

**THE FRASER REGION'S EARLY CHILDHOOD SCREENING
PROGRAM FOR CHILDREN IN CARE: EVALUATION REPORT
AND RECOMMENDATIONS FOR IMPROVED OUTCOMES**

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Jordan Wapass
Political Studies, University of Saskatchewan 2005

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APPROVAL

Name: Jordan Wapass
Degree: M.P.P
Title of Capstone: The Fraser Region's Early Childhood Screening Program
for Children in Care: Evaluation Report and
Recommendations for Improved Outcomes

Examining Committee:

Chair: Jon Kesselman
Professor, Public Policy Program, SFU

Doug McArthur
Senior Supervisor
Professor, Public Policy Program, SFU

Jon Kesselman
Supervisor
Professor, Public Policy Program, SFU

John Richards
Internal Examiner
Professor, Public Policy Program, SFU

Date Defended/Approved: October 1, 2009



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ABSTRACT

This study provides an evaluation of year one of the Fraser Region's Early Childhood Screening program for children in care and provides recommendations to increase program effectiveness. The Fraser Region Ministry of Children and Family Development (MCFD) and the Fraser Health (FH) authority formed the screening program in 2007. This program is designed to support short and long-term best outcomes for the Fraser Region's children in care population through comprehensive health assessments and early intervention services. The program focuses on screening children when they reach 18 and 36 months of age in five key health areas: vision, dental, audiology (hearing), developmental progress and immunizations. This study contains data on 236 total children in care who were eligible for the screening program from January 1, 2008 to September 30, 2008. Of the 236 eligible children, 116 participated in the screening process. Recommendations for optimization of the assessment process and referral programs are provided.

Keywords: Fraser Region, children in care, health screening, evaluation, assessment, early intervention, outcomes

Subject Terms: comprehensive health assessment, integrated health screening

EXECUTIVE SUMMARY

This study provides an examination of the Fraser Region's Early Childhood Screening program for children in care and provides recommendations to increase program participation and effectiveness. The screening program provides health assessments and screenings for children who are in government care when they reach the ages of 18 and 36 months. Five key health areas are assessed in the integrated health screening program: vision, dental, audiology (this is actually a case finding process premised on parental concerns), physical and social emotional development and immunizations. This study analyzes the first year of the health-screening program's data and provides policy alternatives to improve both program participation rates and program effectiveness. Data from January 1, 2008 to September 30, 2008 indicated that 236 total children in care were determined to be eligible for the program. Of the 236 eligible children who reached the ages of 18 and 36 months while in care), 116 participated in the integrated health-screening program for a participation rate of 49.2 per cent in the first year. This study provides further analysis of the data for each key health area as well. The program has proved to be effective in identifying potential health concerns for the children who participated. Therefore, the proposed policy alternatives focused on improving the participation rates for children as 51.3 per cent of eligible children did not participate.

There is a similar integrated health-screening program for children in government care in the state of Illinois. The major difference between the Illinois state program and Fraser Region's health screening program was mandatory participation screening for the Illinois children who enter care. To date, no such policy exists in the Fraser Region.

DEDICATION

To my uncle, John Wapass, my Grandma and Moosum, my mom, Donna Wapass, my uncle Morris, and to my brother, Red and sisters, Lisa and Thisa, thank you for your love, support, encouragement and smiles. You have always been there for me and I will always be there for you. Without you, I wouldn't be the person I am today. Thank you.

Ekosi.

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GLOSSARY

AAP	American Academy of Pediatrics
AIDP	Aboriginal Infant Development Program
ASQ	Ages and Stages Questionnaire
ASQ-SE	Ages and Stages Questionnaire – Social Emotional
BC	British Columbia
CDC	Child Development Center
CYSN	Children and Youth with Special Needs
ECD	Early Childhood Development
ECP	Early Childhood Project
EI	Early Intervention
DCFS	Department of Children and Family Services – Illinois
FRECF	Fraser Region Early Childhood Framework
FH	Fraser Health
FHAN	Fraser Health Assessment Network
IDP	Infant Development Program
MCFD	Ministry of Children and Family Development
MOH	Ministry of Health

1 INTRODUCTION

Governments assume responsibility for the protection of children when their initial home environments have been deemed inappropriate, unsafe or unhealthy. This responsibility is one that government support workers like social workers and health care professionals take very seriously and are passionate about. The most vulnerable sector of the population, children, may be subject to situations beyond their control.

Providing the best situation and outcomes for children is the overall goal of state care. For this reason, government looks to provide the best care for vulnerable children and youth by providing the best programs and services.

2 POLICY PROBLEM

2.1 Overview

Children and youth in foster care have higher medical, emotional, developmental and educational needs when compared to the general population (Canadian Paediatric Society, 2008).

In some cases, researchers contend that between 60 and 80 per cent of children who enter care have at least one medical illness (Clyman, Jones, & Little, 2002). Often, the special needs of the children entering care are chronic, under-recognized and neglected (Canadian Paediatric Society, 2008). Children who are diagnosed with special needs require more attention and resources to address their personal issues and concerns than children without special needs.

Perhaps, even more alarming is the current trend across North American foster care systems. The number of children under the age of six forms the largest cohort of children entering care throughout North America and this population remains in care the longest amount of time (Vig, Chinitz, & Shulman, 2005). Further, the majority of those children under six who enter care are infants and they remain in care twice as long as older children (Vig et al., 2005). Additionally, medical and behavioural conditions increase with time among this vulnerable population. The literature indicates that the large majority of children who enter care are young; they have higher than average medical, emotional, developmental and educational needs, and these conditions tend to increase over time.

In this study, the policy problem is how to provide appropriate and adequate assessment and follow-up for children under the age of six who are in the care and protection of government agencies and who have special needs. The number is rapidly increasing. The prevalence of special needs among these children is startlingly high when compared to the general population (Stahmer et al., 2006; Bruhn, Duval, & Louderman, 2007). In most cases, children who enter care do so with more than one special need. As noted earlier, some researchers estimate the number of young children who have at least one medical illness when they enter care is between 60 and 80 per cent and 25 per cent have three or more chronic conditions (Clyman, Jones, & Little, 2002). Further, the authors note the drastic increase of infants entering the foster care system. From 1986 to 1991 in California, New York and Pennsylvania, the number of infants

under the age of 36 months doubled (Clyman et al., 2002). In Canada, there are over 76,000 children and youth in foster care and these numbers are increasing annually (Canadian Paediatrics Society, 2008). Infants form the largest group to enter and remain in care (Dicker & Gordon, 2004). Further compounding this stress is that medical and behavioural conditions tend to increase with age in this population (Vig et al., 2005). The long-term effects of this trend are disturbing. To neglect this issue is to further disadvantage a highly vulnerable population.

2.2 The Focus of the Study

The Fraser Region's Early Childhood Screening program is an innovative and unique program premised on the early detection of and early intervention for health and developmental delays for the Fraser Region's children in care population¹. In 2005, the British Columbia (BC) Ministry of Health (MOH) announced a three-year plan to provide an integrated cross-ministry implementation of dental, hearing and vision screening for every child under the age of six years in BC. The plan recognized that early intervention and the subsequent treatment encourages the healthy growth and development for all of BC's children (Fraser Health, 2008).

In 2005, The Fraser Region Early Childhood Framework (FRECF) and subsequently the Fraser Early Childhood Partners Council rose out of a joint community consultation about the importance of the early years. This framework and the subsequent collaboration focus on early childhood development (ECD) and relevant best practices for the Fraser Region's birth to six population. The Early Childhood Partners Council implements the vision and goals of the framework while maintaining close relationships with ECD community partners throughout the region. The collaborative framework sets out five key regional priorities²:

- 1.) *Developmental screening*: This is the focus of the Fraser Region's Early Childhood Screening Program
- 2.) *Early childhood and maternal mental health*: This is a targeted approach to an area that the region sees as vital in child and family development.

¹ "Children in care" or "child in care" for this study include those children aged 0 to 6 in MCFD care in the Fraser Region. Throughout this paper, "children in care" and "child in care" will be used in place of foster care children and children in the child welfare system. These terms are found in literature and used to describe children in government care. Terms vary by jurisdiction.

² See Appendix A for the framework

- 3.) *ECD hub models*: The development of ECD hubs provides a space in communities for parental and family support and education – from prenatal education to adult education, food safety and preparation.
- 4.) *ECD communications and public awareness plan*: The emphasis is on public education as to the importance of early childhood development.
- 5.) *Issues of accessibility for children and their families who live in the Fraser Region*: Some families may have difficulties accessing services. This is an important component to consider when planning programs and services for families. (Fraser Health document, 2008).

2.3 The Fraser Region’s Early Childhood Screening Program for Children in Care

The Fraser Region’s Early Childhood Screening program directly fulfils one of the five key priorities of screening and complements the other regional priorities of the FRECF. With respect to screening, the program is unique and innovative in its integrated approach to health and developmental screening. The program provides a comprehensive health and developmental assessment for children in care aged 18 and 36 months in five key health areas:

- 1.) Vision
- 2.) Dental
- 3.) Audiology (hearing)³
- 4.) Developmental (physical and social-emotional)
- 5.) Immunizations

Prior to the program, similar screening took place when all typical⁴ five-year old children entered kindergarten but only to evaluate vision and hearing. The program aims to improve and optimize the health and wellbeing of the region’s children in care through early identification of and early intervention (EI) for potential health and developmental issues. The purpose of the program is to provide an enhanced level of continuity of health care for the Fraser Region’s children in care population and provide for improved access to such services.

³ When the program began, the FH audiology department was planning to provide screening for audiology using audiometric equipment. This decision was changed part way through the program and children were referred to the FH Audiology Program based on case finding (i.e., enquiring about parental concerns). Thus, the audiology component is more of a case finding process as opposed to a screening. Screening uses a validated instrument while case finding uses questions about parental concerns

⁴ This is a term used to describe children who do not have any identified “special needs”

2.4 Screening Program Initial Phase

Fraser Health's Health Promotion and Prevention branch provides the health screening services and Fraser Health and MCFD provide the follow up to ensure that children receive services jointly. Prior to a screening taking place, the guardianship social worker⁵ is notified by the MCFD regional office that he or she has a child who will be turning 18 or 36 months of age. The social worker then faxes referral forms⁶, consent forms⁷ and an Infant Development Program (IDP) summary and plans (if they are available) to the Early Childhood Screening program liaison. The Early Childhood Screening program liaison then distributes the referrals through to local Public Health offices where the children reside. Once referrals have been distributed to Public Health offices, a public health electronic client record and paper record is created to monitor the child's health progress. The next phase sees that the caregiver of the child is contacted and an appointment is scheduled for the child's comprehensive health and developmental screening at the local health unit or a neighbourhood hub.⁸

2.5 Referral Process

Once the comprehensive health and developmental screening has been completed, an Integrated Screening Summary Form⁹ describing the outcomes of the screening services is produced. The summary or outcome form contains the personal information and results of the assessment for each child and indicates whether a referral is needed to eye doctors, family doctors, dentists, ophthalmologists, the fluoride varnish program, audiology (hearing) program, speech and language programs, IDP, and/or Child Development Centers (CDC). The child's social worker is also able to make referrals to mental health services, and occupational and physical therapists. The completed summary or outcome form is then faxed to the child's social worker. The final phase sees that the data are submitted to the Early Childhood Screening program liaison for data collection purposes.

⁵ Guardianship social workers are delegated as the child's legal guardian

⁶ See Appendix B for social worker referral form

⁷ See Appendix C for consent to routine medical form

⁸ Neighbourhood hub includes community spaces such as elementary schools. This is in an effort to increase access to programs and services for families

⁹ See Appendix D for the screening outcome form

2.6 Follow Up and Outcomes

After the recommended referrals for children have been made, FH staff and the MCFD liaison contact caregivers and social workers to obtain the diagnostic outcomes. This acts as another accountability measure to ensure that children who were referred or those who received a red flag¹⁰ actually receive their respective follow up(s). See figure 1 for the program’s process.

