THE UNIVERSITY OF CALGARY

SOCIAL AND BEHAVIOURIAL DIFFERENCES OF CHILDREN IN INSTITUTIONAL AND GROUP HOME CARE

by

IRENE HOFFART

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled, "Social and Behaviourial Differences of Children in Institutional and Group Home Care" submitted by Irene Hoffart in partial fulfilment of the requirements for the degree of Master of Social Work.

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ABSTRACT

SOCIAL AND BEHAVIOURIAL DIFFERENCES

OF CHILDREN IN INSTITUTIONAL AND GROUP HOME CARE

Group homes and institutions constitute some of the primary sources of long-term care for children who cannot stay with their parents. Though the outcomes of treatment in these facilities do not seem to differ, it is suggested that the institutionalized children require more costly and controlled treatment because their disturbances are more severe.

In order to investigate the justification behind institutionalizing children in care, this thesis compared the severity of disorders of children in group homes and institutions. It was hypothesised that there were no differences in severity of the disorders.

Child care workers filled out the Achenbach Child Behaviour Checklist to assess 57 children in three institutions and 57 children in twelve group homes. Hotelling's T^2 was used to compare the severity of disturbances.

The results did not completely support the hypothesis. Children in institutions were more disturbed in Total Behaviourial, Internalizing and some Behaviourial Syndrome scores ($p < .05$). However, statistical differences were generally not accompanied by clinical differences.

It was suggested that the locus of control, clinical status and gender may have to be taken into account in referrals and treatment of children in care. Policy makers were encouraged to examine viability of a more client-driven placement process and expand continuum of services currently available to children in care.

ACKNOWLEDGEMENTS

I wish to express my appreciation to the administration of Alberta Family and Social Services for permitting this study to be conducted. In particular, I would like to thank Mike Stephens who served as an excellent liaison and who greatly facilitated the data collection process.

I would also like to recognize Tak Fung of Academic Computing Services, for his never-ending patience and assistance with statistical techniques.

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DEDICATION

To my parents who have instilled in me the value of education,

who encouraged me to strive for excellence, and

without whose courage none of my achievements would have been possible.

To my best friend, Brian, whose love strengthens me.

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CHAPTER 1

INTRODUCTION

For a variety of reasons, children may not be able to remain in their natural homes (Fein et al., 1983). Children who leave their families may return home after receiving services or remain permanently in government care. In the latter case, they may be placed in family-like foster homes or residential care (Hepworth, 1985; Donley, 1984).

The term "residential care" refers to both large institutions and smaller group homes (Jackson, 1989). Institutions have come under more criticism than group homes for two reasons. First, their restrictive, controlled environment may not be appropriate for the children in government care (Colton, 1989; Jackson, 1989). Second, the costs of institutional care are considerably higher than those of group homes and may be difficult to maintain under present economic conditions (Hazel, 1982; Stephens, 1989).

The proponents of institutional care justify restrictive service delivery and high costs. They claim that institutionalized residents are unique, because they exhibit higher severity of behaviourial problems such as anti-social, aggressive behaviour, delinquency, suicidal tendencies, and depression (Downes, 1982; Hepworth, 1985; Thomas, 1989). They argue that institutions are necessary because they provide

intensive treatment, numerous staff and well-equipped facilities required to treat extreme severity of such problems (Grellong, 1987).

The opponents of institutional care increasingly question the institutions' claim to a unique population, because, in comparison to group homes and foster care, higher severity of behaviourial problems in institutionalized children has not been empirically demonstrated (Kirgan, 1983; Schwab et al., 1985; Cohen, 1986). In fact, some, though limited, evidence suggests to the contrary (Brannon et al., 1986; Sunday & Moore, 1988).

Insufficient data confirming or contradicting the claim to unique client population puts institutions in a vulnerable position in terms of the continuation of service delivery (Jackson, 1989). More studies are needed to compare characteristics of children in institutions to children in other types of substitute care in order to substantiate institutions' claim to unique client population (Jackson, 1989; Brannon et al., 1986).

PURPOSE OF STUDY

The purpose of the present study was to examine the differences between the characteristics of children in institutions and children in group homes. Such an approach sought to determine comparative severity of disturbance in

institutionalized children and, therefore, provide an objective review of institutions' claim to a unique client population. In particular, the study attempted to ascertain the differences between children in institutions and children in group homes in the areas of: (a) severity of behaviourial and social competence problems, and (b) patterns of behaviourial and social competence problems.

SUMMARY

Many children who cannot stay with their families are placed in foster or residential care. The latter is comprised of facilities such as large institutions and smaller group homes. Institutions have come under extensive criticism because of their high costs and questionable effectiveness.

The supporters of institutional care claim that institutions are necessary because they treat children who exhibit most severe disturbances. The present study addressed this claim by comparing characteristics of children in group homes and children in institutions.

CHAPTER 3

METHODOLOGY

This chapter outlines the methodology of the study. The descriptions of the setting, sources of data, characteristics of the sample, instrumentation, sampling methods, data collection methods, and study limitations are discussed.

THE SETTING

The responsibility for the well-being of Canadian children is legislated to the provinces. In Alberta, the Child Welfare Act of Alberta (amended 1985) provides the guidelines for care of children who cannot remain with their natural families. The department which administers the Child Welfare legislation in the province of Alberta is called Alberta Family and Social Services (AF&SS).

Alberta Family and Social Services

AF&SS delivers child welfare services in six geographic regions. The present study was conducted in one of these regions. The region studied was a large metropolitan city with a population of approximately 670,000.

AF&SS Residential Services program supervises facilities which provide residence to Alberta's children in care. According to Alberta Child Welfare

CHAPTER 2

LITERATURE REVIEW

CHILDREN IN CARE

In a Canadian society, parents have the primary responsibility for child care. However, sometimes children and parents are not able to live together because of parental deficiencies or special requirements of the child (Thomlison & Foote, 1987; Barth, 1988). Services, both private and public, become available to such families.

In the extreme cases, the public child welfare system takes on the temporary or long-term responsibility for child care. Whatever the time frame, primary focus of the child welfare services is on returning children to their natural families or providing them with an alternate permanent placement (Barth, 1988; Cornelius and Baker, 1982; Thomlison & Foote, 1987; Taylor et al., 1989).

When children "can no longer be cared for by their natural parents and are, therefore, living in a place other than the natural parents' home" (Hepworth, 1980, pp.6-7, 55-73), they are considered to be 'in care' (or substitute care). Presently 1.4% of all Canadian children under 14 years of age and 1% under 19 years of age remain in care because they cannot return home or become adopted (Thomlinson & Foote, 1987). The province of Alberta has the highest rates in both categories

as 2.2% of children under 14 and .9% of Alberta children under 18 years of age are in care (Hepworth, 1980).

The substitute care arrangements available to these children - the residential and foster placements - have questionable merit, because children in care tend to become estranged from their families, dominate public welfare budgets, and acquire a number of long-term social, emotional, and behaviourial problems (Clayburn et al., 1977; McCord et al., 1978; Taber et al., 1981; Fein et al., 1983; Barth et al., 1988; Maluccio et al., 1972; Steinhauer, 1979; Curtis, 1986).

For many children who cannot stay with their natural families, residential or foster care are the only available options (Kadushin, 1974). It is, therefore, necessary, to study and improve these services. Currently, literature focused on the new family-based treatment options by comparing the relative advantages and disadvantages of family-based and residential care (Thomlison and Foote, 1987; Hepworth, 1985; Maluccio et al., 1972). Few have examined the differences between the residential care options such as group homes and institutions.

The movement towards family-based care is reflected in statistical data on the number of Canadian children in care. From 1956 to 1977 the number of children in family-type care in Canada increased from 68.3% to 73.7%, increased in group homes from zero to 2.4% and decreased in institutions from 28.7% to 20.8%. In

1980, in the province of Alberta 75.9% of children in care were placed in family-like care, 2.4% in group homes and 14.4% in institutions (Hepworth, 1986; Hepworth, 1980). By comparison, in the area of interest, 41.6% of all children in foster and residential care were in foster homes, 42% in group homes and 17% in institutions (Stephens, 1989). As can be noted, the proportion of children who live in residential care is still large enough to examine residential services (Dore, 1984; Hazel, 1982). The next section outlines the criticisms of residential care and contrasts the two options of residential care: institutions and group homes.

RESIDENTIAL CARE OPTIONS

Residential care represents a wide range of government and privately-run residential facilities. It includes short-term and long-term placements. The short-term placements consist of receiving/assessment and day treatment programs. The receiving/assessment facilities's major function is crisis-based assessment and referral. Day treatment centres serve children only during the day (Colton, 1985).

The long-term placements constitute the focus of the present study. Although there is a considerable overlap between the characteristics and functions of long-term care options, two primary types have been identified. Child Welfare League of America (in Laird & Hartman, 1985) and other researchers (Thomlison & Foote,

1987; Hepworth, 1985) divide the residential care in two types of placements: institutions and group homes.

Modern institutions are complete therapeutic programs designed to treat children whose emotional and behaviourial problems preclude treatment in foster and group homes. Such programs include planned and controlled living and emphasize health and future community integration (Maluccio et al., 1972; Vitillo, 1976; Donley, 1984; Dore et al., 1984; Young et al., 1988; Taylor et al., 1989). According to Child Welfare League of America (in Laird & Hartman, 1985) the function of institutional care is to:

> ...provide treatment in a group care therapeutic environment that integrated daily group living, remedial education and treatment services on the basis of an individualized plan for each child, exclusively for children with severe emotional disturbances, whose parents cannot cope with them and who cannot be effectively treated in their own homes, in another family or in other less intensive treatment-oriented child care facilities...

Group homes generally serve fewer children (from six to fifteen) who live under the supervision of several staff members. The staff encourage interaction with the surrounding community and reliance on community resources to provide essential services (Maluccio et al., 1972; Steinhauer, 1979; Donley, 1984). Child Welfare League of America suggest that the function of group homes is to:

> ... provide care and treatment in an agency-owned or operated facility that assures continuity of care and opportunity for community experiences, in combination with a planned group living program and specialized services for small groups of children and youth whose parents cannot care for them adequately and who, because of their age, problems, or stage of treatment can benefit by such a program...

Criticisms of Residential Care

The primary criticisms of institutional care are outlined by Cohen (in Colton, 1988):

1. Institutions are considered ineffective in terms of failing to achieve their formal objectives; they neither deter nor rehabilitate
2. Institutions are considered more costly than community alternatives
3. Theories of stigma and labelling suggest that the further the deviant or dependent person is processed into the system, the more difficult it becomes to facilitate his or her rehabilitation into normal life
4. The causes of most forms of deviance and dependency are rooted in the structures of society. Hence, care/control can only be undertaken in the community and not in artificially created agencies premised on a model of individual intervention
5. Institutions are considered less humane than community alternatives... and may create the very problems they are trying to resolve.

High costs of therapeutic treatment and restrictive environment that may result in questionable outcome effectiveness are cited as the major disadvantages of

institutionalizing children in care (Maluccio et al., 1972; Bush, 1980; Curtis, 1986; Colton, 1988; Jackson, 1989; Stephens, 1989). Group homes represent an alternative to institutionalization. Their closeness to the community, lower costs and smaller size place them between foster homes and institutions on the continuum of costs and restrictiveness (Thomlison & Foote, 1987; Gurry, 1985).

Cost of Institutional and Group Home Care

The current economic conditions dictate the focus on comparative costs of institutions and alternate care options. According to Walton and Elliott, "nearly half of all expenditure on personal social services is spent on residential care and its labour-intensive service" (1980, p.3). Increase in the size of the facility carries a corresponding increase in its staffing, equipment necessary and costs (Prentice-Dunn, 1985). In the United States, many residential centres cost in excess of $25,000-$50,000 per child per year. Among these, institutions were the most expensive option, averaging nearly $3,500 per month per child (Laird & Hartmann, 1985). In one Alberta metropolitan area, Alberta Family and Social Services spends 10 million dollars on institutions it contracts. This is 2.5 times more expensive than the amount spent on comparable number of children in group homes (Stephens, 1989).

Outcomes of Institutional and Group Home Care

Though the costs of institutional care are generally higher than those of the smaller options, the differences in outcomes of institutional and group home care are not as clear. The criticisms of residential care largely stem from longitudinal studies which examine consequences of life in an institution. Many of these studies demonstrate that long-term effect of life in institutions can be harmful. Researchers show that once the child enters care, every move to more restrictive care options increases the probability of psychological problems, as well as future criminal involvement and convictions (McCord et al., 1978; Steinhauer, 1979; Colton, 1988; Bush, 1980; Frank, 1980; Kashani et al., 1984).

For example, children who experienced multiple placements prior to being adopted at three years of age or older had significant emotional or behaviourial problems, learning and developmental disability or a physical handicap, had clinically high levels of aggression, delinquency, hyperactivity, and were also likely to be clinically withdrawn and depressed (Berry & Barth, 1989). Similarly, Tizard and Hodges (1980) found that institutionalized children had poorer concentration, were attention-seeking, aggressive with peers, prone to temper tantrums, either very clinging or very detached, restless, distractible, irritable, resentful of correction and had more difficulties with peer relations than children who live with their families.

Because of long-term consequences of life in institutions researchers propose that children should be kept out of the institutions and other options of care should be strengthened and encouraged (Colton, 1988; Jackson, 1989). However, others (Steinhauer, 1979; Keane, 1973; McIntyre & Keesler, 1986; Berry & Barth, 1989; Pardeck, 1985) point out that long-term consequences of other options can also be harmful. In order to ascertain if institutions are indeed the most damaging, their outcomes must be compared to those of other forms of care.

When institutions were compared to other options, the results were mixed. For example, Velasquez and Lyle (1985) found no difference in improvement of juvenile offenders in day and residential treatment. Frequency with which the youth remained in, or returned to family homes after treatment, rates of school attendance, status offenses and felonies prior to and following treatment did not significantly differ between the two programs. The researchers concluded that the two treatments achieve similar results though day treatment was considerably less costly. In contrast, Deschner's (1980) study with a similar population showed a slightly larger improvement among residential treatment youth by comparison to youth in day-treatment.

Residential treatment programs were also judged more effective than parent-therapist homes (Rubinstein et al., 1978). Children in residential programs showed significant decrease in the severity of their behaviourial problems and increase in

their academic achievement levels. However, in Colton's (1988) comparison of residential treatment programs and foster homes, the residential staff used more inappropriate and ineffective techniques of control, emphasized administrative duties over child orientation and had shorter encounters with children. As a result, children who lived in these residences rated their satisfaction with placements lower and demonstrated more problems in overall behaviourial performance.

The findings are more sparse and as contradictory when institutional outcomes are compared to those of group homes. For example, when community-based home, parental home, and residential institutions for mentally retarded adults were compared, those in a small group home showed the greatest adaptive behaviour change, particularly in the areas of independent functioning, domestic skills and self-direction (Felce et al., 1986). On the other hand, when treatment outcomes of several alternate care facilities were compared, children who lived in those of smaller size demonstrated less improvement in self concept, delinquency, and overall behaviour than children in larger institutions (Cohen, 1986).

