construct of the new workers' vision for the child that comes from their background, practice framework, and perception of the needs of the child based on information provided to them. This information may come from a supervisor, from a file review, or from previous caseworkers – and, hopefully, from caregivers. This comment is reflective of the knowledge that the caregiver has of the child and the impact of change on that child over time resulting from staff turnover.

Caseworkers and caregivers appeared to have similar concerns, with respect to changing workers. As one caseworker states,

> *CW: I'm worried too, 'cause that's what me and M, and me and SL is another foster mom where I've been these kids' worker for four years. They know who I am, they know my role... so now all of a sudden you bring another worker into their lives. Who do they trust?*

Another worker stated that, just as more emphasis has been placed on placement stability and permanency, similar emphasis ought to be placed on maintaining stable connections between workers and children. This illustrates another significant aspect of permanency in care.

According to at least one foster parent, however, worker stability has increased over the duration of the project:

> *FP: There's a lot of stability. They haven't switched out social workers on them every four or five months. I think that's important to the kids. The kids feel more stable.*

In addition to changing workers, broader structural factors also influence worker contact with families. Caseworkers described staff shortages, hiring freezes, and competing priorities such as other various government-implemented projects such as changing information management systems.

RECOMMENDATION RAISED BY FOSTER PARENTS IN RELATION TO HOME VISITS BY CASEWORKERS

As the *Promising Practices* required increased visitation there were primarily positive comments about these visits. One concern raised was that frequent visits by a caseworker to foster parents may be perceived as 'intrusion' especially if every visit involves the parents having to complete paperwork. As completing paperwork was a major component in the FASD CoP this is a fair comment. The need exists to collaborate with foster parents about number of visits needed and focus of the pending visit.

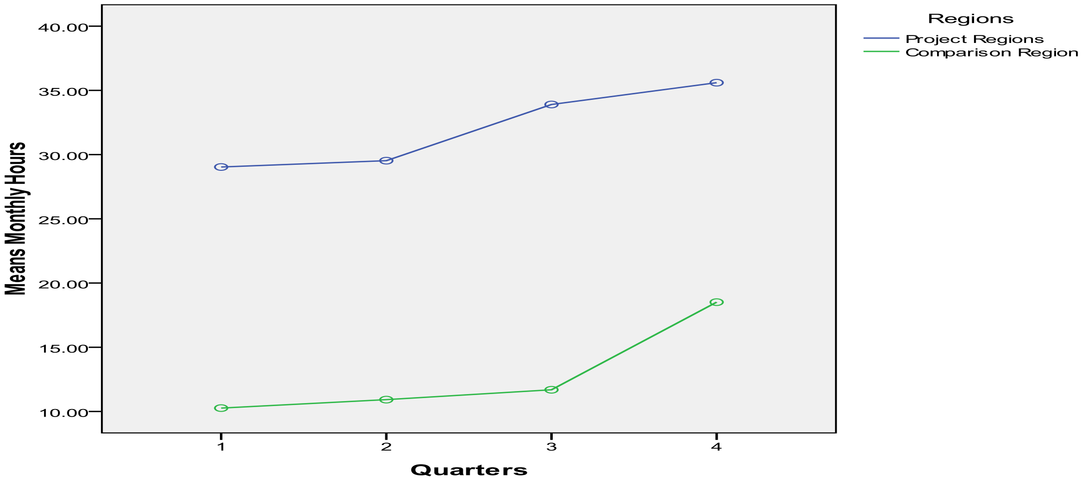
RESPITE

As noted below, there were clearly significant differences in patterns of respite care provision during the reporting period, consistent with the *Promising Practices*, Project Regions offered an mean of 32.015 (*SD* = 21.287) hours of respite, as compared to 12.347 (*SD* = 5.230) hours of respite in Comparison Regions. However, given the high standard deviation which exceeds the mean hours of respite, it is clear that there were wide variation among cases. In Figure 3.8, we note an increasing trend over time for the Project Regions and an even distribution for the Comparison Region. This difference between groups was significant [*F*(1,105)=8.033, *p* =.006].

Table 3.9: Respite Care by Month by Group

Region		Mean	Std. Deviation	N
Quarter 1	Project Regions	29.034	43.095	64
	Comparison Region	10.264	24.464	43
	Total	21.491	37.768	107
Quarter 2	Project Regions	29.526	37.579	64
	Comparison Region	10.923	34.906	43
	Total	22.050	37.497	107
Quarter 3	Project Regions	33.901	45.934	64
	Comparison Region	11.670	31.178	43
	Total	24.975	41.939	107
Quarter 4	Project Regions	35.599	50.693	64
	Comparison Region	18.512	48.945	43
	Total	28.732	50.471	107

Figure 3.8: Respite Care by Month by Group



RESPITE FROM A QUALITATIVE LENS

One phenomenon of great interest is the issue of respite. The quantitative data clearly demonstrated a decrease in the use of respite. Yet, in the focus groups there were many positive comments about the use of respite as a consequence of this project. Some foster parents required encouragement to use respite and also had a strong desire to advise caseworkers about what form or type of respite would work for them. Some foster parents are reluctant to use respite as it does not work for their family. The provision of respite appears to support placement stability at least in relation to the value ascribed by foster families who regularly utilize respite supports. Respite remains an important need for foster families caring for children and youth with FASD. Many families commented on the inclusion of their foster children with their own extended family members and also saw this type of support as crucial and important in their lives.

Focus group discussions examined general supports, as well as specific support types considered important by foster parents and/or caseworkers, such as respite care, supports for transition to adulthood, FASD-specific training, and educational issues. Focus group participants examined issues associated with respite care, such as the need for respite and associated challenges. Caregivers' need for respite care was clearly identified by both foster parents and caseworkers:

> *FP: You don't get a break, you know, or yet get very little break. I was quite frustrated.*
>
> *CW: With my one file, you've got three and the oldest one is 2 ½… two have FASD. She's running at her wits end [foster parent] as it is. Is it really that much to ask for a day off?*
>
> *FP: The last thing I want to see is the kids moved. Just, you know, respite would be nice, you know? Stuff like that – being able to do something about it.*

Access to respite care can provide caregivers with the relief necessary to continue caring for children, and is of particular significance in placements at risk of breakdown due to extreme caregiver stress or frustration.

Some caregivers were very happy with the respite care associated with the project *Promising Practices*. As one foster parent stated, "*We get that 48 hour respite and we love it*". According to some caseworkers, however, other caregivers might not take advantage of available respite care. Caseworkers described efforts to convince foster parents to use respite (*"I am always hounding her [foster parent] to take her respite"*). Another caseworker describes caregivers' changing attitudes regarding the use of respite care resulting from participation in this project, stating that,

> *CW: We encouraged more self-care and to use respite. I think they [foster parents] were more accepting of it as time went along… they [caregivers] under-report the impact that these children have on them… I don't know if they see it as a sign of weakness or if they want to, you know, be these super parents or what it is, but I think as time progresses, you know, a lot of them were not even willing to, or hadn't been doing respite, and picked up on it and now appreciated it.*

This quote can be linked back to the earlier discussion concerning foster parents' fears of being judged or considered "bad" parents – it identifies a fear that admitting the need or desire for respite care might be perceived as a weakness or indicative of poor care giving. It also identifies the value of caseworkers' efforts in addressing these fears and encouraging the use of important supports and services.

For some foster parents, more concrete issues serve as obstacles to accessing respite care. Respite care may ease some burden on caregivers, but creates a new burden when children return from their respite placements. As one foster parent explains,

> *FP: For us, there's a cost to pay for having respite, because they have to come home and settle back in again. The practices or activities or whatever in that home may not be what we would do in our house, right? So there's a price to pay, and yet sometimes we need to be able to just be off…*

Another foster parent explains that, while respite is needed, a lack of appropriate respite placements serves as a barrier: *"We haven't had respite for months because they can't find people. You go somewhere a couple of times and it breaks down".*

Access to respite is dependent on availability of resources. As earlier stated, the use of respite represents a transition for a child that needs to be effectively managed. The need to increase resources for respite is required while appreciating that there are limitations in more rural and remote areas. The need for caseworkers, foster care support workers and foster parents to review this need on a regular basis exists and the need to establish this service consistently should be a priority in all regions.

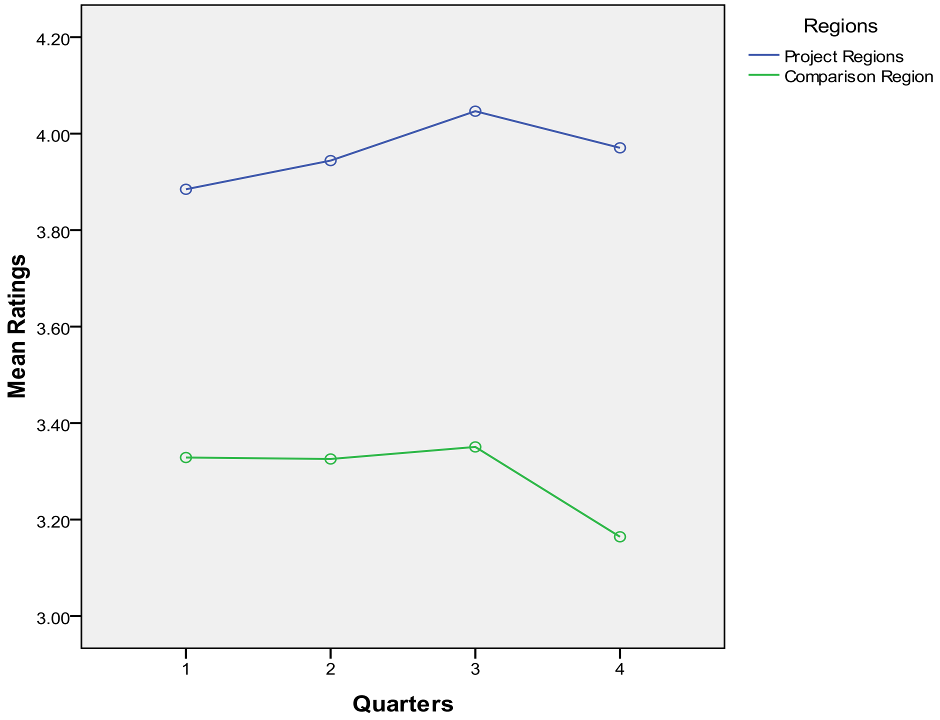
INTERACTIONS WITH CHILD

Significant differences arose relating to rating of perceived interactions by caregivers with their children in the home. Overall, caregivers in the Project Regions reported higher ratings for interactions (*M* = 3.962, *SD* =.089) than in the Comparison Group (*M* = 3.292, *SD* =.119).In addition, significant between group differences emerged [*F*(1,93)=20.390, *p* <.000].

Table 3.10: Interactions at Home by Month by Group

Region		Mean	Std. Deviation	N
Quarter 1	Project Regions	3.885	.554	61
	Comparison Region	3.329	.818	34
	Total	3.686	.709	95
Quarter 2	Project Regions	3.944	.729	61
	Comparison Region	3.326	.826	34
	Total	3.723	.817	95
Quarter 3	Project Regions	4.047	.735	61
	Comparison Region	3.351	.709	34
	Total	3.798	.796	95
Quarter 4	Project Regions	3.971	.928	61
	Comparison Region	3.164	.850	34
	Total	3.682	.977	95

Figure 3.9: Interactions at Home by Month by Group



INTERACTIONS AT SCHOOL

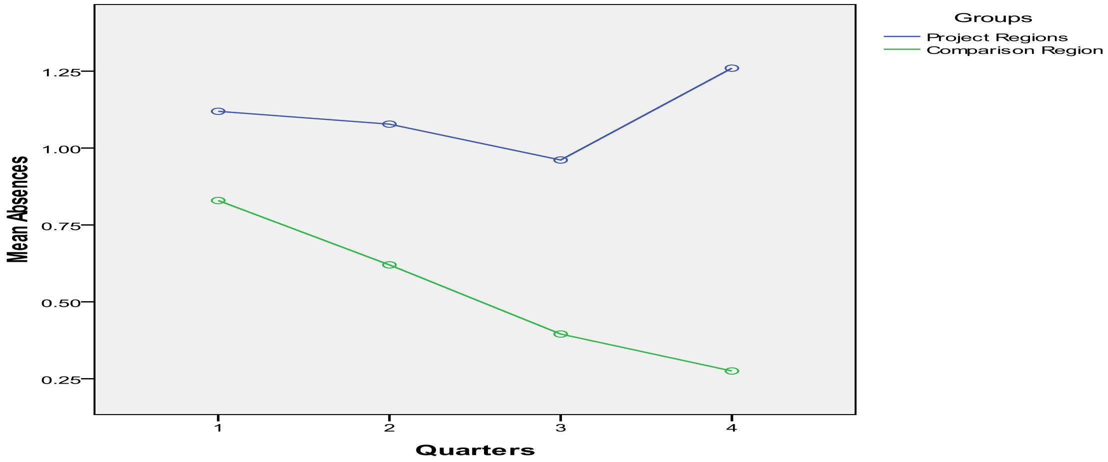
SCHOOL ABSENCES

Quarterly mean school absences for the Pilot Regions (*M*=1.105, *SD*=.196) were higher than those for the Comparison Region (*M*=.530, *SD*=.232). There was a clear downward trend in the reported incidence of school absences in the Comparison Region. However, these differences between groups did not reach significance [*F*(1,101)=3.586, *p*=.061], nor was there significant change over time [*F*(2.544, 256.988)=.730, *p*=.51]}.