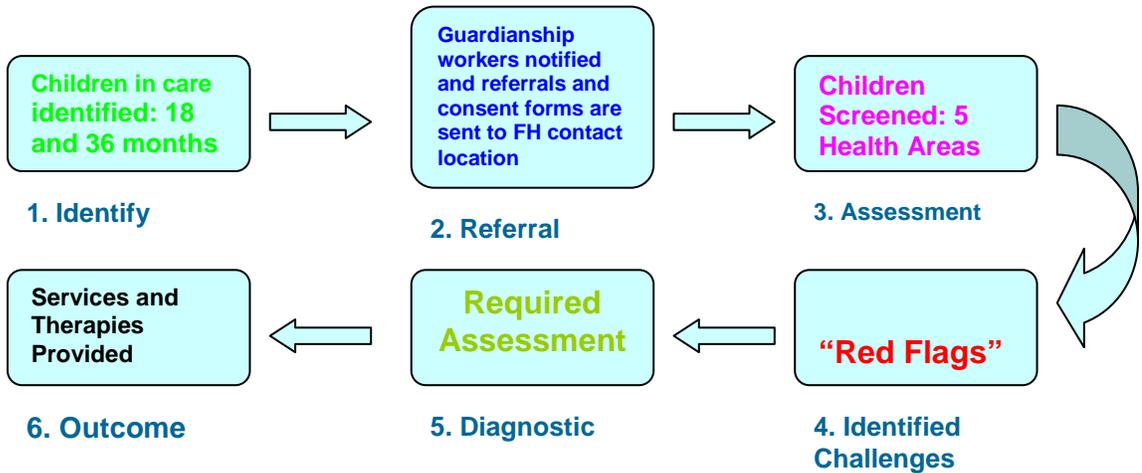


Figure 1 – The Fraser Region’s Early Childhood Screening Program for Children in Care

2.7 Program Evaluation

This study undertakes an evaluation of the first nine months of operation of the Fraser Region’s Early Childhood Screening program and provides policy recommendations to improve program effectiveness. Data are available from program inception on January 1, 2008 to September 30, 2008. During this time period, 236 children in care met the eligibility criteria. The eligibility criteria provide that the children in care must be screened when they reach 18 and 36 months respectively while they are in care. Data were available for only 116 of the 236 eligible children in care who participated in the program. There are a variety of reasons to explain the absence of data from the remaining children. Children in care at the time of eligibility may return to their original homes, move out of the Fraser Region, or be placed for adoption. The policy recommendations in this study will focus on what MCFD can control for while the children are in care.

¹⁰ “red flag” is the term used in MCFD data that refers to the screening program’s referral process. If the data indicated a red flag, children were referred for further services or therapies in the respective areas of concern.

2.8 The Fraser Region – MCFD and FH

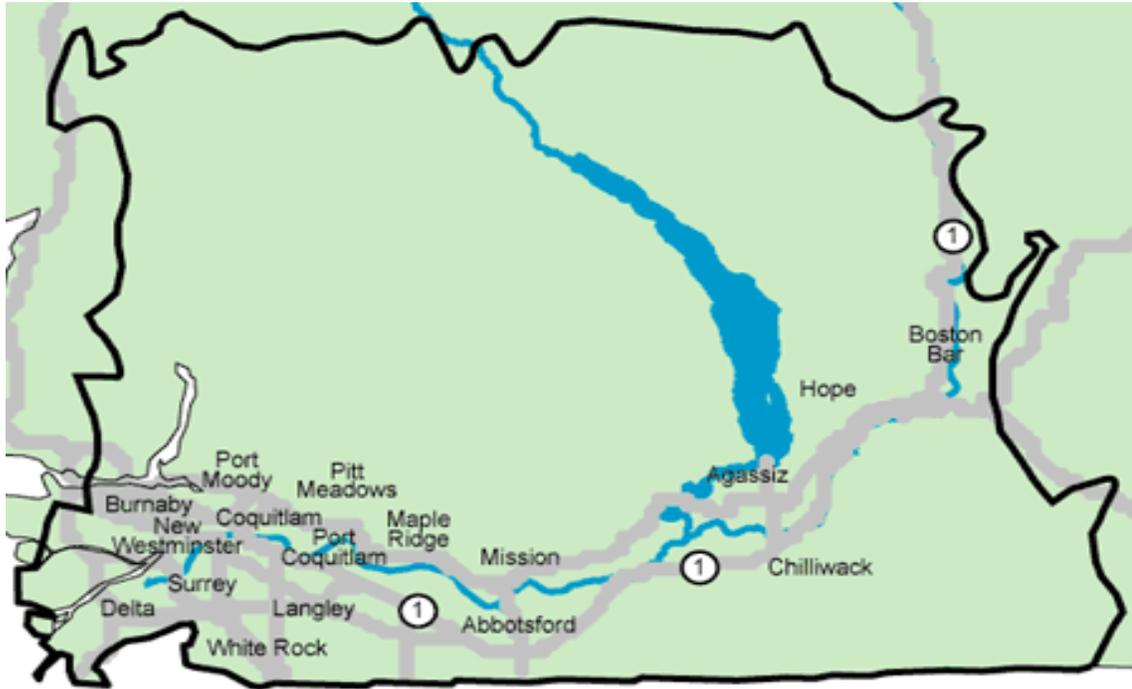


Figure 2 - MCFD and Fraser Region (Source: MCFD, 2009)

The Fraser Region includes BC's lower mainland with the exception of the cities of Vancouver and Richmond. The region is diverse in population and is home to a wide range of people, cultures, traditions and languages. The region is the largest health region in BC by population at nearly 1.5 million people (Fraser Health, 2008). The Aboriginal population in the region is young and growing rapidly. According to the 2001 Statistics Canada census, 46,025 people identified as Aboriginal, 3.5 per cent of the region's total (Fraser Health, 2008). The Fraser Region includes the communities from Burnaby and Surrey to as far north as Boston Bar. These broad boundaries and immense area of the region can at times provide challenges for service delivery and access to communities. As Fraser Health and MCFD share similar boundaries with respect to service and operation, they continue to collaborate.

2.9 Population of Children in BC and the Fraser Region

The total population aged 0 to 18 in BC is approximately 900,000 and the Fraser Region is home to approximately 40 per cent of this total population. The distributions of the 0 to 18

population by age categories 0 to 3 and 0 to 6 for BC and Fraser Region are similar. Figure 3 provides information on the child and youth populations in BC and the Fraser Region.

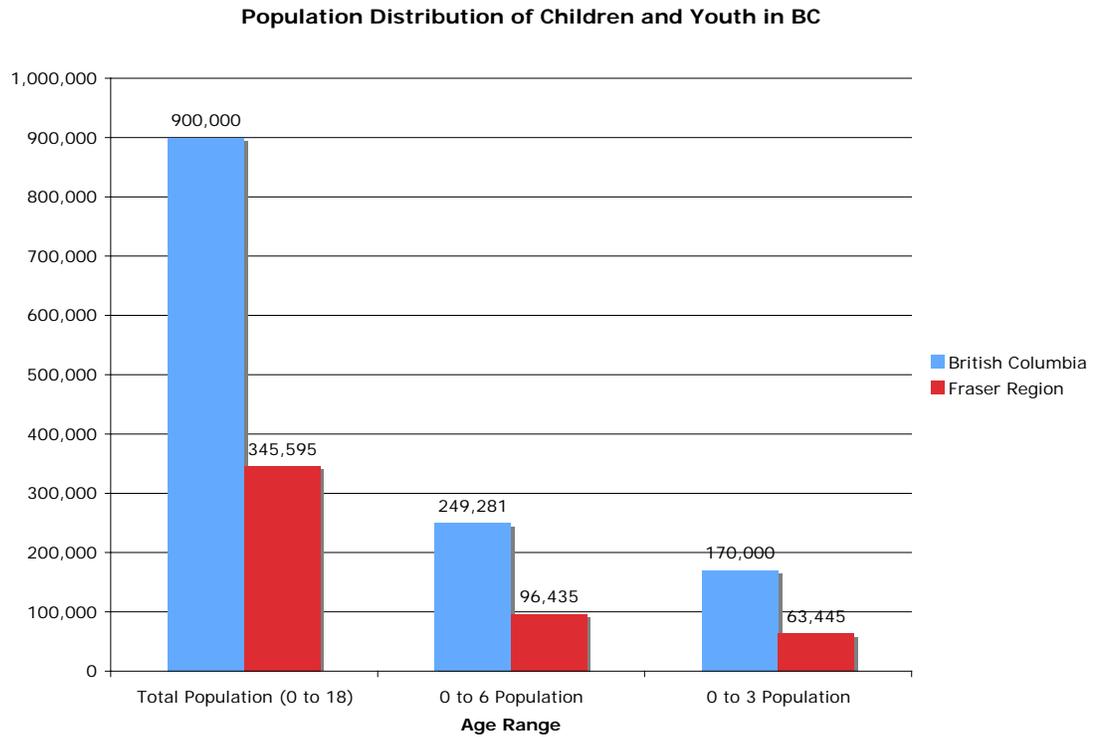


Figure 3 - Population Distribution of Children and Youth in BC (Source: BC Service Plan 2008 and Statistics Canada, Canada Census 2006)

3 OVERALL FRAMEWORK FOR EFFECTIVE INTERVENTION

3.1 Early Intervention

Children's experiences last a lifetime and parents have the challenging responsibility of nurturing and caring for their children. Early Childhood Development (ECD) programs and services are designed to help parents, service providers and family members provide the best possible start for BC's children. (MCFD ECD website, 2009)

This section examines the importance of early intervention (EI) for children, especially for those young children who are in government care. The Fraser Region's Early Childhood Screening program focuses on the child population aged 18 and 36 months. Early detection and early intervention are seen as key components to improving outcomes for children in care. Early intervention for health and development issues also encourages the development of healthy children. By encouraging healthy children, further and future problems that would require more intensive and costly interventions later on in life can be prevented. If early detection and intervention are not addressed, a child's healthy development and growth may be jeopardized. Section 3.1.2 describes how the provision of early intervention benefited an infant in care named Alexis.

More children are entering care in the early years of life. These early years are the most crucial for overall development and health. This is the phase of life when brain growth and development are most significant. Therefore, intervention should commence as early as possible in an effort to enhance the child's development and to maximize the outcomes for the child (Early Intervention Canada, 2009). Research and evidence suggests that the earlier the intervention takes place, the more effective it is. Further, early intervention can decrease the need for further services over time (Early Intervention Canada, 2009):

During the first 3 to 4 years of life, the anatomic brain structures that govern personality traits, learning processes, and coping with stress and emotions are established, strengthened and made permanent. If unused, these structures atrophy...it is known that emotional and cognitive disruptions in the early lives of children have the potential to

impair brain development (American Academy of Pediatrics, Committee of Early Childhood, Adoption and Dependent Care, 2000).

Providing the appropriate child development services including assessment and the link to relevant early intervention services intended to address developmental delays is pivotal for improved outcomes (Clyman et al., 2002). Researchers and educators alike agree that developmental services lead to more favourable outcomes for children with delays due to both biological and social risk factors (Stahmer et al., 2006).

3.1.1 Special Needs Intervention

Special health care needs are prevalent among children in the child welfare system. Many children with special health care needs have cognitive, language, adaptive, social and behavioural functional impairments (Ringeisen, Casanueva, Urato, & Cross, 2008). These are significant health impairments that can severely hinder social and physical progress. Thus, mechanisms are needed to ensure that this vulnerable population has access to and receives coordinated health and related social services (Ringeisen et al., 2008).

Early childhood research also indicates that the health and developmental problems of children in care increase with age. In a study of over 200 foster children, disabilities were documented for young children aged 13 to 36 months. The researchers found that cognitive disabilities were identified for 30 per cent of the 13-month group and 37 per cent for the 36-month group. They found 55 per cent impairment in expressive language for the younger group and 63 per cent for the older group; they found 27 per cent impairment in fine motor movements for the younger group and 31 per cent for the older group (Vig et al., 2005). This study emphasizes the need for early intervention practice and strategies for the children in care population. The Vig et al study provides further proof to the development of medical and behavioural conditions over time if left untreated. In all cases studied, the younger group saw a lower prevalence of special needs conditions when compared to the older group. This suggests that medical and behavioural conditions increase with time among the children in care population. Clearly, early identification and early intervention would benefit all children in care, especially the younger populations.

3.1.2 The Case of Alexis - Early Intervention Works

The following case was extracted from the work of Dicker & Gordon (2004) and provides a real account of the experience of one child involved in government care. Children arrive in care for a variety of reasons that often involve traumatic social circumstances. This case speaks to the responsiveness and resilience of children despite the less than favourable circumstances they may have experienced:

Ten-month old Alexis entered care after her mother left her unattended overnight. The foster mother brought her to a local pediatrician for an initial visit. The foster mother had no medical history or immunization record for Alexis. She reported that Alexis arrived at her home with a severe diaper rash, appeared very thin with a poor appetite and irritability. She informed the physician that Alexis was neither rolling over nor sitting on her own. She made very few verbal sounds and slept many hours of the day. The foster mother also reported that Alexis often did not turn her head when she spoke to her or when other children entered the room (Dicker & Gordon, 2004).

The outcome of this case saw the pediatrician refer Alexis to an early intervention program where she was found to have significant delays. As a result of the referral, Alexis received necessary services including hearing aids. After only a few weeks of therapeutic intervention and the use of hearing aids, Alexis reached a healthy weight and was experiencing rapid physical and social progress (Dicker & Gordon, 2004). The case of Alexis gives credence to the idea that children under 36 months can be severely hindered by untreated health and developmental issues and at the same time, they can prove to be more responsive to intervention. Given the opportunity to experience intervention during the early years allows children the opportunity to learn and grow to their true potential.

3.1.3 Long Term Outcomes

Without proper intervention for required services, children may incur further social, physical and emotional burden in the long run. This may lead to future social problems:

In sum, youth leaving care are under pressure to do more, sooner, and with fewer internal and external resources than their peers. In view of the magnitude and degree of these issues, there is good reason to suspect that when the transition from foster care is not well supported, you are at greater risk for homelessness, sexual exploitation, victimization and involvement in the criminal justice system and child welfare systems when they “age out” of care (Rutman, Hubberstey & Feduniw, 2007).