In view of limited and inconsistent results obtained in comparing outcomes of various care options, many researchers agree that present direction in evaluation is inadequate (Fein et al., 1983; Colton, 1988). Successful outcome may not be determined entirely by the size of the residence but by other factors, such as agency funding, staff training and child's environment after leaving placement

(Deschner, 1980; Cohen, 1986; Malluccio, 1979). According to Whittacker (p. 636): "...outcome research clearly indicates that 'success' in residential care is largely a function of the supports available in the posttreatment community environment and has much less to do with either presenting problem or type of treatment".

High costs associated with institutional treatment should be questioned, as it is unlikely that consistent differences in the effectiveness of the group homes and institutions will be empirically demonstrated. The supporters of institutional care argue that expense is justified, because institutionalized children are too disturbed to be considered for group home placement (Maluccio et al., 1972; Curtis, 1986; Thomas, 1989). However, it has not been empirically demonstrated that children in institutions are more disturbed than the children in group homes. The present thesis addresses this limitation by comparing characteristics of children in institutions to children in group homes.

CHARACTERISTICS OF CHILDREN IN RESIDENTIAL CARE

This section will identify characteristics judged most appropriate for institutional and group home placement, describe the characteristics of children presently receiving residential care and compare characteristics of children in institutions and group homes.

Characteristics of Children Appropriate for Institutional and Group Home Care

It was suggested that older children with certain kinds of emotional and behaviourial problems are better placed in institutions than in smaller, family type foster or group homes (Downes, 1982; Hepworth, 1985; Thomas, 1989). More specifically, the adolescents who are violence-prone, with long histories of school related problems, emotional disturbances and conduct disorders are judged most appropriate for life in the institutions (Maluccio et al., 1972; Grellong, 1987).

For example, Downes' (1982) described adolescents in terms of his/her existing attachments. The capacity for attachment varied from relatively unimpaired to seriously impaired. Among those more impaired, some children were described as passively dependent and others fiercely self-reliant. Where fierce self-reliance was combined with hostility or denial and little capacity for attachment, institutional placement was deemed more appropriate.

According to Shostack (1987) youths whose behaviour arouses fear in the community, who have a disturbance so severe that it endangers the safety or disrupts the treatment of other residents, who require intensive psychotherapy or drug therapy, youths who are violent, who chronically run away, set fires and steal require more structured settings than group homes. By comparison, children who

benefit from living in group homes should be able to participate in and benefit from group living, be able to attend and benefit from public schools and have some degree of self-reliance. In summary, Shostack suggested that group homes should admit only mildly disturbed and socially maladjusted young people.

Schulman and Kende (1988), studied the treatment of runaways from a short-term diagnostic centre. They determined that the child with the most limited capacity for relationships, who is unable to establish any connection within the house, most hostile, angry and aggressive, paranoid, disorganized, and unpredictable seems most likely to run away. The researchers concluded that such children are not likely to remain in open settings and need a closed therapeutic setting.

The proponents of institutional care further emphasize the distinction between group homes and institutions, as increasing number of children bring more severe and complicated array of problems, conditions, patterns of behaviour and levels of disturbance. For example, Young (1988) found that the overall proportion of severely disturbed children in United States' institutions has increased over the last decade. In 1960 27.5% of children in care were severely disturbed (34.6 % in 1981), 47.4 % moderately (46.9 % in 1981), 21.1 % mildly (16.8 % in 1981) and 4 % had no disturbance (1.7 % in 1981). In Canada 62 to 72 % of children in care

today exhibit some form of mental disorder and severe behaviourial problems (Thompson & Fuhr, 1986).

Extreme behaviourial problems described above have been generally associated with higher incidence of physical trauma and childhood illness as well as lower cognitive abilities. Intensive and controlled treatment is recommended to treat such problems (Grellong, 1987). This treatment is costly and requires well-developed facilities and controlled conditions (Young, 1988; Dore, 1984; Cates, 1983; Maluccio, 1972; Curtis, 1986).

Characteristics of Children Receiving Institutional and Group Home Care

The assumption of extreme severity of disturbance serves as the basis for existence of institutions for children in care. It is suggested that the institutionalized children exhibit higher severity of disturbance than the children in group care (Grellong, 1987; Young, 1988; Dore, 1984). This assumption can be examined by comparing characteristics of children in institutions and group homes.

Only a few studies compared children in institutions to children in group homes. Most writers compared children in a variety of residential settings to children in other facilities such as short-term care options and foster care. Though

peripheral to the present purpose, their findings are important to this study in terms of providing more support for the hypothesis.

When children are compared, almost without exception, children in residential care exhibit disturbances that are more severe. For example Kolvin et al. (1986) demonstrated that disturbed children in ordinary schools had the fewest antisocial disturbances and have the least number of severe disorders by comparison to disturbed children in hospitals, residences and special schools. Children in residential treatment had more adverse temperamental characteristics than children in other groups. In another study, Colton (1988) found that fewer foster children lacked guilt about anti-social acts, threatened to commit suicide and had a record of psychiatric treatment or oversight than children in residential treatment.

Thompson (1986) administered a battery of tests to 160 Alberta children in order to assess differences in the extent of psychopathology and emotional disturbance. He found that children in group homes and institutions had higher psychopathology than children in foster care, who, in turn, had higher psychopathology than children living with their relatives. The rates were highest for such behaviourial problems as conduct disorder, psychoticism, criminality and externalizing disorders.

Hornick et al.'s (1989) results demonstrated that females in foster care followed the same general pattern as the residential care group, though foster care group was somewhat lower than the residential care group on externalizing behaviours. Also, the females in residential care had more behaviourial problems and scored significantly higher than the family support group on the anxious-obsessive, schizoid, depressed-withdrawal, immature-hyperactive, delinquent and cruel scales. Males in residential care had more extreme scores on all behaviours. Overall, the foster care group was higher on immaturity and hostile-withdrawal dimension, but lower on delinquency and aggression than all the other groups. The findings cited above differed from those obtained by Jones (1989). When treatment foster care clients were compared with youths served by teaching family model group homes, it was found that foster care youngsters were comparable to, if not more disturbed than the group home youth.

With only one exception, the studies demonstrate that children in residential care are more disturbed than children in other forms of care. However, it is still unclear if any social or behaviourial differences exist between children in institutions and children in group homes.

Some information regarding characteristics of children receiving group and institutional care can be obtained from descriptive case studies. Several facilities which treated children with problems of delinquency were described. Though their

sizes differ, the disorders of children they housed were similar. For example, Adams (1980) described a hostel for 11 delinquent adolescent boys. The range of residents' behaviour problems was wide and varied from those who committed grave physical assaults to the multitude of property offenses. Residents of smaller group homes for girls (Morris, 1980) exhibited comparative behaviourial problems of delinquency such as violence towards self and others. Also, throughout Canada, facilities ranging in size from 4 to 25 all treat delinquency and other seriously deviant behaviourial problems (Hepworth, 1975).

The descriptions of children who live in facilities which treat other disorders are also similar. In Raynor and Manderino's (1988) study, among 19 adolescents residing in a residential treatment program nearly half were diagnosed as having conduct disorder. Two thirds of them reported depressive symptoms. Most of these symptoms fell into the moderate to severe category. In a small group home (Morris, 1980) most of the clients exhibited similar behaviour problems such as lack of personal worth and self esteem as well as feelings of failure and despair. In another small home which housed between four and sixteen residents (Gurry, 1985) most children were also diagnosed with disorders such as adolescent adjustment reaction, schizophrenia, autism, manic and chronic depression.

Absence of significant differences among children in larger and smaller facilities are substantiated by Brannon's (1986) and Sunday & Moore's (1988)

studies, which most closely resemble this thesis. Brannon (1986) found that, overall, the placement of young offenders in institutions, park camp and community based group homes was indistinguishable from random assignment. The Total Behaviour Problem scores did not reveal any significant association between the severity of behaviour and extent of security of the residential programs. Sunday & Moore (1988) determined that there were no differences in type or degree of behaviour problems between boys in group home care and residential treatment settings, while a comparison of girls revealed a number of significant differences.

Brannon's (1986) and Sunday & Moore's (1988) are the only studies cited in this thesis that empirically compared children's characteristics in group homes and in institutions. Though their findings seem to suggest that severity of disturbance of children in institutions does not differ from that of children in group homes, the findings are not conclusive. More studies are needed to examine comparative disturbance of children in group homes and institutions.

SUMMARY

As the debates around the utility of institutionalizing children in care persist, neither argument is supported by empirical evidence demonstrating higher levels of social or behaviourial disturbance in institutionalized children (Schwab et al., 1985; Fitzgerald, 1987). Because of the high costs required and questionable

effectiveness of services, an examination of institutional care would constitute a much-needed addition to the literature.

The assumption of higher severity of disturbance of children in institutions constitutes the primary argument in support of this form of care. The comparative assessment of behaviour of institutionalized children would examine the justification behind institutionalizing children in care (Maluccio et al., 1972; Kirgan, 1983; Schwab et al., 1985; Cohen, 1986; Fitzgerald, 1987).

Hypothesis

Fein, Maluccio, Hamilton, and Ward (1983) propose that fate of children in institutions is determined more by system dynamics than by client considerations. Others suggest that most placement decisions are affected by attitudes, educational background, skills and values of the worker, dynamics of the institution, availability of placement, and shortage of time rather than the severity of their disturbance (Fein et al., 1983; Downes, 1982; Kirgan, 1983; Meddin, 1984; Fitzgerald, 1987; Steinhauer, 1979; Walton and Elliott, 1980). Therefore the hypothesis of the present study is:

> Social and behaviourial disturbances of children in institutional care are not statistically significantly more severe than those of children in group home care.

Program Manual "the Residential Services Program provides services through placement in specialized residential resources to children in care who, because of moderate to severe emotional and/or behaviourial problems, cannot be maintained in their own home or in substitute family care." (Alberta Family and Social Services, 1989, p. 108). Placements into most resources require the approval of the child welfare regional placement committee and are limited to individuals under 18 years of age (Alberta Social Services, 1985).

A variety of residential settings comprise the facilities supervised by the Residential Services Program. These settings provide both short- and long-term services to children in care. Short-term care programs house children for up to three months and render such services as receiving, assessment and day treatment. Long-term care programs provide housing and treatment which last until the child turns eighteen or until a permanent placement, such as adoption, is found.

Facilities Chosen for the Study

This study's focus was on children who have to remain in care of the government. Accordingly, short-term facilities, facilities for handicapped children, those for young offenders, shelters for homeless youth and employment skills programs were not included.

The selected facilities deliver long-term services to children with child welfare concerns. For the purposes of the present study the facilities were divided into two types - group homes and institutions. The two types are distinguished from one another by their size. The residential program defines facilities which house more than six children as institutions, and those with six or less children as group homes (Alberta Family and Social Services, 1989).

With recent expansions in Alberta's alternate care options, the distinction must also be made between group homes and other options such as foster care and professional parent homes. Though all such facilities may house the same number of children (up to six), the primary difference lies in the way the facility is staffed. While the group home operators hire staff who do not live on the premises, the professional parent and foster homes are generally run by a family unit, its members living at the facility on permanent basis (Alberta Family and Social Services Handbook, 1989).

THE SAMPLE

Table 3.1 outlines the number of the facilities chosen for the study. Among 22 suitable facilities, 7 declined participation. The preliminary sample consisted of 3 institutions and 12 group homes.

Table 3.1
Participating Facilities

Facilities	*n*	*Declined*	*N*
Institutions	3	0	3
Group Homes	19	7	12
Total...	22	7	15

Table 3.2 on the following page describes the size (number of beds) of participating institutions and group homes and the sample size. The study identified participating settings as institutions numbered 1 through 3 and group homes numbered 1 through 12.

The total population was based on the number of beds allotted by AF&SS to each facility. The institutions had 74 beds and group homes - 72. Eighty one point one percent of institutionalized children and 80.5% of children in group homes were assessed. On average, 19 (82%) out of 24.7 children at each institution and 4.8 (79.2%) out of 6 children at each group home (or 7.6 (85.2%) out of 9.7 children per facility) were assessed. Due to empty beds and inability to obtain consent to assess some of the children the final sample included 57 children in institutions and 57 children in group homes.

Table 3.2
Size of Facilities by Size of Sample

Facility	Number of Beds		Size of Sample			
	N	*X*	*n*	*X*	%	*X*
Institutions (*n* = 3)						
1	32		16		50.0	
2	17		17		100.0	
3	25		24		96.0	
Sub-total	74	24.7	57	19	81.1	82.0
Group Homes (*n* = 12)						
1	6		5		83.3	
2	6		2		33.3	
3	6		5		83.3	
4	6		5		83.3	
5	6		3		50.0	
6	6		5		83.3	
7	6		5		83.3	
8	6		4		66.7	
9	6		6		100.0	
10	6		5		83.3	
11	6		6		100.0	
12	6		6		100.0	
Sub-total	72	6	57	4.8	80.5	79.2
Total....	146	9.7	114	7.6	78.1	85.2

SAMPLE CHARACTERISTICS

The characteristics of the sample will be compared across two groups of children: those in institutions and those in group homes. Demographic variables included gender, age, Achenbach gender/age groups, ethnicity, the child welfare status, and presence or absence of previous placements. The comparison of the present sample characteristics with other research is provided in the discussion section of this thesis (please see page 62).

Gender

Table 3.3 presents the distribution of gender across placements. The total sample contained more males (63.2%) than females (36.8%). This trend was repeated among children in institutions and in group homes. However, there were more males among institutionalized children (64.9%) than among children in group homes (61.4%). The reverse was found for the females: there were more in group homes (38.6%) than in institutions (31.1%). None of the comparisons demonstrated statistical significance.

Table 3.3
Placement by Gender

	Institutions		Group Homes		Totals	
Gender	*n*	%	*n*	%	*N*	%
Males	37	64.9	35	61.4	72	63.2
Females	20	35.1	22	38.6	42	36.8
Total..	57	100.0	57	100.0	114	100.0

$\chi^2 = 0$, $df = 1$, $p = 1.00$

Age

As seen in the Table 3.4 on the following page, the average age of the sample was 14.2 years. The children placed in the group homes were significantly older ($M = 14.8$) than children in the institutions ($M = 13.5$).

Table 3.4
Mean Age in Years by Placement

Placement	*Mean Age*	*SD*
Institutions	13.5	2.3
Group Homes	14.8	1.2
Total Average...	14.2	1.9

$t = 3.9$, $df = 112$, $p = .000$

Achenbach Gender/Age Groups

Achenbach (1986) suggests dividing children by their gender and age. The distributions of these groups by the type of placements are presented in the Table 3.5 on the following page.

There were fewer children between 6 and 11 years of age in both gender groups (0.9% females and 7% males) than children in the 12 to 16 age group (36% girls and 56% boys). More children in younger age groups lived in institutions (girls - 1.8%, boys - 14%) than in group homes (zero percent in both). The reverse was the trend for older children. There were more females (38.6%) and males (61.4%) aged between 12 and 16 in group homes than in institutions (33.3%, 50.9%). However, the differences were not significant.

Table 3.5
Type of Placement by Gender and Age Group

Gender/ Age groups	Institutions *n*	%	Group homes *n*	%	Totals *N*	%
Girls 6-11	1	1.8	0	0.0	1	0.9
Boys 6-11	8	14.0	0	0.0	8	7.0
Girls 12-16	19	33.3	22	38.6	41	36.0
Boys 12-16	29	50.9	35	61.4	64	56.1
Totals...	57	100.0	57	100.0	114	100.0

$\chi^2 = 9.8$, $df = 3$, $p = 0.205$

Native Status

As presented in Table 3.6 below, 16.8% of the sample were of native origin. There were more native children in institutions (21.4%) than in group homes (12.3%). However, the differences were not significant across placements.