Table: 3.11 Quarterly Incidences of School Absences by Group

	Group	Mean	Std. Deviation	N
Quarter 1	Project Regions	1.119	3.187	60
	Comparison Region	.830	2.064	43
	Total	.998	2.766	103
Quarter 2	Project Regions	1.078	1.728	60
	Comparison Region	.620	2.039	43
	Total	.887	1.868	103
Quarter 3	Project Regions	.961	1.467	60
	Comparison Region	.395	.892	43
	Total	.725	1.285	103
Quarter 4	Project Regions	1.260	2.968	60
	Comparison Region	.275	.889	43
	Total	.849	2.379	103

Figure: 3.10 Quarterly Incidences of School Absences by Group



CONTACTS BY SCHOOLS

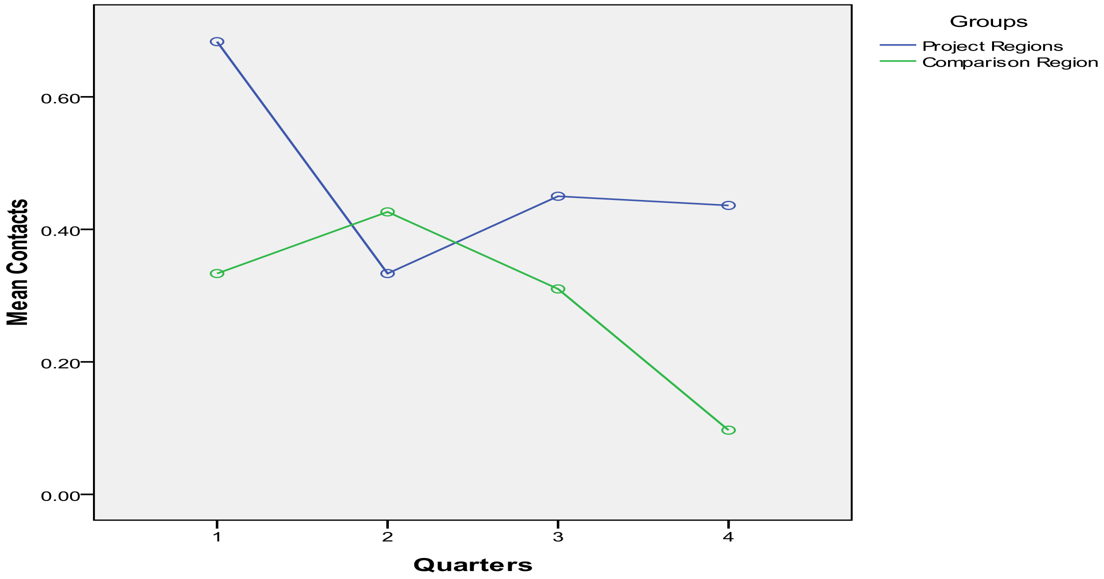
Not unexpectedly, as with school absences a similar pattern of quarterly mean contacts by schools was found, with considerably higher reported school contacts for the Pilot Regions (*M*=.476, *SD*=.085) than for the Comparison Region (*M*=.292, *SD*=.101). There was a similar clear downward trend in the reported incidence of school contacts in the Comparison Region.

However, these differences between groups did not reach significance [*F*(1,101)=1.937, *p*=.167], nor was there significant change over time [*F*(2.251, 227.380)=1.523, *p*=.218].

Table 3.12: Quarterly Incidences of Contact by Schools by Group

Group		Mean	Std. Deviation	N
Quarter 1	Project Regions	.683	1.249	60
	Comparison Region	.333	.987	43
	Total	.537	1.155	103
Quarter 2	Project Regions	.333	.662	60
	Comparison Region	.426	1.360	43
	Total	.372	1.009	103
Quarter 3	Project Regions	.450	1.175	60
	Comparison Region	.310	.627	43
	Total	.392	.983	103
Quarter 4	Project Regions	.436	.981	60
	Comparison Region	.097	.228	43
	Total	.295	.778	103

Figure 3.11: Quarterly Incidence of Contact by Schools by Group

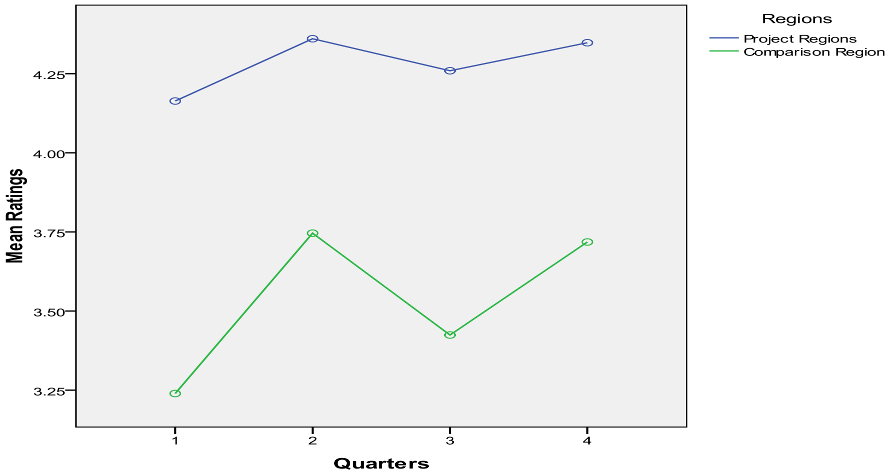


Caregivers were also asked to report on the quality of interactions by their child with others at school. As noted below, we found that the Project regions reported significantly higher mean interactions (*M* = 4.283, *SD* = .117) than the Comparison Group (*M* = 3.532, *SD* = .199) throughout the reporting period (*F*(1,41)=10.579, p=.002). There was an overall increase reported interactions in both the Project and Comparison Regions. Significant differences were detected between groups but there were no significant differences found over time [*F*(1.978, 81.103)=.754, *p*=.472].

Table 3.13: Interactions at School by Group

Region		Mean	Std. Deviation	N
Quarter 1	Project Regions	4.164	.710	32
	Comparison Region	3.239	1.121	11
	Total	3.927	.915	43
Quarter 2	Project Regions	4.361	.590	32
	Comparison Region	3.746	.934	11
	Total	4.203	.733	43
Quarter 3	Project Regions	4.2593	.688	32
	Comparison Region	3.424	1.197	11
	Total	4.046	.909	43
Quarter 4	Project Regions	4.348	.684	32
	Comparison Region	3.718	1.085	11
	Total	4.187	.838	43

Figure 3.12: Interactions at School by Group



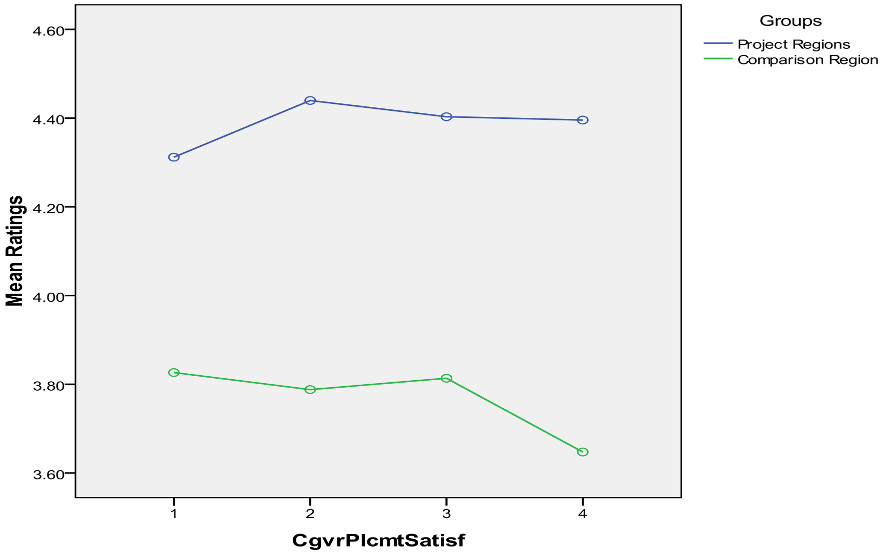
CAREGIVER PLACEMENT SATISFACTION

While qualitative findings may have much to offer in terms of explaining the findings here, it is important to note that the number of cases included declined precipitously for completion of this component. This may well be an artifact of the different data collection methods adopted in the Comparison Region, where file reviews could not offer relative caregiver satisfaction levels. However, despite the limited sample size in the Comparison group (*N*=13), as demonstrated in Figure 3.13 below, significant differences arose between the Project (*M*=4.486, *SD*=.122) and Comparison Regions (*M*=3.769, *SD*=.259) [F(1,70)=6.267; *p*=.015]. There were no significant—within subject changes detected [*F*(1.078, 75.474)=.084; *p*=.792].

Table 3.14: Caregiver Placement Satisfaction by Month by Group

Group		Mean	Std. Deviation	N
Quarter 1	Project Regions	4.312	.625	59
	Comparison Region	3.826	.944	13
	Total	4.224	.710	72
Quarter 2	Project Regions	4.440	.604	59
	Comparison Region	3.788	1.111	13
	Total	4.322	.755	72
Quarter 3	Project Regions	4.403	.752	59
	Comparison Region	3.814	1.029	13
	Total	4.297	.832	72
Quarter 4	Project Regions	4.396	.867	59
	Comparison Region	3.647	1.134	13
	Total	4.261	.957	72

Figure 3.13: Caregiver Placement Satisfaction by Month by Group



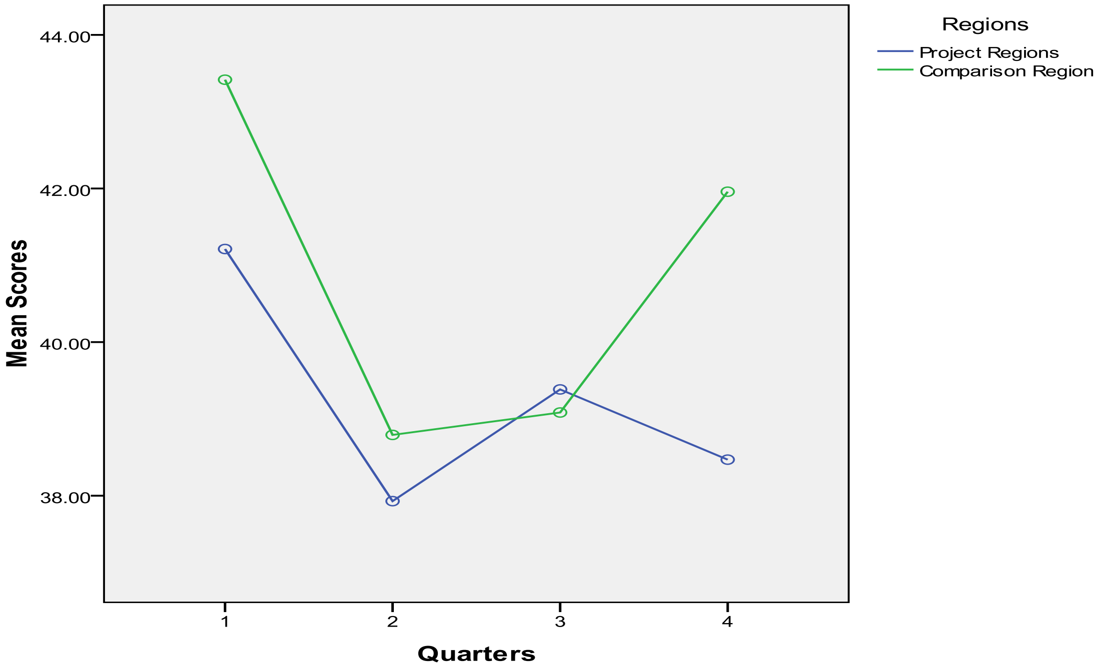
CAREGIVER STRAIN

Participants also completed a questionnaire that measured the strain they experienced each month. The Caregiver Strain Questionnaire is a 21-item self-report with three sub-scales intended to assess perceived strain of caregivers of children and youth with behavioural and emotional problems. A noted in the Table 3.15 and Figure 3.14 - below, caregivers in the Project Regions reported lower strain during this period (*M* = 39.249, *SD* = 1.499) than did caregivers in the Comparison Region (*M* = 40.813, *SD* = 3.045). However, as noted in Figure 3.14 while caregiver strain was initially much higher for caregivers in the Comparison Region, it declined over months converging with the Project Regions. This trend coupled with the small number of responses resulted in non-significant between—group differences for repeated measures analysis [*F*(1,39)=.212; *p*=.648].

