University of Alberta

'It takes a community': An Investigation of Placement Instability for Albertan Children in Protective Care

by

Joanna Mary Bolster 

A thesis submitted to the Faculty of Graduate Studies and Research
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Abstract

This doctoral dissertation includes three studies of placement instability for Albertan children in child welfare care. The goals of these studies include exploring careproviders' perspectives about placement instability, describing a 5 to 17 year old sample of children in protective care, using specific child-based factors to predict placement instability whilst considering the phenomenon of developmental change, and then offering implications for intervention based on the overall investigation.

Methodologically, this topic is addressed first using qualitative techniques to identify key factors contributing to placement instability that could further conceptual clarity. Thereafter, with the goal of greater precision, these techniques are complemented with quantitative investigations that both describe children in protective care and isolate child-specific factors predictive of placement instability. This mixed-methods design provides the greatest methodological range to address the research questions generated for this dissertation.

Three major findings from this dissertation are discussed. First, the results from each of these studies support the argument that placement instability involves complex social processes and variables. This dissertation identifies that a child's socio-demographic, emotional and behavioural presentation can only explain a portion of the variance in placement instability. Furthermore, the careproviders' qualitative contributions support the influences of child, careprovider, and child welfare systems on placement

instability. Secondly, this dissertation highlights the marked heterogeneity of children in protective care. This heterogeneity is captured through psychiatric nomenclature, cultural diversity, reasons for requiring protective care, range in number of placements, behavioural, and emotional markers of functioning. Finally, this research documents the wealth of information that can be accessed from those living the experience of caring for children in protective care. The careproviders offer both extensive information about these children and further the clarity about placement instability. The significant response rate for this dissertation indicates the extent to which individuals are wanting to contribute to the knowledge base about placement instability. The findings from this dissertation are of importance as they offer further conceptual clarity to the phenomenon of placement instability, and provide both descriptive and predictive information that can be added to the existing knowledge base related to this phenomenon.

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ongoing efforts to care for these children, help them grow into strong and capable adults, and make changes to the overall system are recognized as community caring in action.

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Chapter 1 – Introduction

Introduction

From the moment of birth, children depend on adults to care for them. Adults must attend to children's most basic needs for survival, are responsible for shaping the identities of who these children will become, and help to develop the beliefs, values and morals that they will build upon as they become adults and parents themselves. We have recognized, however, that some children do not experience from their parents the kind of nurturing and consistent care known to promote healthy development. In response to the realization that there were children in need of shelter and provisions for the most basic level of care, the child welfare system evolved to assist with and often assume the parenting responsibilities for children who society recognized as neglected, abused or abandoned. Once in protective care, some children fail to experience the stability of having one or only a few placements. This lack of stability in placement is known to have deleterious effects across multiple developmental systems (Newton, Litrownik, Landsverk, 2000; Pardeck, 1984; Steinhauer, 1988, 1991; Zima, Bussing, Freeman, Yang, Belin & Forness, 2000), and yet this social welfare problem continues to exist within child welfare systems. This study, therefore, is designed to address this major concern in social welfare; namely, it investigates placement instability for children in protective care in Alberta. The specifics of this research study are detailed later in this Introduction, but first it is important to place these issues within an historical, social, and psychological context.

Social and Psychological Context

Historically, extended families often took on the parenting role for children in need of out of home care. Children were informally moved between family members as the need arose. Since one's entire extended family was often within one community, the African proverb, 'it takes a whole village to raise a child' came to pass. Later, as society became more complex and families more dispersed, the need for alternate families to care for children developed. Thus the concept of foster families began.

Unlike extended family, however, foster families were often not within a single community, and did not always share the beliefs, culture and practices of a child's family of origin. Although designed with the intention of providing children with healthier care and a sense of stability, some children did not have these experiences within their foster families, and therefore, had to be moved to another family or institution to receive care. In addition, some children's behavioural problems were so significant that institutional care was recognized as the only mode of parenting capable for managing these

children's needs. Institutional care became a common and economical way of parenting large numbers of children with relative ease. Fortunately as the theories of child psychology developed, researchers and practitioners began to recognize the limitations of this kind of care. A family environment was seen as a healthier setting for children. Consequently, institutions caring for orphaned or neglected children closed, and the need for foster families increased (Nordhaus & Solnit, 1998).

With increased public interest in children's rights during the 1980's, problems within the child welfare system came to be acknowledged (Archand, 1993). Reports began to surface of children who had experienced significant instability in living environments during their stay in protective care. And so researchers and childcare practitioners began to consider new developmental issues. John Bowlby, through his study of both children in institutional care and juvenile delinquents in the 1940's, developed the concept of a child's need for an attachment to a caregiver, and the psychological effects of separation on later adaptive functioning (Bowlby, 1969). Bowbly argued that attachment with a caregiver at it's most basic level, increased a child's likelihood for survival, and at it's most sophisticated level enabled healthy psychological and emotional development through childhood and into adulthood. As researchers have further developed attachment theory, several concepts have added to our understanding about both the experience of children separated from their family and taken into protective care, and the effects of multiple separations from new caregivers once in protective care.

The first of these concepts is the notion that children who experience separation from a caregiver engage in a mourning process. Bowlby first developed this concept through observing children temporarily separated from their parents and placed in institutions following the Second World War. Through watching these children be separated from their parents and experience numerous changes in caregivers during their hospitalization, Bowlby identified that children go through stages of loss, anger and grief before they are able to successfully attach to a new caregiver. This process of mourning has been characterized by the child first engaging in numbing behaviours, then a series of yearning, searching and anger-based behaviours, followed by disorganization and despair, and then finally reorganization and rebuilding of a new secure base (Holmes, 1993). If new caregivers do not respond to these stages appropriately and with sensitivity, it has been found that some children are not able to selectively re-attach (Steinhauer, 1991).

That some children lose the ability to selectively re-attach to a new caregiver leads to the second of the concepts that Bowlby developed. Both Bowlby, and later Rutter (1971), identified that permanent detachment can

result when a child either incompletes the process of mourning, or fails to develop an adequate attachment with a caregiver prior to the initial separation, as in situations of neglect or abuse (Steinhauer, 1991). Incomplete mourning can occur when a child stays too long without a sense of consistency in caregiver, as in the case of multiple moves between homes, or when a new caregiver is unable to support the child through the process of mourning (Steinhauer, 1991). Similarly, some children fail to even reasonably attach to their primary caregiver prior to separation, and as a result have been identified as exhibiting disorganized attachment behaviours upon separation (Belsky & Nezworski, 1988; Main & Solomon, 1990). Children with these types of attachment behaviours have often experienced maltreatment and inadequate care from their primary caregiver (Goldberg, 2000). The concept that children need an attachment with a caregiver for healthy development and are only able to tolerate a limited number of separations and re-attachments with new caregivers before permanent detachment occurs, has significant implications for practices within the child welfare system.

So the importance of attachment, consistency in caregiving and limiting the experiences of change for children have been recognized as vital in facilitating healthy development since Bowlby's early work in the 1940's. Although over 60 years have passed since his original work, there continues to be children in contemporary protective care who experience the conditions that Bowlby identified as detrimental to development; insufficient time to mourn the loss of their caregiver before further change occurs, insufficient resources in their new caregivers to cope with the mourning process, and inadequate experiences of attachment with a caregiver because of prolonged abuse and neglect.

Placement instability or foster care drift are terms coined in child welfare literature that recognize these problems and refer to three problematic areas: the disruption in consistency of caregivers for children in protective care, situations where children are allowed to deteriorate within their family of origin once the family has been identified as unable to care adequately for their needs, and the experience of children who frequently move back and forth, in and out of protective care (Steinhauer, 1991). For the purposes of this discussion, I will focus on the phenomenon of multiple placements whilst in protective care.

Current researchers acknowledge the impact of multiple placements for children in care, and have found that the experience of multiple placements can negatively effect children's behavioural symptomatology, attachment, peer relations, academic achievement, ability to sustain further change, and the healthy development of a sense of self (Fanshel, Finch & Grundy, 1990; Nordhaus & Solnit, 1998; Pardeck, 1984; Steinhauer, 1988,

1991). Developmental problems do not just appear to be limited to childhood, however, as other researchers have noted that as adults, individuals with these experiences present with an increased risk of difficulty in maintaining jobs, being homeless, engaging in criminal activity, and experiencing poorer mental health (Kennedy, 1991; Penzerro & Lein, 1995; Steinhauer, 1991). Just as Bowlby theorized many years ago, placement instability has significant implications for the long-term developmental outcome of these children.

The Canadian Contribution to the Literature

Much of the previous research considering placement instability has drawn from an American or European context. Although several Canadian researchers have explored problems for children in the child protection system (e.g. Raychaba, 1993; Stein, Evans, Mazumdar, & Rae-Grant, 1996; Steinhauer, 1991; Trocmé, MacLaurin, Fallon, Daciuk, Billingsley, Tourigny et al., 2001), there continues to be a paucity of research investigating placement instability in a Canadian context. Although child protection issues likely overlap in many ways between American and Canadian based populations, some factors continue to be unique to Canadian child protection systems, and even to geographical areas within Canada thus supporting a need for Canadian based research. One such topic that may be unique to Canada emerges from the needs and problems for Aboriginal peoples given our country's history of residential schools and resulting cultural dislocation (Palmer & Cooke, 1996; Timpson, 1995). Other factors such as careprovider training, access to support and treatment resources for child, biological family, and careproviding family, and financial compensation for caregiving may prove to differ in important ways from American practices. Within the context of this research study, however, it was deemed important to investigate issues related to the phenomenon of placement instability using a Canadian sample, so that any implications that were generated, and if appropriate, later applied, could be related to child welfare practice in Alberta.

This Study

The phenomenon of placement instability has been considered by researchers for many years now, as front-line child welfare staff continue to struggle with limiting the number of changes in placement a given child experiences. Although this phenomenon persists, many researchers continue to work towards gaining a further understanding and offer recommendations for improving the system for all members. Given the far reaching effects of this phenomenon and the relative lack of Canadian based research on this topic, the importance of investigating placement instability

for children in protective care in Alberta seemed appropriate. The goals of this research study, therefore, are fourfold, and include:

- to identify broad factors related to placement instability for Albertan children in protective care as perceived by careproviders;
- to describe Albertan children in protective care;
- to explore the relationship between child-related factors and placement instability at four developmental age groupings; and then finally
- to generate recommendations for intervention based on this investigation of placement instability.

The components of this study are as follows. First, this introduction provides an overview of the study. Next, three articles about the most important findings from the study that are intended for submission to academic journals are presented. These three articles constitute Chapters 2 through 4. Finally, in Chapter 5, key implications of this study and future direction for studies in the broader arenas of child welfare and child development are presented.

This research study develops and elaborates upon the early beginnings of research into the factors associated with placement instability for children in protective care. In particular, I focus on the general identification of factors contributing to placement breakdown as perceived by careproviders, and the more specific identification of child-related factors at four developmental stages (early childhood, middle childhood, early adolescence, and later adolescence) associated with placement instability. By including developmental change within this investigation of child-related factors, the contribution of a child's developmental change to placement instability is considered.

This study's investigation of placement instability begins with a qualitative inquiry exploring careproviders' thoughts about placement breakdown. It was hypothesized that this exploration could generate a broad summary of the range of contributing factors unhindered by researcher bias. Once these factors had been identified by careproviders' (a more thorough description of this inquiry will be provided later in this Introduction), it was then decided to further investigate specific child-factors related to placement instability using data collected from a demographic survey and two behavioural questionnaires. Information about children between the ages of 5 and 17, currently living in protective care in Alberta, was collected and analyzed at four developmental age groupings developed for this study (a more thorough description of these investigations will be provided later in the Introduction). Through the analyses of this quantitative information, a compilation of child-specific factors for the four age groupings that were

associated with placement instability for Albertan children in protective care was generated and possible implications for child welfare practice and policy were offered.

This Introduction is therefore organized so that the reader is first presented with a review of the research literature related to placement instability. Several key conclusions offered by previous researchers are reviewed, and the major methodological issues that have confounded the generalizability of these findings are discussed. Next, an overview of the methods and methodology utilized within this research study is presented. Finally, the focus of the remaining chapters within this doctoral dissertation is presented along with a listing of peer-reviewed journals appropriate for the later dissemination of this research study's findings.

Review of Related Literature

Several researchers have explored the phenomenon of placement instability over the past few decades. Since the recognition of the extent and impact of this problem on healthy development in the late 1970's and early 1980's, researchers have offered a number of key findings about the factors relating to placement instability for children in protective care. Five of these findings are now reviewed, with each identified factor supported within the context of existing literature.

Demographics

A number of studies have considered the influence of demographic factors on placement instability. Most notably, they indicate the significance of gender, ethnicity, age, and reasons for entering care on the experience of placement instability whilst in protective care.

Gender

Several previous researchers have noted that males in protective care tend to exhibit more significant behavioural symptomatology than females and that these behavioural difficulties are typically associated with placement instability (Kupsinel & Dubsky, 1999; Palmer, 1996; Webster, Barth & Needell, 2000). For example, Webster et al., (2000) using a longitudinal design, found that the male children in their study were 33% more likely to experience placement instability than the female children. These researchers studied over 5000 children who first entered protective care in the United States before the age of six, and then followed them for eight years. Similarly, Kupsinel and Dubsky (1999) found that over 70% of the children with behavioural handicaps in their study were boys, and that behavioural impairment was the strongest predictor for both overall length of

time in protective care and placement instability. Palmer (1996) in her study of Canadian children also found that both behavioural impairment and gender contributed to placement instability, and those boys with behavioural impairments experienced the greatest instability. These findings suggest that gender may be an important factor contributing to the experience of placement instability, with males at most risk.

Age

Like gender, researchers have also considered the relationship between the age of the child in protective care and the experience of placement instability. Several researchers have noted that older children tend to experience greater instability, and that age at entry into protective care may also bear upon the experience of later instability. Other studies have found that age of the child has no association with the experience of placement instability, and thus a conclusive trend is difficult to identify (Newton, Litrownik & Landsverk, 2000). Most researchers seem to argue, however, that children older than three years of age are more likely to experience more frequent placement changes than younger children (Rittner, 1995; Webster, Barth & Needell, 2000). The reasons for this age differentiation are varied, but likely are related to young children having spent both fewer of their formative years in compromised environments, and being easier to integrate into a foster family because of these limited maladaptive experiences (Cantos, Gries & Slis, 1996).

Ethnicity

Much of the previous research considering the influence of ethnicity on placement instability has been American in origin. Due to the significant differences in the ethnic composition between the United States and Canada, comparisons between studies, therefore, are difficult to make. Of the limited Canadian research that has been published, however, there have been arguments made by current researchers that children of Aboriginal origin are significantly over-represented within protective care populations (Child & Family Services Information, 1999; Palmer & Cooke, 1996; Timpson, 1995).

As children of Aboriginal ancestry are known to represent only 3% of the Canadian population, governmental inquiries into how and why this over-representation occurs have been spurred. Palmer and Cooke (1996) have suggested that the presence of 'Eurocentric values' by child welfare practitioners may account for the significant prevalence of Aboriginal children in protective care. These 'Eurocentric values' may overemphasize beliefs and values that do not consider Aboriginal lifestyles and cultural practices related to parenting, education, respect and spirituality. In addition, our nation's history of residential schools and the resulting cultural dislocation of

Aboriginal families, have prompted other researchers to postulate that Aboriginal communities are now experiencing the generational sequelae of the historically inadequate parenting models within these school environments (Horesji & Craig, 1992; Palmer & Cooke, 1996). Given this knowledge, therefore, it would appear that Aboriginal children are at an increased risk for being apprehended and placed in protective care, and that because of differing cultural practices and family experiences, they may struggle within more traditionally Eurocentric foster homes.

Reasons for Entering Protective Care

In Canada, legislation has been implemented to protect children's right to be free from abuse and neglect. Within the current Albertan legislature, the Child Welfare Act (1984) decrees that a child can enter protective care for one or more of the following reasons: abandonment; risk of, or actual experience of physical, sexual and emotional abuse or neglect; the lack of an available guardian due to the death of the guardian; or the condition and / or behaviour of the child preventing the guardian from providing adequate care. Recent national statistics compiled by the Canadian Incidence Study indicate that of the range of requests for investigation, emotional maltreatment is the reason for entering protective care that is most often substantiated by formal investigation. For that study, emotional abuse encompassed exposure to family violence, non-organic failure to thrive, emotional neglect and emotional abuse (Trocmé, MacLaurin, Fallon, Daciuk, Billingsley, Tourigny, Mayer, Wright, Barter, Burford, Hornick, Sullivan & McKenzie, 2001). Interestingly, these researchers also found that although emotional maltreatment was the report most often substantiated, neglect (40% of all reports) and physical abuse (31%) were the reasons for needing protecting care that were most often investigated. Sexual abuse was cited as the reason for investigation in 10% of all reports noted by these researchers.

Researchers have found that children who experience maltreatment during their formative years are known to be at an increased risk for experiencing deleterious effects in their development of adaptive emotional and behavioural regulation skills (Cicchetti & Toth, 1995; Kupsinel & Dubsky, 1999; Pearce & Pezzot-Pearce, 1997). These difficulties can include problems with peer relationships, academic achievement, attachment, empathy development, and the healthy development of self (Cantos, Gries & Slis, 1996; Cicchetti & Toth, 1995). Deficits in behavioural and emotional regulation skills in a child can also make the likelihood of sustaining a placement difficult for both child and foster family. Children with these deficits have been observed to engage in more frequent conduct and oppositional related behaviours, as well as increased aggression, impulsivity, hyperactivity and attention problems (Cantos, Gries & Slis, 1996; Dore & Eisner, 1993, Palmer, 1996, Rittner, 1995; Webster, Barth & Needell, 2000). Together, these behaviours are often those identified by careproviders as the

most challenging to manage and contain within a family, community and school environment, and thus compromise long-term placement stability.

Types of Psychopathology for Children in Protective Care

Like demographic factors, researchers have also investigated the influence of child-specific psychopathology on placement stability. Using a psychiatric nomenclature, many researchers have examined the prevalence of psychiatric disorders amongst children in protective care. A summary of these researchers' findings is now discussed as it relates to placement stability for children in protective care.

Researchers considering the mental health of children in protective care have consistently found that these children exhibit a clinically significant range of psychopathology and access mental health services at a rate far greater than their non-in-care peers (Garland, Landsverk, Hough & Ellis-Macleod, 1996; Landsverk & Garland, 1999; Leslie, Landsverk, Ezzet-Lofstrom, Tschann, Slymen & Garland, 2000; Stein, Rae-Grant, Ackland & Avison, 1994; Stein, Evans, Mazumdar & Rae-Grant, 1996). The estimated prevalence of psychopathology for children in protective care varies between studies. This is not entirely unexpected since different methods and varying uses of standardized clinical assessment measures have been utilized between studies. The extent of these problems is discussed below, but in general, the estimated proportion of children in protective care with psychiatric difficulties varies between 35 to 80%; prevalence rates that are significantly higher than that estimated for community samples of children not in protective care (Stein et al., 1994; Thompson & Fuhr, 1992; Zima, Bussing, Yang & Belin, 2000).

The psychiatric diagnoses that researchers find to be prevalent for children in protective care range from the more disruptive behaviour disorders through to the more internalizing disorders. Zima and others (2000) assessed over 300 six to 12 year old children in foster care, and found that 80% of the children met criteria for one or more psychiatric diagnoses. The disruptive behaviour disorders were the most prevalent for this sample, followed by affective disorders, adjustment disorders and then learning disorders. Almost half the children in this study met the criteria for two or more psychiatric diagnoses. Similarly, using a Canadian sample, Stein and others (1994) found in their group of over 300 four to 16 year old children in protective care, that the most prevalent diagnoses included conduct disorders (CD), oppositional defiant disorders (ODD), and attention deficit hyperactivity disorder (ADD/H). Like Zima and his colleagues, Stein and her co-researchers found that 33% of their sample had three or more psychiatric diagnoses. The presence of psychiatric diagnoses has also been associated with greater placement instability.

Conversely, various researchers find that placement stability is affected in part by children's behavioural symptomatology. Specifically, careproviders have identified that behaviours that are difficult to manage are one of the most complicating factors in the likelihood of a child sustaining a placement (Bolster, 2003a). Using the Child Behavior Checklist (CBCL, Achenbach, 1991), Newton and others (2000) found that children with externalizing symptomatology experienced a significantly greater number of placement changes. In addition, and of interest, is that these researchers found that placement change may have an exacerbating effect on existing behavioural symptomatology; suggesting a bi-directional interaction between placement change and psychopathology. This concept is novel in that previous studies have only considered a unidirectional relationship between psychopathology and placement change; specifically, that the presence of psychopathology portends later frequency of placement change.

Current research seems to agree that the prevalence of psychiatric disorders for children in protective care is greater than that found in non-in-care samples of children, that the disruptive behaviour disorders, such as CD, ODD and ADD/H are the most prevalent, and that having a psychiatric diagnosis is associated with the experience of greater placement instability whilst in protective care. That the disruptive disorders are the most prevalent is interesting, and deserving of further inquiry in future studies, as these behaviours by their very definition are the most disruptive to others, and therefore, likely to come to the attention of careproviders at a greater frequency than the more internalizing behaviours. One could postulate that because of the disruptive nature of this symptomatology, and the impact of these behaviours on interpersonal relationships, children with these behaviours are at a greater risk for not only placement instability, but also long term interpersonal stability than those who internalize their psychological distress.

Despite the identification of several child-related factors associated with placement instability, generalizability of findings between studies has been difficult, as much of the previous research related to placement instability is beset with methodological problems. Five of these problems are now explored within the context of existing literature investigating placement instability. Although these issues are not novel to any empirical researcher, they have not yet been consistently resolved within the current research into placement instability.

Methodological Difficulties

Part of the difficulty in interpreting research results from studies in which the phenomenon of placement instability is explored is the lack of a consistent method. This inconsistency makes it almost impossible to compare results between studies. Frequent problem areas are lack of

common reporting methods, differing assumptions of causality, small sample size, use of inadequate assessment measures, and the absence of a developmental conceptual framework when interpreting research results (Newton, Litrownik & Landsverk 2000; Gogan, Randolph & Usher 1999). Each of these is reviewed as they relate to the investigation of placement instability.

Lack of Common Reporting Methods

One problem within previous research studies has been the definition of what the term 'placement' means. Few researchers clearly define the meaning of placement within their unique study and there appears to be a lack of an accepted definition within current literature. Related to definitional difficulties are problems in determining which placements are actually counted when reporting frequency counts, and a lack of consistent method for accurately tallying the total number of placements for a given child. For example, when the average numbers of placements are reported, the mean can be for the child's entire time in care or merely for the time period of the particular study (Rittner, 1995; Newton, Litrownik & Landsverk, 2000; Gogan, Randolph & Usher 1999). It is difficult to interpret the meaning associated with these averages when definitions of placement and methods for capturing frequencies of placements are obscure or not reported in the article.

Many researchers neglect to address the issues of definition and reporting methods. As has been noted by Newton and others (2000), it is difficult to determine from much of the previous research within this area if short-term or intermediate placements were deemed countable when interpreting placement frequencies reported by these studies. Intermediate placements could include those where a child might reside for only a matter of days before being moved to a more permanent placement, or short term receiving facilities for transient adolescents: placements that do not appear to be counted in a consistent manner between traditional studies. Other studies have used arbitrary definitions of when counting periods can begin. Webster, Barth and Needell (2000), for instance, counted all placements occurring after the child had spent one year in care. The provided rationale was that placement instability was frequent during a child's early months in care until a permanent placement was found, and these temporary placements artificially inflate total frequency counts.

To further complicate the issues is whether total placement counts should include times when the child is temporarily absent from the home for either short-term respite purposes (e.g. foster family two-week holidays), or when a child runs away and then returns. Mech and Che-Man Fung's (1999) broad definition of placement as '...living arrangements', considers such situations. If, however, we were to consider a more detailed definition of

placement, then these scenarios could possibly be excluded, leading to less confusion. Clearly, greater clarity in the definition of 'placement' and reporting standards are needed to accurately capture meaningful placement frequencies.

Differing Assumptions of Causality

It has been well documented in child welfare literature that children who require protective care arrive in this system with often-complex behavioural and emotional needs. By virtue of their familial experiences, many of these children have developed behaviours appropriate to the environments in which their formative years were spent (Cicchetti, 1996; Levy & Orlans, 1998). These children are known to be at significant risk for experiencing placement instability whilst in protective care, expressly because of those behaviours, which may have been adaptive in their former environment, but are considered 'problems' or 'symptoms' in their current environment. Although externalizing behaviours such as aggression, hyperactivity and impulse control problems, are most often the strongest predictor of the experience of instability, internalizing behaviours such as withdrawal, anxiety and depression have also been identified as contributing factors (Dore & Eisner, 1993; Newton, Litrownik & Landsverk, 2000).