Table 3.6
Placement by Native Status

Native Status	Institutions *n*	%	Group homes *n*	%	Totals *N*	%
Native	12	21.4	7	12.3	19	16.8
Non-native	44	78.6	50	87.7	94	83.2
Totals...	56	100.0	57	100.0	113	100. 0
Missing data	1	-	1			

$\chi^2 = 1.1$, $df = 1$, $p = 0.294$

Child Welfare Status

According to Alberta Child Welfare Act, the children in care of the government must be registered under a Child Welfare Status. The children in the present sample were represented in five categories: Apprehension, Custody Agreement with parent (CA/parent), Custody Agreement with child (CA/child), Temporary Guardianship Order (TGO) and Permanent Guardianship Order (PGO).

Apprehension occurs when the child is temporarily removed from the guardian's home. In a Custody Agreement the government assumes custody of the child. The parents or the child him or herself must consent to any treatment or changes in placement (Alberta Family and Social Services, 1989). A child with a TGO status is placed in care under the authority of the state, but his or her guardianship can be returned to the parents when they become able to care for the child again. If the child is assigned a PGO status his or her legal guardianship has been taken away from the parents and permanently assigned to the state (Thompson, 1986).

Table 3.7 displays the children's Child Welfare status. Only 3.5% of all children (all in group homes) were apprehended. The other four types of Child Welfare Status were comparably represented in the total sample, institutions and group homes. The smallest was the group of children with Custody Agreement with

Child (4.7%), followed by Temporary Guardianship Order (11.3%), Custody Agreement with Parent (31.1%) and Permanent Guardianship Order (52.8%). There were more institutionalized children in every category, except for the Custody Agreement with Parent. 29.4% of children in institutions by comparison with 32.7% of children in group homes were in this category. None of the groups differed significantly from one another.

Table 3.7
Placement by Child Welfare Status

	Institutions		Group Homes		Totals	
Status	*n*	%	*n*	%	*N*	%
Apprehension	0	0.0	2	3.5	2	1.9
CA/Child	3	5.9	2	3.5	5	4.6
TGO	6	11.8	6	10.5	12	11.1
CA/Parent	15	29.4	18	31.6	33	30.5
PGO	27	52.9	29	50.9	56	51.9
Totals...	51	100.0	57	100.0	108	100.0
Missing data	6				6	

$\chi^2 = 2.3$, $df = 4$, $p = 0.695$

Previous Placements

As can be seen from the Table 3.8 on the following page, the majority of all children (81.1%) have had previous placements. There were more children in group homes with previous placements (85.7%) than in institutions (14.3%). Once again, these differences were not statistically significant.

Table 3.8
Presence of Previous Placement by Current Placement

Previous Placement Present	Institutions *n*	%	Group Homes *n*	%	Totals *N*	%
Yes	38	76.0	48	85.7	86	81.1
No	12	24.0	8	14.3	20	18.9
Totals...	50	100.0	56	100.0	106	100.0
Missing data	7		1		8	

($\chi^2 = 1.1$, $df = 1$, $p = 0.304$)

OPERATIONAL DEFINITIONS OF DEPENDENT VARIABLE

Many instruments which classify childhood behaviour problems are inappropriate for this study because of unsuitable age ranges, inappropriate diagnostic focus, poor reliability in the psychometric assessment of children, and/or participating child care workers' lack of familiarity. Some examples of such scales include Rutter A scale, Residential Treatment Behaviour Rating Scale (RTBRS), Walker Problem Behaviour Identification Checklist (WPBIC), Peterson-Quay Behaviour Problem Checklist, Becker Behaviour Rating Scale, Eyberg Child Behaviour Inventory (ECBI), Eysenck Personality Questionnaire, Minnesota Child Development Inventory, Bayley Infant Scales, McCarthy Scales, and Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (Eysenck and Eysenck, 1975; Achenbach et al., 1978; Eyberg et al., 1978; Wilson et al., 1983; Achenbach, 1985; Brannon et al., 1986).

In response to criticisms associated with standardized measuring instruments which attempt to classify childhood behaviourial disorders, Achenbach and Edelbrock (1983) developed the Child Behaviour Checklist. This instrument is advantageous for several reasons. "...it provides the description of behaviour in a format useful to clinicians,...discriminates among sex and age,... is independent of clinical inferences,...reflects children's positive adaptive, as well as maladaptive behaviours and...enables to group children for purposes of research (Achenbach, 1985).

The Achenbach Child Behaviour Checklist

The Achenbach Child Behaviour Checklist (Achenbach, 1983) is comprised of two scales: social competence and behaviour problems. The items for the scales were derived primarily from content analysis of over 600 case histories of children considered clinically disturbed.

The 20-item social-competence scale reports on amount and quality of child's participation in school, sports, organizations, chores, hobbies and social relationships. The 118-item behaviour-problem scale assesses extent of disturbance in several behaviourial areas.

Child Behaviour Profiles. To score the checklist items Achenbach (1983) provides standardized profiles. To account for differences in children's gender and age, separate editions of the profile are used for each gender and age ranges of 4 to 5, 6 to 11 and 12 to 16 years.

The social-competence items are divided into three scales - Activities, Social, and School. Activities and Social scales are scored in the same way for all groups. The school performance scale is scored only for children of school age. (See Appendix A for the Social Competence profiles used for the present study).

The behaviour-problem scales are derived separately for both genders and four age ranges. Researchers' factor analysis of the 118 behaviourial items resulted in 8 or 9 "narrow-band" behaviour problem scales, which differ for each gender/age grouping. These include such descriptors as socially withdrawn, delinquent, aggressive, hyperactive, schizoid, depressed, uncommunicative, obsessive compulsive, and having somatic complaints. (See Appendices B through E for the Behaviourial profiles used for the present study).

The intercorrelations among the "narrow band" scales have resulted in the continuum between two "broad band" scales: 'Externalizing', or having problems of conflict with the outside world and 'Internalizing', or having problems of conflict with the self. The items which are applicable to both were designated as part of

a 'Mixed' scale. Researchers suggest that the children should not be classified as internalizing or externalizing unless the scores on the two scales differ by at least 10 points and the total behaviourial score exceeds 90th percentile.

Scoring Procedures. The scoring procedures of the social competence items require respondents to list activities and compare amount of time spent by the child in each activity to an average child of the same age (less than average scoring 0, average scoring 1 and more than average scoring 2).

The scoring procedures for the behaviourial problem scale require respondents to indicate the extent of their agreement with various items within each category on a three-step response scale (0 indicating that the item is not true of the child, 1 - the item is somewhat true of the child, and 2 - it is very true of the child) (Achenbach et al., 1978; Achenbach et al., 1979; Achenbach, 1985).

Within each gender/age group, the child's raw scores on each of the social competence and behaviourial scales are transformed into normative T-scores. The T-scores are then entered into the social competence and behaviourial profiles.

The profiles provide a cut-off score for each scale. This represents the 98th percentile of the scores received by the randomly tested non-clinical children. Any score above the normalized cut-off line (or below if a social competence profile)

would demonstrate severe disturbance for that particular scale (Achenbach, 1985).

Reliability and Validity of CBCL. The effectiveness of the Achenbach Child Behaviour Checklist in identifying the severity of behaviourial patterns and requirements of children in care has been well-documented (Achenbach et al., 1983; Marsh et al., 1985; Brannon et al., 1986; Mooney, 1984). Both reliability and validity of the instrument are strong enough to warrant its use in assessment of the childhood behaviourial disorders.

Reliability is defined as consistency of scores produced by a measuring instrument. It can be examined over time and among raters (Anastasi, 1982; Grinnell, 1993). When assessed over time (in intervals ranging from 1 week to 3 months), Pearson correlations of CBCL scale scores ranged from .51 to .92 and of item scores from .996 to .838. When interrater agreement consistency was examined, the Pearson correlations of scale scores ranged from .978 to .985 and of item scores ranged from .927 to .985 (Mooney, 1984; Achenbach & Edelbrock, 1983).

Validity of the instrument is defined as the degree to which the test actually measures what it purports to measure. The instrument is valid if its content is appropriate to its purposes, and if it is comparable to tests which measure the same construct (Anastasi, 1982; Grinnell, 1993). Administration of CBCL to

clinically referred and non-referred children showed that the former group scored significantly higher on behaviour problems and lower on social competence than non-referred children (Achenbach, 1983).

CBCL also fared well when its assessment was compared to those obtained by other instruments. The correlations of internalizing and externalizing dimensions with Conners Parent Questionnaire ranged from .71 to .91 (Achnebach & Edelbrock, 1983). The correlations of scores obtained on "narrow-band" syndromes ranged from .39 to .78 when compared with Conners Questionnaire, and from .40 to .92 when compared with Quay-Peterson Revised Behaviour Checklist (Mooney, 1984). More recently, McConaughy (et al., 1988) demonstrated that modest linear correlations existed between CBCL assessments by teachers and results of direct observations, cognitive tests and personality measures.

Uses of CBCL

The effectiveness of the CBCL in identifying childhood problems has motivated many authors to use it in their research. The checklist was administered for the purposes of determining outcome, prevalence of disorders in a population and to compare groups of children.

Outcome Studies. Freeman, Anderson and Kairey (1980) administered the checklist to evaluate the therapeutic camp for children with social adjustment and behaviourial problems. The researchers concluded that the children with more internal locus of control made more progress toward attaining their goals on Goal Attainment Scaling.

Friedrich (et al., 1984) used CBCL to identify childhood behaviourial problems which result from sexual abuse. Internalizing behaviours were related to such factors as frequency of abuse, sex of the child and severity of abuse. Externalizing disorders were related to duration of and time elapsed since abuse.

Berry and Barth (1989) used the checklist to ascertain factors associated with outcome in adoptions. They found that aggressive and hyperactive children who display anti-social behaviour are at the greatest risk of adoption break down.

Prevalence Studies. McIntyre and Keesler (1986) administered the checklist to foster children in order to describe their psychological disorders. Almost half of the sample showed some problems and all of the disorders assessed by the checklist were represented.

Thompson (1986) assessed the extent of emotional disturbance of children in substitute care. The results demonstrated that children in group homes and

institutions had higher psychopathology than those living at home and with foster parents. The author also found that the rates of psychopathology were highest for those disorders that are more difficult to treat (e.g. externalizing disorders).

Comparative Studies. Many researchers have demonstrated that CBCL is effective in comparing characteristics of different groups of children. This is of special significance, because the present thesis used similar approach.

For example, Achenbach (et al., 1986) administered the checklist to normal Dutch and American children. This testing demonstrated effectiveness of the checklist with other than North American children and found no significant differences in the scores received.

Brannon and Williams (1986) determined that the checklist is effective in providing the profile for the adolescent offenders. Administration of the instrument showed that little relationship exists between the security of the placement and severity of offenders' disorders.

In Brodzinsky's (et al., 1987) study, the checklist was administered to determine prevalence of clinical symptoms in adopted and nonadopted children. The data indicated that higher percentage of adoptees than nonadoptees demonstrated clinical symptoms.

Flintoff (1988) compared social behaviour and emotional adjustment of normal and internalizing clinical children. Results indicated that internalizing children had poorer social and emotional adjustment than children in a non-problem sample.

Hornick (et al., 1989) used the checklist to determine gender differences in behaviourial problems of children in care. They found that females in foster care demonstrated more disturbances than those in family support programs and than the males in care. The researchers also concluded that the CBCL was effective in identifying behaviourial problems of children in care.

The reliability and validity of the Achenbach Behaviour Checklist, its ability to determine the extent of severity in disturbances and its success with this study's population make it an appropriate measurement instrument for the dependent variable-the severity of the behaviourial disturbance in children who live in institutions.

DATA COLLECTION

The data were collected between May and June of 1990. Initial consent for administration was obtained both from the University of Calgary and the Alberta Family and Social Services (Appendixes F and G). Prior to distribution of data, a letter was sent out to all participating facilities (Appendix H) to inform the potential

respondents of the up-coming study. Meetings were also held with the administrators and staff of the larger institutions to answer any further questions the participants may have had.

The letters and meetings of introduction were followed by the delivery of the forms to be completed. These forms included the letter of consent (Appendix I), a demographics questionnaire (Appendix J) and the Achenbach checklist (Appendixes A - E).

The CBCL forms used were designed for children aged 4 to 16. Five of the youths assessed were 17 years of age. According to Achenbach and Edelbrock (1983) these children can be included in the 12 to 16 age group if the individuals most familiar with the children's day-to-day behaviour fill out the forms. The version of the CBCL used in the present study can be filled out by parents or by parent surrogates such as child-care workers, foster parents, and clinicians. The checklists were completed by the residential facility personnel most familiar with the children.

Achenbach computerized data entry program (Lachar, 1985) was used to produce individual profiles on the basis of raw data received from the behaviourial and social competence assessments. Statistical program (SPSSX) enabled easy

manipulation of data. The program was used to run a Hotelling's T^2 test and descriptive statistics.

METHODOLOGICAL LIMITATIONS

This section will discuss several limitations associated with the study. The threats to internal and external validity as well as the narrow scope of the study are addressed.

The generalization of the population beyond that of the institutions and group homes in the region of interest is one of the more important limitations. The variability in regional interpretation of the Child Welfare Act may prevent complete generalizability to all Alberta's facilities. Also, the individuals who declined participation in the study may have been different in some way from those who did not.

Ethical obligation to explain the purpose of the study to the participants may have led to response bias. It is possible that, in order to justify the institutions' existence, some respondents would overestimate severity of children's disorders.

Administration of a single test, even a well-validated one is not always sufficient to eliminate bias in results (Grinnell, 1993). Similarly, differences in assessment by

parents, workers and clients themselves have been known to occur in administrations of CBCL (Marsh et al., 1985). Therefore, absence of a reliability check, such as another test and/or other raters jeopardizes the results.

It has been suggested earlier that the comparative outcomes of institutional and group home treatment have not been consistent (Curtis, 1986; Thomas, 1989). Therefore, the effectiveness of the facilities that took part in the study was assumed equal. This assumption represents another study limitation, as it has not been tested with the participating institutions and group homes. Similarly, while the lengths of stay at the institutions and group homes were not compared, they were assumed equal and may have also influenced the children's severity of disturbance.

The final limitation of the study is its limited scope. It has been confirmed that many children in long-term government's care (professional parent, foster, group homes and institutions) exhibit severe behaviourial problems (Curtis, 1986; Barth et al., 1988). The disturbance of children in institutions was compared only to that of children in group homes. The children in other alternate care options did not participate. Institutions' claims can be fully examined only if children living in all other placement types are assessed. The study as presently planned does not allow for a complete comparison.

SUMMARY

Alberta Family and Social Services in the Calgary region provided the access to the children who were assessed for the present study. Child welfare concerns and long-term separation from natural families characterized children who participated in the study. These children were placed in group homes and institutions supervised by the AF&SS Residential Services Program.

The participating group homes and institutions were distinguished from one another and from other forms of alternate care by their sizes and types of staffing arrangements. Institutions house more than six children and group homes house six or less. Both types of facilities hire staff who do not live on the premises.