Table 3.15: Perceived Caregiver Strain by Month by Group

Region		Mean	Std. Deviation	N
Quarter 1	Project Regions	41.212	12.571	33
	Comparison Region	43.417	7.066	8
	Total	41.642	11.660	41
Quarter 2	Project Regions	37.929	11.512	33
	Comparison Region	38.792	5.563	8
	Total	38.098	10.562	41
Quarter 3	Project Regions	39.384	9.841	33
	Comparison Region	39.083	3.707	8
	Total	39.325	8.938	41
Quarter 4	Project Regions	38.470	9.744	33
	Comparison Region	41.958	8.759	8
	Total	39.150	9.557	41

Figure 3.14: Perceived Caregiver Strain by Month by Group



PREDICTING CAREGIVER STRAIN

While caregiver strain was not found to be predictive of placement change, a regression analysis was completed to examine which of respite, family contact, interactions at home, worker contact, interactions at school, school contact, and risk behaviours were found to be most predictive of caregiver strain. As Table 3.16, notes, a significant model (accounting for 20.4% of variance) was generated including respite and interactions at home and school which predicted caregiver strain. Of these variables, interactions at school were the most influential, followed by interactions at home and respite care. Interactions at school and in the home were negatively associated with caregiver strain. That is as interactions at school and home were perceived to worsen, caregiver strain increased. Somewhat counter-intuitive was the finding that respite was marginally positively associated with caregiver strain.

Table 3.16: Predicting Caregiver Strain

		Unstandardized Coefficients		Standardized Coefficients		
Model		B	Std. Error	Beta	t	Sig.
Interactions	(Constant)	59.662	5.938		10.048	.000
	Mthly Respite	.060	.029	.185	2.079	.040
	Interact at Home	-3.131	1.686	-.186	-1.856	.066
	Interact at School	-2.549	.854	-.300	-2.986	.004

CAREGIVER STRAIN FROM A QUALITATIVE LENS

There is no doubt that caring for children and youth with FASD is that it is stressful. Within the foster parents there were multiple references to problems such as behavioral issues, school issues – homework in particular was noted as a major challenge. Additionally foster parents have their own families and younger foster families often have their own young children in the home. The lived experience of foster parents is important to consider as a factor in caregiver strain. The issue of respite as identified earlier in this report is somewhat puzzling. One recommendation from the original research study on the previous *FASD Practice Standards* (Badry, Pelech & Norman, 2005) was that no more than two children with FASD should be placed in one foster home. The rationale behind this is sound – children and youth with FASD are challenging to care for, and the need exists for a structured and consistent home environment. In the cases of sibling groups in care exceptions have been made to keep children from the same family together. This has to be assessed on an individual case-by-case basis.

It is important for the stability of children and youth in care with FASD that supports are provided to foster placements. Caseworkers and foster care support workers indicated in the focus groups that they work more closely as a team in relation to placements and the foster homes and give attention to the potential stressors associated with placement changes. A caution is also warranted in relation to overloading foster homes where children and youth with FASD live as this is considered another transition that may be difficult to adapt to. The system has often relied on the caring nature of foster parents in relation to taking on new placements but must be cognizant that multiple placements can lead to foster home and placement breakdown. With increased knowledge through the FASD Community of Practice it is clear that increased awareness of these concerns exist. Concurrently, foster parents have a responsibility to advocate for their own limitations and it is believed this awareness has also increased as a result of this project. Foster parents are really parenting in the public and accountable to caseworkers, schools, the community and the health care system in responding to the needs of children in their care. In and of itself being a foster parent comes with its own stresses due to the nature of fostering with children who have experienced trauma and neglect. Appreciating the impact of the intensive care needs of children with FASD will support changes in practice. Reducing caregiver strain is a collaborative process between caseworkers, foster care support workers, foster parents, casework supervisors and managers and with increased knowledge, collaborative training and conversations about this concern, awareness and change can contribute to placement stability.

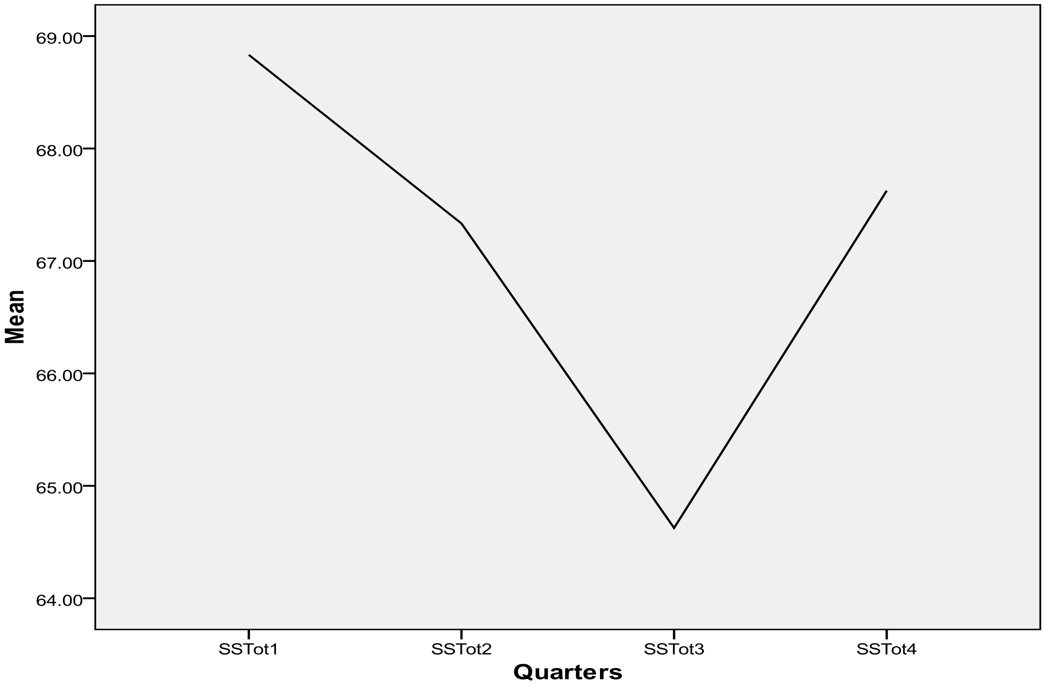
PERCEIVED SOCIAL SUPPORT

The Multidimensional Scale of Perceived Social Support was initially intended to be administered on a monthly basis by caregivers. However, to reduce measurement burden the scale was administered on a quarterly basis. As administration of the scale involved asking the child to rate the level of perceived support in their families, this scale was administered by the caseworker. However, response rates were limited. Due the nature of data collection in the Comparison region, administration of this scale was very limited with only one child completing the scale during each quarter. Consequently, in Figure 3.17, one notes an overall downward trend in perceived social support during the first three quarters (June 2009 to February 2010), followed by an increase in the fourth quarter.

Table 3.17: Ratings of Perceived Social Support in Project Regions by Quarter

SSTotQ	N	Range	Minimum	Maximum	Mean	Std. Deviation
SSTotQ1	45	66.00	18.00	84.00	70.644	11.871
SSTotQ2	36	39.00	45.00	84.00	69.458	11.311
SSTotQ3	28	42.00	42.00	84.00	65.613	13.300
SSTotQ4	37	34.00	50.00	84.00	69.369	9.536
Valid N (listwise)	20					

Figure 3.15: Ratings of Perceived Social Support in Project Regions by Quarter



PLACEMENT STABILITY

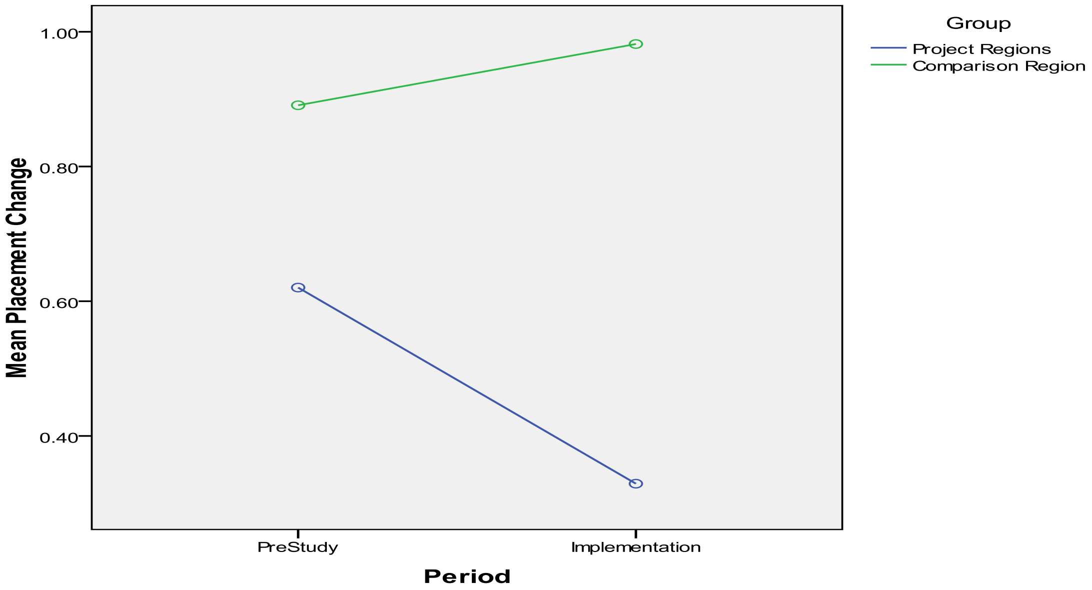
A conceptual innovation that was coined in the original study (Badry, Pelech, & Norman, 2005) was the notion of life disruptions and their impact upon children with FASD. As guardians, child welfare workers and foster parents share primary responsibility for the needs of children in care. Once in foster care, there is evidence that children in care with FASD experience significantly higher rates of placement disruption (Habbick, Nanson, Snyder, Casey, & Schulman, 1996). Placement breakdown has been linked to negative emotional outcomes for foster children as well as the decision by parents to leave the system. Given the documented relationship between placement stability (Streissguth, 2001) and the likelihood of later problematic outcomes in terms of later mental health problems, school difficulties, trouble with the law, and alcohol or drug problems (Streissguth & Kanter, 1997), findings which promote placement stability may contribute to more positive outcomes for children who experience FASD.