The relationship between maladaptive behaviours and multiple placements is a complex one in determining directionality. Previous researchers have found that of the child-related factors, difficult-to-manage behaviours are most likely to contribute to a child being moved to a new placement (Dore & Eisner, 1993; Kupsinel & Dubsky, 1999; Pardeck, 1984; Stone & Stone, 1983). Similarly, the experience of instability once in care can further exacerbate already challenging behaviours, and compromise tenuous relationships between child and careprovider (Palmer, 1996; Steinhauer, 1991). Recent researchers have gone even further to suggest that the experience of placement instability can contribute to development of behavioural and emotional problems in non-symptomatic children (Newton, Litrownik & Landsverk, 2000; Troutman, Ryan & Cardi, 2000).

For example, Newton, Litrownik and Landsverk (2000) used number of placements as the independent variable in their research and found that for children who at the time of their entry into protective care displayed non-clinical levels of symptomatology, the experience of multiple placements within an 18 month span significantly predicted the later development of clinical levels of behavioural and emotional difficulties. They suggest that the experience of placement instability can exacerbate symptomatology in vulnerable children previously assessed as not having significant difficulties. Using this unusual methodology behavioural impairment became the factor predicted by number of placements, and age, gender and ethnicity variables were not found to contribute to subsequent development of behavioural difficulties. Thus, it would appear from these results, that regardless of age

at time of entry into care, gender, or ethnic background, the experience of placement instability could both result from and contribute to clinical levels of behavioural and emotional difficulties.

Sample Size Issues

Most researchers frequently consider child-related factors such as gender, ethnicity, age of the child, behavioural impairments, and length of time in care as factors likely to contribute to placement instability (Kupsinel & Dubsky, 1999; Palmer, 1996; Pardeck, 1984; Webster, Barth & Needell, 2000). Although researchers have suggested that behavioural impairment, age of the child and length of time in care are often associated with greater placement instability, there have been inconsistent results for the gender and ethnicity variables. Some of the problems associated with interpreting the contribution of these variables have stemmed from researchers generalizing the findings from studies of small size. Other difficulties have evolved when researchers have offered conclusions about gender and ethnicity from studies in which the subjects were not representative. For example, the use of only dichotomous ethnic groupings in regions known to have ethnic diversity or generalizations of research findings based on disproportionate gender ratios or limited overall sample sizes make meaningful interpretation difficult.

One such study (Hornick, Phillips, & Kerr, 1989), noted that adolescent girls in foster care or residential care were significantly more likely to have behavioural problems than those involved with family support programs. In addition, adolescent girls were described as being more 'behaviourally pathological' than similarly placed adolescent boys because of their scores on Achenbach's Child Behaviour Checklist (CBCL, 1983). These results were then used to discuss how foster care may not be meeting the needs of these adolescents, and how residential care may be more appropriate based on a limited in-care sample of 33 girls and 42 boys. Such a small sample precludes any strong argument in actual gender differences, differences that may not be present within larger sample groups. In contrast, a more representative study was recently presented by Webster, Barth and Needell (2000), who using a sample of 700 children reported that boys were 33% more likely to experience placement instability than girls.

The role of ethnicity is also poorly understood as a factor potentially associated with placement instability. Like gender, findings reported within research studies have been inconsistent, and given the multicultural composition of the typically American based sample, conclusive trends have been difficult to determine. The issue of sample size becomes important when considering the influence of this multicultural component. Unlike gender, with only two levels of possibility, ethnicity could be captured by upwards of six to seven major ethnic groupings. Having adequate sample

sizes within groups to draw comparative differences, therefore, is very important. Studies that have found significant differences between ethnic groupings often cluster children into Caucasian, African American and Hispanic groupings (Webster et al., 2000; Iglehart, 1993; Rittner, 1995), clusters which may not be representative of the ethnic group breakdown in different areas of the United States or within Canada.

In studies that have not found that ethnic grouping is a significant contributor to placement breakdown, small sample size is often found. As an example, Kupsinel and Dubsky (1999) investigated the relationship between several demographic factors and level of behavioural impairment for children in out of home care. Based on their results, ethnicity was not believed to be a significant factor, although only 131 children were studied, and ethnicity was coded as either 'minority' or 'white'. Such broad divisions fail to capture the complexity of ethnicity in a multicultural society and should prevent generalizations of findings on this issue. To group Canada's children for example, as either minority or white, would fail to capture the multicultural diversity of many urban centers, and the often disproportionate numbers of ethnically diverse children (e.g. Aboriginal) that are in protective care (Bolster, 2003b, Walter, 1993). Sampling these diverse groups, therefore, requires an effort to sample both proportionately and representatively for all children within the child welfare system within the regional area in question.

Use of Inadequate Assessment Measures

As has been reviewed, behavioural impairment is known to be one of the strongest predictors for placement instability (Newton, Litrownik & Landsverk, 2000; Kupsinel & Dubsky, 1999; Webster, Barth & Needell, 2000). The behavioural measure most commonly cited in recent literature appears to be the Child Behavior Checklist (CBCL, Achenbach, 1991), a well standardized measure assessing problematic externalizing and internalizing symptomatology in children ages four through 18. Having well documented reliability and validity across divergent samples of children, this measure is often completed by child and youth care workers or foster families reporting on a child's behaviour.

It is likely that because the CBCL is so often cited within research studies, that this measure is frequently used within studies as the sole measure of children's behavioural adjustment. It is difficult, therefore, to determine the strength of association between behavioural impairment and placement instability, when level of behavioural impairment is based on this single assessment measure, often completed by only a single reporting source. In addition, problems in validity can arise when considering that one set of survey questions assesses behavioural adjustment across such a diverse age range. Sampling children's behaviour from ages four through 18

with the same set of behavioural items suggests that developmental changes in behavioural presentation may not be well captured by this measure (e.g. validity of a delinquent scale for preschool children).

The Behaviour Assessment System for Children (BASC, Reynolds and Kamphaus, 1992) is a less frequently cited, although comparable measure of behavioural adjustment for children ages four through 18. Similarly structured to the CBCL, this measure is both multidimensional and multi-method in the collection of behavioural data for identified children. Unlike the CBCL, however, this measure provides different survey items for three distinct age clusters within the often-studied population of four through 18 year olds. Scales within these three age groupings (i.e. preschool, child and adolescent) differ slightly based on developmental differences inherent to these groupings. Normative data are then further broken down to smaller age groupings based on standardization analyses (Reynolds & Kamphaus, 1992). In comparison with the CBCL, assessments of validity and reliability between the two measures for equivalent scales were strong, and relatively consistent between age protocols. Researchers comparing the two measures have noted that the BASC is more sensitive than the CBCL in differentiating between the various subtypes of Attention Deficit Disorder (with hyperactivity) (ADD) (Vaughn, Riccio, Hynd & Hall, 1997). Furthermore, Doyle and others (1997) have suggested that the BASC externalizing scales of Hyperactivity, Aggression, and Attention Problems are better markers of ADHD and other externalizing disorders groups when compared with the CBCL. These distinctions are of interest when considering the behavioural complexities observed in children involved with the child welfare system.

Contributions of Developmental Psychopathology

Conceptually, researchers have recognized the need for an overarching developmental theory to facilitate the understanding of the process of child maltreatment on the developing child (Cicchetti, 1996, 1989; Cicchetti, Cummings, Greenberg & Marvin, 1990; Cole-Detke & Kobak, 1998), and yet the empirical investigation of placement breakdown is rarely grounded in developmental theory. In neglecting to establish results within a developmental theory, researchers can misinterpret the range of developmental outcomes that can be expressed by children who have experienced abuse or neglect. The developmental psychopathology model has been well supported in theoretical literature, and researchers using this model offer a conceptual schema with which to organize and consider the etiology of developmental aberrations, compensatory coping strategies and lasting maladaptive developmental trajectories that some of these children progress along (Cicchetti & Toth, 1995).

Previously interpreted research findings about the meaning of the association between behavioural impairment and placement instability, for example, might be considered differently if based on the developmental psychopathology model. Researchers using this model postulate that the experience of maltreatment disrupts adaptive resolution of stage-salient developmental tasks: disruption which then precludes the development of adaptive emotional and behavioural regulation skills (Cicchetti & Toth, 1995). Clinically, these children's often overwhelming sense of fear and helplessness has been found to be expressed though conduct or aggression problems, impulsive behaviour, constant restlessness, oppositional conduct, compulsive compliance or caretaking of others, poor self-esteem and difficulties with tolerating intimacy (Cicchetti & Toth, 1995; Dore & Eisner, 1993; Fanshel, Finch & Grundy, 1990; Levy & Orlans, 1998; Pearce & Pezzot-Pearce, 1997). These are the very behaviours that have been associated with the experience of placement instability. Conceptually presented within a developmental framework, these findings could be interpreted as evolving from an aberrant developmental trajectory that predisposes the child to maladaptive compensatory coping strategies for modulating arousal (Cicchetti, 1996).

The implications for practitioners developing therapeutic treatment and training models for careproviders of these children are significantly different if using research findings interpreted within a developmental framework. Interventions would naturally evolve to facilitate the child learning more adaptive ways to modulate arousal within a secure and trusting attachment relationship. Directions for future research might also involve considering child-resilient factors that are present when out-of-home careprovider relationships are sustained despite significant behavioural complexity.

Summary of the Major Findings and Issues from the Relevant Literature

Through this review of the literature related to placement instability for children in protective care, and the confounding issues with method that have surrounded these research studies, several major findings and issues have emerged. These findings and issues are now summarized. Following this summary, the rationale and hypotheses that form the basis of my research study are then discussed.

Of the major findings presented within the relevant literature relating to placement instability for children in protective care, the following results appear to be most strongly supported by current researchers. The prevalence of psychopathology for children in protective care is recognized as both significant and higher than expected when compared with non in-care populations. Of the range of symptoms exhibited by these children, the disruptive behaviour disorders appear to be most prevalent. In addition,

recent researchers have postulated that the once supposed unidirectional effect of psychopathology on later placement instability might in fact be bi-directional. The experience of placement instability may in fact further exacerbate behavioural symptomatology. As well, boys tend to have greater frequencies of placements whilst in care than girls, and older children more so than younger children. Findings that are likely inter-related given the higher prevalence rates of many of the disruptive behaviour disorders for boys, and that older children are more likely to engage in behaviours that are difficult to manage and contain within a family environment than infants and preschoolers. Of additional interest, is the finding that Aboriginal children are over-represented in protective care populations, and the relationship this over-representation may have with placement changes that stem from conflict between Aboriginal and more Eurocentric foster family values. Finally, recent researchers have suggested that although emotional maltreatment is the cause for child welfare intervention that is most often substantiated, neglect and physical abuse continue to be the causes most often investigated and reported.

Together, these researchers' findings highlight several child-related factors associated with placement instability. The problems with method that were reviewed within this discussion of the literature, however, have confounded the interpretation and generalizability of these important findings. Issues of small sample size, inadequate assessment measures, lack of common reporting methods, differing assumptions of causality, and the lack of a unifying conceptual framework with which to interpret the findings of these researchers make generalizations of the findings difficult. It is through recognizing these issues with method and the need to generate meaningful information about the child-related factors associated with placement instability, that the current research study was borne. Several of the problems with method that were noted within previous studies were addressed within the design of this research study. In addition, through reviewing the relevant literature, it was noted that developmental change was not considered within many of the studies considering these child-related factors. Specifically, as many of the studies designs were cross-sectional in nature, child-related factors that were identified as significant were presumed to be present for the entire age range sampled. This finding holds even when the sampled age range encompassed several typical developmental age groupings (i.e. early childhood, later childhood, adolescence).

This Study

The purpose of this research study, as has been stated, is to investigate placement instability for children in protective care in Alberta. The more specific goals for the study include exploring careproviders' perspectives about placement instability, describing a 5 to 17 year old

sample of Albertan children in protective care, investigating specific child-related factors for this sample that are associated with placement instability whilst considering the phenomenon of developmental change, and then offering practice and policy based implications for intervention based on this overall investigation of placement instability. In addition, some of the problems with method encountered by previous studies have been addressed in this research study by accessing a sizeable sample, using a developmentally sensitive assessment measure, clearly detailing the method of measuring the number of placements a given child experienced, and then grounding the reported results of the study in a developmental psychopathology framework. As developmental change in children as they age has importance, the construct of developmental change was operationalized by clustering the children sampled for this research study into four age groupings: early childhood (ages 5 through 7 years), middle childhood (ages 8 through 10 years), early adolescence (ages 11 through 13 years) and later adolescence (ages 14 through 17 years).

As indicated, to begin the investigation of these child-related factors, an inquiry into the factors associated with placement instability as perceived by careproviders was undertaken. It was hypothesized that by using a qualitative method, unique factors that had not been previously identified through the literature could be garnered without the imposed influence of the researcher. In particular, careproviders were asked to respond to the following question: Based on your experience, what are the most common reasons for a child's placement to breakdown? It was also hypothesized that factors previously identified as significant in the literature may have more relative importance to those actually providing the care to these children and experiencing the course of a placement breaking down. This component of the research study is presented in detail in Chapter 2.

The qualitative inquiry provided the groundwork for a quantitative investigation into specific child-related factors associated with placement instability. The quantitative investigation is comprised of two studies, presented respectively in Chapters 3 and 4. In Chapter 3, an investigation into the socio-demographic factors associated with placement instability across the four developmental age groupings is reported. Using a sample of 561 children between the ages of 5 and 17 years, the socio-demographic factors of gender, ethnicity, reason(s) for entering care, and diagnoses were explored as they associated with frequency of placement change at each of the four developmental age groupings. It was hypothesized that the four different developmental age groupings would have different clusters of socio-demographic factors associated with placement instability.

In Chapter 4, the ability of two behavioural questionnaires to predict placement instability for children in protective care is reported. The BASC

(Behavior and Assessment System for Children, Randall & Kamphaus, 1992) was used to identify clusters of behavioural and emotional symptomatology and the Randolph Attachment Disorder Questionnaire (RADQ, Randolph, 1997) was used to identify problematic attachment behaviours. Together these measures were completed for 402 children in protective care between the ages of 5 and 17 years, and again, the results were explored as they associated with frequency of placement change within each of the four developmental age groupings. Like the component of the research study presented in Chapter 3, it was hypothesized that different clusters of behaviours would be significantly associated with placement instability across the four age groupings. Both Chapters 3 and 4 conclude with a presentation of the significant child-related factors associated with placement instability at each of the four developmental age groupings.

Finally, the significant findings from Chapters 2, 3, and 4 are summarized and presented in Chapter 5. This final chapter provides a summary of the components of the research study, the major findings of this dissertation, the overall implications for intervention based on the collective findings of this dissertation, a comment on the limitations of the study, and finally, suggestions for future research in the area of placement instability.

In the next section, a detailed discussion of the method used within this research study is presented.

Method

The purpose of this study is to investigate placement instability for children in protective care in Alberta. Methodologically, this topic is initially addressed using qualitative techniques to identify key factors contributing to placement instability and guide the overall study. Thereafter, in an attempt at greater precision, these techniques are complemented with quantitative investigations that isolate child-specific factors that lead to placement breakdown. This combination of both qualitative and quantitative research techniques within the same study has been coined by current researchers as mixed-methods methodology (Tashakkori & Teddlie, 2003). A mixed-methods design afforded me the greatest methodological range in addressing the research questions I had generated concerning placement instability for children in protective care in Alberta and is discussed in more detail later in this section.

Qualitative Method

The qualitative inquiry into the factors related to placement breakdown, as identified by child welfare careproviders relied on the concept mapping method developed by Trochim (1989). Trochim (1989) constructed the concept mapping method as a means of advancing the structured conceptualization process previously used in evaluation research. Through the concept mapping method, participants' experiences can be explored and a pictorial representation of the participants' groupings of these unique experiences created. This process of generating a pictorial map of concepts provides a visual representation of both the major concepts contributing to a phenomenon and how these concepts interrelate with one another. I selected the concept mapping method to explore placement instability because this method provided a means to further the conceptual clarity of this phenomenon unhindered by researcher bias, and thus generate a starting place for more exact investigations of specific factors relating to placement instability.

Current careproviders to children in protective care were asked to participate in this study. Although the full description of this method is provided in Chapter 2 (pp. 32 - 34), the following summary indicates the procedure used in this qualitative inquiry.

As part of the research study, careproviders were mailed a package containing information sheets and questionnaires about a child identified as within their current care. One part of this package included a one-page sheet detailing two open-ended questions (See Appendix H). The first of these questions was analyzed for the first research study. The probe posed to these careproviders was: 'Based on your experience, what are the most common reasons for placement breakdown?' Careproviders were asked to mail their completed responses back to the researcher within a provided envelope.

Once these 110 careproviders' responses had been received, analyzed, and condensed into 99 unique statements, a smaller subset of 11 careproviders were asked to sort the statements into piles 'according to how they seem to go together' (Paulson, Truscott & Stuart, 1999). These 11 careproviders were also asked to rate the importance of each statement to them using a five point Likert scale. The rating process was included so that the relative importance of each statement to careproviders could be ascertained.

Following this sorting process, a concept map was generated using Trochim's concept mapping method for analysis of the participant statements and groupings. The completed concept map identified nine clusters that

contributed to placement instability as perceived by careproviders. These clusters were described as Inadequate Care, Influence of Child's Relationships, Child's Behaviour, Breakdown between Caregiver and System and between Child and Caregiver, Poor Match, Limitations of the System, Insufficient Information Shared, and Limited Resources.

After these nine clusters were identified, a review of the more specifically child-related clusters relating to placement instability was undertaken using the statements within the clusters as specific cues for further quantitative investigation. A discussion of the quantitative method used in this investigation of placement instability follows.

Quantitative Method

Once the broad identification of factors contributing to placement instability as perceived by careproviders was completed, a more precise investigation of the child-related factors associated with placement instability was undertaken. A quantitative method was selected for this next stage in the study as it was determined that statistical support of my findings based on a sizable sample would be necessary if meaningful interventions at the policy and practice level were to be inferred within the larger child welfare population. Descriptive, correlational and regression analyses were generated from the quantitative data to address the goals of describing children in protective care in Alberta and identifying specific child-related factors predictive of placement instability at four developmental age groupings. These statistical analyses were chosen as they best allowed the results to be meaningfully compared with findings from other studies investigating placement instability (Breakwell, Hammond & Fife-Schaw, 2000; Norušis, 2000). Although the full description of this method is provided in Chapters 3 (pp. 52 – 55) and 4 (pp. 75 - 80), the following summary indicates the procedure used in these qualitative inquiries.

To begin the quantitative investigation, a socio-demographic and diagnostic description of children in protective care was completed. Each child's child welfare case manager was provided with a research package and asked to complete a demographic survey regarding their identified child (see Appendix D). Nine questions addressed information including date of birth, gender, date entering care, reasons for entering care, ethnicity, number of returns to biological home since entering care, legal authority, number of placements, and psychiatric and medical diagnoses. This information was collected for a sample of 561 five to 17 year old children in protective care, and descriptive statistics were generated related to the data obtained from the survey questions. Following this descriptive presentation, several child-related socio-demographic factors were investigated to determine if they

predicted placement instability within each of the four developmental age groupings.

Following the collection of the socio-demographic data for Chapter 3, a child's current careprovider was invited to participate in the study by completing two behavioural questionnaires about the identified child. The two measures used in this component of the study were the Behavioral Assessment System for Children (BASC, Reynolds & Kamphaus, 1992) and the Randolph Attachment Disorder Questionnaire (RADQ, Randolph, 1997). This information about a child's behavioural, emotional and attachment symptomatology was added to the already gathered demographic information from the first quantitative investigation, and complete information was collected for 402 five to 17 year old children in protective care. These children comprised a subset of the larger sample described in the socio-demographic investigation. A descriptive composite of the emotional, behavioural and attachment symptomatology was presented for each of the four developmental age groupings. From this descriptive information about emotional and behavioural functioning, specific child-related factors were investigated to determine if they predicted placement instability within each of the four developmental age groupings.

Mixed-Methods Design

In what researchers are now calling the third methodological movement, mixed methods designs have evolved as a means of answering research questions through the combination of qualitative and quantitative research practices (Tashakkori & Teddlie, 2003). This shift in methodological practice away from more traditional single method design addresses the complexity researchers believe exists in studying some social phenomenon (Newman, Ridenour, Newman & DeMarco, 2003). Placement instability is one such complex social construct.

A mixed methods design provided me with the opportunity to meet several of my research purposes. Although the overall purpose of this research is to investigate placement instability for children in protective care in Alberta, several secondary objectives can be identified. These secondary purposes include providing deeper conceptual clarity of the phenomenon using the concepts and language articulated by those living the experience of providing care to children in protective care. As well, it was important to add to the knowledge base by describing several features of children in protective care in Alberta, and then use these descriptive factors to predict placement instability. A mixed methods design permitted me to provide both a meaningfully and contextually relevant exploration of placement instability, and to generate findings that are descriptive of children in protective care in Alberta and that may be generalizable to other child welfare samples.

Ethics

Two different review panels granted ethical approval for this study. To begin the approval process, the proposal for this study was reviewed and approved by the University of Alberta Ethics Review Committee. Because of the sensitive information being accessed about these children and because child welfare ultimately needed to approve and provide access to the information required for this study, the regional Child and Family Services Authority conducted a second review. Once approved, final access was granted following a completion of an oath of confidentiality by the researcher.

Guide to this Doctoral Dissertation

Each of the following chapters of this doctoral dissertation is presented in research paper format. The individual components of this overall research study are presented in this format, as it is the researcher's intention to submit more condensed versions of these chapters for publication in peer-reviewed journals so that the findings can be disseminated amongst colleagues working and researching within this area. There are currently several journals that specialize in child welfare practices and developmental issues, and therefore, are likely to be appropriate choices for submission of these articles. These journals include:

- Child Welfare;
- Child Abuse and Neglect;
- Journal of Social Service Research;
- Child and Adolescent Social Work Journal; and
- Children and Youth Services Review.

As has been previously stated, Chapters 2 through 4 comprise research paper versions of three components of this doctoral dissertation. In Chapter 2 a qualitative inquiry into careproviders' perspectives of the factors contributing to placement breakdown is presented. In Chapter 3 a socio-demographic profile of Albertan children in protective care at four developmental age periods is developed, and in Chapter 4 a consideration of more specific behavioural and emotional symptomatology completes this profile development. I conclude the presentation of the dissertation in Chapter 5 with a summary and discussion of the major findings of this research. Suggestions for future interventions and a comment on the limitations of the dissertation are also included within Chapter 5.

References

Achenbach, T. M. (1991). *Manual for the child behavior checklist / 4 – 18 and 1991 profile.* Burlington, VT: University of Vermont Department of Psychiatry.

Archand, D. (1993). *Children: Rights and childhood.* London, UK: Routledge.

Belsky, J., & Nezworski, T. (1988). *Clinical implications of attachment.* Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers.

Bolster, J. (2003b). *Socio-demographic factors associated with placement instability for albertan children in protective care: A descriptive profile of children at four age groupings.* Unpublished manuscript, University of Alberta.

Bowlby, J. (1969). *Attachment and loss, Vol. 1. Attachment.* New York, NY: Basic Books.

Breakwell, G., Hammond, S., & Fife-Schaw, C. (2000). *Research methods in psychology.* Thousand Oaks, CA: Sage Publications.

Cantos, A. L., Gries, L. T., & Slis, V. (1996). Correlates of therapy referral in foster children. *Child Abuse & Neglect, 20 (10)*, 921 – 931.

Cicchetti, D. (1996). Child maltreatment: Implications for developmental theory and research. *Human Development, 39,* 18 – 39.

Cicchetti, D. (1989). How research on child maltreatment has informed the study of child development: Perspectives from developmental psychopathology. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment. Theory and research on the causes and consequences of child abuse and neglect* (pp. 377 – 431). Cambridge, UK: Cambridge University Press.

Cicchetti, D., Cummings, E., M., Greenberg, M. T., & Marvin, R. S. (1990). An organizational perspective on attachment beyond infancy: Implications for theory, measurement, and research. In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research and intervention* (pp. 3 – 49). Chicago, IL: University of Chicago Press.

Cicchetti, D., & Toth, S. L. (1995). A developmental psychopathology perspective on child abuse and neglect. *Journal of the American Academy of Child and Adolescent Psychiatry, 34 (5)*, 541 – 565.

Cole-Detke, H., & Kobak, R. (1993). The effects of multiple abuse in interpersonal relationships: An attachment perspective. *Journal of Aggression, Maltreatment and Trauma, 2 (1)*, 189 – 205.

Dore, M. M., & Eisner, E. (1993). Child-related dimensions of placement stability in treatment foster care. *Child and Adolescent Social Work Journal, 10 (4)*, 301 – 317.

Doyle, A., Ostrander, R., Skare, S., Crosby, R. D., & August, G. J. (1997). Convergent and criterion-related validity of the behavior assessment system for children – parent rating scale. *Journal of Child and Adolescent Social Work Journal, 10 (4)*, 301 – 317.

Fanshel, D., Finch, S. J., & Grundy, J. F. (1990). *Foster children in a life course perspective.* New York: Columbia University Press.