Among the total population of institutions and group homes, 3 institutions (74 beds) and 12 group homes (72 beds) comprised the sample for the present study. Due to some empty beds and inability to obtain consent, the final sample included 57 children from group homes and 57 from institutions.

The demographic characteristics of the sample were compared between children in institutions and in group homes. Among institutionalized children there were more males, more children of native origin and more children under Custody Agreement with Child, Temporary Guardianship and Permanent Guardianship

Orders. In group homes children were older, there were more females, more children with previous placements and more children in Achenbach's older gender/age groups.

Achenbach Behaviourial Checklist was administered to the sample in order to assess the severity of the children's disorders. The reliability and validity of the Checklist, its ability to determine the extent of severity in disturbances and its success with this study's population make it an appropriate measurement instrument for the present study.

The checklist enables assessment of childhood social competence and behaviourial problems. Once scored, it produces profiles which are divided into several scales. The severity of disturbance is determined by comparing the scale T-scores with the normative samples provided by the Achenbach.

The checklist and accompanying demographics questionnaire were completed between May and June of 1990. Only the individuals most familiar with the children were asked to fill out the forms. The computerized Achenbach program enabled easy scoring of the data received. SPSSx was used to run descriptive statistics and a Hotelling's T^2 test.

Methodological limitations of the study included limited generalizability to other Alberta's children in institutions and group homes, absence of other tests and other raters, limited comparability scope, assumptions of comparative outcome and length of stay and the possibility that the respondents knowledge of the study's purpose influenced their responses.

CHAPTER 4

ANALYSIS AND FINDINGS

This chapter presents the findings of the study. The differences between children in group homes and institutions were tested for both clinical and statistical significance.

The Manual for the Child Behaviour Checklist (Achenbach, 1983) does not specify tests appropriate for statistical analyses of findings. Generally, in CBCL-based research, the study purpose dictates the choice of an appropriate statistical procedure (Achenbach et al., 1986; Brannon et al., 1986; Hornick et al., 1989). In the present study, Hotelling's T^2 was used to examine the statistical differences between the mean T scores. Hotelling's T^2 is used when comparison of two independent groups along several correlated dependent measures is required (Norman & Streiner, 1986). The CBCL scores constitute the correlated measures of this study's dependent variable - children's severity of disturbance (Achenbach, 1983).

The scores were deemed clinical if they were above (if Behaviour scales) or below (if Social Competence scales) the clinical cut-off line. Achenbach profiles were used to graphically present the findings.

Administration of CBCL results in seven overall scores. There are three scores for the Behaviour scale: Total, Externalizing, and Internalizing. There are four scores for the Social Competence scale: Total, Activities, Social, and School. The Behaviour scale is further sub-divided into syndromes which differ by age and gender.

The overall scores are derived by adding the responses received on identical items for both genders and ages from 6 to 16. Therefore, it is appropriate to combine the total and sub-scale scores of males and females aged 6 to 11 and 12 to 16. The first part of this chapter reports the differences between the overall scores of children in institutions and group homes.

The comparison is not complete without the discussion of differences between the Behaviour syndrome scores of children in group homes and children in institutions. To make this possible, children must first be divided into appropriate age/gender groups. The second section of this chapter reports the results of age/gender comparisons of Behaviourial syndrome scores.

OVERALL DIFFERENCES

The comparisons of the Total Behaviour and Social Competence scores and their sub-scales are presented in Table 4.1 on the following page. The clinical cut-

off established by Achenbach (1983) is at the 90th percentile (or *T* scores of 63) for Total Behaviour, Externalizing, and Internalizing scores, and at the 10th percentile (or *T* scores of 38) for the Total Social Competence score. This is different from the 98th percentile (or *T* scores of 70) for Behaviour syndromes and 2nd percentile (or *T* scores of 30) for Social Competence sub-scales. The discrepancy results from the differences in calculation of scores. Because the Total Behaviour and Social Competence as well as Externalizing and Internalizing scores are calculated from a higher number of items, the respondents tend to endorse at least some of them. The minimum *T* score does not have to be pre-set and is calculated directly from the scores received.

Table 4.1
Overall Mean T-Scores
by Type of Placement

	Institutions			Group Homes				
CBCL Scale	*X*	*SD*	*N*	*X*	*SD*	*N*	*F*	*p*
Behaviour	72.7[c]	8.0	57	66.9[c]	11.4	57	8.9	.003*
Externalizing	69.2[c]	11.2	57	65.8[c]	12.1	57	2.5	.116
Internalizing	67.1[c]	6.8	57	62.6[c]	8.9	57	9.9	.002*
Social Competence	27.8[c]	6.9	38	26.9[c]	7.0	35	0.2	.628
Activities	38.4	10.9	56	31.2	12.6	56	6.9	.010*
Social	25.0[c]	10.9	57	26.6[c]	9.2	56	1.6	.213
School	33.0	11.8	39	36.1	13.6	36	0.8	.373

*$p < .05$
[c] clinically significant

The Hotelling's T^2 test was significant for the overall mean *T* scores of children in group homes and institutions ($T^2 = .3$, $F(7,106) = 3.1$, $p = .005$). The areas

of differences included the Total Behaviour, Internalizing and Activities subscale mean *T* scores.

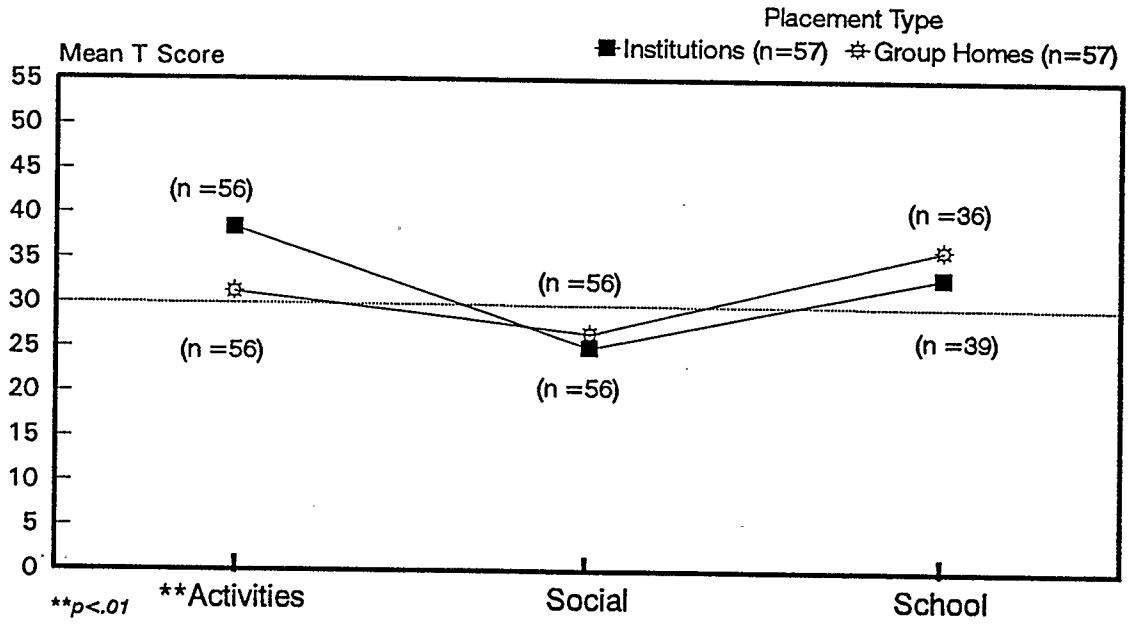
As demonstrated in the Table 4.1, the mean Behaviour *T* scores of institutionalized children were higher (more clinical) than the mean *T* scores of children in group homes when the comparison was made between the Total scores (M(institutions) = 72.7, M(group homes) = 66.7, $F(1,112) = 8.9$, $p = .003$) and Internalizing scores (M(institutions) = 67.1, M(group homes) = 62.6, $F(1,112) = 9.9$, $p = .002$). According to Achenbach (1983), children can be classified as Externalizers or Internalizers if their Total Behaviour score exceeds 90th percentile (or a *T* score of 63) and if there is a 10 point difference between the Externalizing and Internalizing scores. All Behaviour mean *T* scores were in the clinical range. However, the differences between Internalizing and Externalizing scores were too small for classification.

The findings were different for the Social Competence scale. Significant differences were found only for one set (the Activities subscale), and in the opposite direction from the differences of the Behaviour scale scores. The mean Activities *T* scores of children in group homes were significantly lower and more clinical ($M = 31.2$) than the scores of children in institutions ($M = 38.4$, $F(1,112) = 6.9$, $p = .01$). Lack of significance in other Social Competence scores may be due to the missing data in the Total Social Competence and School scores. Both

scores are not calculated if there are no responses for any 4 items on the School scale.

Figure 4.1 presents a visual comparison between the Social Competence profiles of children in the two types of placements. The Social and School sub-scale scores are similar in magnitude and direction of the differences. As reported previously, the direction is reversed and the difference is larger between the Activities scale scores.

Figure 4.1
Social Competence Profiles
by Type of Placement



The children in group homes scored higher (showed less disturbance) in the Social (*M*(group homes) = 26.6, *M*(institutions) = 25.0) and School subscales (*M*(group homes) = 36.1, *M*(institutions) = 33.0). However, they showed more disturbance on the Activities subscale (*M*(group homes) = 31.2, *M*(institutions) = 38.4). Both groups of children scored within the clinical range only on the Social scale.

BEHAVIOUR SYNDROME DIFFERENCES

The previous section compared all of the Social Competence mean *T* scores as well as the Total and subscale Behaviour scores. This section will complete the comparisons by examining disturbances of age and gender groups in behaviourial syndromes.

Hotelling's T^2 test was used to determine if significant differences existed between the severity of disturbances in syndrome scores of children in group homes and institutions. The scores above 70 indicate clinical range of disturbance in a particular syndrome.

It was not possible to include all children in such comparisons, because syndromes are different for each gender and age group. The study sample included members of four groups: females aged 4 to 11 and 12 to 16 and males

aged 4 to 11 and 12 to 16. The number of children in 4 to 11 age groups was not large enough for comparison (see Table 3.5).

The following discussion compares the differences in syndrome severity of males and females aged 12 to 16. Please refer to the Appendixes C and E for the complete list of syndromes and the items they are derived from.

Males' Syndrome Differences

Table 4.2 below compares syndrome scores of males aged 12 to 16.

Table 4.2
Behaviourial Syndromes
of Males by Type of Placement

	Institutions			Group Homes				
Behaviourial Problems	*X*	*SD*	*N*	*X*	*SD*	*N*	*F*	*P*
Somatic	62.7	6.1	29	62.2	7.1	19	0.1	.784
Schizoid	67.5	6.7	29	63.8	7.6	19	4.1	.047*
Uncommunicative	70.1[c]	8.3	29	67.1	10.2	19	1.5	.219
Immature	70.5[c]	10.7	29	68.1	10.1	19	0.8	.370
Obsessive-Compulsive	66.5	9.3	29	64.4	8.4	19	0.9	.342
Delinquent	73.2[c]	9.4	29	71.1[c]	10.1	19	0.8	.389
Aggressive	70.7[c]	10.0	29	68.9	11.5	19	0.4	.523
Hyperactive	69.2	9.6	29	69.5	12.0	19	0.0	.938
Hostile-Withdrawn	73.3[c]	9.2	29	68.7	10.4	19	3.4	.071

* $p < .05$
[c] clinically significant

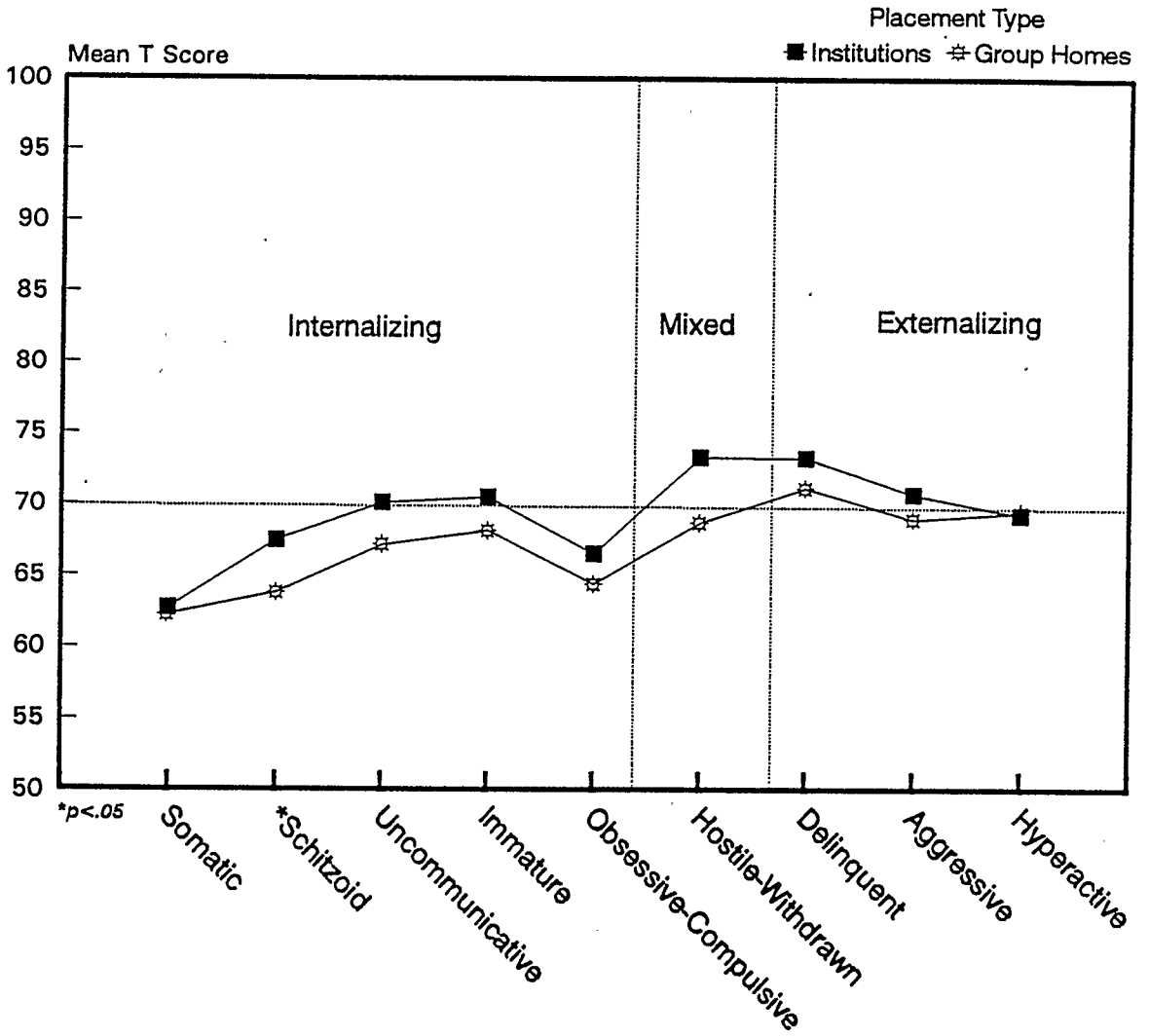
The Hotelling T^2 test was not significant when the syndrome mean T scores of males in institutions and group homes were compared (T^2 = .2, $F(9,54)$ = 1.2, p = .334).