In order to capture this concept in the present study, we tracked placement changes occurring during a 15-month period and compared them to placement changes during the implementation of the project. As Table 3.18 indicates, while there were somewhat lower mean placement changes in the Project Regions prior to implementation of the *Promising Practices*, there was a significant decline in placement changes in the Project Regions as compared to the Comparison Region during the implementation of the *Promising Practices* [F(1,132)=8.82, p=.004].

Table 3.18: Mean Placement Changes by Group

	Group	Mean	Std. Deviation	N
Pre-Study Change	Project Regions	.6203	1.11291	79
	Comparison Region	.8909	1.39673	55
	Total	.7313	1.23948	134
Study Placement Change	Project Regions	.3291	.90187	79
	Comparison Region	.9818	1.43360	55
	Total	.5970	1.18968	134

Figure 3.16: Pre-study and Implementation Placement Changes by Group



PREDICTING PLACEMENT CHANGE

As outlined in the proposal approved by ACCFCR, we examined various factors that would predict placement change through logistic regression (*N*=165). While respite, caregiver strain, and risk behaviours were not found to be significantly influential, worker contact was found to be predictive of placement change. As noted by the *Exp (B)* of 0.76, as worker contact increased, the likelihood of placement change decreased [*B* = -.28 *W*(5.35, *p* = .02].

Table 3.19: Regression Analysis: Predicting Placement Change

	Step	B	S.E.	Wald	df	Sig.	Exp(B)
Step 1	Respite	-.010	.009	1.259	1	.262	.990
	Worker Contact	-.235	.116	4.076	1	.043	.791
	Caregiver Strain	.013	.021	.384	1	.535	1.013
	Risk Behaviour	.037	.063	.348	1	.555	1.038
	Constant	-1.013	.902	1.260	1	.262	.363
Step 2	Respite	-.011	.009	1.441	1	.230	.989
	Worker Contact	-.236	.117	4.082	1	.043	.790
	Caregiver Strain	.014	.021	.455	1	.500	1.014
	Constant	-.935	.888	1.109	1	.292	.392
Step 3	Respite	-.009	.009	1.185	1	.276	.991
	Worker Contact	-.246	.117	4.387	1	.036	.782
	Constant	-.392	.363	1.165	1	.280	.676
Step 4	Worker Contact	-.281	.121	5.345	1	.021	.755
	Constant	-.521	.350	2.222	1	.136	.594

A QUALITATIVE LENS ON CAREGIVER PLACEMENT SATISFACTION

Focus group discussions explored various factors , as well as challenges) associated with caregiver placement satisfaction.

Positive factors in Placement Satisfactions

Foster parents described enhanced relationships or connections with children, better understanding of children and their experiences, a focus on positives, and family and child resiliency. As one foster parent stated during a focus group, "*Us is me, me is us*". This is a fascinating quote, as it speaks to the incredible bond that this particular foster parent has with her foster children. It also speaks to the resiliency of foster parents, their sense of humor and how taking respite actually requires conscious awareness. This quote covers so much ground in terms of the integrated of fostering within the lives of the foster parents. It is much more than a job; it is a commitment to children that is filled with care and genuineness in relation to integrating children into their home and daily lives.

Foster parents described the process of building trusting relationships with their children:

> *FP: I think as foster parents it's really important to us to, if the kids are with us, then it's up to me to try to build that trust relationship… I had a 17-year-old boy who was unattached, he wasn't attached to nobody. He fought and everything for a whole year, just about. All of a sudden he starts trusting.*

This foster parent states that establishing a sense of trust with a foster child can take a very long time. The establishment of some degree of trust, therefore, may be an extremely satisfying and rewarding process for caregivers, and may contribute significantly to positive perceptions of care giving relationships and placement satisfaction.

Challenges to Placement Satisfaction

Caregivers identified certain factors that might influence their degree of placement satisfaction. These include foster parent burden, financial concerns, a lack of services and, as described earlier, a fear of being judged as a foster parent.

Financial issues might also influence caregiver placement satisfaction. Caregivers stated that they had to maintain "24/7" supervision of their children and keep them active through extra-curricular activities, both of which increase costs associated with care. Caregivers also described material damage to household objects and the loss of possessions ("*They go on school trips, and you've got to have sleeping bags and things like that. You think they ever bring their sleeping bags home? No, they left them [at camp]*).

Factors influencing placement satisfaction include foster parents' prior fostering connection, attending training/conferences and experience in care.

CORRELATIONAL ANALYSIS

In Table 3.20, correlational analysis revealed a number of noteworthy significant correlations as well as numerous intuitive findings. As one would expect, risk behaviours were negatively associated with caregiver satisfaction, and with the quality of interactions at home and school. Similarly, caregiver satisfaction was positively related to interactions as home and school and negatively associated with caregiver strain. Caregiver strain was also positively associated with respite. That is, higher caregiver strain was associated with greater provision of respite. A question arises here: Is increased respite normally provided when there is greater strain? One would then expect that it would also be associated with increased risk behaviour and school contacts. However, this does not appear to be the case. Interactions at home were positively associated with interactions at school and with frequency of worker contact. Given the implementation of the *Promising Practices*, it is expected that respite would be positively associated with worker contact. Of some concern and worthy of additional exploration given the high proportion of children with PGO status, is the significant finding that family contact was positively associated with placement change. The child's years in care prior to the study period, would appear to be positively correlated with placement change. Perhaps most noteworthy is that worker contact is negatively correlated with placement change. That is, as worker contact diminished, the incidence of placement change increased.

See Table 3.20 below:

Table 3.20: Correlates of Project Outcomes

Variable	1	2	3	4	5	6	7	8	9	10	11
1. Risk Behaviour											
2. Caregiver Satisfaction	-.182*										
3. Caregiver Strain	-.017	-.226*									
4. Interactions at Home	-405**	.524**	-.275**								
5. Interactions at School	-.180*	.325**	-.375**	.432**							
6. Respite	-.057	.139	.216*	.090	.079						
7. School Contacts	.101	-.073	.161	-.076	-.058	.148					
8. Worker Contacts	.054	.027	-.075	.247**	.160	.180*	.047				
9. Family Contacts	.101	-.155	-.010	-.093	-.003	-.103	.212**	.047			
10. Years in Care	-.048	-.004	.185	-.059	-.122	-.038	-.031	-.134	-.044		
11. Placement Change	.069	-.134	-.001	-.143	-.107	-.137	.059	-.183*	.160*	.171*	
N	171	137	115	168	136	171	169	171	171	.161	177
M	3.14	4.27	39.21	3.67	3.52	20.11	.60	2.73	4.94	7.67	.49
SD	4.97	.87	11.37	.77	1.26	30.71	.97	3.22	7.15	4.00	1.08

** *Correlation is significant at the 0.01 level (2-tailed)*

* *Correlation is significant at the 0.05 level (2-tailed)*

RESEARCH QUESTIONS AND HYPOTHESIS TESTING

The approved proposal included eight research questions and four specific hypotheses. We will address each of these items below:

1. ***What were the experiences of caseworkers, foster home support workers, and foster parents involved with this project?***

This question relates to the qualitative findings and the themes arising in the focus groups conducted in each of the Project regions *(include qualitative findings here).*

2. To what extent did the Pilot sites comply with the *Promising Practices*?

This question relates to the extent to which the *Promising Practices* (formerly Practice Standards) were implemented in the Project Regions. As noted, considerable progress was achieved towards completion of neuro-psychological assessments for children suspected of experiencing FASD, with nearly half of these cases having completed assessments or assessments in progress. Consistent with Ministry requirements, over 90% of files included completed concurrent plans, with 46.2% of files documenting three reviews over the 15-month period. Similarly, over 80% of files for children and youth in foster care included completed Foster Care Support Plans, and over 80% of files for children and youth in residential care settings included completed Individualized Service Plans. However, some of the *Promising Practices* relating to the families of children with FASD were not consistently applied across regions. A lack of clarity and consistency resulted in inconsistent application of practices relating to parental assessments and family visitation plans. However, when examining compliance for the three major pillars of the *Promising Practices* (worker contact, respite and training), significant progress was achieved towards compliance with children and youth receiving these vital supports. While not often meeting the strict interpretation of the *Promising Practices*, caregivers as well as children and youth in the Project Regions reported significantly greater worker contact and respite than those in the Comparison Regions and over 85% of caregivers completed a minimum of 12 hours of FASD-related training.

A QUALITATIVE LENS ON FASD SPECIFIC TRAINING IN THE FASD COP

FASD Training: Focus group participants discussed the value of training, stating that the Promising Practice on training was helpful as it led to a new or greater understanding and awareness of FASD and informed more realistic planning. A number of caseworkers stated a central reason behind the need for FASD-specific training: in many cases, caseworkers (and caregivers) simply do not know how to work with children with FASD. As one worker explains,

> *CW: Working with FASD is counter-intuitive. It's completely against what we're taught to do with anybody else. To wrap your head around it as a practitioner, it takes a bit of work. To help foster parents to do that as well, and anybody else… it really takes some work, so yeah, definitely specialized training.*

An issue raised is that new workers or workers from other agencies do not always start out with the training on FASD in place, and may perhaps create a plan that is not realistic for the child.

This is a delicate and sensitive issue as the relationship between worker and child is critical to move forward, is necessary and yet requires considerable deliberation before creating a plan that may or may not fit. The questions these comments raise are philosophical and emerge from a concern about the best interests of the child from a caregiver's perspective, and suggest that caution must be employed in these circumstances. There is great wisdom and perhaps lessons in this observation from a caregiver who sees on a daily basis the needs of the child and the impact of change.

One worker stated that FASD-specific training is imperative, because without it, planning may not simply be ineffective – it may be detrimental with respect to a child's development and outcomes. Strategies which work for other children with simply not work for children with FASD, and training is necessary to emphasize that and to provide suggestions for effective alternative strategies. Focus group participants discussed the value of training as it informs more realistic planning for children with FASD:

> *CW: If we look back even a year, having this training and being involved in this project and thinking about some of the decisions that were made for children who are FAS – what were we thinking, that was absurd and not even going to work in the first place but we kept running down that, you know, futile road with this kid. Now when you know better, you do better. Now that you know and you understand and you are aware of the problems and the understanding you now have, and ask them to do something they are incapable of doing, you are not going to put a plan in place that isn't going to work.*

3. How did the application of the *Promising Practices* reduce risk behaviors such as AWOLS, criminal behavior, drug and alcohol use, school absence, and self-harming behavior?

A mixed picture arose with respect to various risk behaviours in this project. While no significant differences arose between groups for any of the identified risk behaviours, the one risk behavior that is likely the most relevant across all age groups, physical acting out, was the most the influential in terms of its frequency and impact on the overall trends among risk behavior. While significant differences were not identified through repeated measures analysis, a clear decreasing trend in the incidence of acting out behavior was evident.

4. How did the provision of respite reduce placement breakdown and reduce placement changes?

Somewhat conflicting findings arose with respect to the association of respite with placement changes. While a significantly lower incidence of placement change arose in Project Regions, which provided significantly higher amounts of respite to caregivers, we neither detected a significant negative correlation between the provision of respite and placement change, nor was respite found to be a significant predictor of placement change. Perhaps somewhat helpful in explaining these findings and worthy of additional exploration is the significant positive association of respite and reported caregiver strain.

5. How did the application of the *Promising Practices* affect the quality of caregiver-child relationships?

Significant between—group differences were reported with respect to the perceived quality of caregiver-child relationships, with caregivers in the Pilot Regions reporting significantly more positive interactions at home with their child than those in the Comparison Region.

6. How did the factor of number of years in care due to FASD relate to stability and disruptions?

The number of years that a youth or child spent in care was found to be positively associated with placement change.

7. How did the application of the *Promising Practices* minimize life disruptions for children in care?

As noted above, a significantly lower incidence of placement change was reported in the Pilot Regions than in the Comparison Region.

Specific hypotheses posited in the research proposal include:

1. There will be significantly lower number of placement disruptions and risk behaviors for children in the Pilot group than for those in the Comparison group.

As noted, a significantly lower number of placement changes were found in the Pilot Region as compared to the Project Region. However, while the overall incidence of various risk behaviours in the Pilot Region reduced over time, significant differences were not found with respect to the incidence of risk behaviours between groups.

2. There will be significantly higher perceived quality of foster parent/child relationships in the pilot group than for foster families in the comparison group.