Federal / Provincial Working Group on Child and Family Services Information, (2001, March). *Child and family services statistical report 1996 – 1997 and 1998 – 1999.* Hull, PQ: Author.

Garland, A. F., Landsverk, J. L., Hough, R. L., & Ellis-MacLeod, E. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. *Child Abuse & Neglect, 20 (8)*, 675 – 688.

Gogan, H. C., Randolph, K. A., & Usher, C. L. (1999). Placement patterns in foster care. *Social Service Review, 73 (1)*, 22 – 36.

Goldberg, S. (2000). *Attachment and development.* New York, NY: Oxford University Press.

Government of Alberta. (1984). *Child Welfare Act.* Alberta: Queens Printer.

Holmes, J. (1993). *John Bowlby and attachment theory.* London, UK: Routledge.

Horesji, C., & Craig, B. H. R. (1992). Reactions by native american parents to child protection agencies: Cultural and community factors. *Child Welfare, 71 (4)*, 329 – 343.

Hornick, J. P., Phillips, D. M., & Kerr, N. (1989). Gender differences in behavioral problems of foster children: Implications for special foster

care. *Community Alternatives. International Journal of Family Care, 1 (1)*, 35 – 52.

Iglehart, A. P. (1993). Adolescents in foster care: Predicting behavioral maladjustment. *Child and Adolescent Social Work, 10 (6)*, 521 – 532.

Kennedy, M. R. (1991). Homeless and runaway youth mental health issues: No access to the system. *Journal of Adolescent Health, 12 (7)*, 576 – 579.

Kupsinel, M. M., & Dubsky, D. D. (1999). Behaviorally impaired children in out-of-home care. *Child Welfare, 78 (2),* 297 – 310.

Landsverk, J., & Garland, A. (1999). Foster care and pathways to mental health services. In P. Curtis, & G. Dale, Jr. (Eds.). *The foster care crisis: Translating research into practice and policy.* Lincoln, NE: The University of Nebraska Press.

Leslie, L. K., Landsverk, J. L., Ezzet-Lofstrom, R., Tschann, J. M., Slymen, D. J., & Garland, A. F. (2000). Children in foster care: Factors influencing outpatient mental health service use. *Child Abuse & Neglect, 24 (4)*, 465 – 476.

Levy, T. M., & Orlans, M. (1998). *Attachment, trauma, and healing. Understanding and treating attachment disorder in children and families*. Washington, DC: Child Welfare League of America.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized / disoriented during the ainsworth strange situation. In M. T. Greenberg, D. Cicchetti and E. M. Cummings (Eds.), *Attachment in the preschool years. Theory, research and intervention.* Chicago: The University of Chicago Press.

Mech, E. V., & Che-Man Fung, C. (1999). Placement restrictiveness and educational achievement among emancipated foster youth. Research on *Social Work Practice, 9 (2)*, 213 – 229.

Newman, I., Ridenour, C., Newman, C., & DeMarco, G. M. P. (2003). A typology of research purposes and its relationship to mixed methods. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 167 – 188). Thousand Oaks, CA: Sage Publications.

Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem

behaviors and number of placements. *Child Abuse & Neglect, 24 (10)*, 1363 – 1374.

Nordhaus, B. F., & Solnit, A. J. (1998). Foster placement. *Child and Adolescent Psychiatric Clinics of North America, 7 (2)*, 345 – 356.

Norušis, M. J. (2000). *SPSS© 10.0. Guide to data analysis.* Upper Saddle River, New Jersey: Prentice-Hall, Inc.

Palmer, S. (1996). Placement stability and inclusive practice in foster care: An empirical study. *Children and Youth Services Review, 18 (7)*, 589 – 601.

Palmer, S., & Cooke, W. (1996). Understanding and countering racism with first- nations children in out-of-home care. *Child Welfare, 75 (6)*, 709 – 726.

Pardeck, J. T. (1984). Multiple placement of children in foster family care: An empirical analysis. *Social Work, 29 (6)*, 506 – 509.

Paulson, B. B. L., Truscott, D., & Stuart, J. (1999). Clients' perceptions of helpful experiences in counseling. *Journal of Counseling Psychology, 46 (3)*, 317 – 324.

Pearce, J. W., & Pezzot- Pearce, T. D. (1997). *Psychotherapy of abused and neglected children.* New York: The Guildford Press.

Penzerro, R. M., & Lein, L. (1995). Burning their bridges: Disordered attachment and foster care discharge. *Child Welfare, 74 (2)*, 351 – 366.

Raychaba, B. (1993). *Pain lots of pain. Family violence and abuse in the lives of young people in care.* Ottawa, ON: National Youth in Care Network.

Reynolds, C. R., & Kamphaus, R. W. (1992). *BASC. Behavior assessment system for children manual.* Circle Pines, MN: American Guidance Service.

Rittner, B. (1995). Children on the move: Placement patterns in children's protective services. *Families in Society: The Journal of Contemporary Human Services, October*, 469 – 477.

Rutter, M. (1971). Parent-child separation: Psychological effects on the children. *Journal of Child Psychology & Psychiatry & Allied Disciplines, 12 (4),* 233 – 260.

Stein, E., Evans, B., Mazumdar, R., & Rae-Grant, N. (1996). The mental health of children in foster care: A comparison with community and clinical samples. *Canadian Journal of Psychiatry, 39 (6)*, 341 – 347.

Stein, E., Rae-Grant, N., Ackland, S., & Avison, W. (1994). Psychiatric disorders of children 'in care': Methodology and demographic correlates. *Canadian Journal of Psychiatry, 39 (6)*, 341 – 347.

Steinhauer, P. D. (1991). *The least detrimental alternative. A systematic guide to case planning and decision making for children in care.* Toronto, ON: University of Toronto Press.

Steinhauer, P. D. (1988). The preventive utilization of foster care. *Canadian Journal of Psychiatry, 33 (6)*, 459 - 467.

Stone, N. M., & Stone, S. F. (1983). The prediction of a successful foster placement. *Social Casework: The Journal of Contemporary Social Work, 64,* 11 – 17.

Tashakkori, A., & Teddlie, C. (Eds.). (2003). *Handbook of mixed methods in social and behavioral research.* Thousand Oaks, CA: Sage Publications.

Thompson, A. H., & Fuhr, D. (1992). Emotional disturbance in fifty children in the care of a child welfare system. *Journal of Social Service Research, 15 (3/4)*, 95 – 112.

Timpson, J. (1995). Four decades of literature on native canadian child welfare: Changing themes. *Child Welfare, 74 (3)*, 525 – 547.

Trocmé, N., MacLaurin, B., Fallon, B., Daciuk, J., Billingsley, D., Tourigny, M., et al. (2001). *Canadian incidence study of reported child abuse and neglect: Final report.* Ottawa, ON: Minister of Public Works and Government Services Canada.

Troutman, B., Ryan, S., & Cardi, M. (2000). The effects of foster care placement on young children's mental health. *Protecting children, 16 (1)*, 30 – 34.

Vaughn, M. L., Riccio, C. A., Hynd, G. W., & Hall, J. (1997). Diagnosing ADHD (predominantly inattentive and combined subtypes):

Discriminant validity of the behavior assessment system for children and the achenbach parent and teacher rating scales. *Journal of Clinical Child Psychology, 26 (4)*, 349 – 357.

Walter, B. (1993). *In need of protection: Children and youth in alberta*. Edmonton: Children's Advocate.

Webster, D., Barth, R. P., & Needell, B. (2000). Placement stability for children in out-of-home care: A longitudinal analysis. *Child Welfare, 79 (5)*, 614 – 632.

Zima, B. T., Bussing, R., Freeman, S., Yang, X., Belin, T. R., & Forness, S. R. (2000). Behavior problems, academic skill delays and school failure among school-aged children in foster care: Their relationship to placement characteristics. *Journal of Child and Family Studies, 9 (1)*, 87 – 103.

Zima, B. T., Bussing, R., Yang, X., & Belin, T. R. (2000). Help-seeking steps and service-use for children in foster care. *Journal of Behavioral Health Services and Research, 27 (3)*, 271 – 286.

Chapter 2 – Careproviders' Perspectives about the Factors Contributing to Placement Breakdown for Albertan Children in Protective Care

Abstract

Careproviders of children protected by child protection authorities responded to the question: Based on your experience what are the most common reasons for a child's placement to breakdown? The purpose of the study was to explore the phenomenon of placement breakdown and highlight salient factors as identified by careproviders. Using the concept-mapping method, responses from 110 participants were analyzed and nine factors were elicited that involved an interaction of relationships between the child, careprovider and social services system. These clusters were identified as Inadequate Care, Influence of Child's Relationships, Child's Behaviour, Breakdown between Caregiver and System and between Child and Caregiver, Poor Match, Limitations of System, Insufficient Information Shared, and Limited Resources. Developmental psychopathology theory was useful in conceptualizing these interrelated relationships.

Careproviders' Perspectives about the Factors Contributing to Placement Breakdown for Albertan Children in Protective Care

Introduction

Careproviders of children in protective care can offer researchers wisdom about the experience of caring for these special children. Not only do they provide care to children who frequently present with an often complex array of developmental needs, they do so within an intricate social services organization. From this vantage point, careproviders can provide information about placement breakdown. Placement outcome, therefore, reflects at its most basic level the ability of the child and / or the careprovider to sustain the relationship necessary to maintain the placement. When this relationship fails, the ramifications of breakdown are significant for both the child and the careprovider.

Overview

The study reported herein is a qualitative inquiry into the factors contributing to placement breakdown for children in the child welfare system, as perceived by a sample of careproviders currently working within the system. Careproviders were asked to identify the common reasons for placement breakdown within the child welfare system based on their experience as a careprovider. The current study, therefore, is designed to both explore the phenomenon of placement instability and create greater conceptual clarity about the range of factors contributing to placement instability for children in protective care in Alberta.

To begin the qualitative inquiry a review of the relevant literature was conducted. This review focused on three pivotal areas within the placement instability research: child-related factors, careprovider factors, and factors associated with the child welfare system. The review of the literature in this paper provides a synopsis of previous researchers' findings within this area and uses the developmental psychopathology model to provide a context to these findings. It is believed that this model can provide the infrastructure with which to understand the practical reflections of the careproviders generated within this study. Each of the three areas within the current research literature is reviewed as follows.

The Child

The developmental psychopathology model represents a conceptual framework that integrates diverse fields of academic study with clinical practice to better understand the processes of development, both normal and abnormal. This framework is particularly useful in understanding the

experience and outcomes of child maltreatment. As Cicchetti (1996) suggests, the use of this model furthers the understanding of child maltreatment, because maltreatment represents at its most basic level both an aberrant environment and a series of failed opportunities for normal development. For the developing child, the experience of maltreatment can effect affect and arousal regulation, attachment, healthy development of self, peer relations, and adaptation to school (Cicchetti & Toth, 1995). These are all factors that evolve over the course of a child's development, and that if effected by the experience of maltreatment can be associated with a greater likelihood of placement instability.

A child with the experience of maltreatment arrives to the child protection system with the potential for expressing a range of deviated developmental trajectories. In considering the development of attachment, for example, a child's ability to attach to a new careprovider can be influenced by the quality of the formative attachment, the number of subsequent careproviders, and the child's early experiences with abuse, neglect and / or abandonment (Katz & Robinson, 1991; Steinhauer, 1983). When factors such as these are significantly impairing, the child is likely to exhibit attachment patterns that are similarly impaired. Disrupted attachment patterns have been found in the literature to be expressed behaviourally by children as difficulties with the following: self-esteem, individuation, stress-management, self-control, social skills, interpersonal relationships, aggression and conduct problems, trust, intimacy and affection, hope, empathy, compassion and remorse, learning delays and later parenting of their own children (James, 1994; Levy & Orlans, 1998; Penzerro & Lein, 1995; Steinhauer, 1983). It is this very complex range of maladaptive behaviours in the child that leads to the need for an equally complementary range of coping and management skills by the careprovider if the relationship is to be successfully sustained.

The Careprovider

Careproviders also come to the relationship with the child with a set of personal resources, skills, experiences, strengths, and weaknesses. Brown (1999) surveyed careproviders about their needs related to being a good foster parent. Themes elicited from this research are concordant with existing literature and support the multifaceted interaction for careproviders of personality characteristics with cultural sensitivity, working relationships with social services, and ability to build and sustain a cohesive family. These themes highlight both the need for an adequate match between child and careprovider initially and the need for continuous ongoing support to careproviders once a child is placed. Researchers suggest that children placed into homes without adequate consideration of these issues are at an increased likelihood to experience placement instability (Aldgate, Pratt &

Duggan, 1989; Doelling & Johnson, 1990; Simms, 1991; Steinhauer, et al., 1988; Walter, 1993).

The developmental psychopathology model can contextualize the contribution of the careprovider. Cicchetti and Toth (1995) suggest that careproviders who understand that children's developmental needs can differ from their chronological age and who can be informed of the effects of maltreatment on development and stage-related tasks may better understand the parenting needs of these children. These researchers further imply that an enhanced understanding by careproviders can lead to modified parenting, a process that is liable to increase the likelihood of greater placement sustainability both for child and careprovider family.

The Child Welfare System

Several researchers have documented the importance of adequate respite, support, and treatment services for foster families and children within the literature relating to placement stability. Bruns and Burchard (2000) for example, completed a longitudinal study of the efficacy of respite care for improving outcomes for families caring for children with emotional and behavioural difficulties. These researchers found that families who received an average of 22 hours of respite care services per month were more likely to experience fewer placement disruptions and a lower overall level of reported caregiver stress than those in a matched control group who received no respite services. In addition, these researchers also found that families receiving respite services were more optimistic about sustaining the child at home and reported fewer behavioural incidents in the community. Given the often extensive developmental needs of these children, respite services that can both support and educate over time and that are adequate in availability and range of services can serve to decrease foster family stress and placement disruption.

The working relationship between the careprovider and social service agencies is also important in facilitating placement stability. As social services assumes partial or full guardianship of a child when a child comes into protective care, they also control disclosure of information about the child and biological family, access to respite, support, and treatment services, and have the ability to terminate the placement at their discretion. These are all factors that when functioning poorly have been identified as contributing to placement breakdown (Chamberlain, Moreland & Reid, 1992; Simms, 1991; Steinhauer, et al., 1988; Wilkes, 1974). Ideally, careproviders and social services should engage in a collegial relationship concerning matters related to the care of the child. Researchers suggest that when this occurs careproviders report greater satisfaction, improved ability to manage and cope with the child, and fewer placement disruptions (Chamberlain, et al.,

1992; Glisson & Hemmelgarn, 1998; Martin, et al., 1992; Steinhauer, et al., 1992).

This Study

Previous research in the area of placement breakdown has typically considered careproviders' perspectives through surveys about predetermined factors of interest to the researcher. What is often lacking in this method, however, is the opportunity to witness careproviders' discourse about an entire phenomenon unhindered by researcher bias. In this study, careproviders were encouraged to identify the common reasons for placement breakdown within the child welfare system based on their experience as a careprovider by responding to an open-ended question.

Method

Sample

In using the concept mapping method, two samples of participants were selected for participation in this study. The first group of participants responded to one open-ended question relating to their perceptions about the common reasons for placement breakdown. The second group of participants sorted the first group's responses into groups.

The participants, who responded to the open-ended question, were 110 adult careproviders (e.g. foster parents or child and youth care workers) who provided care to children for a Child and Family Services regional authority in a major city in Western Canada. For this study, two child welfare neighbourhood centres within the regional authority were sampled with a total of 150 children's files being accessed for this study. Completed data were obtained for 73% of the total cohort (n = 110). A neighbourhood centre is a community based office responsible for providing care and services to children within an identified geographical area within the larger child welfare region. The 110 careproviders in the current study were a subset of a larger sample of careproviders that was accessed for the larger research project conducted by this investigator. A full description of the sampling method is described within the procedure section.

Once the survey had been administered a second sample of careproviders was needed to assist with the sorting task of the concept mapping procedure, and these careproviders were recruited from a regional foster parent support group. These 11 careproviders were selected based on availability at the time of recruitment, desire to participate, and residency within the regional area that had participated in the larger research project. The gender composition of the participants was four males and seven females. These participants had a mean age of 51.3 years, and had fostered

on average for 7.7 years, with a range of 1 through 24 years. They provided care to children from infancy through to age seventeen, and all had at least a minimum qualified level of training as an authority foster care provider.

Procedure

The sampling procedure for the larger research project is briefly reviewed so that the selection of careproviders and procedure for the current research study can be delineated. For the larger study, a list of 1247 children's files within the child and family services regional authority was generated based on a file meeting the research project criteria. This criteria included the child being between the ages of 5 and 17 years at the time of the selection, having a legal authority of either temporary or permanent guardianship, and having sustained their current placement for a minimum of three months or longer. The 1247 files that met the research criteria were further narrowed so that an equal number of children of each age and gender were represented, and so that the number of files accessed from child welfare case managers was relatively equal across the geographical areas within the region. In addition, systemic issues within the regional authority that made a file no longer suitable for participation (e.g., child adopted, child no longer in protective care, recent change in placement) resulted in the deletion of several more files. Six hundred and seventy-four files constituted the sample for the larger study.

The total sample of files for the larger study (n=674) was grouped according to neighbourhood centre and centres were approached individually for their participation. Each of the 13 centres within this child welfare authority participated in the larger project, but only participants from the first two of these neighbourhood centres were included within the current research study. A total of 150 children's files were sampled from the first two of these neighbourhood centres for this study. After reviewing the responses provided by these 110 careproviders, a saturation of content in responses was reached. Current careproviders of the identified children sampled for the larger research project were mailed a package of informational sheets, two behavioural questionnaires, and a one-page sheet asking for their responses to two open-ended questions (see Appendix H). The child's child welfare case manager mailed this package to careproviders. The first of these two open–ended questions is considered within the current research study.

The probe posed to participants, and reviewed in this paper was: 'Based on your experience, what are the most common reasons for placement breakdown?' This probe was designed to elicit general views about reasons for placement breakdown from the careproviders perspective, in an anonymous and less threatening fashion. Participants were informed through informational material in the package that their participation or lack there of, would in no way influence their relationship with the regional

authority. Once completed, careproviders returned the completed surveys and responses to the questions to the researcher in the provided stamped envelope.

Once all the responses to the probe had been received (the mail-out was given a 10 week response time), a complete list of statements generated from participants' responses was created. Further analysis of the statements followed Trochim's (1989a) procedural model for statement analysis. Following this model, statements were initially listed in the exact form that participants had written them. Once a complete list was generated, statements were then edited for grammar or complex content, so that each statement captured one complete idea. With this extensive list of statements then complete, a further detailed analysis of statements was conducted, searching both for clear redundancy (duplication of content within statements) and irrelevant content. Content was deemed irrelevant if it appeared to relate only to a specific case or did not directly address the probe. The researcher, two doctoral level students and one professor, all from a Counselling Psychology program, completed analysis at this level. From this process, 99 original statements were retained that reflected the essence of participant's content while maintaining participant language. These 99 statements served as the formative content for the final sorting and rating task.

During the final data-gathering phase, the 99 statements were printed onto individual strips of paper and given to the second set of 11 careproviders sampled within the current study as part of a sorting package. Each sorting package contained an informational sheet, a list of instructions, a bundle of 99 unique statements, paper clips for attaching completed bundles, a demographic questionnaire, and a likert-scale survey to rate the 99 statements. The sorting process was reviewed with careproviders at the support group with the instruction that they were free to not participate, and that their non-participation would in no way influence their relationship with the regional authority. Sorting instructions were provided asking participants to sort the statements into piles 'according to how they seem to go together' (Paulson, Truscott & Stuart, 1999). The only restriction on the sorting process was that participants sort so that there were more than one and less than 99 piles (Truscott, Paulson & Everall, 1999).

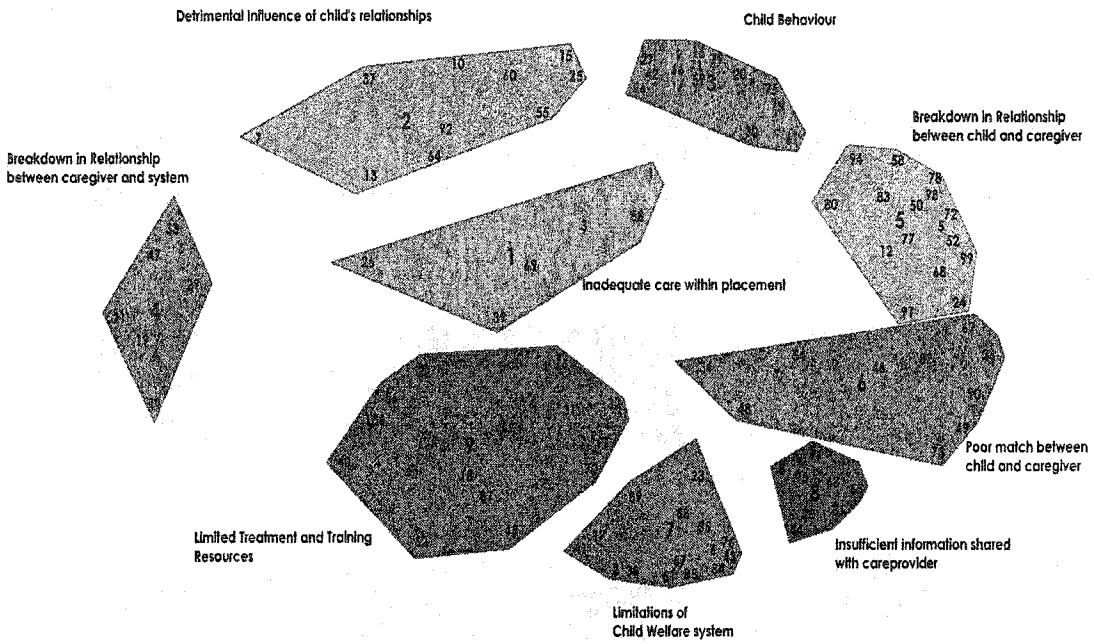
Finally, participants completed the rating survey. The survey listed the 99 statements with space for each statement to be rated on a five point likert scale. Participants were asked to place the number that best describes how important each statement was to them on the blank line beside each statement, with scale endpoints ranging from 1 (not important) through to 5 (extremely important) (Trochim, 1989a). This process was completed to gain

further understanding of the relative importance of each reason for placement breakdown, as rated by careproviders.

The Concept Map and Cluster Statements

Results of the sorting task were analyzed using two separate multivariate statistical analyses: nonmetric multidimensional scaling (MDS) and hierarchical cluster analysis. Together, these analyses form the structure of the final concept map. In MDS, analysis produces a two-dimensional configuration of the 99 statements, known as the point map (Kruskal & Wish, 1978). Once complete, each of the 99 statements is represented as a separate point on the point map. Statements which participants grouped together are put closer together on the map and those less frequently associated are placed further apart. Distance between points, therefore, represents the degree of conceptual connection among the statements (Trochim, 1989a). The configuration generated through the MDS analysis is then analyzed using cluster analysis. A cluster analysis groups individual statements into clusters based on co-ordinate data obtained from the point map and allows pictorial representation of groupings of conceptually similar statements (Trochim, Cook & Setze, 1994). Multidimensional scaling of the 99 statements yielded a two-dimensional configuration with a stress value of 0.2833. Stress values range from 0 (perfectly stable) to 1 (perfectly unstable) and represent an indicator of stability for the two-dimensional MDS configuration (Kruskal & Wish, 1978). The final concept map generated from the participants sorting of the 99 statements of the common reasons for placement breakdown is presented in Figure 1.

Figure 1. Concept map of 99 elements of what 110 careproviders provided in response to the probe 'Based on your experience, what are the most common reasons for placement breakdown?'



Of the 19 clusters generated from the original cluster analysis, an examination of individual clusters and consideration of captured statements suggested that a nine-cluster solution would best represent the participant groupings. Alternate solutions of four, five, six, seven, eight, ten, twelve and thirteen unique clusters were analyzed, with the nine-cluster solution being the most descriptive. Complete listings of statements as they are clustered, cluster titles, bridging indexes and mean rating values are provided in Table 1.