The Rutman et al., (2007) study touches on one of the main criticisms of the child in care system.

As the literature indicates, many of the youth who “age out” have poor long-term social

outcomes. By providing children and youth with the necessary services to optimize healthy growth and development in the early years, then perhaps, these poor social long-term outcomes will be minimized.

3.2 Comprehensive and Integrated Approach

This section provides: (1) a description of the importance of a comprehensive and integrated approach to assessment and intervention; (2) a review of the Illinois Department of Children and Family Services' (DCFS) Early Childhood Project from 1998; and (3) a review of the American Academy of Pediatrics, Committee of Early Childhood, Adoption and Dependent Care's Comprehensive Assessment of Children in Foster Care – After Placement.

3.2.1 The Importance of a Comprehensive and Integrated Approach

The majority of research emphasizes the importance of establishing a comprehensive and integrated approach to assessment and early intervention. The comprehensive assessment must address the children's welfare, medical, developmental, and mental health needs in order to improve a child's outcome in all four domains (Clyman et al., 2006). The Child Welfare League of American (1988) and the American Academy of Pediatrics (1994) both advocate for a comprehensive medical, development and mental health assessment for all children in care (Clyman et al., 2006).

3.2.2 The Illinois Department of Child and Family Services (DCFS) Early Childhood Project 1998

In 1998, the Illinois Department of Child and Family Services (DCFS) launched an integrated health-screening program for children in their foster care system called the Early Childhood Project 1998 (ECP). The program is similar to the Fraser Region's Early Childhood Screening program in its comprehensive approach to health screening but differs in the types of health screening. The DCFS began mandatory developmental screening and referral of all children under the age of three who entered care in the most populous area, Cook County (Stahmer et al., 2007). The ECP 1998 provides for the assessment of a child's development at entry into out-of-home care and continues ongoing assessment thereafter (Stahmer et al., 2007). Like the Fraser Region's screening program, the ECP 1998 focuses on the children under the age

of three and follows a comprehensive approach to assessment. The Fraser Region's Early Childhood Screening program for children in care differs on one significant level. At the time of study, the Fraser Region screening program does not have a mandatory screening policy in place that ensures all children entering care are provided with a comprehensive health assessment. MCFD does ensure children are seen by a doctor for a medical check up but this is not as comprehensive and thorough as the screening program. The Illinois program has witnessed higher rates of identification than jurisdictions with limited or no mandatory policy in place. The authors attribute the higher identification of developmental delays to the implementation of a mandatory screening policy (Stahmer, et al., 2007).

3.2.3 Mandatory Screening Policy Effectiveness

Reported rates of assessment are contingent on the type of policy structure a program has in place (Stahmer et al., 2007). Leslie et al. (2003) studied primary service units where policies requiring an assessment of all children for developmental delays were located. The authors found that in those public service units where a mandatory screening policy existed, 94 per cent of all children were reported to have received an assessment. By contrast, in primary service units where limited policy or no policy existed, the rates were 29 per cent and 26 per cent respectively (Stahmer et al., 2007). In comparing all jurisdictions with a mandatory screening policy in place, Stahmer et al., (2007) found that over 90 per cent of children were reported as having been screened in jurisdictions with mandatory comprehensive screening at entry into care and on-going follow up. In those areas without comprehensive screening, the authors found that approximately 30 per cent of children were reported to have had a comprehensive screening (Stahmer et al., 2007).

3.2.4 American Academy of Pediatrics Comprehensive Assessment Plan

According to the American Academy of Pediatrics (AAP), Committee of Early Childhood, Adoption and Dependent Care, all children who enter government care should have a comprehensive assessment. In their study, "Developmental Issues for Young Children in Foster Care," the AAP recommend that a pediatric assessment occur within 30 days of a child's placement. Moreover, this evaluation must be:

- 1.) Comprehensive
- 2.) Integrative
- 3.) Developmental

- 4.) Preventative
 - 5.) Longitudinal
 - 6.) Summative
 - 7.) Culturally Sensitive
 - 8.) Child Sensitive
 - 9.) Standardized
 - 10.) Child Welfare Sensitive
 - 11.) Parsimonious
- (American Academy of Pediatrics, 2000).

3.2.5 Children and Youth with Special Needs Framework For Action – British Columbia

The BC government has a framework in place that resembles the American Academy of Pediatrics Comprehensive Plan. The CYSN Framework for Action is BC's strategy for improving the system of support for children and youth with special needs and their families. The goal of the framework is to provide a common reference on which to plan ongoing strategic work (Government of BC, 2009). The framework lays the foundation for integrated collaboration between the ministries of health, education and MCFD in providing support to children and youth with special needs and their families. The values and guiding principles of the framework are:

- 1.) Integrated and comprehensive
- 2.) Accessible
- 3.) Child-centred and family-focused
- 4.) Functionally-based
- 5.) Evidence-based
- 6.) Culturally competent and safe
- 7.) Responsive to change
- 8.) Fair and equitable
- 9.) Evaluated
- 10.) Sustainable

Regions are expected to follow the values and principles. The framework, like the AAP's Comprehensive plan and the Fraser Region's Early Childhood Screening program, look to optimize the growth, development and well-being of children. Most importantly, in BC, there is a

provincial emphasis on the importance of an integrated and comprehensive approach to optimize development for young children.

3.2.6 The Illinois DCFS Integrated Assessment Program

The Illinois DCFS has developed a new program which branches off of the ECP 1998, called the Integrated Assessment Program. The program model requires an in-depth assessment of all eligible children of all ages when they enter out-of-home care (Stahmer et al., 2006). This is an important model to consider especially when comparing the success of the ECP 1998. If the Fraser Region would like to emulate the successful model of the Illinois DCFS, then these program characteristics must be carefully considered and in some cases, adopted.

4 METHODOLOGY AND DESCRIPTIVE RESULTS

4.1 Introduction

This section examines the methods employed in this study and the results of the analysis of data. Both qualitative and quantitative approaches were used to analyze and evaluate the Fraser Region's Early Childhood Screening program's effectiveness. While the study focused primarily on the blind data¹¹ provided by MCFD, the study also includes a literature review and elite interviews. The data were analyzed by cross tabulation analysis using SPSS statistical software. The data were provided blind by MCFD to protect the privacy of the children in care who participated in the program. The screening program gathered data from the program's inception on January 1, 2008 through to September 30, 2008.

Through the first nine months of the program, 236 of the Fraser Region's children in care were eligible for the comprehensive health and developmental screening. Children met the eligibility criteria of the program by reaching the ages of 18 or 36 months during the month the health screening was scheduled. Of the 236 children eligible for the program, 116 of the children in care took part in the comprehensive health assessment; 120 or 50.8 per cent of the eligible children did not participate in the health assessment for a variety of reasons. Some parents declined the health screening; some children were adopted out, or children moved out of the region. Therefore, the sample size for this study is 116 (n=116). From the study's sample of 116 screened children, 82 were assessed and referred for further services and therapies as a result of the program. The actual referral a child receives when there are concerns in any of the health or developmental areas is known as the program's "red flag"¹² process.

A cross tabulation analysis using SPSS statistical software was performed on the provided data collected and provided by the MCFD screening program liaison. This process was viewed as the most effective manner for extracting relevant information useful for the program

¹¹ MCFD provided data, which the early childhood screening program's liaison collected about children who participated in the screening program. The data did not include the names of children, caseworker number or any identifiable information for the children.

¹² "red flag" is the term used in MCFD data that refers to the screening program's referral process. If the data indicated a red flag, children were referred for further services or therapies in the respective areas of concern.

evaluation. As this was a client-based evaluation, MCFD was interested in the rates of participation and the outcome rates¹³ (success rates). The outcome results for each child are categorized into whether the child did or did not receive a follow up as a result of the program's red flag process. Therefore, when coding the data, a child was given a "1" if a follow up occurred and a "2" if no follow up had occurred. Frequently, children received a red flag in more than one of the screened areas. When this was the case, if a child received a follow up in at least one of the health and developmental areas, the child was given a "1". However, a large majority of the cases, when a child was recommended for follow up in more than one area, all red flagged areas received a follow up. Thus, this evaluation examined the outcome rates through a broad lens and considered any follow up to be a success.

4.1.1 Elite Interviews

Elite interviews were conducted with those people who possess thorough knowledge of the Fraser Region's Early Childhood Screening program in order to provide background information on the program, help narrow the policy problem and develop and assess proposed policy recommendations. Interviews were conducted with MCFD staff; two ECD and Children and Youth with Special Needs (CYSN) Fraser Region consultants and the liaison for the Fraser Region's Early Childhood Screening program for children in care (See Appendix I)¹⁴. The interviews proved invaluable and instrumental in adding and evaluating policy recommendations.

4.1.2 Literature Review

A literature review was undertaken to aid in this study's policy problem formulation and was useful in providing policy recommendations for improved program effectiveness. The literature also provided solid background information on the importance of early intervention and early childhood development for children in care. The findings of the literature review have been provided in section 3. Similar screening programs do exist in Canada and the United States (US) and these are important to include in the discussion for comparative purposes. These programs are similar to the Fraser Region's Early Childhood Screening program for children in care yet

¹³ The outcome rates refer to the end result of the comprehensive assessment. Once a child was screened, if there was a referral or "red flag" identified, the outcome focused on whether the child received the indicated service or therapy. At this point of the process, all outcomes for the children are viewed as short and long-term successes.

¹⁴ See Appendix C for elite interview questions. The interviews with MCFD staff were conducted in March of 2009.

have subtle differences in terms of the health assessments such as the age at referral, and the specific health areas screened.

4.2 Descriptive Results

This section examines the descriptive results from the cross tabulation analysis performed on the Fraser Region's Early Childhood Screening Program's blind data provided by MCFD. Section 6.1 outlines the characteristics of the population studied including age, sex, identification, and the number of red flags identified. Section 6.2 provides information on the five screened health areas of the program. Section 6.3 provides information on the prenatal exposure rates to drugs and alcohol of the children in care.

4.2.1 Study Sample Characteristics

The Fraser Region's Early Childhood Screening program for children in care had 236 children eligible for screening from January 1, 2008 to September 30, 2008. One month before a child in care reaches the age of 18 or 36 months the child becomes eligible for the screening program. Of the 236 eligible children, 116 or 49.2 per cent of the eligible children in care were screened as indicated earlier; 120 children were not screened. It appears as though some children are getting lost in the process. From those 116 children who were screened, 82 or 70.7 per cent received a red flag and were referred for a follow up service in at least one domain. This number appears high but falls within the range of health conditions found for children entering care throughout North American foster care systems. Clyman et al., (2002) found that between sixty and eighty per cent of young children have at least one medical illness when they enter care and approximately 25 per cent have three or more chronic conditions (Clyman, Jones & Little, 2002). The number of children entering care who have developmental and emotional concerns is increasing and the age of these children is decreasing. Vig et al. (2005) found that 83 per cent of children aged 13 to 36 months entering care were identified with such issues. The following table 3 provides the study sample characteristics previously mentioned¹⁵.

¹⁵ See Appendix F for all crosstabulation results

MCFD Children in Care Screening Program - Study Sample Characteristics

VARIABLE		N = 116	% OF TOTAL N
Age	18 Months	65	56%
	36 Months	51	44%
	Total n = 116		
Gender	Male	56	48.3%
	Female	60	51.7%
	Total n = 116		
Identification	Aboriginal	58	50%
	Non-Aboriginal	58	50%
	Total n = 116		
Red Flag	Red Flag(s)	82	70.6%
	No Red Flag(s)	34	29.3%
	Total n = 116		

Table 1 - MCFD Children in Care Descriptive Statistics (Source: MCFD Early Childhood Screening Program Blind Data, 2008-2009)

4.2.2 Screening Results

This section provides the results of the screening program's five key health areas: vision, dental, audiology (hearing), developmental (physical and social emotional), and immunizations.

4.2.3 Vision Screening Results

Vision screening results from the provided MCFD blind data were coded into four different categories: (1) Completed and Passed: describes whether a child completed and passed the vision screening without any concerns, (2) Red Flag: describes whether a red flag was indicated for follow up services and therapies, (3) Not Completed: in some cases, a vision screening was not completed for the child, and (4) Under Doctor's Care: indicates that a child is already seeing an ophthalmologist¹⁶ for his or her condition. Those under doctor's care have had an assessment and do not participate in the screening. Vision screening was able to capture results for all 116 children who participated in the program.