As noted above, significant differences were found between groups, with caregivers in the Project Regions reporting significantly higher ratings of caregiver/child relationships than in the Comparison Region.

3. The provision of increased respite care will be associated with reduced placement

disruption and risk behaviors.

No significant relationships were found between the provision of respite and placement change, or between respite provision and the incidence of risk behaviours.

4. Worker contact with foster homes will be positively related to quality of foster parent/child relationships.

A significant positive relationship was found between the frequency of worker contact and the quality of caregiver/child relationships.

OTHER ISSUES AND CONCERNS RAISED IN FOCUS GROUPS- A QUALITATIVE LENS ON THE TRANSITION TO ADULTHOOD

Concern: Caregivers worry that children with FASD who have a higher IQ may not be eligible for PDD funding when they turn 18 years old. Some adults with FASD do qualify for the funding but they may not accept the support or other external supports. This is often due to individuals' lack of understanding the importance of self-care and skills to attain other basic needs (e.g., an adult with FASD may show no concern of self-care needs or understanding the role of a landlord).

According to the Province of Alberta - Persons with Developmental Disabilities (PDD) Community Governance Act (2009), in order for an individual to qualify for PDD funding, one must have a developmental disability that meet three criteria: 1) the disability must be childhood onset, 2) a person must have a limitation in intellectual capacity (i.e., an IQ of score 70 or lower), 3) an individual must show that he/she has a significant limitation in adaptive skills (e.g., in communication, home living, social skills, in areas of work, leisure and health and safety and so on).

Recommendation(s) from the discussions: Caseworkers discussed the need for revising/changing PDD policy regarding eligibility to accommodate many adults living with FASD. Despite their higher IQ, they have 'poor' social skills that increase the risk of involvement in criminal activities.

Concern: Need to understand that adults with FASD are at risk of not making good decisions, and thus, these individuals may end up living on a street and/or engage in undesirable activities such as sex with strangers.

Recommendation(s) from the discussions: Need for long-term support systems and consistence in services for adults with FASD. Need for adult transitioning process to begin in early life and continuation of support-services to these individuals beyond their 18th birthday.

<u>*Transition to adulthood:</u> Focus group discussions sometimes focused on the challenges associated with transition to adulthood (age 18) for children with FASD. These discussions indicate that foster parents and caseworkers do not stop caring for or worrying about these young people when they transition out of their care. The need to acknowledge caregivers' emotional concerns associated with a child's transition to adulthood was emphasized. According to one caseworker,

> *CW: It's grief and loss for those caregivers too because they have invested so much in that child and have looked at [the] child as a members of their family.*

This quote reflects the anticipatory worry and concern a foster parent may have with respect to their child's transition to adulthood, and with respect to that young person's vulnerability as they transition from the foster care system.

Commitment to child beyond 18

Commitment to youth beyond 18 is a crucial issue for all those dealing with transitions from foster care. To recognize that a foster parent who has cared for a child with FASD over a lifetime and despite multiple challenges with a very challenged individual who is highly vulnerable, is critical. What drives this sense of commitment? What do we really know about these types of connections? The issue is not one of time but one of care, compassion and love for this young person despite the struggles, challenges and worries. It signifies that the foster parent knows this young person needs her, that there is nobody else to pick up so to speak and clearly indicates a desire based on many years of caring for this individual, to protect her from harm.

Caregivers may desire to maintain contact with their foster children after the child's transition to adulthood. One foster parent described another strategy for maintaining communication with children:

> *FP: I have a 1-800 number and any kids can call. Our kids are our kids even if they don't want you to be. I still have a personal connection and investment in knowing that they are okay, and that doesn't go away.*

The commitment of foster parents often extends past a child's 18th birthday. In this instance the foster parent has maintained a 1-800 number to facilitate her former foster children being able to contact her no matter where they are without cost. This is a strong example of commitment to children in care.

Based on focus group discussions, it seems that the central area of concern with respect to transitions to adulthood for children with FASD in that of continued (or discontinued) services and supports, or eligibility for adult services. One caseworker explains some of these challenges, focusing on adult service eligibility:

> *CW: I have one[young person] right now who is turning 17 and she will not qualify for PDD and is completely incapable of doing any self care whatsoever so I am having to*

> *blackmail foster parent to keep [youth] on room and board situation which will work, I think… as long as young lady agrees, she will qualify for AISH. We can probably make threat what might happen if no PDD [funding available] – she is not functioning fully in any sense doesn't know what a landlord is... She is functioning at 60 on a good day – she is lovely girl, polite, sweet, socially appropriate and you know so vulnerable, she can't think, can't generalize any kind of problem solving…*

A number of caregivers explained their concerns regarding youth transitions to adulthood. One foster parent referred to youth being "dumped" at age 18, left without necessary supports: "*Unless the foster parent fights for them, and really fights for them, there's nobody for them".* Another foster parent explained that, without resources, young adults with FASD are often unable to access (through employment or other financial supports) money for groceries, clothing, baby formula, and so on. Without continued services and supports, young people with FASD face extreme challenges as they transition to adulthood.

> *CW: He is going to need transitional services into adulthood. No, he's not doing what a normal 17 year old would do and there are reasons for that, not that he's a bad kid. The typical route to transition – identify what are their options for training, let's get this kid a job and a future plan… He's at a grade 2 level. Would you ask a kid in grade 2 to go to Youth Connections and make a life plan?*
>
> *CW: The rules that work for the adult world do not work for FASD adults. As soon as entering the adult world, you cannot allow them to take the risks, no, that does not work for the FASD world because they can make their own decisions [but] they still need someone to say 'that's enough'.*

One caseworker described three youth with FASD who turned 18 and transitioned from care, but did not qualify for PDD. Of those three youth, one was in jail, one had been charged, and one had just completed high school, though with very limited employment skills and low social functioning. While these youths' IQs scores were high enough to preclude PDD support, the lack of transitional supports was significantly detrimental to their outcome.

A QUALITATIVE LENS ON OTHER ISSUES: COMMUNICATION

STRATEGIES FOR SUCCESS: COMMUNICATION AND TEAMWORK

During focus groups, two important themes were commonly discussed as being central to the effective and appropriate support of children and families: communication and teamwork.

COMMUNICATION

Focus group statements concerning communication typically fell into two categories: communication between foster parents and children, and between foster parents and caseworkers. Foster parents described various forms of communication between themselves and their children. For example, the use of a cell phone allowing children to freely contact foster parent is considered of importance with respect to the security of both child and foster parent. As communication is a key part of safety, it seems that some foster parents feel a greater sense of security (which fosters stability) in knowing that the child has the capacity to contact the foster parent in the event of a concern or a crisis.

Caseworker explained the importance of communication between worker and caregiver with respect to excellence in case planning. One caseworker described the value of this communication, stating that,

> *CW: If the foster parents have said 'too bad' about something that I think is completely silly and I reverse that or want to reverse that, you know, if I don't understand the reasoning behind it, we haven't already discussed the decision, then it would be pretty bad. But really, both of my homes have been wonderful in terms of, 'this is what we see coming down the pipe, what are we going to do about it?' Then we can talk to the foster parent so we can develop a plan before we ever approach the child with it.*

Effective communication between caregivers and children and between caregivers and caseworkers seems to be viewed as a strategy for decreasing distance and establishing a more immediate awareness of the experiences of others. Caregivers described the value of facilitating more immediate interactions with children, and caseworkers described the value of streamlined case planning with foster parents.

TEAMWORK:

Closely connected to the concept of communication is that of teamwork. Both foster parents and caseworkers appeared to assign great importance to work together as members of a team. One caseworker provides an example of the value of teamwork, stating that,

> *CW: I have found in terms of having a team to support foster parent has been helpful, instrumental, and vital; of course I have a caseload too. For instance, one girl was suicidal two weeks ago and [the] foster parent took [the] child to emergency and I couldn't get there and we needed someone to go and sit with child, and it was wonderful because we had extra people on the team to [deal with this].*

This quote is important as it highlights the nature of how utilizing a team approach to casework offers benefits to children and caseworkers. In the event of this emergency and recognizing that caseworkers are often engaged with other activities a team member was able to step in and offer support during a crisis. This supports excellence with respect to team-based case management working in the best interests of children.

Based on focus group comments, it appears that the project contributed to an enhanced sense of "team" among caseworkers, support workers, caregivers, and others. A number of participants emphasized that they are now "all on the same page" with respect to planning for families and children. The planning process has become more collaborative, focused on a common objective: the well being of the child. Team members share ideas with one another, "brainstorming" instead of working individually when planning or decision-making. As one caseworker explains,

> *CW: I think for me what's made the most difference is developing really good teams with my support workers and the foster parents. Because I feel in both cases, and there are certainly issues with all the kids and both homes, not issues with the homes themselves but issues with the placements... I feel that we're all as much on top of it as we can be. That we are all working together for the same outcome... We all have the same focus. That's very, very nice. I feel supported in my work by knowing that I have assistance from the support workers. I don't know if I make their job any easier, probably harder, but I know that the foster parents are feeling very supported and very cared for.*

Some foster parents discussed the importance of teamwork and feelings of support from workers in the context of school meetings and case conferences. One foster parent identified a significant benefit of working together:

> *FP: I noticed when we didn't have the social worker coming for the IPPs, we often had to struggle somewhat with the special needs teacher on what the child needs and whatnot and demanding on what we think the child needs. But as soon as the social worker comes in, 'Oh, here's another professional'. All of the sudden the whole attitude and the whole air of the meeting…*

A QUALITATIVE LENS ON PERCEPTIONS ABOUT THE PROJECT

As part of focus group discussions, both foster parents and caseworkers voiced their perceptions about this project, discussing some benefits of the project (including feelings of support and shifting perceptions resulting from the project), participation in the research process, and paperwork and documentation.

IMPACT OF THE PROJECT

Foster parents and caregivers described a variety of benefits associated with participation in the project. One caseworker felt that one primary contribution of the project was that it brought much-needed attention to the care-giving experience:

> *CW: I think that the whole project has put a lot more emphasis on foster parents and their needs and just the fact that we recognize that this is a difficult job. That they need supports. That we're thinking about how much this is impacting them and so on.*

Caregivers were able to gain a deeper understanding of FASD, as a result of project training and interactions with a variety of other caregivers and caseworkers. As one foster parent explains,

> *FP: [Understanding] like the disability itself, more permanent, I inform people more around my kids about why, rather than 'just do this' and this, and I didn't give explanations and you know if you explain it – lots of explanations.*

This quote is critical, as it speaks to the way the foster parent has changed communication in relation to the child. In the past, the foster parent recognized the child's needs, intuitively and as a result of experience, and would tell others to "just do this". Following training regarding FASD, the foster parent might realize the importance of explaining to needs of the child, moving beyond saying "just do this". This reflects the development of a new manner of supporting a child's need for safety and congruency across different environments.

Interactions and communication with other caregivers and workers provides project participants with a broader, more comprehensive understanding of the general experience of caring for children with FASD:

> *CW: [One] thing that we did differently probably was meeting with the foster parents, support worker, and the other caseworkers that had youth in the home. I thought that was informative 'cause you got – I got a sense of what foster parents were dealing with on a bigger picture type thing, versus just my kid.*

According to some caseworkers, project-related interactions with foster parents allowed them to learn from those parents, which is a valuable experience and can inform caseworker practice with other children with FASD. As one caseworker states,

> *CW: I found I learned a lot from the foster parents as experts. It's one thing to read about a disorder in a book and then completely another to have people who are experiencing it every day come up with all sorts of strategies... I thought it was very important for them to remain a part of this project, to share that knowledge with other foster parents.*

Project participation might also encourage foster parents to share ideas with one another. Participation in the project might empower foster parents to seek out supports from, for example, their caseworkers. As one focus group participants explains,

> *CW: What we learned in our training is that some of the foster parents haven't even see their caseworker in months, months and months and months and they're not getting the supports. You know, that's when it's great to have your foster parents saying 'Well you know what, it's not in all areas, and this is what we're doing and this is the support we get'. Then it helps them to go back, I think, to their caseworkers and say 'Hey this is what we need' and this kind of stuff.*

The project has enabled foster parents, caseworkers, and others to come together and discuss common concerns and share strategies for supporting children with FASD. As one foster parent states,

> *FP: I think this kind of project is good where we have people who share their experiences, share their frustrations, share the good and the bad and the ugly and are able to talk about it freely, openly, and just get the feedback and just, you know, it's kind of a purging in a way.*

Caseworkers echoed the value of a forum in which caregivers could openly voice their concerns:

> *CW: ... in the past when Donna was out here meeting to meeting, they are telling her stuff we don't know. Foster parents told her stuff we didn't know about – their burden, they felt they could finally tell somebody.*

Participation in this project may have provided caregivers with a mechanism through which to voice concerns or frustrations. As part of the project, foster parents were able to express their concerns (via the caregiver strain measures, for example) in an anonymous manner. As one foster parent explains,

"It's nice to be able to express frustrations and strain and whatnot without having the fear that something is going to end up happening". These quotes reflect a central contribution of the project: it has provided a safe forum in which caregivers (and caseworkers) can voice their concerns and discussed their experiences. Opportunities for such collective discussions might not otherwise be readily available for many participants.