Table 1

Clusters and Items from Foster Parents' Concept Map of the Common Reasons for Placement Breakdown

Cluster and item	Bridging Value	Rating Value (mean)
Cluster 1: Inadequate care within placement	0.47	3.72
1. Neglect within previous placement	0.30	4.20
3. Improper consequences or punishment	0.38	3.90
53. Foster home too controlling and restrictive	0.30	3.70
26. Age at entry into care	0.80	2.90
39. Foster parent's inability to work with birth families	0.50	3.40
69. Foster parents unable to protect the child	0.51	4.20
Cluster 2: Detrimental influence of child's relationships	0.40	3.59
7. Teenagers wanting independent living	0.74	2.80
37. Peers suggesting life is better elsewhere	0.47	2.50
13. Abuse within previous placement	0.60	4.40
64. Jealousy between biological children and foster child	0.49	3.20
92. Too much back and forth with birth family	0.44	4.40
10. Child AWOLS	0.33	4.30
60. Difficult to separate child from peers	0.31	3.30
15. Child's delinquent behavior	0.20	4.00
25. Child's sexual behaviour	0.16	3.60
55. Child misses biological family	0.25	3.40
Cluster 3: Child's Behaviour	0.07	3.67
9. Not getting along with other children in the home	0.01	3.50
66. Child refuses to stay	0.07	3.70
16. Child's violence toward siblings or other	0.01	4.10
79. Child's refusal to follow rules in household	0.00	3.50
71. Child's self-harming behaviour	0.00	3.80
59. Child's unhappiness	0.03	3.60
20. Child's fear of abandonment	0.08	4.00
14. Child's aggression	0.04	3.70
27. Child not taking responsibility for own actions	0.04	2.80
42. Child's behaviour deteriorates	0.02	3.50
96. Lack of respect for foster parents	0.14	4.30
30. Unrealistic expectations of child	0.15	3.40
61. Child's inability to bond	0.22	4.20
74. Lack of progress with child's behaviour	0.09	3.70
75. Child's attitude towards placement	0.13	3.20

Cluster and item	Bridging Value	Rating Value (mean)
Cluster 4: Breakdown in relationship between caregiver and system	0.82	3.66
4. False accusations	1.00	4.20
19. Violence from biological family towards foster families	0.79	4.40
21. Interference or sabotage by natural parents	0.79	4.30
11. Children go to permanent placement	0.79	2.60
29. Too much outside interference	0.79	3.40
47. Child returned to family	0.76	3.60
33. Beds close after a child AWOLS	0.92	3.84
Cluster 5: Breakdown in relationship between child and caregiver	0.22	3.84
5. Foster parents taking behaviours personally	0.20	3.10
72. Caregiver's priority may not be the foster child	0.22	3.10
50. Change within foster family	0.14	3.40
78. Child doesn't fit into foster parent's lifestyle	0.21	3.70
98. Lack of communication between child and caregiver	0.19	3.70
83. Personality conflict between child and foster parents	0.24	3.80
58. Lack of trust between child and parent	0.18	4.00
94. Child needs a lot of attention	0.16	3.40
80. Child has a problem with the gender of one of the parents	0.20	3.80
12. Arguments between foster parents about the child	0.17	4.20
77. Foster parent's lack of patience and understanding	0.19	4.20
52. Foster parents give up on child	0.22	4.00
99. Caregiver's frustration and fear	0.22	4.00
24. Caregiver burnout	0.31	4.40
68. Foster home overloaded with children	0.25	3.80
91. Too many moves for child to settle in foster home	0.39	4.10
Cluster 6: Poor match between child and caregiver	0.30	3.90
34. Lack of experience by the caregiver	0.20	4.30
48. Native children being moved to native non-familial care	0.27	3.50
46. Placement unable to meet child's need	0.29	4.20
54. Foster families' lack of freedom to discipline	0.25	4.00

Cluster and item	Bridging Value	Rating Value (mean)
36. Caregiver accepting child into their home to meet own needs	0.37	3.40
67. Foster family dynamics not conducive to placement	0.28	3.50
82. Child's needs exceed skills of foster home	0.30	4.20
49. Child not properly matched with foster home	0.3	3.70
90. Unrealistic expectations of caregivers	0.34	3.90
73. Treatment kids are placed in general care	0.40	4.30
Cluster 7: Limitations of Child Welfare system	0.08	3.89
2. Social workers giving in to the child's demands	0.07	3.50
38. Social worker turnover	0.05	3.30
17. Lack of social worker support	0.07	4.00
41. Not enough support from agency support workers	0.09	2.90
23. Not enough help given to caregiver	0.15	4.10
35. Improper diagnosis of child	0.14	4.10
88. Lack of early assessments	0.13	4.30
89. Lack of early intervention	0.17	4.30
6. Inability of Social Services to properly assess new placements	0.08	4.00
76. Lack of communication between those involved with child	0.05	4.00
84. Lack of contact between the foster parent and social worker	0.06	3.80
43. Inappropriate placements from crisis	0.03	4.10
51. Conflict between foster parent and social worker	0.07	3.70
85. Social worker and foster parents have different agendas	0.03	3.70
57. Poor case management	0.07	4.00
Cluster 8: Insufficient information shared with care provider	0.16	3.81
8. Child's file doesn't contain all the information about the child	0.18	3.70
97. Lack of support in facilitating child "settling in" to placement	0.22	3.60
63. No transition opportunities between placements	0.15	3.50
95. Service plan unavailable to the foster parents	0.10	3.50
65. Inadequate information about child given to caregiver	0.18	4.00
28. Placements not researched enough to lead to a good match	0.13	3.90
44. Exclusion of foster parents from planning	0.16	4.60

Cluster and item	Bridging Value	Rating Value (mean)
81. Lack of preparation prior to the actual placement of the child	0.16	3.70
Cluster 9: Limited treatment and training resources	0.41	3.63
18. Lack of resources available to child in the community	0.34	3.60
87. Lack of psychological counselling	0.30	3.80
45. Not putting into place services to help child cope	0.18	4.10
62. Premature discharge from treatment centres	0.45	4.00
40. Only being allowed to keep children to a certain age	0.68	3.00
56. Too many people involved in child's life	0.64	3.00
86. Political pressure when the child in care is native	0.58	3.30
22. Caregiver not adequately trained	0.52	4.00
93. Lack of skilled homes in the area	0.38	4.20
31. Unrealistic expectations of how much one family can cope with	0.28	4.00
32. Lack of capable and available respite	0.23	3.80
70. Too much paperwork	0.30	2.80

Bridging indices are represented on a 0 to 1 scale. Values closer to zero reflect the degree to which statements are grouped with other statements close in proximity (Trochim, 1993). Values closer to one represent a statement that was likely to be grouped with any other statement, representing little consistency in sorter groupings of that statement. Rating values range from 1 (not important) to 5 (extremely important) and represent the degree of importance of individual statements as a common reason for placement breakdown. Mean rating values for the nine clusters ranged from 3.59 (Cluster 2) to 3.90 (Cluster 6). Low ratings on this scale indicate that the statement has less relative importance as a reason for placement breakdown, and higher ratings represent greater importance.

Discussion

The final concept map generated by the participants identified nine distinct concepts representing common reasons for placement breakdown for children in care. These nine concepts were further clustered into three groups: 'Attributes of the child', 'Attributes of the child welfare system', and 'Attributes of the careprovider'. The rationale for this further grouping was so that the overlap in relationships between the clusters and in the perceived importance of all the clusters to these careproviders could be more

accurately described. Each of these groups is now discussed within the context of the developmental psychology model and implications for intervention are generated based on this discussion.

'Attributes of the Child' in relation to the other groups

Considerable literature has explored and documented some of the characteristics of children in care and acknowledges that children with early histories of maltreatment or unstable home lives due to parental violence, substance abuse, or mental illness are at greater risk for exhibiting behavioural and emotional difficulties as they develop (Cicchetti, 1989; Herman, 1992; Iwaniec, 1995; Kashani & Allan, 1998; Levy & Orlans, 1998; Pearce & Pezzot-Pearce, 1997). Often these children re-enact previous experiences or engage in behaviour that developmentally mirrors their complex emotional experience. Careproviders for these children are trained to manage these intricate behaviours and, yet, at times children's behaviours can exceed the skills and resources of the careprovider and difficulties arise in the stability of the placement. Similarly, each provider comes personally equipped to manage certain behaviours, stressors, and relationship dynamics with a child because of their own history and life experiences. Careproviders in this study acknowledged the complex interaction of these factors through identifying the effects of the child's behaviour (Cluster 3), the influence of the child's relationships with others (Cluster 2), the importance of the initial match between child and careprovider (Cluster 6), and the relationship between child and caregiver (Cluster 5) on placement stability.

In Cluster 2 (Detrimental influence of child's relationships) and Cluster 3 (Child's Behaviour) children's behaviour and their relationships with others in their community are considered. Statements within these clusters appear to describe the behaviours associated with the abnormal developmental progressions that these children tend to exhibit in their efforts to manage the demands of both living away from their family of origin and coping with the sequelae of maltreatment. These difficulties are highly concordant with symptomatology commonly associated with disrupted attachment patterns. Levy and Orlans (1998) note that behaviours reported in this study such as difficulties with bonding, impulse control deficits, delinquency, fears of abandonment, aggression and sexual acting out are all correlates of attachment difficulties and have been identified by other researchers as child-related factors associated with placement instability (Newton, Litrownik & Landsverk, 2000; Pilowsky, 1995; Stein, Rae-Grant, Ackland & Avison, 1994).

'Attributes of the Careprovider' in relation to the other groups

It is not surprising when considered within this context, therefore, that the relationship between the child and careprovider is of great importance. In

Cluster 5 (Breakdown in Relationship between child and caregiver) and Cluster 6 (Poor match between child and caregiver) temporal dimensions of this relationship are addressed: the initial likelihood of a relationship between child and caregiver being successful (the match), and the later likelihood that the relationship can be sustained. Cicchetti and Toth (1995) suggest that children whose development has been compromised by maltreatment have difficulties sustaining relationships. Careproviders for these special children, therefore, are faced with a daunting challenge: the challenge to connect with a child who does not know how, or cannot connect in a meaningful reciprocal fashion (James, 1994; Penzerro & Lein, 1995). The 'goodness of fit' between child and caregiver, therefore, is recognized as crucial to the likelihood that the placement can be sustained over the long term. Doelling and Johnson (1990) support the thorough consideration of this match through an examination of both child and careprovider characteristics. These researchers suggest that when a fit is optimal placement disruption is significantly decreased.

In addition, careproviders must manage the stress associated with parenting a special needs child often with insufficient or inadequate ongoing training or resources to support this process. Researchers have suggested that careproviders who receive additional training, support, and resources perceive their child's difficulties as less worrisome, experience greater satisfaction and less stress, and are better able to sustain a placement (Bruns & Burchard, 2000; Chamberlain, et al., 1992; Steinhauer, et al., 1988). The effects of the often limited available treatment and training resources were captured in Cluster 9 (Limited treatment and training resources). Statements reflected the limitations of current resources including limited psychological treatment, respite, training, capable foster homes, and premature termination of treatment services. The perceptions of the careproviders in this study are similar to recommendations existing within current literature; the need for capable and available community-based resources both for the child and careprovider (Walter, 1993).

One unfortunate outcome of this lack of support, training and monitoring of placements was captured in Cluster 1 (Inadequate care within the placement). A problem with a well-established history, substandard careproviders subject the children they care for to further abuse, neglect, and / or abandonment. Within the context of developmental psychopathology, additional experiences of maltreatment further the likelihood of deviated developmental outcomes. Subsequent careproviders must cope with the ramifications of yet another adult having failed the child, and the child must cope with yet another experience of trauma and the compromised potential for healthy development. Although an obvious precursor to placement breakdown, inadequate care within the placement appears to receive less attention in more recent literature than other more

tangible factors such as the child's behaviour (Raychaba, 1993). It is of interest, therefore, that in this study participants ranked this cluster as having more importance as a factor that contributes to placement breakdown than either the child's behaviour or the limited available resources, suggesting a need for further consideration of how to manage and limit this problem more effectively.

'Attributes of the Child Welfare System' in relation to the other groups

Finally, the role of the Child Welfare system in contributing to placement breakdown was considered. Cluster 7 (Limitations of Child Welfare system) and Cluster 8 (Insufficient information shared with careprovider) address the complex nature of this factor. Researchers considering placement instability have explored the themes of frequent social worker turnover, inadequate history being shared about the child, and the lack of a concerted team effort between those involved with the child's care (Pardeck, Murphy and Fitzwater, 1985; Frank, 1980; Walter, 1993). Statements within these clusters repeat these themes and support the need identified in previous literature for further exploration of how to best manage these difficulties. Strong case management that is continuous and stable seems to be a fundamental starting place and yet social workers are often overworked and energy-depleted because of the very nature of their work. Solnit, Nordhaus and Lord (1992) reflect this dynamic through recognizing the parallel process of sadness and helplessness that can be inherent to child protection work. Faced with too few careproviders, insufficient resources to disperse, and growing numbers of children in need of care (Walter, 1993), social workers appear to case manage to the best of their capability – placing children in available homes in as little time as possible. A process of matching that has the potential to be fraught with complications that can contribute to placement instability and to careproviders feeling at the mercy of children's services (Brown, 1999a).

The relationship between the child welfare system and the careprovider, therefore, is crucial. When the relationship is less than optimal, careproviders are likely to feel isolated from decisions and less able to manage the demands of outside influences (e.g. biological family). Themes of this nature are captured in Cluster 4 (Breakdown in relationship between careprovider and system). These statements reflect phenomena reported within existing literature as vital to quality care: placement stability and adequate skills in managing relationships with biological family. Careproviders who receive support and attention from the child welfare system are known to have fewer placement breakdowns and diminished stress in providing for the child in their care (Bruns & Burchard, 2000; Chamberlain, et al., 1992). Interestingly, careproviders in this study did not specifically address feelings of lack of respect or being taken advantage of, which are common by-products of poor relationships although the

emotionality of the phrases in several of the respondents statements could be inferred as identifying these feelings. It was also noteworthy that this cluster was the least stable of the nine clusters, and likely reflects the variance in participant sorting of these multifaceted statements.

Conclusion

In this study, participants were asked to generate responses to the probe 'Based on your experience, what are the most common reasons for placement breakdown?' Nine clusters were identified from the statements that conceptually mapped these participants' experience. The individual statements contained within the clusters addressed facets of the child, careprovider and child welfare systems. The findings from this study furthered the conceptual clarity about placement instability by not only naming the various factors contributing to placement instability, but also grouping them in such a way that the interrelated nature of these three systems was made more apparent than in much of the previous literature. Furthermore, the depth of meaning provided by individual statements within the nine clusters will be useful to future researchers as they seek to draw greater clarity concerning placement instability.

These findings, therefore, met the general purpose of this study; namely to explore the phenomenon of placement instability and create greater conceptual clarity about the range of factors contributing to placement instability for children in protective care in Alberta. Interestingly, with the exception of the one cluster that pertained exclusively to the child's behaviour, one could conclude that the remaining clusters identified problems primarily stemming from the philosophy and practices of the child welfare system. Problems such as insufficient information about the child being shared, inadequate care within a placement, poor match between child and caregiver, and general limitations of the child welfare system that compromise placement sustainability. The findings from this study are novel in that the child and careprovider contributions to placement breakdown have historically been more thoroughly researched in the existing literature, and with the support of the findings from this research, it now seems important to more thoroughly explore the contribution of the child welfare system.

In particular, the questions of why and what become important. Why do these barriers to placement success exist within the child welfare system? What about the child welfare system philosophy and practices enables placements to breakdown? Researchers exploring these questions should also consider how the themes of class, race, and religion weave into their explorations of the child welfare system. These themes provide a context through which to understand not only how child welfare practices have

evolved historically, but also in which to clarify the current phenomena of placement instability.

Further questions are also needed to answer why careproviders identified the specific factors in this study as important. What is it about these factors that make placement sustainability difficult? For example, the factor rated as most important in contributing to placement breakdown by these careproviders was a poor match between child and careprovider. A poor match is in part precipitated by child welfare practices but can also be effected by careprovider beliefs about the need to assimilate cultural, racial, class and religious differences in the child and child's biological family into their own standards of acceptability. This assimilation process, although likely difficult for careproviders and the child welfare system to acknowledge as such, is worthy of further exploration. Understanding the contributions of beliefs about assimilation by careproviders and the child welfare system in general may further the clarity needed to not only understand but perhaps also shift philosophies about the factors contributing to placement instability.

References

Ainsworth Salter, M. D., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment. A psychological study of the strange situation.* Hillsdale, New Jersey: Lawrence Erlbaum Associates, Publishers.

Aldgate, J., Pratt, R., & Duggan, M. (1989). Using care away from home to prevent family breakdown. *Adopting & Fostering, 10*, 44 – 49.

Alexander, P. C. (1993). The differential effects of abuse characteristics and attachment in the prediction of long-term effects of abuse. *Journal of Interpersonal Violence, 8 (3)*, 346 – 362.

Allen, J. G. (1995). *Coping with trauma. A guide to self-understanding.* Washington, DC: American Psychiatric Press.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders (4th ed.).* Washington, DC: Author.

Belsky, J., & Nezworski, T. (1988). *Clinical implications of attachment.* Hillsdale, New Jersey: Lawrence Erlbaum Associates, Publishers.

Bowlby, J. (1988). *A secure base. Clinical implications of attachment theory.* London,UK: Routledge.

Bowlby, J. (1973). *Attachment and loss. Volume II. Separation, anxiety and anger.* New York, NY: Basic Books, Inc.

Brown, J., & Calder, P. (1999a). *Concept-mapping the needs of foster parents.* Unpublished manuscript, University of Alberta.

Bruns, E. J., & Burchard, J. D. (2000). Impact of respite care services for families with children experiencing emotional and behavioral problems. *Children's Services: Social, Policy, Research, and Practice, 3 (1)*, 39 – 61.

Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. (1989). Disorganized and disoriented attachment relationships in maltreated infants. *Developmental Psychology, 25 (4)*, 525 – 531.

Chamberlain, P., Moreland, S., & Reid, K. (1992). Enhanced services and stipends for foster parents: Effects on retention rates and outcomes for children. *Child Welfare, 71*, 387 – 401.

Cicchetti, D. (1989). How research on child maltreatment has informed the study of child development: Perspectives from developmental psychopathology. In D. Cicchetti and V. Carlson (Eds.), *Child*

Maltreatment. Theory and research on the causes and consequences of child abuse and neglect. New York, NY: Cambridge University Press.

Doelling, J. L., & Johnson, J. H. (1990). Predicting success in foster placement: The contribution of parent-child temperament characteristics. *American Journal of Orthopsychiatry, 60 (4)*, 585 – 593.

Frank, G. (1980). Treatment needs of children in foster care. *American Journal of Orthopsychiatry, 50,* 256 – 263.

Glisson, C., & Hemmelgarn, A. (1996). The foster care experience in Ireland: Findings from a postal survey. *Child Care, Health & Development, 22,* 85 – 98.

Herman, J. L. (1992). *Trauma and recovery.* New York, NY: BasicBooks.

Iwaniec, D. (1995). *The emotionally abused and neglected child. Identification, assessment and intervention.* New York, NY: John Wiley and Sons.

James, B. (1994). *Handbook for treatment of attachment-trauma problems in children.* New York, NY: The Free Press.

Kashani, J. H., & Allan, W. D. (1998). *The impact of family violence on children and adolescents.* Thousand Oaks, CA: Sage Publications, 1998.

Katz, L., & Robinson, C. (1991). Foster care drift: A risk-assessment matrix. *Child Welfare League of America, 70 (3)*, 347 – 358.

Kruskal, J. B., & Wish, M. (1978). *Multidimensional scaling.* Beverly Hills, CA: Sage Publication.

Levy, T. M., & Orlans, M. (1998). *Attachment, trauma, and healing. Understanding and treating attachment disorder in children and families.* Washington, DC: Child Welfare League of America.

Main, M., & Cassidy, J. (1988). Categories of response to reunion with the parent at age 6: Predictable from infant attachment classifications and stable over a 1-month period. *Developmental Psychology, 24 (3)*, 415 – 426.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized / disoriented during the ainsworth strange situation. In M. T. Greenberg, D. Cicchetti and E. M. Cummings (Eds.), *Attachment*

in the preschool years. Theory, research and intervention. Chicago: The University of Chicago Press

Martin, E. D., Altemeier, W. A., Hickson, G. B., Davis, A., & Glascoe, F. P. (1992). Improving resources for foster care. *Clinical Pediatrics, 31*, 400 – 404.

Mikulincer, M., & Florian, V. (1996). Coping and adaptation to trauma and loss. In M. Zeidner and S. Endler (Eds.), *Handbook of coping. Theory, research, applications.* New York, NY: John Wiley and Sons, Inc.

Morrison Dore, M., & Eisner, E. (1993). Child-related dimensions of placement stability in treatment foster care. *Child and Adolescent Social Work Journal, 10 (4)*, 301- 317.

Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect, 24 (10)*, 1363 – 1374.

Pardeck, J. T. (1984). Multiple placement of children in foster family care: An empirical analysis. *Social Work, 29 (6)*, 506 – 509.

Pardeck, J. T., Murphy, J. W., & Fitzwater, L. (1985). Profile of the foster child likely to experience unstable care: A re-examination. *Early Child Development and Care, 22,* 137 – 146.

Paulson, B. B. L., Truscott, D., & Stuart, J. (1999). Clients' perceptions of helpful experiences in counselling. *Journal of Counseling Psychology, 46 (3)*, 317 – 324.

Pearce, J. & Pezzot-Pearce, T. D. (1997). *Psychotherapy of abused and neglected children.* New York, NY: The Guilford Press.

Penzerro, R. M., & Lein, M. (1995). Burning their bridges: Disordered attachment and foster care discharge. *Child Welfare League of America, 74 (2)*, 351 – 367.

Pilowsky, D. (1995). Psychopathology among children placed in family foster care. *Psychiatric Services, 46 (9)*, 906 – 910.

Raychaba, B. (1993). *Pain lots of pain. Family violence and abuse in the lives of young people in care.* Ottawa, ON: National Youth in Care Network.

Simms, M. D. (1991). Foster children and the foster care system, part II: Impact on the child. *Current Problems in Pediatrics*, *9*, 345 – 369.

Solnit, A. J., Nordhaus, B. F., & Lord, R. (1992). *When home is no haven. Child placement issues.* Chelsea, Michigan: BookCrafters, Inc.

Stein, E., Rae-Grant, N., Ackland, S., & Avison, W. (1994). The mental health of children in foster care: A comparison with community and clinical samples. *Canadian Journal of Psychiatry, 39 (6)*, 341 – 347.

Steinhauer, P.D. (1991). *The least detrimental alternative. A systematic guide to case planning and decision making for children in care.* Toronto, ON: University of Toronto Press.

Steinhauer, P. D., Johnson, M., Snowden, M., Santa-Barbara, J., Kane, B., Barker, P., & Hornick, J. P. (1988). The foster care research project: Summary and analysis. *Canadian Journal of Psychiatry*, *33*, 509 – 516.

Trochim, W. M. (1993). *The concept system.* Computer software manual. Ithaca, NY: Author.

Trochim, W. M. (1989a). An introduction to concept mapping for planning and evaluation. *Evaluation and Program Planning*, *12,* 1 – 16.

Trochim, W. M., Cook, J. A., & Setze, R. J. (1994). Using concept mapping to develop a conceptual framework of staff's views of a support employment program for persons with severe mental illness. *Journal of Consulting and Clinical Psychology*, *62 (4)*, 766 – 775.

Truscott, D., Paulson, B. L., & Everall, R. D. (1999). Studying participants' experiences using concept mapping. *The Alberta Journal of Educational Research, 45 (3)*, 320 – 323.

Walter, B. (1993). *In need of protection: Children and youth in alberta.* Edmonton: Children's Advocate.

Wilkes, J. R. (1974). The impact of fostering on the foster family. *Child Welfare*, *53*, 373 – 379.

van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (1996). *Traumatic stress. The effects of overwhelming experience on mind, body, and society.* New York, NY: Guilford Press.

Chapter 3 – Socio-demographic Factors associated with Placement Instability for Albertan Children in Protective Care: A Descriptive Profile of Children at Four Age Groupings

Abstract

The role of diagnosis, gender, ethnicity, frequency of placement change, and reason(s) for entering care were investigated in 561 Albertan children in child welfare care at four developmental age groupings. A socio-demographic profile was generated for each of the age groupings, and socio-demographic factors predictive of placement instability were identified. These factors included the experience of emotional abuse, a diagnosis of fetal alcohol syndrome or effects, having a medical condition or physical disability, and having a diagnosis of conduct disorder. Three significant findings included the high frequency of both placement instability and the experience of emotional abuse, and the over-representation of Aboriginal children within this population. Each finding is discussed within the context of previous child protection research.

Socio-demographic Factors associated with Placement Instability for Albertan Children in Protective Care: A Descriptive Profile of Children at Four Age Groupings

Introduction

Children can come into protective care with a range of psychological and psychiatric needs related to their early familial experiences. Given the current emphasis on governmental fiscal restraint, available mental health interventions need to be both cost effective and clinically efficacious. Before matching treatment services to the needs within this population, however, knowledge of the basic demographic facts about Albertan children in protective care is needed. One focus of this paper, therefore, is to present these demographic facts. Five points of interest including diagnosis, experiences necessitating care, ethnicity, number of placements and gender are used to describe the socio-demographic presentation of these children. Following this descriptive inquiry, four of these child-related factors are investigated to determine if they are predictive of placement change at four developmental age groupings. The current study, therefore, was designed to advance the current child welfare knowledge base by providing regionally based facts that could both inform and identify further areas for investigation within the child protection system.