Vision Screening Results By Age

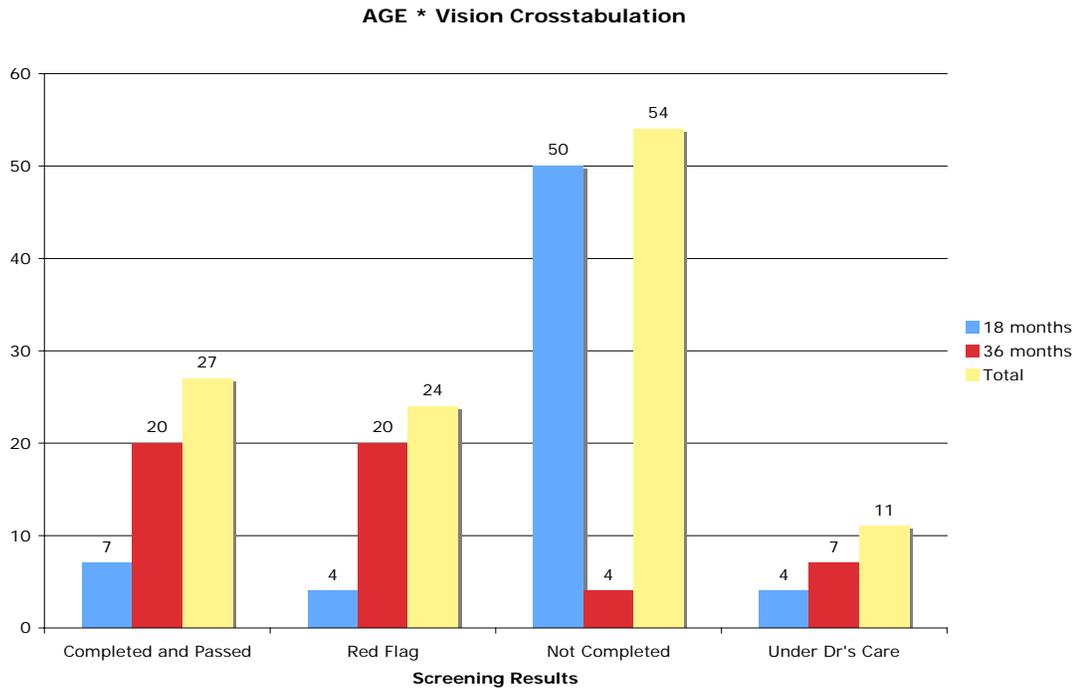


Figure 4 - Screening Program Vision Results (Source: MCFD Blind Data, 2008-2009)

Figure 4 captures the vision results for the screening program. A total of 27 children completed and passed the vision test without any concerns. However, 24 children or 20.1 per cent of the children who participated were referred for a vision follow up. Perhaps, just as startling is the number of children who did not complete the vision screening. When asked why

¹⁶ Ophthalmologist also known as an eye doctor

this number of children did not complete the vision testing, the MCFD screening program liaison cited a child's non-compliance as the main reason. In order to complete the eye test, a child must remain still for a few minutes and this has proven difficult in many circumstances. 54 children or 46.6 per cent of the children did not complete the vision screening. The number of children who were already under the continuous care of an eye doctor was 11 or 9.5 per cent. Table 4 contains the information mentioned above.

Vision Screening Results for All Children (n=116)

RESULT	N = 116	% OF N
Completed and Passed	27	23.3%
Red Flag	24	20.1%
Not Completed	54	46.6%
Under Dr's Care	11	9.5%

Table 2 - Vision Screening Results (Source: MCFD Blind Data, 2008-2009)

4.2.4 Dental Screening Results

Dental screening results from the provided MCFD blind data were coded into five different categories: (1) Completed and No Concerns: describes whether a child completed and passed the dental screening without any concerns, (2) Red Flag: describes whether a red flag was indicated for follow up services, (3) Not Completed: in some cases, a dental screening was not completed for the child, (4) Under Doctor's Care: indicates whether a child is already seeing a dentist, and (5) High Risk for Decay and those already in the Fluoride Varnish program: this category combines those children who are at risk for decay and those children who are already involved with Fraser Health's fluoride and varnish program. The dental screening captured results for all 116 children who participated in the program. Figure 5 provides the results of the dental screening.

Dental Screening Results By Age

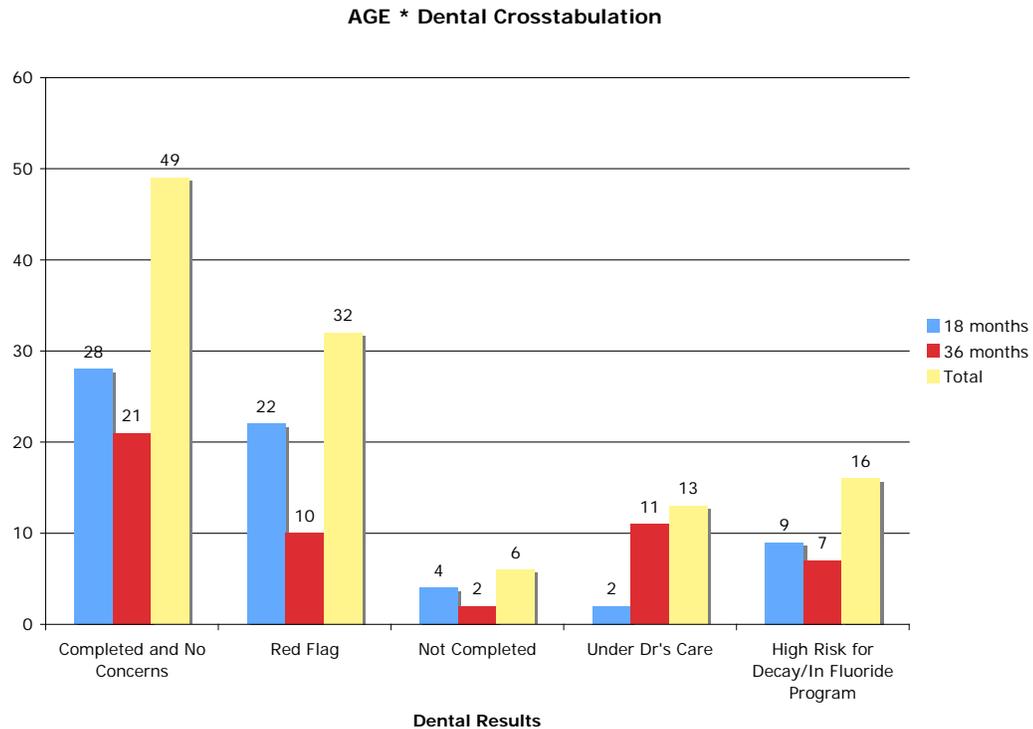


Figure 5 - Screening Program Dental Results (Source: MCFD Blind Data, 2008-2009)

Figure 5 captures the dental results for the screening program. 49 total children completed and passed the dental examination without any concerns. However, 32 children or 27.6 per cent of the children who participated were referred for a dental follow up. Only 6 or 5.2 per cent of the children did not complete the dental screening and suggests that the dental screening is proving most effective in its reach and access for children. The reason for this has to do with the assessment process. Health care professionals do a visual assessment of the child's teeth and then use a swab to coat the child's gums with fluoride treatment, which has proven to be effective as it does not cause the child much trauma. 13 or 11.2 per cent of the children were already seeing a dentist for their condition(s). 16 or 13.8 per cent of the children were either high risk for decay or already involved in Fraser Health's fluoride program. The next table illustrates the previously mentioned statistics.

Dental Screening Results for All Children (n=116)

RESULT	N = 116	% OF N
Completed and No Concerns	49	42.2%
Red Flag	32	27.6%
Not Completed	6	5.2%
Under Dr's Care	13	11.2%
High Risk for Decay/In Fluoride Program	16	13.8%

Table 3 - Dental Screening Results (Source: MCFD Blind Data, 2008-2009)

4.2.5 Hearing (Audiology) Screening Results

Hearing (audiology) screening results from the provided MCFD blind data were coded into three different categories: (1) Completed and Passed: describes whether a child completed and passed the hearing (audiology) screening test without any concerns, (2) Red Flag: describes whether a red flag was indicated for follow up services, (3) Not Completed: in some cases, a hearing (audiology) screening was not completed for the child. The hearing (audiology) screening captured results for all 116 children who participated in the program. Figure 6 provides the results of the hearing (audiology) screening.

Hearing (Audiology) Screening Results By Age

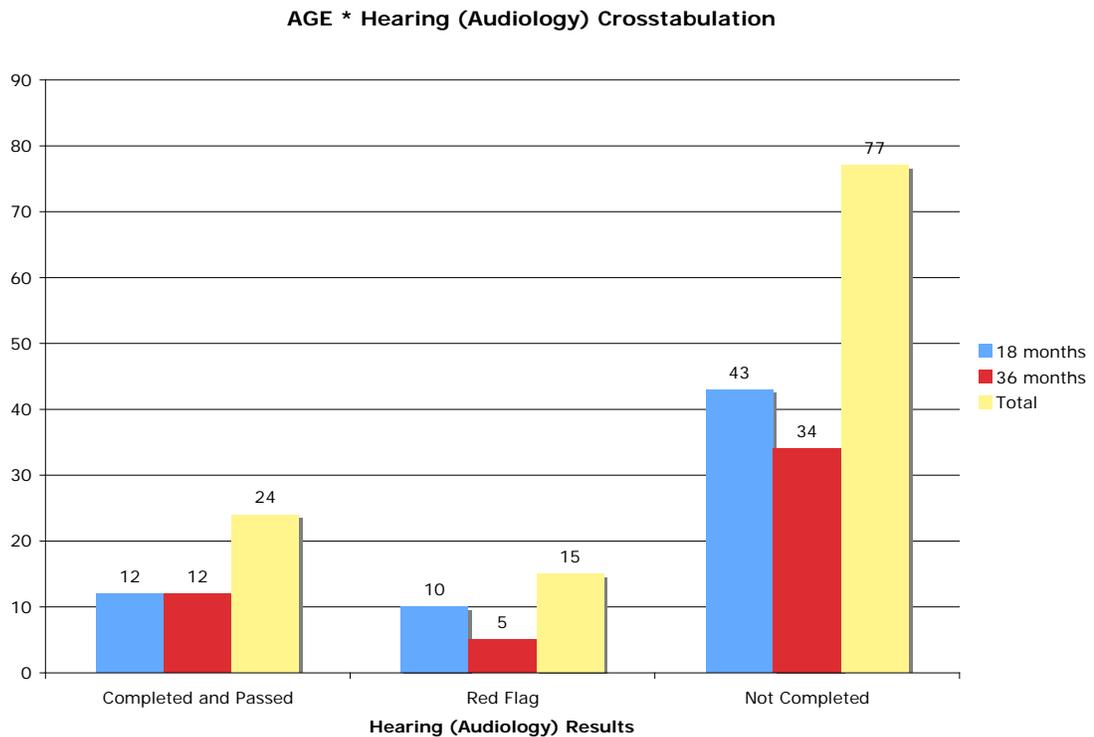


Figure 6 - Screening Program Hearing (Audiology) Results (Source: MCFD Blind Data, 2008-2009)

Figure 6 captures the hearing (audiology) results of the screening program. 24 total children completed and passed the hearing (audiology) examination without any concerns. 15 of the children or 12.9 per cent of the children were referred for a hearing (audiology) follow up. However, 76 or 65.5 per cent of the children did not complete the test. As indicated earlier, when the program began, the audiology department initially planned to provide screening for audiology using audiometric equipment. However, this decision was changed part way through the program and children were referred to the Fraser Health Audiology Program based on case finding only.¹⁷ Professional health care staff also made reference to the environment where the testing occurred.

¹⁷ Screening uses a validated instrument whereas case finding uses questions about parental concerns to identify issues.

Concerns surrounding the noise levels at the hub sites limited successful testing¹⁸. Despite the reasons for this attrition, the results indicate that there is room for improvement in this screening area. Table 6 illustrates the information mentioned on the hearing (audiology) results.

Hearing (Audiology) Screening Results for All Children (n=116)

RESULT	N = 116	% OF N
Completed Passed	24	20.1%
Red Flag	15	12.9%
Not Completed	77	66.4%

Table 4 – Hearing (Audiology) Screening Results (Source: MCFD Blind Data, 2008-2009)

4.2.6 Developmental (Physical and Social Emotional) Screening Results

The developmental screening has two components to it: The first area of developmental screening examines the child’s physical development. The Ages and Stages Questionnaire (ASQ), completed by foster parents, measures a child’s physical progress. For example, by certain ages, children should be holding their heads up or crawling. The questionnaire measures the progress and provides a score based on caregiver response. Those children who score below the normal development range will be referred to the Infant Development Program (IDP), the Aboriginal Infant Development Program (AIDP), a local Child Development Center (CDC), or Fraser Health Assessment Network (FHAN) for further service. The second area of the developmental screening examines the child’s social-emotional development. Similarly, progress is measured by the Ages and Stages Questionnaire – Social-Emotional tool (ASQ:SE) (See Appendix D for both questionnaires). The results from the MCFD blind data were coded into five different categories for each area: (1) Completed and No Concerns (child completed and passed the developmental screening test without any concerns); (2) Red Flag (a red flag was indicated for follow up services); (3) Not Completed (in some cases, a developmental screening was not completed by the caregiver of the child); (4) Agency Already Involved: (child is already involved with one of the previously mentioned agencies), and (5) Unknown (no information was

¹⁸ Interview with MCFD ECD Consultant, Susan Whittemore (March 2009).

provided to the MCFD screening program liaison). Figures 7 and 8 provide the results of the physical and social-emotional developmental screening respectively.