As presented in Table 4.2, the groups were significantly different in only one Behaviour syndromes (Schizoid). The Schizoid syndrome scores of males in group homes were significantly lower (M = 63.8) than the scores of males in institutions (M = 67.4, $F(1,62)$ = 4.1, p = .047).

Examination of Figure 4.2 on the following page reveals that the patterns of the profiles are similar. The scores of males in group homes are consistently lower than the scores of the institutionalized males in all syndromes, except Hyperactive. The males in group homes scored slightly higher in this syndrome (M(institutions) = 69.2, M(group homes) = 69.5).

Institutionalized males also had more syndrome scores in the clinical range. They received clinical scores on Delinquent (M = 73.3), Uncommunicative (M = 70.1), Immature (M = 70.5), Aggressive (M = 70.7) and Hostile-Withdrawn syndromes (M = 73.3). Males in group homes scored within clinical range only on Delinquent syndrome (M = 71.1).

Figure 4.2
Behaviour Profiles of Males
by Type of Placement



Females' Syndrome Differences

Table 4.3 compares syndrome scores of females aged 12 to 16. The Hotelling T^2 test was not significant when the syndrome mean T scores of females in institutions and group homes were compared (T^2 = .5, $F(8,32)$ = 2.1, p = .069).

Table 4.3
Behaviourial Syndromes
of Females by Type of Placement

	Institutions			Group Homes				
Behaviourial Problems	*X*	*SD*	*N*	*X*	*SD*	*N*	*F*	*P*
Somatic	69.1	9.5	35	61.3	9.2	22	7.1	.011*
Schizoid	67.8	9.5	35	63.3	9.7	22	2.2	.145
Depressed-Withdrawn	66.5	6.2	35	62.1	5.6	22	5.7	.022*
Anxious-Obsessive	68.6	7.7	35	63.6	9.0	22	3.5	.069
Delinquent	76.0[c]	8.5	35	68.6	10.8	22	5.9	.020*
Aggressive	71.4[c]	9.3	35	68.2	10.8	22	1.0	.326
Cruel	77.3[c]	8.1	35	71.6[c]	9.2	22	4.5	.041*
Immature-Hyperactive	69.9	10.2	35	66.3	7.9	22	1.6	.213

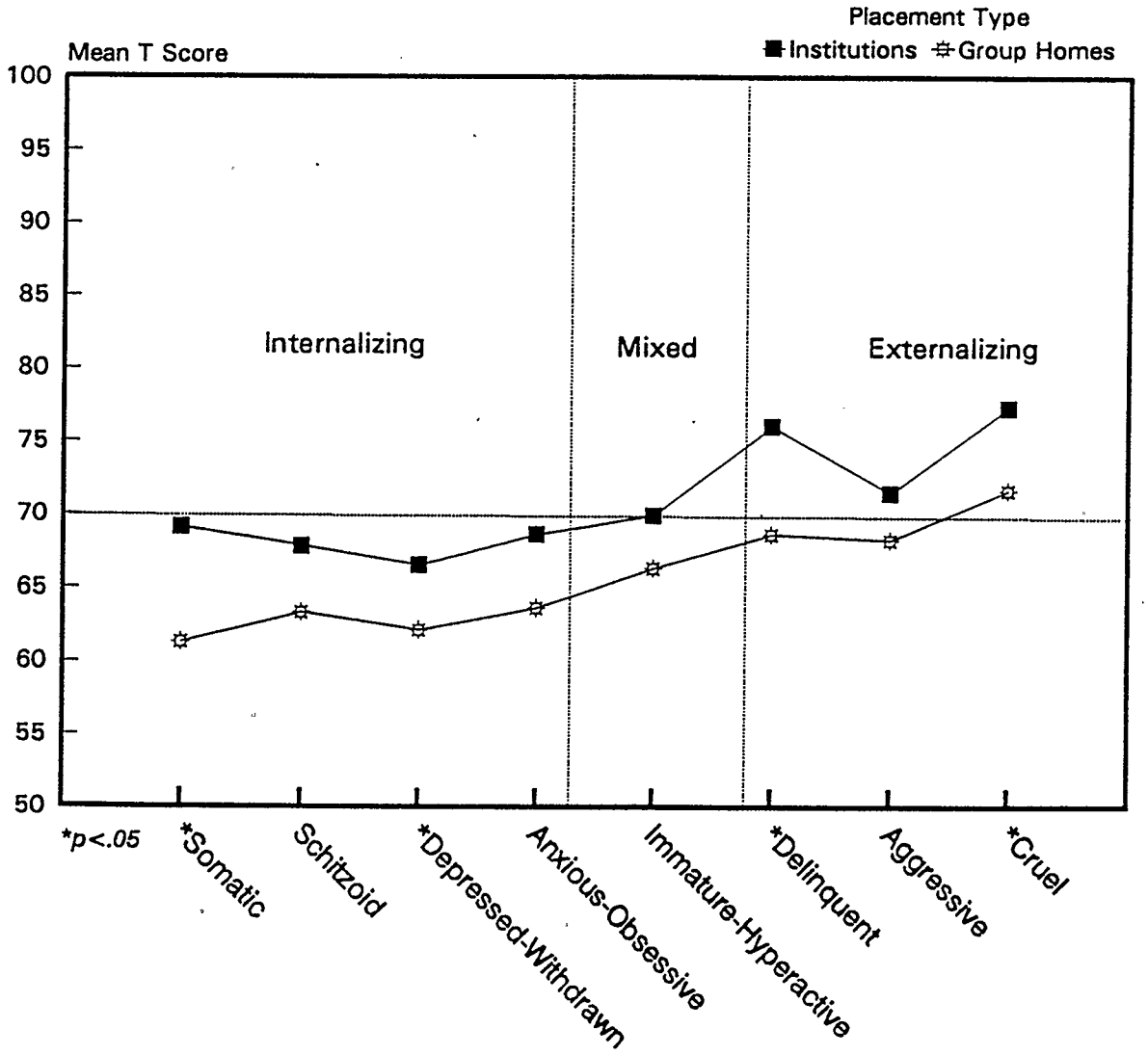
* $p < .05$
[c] clinically significant

As presented in Table 4.3, the scores were significantly higher for institutionalized females in the following syndromes: Somatic (M(institutions) = 69.1, M(group homes) = 61.3, $F(1,39) = 7.1$, $p = .011$), Depressed-Withdrawn (M(institutions) = 66.5, M(group homes) = 62.1, $F(1,39) = 5.7$, $p = .022$), Delinquent (M(institutions) = 76.0, M(group homes) = 68.6), $F(1,39) = 5.9$, $p = .020$), and Cruel ((M (institutions) = 77.3, M(group homes) = 71.6), $F(1,39) = 4.5$, $p = .041$).

Once again, examination of the profiles (Figure 4.3 on the following page) reveals similarity in patterns of the syndrome scores. All of the scores of females

in group homes are lower than the scores of the institutionalized females. As follows, the females in group homes scored in the clinical range in fewer syndromes (Cruel, M = 71.6) than the females in institutions (Delinquent, M = 76.0; Aggressive, M = 71.4; and Cruel, M = 77.3).

Figure 4.3
Behaviour Profiles of Females
by Type of Placement



SUMMARY

Both visual and statistical comparisons were carried out to determine if any social and behaviourial differences existed between the children in institutions and children in group homes. The Hotelling's T^2 test was used to determine the differences between the overall and syndrome mean *T* scores.

The Hotelling's T^2 test demonstrated that the overall mean *T* scores of the children in institutions and children in group homes were significantly different ($p < .01$). The significant differences were in the areas of the Total Behaviour, Internalizing and the Activities mean *T* scores. The Total Behaviour and Internalizing scores were higher (more clinical) for institutionalized children, while the Activities score was more clinical (lower) for the children in group homes. Both groups' Behaviour scores and the Social sub-scale scores were in the clinical range.

The Hotelling's T^2 test was also used to compare the Behaviour syndrome *T* scores of females and males aged 12 to 16. Profiles provided by Achenbach enabled visual comparisons.

The Hotelling's T^2 statistic was not significant for either gender group ($p > .05$). Also, visual examination revealed that the profile patterns were similar. In

group homes children of both genders scored consistently lower than the children in institutions. The males and females scored in the clinical range only on one syndrome each (Delinquent and Cruel respectively).

In institutions both males and females scored in the clinical range on Delinquent and Aggressive syndromes respectively. Females also scored in the clinical range on the Cruel syndrome and Males on Uncommunicative, Immature, and Hostile-Withdrawn syndromes.

The difference between males in institutions and group homes was significant in only one syndrome (Schizoid, $p < .05$). Females in institutions scored significantly higher on Somatic, Depressed-Withdrawn, Delinquent and Cruel syndromes ($p < .05$).

The findings provide partial support for the thesis hypotheses as children in institutions are not consistently more disturbed than children in group homes. However, the hypothesis cannot be retained because children in institutions did demonstrate (in some areas) both clinically and statistically higher levels of disturbances.

CHAPTER 5

DISCUSSION AND CONCLUSIONS

Group homes and institutions constitute some of the primary sources of long-term care for children who cannot stay with their parents. Separation from natural families is generally associated with social and/or behaviourial disturbances (Thomlison & Foote, 1987). Group homes and institutions provide shelter and treatment to these children.

Though the two types of facilities do not seem to differ in their treatment outcomes, services in institutions are more expensive and restrictive (Stephens, 1989; Colton, 1989). It is suggested that the institutionalized children require more costly and more controlled treatment because their disturbances are more severe. To prevent possible harm to children, institutions should be examined as a viable form of long-term care.

This study compared the severity of behaviourial and social disorders of children in group homes and institutions in order to investigate justification behind institutionalizing children in care. Child care workers at both types of facilities filled out the Achenbach Child Behaviour Checklist for each resident. Hotelling's T^2 was used to compare the severity of disturbances.

STUDY FINDINGS

It was hypothesized that there would be no significant differences in severity of disturbance between the children in group homes and children in institutions. This hypothesis was rejected, because the multivariate comparison was statistically significant ($p < .05$). Examination of the mean scores revealed that most of the time children in institutions were more severely disturbed than the children in group homes.

A quick analysis of such findings would suggest that there is justification behind institutionalizing children in care. However, more detailed comparisons of the sub-scale and syndrome scores revealed that the differences were not consistently statistically or clinically significant. As a result, the hypothesis was rejected only in certain areas of behaviourial and social disturbances.

The following will analyze the findings in light of other research and propose some causes for any discrepancies or similarities. First the demographic characteristics will be compared. Then the social competence and the behaviourial comparisons will be considered. The implications of the findings and suggestions for future research will conclude the chapter.

Demographic Differences

The inclusion of demographic characteristics served a dual purpose. First, the knowledge of the population's characteristics will allow future researchers to compare their findings. Second, the characteristics discussed are often regarded as referral criteria to group homes and institutions (Thompson, 1986; Wolkind & Rutter, 1973; Thomas, 1989).

The children's gender, native status, child welfare status, the presence of previous placements, age, and Achenbach groupings were compared. Among these, only the variables associated with clients' ages (i.e., mean age and Achenbach age/gender groups) differed significantly.

Children in group homes were significantly older than children in institutions. Same pattern was demonstrated when children were divided into appropriate age/gender groups. In group homes there were fewer boys and girls in 6 to 11 age bracket, and more boys and girls aged 12 to 16. Keane (1983) contends that the prevalence of problems varies with age, with the most problematic age group being 7 to 9-year olds. The combination of the current and Keane's findings implies higher levels of disturbance in institutions. This is unlikely, as most researchers suggest that emotional problems of older children make them better candidates for placement in institutions rather than in smaller, family type foster or

group homes (Downes, 1982; Hepworth, 1985; Thomas, 1989). The differences in age do not support the contention that children in institutions are more disturbed.

Similarly, absence of association between children's gender and placement is supported by some literature. Thompson (1988) also determined that there were no meaningful differences between placement of males and females in the various care options. However, other researchers (Stephens, 1989; Hornick, 1989) showed that more males are placed in residential facility (group home or institution) than females (who were more often placed in foster care). It is possible that the significant gender differences exist only between foster care and residential options, though not within residential care - group homes and institutions.

As in other research (Thomlison & Foote, 1987; Thompson, 1986; Stephens, 1989) the proportion of children with native status in both groups exceeded the 5% found in general population (Thomlison & Foote, 1987). Though Stephens (1989) determined that native children are more likely to be placed into less restrictive options of care (e.g., foster care), the present study showed no significant ethnic differences. In fact, more native children were placed in institutions (21.4%) than in group homes (12.3%). It is unlikely that the number of native children in institutions could lead to increased severity of their disturbance because levels of

psychopathology in Native children in care do not differ from those found for non-Native children (Thompson, 1986).

The levels of psychopathology do seem to vary with Child Welfare Status. Disturbance is highest for children with Custody Agreements, lowest for those with Support Agreements, while children with Temporary and Permanent Guardianship Orders fall in the middle (Thompson, 1988). In the present study no status was over- or underrepresented in either placement group. As in Stephen's (1989) study, most children in both settings were under a Permanent Guardianship Order (the most restrictive). The number of children with the Custody Agreement with Parent (less restrictive than TGO) being the close second. Absence of differences allows to question provision of institutional care, especially because the restrictiveness in status does not seem to be consistent with restrictiveness in placement.

Finally, Thompson (1988) and Wolkind and Rutter (1973) suggests that children with multiple placements are more likely to have a disorder than children with no previous placements. More specifically, the longer children remain in care the greater the external direction of their orientation (Wiehe, 1986). Externalizing scores are characterized by disorders that are extremely difficult to alleviate without concentrated and planned treatment generally associated with institutionalized placement (Shostack, 1987; Schulman & Kende, 1988). In this study, two

placement groups did not differ in presence or absence of previous placements. Such a finding once again suggests that there may not be any emotional and behaviourial differences between children in institutions and children in group homes.

As can be noted, most of the demographic characteristics of children in institutions did not differ from those of children in group homes. The differences that did exist were at variance with suggested criteria for placement into institutions. Because the characteristics discussed are associated with social and behaviourial disturbances in children, the absence of differences in the former area implies the same in the latter. It is not surprising that the differences were also absent in several social competence and behaviourial scores.

Social Competence Differences

The social competence scores reflect the quality and quantity of the child's participation in sport and non-sport activities, organizations, relations with friends and school achievement (See Appendix A). The multivariate comparisons showed no significant differences in the Social Competence scores ($p > .05$). The differences were not significant between the Total Social Competence and Social and School subscale scores as well.

The similarity of children's social competence profile patterns demonstrated absence of clinical differences. The members of both groups would be considered clinically disturbed in the extent of their participation in organizations and relations with friends and less disturbed, though needing attention in the area of school achievement. Thompson's (1986) findings were similar: the number of children whose Social Competence scores were above 90th percentile (or in the clinical range) were the same (94%) in group homes and in institutions.

However, in the present study the children differed significantly in their Activities subscale scores. Among all of the study's findings, this was the only score that revealed significantly higher disturbance of children in group homes. Similarly, in Bangs' (1988) study the Total Social Competence scores did not differ between boys just placed in a group home and those already in placement for four months. However, the boys placed most recently were significantly more active. The author (Bangs, 1988) suggested that longer time in placement is associated with increased isolation from social activities.