Treatment Issues for Children in Protective Care

Children removed from their biological home for reasons of abuse, neglect, abandonment, or because their family was unable or unwilling to care for them face unique developmental challenges. Researchers considering the mental health needs of these children have consistently suggested that they both exhibit a clinically significant range of psychopathology and access mental health services at a rate far greater than their non-in-care peers (Garland, Landsverk, Hough & Ellis-Macleod, 1996; Landsverk & Garland, 1999; Leslie, Landsverk, Ezzet-Lofstrom, Tschann, Slymen & Garland, 2000; Stein, Rae-Grant, Ackland, & Avison, 1994; Stein, Evans, Mazumdar & Rae-Grant, 1996). The estimated prevalence of psychopathology within this population has varied between studies due to methodological differences. Nevertheless, rates vary between 35 to 80%, findings significantly higher than the estimated prevalence of 17 to 22% found in community samples of children not in protective care (Stein et al., 1994; Thompson & Fuhr, 1992; Zima, Bussing, Freeman, Yang, Belin & Forness, 2000).

Types of Psychopathology

Despite problems with inconsistent methodologies between studies and varying use of standardized clinical assessment measures, several diagnostic themes emerge about the mental health of children in protective care. Attention Deficit Disorder with Hyperactivity (ADD/H), Oppositional Defiant Disorder (ODD), and Conduct Disorder (CD) (i.e. the disruptive behaviour disorders) tend to be the most common psychiatric diagnoses within this population. Zima, Bussing, Yang & Belin (2000) found that 41% of their school-aged sample met the diagnostic criteria for one or more of these disruptive disorders, with slightly fewer than half of these children having an additional one or more co-morbid diagnoses. Similarly, Stein and others (1994) reported that for their Canadian in-care sample between 41 and 63% of children had more than one diagnosed psychiatric disorder. These researchers found that conduct disorder, oppositional defiant disorder, and over-anxious disorder were more frequent among children who had experienced maltreatment.

Reasons for Needing Protective Care

Children who experience maltreatment are known to be at greater risk for experiencing deleterious effects in their development of adaptive emotional and behavioural regulation skills (Cicchetti & Toth, 1995; Kupsinel & Dubsky, 1999; Pearce & Pezzot-Pearce, 1997). These difficulties often extend beyond traditional psychiatric nomenclature and include problems with peer relationships, academic achievement, attachment, empathy development, and healthy development of self (Cantos, Gries & Slis, 1996; Cicchetti & Toth, 1995). Due to a paucity of operationalized definitions, however, nebulous categories describing types of maltreatment still exist. Much of the existing literature continues to broadly define maltreatment as comprising these four types of experiences: neglect, physical abuse, sexual abuse, and emotional abuse.

Recent national statistics compiled by Canadian Incidence Study researchers indicate that of these four clusters, neglect was the primary reason for investigation (40% of all reports) followed by reports of physical abuse (31%), emotional maltreatment (19%), and sexual abuse (10%) (Trocmé, MacLaurin, Fallon, Daciuk, Billingsley, Tourigny, Mayer, Wright, Barter, Burford, Hornick, Sullivan & McKenzie, 2001). Of these clusters, emotional maltreatment was most often substantiated by further investigation. This cluster of maltreatment included exposure to family violence, non-organic failure to thrive, emotional neglect, and emotional abuse (Trocmé et al., 2001). Interestingly, emotional abuse has been relatively neglected in both previous child maltreatment research and intervention-based literature, with the majority of studies focusing on the

experiences and sequelae of physical and sexual abuse (Hamarman, 2000). Despite this, at its most basic level, emotional abuse is believed to '...damage immediately or ultimately the behavioural, affective or physical functioning of the child' (Garbarino, Guttman & Seeley, 1986, p.8). Much like physical or sexual abuse, the effects of emotional abuse can be pervasive in both severity and intensity of impairment on later adaptive functioning.

The Contribution of Ethnicity

Aboriginal peoples in Canada have sustained a long and difficult journey with both Child Welfare and other governmental authorities (Palmer & Cooke, 1996; Timpson, 1995). The legacy of residential schools and the pervasiveness of cultural dislocation that frequently places Aboriginal children with non-Aboriginal families often means that these families experience generational effects of limited healthy parenting experiences within their family or community of origin. Problems with substance abuse, poverty, family violence, abandonment, frequent loss, and depression appear common and some researchers believe that these factors contribute to a repetitive cycle of child abuse and neglect (Horejsi & Craig, 1992).

Palmer and Cooke (1996) have suggested that the presence of 'Eurocentric values' may account for the significant prevalence of Aboriginal children in protective care and may explain the greater than average apprehension rates in these communities. Concentrating on Eurocentric values means that Aboriginal values related to lifestyle, cultural beliefs about parenting, education, respect and spirituality, and the role of extended family in caring for a child may impede these communities from providing for their own children. In addition, self-harming behaviours such as substance abuse, family violence, and suicidality can be understood as evolving within a context where oppression is internalized through the knowledge that parents cannot care for their children (Palmer & Cooke, 1996; Horejsi et al., 1992).

Aboriginal peoples are known to represent approximately 3% of the Canadian population (Statistics Canada, 1996 Census Data). The four Western Canadian provinces are home to almost two-thirds of the Aboriginal population, and account for the heaviest concentration of Aboriginal peoples amongst all Canadian provinces (Statistics Canada, 1996 Census Data). Despite this known concentration of Aboriginal peoples within western provinces, Aboriginal children accounted for only 2% of the total child population census data for the urban centre captured within this research study (Statistics Canada, 1996 Census Data). Recent governmental statistics indicate, however, that 37% of all children in protective care within this province are of Aboriginal descent (Child and Family Services Information, 1999). This significant discrepancy is far greater than would be

statistically expected, and supports traditional beliefs that Aboriginal peoples are over-represented in child welfare populations.

This Study

The purpose of this research study is to statistically explore the socio-demography of Albertan children in protective care. As was discussed earlier, it was anticipated that the results from this study could further the development of more efficacious child welfare service delivery models. To begin this process, four developmental age groupings were made from the larger sample. These groupings were identified as early childhood, middle childhood, early adolescence, and later adolescence. Results were then analyzed according to these age groups in anticipation of both generating a socio-demographic profile of these children in protective care at four key developmental periods, and in identifying those specific socio-demographic factors predictive of placement instability.

Method

Sample

Participants were randomly selected from a regional Child and Family Services Authority in a major city in Western Canada. This region's mandate is to provide services to children and families. Services within this authority were provided to an average of 3843 children per month (Government of Alberta, p.7) during the years 1999-2000.

For the analyses in this study, socio-demographic and diagnostic data was obtained about identified children in protective care from Child Welfare case managers and the Child Welfare Information System database (CWIS). The CWIS is an informational database containing historical information about each child, his/her placement history, reasons for entering care, legal authority, service history, investigations and yearly case reviews. Children's files were selected for participation if they met the following criteria: between the ages of 5 and 17 years, temporary or permanent guardianship, and having maintained their current placement for three months or longer. To attain a representative sample that was balanced among the various child welfare worksites within this region, participants were then further selected for gender, age, and legal authority. The total sample included 674 children from 13 child welfare worksites. Complete data were obtained for 83% of the total cohort (n=561).

The final sample was composed of 561 participants, of whom 50.1% were female, 78.6% had the province as permanent guardian, 43.7% were

Aboriginal, 42.6% were Caucasian, and 13.8% were either of unknown or of 'Other' ethnic origins (based on the biological mother's ethnicity).

Procedure

Each child's case manager was provided with a demographic questionnaire that could be completed through two processes. Initially, information easily obtained through CWIS (i.e. ethnicity of mother, date that child first entered protective care, number of placements, gender and legal authority) was completed by the primary researcher and / or administrative staff at each child welfare worksite trained in the completion of the questionnaire. Partially completed questionnaires were then forwarded to the child's case manager for completion and review. These remaining questions included information specifically known to the case manager through interactions with the child and his or her family (i.e. diagnoses, reasons for entering care). Completed questionnaires were then mailed to the researcher.

Instrument

A demographic questionnaire was created by the researcher to obtain specific, readily accessible demographic information about children in protective care (see Appendix D). Nine questions were compiled accessing information about a child's date of birth, gender, ethnic origins of biological parent(s), number of placements, number of returns to parental care, reasons for entering care, legal authority and diagnoses. Several child welfare case managers, area supervisors, and a regional manager, previewed questions during the creation of the questionnaire to assist with question clarity.

Variables

Number of Placements

All listed placements recorded within the child's placement history on CWIS were summed for a total number of placements count for each child. Placements included the child's initial placement involvement with the child welfare system and all subsequent placements up to and including the current placement. In addition, all unapproved absences (AWOL's) were included as relevant placements, as although the child was residing in a location other than the approved placement, he or she was still theoretically under the protective care of the child welfare system. For this sample, the average number of placements experienced by a given child was 8.25 (SD= 7.81, Range = 1 – 84).

Diagnosis

Each child's case manager was asked to identify if a child had one or more known or suspected psychiatric or medical diagnoses. Using the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV, American Psychiatric Association, 1994) nomenclature, several diagnoses and two medical conditions were listed. These included: attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD), fetal alcohol syndrome or effects (FAS / FAE), Reactive Attachment Disorder (RAD), Medical Condition / Physical Disability, Learning Disabilities (LD) and an 'Other' category. Diagnostic information was reported by the case manager based on previous psychiatric, psychological or medical assessments of the child as listed within the child's child welfare file. The children within this in-protective care sample frequently had more than one diagnosis (M=1.25, SD = 1.28).

Ethnicity

A child's ethnic origin was determined by accessing information about the child's biological parent's (or parents') identified racial origin on CWIS. Because a large group (30.3%, n=170) of childrens' fathers' racial origin was identified as unknown, a child's ethnicity was discussed in terms of the mother's racial origin. In this study, therefore, all of the childrens' ethnicity has been operationalized as 'mother's ethnic origin'. Based on this information, the two predominant ethnic groups were Aboriginal (comprised of Treaty, Status and Métis), and Caucasian, accounting for 86.3% of the total population (n=484).

Reasons for Entering Care

Each child's case manager identified one or more reasons that a child initially came into protective care. Listed reasons were based on the Child Welfare Act legislation (1984), within the province of Alberta. Both known and suspected options were possible for each identified reason. The nine listed reasons included abandonment, physical abuse, sexual abuse, emotional abuse, out of parental control, risk of abuse, developmental disabilities, parent being unable or unwilling to provide care, and an 'other' category. The three most common reasons for entering protective care were a parent being unable or unwilling to provide care (73.1%, n=410), emotional abuse (44.1% n=251), and physical abuse (36.5%, n=205). The children in this study typically came into care because of experiencing more than one condition requiring services from Child Welfare (M=2.86, SD = 1.54), with one-third of the children being placed because of four or more reasons.

Legal Authority

Once a child becomes involved with the Child Welfare system, guardianship and legal responsibility for the child is identified by a specific legal authority as defined by the Child Welfare Act (1984). A child's legal authority within the Child Welfare system was identified using CWIS. For the purposes of this study, three primary legal authorities were identified: permanent guardianship, temporary guardianship, and other. Permanent guardianship accounted for 78.4% of the entire sample (n=440), and represents the situation where a child welfare director is the child's only guardian, and the parent or any other guardian has no legal rights or responsibilities in caring for the child. Temporary guardianship was the legal authority for 13.5% of the sample (n=76). This type of guardianship occurs when the legal responsibility for the child is shared between the child welfare director and the child's other guardians. Finally, the 'Other' category comprises those legal authorities less well represented within this sample; custody agreements, interim custody agreements, orders to extend temporary guardianship or custody agreements, and permanent guardianship agreements. These 'Other' legal authorities accounted for 7% of the sample (n=45), and represent situations where there is a voluntary agreement between the guardian and child welfare director to provide temporary out-of-home care for the child (custody agreement), or where the guardian voluntarily relinquishes legal responsibility for the child to the child welfare director (permanent guardianship agreement).

Number of Months per Placement

As has been described previously, the average number of placements for a given child within this sample was calculated. It was determined that this broad mean did not consider the variable length of time a given child might be in protective care. A new variable was therefore created, that considered both number of placements and length of time a child has been in care. This variable is represented in the units of number of months per placement. For this sample, the mean number of months per placement was 15.90 (SD= 16.71).

Number of Returns to Parental Care

During the history of a child's involvement with child welfare, he or she may be returned to parental care on one or more occasions for family reunification, usually under a supervision order. A supervision order is a legal order directing mandatory services and provisions for a family that can support them in maintaining their child safely at home. If the child requires additional protection, or cannot remain safely in the home, the child returns to the care of the child welfare director. Many children in protective care have

been returned home from protective care and then brought back later into care because of these situations. For the children in this sample, most had been returned home one or more times following their initial placement with Child Welfare (M=1.59, SD=1.58).

Ethics

Ethical approval was granted for this study by the University of Alberta Ethics Review Committee. Given the sensitive needs of this population and the extent of confidential information potentially being accessed additional ethical review was required by the regional Child and Family Services Authority. Following the completion of an oath of confidentiality by the researcher, ethical approval was granted for the data collection required for this study.

Results

The socio-demographic and diagnostic data used within this study were analyzed using SPSS© software (version 10.0). The total sample of 561 children in protective care accessed for this study was grouped into four developmental age groupings; early childhood (ages 5 – 7 years), middle childhood (ages 8 – 10 years), early adolescence (ages 11 – 13 years), and later adolescence (ages 14 – 17 years). Socio-demographic data are reported for each of these age groupings and are presented in a question and answer format. These findings are a synopsis of the following socio-demographic factors: known psychiatric or medical diagnosis, gender, and reasons for entering care as they relate to placement stability.

In addition, basic socio-demographic information is provided for each age grouping for descriptive purposes. Information presented within this context includes descriptors such as gender, ethnicity, legal authority, mean number of placements (child welfare placements and parental care placements), mean number of returns to parental care once in protective care, mean number of months per placement, mean percent of a child's life spent in protective care, mean number of child welfare placements, and range of placements experienced for each of the four developmental age groupings.

The final results of these socio-demographic data analyses are presented as a compilation of information known about this study's sample of children at each of the four developmental age groupings. In addition, specific socio-demographic factors that relate to placement instability are identified for each of the age groupings.

Research Questions

1. **What basic socio-demographic information is known about this sample of Albertan children in protective care?**

Basic socio-demographic information was collected about each child through accessing information either known by the child's child welfare case manager or through information compiled within CWIS about the child. To provide a context in which to understand basic information about these children, a summary of their information is presented in Table 1 for each of the four developmental age groupings.

For the early childhood aged children in this sample, many had spent most of their young lives in protective care (M=0.73%, SD= 0.24%). Naturally, therefore, the most common legal authority for more than 80% of the children in this age grouping was that of permanent guardianship. Additionally, these young children were primarily of Aboriginal or Caucasian ethnicity, and were equally likely to be either male or female. They spent on average 14 months per placement, with the children in this sample experiencing a range of 1 through 17 different placements.

The middle childhood aged children were also equally likely to be either male or female, and although they spent less of their childhood in protective care than their younger counterparts did, the average child in this age grouping spent almost two-thirds of his or her life in protective care (M=0.63%, SD=0.26%). It was also noted that children of Aboriginal ancestry were more prevalent than children of Caucasian ancestry at these middle childhood ages although this finding was not statistically significant. Permanent guardianship was again the most common legal authority. In addition, it was noted that children within this age grouping spent on average 15 months per placement, with the total number of placements experienced ranging from 1 through 18.

The early adolescent aged children were similar in description to the middle childhood aged children for several of the demographic variables. These children had also spent on average, almost two-thirds of their lives in protective care, were primarily of Aboriginal and Caucasian ancestry, and almost equally likely to be either male or female. Interestingly, more of these children than those of both the middle and early childhood ages had permanent guardianship orders (83.9%). In addition, children in this age grouping experienced on average more months per placement than either their younger or older peers in care, although this finding was not statistically significant ($F=2.18$, $p=0.09$).

Finally, the later adolescent aged youth accounted for the largest percentage of the entire sample (29.9%), likely a result of this age grouping covering four years of development as opposed to the three years for the other age groupings. Youth in this age grouping were significantly more likely to be of Caucasian ancestry (χ^2=61.48, p=0.00). They also had spent on average only half of their lives in protective care, and experienced the greatest range of number of placements (1 – 84). The average number of months per placement, however, did not differ significantly from the other age groupings or from the overall sample mean (F=2.18, p=0.09).

Table 1

Summary of socio-demographic variables for each of the four developmental age groupings.

Variable	Early Childhood	Middle Childhood	Early Adolescence	Later Adolescence
	Percent	**Percent**	**Percent**	**Percent**
Sample (N=561)	22.1	23.5	24.4	29.9
Female	50	50	51.8	48.8
Ethnicity				
Aboriginal	48.4	50.8	48.2	31.0
Caucasian	40.3	40.2	42.3	46.4
Other / Unknown	11.3	9.1	9.4	22.6
Legal Authority				
PGO	81.5	74.2	83.9	75.0
TGO	14.5	19.7	11.7	9.5
Other	4.0	6.0	4.3	15.5
	Mean (SD)	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**
Number of Placements (CW + Parental)*	5.44 (3.10)	6.22 (3.64)	8.43 (1.82)	11.76 (11.60)
Number of returns to parental care**	1.28 (1.23)	1.73 (1.48)	1.82 (1.71)	1.51 (1.73)
Number of months per placement	14.27 (12.360)	15.57 (13.35)	18.97 (22.55)	14.87 (16.09)
Percent of life in care	0.73 (0.24)	0.63 (0.26)	0.65 (0.27)	0.50 (0.31)
Range of Placements	1 - 17	1 – 18	1 – 36	1 - 84

* CW = Child Welfare

** Number of returns to parental care following initial out-of-home placement with CW

2. What are the most common diagnoses for each of the four age groupings?

The psychiatric and medical diagnoses were reported by a child's child welfare case manager. These results are now summarized for each of the four developmental age groupings, and are presented in Table 2. Learning disabilities was the most commonly identified psychiatric disorder for the children in the three youngest age groupings with reported incidences of 25 to 37 percent. These prevalence rates are significantly higher than established community (i.e. not in-care) prevalence rates for LD's (DSM-IV report of 2 – 10%, APA 1994). Interestingly, youth in the later adolescence group experienced ADHD as the most commonly identified disorder (31%); again with prevalence rates far higher than those established for community populations (DSM-IV report of 3 – 5% for school age children, APA 1994).

Table 2

Summary of the psychiatric and medical diagnostic variable for each of the four developmental age groupings presented as percentages.

Variable*	Early Childhood	Middle Childhood	Early Adolescence	Later Adolescence
	Percent	**Percent**	**Percent**	**Percent**
Diagnoses				
ADHD	20.2	25.0	34.3	31.0
ODD	3.2	5.3	13.1	17.9
CD	4.0	2.3	8.8	16.7
FAS/FAE	21.0	9.1	10.9	10.7
RAD	15.3	8.3	7.3	5.4
Medical/ Physical Disability	16.1	10.6	8.0	10.7
LD	33.1	25.8	37.2	21.4
Other	12.1	14.4	19.0	22.0
Mean	1.25	1.00	1.38	1.35
SD	1.29	1.19	1.31	1.31

* Numbers add up to more than 100% because respondents could acknowledge more than one diagnosis for a given child.

3. Does a child who has a known psychiatric or medical diagnosis experience more placements?

There was not a significant correlation between diagnosis and frequency of placements for three of the age groupings (early childhood r=0.042, middle childhood, r=-0.089, and later adolescence, r=0.131). This suggests that the experience of a psychiatric or medical diagnosis does not relate to a greater frequency of placements whilst in protective care for children in these age groupings. For children and youth in the early adolescence age grouping, however, there was a weak but significant positive correlation between diagnosis and frequency of placements (r=0.171). Children in this age grouping, therefore, who have a known

psychiatric or medical diagnosis are more likely to experience a greater number of placements during their time in protective care.

4. **What are the most common reasons a child comes into protective care for children in each of the four developmental age groupings?**

Each child's child welfare case manager was asked to identify the one or more reasons that their identified child required protective care. The overall results for each developmental age grouping are presented in Table 3. The primary reason that a child required protective care across the four age groupings was because of the child's parent(s) being unable or unwilling to provide care. Of interest, was the pervasiveness of emotional abuse as a reason for needing protective care. For children between the ages of 5 and 13, emotional abuse was the second most prevalent reason for requiring protective care, and was identified as occurring for over one-third of the larger sample. Similarly, abandonment and physical abuse were common reasons for entering care, and varied in frequency across the age ranges. Developmental needs also appeared to be a factor in the reasons a child required protective care, with early childhood aged children being more likely to experience abandonment and be at risk for abuse, whereas the later adolescent aged children were more likely to have experienced physical abuse (45.2%, n=76), and be out of parental control (36.9%, n=62).

Given the complexity of many of these children's situations prior to entering care, it was not surprising to note the range of reasons a child required protective care. Ranges of identified reasons for each age range are included within Table 3. Most children in this sample came into protective care because of two or more reasons (M= 2.86, SD= 1.54, n=428).

Table 3

The known reasons a child requires protective care for four developmental age groupings reported as percentages.

Variable*	Early Childhood	Middle Childhood	Early Adolescence	Later Adolescence
	Percent	**Percent**	**Percent**	**Percent**
Abandonment	33.9	36.4	32.8	25.6
Physical Abuse	20.2	32.6	44.5	45.2
Sexual Abuse	9.7	12.1	16.8	17.9
Emotional Abuse	37.9	47.0	51.8	42.3
Out of Parental Control	4.8	9.1	15.3	36.9
Risk of Abuse	27.4	22.7	31.4	26.2
Developmental Disabilities	16.9	11.4	10.9	10.7
Unwilling / Unable to Provide Care	76.6	73.5	78.1	66.1
Other	25.8	32.6	26.3	28.0
Range	1 - 7	0 – 8	0 – 7	0 - 7

* Numbers add up to more than 100% because respondents could acknowledge more than one reason for entering care for a given child.

5. What socio-demographic factors are associated with placement instability for children in protective care?

A regression analysis was used to statistically predict the variance in the dependent variable number of months per placement, based on linear combinations of the following independent variables: emotional abuse, abandonment, FAS / FAE, LD, gender, ADHD, physical abuse, medical

condition / physical disability, out of parental control, ODD, and conduct disorder. A separate step-wise multiple regression analysis was conducted for each of the four developmental age groupings.

Ethnicity was converted to a dichotomous variable by pre-selecting the final sample to include only the two largest ethnic groups: Aboriginal and Caucasian. The two other ethnic groups of unknown or other ethnic origin were deleted from these analyses, as sample sizes for these two groups were too small for statistical comparisons. The sample size was thus reduced from 561 to 484 for the regression analyses.

Independent variables were selected for each age grouping based on the relationship between these variables and the dependent variable at each of the age ranges. A step-wise multiple regression analysis was selected, given the exploratory nature of this research. A summary of these results are discussed below and presented in Table 4.

For the early childhood aged children, the experience of emotional abuse was the strongest and only significant predictor of placement stability. Accounting for 8.4% of the variance in the dependent variable, early childhood aged children with the experience of emotional abuse were more likely to experience greater placement instability, with on average, fewer number of months per placement than those without this experience. The other independent variables selected for this model included abandonment, FAS/ FAE, LD, and gender, and as none of these met the statistical criteria for entry into the model, they were excluded as predictors for the regression model.

For the middle childhood aged children, the diagnosis of fetal alcohol syndrome or effects was the strongest and only predictor of placement instability. Children with these diagnoses were more likely to experience greater stability in their placements, than those without these diagnoses, and this independent variable accounted for 3.5% of the variance in the dependent variable. The other independent variables considered for this model were not significant, and therefore, were excluded from the final model. These independent variables included emotional abuse, abandonment, LD, gender, and ADHD.

For the early adolescent aged children, two predictors of placement instability were identified within the regression model. These variables accounted for 13.4% of the variance in the dependent variable, and included having a known medical condition or physical disability, and experiencing emotional abuse. As with the other age groupings, several of the other identified independent variables were not significant, and were excluded from the final model. These variables included gender, LD, ADHD, and physical

abuse. For children in this age range having a medical condition and/or physical disability served as a protective factor, increasing the likelihood that they would experience a greater number of months on average per placement. The experience of emotional abuse, however, increased the likelihood of the experience of instability. Children with these experiences experienced on average, fewer months per placement.

Finally, for the later adolescent aged children, two predictor variables were identified within the regression model. Having a known conduct disorder and having had the experience of emotional abuse were identified as accounting for 7.2% of the variance in the dependent variable. For these youth, the experiences of emotional abuse and having a known conduct disorder increased the likelihood of placement instability. Children with this socio-demographic presentation were more likely to experience, on average, a fewer number of months per placement.

Table 4

Summary of step-wise multiple regression analyses for significant predictor variables of the number of months per placement for four developmental age groupings (N=484)

Variable	B	SE B	β
Early Childhood			
Emotional Abuse	-6.24	1.98	-0.29
Middle Childhood			
FAS / FAE	9.70	4.67	0.19
Early Adolescence			
Medical Condition / Physical Disability	24.97	6.05	0.35
Emotional Abuse	-7.83	3.45	-0.19
Later Adolescence			
Conduct Disorder	6.72	2.99	-0.19
Emotional Abuse	-5.12	2.29	-0.19

Note. R^2=0.084 for Early Childhood, 0.035 for Middle Childhood, 0.134 for Early Adolescence, and 0.072 for Later Adolescence.