Developmental (Physical) Screening Results By Age

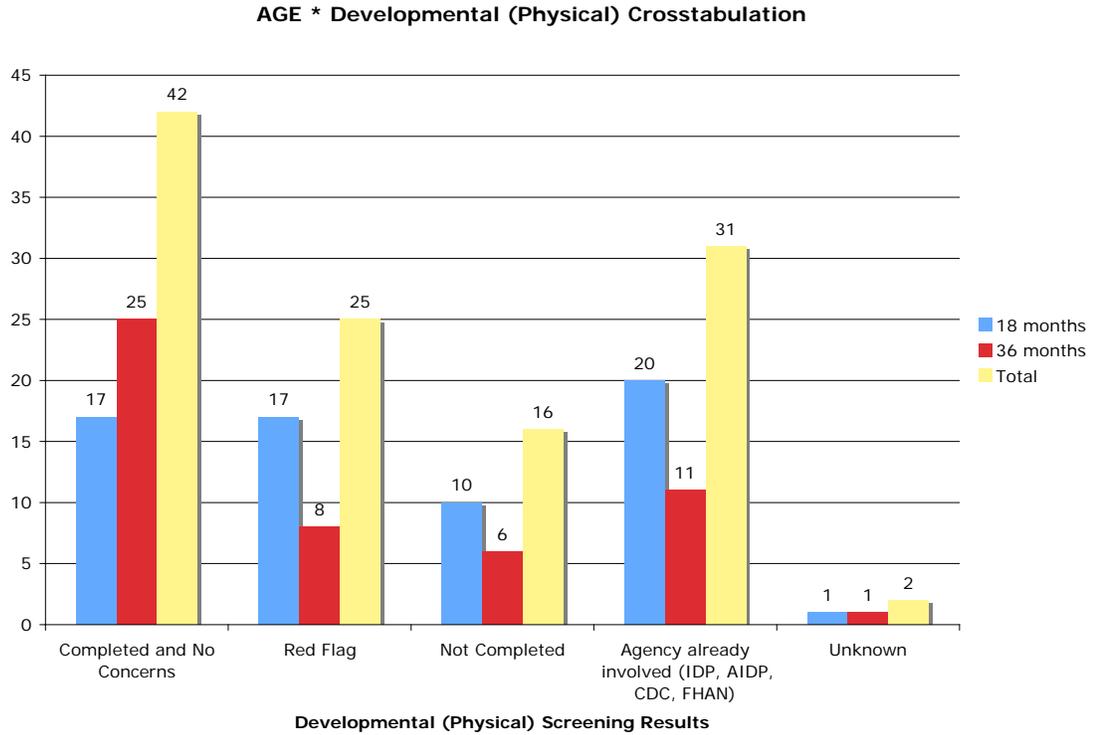


Figure 7 – Screening Program Developmental (Physical) Results (Source: MCFD Blind Data, 2008-2009)

Figure 7 captures the developmental (physical) results of the screening program. The ASQ was completed for 42 total children without any concerns being raised. 25 or 21.6 per cent of the children were referred for a follow up. The questionnaire was not completed for 16 or 13.8 per cent of the children. 31 or 26.7 of the children were already involved with an agency at the time of screening. Information was unavailable for 2 of the children, which indicates good cooperation by foster parents taking the time to complete the questionnaire. Table 7 provides the information previously mentioned.

Developmental (Physical) Screening Results for All Children (n=116)

RESULT	N = 116	% OF N
Completed and No Concerns	42	36.2%
Red Flag	25	21.6%
Not Completed	16	13.8%
Agency Already Involved	31	26.7%
Unknown	2	1.7%

Table 5 – Developmental (Physical) Screening Results (Source: MCFD Blind Data, 2008-2009)

Developmental (Social-Emotional) Screening Results By Age

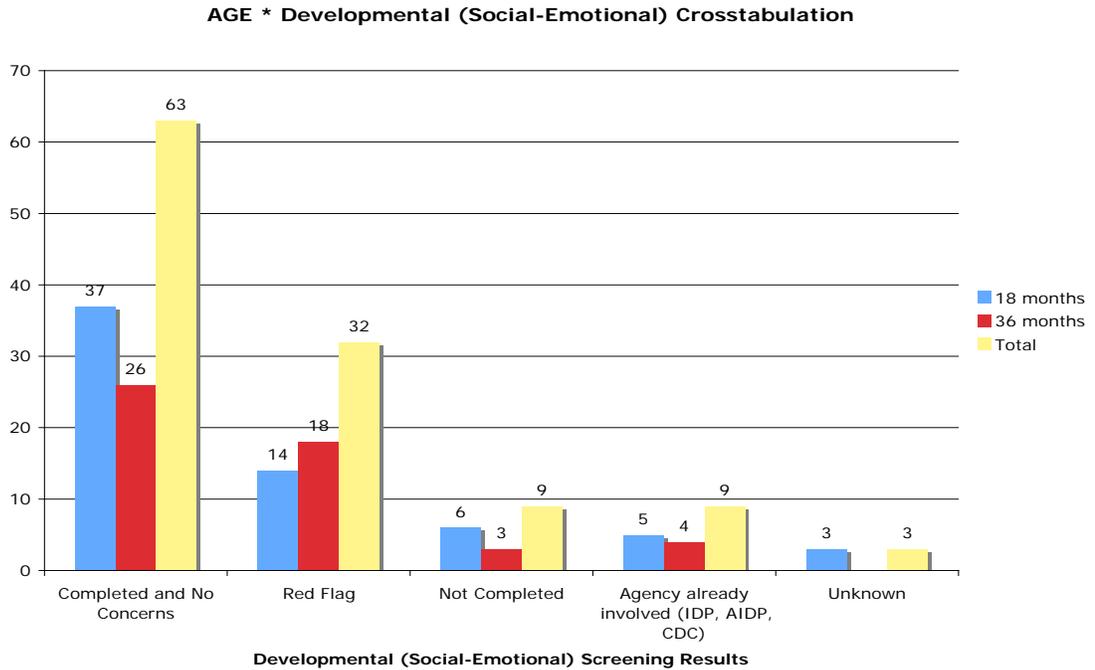


Figure 8 - Screening Program Developmental (Social-Emotional) Results (Source: MCFD Blind Data, 2008-2009)

Figure 8 captures the developmental (social-emotional) results of the screening program. The ASQ-SE was completed for 63 children without any concerns being raised. 32 or 27.6 per cent of the children received a red flag as a result of the questionnaire completed by a foster parent. On the other hand, the questionnaire was not completed for 9 or 7.8 per cent of the children. This again indicates good cooperation by foster parents. Information was unavailable for 3 of the children. Table 8 below provides the information previously mentioned.

Developmental (Social-Emotional) Screening Results for All Children (n=116)

RESULT	N = 116	% OF N
Completed and No Concerns	63	54.3%
Red Flag	32	27.6%
Not Completed	9	7.8%
Agency Already Involved	9	7.8%
Unknown	3	2.6%

Table 6 – Developmental (Social-Emotional) Screening Results (Source: MCFD Blind Data, 2008-2009)

4.2.7 Immunization Screening Results

Immunization screening results from the provided MCFD blind data were coded into three categories: (1) Yes, a child received an immunization at the health screening, (2) No, the child did not receive an immunization, and (3) Unknown: there was no data provided as to whether a child received an immunization.

This is an area where the numbers have provided more questions than answers for the researcher. The last immunization a child would have received prior to kindergarten (before the screening program) was provided at 18 months of age. An 18 month-old child who received an immunization may have been up to date at the time. They may have been receiving their routine immunizations at the correct time. The more relevant data to consider are for the 36 month-old children. Those 36 month-old children who received their immunizations on the screening date

were not up to date. This shows that these children missed immunizations that other children would have received. Figure 9 provides the results of the immunization screening and contains data on the children who were 18 and 36 months of age at the time of the screening. However, it is important to note that the numbers for the 36 month-old children is considered in table 9 below because 18 month-old children were likely up to date with their immunizations.

Immunization Screening Results By Age

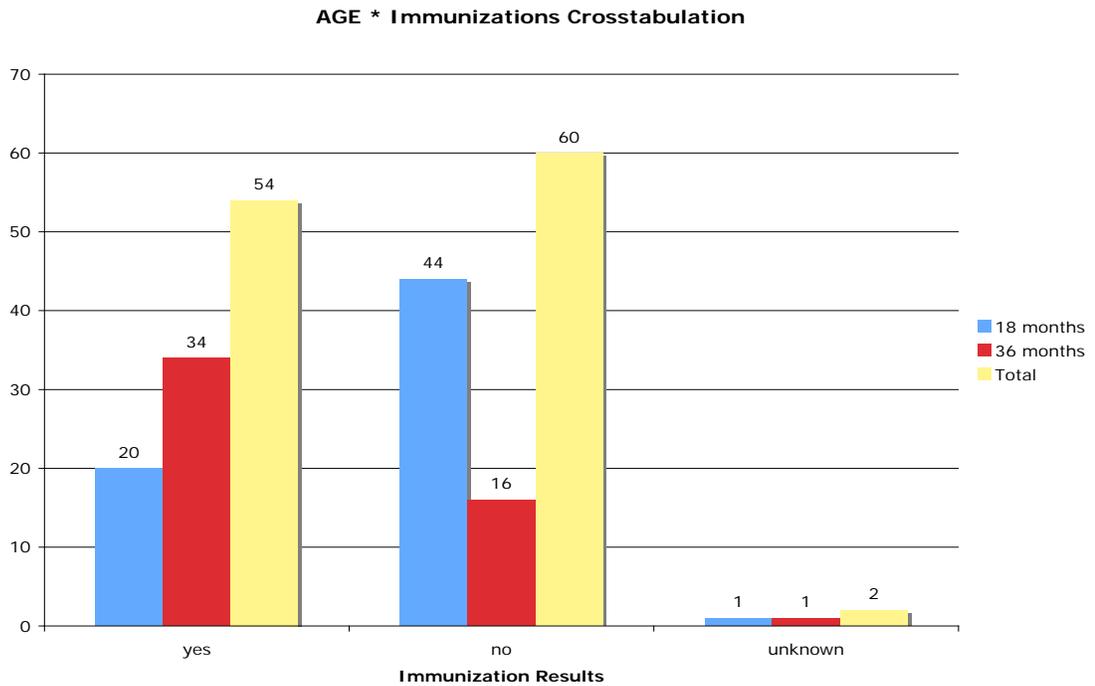


Figure 9 - Screening Program Immunization Results (Source: MCFD Blind Data, 2008-2009)

Immunization Screening Results for children 36 months (n=51)

RESULT	N = 51	% OF N
Yes	34	66.7%
No	16	31.4%
Unknown	1	1.9%

Table 7 – Immunization Screening Results (Source: MCFD Blind Data, 2008-2009)

The screening program's immunization indicates that 66.7 per cent of the 36-month-old children received their immunizations at the time of screening. Meanwhile, 31.4 per cent of the 36-month-old children did not receive their immunizations. This is a profound number because it shows that these children missed their immunizations that other children would have received otherwise. This raises questions as to why some children receive their immunizations while others do not. Perhaps, this is a question of access for those parents with children, which may require increased support from FH and MCFD. The data for one child was unavailable.

4.2.8 Alcohol and Drug Exposure Rates of the Fraser Region's Children in Care

Understanding the prenatal exposure rates among the child in care population illustrates how vulnerable, medically fragile and pre-disposed to developmental delay children are when they enter care. This adds yet another reason as to why early intervention strategies for children in care are needed. Figure 10 lists the exposure rates for the Fraser Region's children in care.