In conjunction with present findings, the interpretation may be somewhat different, because children in group homes are generally less isolated than the children in institutions (Colton, 1988; Jackson, 1989). It is possible that the structured environment of institutions mandates participation in activities more so than the less structured environment of group homes. The positive relationship

between structure and social competence is confirmed by Leitenburg (et al., 1981), who found that children living with their natural parents had a higher incidence of poor school attendance than those living in group or foster homes.

The absence of statistical and clinical differences in the Total Social Competence, Social and School subscale scores, and scores for children in group homes in the Activities subscale support the original thesis hypothesis. In the area of Social Competence, the children in institutions do not seem to be more severely disturbed than the children in group homes. However, validity of these interpretations is subject to the comparatively large numbers of missing data in the School subscale (N(institutions) = 39, N(group homes) = 36) and Total Social Competence scores (N(institutions) = 38, N(group homes) = 35).

Behaviourial Differences

The administration of the Behaviourial Problems section of the checklist results in three areas for comparison: Total Behaviourial, Internalizing/Externalizing, and Behaviourial Syndrome scores. The differences were significant for Total Behaviourial, Internalizing and some Syndrome scores.

Total Behaviourial Scores. The Total Behaviourial score describes the overall severity of the child's disturbance. This number is derived by adding the ratings the child received in 118 specified behaviours (see Appendixes B - E).

The multivariate comparison of the total scores did not support the thesis hypothesis, because the difference between the groups' overall scores was significant ($p < .05$). Children in institutions were more severely disturbed than the children in group homes.

However, statistical differences were not accompanied by clinical differences. Though children in institutions scored slightly higher, both groups scored above 90th percentile, leading to an identical diagnosis - need for treatment in the area of behaviourial problems.

These findings are not always consistent with other research. For instance, Brannon (1986) established that the Total Behaviourial scores of adolescent male offenders in training schools, non-secure park camps, and community-based group homes were not significantly different ($p > .05$). However, Hornick (1989) and Sunday and Moore (1988) found that the behaviourial differences between children in various types of placements were most significant for the females.

It is possible that the inclusion of females in the present sample led to significant findings. Gender differences in scoring are repeatedly identified in the literature. Many researchers (Flintoff, 1988; Hornick et al., 1989; Brodzinsky & Radice, 1987) indicate that raters may be influenced by socialization process, where females' acting out is judged as more abnormal than that of the males.

Alternate explanations notwithstanding, the groups significantly differed along their Total Behaviourial scores. However, absence of clinical differences prevents outright rejection of the thesis hypothesis. The discussion of Externalizing and Internalizing scores as well as Behaviourial Syndrome scores will assist in further specifying if and in what areas the two groups of children differ.

Externalizing and Internalizing Scores. Behaviourial problems can be grouped in two broad areas - Internalizing and Externalizing. Children who score in the clinical range on Internalizing scale tend to have difficulties with self and exhibit fearful, inhibited, overcontrolled behaviour. Children who score in the clinical range on Externalizing scale, tend to have difficulties with the outside world and exhibit aggressive, antisocial and undercontrolled behaviour (Flintoff, 1988; Achenbach & Edelbrock, 1983).

The present study determined that the two groups of children differed significantly only on the Internalizing dimension. In this area, children in institutions

were more severely disturbed than the children in group homes ($p < .05$). Once again, statistical differences were not accompanied by clinical differences. Though children in institutions scored significantly higher on the Internalizing dimension, both groups scored above 90th percentile, demonstrating a similar need for treatment.

The literature comparing Internalizing scores of children in institutions and group homes is somewhat consistent with the present findings. For instance, Thompson's (1986) results showed little difference between the percentages of children who scored in a clinical range on Internalizing subscale in institutions (81%) and group homes (82%). In Sunday and Moore's (1989) and Hornick's (1989) studies the locus of control scores varied only when the severity of disturbance was also compared across gender groups. In both studies males were more likely to exhibit externalizing behaviours while females' problems were of more internalizing nature and females in general had more problems than males. It may be hypothesized that the significant differences found in Internalizing scores were by the scores of the female clients.

Externalizing scores are characterized by disorders that are extremely difficult to alleviate without concentrated and planned treatment generally associated with institutionalized placement (Shostack, 1987; Schulman & Kende, 1988). Neither the present study nor Thompson's (1986) has found significantly higher severity

in Externalizing disorders of children in institutions. In fact, in Thompson's study more children in group homes scored above 90th percentile on the Externalizing subscale (88%) than children in institutions (81%). Such findings merit serious examination if it is generally recommended that children with extreme Externalizing disorders should be placed in institutions.

Once again, the thesis hypothesis can be rejected on the basis of statistical findings in Total and Internalizing scores. However, absence of clinical and Externalizing differences minimizes the significance of these findings and prevents an unequivocal conclusion.

Behaviourial Syndrome Scores. Behaviourial syndromes constitute the final unit of analysis. Eight or nine syndromes identified by Achenbach (1983) differ for each gender and age group. Each syndrome is assigned a name that summarizes the items comprising the scale (Appendixes B - E).

In order to examine differences in syndrome scores between children in group homes and children in institutions, the placement groups were further divided into two age/gender groups. Groups of males and females aged 12 to 16 were compared across the two settings. The multivariate comparisons showed both gender groups scoring consistently, though not significantly ($p > .05$) higher in institutions.

Absence of significance is not supported by other findings of the present study. The age of the children in the present sample may have played a role. Several researchers indicate that adolescence is characterized by heightening psychopathology for females and declining psychopathology for males (LeClave & Campbell, 1986). The presence of nine younger group members (eight males and one female) in analyses at other levels may have accounted for some of the differences in the findings.

Though the multivariate comparisons of syndromes did not culminate in significant differences, comparison of individual syndrome scores resulted in some significant findings, particularly for the groups of females.

Males' Syndrome Scores. The absence of significant differences between the males' syndrome scores supported the thesis hypothesis. The only syndrome that demonstrated significant difference in scores was Schizoid ($p < .05$). The single significant finding may be due to repeated statistical testing, rather than to the differences that are actually present (Streiner, 1986). Absence of significant differences in males' syndrome scores is consistent with other research (Sunday & Moore, 1988; Hornick et al., 1989).

Further confirming the thesis hypothesis was the similarity in profiles of the two groups of males. The syndromes which demonstrated clinical need in institutions

were either also clinical (Delinquent) or sufficiently near the clinical cut-off line to require treatment (Immature, Hostile Withdrawal, Uncommunicative and Aggressive). Three out of these five syndromes were also noted in Sunday and Moore's (1988) study as both placement groups had treatment needs in the areas of Delinquency, Immaturity, Hostile Withdrawal, and Hyperactivity.

Females' Syndrome Scores. The overall comparison of the two groups of females supported the thesis hypothesis, though the probability level was almost small enough to reject it ($p = .069$). The hypothesis was indeed rejected when the syndrome scores were compared. The females in institutions scored significantly higher in Somatic, Depressed-Withdrawn, Delinquent and Cruel syndromes ($p < .05$).

These findings are generally confirmed by other researchers (Hornick et al., 1989; Sunday & Moore, 1988). Though the differences were not always in the same areas as in the present study, some syndromes are consistently higher for females in institutions. Sunday and Moore (1988) found significant differences in the Cruel syndrome scores and Hornick's residential care group was significantly higher than the family support group in, among others, Depressed-Withdrawal, Delinquent and Cruel scales.

As with the two groups of males, the females' profile patterns are almost identical. The syndromes which demonstrated clinical need in institutions were either also clinical in group homes (Cruel) or sufficiently near the clinical cut-off line to require treatment (Immature-Hyperactive, Delinquent and Aggressive). Among these, Cruel and Delinquent syndromes were also statistically different. Interestingly, Sunday and Moore (1988) also found significant differences in Cruel, Immature-Hyperactive and Aggressive syndromes. The higher severity of disorders in females may contribute to overall differences between the children in group homes and in institutions. Absence of significant findings among older males may be due to lower levels of disturbance generally found in this age/gender group (LeClave & Campbell, 1986).

STUDY IMPLICATIONS

The exploratory nature of the study prevented a conclusive statement in reference to the thesis hypothesis. For example, it could be suggested that institutionalized treatment is justified (though only for the females in care). However, sex-role expectations and inconsistent differences prevent an unequivocal conclusion regarding usefulness of institutional care for females.

Neither can it be stated that institutional treatment is inappropriate. Absence of differences in several areas of disturbance (such as Social Competence and

Externalizing syndromes) and for some children (males) may be due to differences in effectiveness of the two types of facilities. Effectiveness of the group homes and institutions was assumed equal, because the differences in outcomes are not consistently supported in literature (Velasqueez & Lyle, 1985; Bangs, 1986; Colton, 1988; Jackson, 1989). However, problematic staffing ratios, staff training and supervision, expectations of care-givers regarding what constitutes normal behaviour, and degree of explicit treatment planning and programming may have influenced outcomes of the participating group homes (Sunday & Moore, 1988; Fein et al., 1983).

Provision of expensive and restrictive services to children in care should be questioned if the characteristics of children in various types of care do not differ. The present study did show that institutionalized treatment may not be appropriate for all of the children who presently receive it. The following discusses the implications of these findings to social work practice and policy.

Implications for Practice

The data indicated that there are discrepancies between the characteristics of children presently placed institutions and types and levels of disturbances that are best treated in there. For instance, children's participation in activities, presence of internalizing and externalizing disorders, scoring within or outside the clinical

and gender and age differences all carry implications for appropriateness of social work practice in institutionalized setting.

Activities. The finding that children in group homes scored significantly higher in the Activities sub-scale may attest to the value of institutionalized approach in this particular area of intervention. However, activity orientation in institutions may be limited to treatment of outward expression, rather than internal influences for behaviourial problems (Moffat et al., 1985).

Perhaps children's participation in activities may be seen as an area of improvement for treatment in group homes. A variety of new methods may be required to enhance quality and quantity of children's participation in sport and non-sport activities and jobs in group homes. The employment aspect is particularly important for the adolescents in care. Intensified focus and a more structured approach in this area may enhance their future integration into society.

Clinical Status in Syndromes. CBCL scores at or above clinical levels indicate a need for treatment (Achenbach & Edelbrock, 1983). The findings showed that clinical scores in institutions corresponded to clinical (or near clinical) scores in group homes. The advocates of institutional care suggest that children with clinical disturbances may be best treated in more restrictive facilities (Shostack, 1987; Thomas, 1989). The results of the present study do not reflect this outlook.

Externalizing/Internalizing Dichotomy. The disorders that are most difficult to deal with and that should be treated in more controlled settings (such as institutions) include conduct disorder, psychoticism, criminality, hostility, anger and aggression (Thompson, 1988; Schulman & Kende, 1988; Grellong, 1987; Shostack, 1987). Translated into the terms used by Achenbach, these correspond to Externalizing syndromes such as Delinquency and Aggression (Hornick, 1989; Thompson, 1988; Barker, 1988).

The evidence of the current study indicated that, instead, institutionalized children scored higher than children in group homes in Internalizing disorders. It is possible that the institutions are more effective in minimizing Externalizing than Internalizing disorders, while the opposite is true for group homes. However, if outcomes are assumed equal, the appropriateness of institutional treatment should be examined. In either case the locus of control should play a major role in children's placement and treatment.

Gender Differences. Previous research has concluded that there are sex differences in assessment of children in care (Brodzinsky et al., 1987; Flintoff, 1988; Hornick et al., 1989). The present study also showed that the adolescent females in institutions were assessed with more severe disturbance than the adolescent females in group homes, while there was no difference between the groups of adolescent males.

Only the females differed significantly in some of the most difficult to treat behaviours (i.e., Externalizing disorders such as Delinquent and Cruel). While it is clear that the institutions do not treat all of the children with most severe disturbances, the females in institutions do score significantly higher in areas which warrant intervention and are most difficult to treat.

Several researchers explain that much of the differences in assessments of the female adolescents is due to socialization processes (Flintoff, 1988; Hornick et al., 1989; Brodzinsky et al., 1987). Others (Johnson & Kaplan, 1988; Campbell & Cooper, 1975) suggest that both physical and social factors, earlier sexual maturation of female adolescents and the difference in sex role expectations may influence the raters toward a more negative perception of the females. In either case, care providers should be aware of the potential for gender bias in assessment.

Implications for Policy

Absence of significant differences in social competence and externalizing scores and between males demonstrated that some children are still being placed in group homes and institutions for reasons other than the severity and type of their disturbance. The following describes the Alberta Family and Social Services

policies relevant to the placement of children in care and the implications of the findings for future policy development in the region.

AF&SS Placement Policies. Alberta Family and Social Services mandates that each region establishes and utilizes a "regional placement committee" with the function of screening and approving all referrals (Alberta Family and Social Services, 1989). The primary principles which direct the AF&SS planning process include choosing the least intrusive, most appropriate service to meet the child's need, proximity and availability of placement. However, there is no distinction in policy between children who should be placed in group homes or the more intrusive institutions. The AF&SS Handbook (1985) states that: "..residential resources [group homes and institutions] are provided to children in care who because of moderate to severe emotional and/or behaviourial problems cannot be maintained in their own home or in substitute family care". The combination of policies and budget cut backs may have resulted in increased focus on availability of placement.

The downward economic trend in Alberta has culminated in decrease of resources to children in care. As a result, both group homes and institutions may be experiencing an increase in children's problematic behaviours, placement disruptions, as well as staff dissatisfaction and turnover. The examination of existing policies is vital to ensure appropriate placement of children within the

constraints of the resources provided. Client-driven rather than system-driven placement process and provision of full continuum of care are some of the policy areas suggested for examination.

Client-Driven System. Currently, system characteristics (e.g., treatment modality, availability) are the primary distinguishing factors in placement (Brannon, 1986; Burns, 1990). However, facilities which use different treatments may be equally effective for the same group of children. Also, placement based on availability is unlikely to ensure positive outcome. To minimize duplication of services, increase fiscal responsibility and ensure effectiveness, the match should not be based on the type of treatment provided by the facility, but on its abilities to manage the unique characteristics of the child.

This thesis and prior research suggest that extent of disturbances as well as the types of behaviours and demographics should serve as primary criteria for placement (Schwab et al., 1985; Donley, 1984; Meddin, 1984). A standardized measuring instrument such as Child Behaviour Checklist and some demographic descriptors can be used by the placement agency to distinguish several profiles of children. A record of profiles will allow a government agency such as AF&SS to set up functional contracts with group homes and institutions on the basis of a match between the child's needs and facility's ability to answer these needs.

Full Continuum of Care Options. The study findings suggest that the residential options currently available to children in care do not account for needs of all individual children. Other researchers advocate for provision of a full continuum of care to accommodate greater differences in children's characteristics (FFTA, 1990; Algarin & Friedman, 1990). Residential care as presently conceptualized seems appropriate only for a handful of children. Exploring feasibility of alternative group care options such as Teaching Family Model group homes and Treatment Foster Care is likely to benefit these children (Foster Family-based Treatment Association, 1990).