Finally, some foster parents stated that they were feeling more supported as a result of participation in the project. As one parent states, *"As foster parents, we feel more confident to say to workers well things aren't going as smooth… we feel more supported".*

This quote speaks to both the fact that communication is more open as a result of project participation, and that foster parents feel more supported. As indicated by foster parents, with more open communication, it is easier to contact the caseworker when struggles or conflict take place. This is a critical issue and one that appears to be directly related to benefits from this project.

The project has brought various caseworkers and foster parents together "on the same page," reflecting once again the importance of working together as a team. As one focus group participant explains,

> *I think it's changed our job too, 'cause we don't have to, I know if, like, the caseworker's in the project I no longer have to advocate for my foster parents with the caseworker. I don't need to tell you guys this is what they need. 'Cause we're all on the same page and so we're all advocating for the whole family unit together.*

Paperwork and documentation

Based on focus group statements made by foster parents, it seems that they do try to complete the paperwork required by the project, and that they feel they have a responsibility (and duty) to do so. Completing the paperwork may be seen to indicate commitment to the project, the child, and the caseworker, as well as the desire of foster parent to be involved in the project. In addition, as described earlier, the behavior tracking process enabled the identification of patterns or trends in children's behavior.

Some caregivers incorporated the project paperwork into their regular routine. As one foster parent states,

> *FP: The tracking itself for us, anyway, has been actually pretty, fairly easy because it's what we do across the bases anyways – day-to-day tracking with the other kids, so it's almost part of the rule already.*

Other focus group participants, however, considered the project paperwork to be challenge or a hindrance. Some case managers stated that staff members were overwhelmed by the paperwork, and that they had to "nag" foster parents in order to collect completed paperwork. Caseworkers stated that some caregivers felt the paperwork was overly cumbersome:

> *CW: Because they [children] have FAS they are high maintenance. You have so much to do with school, and paperwork [is] not a priority all the time – one more thing on the list of extra things to do for these children.*

Challenges associated with the project:

While the project seemed to be generally perceived as beneficial, challenges did exist. The project entailed a great deal of time and effort, as explained by one case manager, who states that,

> *CW: It is way more work than anyone ever said it would be or imagined it would be. Either way [the] project sounds good going in. It's a huge amount of work, [but it] doesn't mean it is not valuable work, that we can't see the benefits...*

Another caseworker stated that timing of the project may have increased the challenges faced by those trying to implement the project and carry it out:

> *CW: One of the things, the feedback that has come to me from the workers, is that the project came at a time where it was unfortunate, because it came at a time where budgets kind of dictated what could or couldn't be done. So the project in its pure sense maybe didn't get implemented as well or as in detail as they could have been. So where they saw the potential of it, we weren't able to put all that into practice.*

Some caseworkers expressed concerns regarding the end of the project – concerns about the continuation of services and supports provided as part of the project, and concerns about caseload transfers associated with project termination. These concerns reflect the value assigned to the *Promising Practices* and enhanced case management. As some caseworkers explained,

> *CW: What about respite, what if they say, now you know what, we're not going to be paying this out for respite no more. No, we're going to take away the laundry service. No, we're going to take away this and this and this from our families. Is that going to happen?*
>
> *CW: I've already transferred five files yesterday that were part of this and I have four more to transfer next week 'cause the project is ending. Therefore they go back to their original offices. I've got scared foster parents.*

RECOMMENDATIONS EMERGING FROM THE FASD COMMUNITY OF PRACTICE RESEARCH

Research about children with FASD in care has been on the agenda within Alberta Children & Youth Services since 2003. Alberta has become known nationally and internationally as a leader in Alberta through its FASD research agenda that includes research related to medical and social sciences. The leadership of the FASD-Cross Ministry Committee along with the commitment to effectively support children in care living with the psychosocial impact and often, related trauma associated with issues of addiction in families has been exemplary. As a guardian to many children and youth in care living with FASD, it was recognized amongst ministry staff that intensive supports and enhanced casework practice was important. It was also recognized that children and youth with FASD had struggles in care, frequent placement breakdowns and struggles in day-to-day living. Caseworkers and Foster Parents alike worried about these youth transitioning to adult services and wondered what would become of them in transitioning to the world of adulthood. There were very dedicated foster parents and residential care facility staff that have faced challenges in caring for children and youth with FASD. They also recognized that more intensive supports were required, in particular when a child was diagnosed with FASD. A primary concern was the need for constant supervision, structure and care for children and youth with FASD. Concerns also emerged that behavioral challenges were a recurring problem in the home and often in the community. Awareness grew of the vulnerability of children with FASD to become a victim and potentially, to victimize others out of their own awareness.

The notion of being a “good guardian” for children in care with FASD was raised as a critical factor in child protection casework for this population. The notion of guardianship and the associated responsibilities in relation to vulnerable children and youth was a guidepost for this project. This concept served as an underpinning of the pilot research project in 2005 in Region 1 (Badry, Pelech & Norman, 2005) and was consistently raised in the early years of this initiative. What does it mean to be a good guardian to children with FASD? What supports are required to effectively meet the needs of children with FASD, their caseworkers and foster parents/caregivers? Why is this important? What will be achieved through this work? How do we best convey what translates to best practice for children and youth with FASD? Can we state that we have designed an effective practice model to help children and youth with FASD mediate their own challenges of being in care with enhanced supports? These questions are critically important to the recommendations made here and have been influential philosophically and practically within this project.

The *Promising Practices* examined in this inquiry, the aforementioned findings as well the recommendations that will follow are in alignment and support several of the outcomes outlined in the Province of Alberta’s FASD 10-Year Strategic Plan including:

1. Assessment and Diagnosis- adults, children and youth suspected as being affected by FASD have access to timely and affordable assessment and diagnostic services;

2. Supports for Individuals and Caregivers- individuals affected by FASD and their caregivers have coordinated access to supports and services that meet their needs;

3. Service providers and families/caregivers have knowledge of and access to training and educational resources that are based on research and leading practices;

4. The planning and delivery of provincial government programs and services associated with FASD is accomplished through a collaborative approach;

5. Basic and applied research findings including those from monitoring and evaluation systems, are used to inform FASD strategic planning. FASD prevention activities and FASD related programming.

The FASD CoP research project clearly furthering the aims and outcomes of the 10 Year Strategic Plan on FASD. In keeping with Outcome 6 of the Strategic Plan where research findings are to be used in FASD strategic planning and related programming we offer the following recommendations which emerge from the experience of the FASD CoP between the years 2009-2011.

The recommendations based on this research are identified in three key areas: Practice Recommendations; Policy Recommendations and Research Recommendations.

PRACTICE RECOMMENDATIONS

- **The implementation of the *Promising Practices* align with the goals of Alberta Children & Youth Services in effectively responding to the needs of children and youth with FASD in care. These practices should become standard casework practice guidelines and interventions for each region in the province of Alberta.**
    - **Why?** The research clearly demonstrates that children and youth benefit from these interventions. They have less placement disruptions, decreased behavioral problems and maintain greater stability in their placement. The most valuable support we give to individuals with developmental disabilities is the consistent care provided by stable placements.

- **That screening, assessment and diagnosis be made available to all children and youth in care where referral is deemed appropriate based on objective screening measures. Protocols for screening must be established in a consistent framework within Children's Services.**
    - **Why?** Families that come to the attention of Children & Youth Services often have problems with addictions and in some cases, intergenerational trauma. The importance of exploring the potential for FASD as a concern is crucial when screeners and caseworkers begin their work with families at all stages of child protection work. If a child does have an FASD and this remains undiagnosed that

  child will face challenges in care that could be mediated differently through referral and diagnosis. If a child does have an FASD casework planning will be different for that child than a child who does not have an FASD. An unidentified /undiagnosed individual with FASD will not respond to traditional risk assessment protocols and this is important information to guide both practice and intervention

  - FASD and Fetal Alcohol Syndrome (FAS) and its related effects are disproportionately over represented in children and families that need service from Child Protection. Critical case management errors can occur when FASD goes unrecognized. In the screening process when children come into care it is important to consider the possibility of FASD in the child, its attendant long-term ramifications and also fails to consider the possibility that the parent(s) may be compromised by this disability as well. Challenges in adaptive functioning and behavior associated with FASD often do not respond to traditional case management practices. Case plans need to be crafted uniquely with FASD in mind and goals and objectives that are a good fit for children and youth with FASD.

- **Increased casework hours and decreased caseloads support a stronger role as an involved guardian for children with FASD.**
  - **Why?** Children with FASD have intensive needs and casework at the outset of involvement with a child and family requires a great deal of time. Due to the vulnerability of children and families who experience trauma related to addictions the process of assessment and case planning is very time consuming when children come into care, when crises arise such as a placement breakdown. The notion of time becomes important in casework practice given the nature of child welfare work and child protection and the fact that emerging crises on cases can take a great deal of time to resolve.
  - Establishing an environment that works for children with FASD that is safe and secure is a primary goal of child protection work. It takes time to develop relationships that are meaningful with children and youth as well as foster parents/caregivers. The benefit of this project in relation to decreasing caseload size had a very positive impact on deepening relationships all the way around. Relationships with their caseworker are very important to children and youth in care, particularly if there is no contact with biological family. A child/youth values contact with the worker and both the child and caregiver home benefit from this contact. Increased visitation takes time and evaluating the time it takes to carry out this model is important to casework practice in relation to children and youth in care with FASD.

- **That a team be established from the outset of a child/youth's involvement with child protection services that collaborates on developing a plan to meet the needs of the child/youth across different environments such as the foster home, school setting and community. This team should include the foster parent, the caseworker, the foster care worker and other members as deemed important for consultation.**
  - **Why?** One of the major findings of the FASD CoP research, particularly from the focus groups with foster parents across regions was that as a result of this project there was a deeper connection developed between the child/youth, caseworker and foster parents. Fostering a sense of "team" around a child/youth became a focal point of much of the discussion within focus groups and was clearly identified as a concept that was valued. One of the reasons a strong sense of team was developed is that caseworkers were required to visit children and youth on their caseload on a monthly basis. Although the data suggests that visits did not always occur on a monthly basis there was increased home visits for the duration of the project, which in turn facilitated stronger connections between the child's guardian (caseworker) and the child. As a result of regular contact with the child, regular contact also occurred for the foster parent and foster parents felt that the caseworker knew both the child/youth better, developed deeper connections with the child and foster parent through increased engagement.

- **That children and youth in care with FASD have regular (at least monthly) contact with their caseworker.**
  - **Why?** Increased casework contact is a critical factor in improved placement stability for children and youth in care with FASD. As identified in Table 3.18 & Figure 3.16 children in the Project regions experienced significantly reduced placement change than those in the Comparison Region. Through in-depth analysis (see Table 3.19), it was determined that the single most important factor predictive of placement stability was caseworker contact. Casework for children who come into care generally involves securing a placement for the child, referrals for medical and psychosocial assessments as necessary, establishing school placements, and developing an overall case plan. When children are placed the current policy requires that caseworkers have contact at least every three months. There is clear evidence from both the quantitative and qualitative analysis of this research that increased contact results in improved placement stability.