Exposure Rates By Age

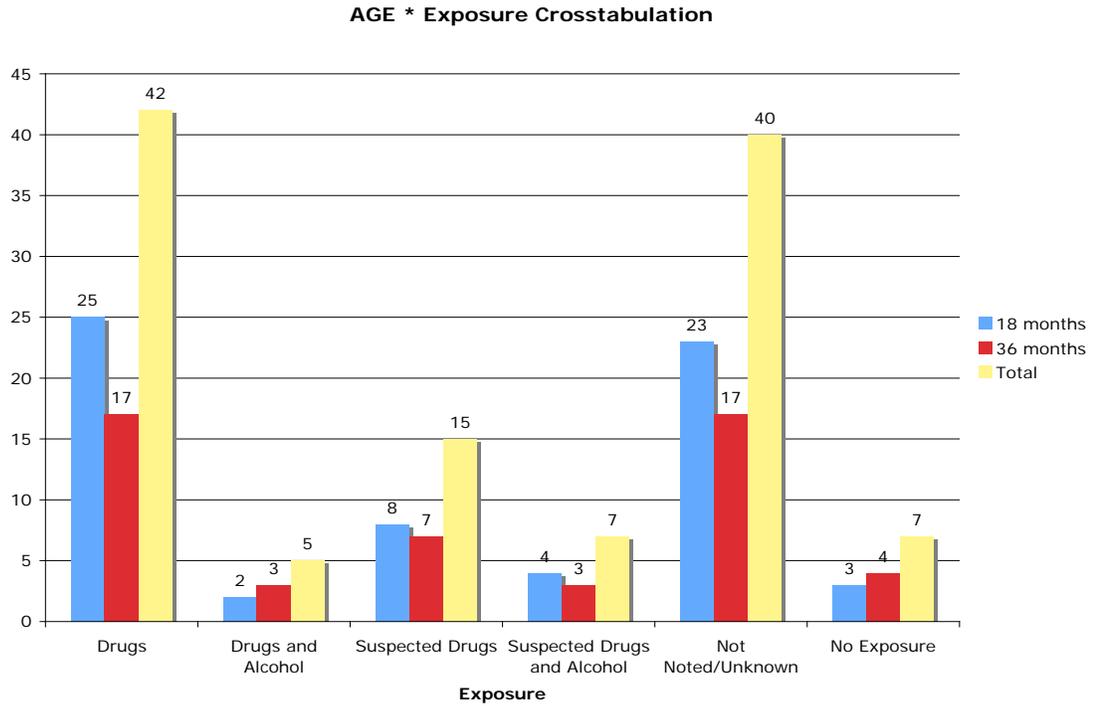


Figure 10 - Screening Program Exposure Rates (Source: MCFD Blind Data, 2008-2009)

Exposure Rates for All Children in Care Aged 18 and 36 Months (n=116)

RESULT	N=116	% OF N
Drugs	42	36.2%
Drugs and Alcohol	5	4.3%
Suspected Drugs	15	12.9%
Suspected Drugs and Alcohol	7	6.0%
Not noted/Unknown	40	34.5%
No Exposure	7	6.0%

Table 8 – Exposure Rates for All Children in Care Aged 18 and 36 Months (Source: MCFD Blind Data, 2008-2009)

These results are of considerable concern. It is likely that the number of children with special needs is related to these findings. Exposure rates of children who participated in the program were collected by the MCFD screening program liaison. The “drugs” and “drugs and alcohol” categories include information that was confirmed by testing or admission by natural parent. The suspected categories were noted by social workers as “probable” because the parents had histories of alcohol and drug abuse. The “Not noted/Unknown” category indicates that information was unavailable. The “No Exposure” category indicates that the child has no known exposure to drugs or alcohol. These are startling figures. If we combine the known and suspected categories then 59.5 per cent of the children in care have been exposed in some form to drugs and alcohol. This also aligns with the conclusions from the literature that a large majority of children are entering care with high special needs. In contrast, a mere 6 per cent of the children in care studied have no known exposure to drugs and alcohol.

4.3 Summarizing the findings

The analysis of the data has revealed important findings about the first year of the screening program:

- The analysis has shown that there are low participation rates, which has been attributed to children being adopted out of care, children moving out of the region and parents declining the health screening. The policy focus around this issue will focus on increasing participation going forward with the program.
- The process for the dental screening process has proven to be very successful to date. Only 6 of the children did not complete the screening, which is a shining endorsement for foster parent’s ability to get their children to screenings. The dental screening process is also not as traumatic or anxious for children completing, which provides reason for the effectiveness.
- The audiology screening was changed part way through the program so the data are not completely reliable. This is because Fraser Health switched to case finding (addressing parental concerns) rather than the audiometric equipment to test hearing. In subsequent years, consistency will be needed to secure accurate data for the children participating in the screening program.
- The completion rates of both the ASQ and ASQ-SE questionnaires were reasonably high considering this was the first year of the program. This is a direct indication of the foster

parents' involvement in the program as they are the ones who complete the questionnaires for their children.

- The immunization screening is another area that must be addressed in subsequent years. Data collection methods need to be refined and more specific in order to capture accurate data. More attention must be concentrated on the 36 month-old children entering care as these are the ones who may have missed their immunizations. The data shows that 31.4 per cent of 36 month-old children were not immunized and this must be addressed.
- The exposure rates of children entering care are of considerable concern. When considering those children with exposure to drugs and alcohol and those suspected of drugs and alcohol, 59.5 per cent of children involved in the screening program have had some form of exposure. This speaks to the importance of early intervention. From the literature reviewed, early intervention increases the probability of positive outcomes for children provided problems are identified early enough.

5 POLICY ALTERNATIVES

This section reviews the current state of the Fraser Region's Early Childhood Screening program for children in care and provides four policy alternatives to improve the effectiveness of the screening program. The policy alternatives were generated by way of literature review, elite interviews and the blind data provided by MCFD. Based on my research, it is reasonable to conclude that the participation rate for the first year of the program can be considered poor. The literature on similar programs shows higher program participation rates in other jurisdictions with different policy and lower participation rates with similar policy. Thus, the proposed policy alternatives focus on increasing the participation rates in the screening program.

5.1 Objectives

The objectives of the policy alternatives are to address the findings revealed from the data analysis in section 4:

- Increase participation rates in the program in subsequent years.
- Better completion rates for each assessment (vision, dental, audiology, developmental (physical and social emotional) and immunizations).
- An effective follow up process.
- The importance of early intervention.

5.2 Current Program: The Status Quo

This option involves maintaining the status quo of the current screening program. This is a viable policy alternative. As the program enters the second year of operation, the initial growing pains may work themselves out as those involved in the system become more familiar with their roles, and with the goals and processes of the program.

5.2.1 Status Quo: Critical Issues to Consider

The following assumptions are required if the status quo is the chosen policy direction:

- There are a variety of reasons as to why an eligible child in care may not have received an assessment: (1) a child was returned home, (2) a child was placed for adoption, or (3) a child moved out of the Fraser Region.
- Participation rates will likely remain low when considering the transience of the child in care population.
- From the outcome data, 82 of the 116 children received a red flag in at least one of the health areas. Of the 82 children who received a red flag, 56 or 68.3 per cent of the children received a follow up service or therapy in at least one domain.
- As this is the first year of the program, 68.3 per cent is the baseline for the outcome data. This suggests that the program has a satisfactory success rate once children have been screened and referred. The question to consider is: *if the program participation rate increases, will the number of children with red flags and subsequent follow up service increase as well if the current program is maintained?*

5.3 Alternative 1: Mandatory Screening of all Children in Care Aged 18 and 36 Months in the Fraser Region

The current structure of the screening program saw 49.6 per cent of the eligible children receive a comprehensive health assessment. This suggests that there may be a gap in access for the eligible children. The research also indicates that children may not receive their health screening for a variety of reasons. Children may be adopted out of care, they may move out of the region or parents may decline the screening. Currently, there is no policy in place that promotes mandatory screening for children in the Fraser Region. The screening program is continually evolving and adapting to the better suit the children's needs. Although, no concrete policy exists in place that promotes mandatory screening; health and MCFD staff work diligently within the policy parameters to include children in the screening program process.

The Child Welfare League of America (1988) and the American Academy of Pediatrics (1994) recommend that all children receive a comprehensive medical, developmental and mental health assessment within one month of entering care (Clyman et al., 2006). Certainly, implementing a mandatory screening policy for all of the Fraser Region's children in care aged 18 and 36 months will most likely increase participation rates.

5.3.1 Alternative 1: Critical Issues to Consider

This section lists considerations associated with implementing a mandatory screening policy for the current early childhood screening program. These considerations were developed through elite interviews, extensive literature reviews and analysis of MCFD blind data:

- There would be an increase in the program’s participation rate, as all eligible children in care would receive a comprehensive health and developmental screening assessment.
- The Illinois DCFS ECP 1998 has a mandatory screening policy in place for all children who enter out-of-home care. This has resulted in 94 per cent of children who enter care having received a comprehensive health assessment. When compared to jurisdictions with limited or no mandatory policy for screening, the ECP 1998 number is significantly greater.
- Mandatory screening fits with the Government of BC’s Framework for Action:
 - The CYSN Framework for Action includes a set of values and strategies to guide collaborative work among health, education and social service sectors in the creation of an integrated, accessible continuum of quality services for children and you with special needs and their families (Government of BC, 2009).

5.4 Alternative 2: Revise Standards for Foster Homes 1998

This alternative looks to revise “Standard D.6 Health” of the MCFD Standards for Foster Homes 1998, specifically Standard D.6.6. Foster parents are not only crucial to the health and wellbeing of the children they care for but also for the success of the Fraser Region’s Early Childhood Screening program for children in care. Foster parents provide frontline one to one service to a vulnerable population and they share identical outcome goals for children in their care with Fraser Health and MCFD staff. Often, policy recommendations and data collection systems are not able to validate foster parents’ contributions. Foster parents fulfil the role of caring consistent adult that current literature documents as being essential for all children, but especially for children in care. This alternative acknowledges the integral role foster parents play in optimizing healthy growth and development for children in their care. The Standards for Foster Homes: Caregiver Practices (Government of BC, 1998) is the area where a direct reference to the screening program would be a benefit to the program and likely increase the program participation rate.

Standard D.6.6 Within the context of the child’s comprehensive plan of care, the caregiver arranges for routine medical and dental care for the child with the child’s identified health care providers (Government of BC, 1998).

This section makes reference to the comprehensive plan of care, which is a document that speaks to all the life domains of a child in care. The plan includes the social, residential, health, educational, recreational and cultural concerns for each individual child and is updated on an annual basis. The comprehensive plan of care calls for the documentation of routine medical and dental care. The intent of the plan is identical to the intent of the Fraser Region’s Early Childhood Screening program as both seek to improve overall outcomes for children in care. It will be a natural fit with the requirements of the plan of care to fulfil the requirement for routine medical and dental care. By including reference to the Fraser Region’s Early Childhood Screening program for children in care in the standard, foster parents across the province will gain increased knowledge of the program, children will receive routine and comprehensive screening and follow up and future children in care will benefit from the fact that screening is a standard requirement.

5.4.1 Alternative 2: Critical Issues to Consider

This section lists the considerations associated with revising the Standards for Foster Homes 1998. These considerations were developed by analysis of MCFD blind data and through elite interviews with MCFD ECD/CYSN staff¹⁹:

- The Standards for Foster Homes 1998 is a provincial document given to all foster parents throughout BC. As foster parents are provided with extensive training that is developed around the standards, there is no other health screening program similar to the Fraser Region’s in the province. This revision may be somewhat confusing to those outside the Fraser Region.
- Perhaps, prior to revising the Standards for Foster Homes 1998, the Fraser Region can implement a region wide foster parents guide that explicitly states the importance of the screening program and how the goals of the program align with the Standards for Foster Homes 1998.

¹⁹ Interview with Ken Kabool, Fraser Region MCFD ECD consultant (March 2009).

5.5 Alternative 3: Rely on Basic Medical Check

This alternative looks to revert to the process prior to 2006 for a child's health check up. Recall that children do receive a basic medical exam when they enter care; however, this is by no means as comprehensive and thorough as the current screening program²⁰. Children would see a doctor upon their initial entry into care. The doctor would then perform a basic medical check up on the child and complete medical checklist for the child's care worker to include in the child's file. In some cases, the basic medical check up may innocuously overlook a condition that a child may have. This unintended oversight may lead to a child not receiving a necessary service or therapy that would be crucial to healthy development.

5.5.1 Alternative 3: Critical Issues to Consider

This section lists the considerations associated with eliminating the current screening program. These considerations were developed through elite interviews with MCFD ECD/CYSN staff and analysis of MCFD blind data:

- 68.3 per cent of the children in care had a follow up service as a result of the screening program's red flag process²¹.
- The question to consider is: *would these children have received the services they required as early on in their development without the Fraser Region's Early Childhood screening program for children in care?*
- Early intervention works. Considerable research and studies have formed this conclusion. Younger children are far more responsive to early intervention strategies.
- Prior to the Fraser Region's Early Childhood screening program, in BC, vision and hearing screening typically took place when children reached kindergarten at age 5. At this point in a child's development, they may have already fallen behind their peers in developmental progress.
- Children in care are an already disadvantaged and high-risk group. When compared to the general population, the prevalence of special needs of children is substantially greater.

²⁰ The basic medical check up involves a child seeing a doctor for a quick visual assessment, which is not as thorough as the screening program. Once the child's assessment is complete by the doctor, a medical summary form is completed and sent to the child's social worker.

²¹ 56 of the 82 children with a red flag received a follow up in at least one domain as a result of the screening program. See Appendix E for all results.

- In Canada, the number of children in care is 76,000 and this number is steadily growing (Canadian Paediatric Society, 2006). This is an important number to remember as literature indicates that the 0 to 6 age cohort form the largest number of children entering care. Further, the number of children with developmental concerns is also increasing.
- Infants form the largest cohort entering care and this population remains in care the longest.
- If not, medical and behavioural conditions tend to increase over time among the child in care population if not addressed.
- There is an increasingly young population entering care with higher than average special needs. The long-term outcomes of children “aging out” of care are well documented. In most cases, this segment of the population has poor financial and social outcomes.