Service integration and coordination among the funders and the service providers is necessary for the effective use of the alternatives. Clearly spelled out interagency agreement containing joint goals, objectives and activities an on-going meetings with representatives from every agency are some of the suggested aspects of community integration (Greenley, et al., 1990).

A well-developed continuum of care within a client-driven system may decrease the number of children placed in unsuitable care options, while remaining within the limits of the available resources (Algarin & Friedman, 1990). Potential for harming children by not providing enough or by providing inappropriate services would then be minimized.

SUGGESTIONS FOR FUTURE RESEARCH

Several limitations of the present research were outlined in the methodology section and referred to throughout the thesis. The implications section also pointed out some areas for future exploration in practice and policy. The following outlines the suggestions for future research as derived from the study limitations and implications to practice and policy.

Replication Research. The studies exploring a similar research question could minimize current limitations by including several raters, assessment instruments and a full array of placement options. Future research may focus on clarifying the differences between children in institutions and group homes by assessing the seriousness of behaviours with a battery of tests and methods. More extensive, in-depth clinical assessments of clients could be used. These could include the behaviourial and placement history and/or measures which tap additional behaviours or disturbances.

The study results may have been influenced by the characteristics of different raters and changes in individual ratings over time (Marsh et al., 1985; Bangs, 1988). Future studies may ask several participants to rate the same child. Social workers, child care workers and, in some cases parents, may be involved. Such approach would also minimize the response bias. Social workers' and parents'

knowledge of the study purpose is unlikely to influence their assessments in the same way as the child care workers' may have been.

This study was conducted only with two types of settings. As was explained previously, the results may not be generalizable to children in other facilities. In future studies, children receiving alternative treatment such as foster care, professional parent care and day treatment should be included in the comparison.

Problems associated with aggregating individual scores could be minimized by dividing children into groups on the basis of their classification. For instance, the placements of Externalizers, Internalizers, those with clinical or non-clinical status could be compared. Relationship between the classification and the type of placement would demonstrate if children are appropriately placed.

Practice Research. Studies that examine influence of locus of control, clinical status and gender on treatment outcome would benefit social work practitioners. Although this study assumed equal effectiveness, an empirical demonstration would greatly enhance reliability of the findings. Each child could be assessed at the outset of treatment, after a period of six or twelve months, and finally some time after the child terminates with the particular placement. This would document any comparative behaviourial change or stability for children within both types of settings. If particular attention is paid to the changes in locus of control scores

and in the clinical status the characteristics of children best served by placement types could also be determined.

To further examine the need for institutional care, the children with similar characteristics could be randomly placed in various options of care. After pre-determined period of time the placement outcomes could be compared. The decrease in severity of scores could serve as determinants of successful outcome.

The present study confirmed that gender differences in assessment exist. However, it was unclear whether the socialization process caused differential assessment. Vignettes could be used to determine the influence of the sex-role expectations on assessments. The vignettes would be identical with the only difference being the gender of the child. A variety of child care professionals could then be asked to rate the disturbance of the children described in the vignettes. The comparison of ratings would help determine relative influence of socialization processes on assessment.

Policy Research. Research outlining distinct profiles of children, the alternate types of placements and a system for matching children were the suggestions for research in the policy area. Innovative pilot projects within existing programs could provide opportunity to evaluate alternate options of care (e.g., professional parent

homes, treatment foster care) to determine the characteristics of children they serve most effectively.

The children can best be matched with programs by identifying patterns in the practice of child placement. In order to do this detailed information about a particular child and the kinds of placements most beneficial for certain children is needed. Rigorous assessments with a variety of instruments in conjunction with historical data about the child would provide the needed information. Experts in the child care field and the relevant literature could help select the characteristics most appropriate to a certain type of placement. A computerized model containing this information would enable fast and effective matching process.

SUMMARY

The discussion section contained analyses of the study findings and their implications for practice and policy. The suggestions for future research to both address the limitations of the present study and to enhance the body of knowledge in the area concluded this chapter.

The multivariate comparison demonstrated that significant differences between children in institutions and group homes did exist in Total Behaviourial and

Internalizing scores. However, the children in institutions were not consistently more disturbed in every demographic, behaviourial or social competence area.

The children in group homes were older and less active than the children in institutions. In reference to the latter, it was suggested that the institutionalized environment mandates participation in activities more so than the less structured environment of group homes. The differences in age and absence of differences in externalizing and clinical areas encourage further questioning of treatment in institutions.

The comparisons of behaviourial syndromes showed that the males were significantly different on only one of the syndromes - Schizoid. The females, however, differed significantly on several syndromes: Somatic, Depressed-Withdrawn, Delinquent and Cruel. Review of literature confirmed the absence of differences between males and presence of difference between females which is sometimes attributed to sex-role expectations.

The exploratory nature of the study prevented from drawing unequivocal conclusions. The absence of consistent differences may have been due to socialization processes or differences in effectiveness of the two placements. Nevertheless, it was possible to outline implications of the findings to social work practice and policy. The social work practice with children in group homes may

benefit from strengthening their activities component. Locus of control, clinical status and gender may have to be taken into account in referrals and treatment. The policy makers were encouraged to examine a possibility for a more client-driven placement system and expand the continuum of services available.

The chapter concluded by outlining several suggestions for future research. The replication studies could benefit from the use of several raters and assessment instruments. Including the full array of placement options would improve the generalizability of the findings.

The social work practitioners could examine outcome of treatment in group homes and institutions on children with varying locus of control, clinical status and gender. Research outlining distinct profiles of children, development of alternate types of placements and a system for matching children were the suggestions for appropriate directions for future policies.

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APPENDIX A

SOCIAL COMPETENCE PROBLEMS BY SUBSCALES

SOCIAL COMPETENCE PROBLEMS BY SUBSCALES

ACTIVITIES

- *Number of sports*
- *Participation and skill in sports*
- *Participation and skill in activities*
- *Number of nonsport activities*
- *Number of jobs*
- *Job quality*

SOCIAL

- *Number of organizations*
- *Participation in organizations*
- *Feels or complains that has no friends*
- *Behaviour alone*
- *Frequency of contact with friends*
- *Number of friends*
- *Behaviour with others*

SCHOOL

- *Performance*
- *Special class*
- *Repeated grade*
- *School problems*

APPENDIX B

PROBLEM BEHAVIOURS OF BOYS AGED 6-11 BY SYNDROME

PROBLEM BEHAVIOURS OF BOYS AGED 6-11 BY SYNDROME

INTERNALIZING SYNDROMES

Schizoid or Anxious

- *Hears things that are not there*
- *Sees things that are not there*
- *Fears certain animals, situations*
- *Shy or timid*
- *Clings to adults*
- *Too fearful or anxious*
- *Nightmares*
- *Plays with sex parts in public or places, other than school*
- *Fears going to school*

Depressed

- *Feels worthless or inferior*
- *Feels too guilty*
- *Feels he has to be perfect*
- *Feels or complains that no one loves him*
- *Worrying*
- *Unhappy, sad or depressed*
- *Fears own impulses*
- *Deliberately harms self*
- *Suspicious*
- *Cries a lot*
- *Too fearful or anxious*
- *Self-conscious or easily embarrassed*
- *Feels persecuted*
- *Sulks a lot*
- *Nervous, highstrung or tense*
- *Talks about killing self*
- *Complains of loneliness*

Uncommunicative

- *Refuses to talk*
- *Secretive, keeps things to self*
- *Shy or timid*
- *Confused*
- *Stares blankly*
- *Self-conscious or easily embarrassed*
- *Unhappy, sad, or depressed*
- *Stubborn, sullen or irritable*

Obsessive Compulsive

- *Strange ideas*
- *Too fearful or anxious*
- *Hoarding*
- *Repeats certain acts over (compulsions)*
- *Obsessive thoughts*
- *Walks, talks in sleep*
- *Stares blankly*
- *Daydreams*
- *Nervous movements or twitching*
- *Trouble sleeping*
- *Sleeps less than most children*
- *Strange behaviour*
- *Overtired*
- *Confused*
- *Talks too much*
- *Nightmares*

Problem Behaviours of Boys Aged 6-11 by Internalizing Syndromes (Continued)

Somatic Complaints (behaviours without medical cause)

- *Stomachaches or cramps*
- *Headaches*
- *Nausea*
- *Aches or pains*
- *Overtired*
- *Constipated*
- *Dizziness*
- *Sleeps more than most children*
- *Vomiting, throwing up*

MIXED SYNDROMES

Social Withdrawal

- *Not liked by other children*
- *Poor peer relations*
- *Withdrawn, does not get involved*
- *Feels persecuted*
- *Gets teased a lot*
- *Prefers playing with younger children*
- *Likes to be alone*
- *Underactive, lacks energy, slow*

EXTERNALIZING SYNDROMES

Hyperactive

- *Cannot concentrate*
- *Acts too young for his age*
- *Poor school work*
- *Restless, hyperactive*
- *Speech problem*
- *Destroys own things*
- *Impulsive*
- *Prefers playing with younger children*
- *Poorly coordinated or clumsy*
- *Confused*
- *Daydreams*

Aggressive

- *Argues a lot*
- *Disobedient at home*
- *Temper tantrums or hot temper*
- *Disobedient at school*
- *Sulks a lot*
- *Bragging, boasting*
- *Lying or cheating*
- *Easily jealous*
- *Sudden changes in mood*
- *Demands a lot of attention*
- *Unusually loud*
- *Not liked by other children*
- *Screams a lot*
- *Swearing or obscene language*
- *Poor peer relations*
- *Stubborn, sullen or irritable*
- *Gets in many fights*
- *Cruel to others*
- *Threatens people*
- *Teases a lot*
- *Showing off or clowning*
- *Physically attacks people*
- *Talks too much*

Problem Behaviours of Boys Aged 6-11 by Externalizing Syndromes (Continued)

Delinquent

- *Steals outside the home*
- *Steals at home*
- *Vandalism*
- *Sets fires*
- *Truancy, skips school*
- *Disobedient at school*
- *Runs away from home*
- *Destroys others things*
- *Lying or cheating*
- *Destroys own things*
- *Swearing or obscene language*
- *Hangs around with children who get into trouble*

APPENDIX C

PROBLEM BEHAVIOURS OF BOYS AGED 12-16 BY SYNDROME

PROBLEM BEHAVIOURS OF BOYS AGED 12-16 BY SYNDROME

INTERNALIZING SYNDROMES

Somatic Complaints (problems without medical cause)

- *Nausea, feels sick*
- *Aches or pains*
- *Stomachaches or cramps*
- *Underactive, lacks energy*
- *Overtired*
- *Feels dizzy*
- *Vomiting, throwing up*
- *Rashes or other skin problems*
- *Problems with eyes*
- *Headaches*
- *Accident prone*
- *Constipated*
- *Worrying*
- *Too fearful or anxious*
- *Stares blankly*

Schizoid

- *Feels too guilty*
- *Fears own impulses*
- *Too concerned with neatness or cleanliness*
- *Worrying*
- *Fears going to school*
- *Feels dizzy*
- *Feels he has to be perfect*
- *Clings to adults*
- *Acts like the opposite sex*
- *Hears things that are not there*

Uncommunicative

- *Secretive, keeps things to self*
- *Underactive, lacks energy*
- *Refuses to talk*
- *Withdrawn, does not get involved*
- *Stares blankly*
- *Sudden changes in mood*
- *Worrying*
- *Confused*
- *Shy or timid*
- *Sulks a lot*
- *Suspicious*
- *Stubborn, sullen or irritable*
- *Likes to be alone*
- *Unhappy, sad, or depressed*
- *Self-conscious or easily embarrassed*

Immature

- *Cries a lot*
- *Acts too young for his age*
- *Demands a lot of attention*
- *Whining*
- *Wets the bed*
- *Prefers playing with younger children*
- *Clings to adults*

Problem Behaviours of Boys Aged 12-16 by Internalizing Syndromes (Continued)

Obsessive-Compulsive

- *Obsessive thoughts*
- *Repeats certain acts over and over (compulsions)*
- *Strange ideas*
- *Hoarding*
- *Fears own impulses*
- *Daydreams*
- *Bragging, boasting*
- *Unusually loud*
- *Strange behaviour*

MIXED SYNDROME

Hostile Withdrawal

- *Not liked by other children*
- *Acts too young for his age*
- *Gets teased a lot*
- *Feels worthless or inferior*
- *Feels or complains that no one loves him*
- *Prefers playing with younger children*
- *Gets in many fights*
- *Complains of loneliness*
- *Poor peer relations*
- *Destroys others' things*
- *Destroys own things*
- *Poorly coordinated or clumsy*
- *Feels persecuted*
- *Withdrawn, does not get involved*

EXTERNALIZING SYNDROMES

Delinquent

- *Steals outside the home*
- *Steals at home*
- *Hangs around with children who get into trouble*
- *Vandalism*
- *Lying or cheating*
- *Truancy, skips school*
- *Destroys others' things*
- *Uses alcohol or drugs*
- *Disobeys at school*
- *Runs away from home*
- *Destroys own things*
- *Poor school work*
- *Sets fires*

Aggressive

- *Threatens people*
- *Temper tantrums or hot temper*
- *Cruel to others*
- *Disobeys at home*
- *Swearing or obscene language*
- *Screams a lot*
- *Demands a lot of attention*
- *Nervous, highstrung or tense*
- *Physically attacks people*
- *Stubborn, sullen or irritable*
- *Teases a lot*
- *Easily jealous*
- *Sudden changes in mood*
- *Restless or hyperactive*
- *Impulsive*
- *Gets in many fights*
- *Sulks a lot*
- *Argues a lot*
- *Feels persecuted*
- *Unusually loud*
- *Suspicious*
- *Talks too much*

Problem Behaviours of Boys Aged 12-16 by Externailizing Syndrome (Continued)

Hyperactive

- *Cannot concentrate*
- *Restless or hyperactive*
- *Acts too young for his age*
- *Poorly coordinated or clumsy*
- *Nervous, highstrung or tense*
- *Disobeys at school*
- *Poor school work*
- *Showing off or clowning*
- *Impulsive*
- *Bites fingernails*

APPENDIX D

PROBLEM BEHAVIOURS OF GIRLS AGED 6-11 BY SYNDROME

PROBLEM BEHAVIOURS OF GIRLS AGED 6-11 BY SYNDROME

INTERNALIZING SYNDROMES

Depressed

- *Worrying*
- *Feels worthless*
- *Anxious*
- *Feels guilty*
- *Fears own impulses*
- *Sad*
- *Feels unloved*
- *Feels persecuted*
- *Lonely*
- *Fears school*
- *Needs to be perfect*
- *Self-conscious*
- *Clings to adults*
- *Withdrawn*
- *Is teased*
- *Shy, timid*
- *Sulks*

Social Withdrawal

- *Withdrawn*
- *Likes to be alone*
- *Secretive*
- *Slow moving*
- *Won't talk*
- *Sad*
- *Sulks*
- *Shy, timid*
- *Confused*
- *Moody*
- *Stares blankly*

Somatic Complaints (problems without medical cause)

- *Nausea*
- *Pains*
- *Stomach problems*
- *Headaches*
- *Vomits*
- *Dizziness*
- *Rashes*
- *Eye problems*
- *Walks, talks in sleep*
- *Nightmares*
- *Allergy*
- *Overtired*
- *Sleeps much*