- **Caseworkers, foster parents and other allied supports in child welfare casework require specialized training in FASD.**
  - **Why?** The high and intensive needs of children with FASD and the nature of this disability are such that daily intervention and accommodations are made across

environments for the child. Although one could state that this is true for all children, particularly those who have come into care because they were in need of protection from abuse or neglect; exigent circumstances unique to child/youth with FASD exist. Caseworkers, foster parents and others professionals involved require basic, advanced and practically focused training on FASD. **Training was seen as highly valued by caseworkers, foster parents and casework supervisors throughout this project.**

  - The neurological impairment and disabilities associated with FASD are different from other children. Their needs may not be higher than other children who have experienced abuse and trauma, but the important point is that their needs are different and exceedingly demanding/intensive because of their disability. Children with FASD are vulnerable to being misunderstood because their disability is not always readily visible and it needs to be recognized that the apparent strong verbal presentation of child with FASD does not always translate into action. In fact children with FASD are prone to memory and behavioral problems that and if undiagnosed, their actions seen as purposeful, manipulative and non-compliant. This creates a risk for the child who cannot meet expectations without adequate support and understanding of FASD and the implications of this diagnosis for casework practice.

- **Strengthen the collaboration through Alberta Child & Youth Services and Education in responding to the special needs of children with FASD in care.**
  - **Why?** The issue of challenges for children with FASD in the school system was consistently raised in the focus groups. Foster parents frequently expressed concerns that there were differential understandings of FASD between the home and the school system. Another salient finding in the data analysis was a major drop in behavioral difficulties for children with FASD over the summer months. This finding was interpreted and identified as representative of how much stress children/youth feel within the school setting. Children and youth with FASD have struggles in transitions between environments and their behavioral challenges during the school year, we believe are somewhat indicative that school may be a stressful environment. Children and youth are also interacting and influenced at times by their peers and some experience bullying. Foster parents also indicated that if there was a problem with the school they often needed to have the caseworker intervene because they felt the teacher may not listen to their concerns and these concerns required validation by caseworkers. As primary caregivers for children, foster parents are charged with day-to-day care and smooth communication with the school system important and valued.

POLICY RECOMMENDATIONS

- **That a cultural framework be established to respond to FASD in relation to Aboriginal communities.**
    - **Why?** The *Alberta Children & Youth Services Policy Manual* (2011) specifically addresses the cultural issues relevant to First Nations communities and further elaborates on the concept of *meaningful involvement,* for children and youth in relation to culture. In this project the majority of children came from First Nations communities are mostly in permanent care. (See Table 2.6 & Figure 2.4) Within the project regions 89.8% of children were Aboriginal and 83.8% from the comparison region. Undertaking responding to FASD from a cultural lens makes sense. Although this activity occurs within families, communities and regions the need for a consistent framework from a lifespan perspective is crucial.
    - The issue of youth transitioning from care into the adult world emerged as a great source of stress for foster parents and caseworkers who are concerned about differential resources in the adult world. A youth who has been permanently in care is not guaranteed to receive similar services as an adult and may not even be eligible for funding that is equivalent to meet their support needs.

RESEARCH RECOMMENDATIONS

- **That establishment of prevalence rates be a key priority for Alberta Children & Youth Services and that information about FASD be identified as a diagnostic category under the broader umbrella that track children in care and otherwise receiving services from the province that have a disability.**
    - **Why?** The need to know prevalence and incidence is a critical factor in responding to the needs of children who come into care and are living with FASD. The outreach and work required for children, youth and families is labor intensive and requires additional funding supports. As knowledge about FASD becomes more broadly disseminated internationally a key research focus is that of prevalence. There should be a national method identified for collecting this data as well. The reasons for this relate to the allocation of resources; understanding of areas/regions/populations to offer prevention resources/programs/initiatives.
- **That both short term and longitudinal case studies in relation to children, youth and families involved with the child welfare system be developed.**
    - **Why?** There are many families that experience intergenerational problems with addictions and awareness has grown of the establishment of intergenerational contact with child welfare programs over many years. There is a lot of useful information collected on these families that is not necessarily transferred between workers. This came to our attention from a caseworker who advised she was now working with the children of children who had left care. There is

still a great deal to learn about FASD, about FASD prevention and intervention. Such case studies could be informative. A culture of research within child welfare from the front line to administration is very important. The work that is done on the front line impacts allocation of resources, budgets and limitations within the system. Caseworkers collect data all the time on families and much of this information is located in case files. The involvement of caseworkers, case work supervisors and management is critical to the research agenda of the needs of children, youth and families living with FASD.

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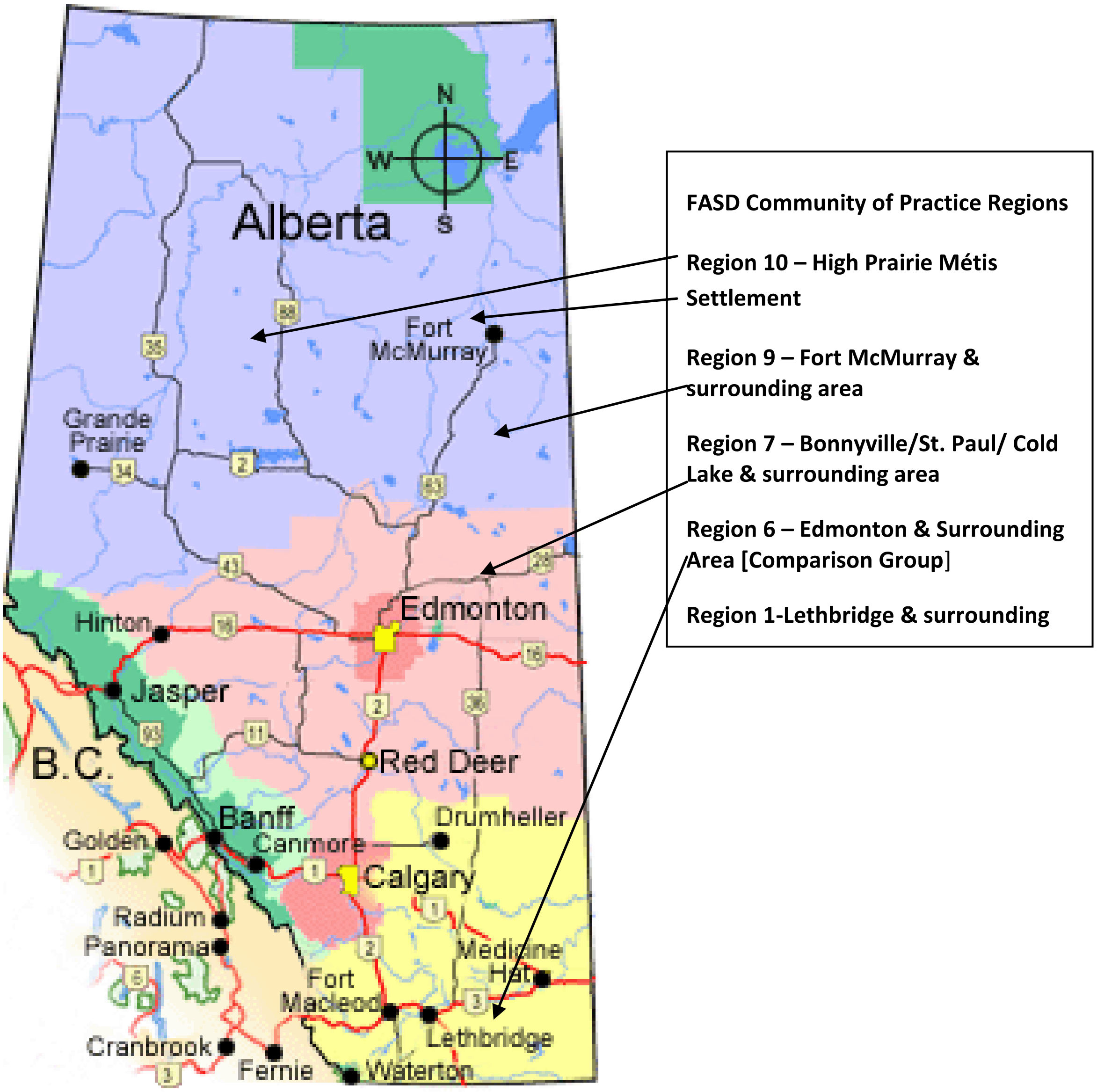
APPENDICES

APPENDIX 1-REGIONAL MAP



FASD Community of Practice Regions

Region 10 – High Prairie Métis Settlement

Region 9 – Fort McMurray & surrounding area

Region 7 – Bonnyville/St. Paul/ Cold Lake & surrounding area

Region 6 – Edmonton & Surrounding Area [Comparison Group]

Region 1-Lethbridge & surrounding

APPENDIX 2-CASE PLAN REVIEW

PREPARED BY DONNA DEBOLT

Through the project, one of the *Promising Practices* was to review service plan through a formal case conferencing process. Formal case consultations occurred in each one of the participating project regions. In total, 54 formal case consultations occurred over the length of the project and resulted in the following practice considerations:

- Case plan review supports the anticipation of the often-predictable developmental trajectory of this disability. It allows participants to avoid "crisis management "and lets you "get there first".
- The process supports the concepts surrounding "unified" expectations – it is difficult to provide consistent and effective care when there are many resources involved in the lives of individuals with diagnosed or suspected FASD.
- The process includes a variety of approaches in intervention that is geared to the specific needs of the child/family and the disability.
- The process bases the plan on a comprehensive assessment. It allows the participants to filter the child's needs through the "lens of FASD".
- Working collaboratively (and at the same table) enables a more efficient use of limited resources and prevents inefficient parallel intervention models.
- In CW, the focus often results in specific time and attention being spent on legal authority work and not managing the developmental trajectory of this disability. Case Plan Review I an opportunity to prioritize this work into case planning.

The **purpose** of the case conference review process:

1. Reporting to the Case Review Committee is simply a meeting of the team responsible for the care of the child. This team consists of all key players and invited "specialists".
2. The draft case plan is presented with a clear picture of the assessment and the agreed upon plans designed to minimize risk and enhance permanency planning.
3. Case Plan Review increases the circle of influence, provides "training" and advocacy and expands skills and knowledge beyond the case manager's capacity.
4. Case Plan Review understands the concept of "collective wisdom" and can support the "trends" of resource issues/needs.

In finalizing the plan we hope to:

1. Ensure that the plan is based on current research and effective practice.

2. Include a variety of approaches in intervention that are geared to the specific needs of the child/family.

3. Base all recommendations on a comprehensive assessment.

4. Guarantee that the case plans are supported by a multidisciplinary team that includes caregivers

5. Ensure that it is reflective of the affective individual's needs.

6. Provide outcome-based information to our funders and community and government partners.

7. Support the concepts of "cross training" and shared "work".

Process

1. There will be 1.25 hrs allotted for each consultation unless more time is anticipated and arranged for. The session will be chaired and co-chaired by the Social Work Consultant and the child's social worker.
2. The participants will include all individuals responsible for the care of the child and will always include but not be limited to: the child's social worker, the parents/caregivers, the school, respite care providers, program personnel and potential service providers.
3. The format will include summarizing what we know about the child, what that information means within the context of the disability and how that influences what we do or what we need to do.

In SUMMARY we accomplished the following:

- Participants reporting a reduction of secondary disabilities that are often associated with FASD – school disruptions, placement disruptions, mental health issues, substance use/abuse

- By report we had an improved collaboration of service partners

- Additionally, we improved community explanations of management options for individuals and families coping with FASD. The process created advocacy for all involved.

- We created improved utilization of service – the right needs were being managed by the right service

- The process also had as an outcome, situations where community agencies left the case consultation process to explore their policies, mandates and partnerships.

APPENDIX 3- SUMMARY OF CAREGIVER TRAINING

PREPARED BY: DONNA DEBOLT

What was the most valuable?