6 EVALUATION OF POLICY ALTERNATIVES

This section gives an evaluation of maintaining the status quo and three proposed policy alternatives. Section 8.1 describes the five criteria used to evaluate the ability of each policy alternative to improve the effectiveness of the Fraser Region’s Early Childhood Screening program²². Section 8.2 provides the assessment of each policy option relative to the criteria set out in section 8.1. The policy matrix provides the necessary information for an evaluation of the status quo and three policy alternatives, while considering criteria, literature, elite interviews and MCFD blind data.

6.1 Definitions and Measurement

The table below provides a list of the criteria used to evaluate the proposed policy alternatives.

CRITERIA	DEFINITION		MEASUREMENT
Effectiveness	To what extent will the proposed policy result in a significant improvement to the health and wellbeing of the Fraser Region’s children in care population?		High = 3 Medium = 2 Low = 1
Equity	Is the proposed policy equitable for all parties involved?	Children in Care	Yes = 1 No = 0
		Foster Parents	Yes = 1 No = 0
Public and Interest Group Acceptability	What are the political implications of this proposed policy?		High = 3 Medium = 2 Low = 1
Administrative Capacity	Do MCFD and FH have the capacity to	MCFD	High = 3 Medium = 2 Low = 1

²² The criteria used in this study were determined to provide the best assessment of each policy alternative and are not an extensive list by any means.

	implement the proposed changes?	FH	High = 3 Medium = 2 Low = 1
Cost	What are the costs associated with each proposed policy alternative?	Short term	High = 1 Medium = 2 Low = 3
		Long term	High = 1 Medium = 2 Low = 3

The purpose of the criteria and measurement list is to provide a tool to evaluate the policy alternatives. For the evaluation of each policy alternative, *Effectiveness* refers to whether the proposed policy alternative will result in an improvement to the screening program. *Equity* looks at whether the proposed policy alternative is an equitable approach for the parties involved (MCFD, FH, children in care). *Political acceptability* tests the political strength of the proposed policy alternative. *Administrative capacity* refers to the feasibility of the policy alternative. Is this alternative viable in terms of available space, time, resources, and staffing? *Cost* considers the potential fiscal and social costs associated with the proposed policy alternative in the short term and the long term.

6.2 Assessment of Policy Alternatives

This section presents an assessment of how each policy alternative listed in section 7 measures against criteria listed in section 8.1. The criteria outlined in the previous section are used as measures to evaluate each alternative. The data included in this assessment result from interviews with MCFD ECD/CYSN staff, literature reviews and the blind data provided by MCFD. The purpose of the following policy matrix is to compare the proposed alternatives in relation to one another.

6.3 Review of Policy Alternatives

The following section is a summary of the alternatives listed in the policy matrix from section 8.3.

6.3.1 The Status Quo

Based on the policy alternatives matrix, the status quo is a viable option, ranking below alternative 1 and 2. This is the first year of the program's operation and the issue of low participation rates may work itself out over time as social workers, health care professionals and foster parents become more familiar with the program. Children who did participate in the program were provided with a comprehensive health assessment that they otherwise may not have received. 82 of the 116 children screened were identified with at least one red flag in one of the domains. Of the 82 children who received a red flag as a result of the program, 56 ended up with follow up service. The status quo has aided in early identification and intervention for 56 children in care who may not have had these conditions identified if the program had not existed.

6.3.2 Mandatory Screening of all Children in Care Aged 18 and 36 Months

The mandatory screening of all children aged 18 and 36 months in care is a viable alternative to consider. The alternatives matrix scored this option the highest based on the criteria. This has been echoed in the literature and supported by elite interviews. The policy matrix in section 8.3 scores this alternative identically to the status quo option. If we consider the impact mandatory screening would have on the effectiveness of the program, we could expect to see an increase in participation rates. A similar comprehensive assessment program for foster children exists in the US where a mandatory screening policy is in place. The result of this policy has seen the majority of children receive their assessments when compared to those jurisdictions with limited to no policy in place.

6.3.3 Revise "Standard D.6 Health" of the MCFD Standards for Foster Homes 1998

The policy matrix in section 8.3 scores this alternative the second highest based on the criteria presented in section 8.1. Revising Standard D.6.6 of the MCFD Standards for Foster Homes 1998 to include direct reference to the Fraser Region's Early Childhood screening program as an essential component of the child's comprehensive plan of care would likely increase program participation rates. Such a revision would further emphasize the importance of early identification and intervention for children in care and identify the pivotal role foster parents play. Essentially, this emphasis on the program in the standards increases access to the program for children. In practical terms, foster parents are responsible for ensuring that the child physically attends the screening. The physical appearance at the screening site is an issue when

considering the MCFD blind data. Recall, 116 of the 236 eligible children participated in the screening program.

However, the Standards for Foster Homes 1998 is a BC provincial document and as a result, is not specific to the Fraser Region. There are foreseeable challenges associated with this proposed action: (1) revising a provincial document is a time consuming process, and (2) it may be difficult to implement changes that are tailored toward a particular region.

6.3.4 Eliminate the Screening Program

Eliminating the screening program is *not* a viable alternative if improving the long-term outcomes of children in care is a priority. The literature on early intervention is clear on this issue. Young children are far more responsive to intervention in the early years of development. The child in care population in Canada is rapidly increasing and the age of children entering care is decreasing. This segment of the population enters care with higher than average prenatal exposure rates to drugs and alcohol. There is not only a need for an early intervention service for children in care there is an outright cry. Strategies to improve short and long-term outcomes for the children in care population must be addressed and implemented.

6.4 Policy Matrix

POLICY ALTERNATIVES		<u>Status Quo</u> Current Situation	<u>Alternative 1</u> Mandatory Health Screening	<u>Alternative 2</u> Revise Standards for Foster Homes	<u>Alternative 3</u> Rely on Basic Medical Check
CRITERIA					
Effectiveness		Low (1) the status quo will not improve program effectiveness or increase participation rates	High (3) program has proven to be successful with the children to date (>68%). Mandatory screening will only increase the number	High (3) another avenue to maintain and increase program participation rates. Emphasizes the importance of screening children for foster parents	Low (1) not as thorough a medical when child enters care. Has proven that certain conditions have been overlooked in the past
Equity	Children in care	No (0)	Yes (1)	Yes (1)	No (0)
	Foster Parents	No (0)	Yes (1)	Yes (1)	No (0)
Political Acceptability		High (3) Goal of the program is premised on improving health outcomes	High (3) academics and consultants agree that the program will produce positive results and outcomes for children in care	Medium (2) may appear to be adding more responsibility to an already full slate.	Low (1) given the importance of early intervention and the success of the current program. The results of this evaluation indicate that basic check not as thorough
Administrative Capacity	For MCFD	High (3) existing structure in place	High (3) structure and resources exist. This is a joint venture and parties have ability to handle influx	High (3) structure and resources exist.	High (3) not difficult
	For FH	High (3) similar to MCFD	High (3) FH has screening time slots open every month and could handle the influx of children	High (3) space and resources available	High (3) similar to MCFD
Cost	Short term	Medium (2) funding in place	Medium (2) start up costs	High (1) more resources needed and long process to amend the foster standards	Low (3) would reduce cost
	Long term	Medium (2) gaps in access	Low (3) early intervention decreases long term costs	Low (3) early intervention decreases costs	High (1) poor long term outcomes for children in care
	Totals	16	19	17	14

9 RECOMMENDATIONS

Based on this evaluation and analysis, the recommendation for the Fraser Region MCFD to pursue involves implementing a mandatory health screening policy for all children once they enter care within thirty days. It is important to place a set time frame so that children are not forgotten. Implementing this strategy will improve program participation rates, continue to emphasize the importance of early intervention and will continue to benefit the children of the Fraser Region. As we have discovered through this study, the health-screening program has been successful in setting benchmarks to measure future progress as well. Implementing a mandatory policy will surely benefit those children in care who at times may slip through the cracks and improve their short term and long term outcomes.

10 CONCLUSION

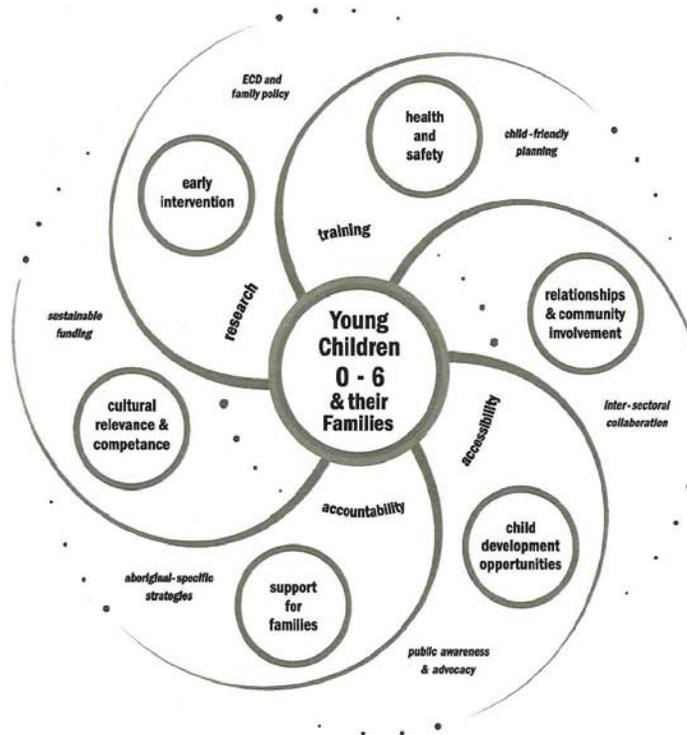
Early intervention is the key factor for the healthy development and growth of all children in care and especially for those in the Fraser Region. Strategies that promote and foster early intervention are critical if the health, optimal growth and improved outcomes for children in care are priorities. The majority of children who enter care are doing so with higher than average medical and behavioural needs when compared to the general population. The Fraser Region's Early Childhood Screening program for children in care is an innovative and effective strategy to address the needs of the children in care population. The most important number to take away from the first nine months is 56. This is the number of children who received a necessary service or therapy in at least one domain that they otherwise may not have received as a direct result of the program.

The purpose of this evaluation was to assess the progress of the program through the first nine months of operation from January 1, 2008 to September 30, 2009. Along with identifying progress in the health domains for children in care, the program has also set baseline data to which future progress can be measured. Despite the successes of the program, there is considerable room for improvement to be made in the future especially when we consider the low participation rate of eligible children in the first year of the program. This is the area for concern as less than 50 per cent of eligible children received the comprehensive health assessment provided by the program. The policy recommendations in this study focus on increasing the participation of children and suggest mandatory screening for all children in care aged 18 and 36 months as the most viable and feasible alternative for the Fraser Region to consider based on analysis.

APPENDICES

APPENDIX A

Early Childhood Framework FRASER REGION



"Healthy children supported by nurturing families and child-friendly communities."

July 2006



KEY COMPONENTS

Basic health & safety needs

- Freedom from violence & neglect
- Nurturing care & responsible adult supervision
- Nutrition & food security
- Affordable family oriented housing
- Clean air & water
- Economic security for families
- Access to health & dental care including mental health services
- Community safety & social cohesion
- Opportunities to play

Nurturing relationships & community involvement

- Parent/child attachment & bonding
- Intergenerational & neighbourhood support
- Opportunities to make friends & meet other families
- Opportunities to participate in community activities

Universal opportunities for healthy child development

- Family planning, prenatal, birthing & infant support & care
- Early identification of developmental delays including social-emotional concerns
- Parent-child interactive play opportunities
- Participation in early learning & care programs
- Focus on physical activity, oral language, emotional wellbeing, social responsibility & play

Universal supports for families

- Information & referral services
- Child development & parenting information
- Parent education
- Family support through community based family resource programs
- Affordable, high quality childcare options
- Peer mentoring, family counseling and mental health supports

Cultural relevance & cross-cultural competence

- Integration of cultural teachings, heritage language & elder participation
- Cross-cultural awareness & skill development
- ESL support for young children & their families
- Supports for new immigrant families to develop bi-cultural parenting models
- Outreach & ECD supports for new immigrant & refugee families

Early intervention services

- Assessment & services for children with special needs
- Supports for young children who have experienced violence & trauma
- Supports for parents with mental illness
- Outreach & access strategies for multi-barriered families
- Family development services

GUIDING PRINCIPLES:

- Strength based, holistic
- Child focused, family centred, community based
- Accessible
- Inclusive
- Honors diversity
- Research informed, evidence based
- Comprehensive continuum of universal and targeted services
- Collaborative, integrated approach
- Aboriginal control of Aboriginal specific ECD services
- Sustainable
- Accountable
- Collective responsibility



SUPPORTING STRATEGIES

- Public awareness & Advocacy
- ECD and family policy
- Child and family-friendly planning
- Aboriginal specific strategies
- Research
- Inter-sectoral collaboration
- Accessibility
- Training
- Sustainable funding
- Outcome-based evaluation

early childhood framework
FRASER REGION

FH and MCFD Strategic Commitment to ECD

As first steps, Fraser Health (FH) and Ministry of Children and Family Development - Fraser Region (MCFD) have agreed to:

1. Endorse and support the work of the ECD Community Tables and the Fraser Region Aboriginal ECD Network
2. Establish a Fraser Region Early Childhood Partners Council
3. Engage School Districts, local governments (planning, parks and recreation and public libraries) and other stakeholders
4. Based on two to three year planning cycles, jointly develop and implement regional priorities.