Schizoid-Obsessive

- *Sees things that are not there*
- *Hears things*
- *Strange behaviour*
- *Strange ideas*
- *Obsessions*
- *Harms self*
- *Runs away*
- *Can't sleep*
- *Sleeps little*
- *Daydreams*
- *Suicidal talk*
- *Compulsions*

Problem Behaviours of Girls Aged 6-11 by Syndromes (Continued)

EXTERNALIZING SYNDROMES

Immature-Hyperactive

- *Acts too young for her age*
- *Cannot concentrate*
- *Poor school work*
- *Daydreams*
- *Poorly coordinated or clumsy*
- *Prefers young kids*
- *Impulsive*
- *Confused*
- *Hyperactive*
- *Stares blankly*
- *Is teased*
- *Unliked*
- *Speech problem*
- *Disobeys at school*

Sex Problems

- *Sex preoccupations*
- *Sex problems*
- *Impulsive*
- *Plays with sex parts too much*
- *Excess talk*
- *Feels guilty*

Delinquent

- *Steals at home*
- *Steals outside the home*
- *Lying or cheating*
- *Bad friends*
- *Runs away from home*
- *Impulsive*

Aggressive

- *Temper tantrums or hot temper*
- *Unusually loud*
- *Stubborn, sullen or irritable*
- *Screams a lot*
- *Teases a lot*
- *Threatens people*
- *Easily jealous*
- *Showing off or clowning*
- *Cruel to others*
- *Demands attention*
- *Disobeys at school*
- *Unliked*
- *Destroys others' things*
- *Talks too much*
- *Moody*
- *Sulks a lot*
- *Gets in many fights*
- *Bragging, boasting*
- *Argues a lot*
- *Disobeys at home*
- *Feels unloved*
- *Impulsive*
- *Easily jealous*
- *Whining*
- *Cries much*

Cruel

- *Destroys others' things*
- *Cruel to animals*
- *Gets in many fights*
- *Cruel to others*
- *Attacks people*
- *Acts like opposite sex*
- *Destroys own things*

APPENDIX E

PROBLEM BEHAVIOURS OF GIRLS AGED 12-16 BY SYNDROME

PROBLEM BEHAVIOURS OF GIRLS AGED 12-16 BY SYNDROME

INTERNALIZING SYNDROMES

Anxious Obsessive

- *Too fearful or anxious*
- *Worrying*
- *Cries a lot*
- *Feels worthless or inferior*
- *Feels she has to be perfect*
- *Fears own impulses*
- *Complains of loneliness*
- *Obsessive thoughts*
- *Sleeps less than most children*
- *Feels or complains that no one loves her*
- *Nightmares*
- *Fears going to school*
- *Feels persecuted*
- *Trouble sleeping*
- *Fears certain animals, situations or places other than school*
- *Self-conscious or easily embarrassed*
- *Feels too guilty*
- *Easily jealous*

Somatic Complaints (problems without medical cause)

- *Nausea, feels sick*
- *Stomachaches or cramps*
- *Aches or pains*
- *Headaches*
- *Feels dizzy*
- *Vomiting, throwing up*
- *Problems with eyes*
- *Fears going to school*

Schizoid

- *Hears thing that are not there*
- *Thinks about sex too much*
- *Sees things that are not there*
- *Nightmares*
- *Fears certain animals, situations or places other than school*
- *Stares blankly*
- *Strange ideas*
- *Strange behaviour*
- *Daydreams*

Depressed Withdrawal

- *Withdrawn, does not get involved*
- *Unhappy, sad or depressed*
- *Stubborn, sullen or irritable*
- *Secretive, keeps thing to self*
- *Likes to be alone*
- *Stares blankly*
- *Shy or timid*
- *Sulks a lot*
- *Refuses to talk*
- *Overtired*
- *Self-conscious or easily embarrassed*
- *Underactive, lacks energy*
- *Sleeps more than most children*

Problem Behaviours of Girls Aged 12-16 by Syndrome (Contd)

MIXED SYNDROMES

Immature-Hyperactive

- *Acts too young for her age*
- *Prefers playing with younger children*
- *Clings to adults*
- *Gets teased a lot*
- *Stares blankly*
- *Daydreams*
- *Thumbsucking*
- *Poor peer relations*
- *Hoarding*
- *Restless, hyperactive*
- *Poorly coordinated or clumsy*
- *Cannot concentrate*
- *Not liked by other children*
- *Picks nose, skin, or other parts of the body*
- *Confused*

EXTERNALIZING SYNDROMES

Delinquent

- *Hangs around with children who get in trouble*
- *Steals outside the home*
- *Impulsive*
- *Runs away from home*
- *Cannot concentrate*
- *Disobeys at home*
- *Secretive*
- *Lacks guilt*
- *Steals at home*
- *Lying or cheating*
- *Swearing or obscene language*
- *Truancy, skips school*
- *Poor school work*
- *Uses alcohol or drugs*
- *Disobeys at school*
- *Prefers playing with older children*

Aggressive

- *Temper tantrums or hot temper*
- *Unusually loud*
- *Stubborn, sullen or irritable*
- *Screams a lot*
- *Teases a lot*
- *Threatens people*
- *Physically attacks people*
- *Demands a lot of attention*
- *Swearing or obscene language*
- *Showing off or clowning*
- *Feels or complains that no one loves her*
- *Talks too much*
- *Sudden changes in mood*
- *Sulks a lot*
- *Gets in many fights*
- *Bragging, boasting*
- *Argues a lot*
- *Easily jealous*
- *Feels persecuted*
- *Disobeys at home*
- *Suspicious*
- *Cruel to others*

Problem Behaviours of Girls Aged 12-16 by Externalizing Syndromes (Continued)

Cruel

- *Destroys others' things*
- *Cruel to animals*
- *Physically attacks people*
- *Not liked by other children*
- *Destroys own things*
- *Cruel to others*
- *Steals at home*
- *Threatens people*
- *Feels persecuted*
- *Gets in many fights*

Poor peer relations

- *Vandalism*

APPENDIX F

FACULTY OF SOCIAL WORK
CERTIFICATE OF APPROVAL

THE UNIVERSITY OF CALGARY

Faculty of SOCIAL WORK

2500 University Drive N.W., Calgary, Alberta, Canada T2N 1N4

Telephone (403) 220-5942

CERTIFICATE OF APPROVAL

by

THE RESEARCH ETHICS COMMITTEE
FACULTY OF SOCIAL WORK

The PROJECT entitled:

Social and Behavioral Differences of Children In Institutional and Group Home Care

of Irene Hoffart (student)

in the judgement of this Committee, has met The University of Calgary ethical requirements for research with human subjects.

June 19, 1990
Date

Christopher Bagley
Christopher Bagley, Ph.D.
Director of Research Services

APPENDIX G

LETTER OF CONSENT FROM ALBERTA FAMILY AND SOCIAL SERVICES

Alberta
SOCIAL SERVICES
#200, Willow Park Centre, 10325 Bonaventure Dr. S.E., Calgary, Alberta, Canada T2J 5R8 403/258-4711

May 15, 1990

Ms. Irene Hoffart
c/o University of Calgary
Faculty of Social Work
Calgary, Alberta

RESEARCH PROPOSAL: SOCIAL AND BEHAVIORAL DIFFERENCES OF CHILDREN IN INSTITUTIONAL AND GROUP HOME CARE.

I have reviewed the above named proposal and am pleased to advise you of its approval. You may consider this letter as your approval to proceed with your study. For your information the research project of which you are a part has received approval of our Regional Research and Ethics Committee.

This approval is subject to the following conditions:

1/ It is my understanding that you are volunteering to collect data for the Children and Family Program Services Unit approved research project under the direction of Mike Stephens. It is further my understanding that in exchange for the collection of data we are allowing you to test the various hypotheses you may have concerning the differences between children in institutions and children in group homes.

2/ That the signed Alberta Family and Social Services Statement of Agreement to Guidelines for Research are adhered to.

3/ That you sign an Oath of Confidentiality with the Department. Arrangements for signing to be made through Mike Stephens who can be reached at 258-4759.

4/ That you provide the Department (again through Mike Stephens) a copy of your completed project/thesis.

5/ All research reports written (including but not limited to publications and workshops) will require prior approval of the Regional Research and Ethics Committee.

6/ You will be assigned a Departmental Child Welfare staff person who will assure that all Departmental requirements are met and will facilitate access to the required research data. That staff member will serve as your liaison to the Department. For the purposes of your research project that liaison person will be Mike Stephens.

7/ That a copy of this letter to proceed with research accompany any requests to agencies for their consent to participate.

8/ That this approval becomes invalid should the research project change in any way from the proposal which you have submitted.

9/ That the data collected is the property of Alberta Family and Social Services with the exception of the data directly related to your thesis/project for which we are allowing shared use.

We hope that the study will provide useful information for the provision of services.

Gene Tillman
Regional Manager, Child Welfare
Calgary

ALBERTA SOCIAL SERVICES
STATEMENT OF AGREEMENT TO GUIDELINES FOR RESEARCH
(for non-Alberta Social Services researchers)

Project Title: Social and Behavioral Differences of Children in Institutional and group home care.

Project Personnel: Irene Hoffart

Alberta Social Services, Calgary, has a commitment to on-going research as part of its commitment to the welfare of clients. The researcher's commitment to educational and professional affiliations is recognized as well as the Department's obligation to protect clients and staff. Therefore, we require that anyone undertaking research, abide by the following conditions:

1. Persons conducting research are bound by their own professional code of ethics and by Alberta Social Services legislation and policies on confidentiality and release of information;

2. Persons conducting research must respect and ensure the anonymity of the client. The use of client records is impersonal and no identifying information is used in the preparation of reports or in the final report. Code identifiers will be used instead of names on all research forms in order to protect confidential information;

3. Non Alberta Social Services staff conducting research at the Agency must be responsible to a designated Calgary Social Services staff member who will assure that all Departmental requirements are met and will facilitate access to the required research data;

4. The researcher will have approval from appropriate departmental sources before direct client contact is made;

5. Informed written consent is required from the client subject (or legal guardian if the client is under 18 years of age) which is signed, dated, and witnessed, prior to participation;

6. Access to records, manual and computerized must be limited to the minimum amount of information required for the research project; and must be approved by appropriate persons.

STATEMENT OF AGREEMENT IN GUIDELINES FOR RESEARCH

I have read, understood, and accept the above guidelines and agree to abide by them.

(Signature of Non-Department Researcher) — June 1/1990 (Date)

(If Researcher is a Student, Signature of Thesis or Project Supervisor) — May 29, 1990 (Date)

(Witness) — 01 Jun 90 (Date)

APPENDIX H

INTRODUCTORY LETTER FROM ALBERTA FAMILY AND SOCIAL SERVICES

Alberta
FAMILY AND SOCIAL SERVICES

#200, Willow Park Centre, 10325 Bonaventure Dr. S.E., Calgary, Alberta, Canada T2J 5R8 403/258-4711

May 14, 1990

SAMPLE ONLY

Ms. Patti Kilgallon
Childrens Cottage
1715 - 32 Street S.W.
Calgary, Alberta
T2P 0C5

Dear Patti:

Last summer our unit ran a small research project collecting selected demographic data on children in care in the Calgary Region. Our response rate was high and our results were very exciting. This year we are about to embark on the second stage of learning more about our children in care.

Our intention is to generate a behavioral profile on each of our children in contracted beds. We will be using the Achenbach Child Behavior Checklist. We have been able to enlist the assistance of three graduate students at the University of Calgary. These students will use the data collected to test a variety of hypotheses.

The project has been approved by the Regional Research and Ethics Committee. Naturally, participation for your agency is voluntary. Sometime in the next week or two, you will be contacted by one of the three students to ask if your agency is willing to participate. Should you be so inclined a subsequent meeting will be set to arrange for the completion of the Achenbach.

Since our unit has initiated the project, we are obviously in 100% support of the initiative. However, we also respect your "Right to Choice" over participation. Agencies will not be identified in subsequent reports and both confidentiality and anonymity are assured. The students participating, the agencies they are responsible for and their research question follows:

Irene Hoffart - Irene will be collecting the data from the Institutional programs. Irene's research question will explore the behavioral differences between children in Institutions and long term group home care.

Toni Maier - Toni will be collecting the data from long term group homes and professional parent programs. Toni's research question will explore behavioral differences between males and females in care.

Lynne Downey - Lynne will be collecting the data from receiving and assessment programs. Lynne's research question will explore the behavioral differences between children in receiving group care and receiving professional parent care.

If you have any questions, please don't hesitate to contact me at your convenience.

Yours truly,

Mike Stephens
Contract Manager
Children & Family Program Services

Darryl Wernham
Manager
Children & Family Program Services

MS/jd

APPENDIX I

LETTER OF RESPONDENT CONSENT

Date:_____

Dear Colleague:

Increasingly more children are unable to stay with their natural families and have to be cared for by the government and the community. To provide them with the best service possible, a clear understanding of the problems that these children experience is necessary. Would you participate by completing the enclosed assessment of the children assigned to you?

This project was initiated by the Alberta Family and Social Services (AF&SS) and will be carried out by the AF&SS representative and the University of Calgary, Faculty of Social Work MSW student. The data collected will enable the researchers to assess the social and behaviourial differences of children in institutional and group home care.

The assessment has two parts: the demographics questionnaire and the Achenbach Child Behaviour Checklist. We have requested that you supply children's demographic information only to provide relevant dimensions for groupings. If you are not familiar with the use of the Achenbach Child Behaviour Checklist the training will be provided to you by the researchers.

Your participation is voluntary. In returning the completed forms, you are granting the Alberta Family and Social Services and the University of Calgary permission to use the data for the purposes described above.

All responses will be treated confidentially. You need not place your name anywhere on the forms. Your client's privacy also will be protected as we request that you identify him or her only by the case number assigned by the AF&SS. The data will be reported in a general way, so that there will be no specific information about the particular child or agency in the final report. Similarly, no individual group home or institution will be compared to one another.

We recognize that the assessment is long and appreciate your participation, Completing the forms should take about 30 to 45 minutes of your time. If you have any question regarding this project, please do not hesitate to contact Irene Hoffart at 278-1613 or Mike Stephens at 258-4759.

The completed forms will be collected on _____ . Thank you for your valuable time.

Sincerely,

Irene Hoffart

APPENDIX J

CLIENT DEMOGRAPHICS QUESTIONNAIRE

CLIENT DEMOGRAPHICS QUESTIONNAIRE

1. DEPARTMENTAL FILE NUMBER _____

2. TYPE OF PLACEMENT (please circle appropriate number)

    1. Institution
    2. Group Home

3. GENDER (please circle appropriate number)

    1. Female
    2. Male

4. AGE (in years) _____

5. IS THE CHILD NATIVE? (please circle appropriate number)

    1. No
    2. Yes

6. CHILD WELFARE STATUS (please circle appropriate number)

    1. Custody Agreement w/parent
    2. Custody Agreement w/child
    3. T.G.O.
    4. P.G.O.

7. IS THIS THE CHILD'S FIRST PLACEMENT? (please circle appropriate number)

    1. No
    2. Yes

8. ACHENBACH GROUPING (please circle appropriate number)

    1. Boys Age 4-5
    2. Boys Age 6-11
    3. Boys Age 12-16
    4. Girls Age 4-5
    5. Girls Age 6-11
    6. Girls Age 12-16