Discussion

Several significant results evolved through this exploration of demography and psychopathology within an Albertan child welfare population, and bear discussion when compared with previous researchers' findings. In compiling the findings from this study, a preliminary socio-demographic profile of Albertan children in protective care at four key developmental age groupings was initiated. Further to this, several significant details within the profiles were noted. These included the extent of placement instability experienced by the children within this sample, regardless of age; the prevalence of emotional abuse experienced by this sample of children prior to entering protective care; and the statistical over-representation of children of Aboriginal ancestry in protective care within this sample. Each of these features is discussed within the broader context of both child protection and developmental psychopathology research.

Placement instability, long recognized as a systemic problem for child protection services, was again highlighted within this study as an ongoing issue. Children in this study, regardless of age, were on average able to sustain a placement for slightly more than one full academic year. This finding has significant implications for the more than 20% of children in this sample with identified learning delays or disabilities, children who often require consistency, structure, and familiarity in their learning environments. Frequent changes in home, school and peer communities can also mean that children become at a greater risk for further behavioural and emotional sequelae as they struggle to cope with repeat multiple losses.

Cicchetti and Toth (1995), in the developmental psychopathology model, have suggested that these children by virtue of their early experiences of maltreatment follow different developmental trajectories and consequentially deviate in their acquisition of meaningful stage-related skills. Skills such as the ability to attach and sustain significant relationships, regulate affect, be cognitively flexible, and comprehend social cues. Significant placement instability seems likely, therefore, to further exacerbate the behavioural symptomatology these children tend to exhibit in response to their already compromised development.

Based on the results of this research study, the preliminary socio-demographic profile for an early childhood aged child in protective care included the following features. Children within this five to seven year old age range were equally likely to be of either Aboriginal or Caucasian ancestry, and of male or female gender. These children were on average able to sustain a placement for approximately 14 months, a time period slightly longer than one academic year. Despite the young age of these children, and that on average they had spent more than 70% of their lives in

protective care, the frequency of placement instability was still high, with the children in this age range experiencing on average five placements. In addition, more than 20% of the children in this age range had been diagnosed with a learning disability, FAS/ FAE, and / or ADHD, a finding not surprising given the symptomatology of FAS / FAE and the associated cognitive, attention and impulse control deficits. Furthermore, the most common reasons these children initially required protective care were because of experiences related to emotional abuse, abandonment, and / or risk of abuse. When these variables were considered relative to placement instability, the experience of emotional abuse was found to be the strongest and only predictor of placement instability.

For the middle childhood aged children, many of their socio-demographic features were similar to their younger peers. Children in this eight to ten year old range were again equally likely to be of Aboriginal or Caucasian ancestry, and to be of male or female gender. The experience of emotional abuse was again the most prevalent reason for a child in this age range to require protective care, and other common reasons included parental abandonment, physical abuse, and a broad spectrum of reasons clustered under the 'other' category. These reasons could include neglect, and / or parental drug or prostitution involvement. Learning disabilities and ADHD were the two most common psychiatric diagnoses for the middle childhood aged group, with the 'Other' category of psychiatric diagnoses being the third most common diagnostic category. This 'Other' category predominantly clustered either the internalizing diagnoses of anxiety, depression, adjustment disorders, and bereavement, or sub-clinical syndromes of increased aggression, irritability, poor social skills, and general oppositional defiance. The average placement for these children lasted 15 months, and the children in this age range had spent about two-thirds of their lives in protective care.

When these socio-demographic variables were considered relative to placement instability, the diagnosis of fetal alcohol syndrome or effects was found to be the strongest and only predictor of placement stability for the middle childhood aged children. In fact, this diagnosis appeared to be a protective feature for these children, contributing to greater placement stability. Because of the exploratory nature of this research, definitive reasons as to why a diagnosis of FAS or FAE is protective for this age group are difficult to ascertain. Future researchers may want to consider if these children and their careproviders receive more support from the child welfare system, and if this additional support is an important component in what mediates placement success.

The early adolescent aged children were again much like their younger peers, with equal representation for both Aboriginal and Caucasian

ancestries, and between genders. In addition, the three most common diagnoses for these pre-teens were similar to the middle childhood aged children with learning disabilities, ADHD and / or the 'Other' category being diagnosed for more than 15% of this grouping. Children in their early adolescent aged years were able to sustain a placement for an average of almost 19 months, the longest of any of the developmental age groupings.

The experience of emotional abuse was again the primary reason that these early adolescent aged children required protective care, and was followed in prevalence by the experience of physical abuse and being at risk of abuse. Interestingly, when all these factors were considered relative to placement stability, two predictive variables were identified, with one variable being protective, and the other increasing the likelihood of placement instability. Children with an identified medical condition or disability were more likely to sustain an out-of-home placement for a longer duration. This finding seems consistent with current practice, as many of the families caring for these children receive considerable external supports for the child, and that these children because of their limitations and the additional supports are often easier to manage within family, community and school settings. The experience of emotional abuse, however, increased the likelihood of placement instability, and over 50% of this age group was identified as having this experience before entering protective care. As has been suggested by Newton and others (2000), the associated behavioural and emotional sequelae resulting from maltreatment prior to entering care are likely exacerbated by the in-care experience of placement change; a cycle which over time compounds the likelihood for further placement disruption, behavioural exacerbation, and difficulties with overall placement sustainability.

The socio-demographic profile for the later adolescent aged youth differed from the profiles for the three younger age groupings. To begin with, these youth were significantly more likely to be of Caucasian ancestry. They were also brought into protective care for reasons of physical abuse, emotional abuse and for being out of parental control. Although there was a gradual increase in the prevalence of the more severe behavioural dyscontrol diagnoses such as conduct and oppositional defiant disorder within this age grouping, the three most prevalent disorders continued to be ADHD, 'other' diagnoses or sub-clinical syndromes, and learning disabilities.

Interestingly, the diagnosis of conduct disorder and the experience of emotional abuse were the two socio-demographic variables identified for this age grouping as predictive of placement instability. It would seem that youth with the most severe problems with aggression, poor impulse control, hyperactivity, and oppositional and rule breaking tendencies were more likely to experience greater placement instability, a finding which is consistent with

the known difficulty in managing these children in traditional school, family and community settings. In addition, the youth in this study were found to have experienced, on average, 11 placements. It is suggested that the effects of repeat multiple losses whilst in care likely exacerbates pre-existing behavioural and emotional symptomatology that becomes increasingly difficult to manage as a child ages.

One socio-demographic factor present throughout the four developmental age groupings was the significant prevalence of the experience of emotional abuse. Additionally, this factor was identified as predictive of placement instability for three of the four age groupings. A relatively neglected area in previous research, almost half the children in this sample were reported as having experienced emotional abuse and/or neglect prior to entering care. Known to have potentially deleterious effects on relationship development, trust, empathy, social reciprocity, and cognitive development, the experience of emotional abuse was significantly associated with a child's ability to healthily sustain a placement. It appears likely therefore that some behavioural symptomatology that can be measured within current diagnostic schemas might well represent maladaptive coping efforts intensified by length and quality of experiences within an emotionally impoverishing environment.

Another interesting finding within this study was the disproportionate representation of children of Aboriginal ethnicity. Known to represent less than 2% of the overall Canadian child population (Statistics Canada, 1996 Census Data), children with Aboriginal ethnicity accounted for 45% of this in-care sample. One important historical factor for Canadian Aboriginal peoples that may in part account for this over-representation is their ancestors' traumatic experience of residential schools. Some researchers have suggested that the lasting traumatic effects of being abused within these schools, being isolated from their communities, and being denied recognition of their cultural ancestry may mean that aboriginal families and their communities have generational sequelae. Effects expressed through limited parenting knowledge, attachment difficulties, child abandonment, substance abuse, familial violence, neglect, and generations of deviated developmental trajectories (Horejsi & Craig, 1992; Palmer & Cooke, 1996). Although only descriptive in nature, these findings highlight the need for further research that investigates how to better meet the needs of Aboriginal families.

Limitations

The limitations of this study were primarily related to the means in which the information about children was collected. Due to the size of the sample, and the need to have a consistent procedure for obtaining information, there was a reliance on information readily obtained through

CWIS. As with any large database, information is only as reliable as the data entry, and the abundance of information known to the case manager at the time of report. In addition, it was not feasible within this study to verify the diagnostic assessments of individual children, and so diagnostic information reported by case managers was presumed to be accurate. Furthermore, case managers with varied education and training levels completed the demographic questionnaire, and therefore the reporting of diagnostic information was dependent on their familiarity with this nomenclature. Finally, this sample was obtained from one urban centre. Results from this study, therefore, may not be generalizable to other Canadian communities.

Conclusion

The purpose of this study was to explore statistically the socio-demographic factors that both describe Albertan children in protective care and predict placement instability. Three significant findings emerged from the analyses and each contributes to the existing literature in important ways. These findings documented the high frequency of placement instability, the prevalence of emotional abuse experienced by these children prior to entering care and the predictive value of this experience in regards to later placement instability, and the disproportionate representation of Aboriginal children within this sample. In addition to these findings, the beginnings of a socio-demographic profile of children in protective care in Alberta at four developmental age groupings was developed. Together, these findings are important and novel contributions to the existing literature. This study provides current data which uses a sizable sample and involves a documented method: two problems that have been widely discussed in the literature.

On a broad level, these findings met the purpose of this research study. These statistical analyses now document the socio-demographic realities of an urban sample of Albertan children in care. Several further questions, however, evolve from a more in-depth consideration of the results. It is apparent, for example, that socio-demographic factors alone were insufficient to predict placement instability. As only a small portion of the variance was accounted for by these factors, the question than becomes 'What else is contributing to this phenomenon?' Several directions for future researchers emerge from this question. One such direction involves exploring the paradigms that support child welfare practice and more specifically considering how these paradigms define beliefs and practices about risk and placement. Risk assessment is an important component in child welfare practice and determines which children come into protective care and the nature of their placement experience. Risk, however, is also a socially and culturally constructed phenomenon that can in part evolve from an organization with an inherent power imbalance making moral assumptions

about parenting, family and other complex social processes. By acknowledging the social nature of placement instability and child welfare practices, future researchers can shape their explorations with the realization that factors such as reasons for entering care, psychiatric diagnoses, and even number of placements while in care are not isolated and must be researched for their risk value within the context of the power imbalances for issues such as class and race.

Further research is also needed to understand the disproportionate representation of Aboriginal children in care within this sample. The effects of colonization and assimilation in current society and the social exclusion these communities face provides one context for understanding the social processes involved in this discrepancy. An examination of the child welfare practices that may further the colonization effect and promote assimilation are two areas worthy of investigating for future researchers. Understanding these historical, social and cultural influences not only provides the context with which to challenge traditional governmental practices and failed policies, but also the means to implement informed and meaningful social change in a manner that promotes growth within diversity.

References

1996 census: Aboriginal data. (n.d.). Retrieved February 7, 2002, from http://www.statcan.ca/Daily/English/980113/d980113.htm

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Bolster, J. M. (2003a). *Careproviders' perspectives about the factors contributing to placement breakdown for children in protective care.* Unpublished manuscript, University of Alberta.

Cantos, A. L., Gries, L. T., & Slis, V. (1996). Correlates of therapy referral in foster children. *Child Abuse & Neglect, 20 (10)*, 921 – 931.

Cicchetti, D., & Toth, S. L. (1995). A developmental psychopathology perspective on child abuse and neglect. *Journal of the American Academy of Child and Adolescent Psychiatry, 34 (5)*, 541 – 565.

Federal/Provincial Working Group on Child and Family Services Information. (2001, March). *Child and family services statistical report 1996-97 to 1998-99.* Hull, PQ: Author.

Garbarino, J., Guttman, E. & Seeley, J. W. (1986). *The psychologically battered child.* California: Jossey-Bass Publishers

Garland, A. F., Landsverk, J L., Hough, R, L., & Ellis-MacLeod, E. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. *Child Abuse & Neglect, 20 (8)*, 675 – 688.

Government of Alberta. (1984). *Child Welfare Act.* Alberta: Queens Printer.

Hamarman, S., & Bernet, W. (2000). Evaluating and reporting emotional abuse in children: Parent-based, action-based focus aids clinical decision-making. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 928 – 930.

Horejsi, C., & Craig, B. H. R. (1992). Reactions by native american parents to child protection agencies: Cultural and community factors. *Child Welfare, 71 (4)*, 329 – 343.

Kupsinel, M. M., & Dubsky, D. D. (1999). Behaviorally impaired children in out-of-home care. *Child Welfare, 78 (2)*, 297 – 310.

Leslie, L. K, Landsverk, J. L., Ezzet-Lofstrom, R., Tschann, J. M., Slymen, D. J., & Garland, A. F. (2000). Children in foster care: Factors influencing outpatient mental health service use. *Child Abuse & Neglect, 24 (4)*, 465 – 476.

Ma'Mowe capital region child and family services authority. (n.d.). Retrieved March 2001, from http://www.acs.gov.ab.ca/mamowe.us.html.

Palmer, S., & Cooke, W. (1996). Understanding and countering racism with first-nations children in out-of-home care. *Child Welfare, 75 (6)*, 709 – 726.

Pearce, J. W., & Pezzot-Pearce, T. D. (1997). *Psychotherapy of abused and neglected children*. New York,NY: The Guilford Press.

Pilowsky, D. (1995). Psychopathology among children placed in family foster care. *Psychiatric Services, 46 (9)*, 906 – 910.

Stein, E., Evans, B., Mazumdar, R., & Rae-Grant, N. (1996). The mental health of children in foster care: A comparison with community and clinical samples. *Canadian Journal of Psychiatry, 41 (6)*, 385 – 391.

Stein, E., Rae-Grant, N, Ackland, S., & Avison, W. (1994). Psychiatric disorders of children 'in care': Methodology and demographic correlates. *Canadian Journal of Psychiatry, 39 (6)*, 341 – 347.

Steinhauer, P. D. (1991). *The least detrimental alternative. A systematic guide to case planning and decision making for children in care*. Toronto: University of Toronto Press.

Thompson, A. H., & Fuhr, D. (1992). Emotional disturbance in fifty children in the care of a child welfare system. *Journal of Social Service Research, 15 (3/4)*, 95 – 112.

Timpson, J. (1995). Four decades of literature on native canadian child welfare: Changing themes. *Child Welfare, 74 (3)*, 525 – 547.

Trocmé, N., MacLaurin, B., Fallon, B., Daciuk, J., Billingsley, D., Tourigny, M., et al. (2001). *Canadian incidence study of reported child abuse and neglect: Final report*. Ottawa, ON: Minister of Public Works and Government Services Canada.

Zima, B. T., Bussing, R., Freeman, S., Yang, X., Belin, T. R., & Forness, S.R. (2000). Behavior problems, academic skill delays and school failure among school-aged children in foster care: Their relationship to

placement characteristics. *Journal of Child and Family Studies, 9 (1)*, 87 – 103.

Zima, B. T., Bussing, R., Yang, X., & Belin, T. R. (2000). Help-seeking steps and service use for children in foster care. *Journal of Behavioral Health Services & Research, 27 (3)*, 271 – 286.

Chapter 4 – An Investigation of the Emotional and Behavioural Functioning of Children in Protective Care in Alberta and the Relationship of this Functioning to Placement Instability

Abstract

The emotional and behavioural functioning of children in protective care in Alberta was explored through analyzing data from two behavioural questionnaires completed by a child's current careprovider. Results from these measures were used to describe these children and then predict placement instability across four developmental age groupings. The children in this sample were described as exhibiting consistently elevated levels of aggression, conduct problems, inattention, and poor impulse control, and these behavioural dyscontrol problems increased in severity as children grew older. In addition, conduct problems and attention problems were identified as predictive of placement instability for the youth in this sample. It was noted that behavioural and emotional factors are not sufficient in fully explaining the complexity of placement instability.

An Investigation of the Emotional and Behavioural Functioning of Children in Protective Care in Alberta and the Relationship of this Functioning to Placement Instability

Introduction

Placement instability is a well-recognized problem within child welfare organizations. That children in protective care often move from placement to placement is a reality for most service providers and that this phenomenon can have potentially deleterious developmental outcomes is a reality verified within numerous studies (Newton, Litrownik, Landsverk, 2000; Pardeck, 1984; Penzerro & Lein, 1995; Zima, Bussing, Freeman, Yang, Belin & Forness, 2000). Fortunately, the literature related to placement instability for children in protective care is growing and becoming more consistent and expansive with each new study. For instance, researchers have found relatively consistent results about some of the child-based factors related to an increased risk for placement instability. Specifically, factors associated with a child's behaviour (i.e. aggression, impulsivity, hyperactivity, attention problems, delinquency, etc.), learning needs, gender, experience of abuse as opposed to neglect, age, and ethnicity have all been noted within the literature as being associated with placement instability (Cantos, Gries & Slis, 1996; Dore & Eisner, 1993; Kupsinel & Dubsky, 1999; Palmer, 1996; Rittner, 1995; Webster, Barth & Needell, 2000; Zima et al., 2000).

As these child-based factors have been identified, the knowledge base related to placement instability has grown and further clarity has been added to understanding these risk factors. The purpose of this study, therefore, is to continue to add to the knowledge base through describing the behavioural and emotional presentation of children in protective care in Alberta across four developmental age groupings, and then use these behavioural and emotional markers to predict placement instability. In addition, through including developmental age groupings within the design of this investigation, the dimension of developmental change has been added to the descriptive and predictive purposes of this study.

Behavioural and Emotional Difficulties for Children in Protective Care

Several researchers have described some of the behavioural and emotional difficulties expressed by children in protective care. Rather consistently, these researchers have found that these children exhibit behavioural and emotional symptomatology that is psychiatrically clinical in nature, which as a result, often means that mental health treatment services are required for proportionately more of these children than their non-in-care peers (Garland, Landsverk, Hough & Ellis-Macleod, 1996; Landsverk & Garland, 1999; Stein, Rae-Grant, Ackland & Avison, 1994; Stein, Evans, Mazumdar & Rae-Grant, 1996). That said, the more disruptive behavioural

presentations have been found to be prevalent for children in protective care. Zima and others (2000) measured behavioural symptomatology for 300 children in foster care, and found that the disruptive behaviour disorders such as conduct disorder (CD), oppositional defiant disorder (ODD), and attention deficit disorder (ADD/H) were the most prevalent, followed by affective disorders, adjustment disorders, and then learning disorders (Zima, Bussing, Yang & Belin, 2000). Likewise, Stein and colleagues (1994) found similarly higher than expected frequencies for the disruptive behaviour disorders in her sample of 300 Canadian children in protective care (Stein, Rae-Grant, Ackland & Avison, 1994).

The relationship between behavioural and emotional symptomatology and placement instability is likely complex. Several researchers have found that placement instability is affected in part by children's behavioural needs, and careproviders have identified that behaviours that are difficult to manage are one of the most complicating factors in the likelihood of a child sustaining a placement (Bolster, 2003a). As the literature has identified, the disruptive behaviour disorders appear to be the most prevalent type of behavioural presentation. This finding is interesting given that these behaviours by their very definition are the most disruptive to others, and therefore, likely to be attended to by careproviders at a greater frequency than internalizing behaviours. That said, both Zima and his co-researchers (2000) and Stein and her colleagues found that the internalizing disorders such as depression and anxiety were also prevalent (Zima et al., 2000; Stein et al., 1994).

Placement Instability

As has been mentioned, several studies have explored the phenomenon of placement instability for children in protective care. Webster, Barth and Needell (2000) in their longitudinal study of young children in protective care found that gender, age and coming into care for reasons other than neglect were all significantly associated with greater placement instability. Males experienced instability more so than females, toddlers more so than infants and children with experiences of physical or sexual abuse more so than those having experienced neglect. In addition, these researchers found that those children who experienced more than average instability during their first year of protective care were more likely to continue to experience significant instability. These findings have been furthered by Newton and others (2000) who found that early behavioural problems were the strongest predictor of placement changes for their sample. Similarly, Kupsinel and Dubsky (1999) noted that behavioural impairment could also predict a lengthier time in protective care (regardless of frequency of placement change), with behaviourally challenged children spending more overall time on average than their non-handicapped peers.

Placement instability is also known to have an effect on learning and academic needs. Zima and others (2000) found that greater placement instability was associated with children experiencing one or more severe academic skill delays. It would seem that the experience of even one additional placement increased the risk ratio for academic problems significantly. As would be expected, these researchers also found those children in protective care for longer periods were more likely to have also experienced suspension or expulsion from school. This finding is not surprising given the association between length of time in care and behavioural difficulty. To support these findings, Altshuler (1997) summarizes that children in protective care exhibit significantly lower academic achievement and performance than their community-based peers, and have higher rates of learning disabilities and emotional problems that interfere with optimal learning success.

This Study

The intention of this investigation, therefore, is to further add to the current knowledge base about both children in protective care and placement instability. To meet this goal, this study was designed to explore the emotional and behavioural functioning of children in protective care in Alberta, and then use these descriptive findings to identify child-related behavioural and emotional factors that predict placement instability over four different developmental periods of a child's life. These four age groupings were operationalized as early childhood (ages 5 – 7 years), middle childhood (ages 8 – 10 years), early adolescence (ages 11 – 13 years), and later adolescence (ages 14 – 17 years). The two assessment measures utilized in this study were the Behavioral Assessment System for Children (BASC, Randall & Kamphaus, 1992) and the Randolph Attachment Disorder Questionnaire (RADQ, Randolph, 1997).

Method

Sample

Participants were randomly selected from a Child and Family Services Authority in a major city in Western Canada. The mandate of this children's authority is to provide services to children and families, services that include child protection. Child protection services were provided to an average of 3843 children per month within this regional authority during the years 1999-2000 (Government of Alberta, p.7).

For this investigation, children in protective care were selected to participate if their file met three criteria, and if once selected, they contributed to both a representative and balanced sample for gender, age, and legal authority across the 13 child welfare worksites working within this regional

authority. The three selection factors included being between the ages of 5 and 17 years, having a legal authority of either temporary or permanent guardianship, and having sustained their current child welfare placement for a minimum of 3 months.

The data for this study was a subset of data collected by this researcher (Bolster, 2003b) as part of a larger research study. For this investigation, only those children's files with complete information from two reporting sources were considered. The two reporting sources that described the children for this investigation were a child's child welfare case manager and current careprovider. The larger research study sampled 674 children's files in protective care from 13 child welfare worksites within this regional authority.

For this investigation, the final sample was comprised of 402 participants, of whom 50.5% were female and 78.9% had the province as permanent legal guardian. The two main ethnic groups were Aboriginal and Caucasian, with representations of 43.3% and 41.8% respectively. A further 14.9% of these children were either of Unknown or of 'Other' ethnic origins (based on the biological mother's ethnicity). Complete data from the first respondent (the child's case manager) was obtained for 83% of the total cohort (N = 561), and complete data from both reporting sources (the case manager and current careprovider) was obtained for 71.6% of this smaller cohort (N = 402).

Procedure

Information was obtained about each child participating in this study from two different sources. The first source, and the provider of demographic information, was the child's case manager within the Child Welfare system. The second source, and the provider of information specific to the child's emotional and behavioural functioning was the child's current careprovider; either foster parent, group home worker, or treatment worker at a residential setting (i.e. correctional services, addictions centres).

The first phase of the study involved collecting demographic information from the child's case manager. The demographic information that was collected about each child included data such as age, date of birth, ethnicity of biological mother and father, gender, legal authority, number of placements, number of returns to parental care, reasons for entering care and diagnoses. A full description of this procedure is detailed in Bolster (2003b). Once complete, this information was then returned to the researcher.

The second phase involved having case managers forward a package of two questionnaires assessing a child's behavioural and emotional functioning, to the child's primary careprovider. Careproviders were asked to

complete the questionnaires based on their knowledge of the child in their care and his or her psychological functioning within the past 3 to 6 months. Once questionnaires were complete, careproviders were then asked to mail the information back to the researcher.

Due to difficulties with data collection for some of the gender and age groupings, random files were selected from the list of incomplete files and with the permission of the case managers, careproviders for these children were contacted by phone. Careproviders were phoned and asked to participate, and for those in agreement the options of having the package mailed or participating in a telephone interview were presented. Fifteen careproviders were contacted and all preferred to participate in a telephone interview.

Instrument

A demographic questionnaire was created by the primary researcher to obtain specific readily accessible demographic information about children in protective care (see Appendix D). Information was obtained through the use of nine questions assessing the factors of age, gender, legal authority, number of placements, number of returns to parental care since entering protective care, reasons for entering protective care initially, diagnoses, date of birth, and ethnic origins of both biological mother and father. The questionnaire was previewed by several case managers, area supervisors, and a regional manager, all of who assisted with both question clarity and procedural details.