Joint priority areas identified in 2006:

- Developmental screening
- Early childhood/maternal mental health
- ECD hub models
- ECD communications/public awareness plan
- Accessibility issues



This document has been developed as a collaborative project of Fraser Health & the Ministry of Children and Family Development Fraser Region, in consultation with community and public stakeholders interested in the health, wellbeing and learning potential of children during their first six years of life. The purpose is to bring a comprehensive and coherent early childhood lens to future regional and community planning, service delivery and funding decisions in the Fraser Region.

Fraser Health and the Ministry of Children and Family Development are committed to the implementation of this framework. Community groups, school districts, businesses and all levels of government are invited to work towards making the Fraser Region ECD vision a reality for children and families.

Linda Bachmann, Fraser Health
PH: 604-613-6973 Email: linda.bachmann@fraserhealth.ca
Barbara Walsh, MCFD
PH: 604-586-4100 Email: barbara.walsh@gov.bc.ca

to view the full report go to: <http://www.fraserhealth.ca/News/Publications/ECD.htm>



APPENDIX B

Referral Form

Fraser Health Early Childhood Screening Program Children in Care Referral



Referral Guidelines for Social Workers

When you are notified that a child on your caseload is eligible for Integrated Screening services through the Fraser Health Early Childhood Screening Program, please do the following:

- Complete referral form.
- Complete Consent to Routine Medical Care form
- Fax both by the 30th of that month to Fraser Health contact at (604) 581-1543
- Place originals of referral and consent forms in Child Services file

The contact person (foster parent, etc) will then be contacted by a Public Health Nurse to book an appointment.

You will receive a summary form of screening outcomes and should discuss with the child's care team any follow up referrals or appointments required.

Information about Child

Child's Name: _____
 Date of Birth (Day/Month/Year) _____ Male _____ Female _____
 CS File Number: _____
 Personal Health Number: _____
 Child's Address: _____

Related Health Information

Include any relevant health information here (e.g. wears glasses, hearing aids, Cerebral Palsy, other developmental condition)

Contact Information for Appointment

Contact Name: _____ Home Phone: _____
 Relationship to child: _____ Work Phone: _____
 Cell Phone: _____

Referring Office Information

Social Worker Name: _____
 Office Address: _____
 Office Phone Number: _____
 Office Fax Number: _____
 Date: _____ Social Worker Signature: _____

APPENDIX C

Consent to Routine Medical Care



CONSENT TO ROUTINE MEDICAL CARE In accordance with Section 94 of the CFCSA

CHILD'S FULL NAME:	GENDER:
PERSONAL HEALTH NUMBER:	DATE OF BIRTH: <i>(Day/Month/Year)</i>

I, _____, the legal guardian of the above named child,
NAME OF LEGAL GUARDIAN (social worker)

consent to the routine medical care as follows:

EARLY CHILDHOOD SCREENING PROGRAM
IMMUNIZATIONS
APPLICATION OF DENTAL VARNISH

of the above named child to: _____
NAME OF CAREGIVER

This consent applies from _____ to _____
DATE CONSENT IS VALID DATE CONSENT EXPIRES
(Dependent on Child's Legal Status to a maximum of 1 year)

LEGAL GUARDIAN/SOCIAL WORKER SIGNATURE:	DATE: <i>(Day/Month/Year)</i>
LEGAL GUARDIAN/SOCIAL WORKER ADDRESS:	
TELEPHONE NUMBER:	

APPENDIX D

Screening Summary for Social Worker



EARLY CHILDHOOD SCREENING PROGRAM SCREENING SUMMARY FOR SOCIAL WORKER

Screening Date: _____

Social Worker	_____	Fax #	_____
Office Address	_____		
Child's Name	_____	Date of Birth	_____
		Age:	_____ months
CS File Number	_____	PHN#	_____
Public Health Nurse	_____	Health Unit	_____
Phone	_____	Fax	_____

1. VISION: Passed Did Not Pass
 Vision Referral Form given to caregiver
 Form to be completed by Eye Doctor
 Eye Doctor will fax results of eye examination to Health Unit

Other observations re: eye health: _____

Recommendations: _____

2. HEARING: Passed Did not hear all required sounds
 Referral sent to FH Audiology Program (Community)
 (Note: Caregiver will be contacted by Audiology Program staff to schedule appointment)

Recommendations: _____

3. DENTAL: Findings _____
 Fluoride Varnish Applied Referred to Dentist
 Referred to Fluoride Varnish Program
 (Note: Information given to caregiver about how to schedule a Fluoride Varnish appointment)

Recommendations: _____

4. DEVELOPMENTAL SCREENING (ASQ & ASQ:SE)

Ages and Stages Questionnaire (ASQ)
 Areas Screened: Communication, gross motor, fine motor, problem solving, and personal-social

Ages and Stages Questionnaire Social-Emotional (ASQ:SE)
 Areas Screened: Social-emotional (self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people)

- ASQ Appears to be doing well Needs further evaluation
 ASQ:SE Appears to be doing well Needs further evaluation

Actions Taken: _____

Recommendations: _____

5. Immunizations Up To Date Yes No

Action Taken: _____

Recommendations: _____

PHN Signature _____

APPENDIX E

Interviews:

- 1.) Susan Whittemore, Fraser Region MCFD ECD/CYSN Consultant (March 2009) – Coquitlam, BC
- 2.) Ken Kabool, Fraser Region MCFD ECD Consultant (March 2009) – Coquitlam, BC
- 3.) Karen D. Berry, MCFD Fraser Region’s Early Childhood Screening Program for Children in Care liaison (March 2009) – Coquitlam, BC

Interview Questions:

- 1.) What is your overall assessment of the screening program?
- 2.) Have you heard of any similar programs?
- 3.) What are the benefits of a screening program of this nature?
- 4.) Do you foresee any challenges for the program if it is to be successful? (Associated with cost, effectiveness, fairness, efficiency, and capacity?)
- 5.) Do you consider this program to be a major improvement over past practices?
- 6.) What are your thoughts on the proposed policy alternatives?
- 7.) Do you have any recommendations as to how the program could be enhanced to provide better service for the Fraser Region’s children in care?
- 8.) How would a program such as this aid in fostering better outcomes for the Fraser Region’s children in care?

APPENDIX F

Descriptive Results

Case Processing Summary

	Cases		Missing	Percent	Total	Percent
	Valid	N				
SEX *	116	100.0%	0	.0%	116	100.0%
VISION	116	100.0%	0	.0%	116	100.0%
SEX *	116	100.0%	0	.0%	116	100.0%
HEARING	116	100.0%	0	.0%	116	100.0%
SEX *	116	100.0%	0	.0%	116	100.0%
DENTAL	116	100.0%	0	.0%	116	100.0%
SEX * ASQ	116	100.0%	0	.0%	116	100.0%
SEX *	116	100.0%	0	.0%	116	100.0%
ASQ_SE	116	100.0%	0	.0%	116	100.0%
SEX *	116	100.0%	0	.0%	116	100.0%
IMMUNIZA	116	100.0%	0	.0%	116	100.0%

SEX * VISION Crosstabulation

		VISION				Total	
		Completed and Passed	Red Flag	Not Completed	Under Dr's Care		
SEX	male	Count	13	12	26	5	56
		% within SEX	23.2%	21.4%	46.4%	8.9%	100.0%
		% of Total	11.2%	10.3%	22.4%	4.3%	48.3%
	female	Count	14	12	28	6	60
		% within SEX	23.3%	20.0%	46.7%	10.0%	100.0%
		% of Total	12.1%	10.3%	24.1%	5.2%	51.7%
Total		Count	27	24	54	11	116
		% within SEX	23.3%	20.7%	46.6%	9.5%	100.0%
		% of Total	23.3%	20.7%	46.6%	9.5%	100.0%

SEX * HEARING Crosstabulation

		HEARING				Total
		Completed and Passed	Red Flag	Not Completed	4	
SEX	male	Count	8	10	38	56
		% within SEX	14.3%	17.9%	67.9%	100.0%
	% of Total	6.9%	8.6%	32.8%		48.3%
female	Count	Count	16	5	38	60
		% within SEX	26.7%	8.3%	63.3%	1.7%
	% of Total	13.8%	4.3%	32.8%	.9%	51.7%
Total	Count	Count	24	15	76	116
		% within SEX	20.7%	12.9%	65.5%	.9%
	% of Total	20.7%	12.9%	65.5%	.9%	100.0%

SEX * DENTAL Crosstabulation

		DENTAL					Total	
		Completed and No Concerns	Red Flag	Not Completed	Under Dr's Care	High Risk for Decay/In Fluoride Program		
SEX	male	Count	22	18	2	7	7	56
		% within SEX	39.3%	32.1%	3.6%	12.5%	12.5%	100.0%
	% of Total	19.0%	15.5%	1.7%	6.0%	6.0%	48.3%	
female	Count	Count	27	14	4	6	9	60
		% within SEX	45.0%	23.3%	6.7%	10.0%	15.0%	100.0%
	% of Total	23.3%	12.1%	3.4%	5.2%	7.8%	51.7%	
Total	Count	Count	49	32	6	13	16	116
		% within SEX	42.2%	27.6%	5.2%	11.2%	13.8%	100.0%
	% of Total	42.2%	27.6%	5.2%	11.2%	13.8%	100.0%	

SEX * ASQ Crosstabulation

			ASQ					Total
			Completed and No Concerns	Red Flag	Not Completed	Agency already involved (IDP, AIDP, CDC, FHAN)	Unknown	
SEX	male	Count	17	15	6	17	1	56
		% within SEX	30.4%	26.8%	10.7%	30.4%	1.8%	100.0%
		% of Total	14.7%	12.9%	5.2%	14.7%	.9%	48.3%
	female	Count	25	10	10	14	1	60
		% within SEX	41.7%	16.7%	16.7%	23.3%	1.7%	100.0%
		% of Total	21.6%	8.6%	8.6%	12.1%	.9%	51.7%
Total	Count		42	25	16	31	2	116
	% within SEX		36.2%	21.6%	13.8%	26.7%	1.7%	100.0%
	% of Total		36.2%	21.6%	13.8%	26.7%	1.7%	100.0%

SEX * ASQ_SE Crosstabulation

			ASQ_SE					Total
			Completed and No Concerns	Red Flag	Not Completed	Agency already involved (IDP, AIDP, CDC)	Unknown	
SEX	male	Count	26	19	5	4	2	56
		% within SEX	46.4%	33.9%	8.9%	7.1%	3.6%	100.0%
		% of Total	22.4%	16.4%	4.3%	3.4%	1.7%	48.3%
	female	Count	37	13	4	5	1	60
		% within SEX	61.7%	21.7%	6.7%	8.3%	1.7%	100.0%
		% of Total	31.9%	11.2%	3.4%	4.3%	.9%	51.7%
Total	Count		63	32	9	9	3	116
	% within SEX		54.3%	27.6%	7.8%	7.8%	2.6%	100.0%
	% of Total		54.3%	27.6%	7.8%	7.8%	2.6%	100.0%

SEX * EXPOSURE Crosstabulation

			EXPOSURE					Total	
			Drugs	Drugs and Alcohol	Suspect Drugs	Suspect Drugs and Alcohol	Not Noted Unknown	No Exposure	
SEX	male	Count	21	1	10	3	16	5	56
		% within SEX	37.5%	1.8%	17.9%	5.4%	28.6%	8.9%	100.0%
		% of Total Count	18.1%	.9%	8.6%	2.6%	13.8%	4.3%	48.3%
	female	Count	21	4	5	4	24	2	60
		% within SEX	35.0%	6.7%	8.3%	6.7%	40.0%	3.3%	100.0%
		% of Total Count	18.1%	3.4%	4.3%	3.4%	20.7%	1.7%	51.7%
Total		Count	42	5	15	7	40	7	116
		% within SEX	36.2%	4.3%	12.9%	6.0%	34.5%	6.0%	100.0%
		% of Total	36.2%	4.3%	12.9%	6.0%	34.5%	6.0%	100.0%

REFERRED * OUTCOME Crosstabulation

			OUTCOME				Total
			yes	no	on a waitlist	unknown	
REFERRE D	yes	Count	56	17	1	8	82
		% within REFERRED	68.3%	20.7%	1.2%	9.8%	100.0%
		% of Total Count	48.3%	14.7%	.9%	6.9%	70.7%
	no	Count		34			34
		% within REFERRED		100.0%			100.0%
		% of Total Count		29.3%			29.3%
Total		Count	56	51	1	8	116
		% within SEX					

% within REFERRED	48.3%	44.0%	.9%	6.9%	100.0%
% of Total	48.3%	44.0%	.9%	6.9%	100.0%

AGE * IMMUNIZA Crosstabulation

Count

	IMMUNIZA			Total
	yes	no	unknown	
AGE 18 months	20	44	1	65
36 months	34	16	1	51
Total	54	60	2	116

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