1. The philosophy of intervention – strategies around building skills (habits) to support behaviour
2. The practical training – instructors knowledge
3. Case examples – the sharing of stories – both Donna's and the participants
4. Validation of the experiences in parenting children with FASD
5. The importance of training
6. The understanding of the "grief response"
7. That the disability is life long
8. That there are implications for adoptive parents – must be clear in a post adoption support agreement
9. There was permission to grieve – I must give up what I wish this was to take on what it is – to quote Donna
10. The information on executive function
11. Non- compliance versus non-competency
12. The developmental trajectory of FASD
13. Knowing that I need to have training, training and more training to support the placement
14. Understanding how a placement "disruption" occurs.

What was the least valuable?

1. The schools were not in attendance
2. Not enough time
3. People who came with their own agendas
4. Rehash of the first session material as some participants were not at day one

What were 3 "take home" messages from the training?

1. FASD is permanent but can be supported
2. Feeling competent as a caregiver is integral to placement stability
3. Need to work as a team
4. The ongoing need for respite and support
5. Celebrate the successes – find others to share with
6. Don't force individuals who have processing deficits to process information – the role of lecturing and moralizing???
7. Consequences are not as effective as preventing the behaviour in the first place
8. Caregivers need 4 things – training, support and coaching, respite and grief and loss therapy
9. Individuals with FASD know more than they can do. Non-compliance is often non-competency.
10. Take all the training offered and DEMAND more!
11. "Patience" – what will it take to do this work?
12. Homelessness starts in infancy for individuals with FASD unless we create placement stability.
13. Make individuals with FASD feel useful.
14. Don't see their lives through our eyes

15. Postpone conflict – I was already doing this without understanding how useful it could be. I now know that I was doing “all the right things for the wrong reasons”.
16. “I am not a bad parent” “I am not a bad parent” I am NOT a bad parent”.
17. They always seem more capable than they are.
18. Other stories are similar to mine
19. I spent too much time on “why”.
20. Dependency is useful as concept- independence is what is often valued.
21. Need lifelong support
22. Don’t teach them things you do not want them to know
23. Make a path for them to follow

What skills did you take home from the first six hours of training?

1. Give them credit for how hard they work
2. The diagnosis of FASD means something
3. To be more understanding and compassionate
4. They know more than they can do
5. Teach skills and reinforce habits
6. Work together – create partnership
7. Less discipline and more prevention and support
8. That this is hard work and I must be on top of my game

What do you need next?

1. Training – make it mandatory and make it a weeklong!
2. To see the resources working together
3. To be part of a discussion group
4. To have available respite that is trained and financially resourced
5. Teach me so I can teach others
6. More funding to support placement stability
7. Assurance that I will get help when I need it
8. Train the community
9. Training to the concepts of transitional care – what does it take to support adults with FASD?
10. A newsletter?
11. More information on grief and loss
12. To have opportunity to case plan reviews – to have everyone on the same page

APPENDIX 4- FASD COP SHOWCASE THEMES

Prepared by Alberta Children & Youth Services Research & Innovation Branch

On November 30, 2011 the Research and Innovation Branch (RIB) in partnership with the FASD Cross Ministry Committee (FASD – CMC) and the Alberta Centre for Child, Family and Community Research (ACCFCR) facilitated a Community Showcase to provide preliminary research results from the 18-month implementation of the *Promising Practices* project.

During the Showcase, table group discussions were convened for the purpose of obtaining information from participants about what they believed were the most critical and would essentially be the most important contributions or changes to practice which they heard from those who were involved in the project.

The comments, observations and suggestions which were documented by each of the table groups have been grouped into primary themes. The themes have been ranked, based upon the number of comments or times they were listed by each of the groups. The assumption derived by this process is that the more comments made about certain *Promising Practices* by participants, the greater the degree of importance they attributed to them. Although not a reliable scientific process, it does provide an initial ability to rank the *Promising Practices*, which can then be re-evaluated when the final research findings released.

In addition to the seven primary themes which were identified and are listed with direct comments below, **Communication** was listed by some as a specific theme as well. Although it could be considered a theme in itself, it appears that this is a critical aspect which is inter-woven with all other identified themes. There is clearly the need for open and honest communication in order to ensure effective services are provided to FASD affected children and their caregivers. Communication ensures ongoing contact, collaboration and service plan development which ultimately results in the desired benefits and outcomes required by FASD affected individuals, regardless of whether they are directly receiving the services or are service providers to those affected. As such, Communication is considered a vital theme which does not stand alone, but rather is an aspect of each and every primary theme identified.

The following are the actual comments from symposium participants broken into 7 key themes identified by ranking the most commented upon down to the least:

MANDATORY TRAINING ON FASD

- The typical training practice is a few hours when it should be far more extensive.
- Continued training! Webinars by Donna Debolt? or Train the Trainer? multidisciplinary teams, not only caseworkers at once shared training
- Ongoing opportunities for consultation (professional) & education about FASD
- More education
- Education; The Criminal systems need to be on board; Cross Ministry Training
- Educate and support adults with FASD to break the cycle of more FASD babies.

- Ongoing Mandatory FASD training for CFSA staff and Foster Families
- Be open to learn
- Mandatory and ongoing FASD training for all social workers
- To make sure everyone is trained in FASD
- FASD training should be mandatory for all Human Services workers
- The continuation of FASD Training
- Mandatory training
- Training & Education
- FASD training needs to be Mandatory and it needs to be YEARLY mandatory training
- Training (e.g. 12 hrs.)
- more training/education
- train stakeholders
- Training that involves all systems - caseworkers, foster parents, teachers, childcare staff etc
- P.D. Day for teachers that also includes social workers & foster parents to provide training about children with FASD (all together in one room)
- Training for all public. Not just for the CFSA staff. This training needs to be at no cost
- Focus on strengths, not just behaviours.
- Matching the needs of the child to the skills and dynamics of the foster home….very important.

TRAINING: FOR COLLABORATIVE PARTNERS AND HUMAN SERVICE WORKERS

- Schools need to be brought on board with FASD best practices. Teachers, counselors, student assistants, teacher assistants - any school staff really need this information.
- Education for educators - lunch & learns - with practical approaches for implementation
- Train school staff right from the top.
- Workers & multidisciplinary go into schools to build on success
- Multidisciplinary teams, not only caseworkers at one shared training including school personnel.
- FASD education to our Teachers (schools)
- To have an FASD Individual come into educate students to have and impact.
- Expand this program to include high school family/sex ed. Prevention!
- FASD training should be mandatory for all Human Services workers
- Training for education system/teachers - so they're not setting kids up for failure by using behavioural approaches that don't work with FASD
- P.D. Day for teachers that also includes social workers & foster parents to provide training about children with FASD (all together in one room)

TEAM APPROACH AND COLLABORATION

- Cannot work in isolation, everyone in contact with that child and family must collaborate.
- team approach & collaboration
- Focused collaboration with clear vision and direction leads practice to encourage motivation
- Relationship building
- Collaboration and continuing the *Promising Practices*
- Support and collaboration between caseworkers and caregivers
- Networking with:
    - - Alberta Children and Youth Services
    - - The Foster Care Support
    - - Children Services
    - - AHS
    - - Organizations working with immigrant and Refugee communities which offer support services addressed to FASD clients
- Teams support/Communication
- Working from the collaboration team model
- To continue collaboration with all supports including communities
- Caregivers did not feel supported and after the research was completed it became very clear we need to support them better which will build better relationships, conversation and trust.
- Interdisciplinary work is very, very valuable to supporting children/youth with FASD and the caregivers who care for them
- Honest & Open Relationships
- A strong understanding of the areas of involvement & commitment to a support system. Each one to be identified, and networking encouraged
- Pull together a regional case plan review team
- exchange information/teamwork
- True Collaboration and Training that involves all systems - caseworkers, foster parents, teachers, childcare staff etc
- These practices should be shared with all groups not just CFSA. What are the Standards?
- The behaviour checklist should also be shared to community agencies/service providers.
- Use the networks to get this information out
- Continued investment in collaboration & relationship building b/w foster parents, SW, team.

TRANSITION TO ADULTHOOD SUPPORT

- Transition to adulthood, stability must be provided beyond 18 yrs.

- Ease transition from child to adult support
- After 18 service program. Age out of system but not mentally 18
- Transition planning to adulthood
- Transitions to Adulthood
- More money to the centers for assessment & diagnosis & over time with key transition partners
- Strong transitioning programs & more supports for adults
- What supports are in place for the adult FASD individual. How do we support the caregivers who are still supporting the adults with FASD?
- Put this to use towards TGO to help transition the child to go back to their bio family
- FASD children won’t be totally independent and this view needs to be accepted, generally the view of social workers and society is to make individuals independent.

ACROSS THE LIFE-SPAN VIEW

- Look at how do we apply supports & structures to adults (diagnosed or un) with FASD
- Not cut off on age limits
- FASD children won't be totally independent and this view needs to be accepted, generally the view of social workers and society is to make individuals independent
- Educate and support adults with FASD to break the cycle of more FASD babies
- Application of practices across the life span
- Strong transitioning programs & more supports for adults
- What supports are in place for the adult FASD individual. How do we support the caregivers who are still supporting the adults with FASD?

ABORIGINAL/CULTURAL FOCUS

- For Aboriginal children and youth the bio family should be involved in providing supports to the child. Also aboriginal culture and practices should be incorporated into the supports to the child/school/family
- Métis child in care need to be connected with sibling groups and extended family
- Aboriginal foster care recruitment
- more attention paid to culture for indigenous children in care
- Advocate with local bands to assist with bringing training and support to those supporting band members with FASD.
- We need to get the numerous (ALL) Indian Bands and Federation of Saskatchewan Indian Nations and Assembly of First Nations to get involved and help bridge the gap and help First Nations people affected with FASD by providing education and financial support which would directly benefit their band members and First Nations people as a whole

BIO FAMILY INVOLVEMENT & SUPPORT

- For Aboriginal children and youth the bio family should be involved in providing supports to the child. Also aboriginal culture and practices should be incorporated into the supports to the child/school/family
- Put this to use towards TGO to help transition the child to go back to their bio family
- Métis child in care need to be connected with sibling groups and extended family
- More focus on supporting the biological family and original community
- Bio mother involvement extremely beneficial if that mother has accepted her role, and can be positive.

INCREASED INTERACTION WITH CASEWORKERS

- High rate of interaction with caseworker and family/child is essential, communication must be ongoing.
- More contact between Foster Family and Caseworker
- Worker contact to increase with caregivers requires decrease in # of children/families assigned. This includes FSCD
- creating a system where caseworkers can develop a relationship with family
- Caseworkers need to follow through and be held accountable to monthly visits and supervisors need to support them.
- Meeting once a month – Funding to support it.

WORKLOAD STANDARDS & FOCUSED CASELOAD

- Caseload numbers/maximums must change with different changes in practice i.e. Casework Practice Model
- Practices need to reflect the paradigm shift
- Managers need to make the shift. All levels above the front line workers need to shift their way of thinking and then their practice, for all of this to work!!
- changes would need to be made to policy / child care legislation in order to implement changes to practice
- have a reasonable caseload for workers who can implement these practices and who are obligated to be a part of the team process

INCREASED FUNDING FOR RESPITE AND FLEXIBLE SUPPORT SERVICES

- More funding
- Funding for respite
- Is there capacity within the regions to carry this project forward? (after project is done)
- Funding, money
- Funding for more trained respite providers and for providing respite
- Change our special rate system
- More money to the centers for assessment & diagnosis & over time with key transition partners
- Continue being creative in accessing services and what services/supports for families are implemented
- Openness to flexibility of support
- How do you support grandparents who are parenting grandchildren? How do you support a 72 year old? this needs to be addressed
- Linking of services for the benefit of the person.
- Don’t have to justify support. Needs recognized either foster or social/care worker
- These strategies to change and support environment are specific to FASD children. We need to respect differences. Specific treatment for specific children.

RESEARCH AND INITIATIVES ON FASD PREVENTION/EARLY INTERVENTION, DIAGNOSIS AND ASSESSMENT

- Pilot PREVENTATIVE *Promising Practices*
- What is being done about prevention?
- Expand this program to include high school family/sex ed. Prevention!
- Develop more programs to raise awareness in community : schools, police, healthcare
- Research on the development of neuropathways
- Research on FASD prevention. How do we stop this from happening??
- Earlier intervention and assessment
- Early Diagnosis/Assessments
- More money to the centers for assessment & diagnosis & over time with key transition partners