The Behavioral Assessment System for Children (BASC, Reynolds & Kamphaus, 1992) was used to assess externalizing problems (conduct, aggression, and hyperactivity), internalizing problems (anxiety, depression and somatization), and adaptive skills (adaptability, social skills and leadership). Composite scores for externalizing and internalizing clusters were generated as was an adaptive skills cluster and an overall behavioral symptoms composite. Information was completed by the child's primary careprovider. Three age-specific forms were available for this measure and included a preschool form (ages 4 and 5 years), a school-aged form (ages 6 through 11 years), and an adolescent form (ages 12 through 18 years). Relevant norms were available for each form, and for both genders.

The BASC has been used to assess behavioural and emotional symptomatology in children in both clinical and general samples (Randall & Kamphaus, 1992). The BASC was selected for this study because the questions are tailored to three distinct developmental periods, because of the strong reliability, validity, and ease of use, and for the range of psychological dimensions assessed within the measure. The internal-consistency reliabilities for the composite scores in this measure range from a low of 0.84

for the Preschool Internalizing Composite to a high of 0.94 for the Adolescent Behavioral Symptoms Index. As would be expected, the internal-consistency reliabilities of individual scales vary more than the reliabilities for the composite scores, but still are highly reliable. Test-retest reliability for this measure was also high, with a range from a low of 0.71 for the Adolescent Adaptive Skills Composite to a high of 0.94 for the Child Internalizing Problems Composite. Finally, validity for this measure was assessed in three ways by the authors. The BASC was highly correlated with the Child Behavior Checklist (CBCL, Achenbach, 1991) for similar scales, supporting the construct validity of the BASC. An important finding given that the CBCL is the child behavioural measure most often cited in the literature. In addition, the authors completed several principal-factor analyses for the preschool, child, and adolescent forms of this measure. They found support for their original model of three correlated factors: Externalizing Problems, Internalizing Problems, and Adaptive Skills; factors which once empirically supported became composite scores for this measure.

Finally, a measure of attachment was completed by the primary careprovider. The Randolph Attachment Disorder Questionnaire (RADQ, Randolph, 1997) was selected to measure the extent of attachment symptomatology. This measure is a 30-item questionnaire assessing different behavioural symptoms on a five point likert scale and provides an overall score for the measure. The RADQ has been used to distinguish between children with attachment difficulties, and children with conduct or other behaviorally based psychiatric disorders in clinical populations (Randolph, 1997).

This measure was selected because it accesses specific symptomatology hypothesized to be exhibited more frequently within child welfare populations. In addition, specific information about attachment symptomatology is not usually assessed in general behavioural measures and attachment problems can often be confused with more common externalizing problems such as conduct and oppositional defiance behavioural sets. As this is a relatively new measure, extensive validity and reliability information is limited. The author of this measure reports the internal-consistency reliability to range from 0.81 to 0.84 using the split-half technique. The validity for this measure in distinguishing between children with various psychiatric disorders was also strong. When compared with the CBCL, the RADQ was highly correlated for only a few scales, supporting the construct validity for this measure.

Variables

Reasons for Entering Care

Each child's case manager identified the one or more reasons that a child had entered protective care. Listed reasons were adapted from those identified by the Child Welfare Act legislation (1984) within the province of Alberta. The nine available choices, therefore included, abandonment, physical abuse, sexual abuse, emotional abuse, out of parental control, risk of abuse, developmental disabilities, parent being unable or unwilling to provide care, and an 'other' category. Both known and suspected options were available for each choice. For these children, the three most common reasons for entering protective care were a parent being unable or unwilling to provide care (71.6%, n = 288), emotional abuse (45.5%, n= 183), and physical abuse (38.8%, n= 156). The children in this study typically came into care because of experiencing more than one condition requiring intervention by Child Welfare (M=2.95, SD=1.53).

Ethnicity

Ethnic information related to each biological parent was accessed through the Child Welfare Information System (CWIS) database and was provided by the case manager. A significant portion (29.4%, n=118) of these childrens' information about their biological father was unknown to the child welfare system, and therefore, for the purposes of this study, a child's ethnicity was operationalized as 'mother's ethnic origin'. The two predominant ethnic groups, therefore, were Aboriginal (comprised of Treaty, Status and Métis), and Caucasian, accounting for 85.1% of the total sample (n=342).

Diagnosis

Case managers were asked to identify the one or more psychiatric diagnoses or medical conditions that a given child might have. Five possible psychiatric choices were available based on the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV, American Psychiatric Association, 1994) nomenclature. In addition, two medical conditions were listed. The choices included: Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), Fetal Alcohol Syndrome (FAS/FAE), Reactive Attachment Disorder (RAD), Medical Condition / Physical Disability, Learning Disabilities (LD), and an 'Other' category. To assist with the completion of diagnostic information, the case manager used previous psychiatric, psychological, or medical assessments contained within the child's child welfare file. Two-thirds of these children had one or more identified diagnoses (M=1.29, SD=1.29).

BASC

A child's primary careprovider completed the BASC, a measure designed to assess behavioural and emotional functioning over a variety of areas. Scores for each scale are presented as T scores with scores between 60 and 69 indicating at-risk problems and scores greater than 70 as being clinically significant. Scales could be clustered and represented as composite scores for externalizing and internalizing problems and adaptive skills. The children in this sample were described as exhibiting more externalizing problems (M=68.51, SD=17.67) than internalizing problems (M=55.16, SD=12.96).

RADQ

A child's primary careprovider completed the RADQ, a measure designed to assess attachment symptomatology. Total scores greater than 65 are considered indicative of attachment disorder and those scores between 50 and 64 are considered indicative of attachment difficulties. The mean score for this measure was 41.52 (SD=24.06), with a score range of zero through 108. Almost 20% of the children in this sample had total scores greater than 65.

Number of Placements

Each child receiving child protection services has a placement history recorded on CWIS. This placement history lists each placement that a child has experienced (including both the current and initial placement), and the duration of the placement. For this study, all listed placements on CWIS were summed for a total number of placements count for each child. This total placement count also included all unapproved absences (AWOL's), as although the child was residing in a location other than the approved placement, he or she was still theoretically under the protective care of the child welfare system. For this sample, the average number of placements experienced by a given child was 8.25 (SD= 8.00, Range = 1 – 84).

Number of Months per Placement

A new measure of placement stability was created for this study. This measure reflected the total number of placements experienced by a given child controlled for by the length of time that the child was in protective care and is expressed in the units of number of months per placement. This new measure was believed to be a more accurate descriptor of placement stability for the entire sample; by controlling for the likely increase in frequency of placements experienced the longer a child was in protective care. Using this new variable, these children were found to be able to sustain a placement for just under 15 months (M=14.82, SD=14.43).

Developmental Age Groupings

All of the participants for this study were clustered into four age groupings. Groupings were based on developmental age periods, and for the purposes of this study were operationalized as early childhood (i.e. ages 5 – 7 years), middle childhood (i.e. ages 8 – 10 years), early adolescence (i.e. ages 11 – 13 years), and later adolescence (i.e. ages 14 – 17 years).

Ethics

Two different review panels granted ethical approval for this study. First, the University of Alberta Ethics Review Committee reviewed the proposal and granted approval, and then given the sensitive needs of this population, a second review was conducted by the regional Child and Family Services Authority. Final ethics approval was granted following a completion of an oath of confidentiality by the principal researcher.

Results

The socio-demographic, diagnostic, BASC and RADQ data collected for this study were analyzed using SPSS© software, version 10.0. To begin the process of describing this sample of Albertan children in protective care, a summary of the socio-demographic factors describing these children at the four developmental age groupings is presented. Following this descriptive summary, further analyses are presented in question and answer format and use frequency, correlational, and regression statistics.

The childhood aged children were clustered into two developmental groupings described as early and middle childhood. There were 93 early childhood aged children in this sample. These children most often required protective care because of more than one reason according to the provincial child welfare act, with the three most frequent reasons being that their parent(s) were unable or unwilling to provide care (n=70), they were abandoned (n=36), and the experience of emotional abuse (n=35). In addition, over a third of these children had one more diagnoses, with the three most prevalent being a learning disability (n=32), fetal alcohol syndrome or effects (n=23), and ADHD (n=21). Like their younger peers, the 92 middle childhood aged children were most likely to enter protective care for reasons of their parent(s) being unable or unwilling to provide care (n=65), and the experiences of emotional abuse (n=44), physical abuse (n=32) and abandonment (n=32). Learning disabilities were again the most prevalent psychiatric diagnosis (n=25), followed by ADD/H (n=21), and medical diagnoses such as quadriplegia, spina bifida, and cerebral palsy (n=12).

The adolescent aged children were also clustered into two groupings according to age, described as early and later adolescence. For the 101 younger adolescents, the most prevalent reasons for coming into protective care were because their parent(s) were unable or unwilling to provide care (n=76), experiences of emotional abuse (n=52) and physical abuse (n=46). The most frequent psychiatric diagnoses for these youths included ADD/H (n=38), learning disabilities (n=37), and difficulties captured in the 'Other' category such as depression, anxiety, bereavement, and loss issues (n=16). For the 116 oldest youths, the most common reasons for entering protective care were because their parent(s) were unable or unwilling to provide care (n=77), and experiences of physical abuse (n=55) and emotional abuse (n=52). Like their younger peers, the three most prevalent diagnoses were ADD/H (n=41), difficulties captured in the 'Other' category (n=27), and learning disabilities (n=25).

Research Questions

1. **Using the four developmental age groupings, what is the behavioural presentation for each age range?**

Four composite scores were calculated for the BASC and represent clusters of behaviours that often occur in concert with each other. They are broadly represented as: the Behavioral Symptoms Index (BSI) an overall measure of problematic emotional and behavioural functioning; the Externalizing Problems Composite (EPC) a summary of disruptive behaviour problems; the Internalizing Problems Composite (IPC) a summary of emotional difficulties not marked by acting-out behaviours; and the Adaptive Skills Composite (ASC) a summary of positive interpersonal and individual-oriented life skills. Each composite is presented for the four age groupings. Scores for the composites are presented as mean T scores.

The BSI was within the at-risk range for each of the four age groupings (Early Childhood (M=63.99, SD=15.46), Middle Childhood (M=63.13, SD=15.75), Early Adolescence (M=68.26, SD=17.10), and Later Adolescence (M=66.76, SD=15.68)). There was little difference between the groups and at-risk scores for this composite suggest that the children considered within this study experience on average, marked problems in overall emotional and behavioural functioning. These findings were consistent with community based samples identified as having behavior disorders that were assessed during the BASC standardization analyses (child M=63.3, SD=14.2; adolescent M=63.3, SD=14.0) (Reynolds & Kamphaus, 1992).

The EPC was within the at-risk range for the two younger age groupings (Early Childhood (M=64.02, SD=65.09), and Middle Childhood

(M=65.09, SD=17.39)). The two older age groups scored within the clinically significant range (Early Adolescence (M=70.36, SD=18.04), and Later Adolescence (M=73.25, SD=17.78)). Significant differences were noted between the age groupings, with the older youth being significantly more likely to have greater behavioural dysfunction in areas including aggression, hyperactivity and delinquency than both the early childhood and middle childhood aged children (F (3,397)=6.54, p=0.00).

The IPC was within the normal range for each of the four age groupings (Early Childhood (M=51.85, SD=12.70), Middle Childhood (M=52.37, SD=11.47), Early Adolescence (M=57.96, SD=12.59), and Later Adolescence (M=57.58, SD=13.68)). These scores suggest, on average, that these children experienced within normal limits of anxiety, depression, and somatization.

Finally, the ASC was within the at-risk range for each of the four age groupings (Early Childhood (M=38.12, SD=12.00), Middle Childhood (M=38.85, SD= 9.98), Early Adolescence (M=39.57, SD=8.93), and Later Adolescence (M=37.73, SD= 8.63)). There was little difference between the groups, and the at-risk scores for this composite suggest that these children have trouble with interpersonal and organizational adaptive skills. Again, like previous assessments using the BASC these findings were consistent for the behavior disordered grouping within community based samples (child M=38.2, SD=8.2; adolescent M=38.1, SD=8.6)(Reynolds & Kamphaus, 1992).

The RADQ was within the normal range for each of the four age groupings (Early Childhood (M=42.41, SD=24.74), Middle Childhood (M=39.20, SD=25.06), Early Adolescence (M=41.36, SD=24.59), and Later Adolescence (M=42.78, SD=22.36)). These scores suggest, that on average, these children experienced within normal limits of attachment difficulties. Average scores for the various scales of the BASC and the composite score for the RADQ are presented for each age grouping in Table 1.

Table 1

Summary of emotional and behavioural rating scale scores for the four developmental age groupings presented as mean scores

Variables	Early Childhood	Middle Childhood	Early Adolescence	Later Adolescence
N (402)	93	92	101	116
BASC*	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Hyperactivity	63.75 (14.70)	61.85 (16.67)	64.70 (18.28)	63.26 (16.51)
Aggression	60.81 (15.74)	61.01 (16.42)	65.57 (15.98)	66.23 (15.35)
Conduct Problems	61.24a (16.53)	66.05 (16.83)	71.68 (20.06)	79.04 (23.24)
Anxiety	49.57 (12.46)	49.00 (9.24)	56.95 (13.06)	56.78 (12.16)
Depression	57.03 (13.08)	59.02 (16.19)	61.86 (14.84)	61.83 (15.70)
Somatization	47.64 (11.37)	47.13 (10.02)	50.95 (12.37)	50.71 (12.67)
Atypicality	60.37 (17.81)	60.96 (16.67)	64.59 (17.81)	60.83 (16.83)
Withdrawal	50.83 (13.55)	52.74 (10.40)	57.00 (10.23)	61.06 (14.61)
Attention Problems	67.11 (13.02)	63.29 (10.73)	65.28 (12.17)	64.53 (10.87)
Adaptability	36.66 (13.25)	38.50 (9.96)	35.54b (13.11)	____c
Social Skills	40.86 (11.28)	41.91 (10.45)	41.35 (9.50)	38.95 (8.99)
Leadership	40.84 (11.55)	40.53 (10.15)	41.61 (8.67)	38.62 (8.56)
BASC Composite Scales				
Externalizing	64.02 (15.77)	65.09 (17.39)	70.36 (18.04)	73.25 (17.78)
Internalizing	51.85 (12.70)	52.37 (11.47)	57.96 (12.59)	57.58 (13.68)

Variables	Early Childhood	Middle Childhood	Early Adolescence	Later Adolescence
Behavioral Symptoms Index	63.99 (15.46)	63.13 (15.75)	68.26 (17.10)	66.76 (15.68)
Adaptive	38.12 (12.00)	38.85 (9.98)	39.57 (8.93)	37.73 (8.63)
RADQ**	42.41 (24.74)	39.20 (25.06)	41.36 (24.59)	42.78 (22.36)

*Numbers represent mean T scores and standard deviations in T scores for each scale.
**Numbers represent mean scores for the scale, with scores over 50 indicative of attachment difficulties
a. Mean scores based on an n of 65 as scale not scored for 5 year old children
b. Mean score based on an n of 37 as scale not measured for children 12 years and older
c. Mean scores not generated for this scale, as not measured for children 12 years and older

2. Which child-based behavioural and emotional factors are associated with placement stability?

Several factors were selected for consideration within the multiple regression analyses based on correlations between the factors and the predictor variable, number of months per placement. These factors included RADQ score, BASC hyperactivity, BASC aggression, BASC conduct problems, BASC attention problems, BASC adaptability, and BASC atypicality scale scores. Separate step-wise multiple regression analyses were computed for each of the four age groupings so that factors could be tailored to the unique presentation of each developmental period. In addition, because of the small representation of both 'Unknown' ancestry and 'Other' ancestry, ethnicity was considered to only include the two primary ethnic groupings of Aboriginal and Caucasian, thus reducing the total sample from 402 to 342 children between the ages of 5 and 17 years.

For the childhood aged children, both early and middle childhood years, none of the independent variables selected significantly predicted the dependent variable, number of months per placement.

For the early adolescence aged children, the BASC attention problems scale was the strongest and only predictor of the number of months per placement. This factor accounted for 6.7% of the variance ($F(1,87) = 6.23$, $p = 0.01$, $B = 0.42$, $SE\ B = 0.17$). Interestingly, this factor was associated with greater stability in placement suggesting that children with difficulties with sustained attention were more likely to be more stable in their placement. Finally, for the later adolescence aged group, the BASC conduct scale was the strongest and again, only predictor of number of months per placement. This BASC scale accounted for 13.3% of the variance (F (1,83)

=12.68, p=0.00, B=-0.20, SE B=0.06). Attributes captured by this scale include anti-social and rule breaking tendencies and higher scores for this variable increased the likelihood of greater placement instability.

Discussion

The purpose of this investigation was to explore the behavioural and emotional presentation of Albertan children in protective care through describing these children, and then using the descriptors as independent variables to predict placement instability within four developmental age groupings. The behavioural and emotional information provided by the careproviders of these children for this investigation highlighted several important findings. On a descriptive level, the results from the two behavioural measures used in this study indicate that these children exhibit consistently elevated levels of aggression, conduct problems, inattention and poor impulse control. In addition, these disruptive behavioural problems were described as being at clinically significant levels for the average child in the adolescent age groupings. Despite the prevalence of these behavioural problems and the average length of placement being just 14 months for the children in this sample, when these behavioural factors were used to predict placement instability, significant associations were only noted for two of the factors at two of the age groupings.

Like earlier research in this area, the descriptive findings from this investigation supported the concept that children in protective care demonstrate greater overall levels of behavioural and emotional difficulties (Garland, Landsverk, Hough & Ellis-MacLeod, 1996; Pilowsky, 1995; Stein, Evans, Mazumdar & Rae-Grant, 1996). Patterns of significant externalizing problems across the age groups and experiences of emotional abuse, physical abuse, and abandonment were noted for many of the children in this sample. In addition, specific difficulties with hyperactivity, attention problems, aggression and conduct problems were evident throughout the ages, but the more severe behavioural symptomatology such as antisocial and rule-breaking tendencies increased significantly as children grew older. This descriptive trend is of importance given that conduct problems in older youth were identified as predictive of greater placement instability.

Another interesting finding was that the RADQ did not detect significant levels of attachment symptomatology in this sample of children in protective care. Although more than one-fifth of these children were described as exhibiting significant attachment problems, overall means for the four age groupings were relatively consistent between the age groupings and within normal limits for the measure. Despite this finding, the prevalence of significant attachment symptoms for a cluster of these children bears further investigation. Difficulties with forming attachments to multiple

caregivers and the behavioural problems that can result from disrupted attachment patterns are issues that have been both well established in the child protection literature and identified as associated with contributing to placement instability (Levy & Orlans, 1998; Pearce & Pezzot-Pearce, 1997; Steinhauer, 1991).

Limitations

The primary limitation of this study was related to the design. As a cross-sectional design, these results were measured at one point in time within a given child's life, and do not reflect behavioural growth patterns of the same child over time. Naturally, a longitudinal study would have strengthened these results and have added further validity to the compilation of factors. For a variety of logistic factors, a longitudinal design was not practical for this research but should be considered by future researchers investigating this phenomenon. A further limitation was related to the means by which the data were collected. Due to the size of the sample and the need for a consistent procedure for obtaining information, information that was readily accessed through CWIS was selected as the primary source for demographic information. This information is, therefore, only as reliable as the data entry into CWIS and the familiarity of the child's history to the assigned case manager. In addition, diagnostic information was not verified by independent psychological assessments of each child and case manager information was presumed to be accurate. Finally, only one regional authority in Western Canada was accessed and results, therefore, may not be generalizable across other urban or rural regional authorities.

Conclusion

This study assessed the extent of behavioural and emotional symptomatology across a range of specific difficulties for a sample of Albertan children in protective care and then used these difficulties to predict placement instability at four developmental age groupings. The purposes of this study, therefore, were both descriptive and predictive in nature. Through the reports of children's careproviders, a relatively thorough description of the emotional and behavioural presentation of these children was depicted. Overall, the children in this sample were described as exhibiting marked levels of disruptive behaviours, within normal limits of the more internalizing symptoms and attachment symptomatology, and having borderline adaptive skills. This descriptive summary is meaningful as it provides behavioural and emotional data about Albertan children in protective care using a sizable sample with a documented method.

The predictive value of these behavioural and emotional factors, however, was found to be limited for this sample as a child's behavioural and emotional functioning accounted for only a small portion of the variance in

the number of months per placement variable. So although the general purposes of this study were met, the limited findings from the predictive component of the analyses evoked further research questions about what other processes or factors can help to explain placement instability. To shift the focus away from the child means that a more in-depth consideration of the child welfare system must occur. Questions, for example, arise related to the effects of the inherent power imbalance of the child welfare system on those already marginalized by society for issues of class, race or religion. What effect does being marginalized have on mental health? Other questions could address aspects of the generational effects of separation and multiple losses on a community and the complex effects of assimilation into what traditionally has been recognized as eurocentric definitions of 'normal'. In acknowledging both the social nature and origins of mental health, future researchers can shift the isolated nature in which statistics about child welfare populations are traditionally interpreted to a more interactive consideration of all the social processes associated with these constructs.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Alshuler, S. (1997). A reveille for school social workers: Children in foster care need our help! *Social Work in Education, 19 (2)*, 121- 128

Bolster, J. M. (2003b). *Albertan children in protective care: What do we know about these children and their needs?* Unpublished manuscript, University of Alberta.

Cantos, A. L., Gries, L. T., & Slis, V. (1996). Correlates of therapy referral in foster children. *Child Abuse & Neglect, 20 (10)*, 921 – 931.

Dore, M. M., & Eisner, E. (1993). Child-related dimensions of placement stability in treatment foster care. *Child and Adolescent Social Work Journal, 10 (4)*, 301- 317.

Garland, A. F., Landsverk, J L., Hough, R, L., & Ellis-MacLeod, E. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. *Child Abuse & Neglect, 20 (8)*, 675 – 688.

Government of Alberta. (1984). *Child Welfare Act*. Alberta: Queens Printer.

Kupsinel, M. M., & Dubsky, D. D. (1999). Behaviorally impaired children in out-of-home care. *Child Welfare, 78 (2)*, 297 – 310.

Landsverk, J., & Garland, A. (1999). Foster care and pathways to mental health services. In P. Curtis, & G. Dale, Jr. (Eds.). *The foster care crisis: Translating research into practice and policy*. Lincoln, NE: The University of Nebraska Press.

Levy, T. M., & Orlans, M. (1998). *Attachment, trauma, and healing. Understanding and treating attachment disorder in children and families*. Washington, DC: Child Welfare League of America.

MaMowe capital region child and family services authority. (n.d.). Retrieved March 2001, from http://www.acs.gov.ab.ca/mamowe.us.html

Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect, 24 (10)*, 1363 – 1374.

Palmer, S. (1996). Placement stability and inclusive practice in foster care: An empirical study. *Children and Youth Services Review, 18 (7)*, 589 – 601.

Pardeck, J. T. (1984). Multiple placement of children in foster family care: An empirical analysis. *Social Work, 29 (6)*, 506 – 509.

Pearce, J., & Pezzot-Pearce, T. D. (1997). *Psychotherapy of abused and neglected children*. New York, NY: The Guilford Press.

Penzerro, R. M., & Lein, L. (1995). Burning their bridges: Disordered attachment and foster care discharge. *Child Welfare, 74*, 351 – 366.

Pilowsky, D. (1995). Psychopathology among children placed in family foster care. *Psychiatric Services, 46 (9)*, 906 – 910.

Randolph, E. M. (1997). *Manual for the randolph attachment disorder questionnaire (RADQ)*. Evergreen, CO: The Attachment Centre Press

Reynolds, C. R., & Kamphaus, R. W. (1992). *BASC. Behavior assessment system for children manual*. Circle Pines, MN: American Guidance Service.

Rittner, B. (1995). Children on the move: Placement patterns in children's protective services. *Families in Society*, p. 469 – 477.

Stein, E., Evans, B., Mazumdar, R., & Rae-Grant, N. (1996). The mental health of children in foster care: A comparison with community and clinical samples. *Canadian Journal of Psychiatry, 41 (6)*, 385 – 391.

Stein, E., Rae-Grant, N., Ackland, S., & Avison, W. (1994). Psychiatric disorders of children 'in care': Methodology and demographic correlates. *Canadian Journal of Psychiatry, 39 (6)*, 341 – 347.

Steinhauer, P. D. (1991). *The least detrimental alternative. A systematic guide to case planning and decision making for children in care*. Toronto, ON: University of Toronto Press.

Webster, D., Barth, R. P., & Needell, B. (2000). Placement stability for children in out-of-home care: A longitudinal analysis. *Child Welfare, 79 (5)*, 614 – 632.

Zima, B. T., Bussing, R., Freeman, S., Yang, X., Belin, T. R., & Forness, S.R. (2000). Behavior problems, academic skill delays and school failure among school-aged children in foster care: Their relationship to

placement characteristics. *Journal of Child and Family Studies, 9 (1),* 87 – 103.

Chapter 5 – Summary for the Dissertation and Implications for Practice

Introduction

The purpose of this doctoral dissertation was to investigate placement instability for children in protective care in Alberta. Several researchers have investigated the phenomenon of placement instability for children in child welfare care and have suggested some common factors associated with this experience. Factors have typically included aspects of a child's behaviour (i.e. aggression, hyperactivity, impulsivity, attention problems and delinquency), specific learning needs, gender, age, ethnicity, and type of experienced maltreatment (Cantos, Gries & Slis, 1996; Dore & Eisner, 1993; Kupsinel & Dubsky, 1999; Palmer, 1996; Rittner, 1995; Webster, Barth & Needell, 2000; Zima, Bussing, Freeman, Yang, Belin & Forness, 2000). As placement instability continues to be prevalent amongst children in protective care, and because of the paucity of Canadian based research in this area, this investigation of placement instability for Albertan children in child welfare care was conducted. The more specific goals for the study included exploring careproviders' perspectives about placement instability, describing a 5 to 17 year old sample of Albertan children in protective care, investigating specific child-based factors for this sample that are associated with placement instability whilst considering the phenomenon of developmental change, and then offering practice and policy based implications for intervention based on the overall investigation of placement instability. This chapter provides an overview of the entire research study, summarizes the three major findings from this investigation of placement instability, and addresses the final goal of the research study; namely to offer practice and policy based implications for intervention.

An Overview of the Research Study

Three studies were conducted for this dissertation, and each offered an investigation into a discrete facet of the phenomenon of placement instability. To begin, qualitative information from careproviders' of children in protective care about common reasons for placement breakdown was used to conceptually clarify the phenomenon of placement instability. Nine concepts were conceptually mapped from the statements provided by the careproviders. These concepts included Inadequate Care, Influence of Child's Relationships, Child's Behaviour, Breakdown between Caregiver and System, Breakdown between child and Caregiver, Poor Match, Limitations of the System, Insufficient Information Shared, and Limited Resources. These nine concepts and the statements captured within the concepts illustrated the interrelatedness in relationship between child, careprovider and child welfare systems in contributing to placement instability, and therefore, were further grouped into three system clusters in the discussion of these findings. These

clusters were identified as 'Attributes of the Child' in relation to the other systems, 'Attributes of the Careprovider in relation to the other systems', and 'Attributes of the Child Welfare System in relation to the other systems'.

Following this qualitative exploration, two quantitative studies were completed. Each investigation was designed to both add to the existing knowledge base describing children in protective care and identify specific child-based factors predictive of placement instability across four developmental age groupings. The four age groupings were operationalized as early childhood (ages 5 – 7 years), middle childhood (ages 8 – 10 years), early adolescence (ages 11 – 13 years), and later adolescence (ages 14 – 17 years). A descriptive summary for each of these four age groupings was generated based on data collected from children's careproviders and child welfare case managers. The collected information encompassed socio-demographic information such as ethnicity, gender, number of placements, reasons for coming into protective care and diagnoses, and information describing emotional and behavioural functioning across externalizing and internalizing clusters as well as measures of adaptive skills.

In the first quantitative study, socio-demographic information was provided by child welfare case managers about 561 children in protective care in Alberta between the ages of 5 and 17 years. The case managers provided this information through a survey that accessed specific demographic information (see Appendix D). Based on analyses of this information, a preliminary socio-demographic profile of Albertan children in protective care at the four identified age groupings was generated. In addition, these analyses indicated that this sample of children in protective care experienced significant placement instability, being able to sustain a placement on average for less than 16 months at a time. Furthermore, children of Aboriginal ancestry were significantly over-represented within this study, accounting for 43.7% of the sample, when known to represent less than 2% of the overall Aboriginal child population for this urban centre (Statistics Canada, 1996 Census Data).

Using step-wise regression analyses, the variance in the number of months per placement variable was predicted for each developmental age grouping based on linear combinations of several of the demographic and diagnostic variables. Based on these analyses, a compilation of factors that statistically predicted placement instability was generated for each of the four developmental age groupings. The factors supported through the regression analyses were the experience of emotional abuse, the diagnosis of fetal alcohol syndrome or effects, having a known medical condition or physical disability, and having a known diagnosis of conduct disorder.

In the second quantitative study, information related to a child's behavioural and emotional functioning was generated from two behavioural questionnaires that were completed by a child's current careprovider. The measures utilized in this investigation were the Behavioral Assessment System for Children (BASC, Reynolds & Kamphaus, 1992) and the Randolph Attachment Disorder Questionnaire (RADQ, Randolph, 1997). These measures were completed for 402 children in protective care in Alberta between the ages of 5 and 17 years. Based on analyses of this information, the children in this sample were identified as exhibiting consistently significant difficulties with aggression, conduct problems, inattention and poor impulse control. For some of the older age groupings, clinical levels of symptomatology were found to be the average, and for all the age groupings, many of the scales were within the at-risk range for the BASC. Attachment difficulties were reported to be within normal limits for each of the age groupings using the RADQ. Despite these findings, however, more than 20% of this sample were described as having clinically significant levels of attachment symptomatology, a finding that is greater than what would be expected in community-based samples and, therefore, bears further investigation (DSM-IV prevalence rates of Reactive Attachment Disorder are unknown but described as uncommon; Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), American Psychiatric Association, 1994).

Finally, using step-wise regression analyses, these emotional and behavioural child-based factors were used to predict placement instability. Two factors were identified that accounted for some of the variance in this variable used to describe placement instability, number of months per placement. These emotional and behavioural factors included attention problems and conduct problems and these factors were only significant for the adolescent aged youth.

The Major Findings from this Study of Placement Instability

The major findings for these three studies are now summarized as three contributions to the existing literature.

The first major finding was that the results from each of the three investigations supported the argument that placement instability involves complex social processes and variables that likely extend beyond the individual child and delve more fully into the practices and philosophies of the child welfare system. Each of the quantitative investigations identified variables that were predictive of placement instability but neither study's contribution accounted for all the variance in placement instability. Furthermore, this dissertation identified that a child's socio-demographic, emotional and behavioural presentation can only explain a portion of what

contributes to placement instability. That placement instability may be better explored by considering the social nature of the phenomenon was also supported through the qualitative inquiry, where careproviders identified that placement instability results from the contributions of not only child, but also careprovider and child welfare systems. The recognition that placement instability is a complex social phenomenon also leads to questions about how the issues of class, race and religion influence our understanding .

The second finding of this dissertation was that these children are markedly heterogeneous as a group. The importance of noting this diversity is significant for both practitioners and policy makers, as it seems important to consider how this diversity is understood and influenced by the traditionally eurocentric values of governmental organizations such as child welfare. Does this diversity contribute to further marginalization and subsequent efforts at assimilation by mainstream society? Questions such as these are important directions for future researchers in their efforts to understand the social phenomenon of placement instability.

Finally, this dissertation documented the wealth of information that can be accessed from those living the experience of caring for children in protective care. Through both the qualitative and quantitative investigations, these careproviders offered a depth of meaning about placement instability to researchers and practitioners trying to further understand this complex phenomenon. In addition, almost 75% of the careproviders selected for these studies chose to participate, a response rate suggesting that these individuals are wanting to contribute to the better understanding of placement instability. Furthermore, the range and specificity of factors that were identified by these careproviders, in response to the question about reasons for placement breakdown supports the notion that these individuals are intimately aware of the extent and complexity of this social problem. Together, these investigations highlight the importance of exploring a phenomenon through the lens of those living the experience. These individuals' contributions to this field of knowledge added not only conceptual clarity, but also descriptive and predictive information.

The final goal for this dissertation was to provide clinically meaningful implications for practice for both front-line practitioners and policy makers based on the broad findings of these investigations. This next section reviews some indicated practice recommendations.

Implications for Practice

Many implications for practice were generated through this consideration of the phenomenon of placement instability. Despite the different facets of placement instability that were investigated within each of

these studies, several overarching implications for practice and intervention were generated based on the cumulative findings of the studies. Each implication is listed below, followed by a brief discussion of directions for future practice.

Early Assessment and Intervention

The children in this study were described as experiencing greater than average emotional and behavioural symptomatology. Many of the adolescents (early and later) were exhibiting significant difficulties with antisocial and rule-breaking tendencies, aggression, poor impulse control, and inattention and had co-morbid learning disabilities. Earlier proactive intervention when these difficulties are more manageable and amenable to change, and if possible when the child is with his or her family of origin, might mitigate the complexity of issues these youths face and the likelihood of later involvement with the justice or adult welfare system. Related to the concept of earlier assessment and intervention is the understanding that social processes are complex and change requires the meaningful contribution of those involved (i.e. the family and community). Meaningful change also suggests a shift in both the power imbalance between organization and recipient and the paradigms that support those in power making moral assumptions about what is acceptable.

Increased Training, Support, Resources, and Respite

Careproviders' in these studies repeatedly identified the need for ongoing support and training in helping them to further develop their skills in parenting these children. Given the level of symptomatology documented as existing for these children, it seems imperative that for careproviders and children to experience placement success, ongoing culturally and developmentally based training is warranted. Training that attends to the needs of Aboriginal children and their families, and evolves from a developmental and cultural context for healthy recovery and healing needs to be a foundation for these systems. This would include, but not be limited to, ongoing and improved training about the needs of these children and their families for careproviders and case managers, with a focus for example, on the effects of marginalization and assimilation on mental health. In addition, increased resources are needed so that the social processes that contribute to the sustainability of a placement can be explored.

Improved Matching between Child and Careprovider

The compilation of child-related information generated for each of the four age ranges from these studies could assist with improving the initial matching process of child to careprovider. Careproviders' noted that a poor

match was often the reason for placement breakdown, and matching the needs of the child (i.e. emotionally, behaviourally and culturally) to the strengths of a careprovider could avert later disappointment for both child and family. The continual shortage of quality placements suggests that some of the increased support to the child welfare system mentioned previously should be used to recruit, train, and retain good placements.

As with all studies of this magnitude, limitations were noted that might provide boundaries to the generalization of these findings. A review of these limitations is now discussed.

Limitations of the Studies

The predominant limitation of this research evolves from the design of the studies. A cross-sectional design, such as was used in this research, offers only a point-in-time measure of a given child's functioning, and does not follow the development of the same child over actual changes in placement. Future research considering placement stability should use a longitudinal design to determine if the trends noted within these studies are supported as a child grows and develops. Furthermore, although diagnostic information was not verified for these studies due to logistics associated with sample size, future research of a larger scale than was available to this researcher, could independently assess and diagnostically review each child. Finally, only one regional authority was considered thus limiting the generalizability of the current findings. Larger scale research projects would do well to assess multiple urban and rurally based regional authorities to determine overall trends across provincial areas.

Conclusion

This doctoral dissertation is comprised of three studies that investigated the phenomenon of placement instability for Albertan children in protective care. Together, the collective findings of this dissertation provided Canadian based information about placement instability. The findings from this dissertation provided descriptive information about the interrelationships between child, careprovider and child welfare systems, and how collectively these systems interact to contribute to placement instability. In addition, general facts about Albertan children in care were noted, including the high frequency of placement instability experienced by these children regardless of age, the significant prevalence of emotional abuse experienced prior to entering protective care, the over-representation of children of Aboriginal ancestry within this sample, and the marked levels of externalizing behavioural symptomatology exhibited by these children.

Demographic, diagnostic, behavioural, and emotional functioning descriptors were also generated for each of the four age groupings

considered within this sample of Albertan children in protective care. This descriptive information was combined with factors statistically identified as predictive of placement instability, and a compilation of information was created. All of this information was sought with the intention that practical and clinically relevant information could be provided to both front-line practitioners and policy makers.

Providing meaningful information that would add to the understanding of placement instability proved consequential as the significant developmental sequelae associated with placement instability has been repeatedly recognized in the literature (Newton, Litrownik, Landsverk 2000; Penzerro & Lein, 1995; Steinhauer, 1991). A discussion of this social context for placement instability began in Chapter 1 with a reference to the African proverb that 'it takes a whole village to raise a child'. The conclusion to this chapter comes full circle by acknowledging that it takes a community listening to each other and working together to provide the depth of understanding that is necessary to facilitate change across all the systems that make a child's placement stable.

References

American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC: Author.

Cantos, A. L., Gries, L. T., & Slis, V. (1996). Correlates of therapy referral in foster children. *Child Abuse & Neglect, 20 (10)*, 921 – 931.

Cicchetti, D., & Toth, S. L. (1995). A developmental psychopathology perspective on child abuse and neglect. *Journal of the American Academy of Child and Adolescent Psychiatry, 34 (5)*, 541 – 565.

Dore, M. M., & Eisner, E. (1993). Child-related dimensions of placement stability in treatment foster care. *Child and Adolescent Social Work Journal, 10 (4)*, 301 – 317.

Kupsinel, M. M., & Dubsky, D. D. (1999). Behaviorally impaired children in out-of-home care. *Child Welfare, 78 (2)*, 297 – 310.

Levy, T. M., & Orlans, M. (1998). *Attachment, trauma, and healing. Understanding and treating attachment disorder in children and families*. Washington, DC: Child Welfare League of America.

Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect, 24 (10)*, 1363 – 1374.

Palmer, S. (1996). Placement stability and inclusive practice in foster care: An empirical study. *Children and Youth Services Review, 18 (7)*, 589 – 601.

Penzerro, R. M., & Lein, L. (1995). Burning their bridges: Disordered attachment and foster care discharge. *Child Welfare, 74*, 351 – 366.

Pilowsky, D. (1995). Psychopathology among children placed in family foster care. *Psychiatric Services, 46 (9)*, 906 – 910.

Randolph, E. M. (1997). *Manual for the randolph attachment disorder questionnaire (RADQ)*. Evergreen, CO: The Attachment Centre Press.

Reynolds, C. R., & Kamphaus, R. W. (1992). *BASC. Behavior assessment system for children manual*. Circle Pines, MN: American Guidance Service.

Rittner, B. (1995). Children on the move: Placement patterns in children's protective services. *Families in Society, October,* 469 – 477.

Stein, E., Rae-Grant, N., Ackland, S., & Avison, W. (1994). Psychiatric disorders of children 'in care': Methodology and demographic correlates. *Canadian Journal of Psychiatry, 39 (6)*, 341 - 347.

Steinhauer, P. D., (1991). *The least detrimental alternative. A systematic guide to case planning and decision making for children in care.* Toronto, ON: University of Toronto Press.

Webster, D., Barth, R. P., & Needell, B. (2000). Placement stability for children in out-of-home care: A longitudinal analysis. *Child Welfare, 79 (5)*, 614 – 632.

Zima, B. T., Bussing, R., Freeman, S., Yang, X., Belin, T. R., & Forness, S. R. (2000). Behavior problems, academic skill delays and school failure among school-aged children in foster care: Their relationship to placement characteristics. *Journal of Child and Family Studies, 9 (1)*, 87 – 103.

Appendices

Appendix A

Contents of Research Package and Instructions for Completion

Child Welfare Case Manager

Step 1:

- Read letter from Primary Researcher (Joanna Bolster) to Child Welfare Case Manager. This letter explains the research goals and the instructions for the study.

Step 2:

- Read the Research Consent form, and then sign on the reverse side if in agreement.

Step 3:

- Complete the Demographics Information Sheet with information specific to the identified child on your caseload. Most of this information can be obtained from CWIS. Use the provided information (i.e. identification number, date of birth, age of child, gender, and legal authority) on the front of the form to assist you in identifying the child. Once completed, put this form and the research consent form into the largest envelope provided, and then return to the researcher in the self-addressed stamped envelope.

Step 4:

- Once you have completed the Demographics Form, please sign the letter from you the caseworker to the foster parent or careprovider, and place into the envelope that is being sent out to the careprovider.

Step 5:

- Write the address of the identified child's foster parent or other careprovider on the provided envelope, seal the envelope, and then mail to this identified individual(s).

Summary

Please make sure you have signed or completed the following forms before putting the two envelopes into the mail.

Check if completed:

- ❑ Address on package to foster parent / careprovider
- ❑ Your Signature on:
  - ❑ Research Consent Form
  - ❑ Letter from Case Manager to foster parent / careprovider
- ❑ Demographics Information Form

Thank you very much for your significant contribution to this research!!!

Appendix B

Dear Child Welfare Social Worker:

I am a graduate student at the University of Alberta and with my supervisor, Dr. Hess, am currently completing my Doctoral studies in Counselling Psychology. As a counsellor who has worked within the Child Welfare system for several years, I have developed an interest in the early childhood risk factors that relate to placement breakdown. As you are the case manager for this child, I am interested in gaining some basic demographic information specific to this child. Combined with information provided by the child's foster parent (s) or key worker, I think that the results of this research will be useful in planning early intervention programs that will help both foster families (and other careproviders), case managers, and children in maintaining child welfare placements.

In order to do this study, I need your permission to participate. Please read the attached consent form, and if you would like to participate please sign the consent form. Your decision whether or not to be a part of this research will not influence your working relationship with Child Welfare.

I have enclosed a sheet of questions that I would like you to answer about the child. Because your time is valuable, I have tried to make all of the questions clear and short. As I am not directly asking the child any questions, I am dependent on your knowledge of the child and his or her history within the Child Welfare system. Please answer these questions to the best of your knowledge and experiences with this child. None of the information reported in the final results will report any identifying information about you or this child. Once completed please return the forms to me in the accompanying envelope.

Your co-operation in this research is greatly appreciated. If you have any questions please feel free to contact me directly at

Sincerely,

Joanna Bolster, M.Ed.
Ph. D. Student

Gretchen C. Hess, Ph.D.
Professor, Department of
Educational Psychology

Appendix C

Research Consent Form

Project Title: Early Childhood Risk Factors that Relate to Later Difficulty in Maintaining Foster or Adoptive Placements

Principal Investigator: Joanna Bolster

I am a graduate student at the University of Alberta, and I am currently completing my Doctorate program in Educational Psychology, with a specialization in counselling. I am interested in exploring the relationship between eleven childhood factors, that when considered alone, or in combination, may predict placement disruption in later childhood or adolescence. You are invited to participate in a research study that will explore these issues and form the basis of my dissertation. If you decide to participate, you will be asked to complete a one page survey that will elicit information specific to a child within your caseload. Completion of the survey is anticipated to take between 3 and 5 minutes.

Your decision whether or not to participate **will not** affect your relationship with Child Welfare. If you decide to participate, you are free to discontinue participation at any time, or refuse to answer individual questions without affecting such relationships.

Any information obtained as a result of participation in this study that can identify you, or the child within your caseload, will remain confidential. In addition, only general overall group findings will be passed on to Child Welfare. No information that is specific to you as an individual will be included in the discussion of these findings. This consent form will be kept separate from the completed measures, and will be destroyed upon completion of the study.

If you have any questions about the research please call Joanna Bolster at or her advisor Dr. Gretchen Hess at

Consent Form

My signature on this consent form acknowledges my agreement to participate in this research study. I am aware that all efforts will be taken to protect my identity and the child's identity within my caseload. I am also aware that my participation is voluntary, and that I am free to withdraw my participation at any time without penalty.

_____ _____

Signature Date

_____

Printed Name

_____ _____

Witness Signature Date

_____

Child's File Number

_____

Child's Gender

_____

Child's Date of Birth

Appendix D

To be completed by Child Welfare Case Worker

Thank you for your assistance in the completion of this form. This form is designed to gather basic demographic information about one child currently on your case load. This child ***must have either PGO or TGO / Custody Agreement status, and must have resided in their current placement for at least three months.***

For confidentiality purposes, please **do not** include the child's name anywhere on this form.

1. Birthdate of child _____/ _____/ _____
   (Year) (Month) (Day)

2. Gender (circle) Male Female

3. Racial Background: Mother : Aboriginal (Treaty/Metis) Asian
   African Canadian Caucasian Hispanic
   Other (please describe)
   _____

   Father : Aboriginal (Treaty/Metis) Asian
   African Canadian Caucasian Hispanic
   Other (please describe)
   _____
   (indicate not known if information is not available)

4. Age entering initial foster or other placement care _____

5. Number of previous placements _____ (including current placement)

6. Number of times child has been returned to parental care since initial placement _____

7. Nature of reason(s) for entering care:

	Known	Suspected
abandonment	_____	_____
physical abuse	_____	_____
sexual abuse	_____	_____
emotional abuse	_____	_____
out of parental control	_____	_____
risk of abuse	_____	_____
developmental disabilities	_____	_____
parent unable / unwilling to provide care	_____	_____
other (please describe)		

_____

Please turn over the page for the last two questions

8. Current status of child:

PGO _____
TGO _____
Custody Agreement _____

9. To the best of your knowledge, has this child / adolescent ever been diagnosed, or do you suspect they have:

	Known	Suspected
Attention Deficit Hyperactivity Disorder	_____	_____
Oppositional Defiant Disorder	_____	_____
Conduct Disorder	_____	_____
Fetal Alcohol Syndrome	_____	_____
Reactive Attachment Disorder	_____	_____
Medical Condition / Physical Disability (describe)	_____	
Learning Disabilities	_____	_____
Other (please describe)	_____	

Thank you for your co-operation. Please contact Joanna Bolster at you have any questions or concerns. Once completed, please return this form in the accompanying envelope.

Appendix E

Contents of Research Package and Instructions for Completion

Foster Parent or other Careprovider (e.g. keyworker)

Step 1:

- Read letter from Child Welfare Case Manager to foster parent / careprovider. This letter explains the general research goals.

Step 2:

- Read the letter from the Primary Researcher (Joanna Bolster) to foster parent or other careprovider (e.g. keyworker), explaining research details and instructions for completion of forms.

Step 3:

- Complete the green and white questionnaire and the black and white questionnaire (questions are on both sides of page) specific to the child identified within your care. Use the identified criteria (age of child, gender, and date of birth) at the top of the questionnaires as the guide for completion. Both questionnaires are asking questions about the same child. **Do not skip any questions or provide more than one response to a question**.

Step 4:

- Complete the form with the two open ended questions. Refer to your general experiences as a careprovider, and **provide as many responses as possible**.

Step 5:

- Once completed, put the two questionnaires and the form with the open ended questions into the provided envelope, and mail to the primary researcher.

Summary

Please make sure you have completed the necessary information on the following forms before mailing them to the primary researcher.

Check if completed:

- ❑ green and white questionnaire,
- ❑ black and white questionnaire, and
- ❑ sheet with two open ended questions

Thank you very much for your significant contribution to this research!!!

Appendix F

Child's File Number: _____
Gender:
Date of Birth:

September 2000

Dear Careprovider,

Enclosed in this envelope is information that is part of a research study that the Ma'Mowe Capital Region Child and Family Services Authority is participating in. To assist in the completion of this research project, we ask that you complete the following surveys about the child (identified by file number, gender and date of birth above) in your care. Please make note of the attached information sheet that discusses the purpose of the study, and read this first before completing the surveys. The surveys are short and require **only** your feedback about your perceptions of the identified child within your care.

This research project is part of a doctoral student's dissertation project, and it is hoped that through the information gathered in this study, we can meet the needs of children at risk for placement breakdown in a more effective manner. We appreciate your co-operation in completing these forms in a timely manner. A self-addressed stamped envelope is included within this package, and it would be appreciated if when you had completed the forms you placed them into the envelope and returned them to the researcher as soon as possible. If you have any questions about the research project please feel free to contact the primary researcher Joanna Bolster, supervisor, Dr. Gretchen Hess, at

Thank you in advance for your assistance with this research,

Child Welfare Case Worker

Appendix G

Dear Foster Parent / Key Worker:

I am a graduate student at the University of Alberta and with my supervisor, Dr. Hess, am currently completing my Doctoral studies in Counselling Psychology. As a counsellor who has worked within the Child Welfare system for several years, I have developed an interest in the early childhood risk factors that relate to placement breakdown. As you are the primary careprovider (s) for this child, I am interested in gaining your expert knowledge about specific aspects of the child in your care. I think that the results of this research will be useful in planning early intervention programs that will help both foster families (and other careproviders) and children in maintaining child welfare placements.

I have enclosed 2 sets of questionnaires that I would like you to answer about the identified child. I have also asked you to answer two questions based on your general experiences as a careprovider for Child Welfare. Because your time is valuable, I have tried to make all of the questions clear and short. As I am not directly asking the child any questions, I am dependent on your knowledge of the child and his or her unique qualities. Please answer the questionnaires to the best of your knowledge and experiences with this child. None of the information reported in the final results will report your or the child's specific experiences. Once completed please return the forms to me in the accompanying stamped envelope.

Your co-operation in this research is greatly appreciated. If you have any questions please feel free to contact me directly at <>.

Sincerely,

Joanna Bolster, M.Ed.
Ph. D. Student

Gretchen C. Hess, Ph.D.
Professor, Department of
Professor, Department of
Educational Psychology

Appendix H

To be completed by the child's foster parent (s), or primary careprovider **(e.g. key worker)**

*For confidentiality purposes, please **do not** include the child's name anywhere on this form*

Please provide as many responses as possible, in statement form, to the following two questions.

1. Based on your experience, what are the most common reasons for a child's placement to break down?

2. How do you think we (the Child Welfare system) could decrease the number of unsuccessful placements?