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# A Study of the relationship between intake data and duration of care of wards

Being the report of a Research Project submitted in Partial Fulfillment of the Requirement for the Degree of Master of Social Work

by

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## ABSTRACT

This is a study of one hundred and thirty-six wards of the Children's Aid Society of Winnipeg who were admitted into care during the period of February 1 to September 30, 1969.

The object of the study was to examine certain areas of the personal data of the child and of the family conditions to determine whether or not there were indicators of the duration of care at the point of intake.

The major finding was that the Indian and Metis child tended to remain in long-term care more frequently than the non Indian and non Metis child. Several other factors tested, including the sex of the child, the number of parents, the number of siblings, parents who were former wards and alcoholism of parents related partially to duration of care.

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# CHAPTER I

## INTRODUCTION

In 1959, the General Assembly of the United Nations unanimously extended the 1948 Declaration of Human Rights to children adopting the Declaration of the Rights of the Child. This states in part that the child shall:

> enjoy special protection and shall be given opportunities and facilities by law, and by other means to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose the best interest of the child shall be the paramount consideration.[1]

This declaration reflects society's increased concern for the care and development of children.

This declaration also suggests other trends. For example, it appears that society is demanding higher basic manimum care for children. It may be that society raises its standard of the basic minimum care of children as its standard of living increases. An implication of this is that what was considered adequate care a decade ago may now be considered negligent care. Increased knowledge about the needs and healthy development of children may be reflected here also.

This declaration also suggests that society is looking increasingly to public and private agencies for aid in the

development and care of children. Greater social, emotional, and psychological stresses placed on the individual and family have increased the number of breakdowns. Herie and Garvie have stated in their recent report that "There has been a long tradition of parental power over their children and a hesitancy about outside intervention."[2] Although there has been this long tradition, the inability of some families to cope with the environmental stresses has made it necessary for them to increasingly look outside their family units for help. In addition, society's view as expressed in the United Nations Declaration of the Rights of the Child has spurred the community to protect and support the neglected child. As Herie and Garvie state, "the child's needs and rights become the nation's imperative."[3]

Governments who believe in this United Nations Declaration look to the Child Welfare agencies for implementation. Although it is the goal of such agencies to preserve, aid, and enhance family units, there are times when the Agency, if it is also going to uphold its responsibility for the rights of a child, must remove a child from his natural family. This means that under certain circumstances, child welfare agencies have a legal and moral responsibility to determine whether a child's original home is adequate or not. In addition, children may be handed over to the Agency and the Agency is requested to become responsible for their care. For all these children, the Agency must provide suitable placement.

The Agency then must basically make two decisions, one of which cannot be made without a consideration of the other. One decision involves the removal of a child from his natural home; the other the placement of the child in another unit, be it foster home, group home or institution. Matek underscores the importance of relating the two decisions.

> ...separation of a child from his own family may be a terribly damaging and traumatic experience and ought not to be undertaken unless it is a part of a treatment plan..., it is insufficient to move him out of that environment unless one has something better to offer.[4]

Agencies are constantly searching for new ways of making decisions regarding the removal and placement of a child that will prove in the long run to be the best possible alternative for the child. Dr. John Rose has noted the difficulty of this task and the result that workers, uncertain of the future for the child, hesitate in their decisions.

This has resulted in many children remaining in the care of almost totally disorganized parents. A high degree of emotion surrounds such decisions. As Dr. Rose notes,

> It is our impression that those who have to make decisions to separate children from their parents are very sensitive to the pain involved in such drastic measures. Perhaps the greater danger in the placement drama is that Workers may become reluctant to support such separations when the situation requires it.[5]

What should be the criteria used by agencies in the making of such decisions? With respect to the removal decision, Glickman has said that "not just the kind of conflict but the extent to which it intrudes and interferes...determines whether a family must separate."[6] She goes on to make three general divisions of such situations.

> First, long time physical and emotional violence by a criminal, alcoholic, or psychotic parent. Secondly, situations where those parents whose psychic equilibrium is maintained by emotionally feeding on their children without satisfying their inherent dependence upon them. Thirdly, the highly narcissistic immature parent.[7]

Governments also have tried to provide criteria for the Agency that would authorize it to remove a child from his home. For instance, the Government of Manitoba has defined situations of child neglect in the Child Welfare Act of Manitoba.

Although such criteria provide guidelines for the Agency, implementation requires interpretation by the worker and recommendation to the local courts who make final decisions.

Again criteria need to be established with respect to the placement decision. Because this decision is so paramount to the child's future well being, it is imperative that research be continued in order that better guidelines be set for the Agency which must make such decisions. Scott Briar comments that

> Perhaps no decisions in social casework practice pose more awesome responsibilities for the caseworker and are more far reaching in their potential consequences for the client than those involved in the placement of children in foster care.[8]

It is this area of the placement decision which has been chosen as the focus in this particular research. When a child comes into the agency, one of the crucial factors is the initial diagnosis of the problems of the natural family and the child. Not only does the diagnosis need to be as accurate as possible, but the decisions and plans for that child need to be made as quickly as possible. As Weaver says

> In as much as children grow older each day, diagnosis and planning are of the essence. As rapidly as possible the study process must yield to decisions about the plan and the goals for a child and his family.[9]

The earliest possible point for decisions is at intake. Presently, workers make evaluations and plan on the basis of their knowledge, experience, intuition and the available resources. If workers at the point of intake had a model or theoretical construct that they could apply as a framework to the situation, this would aid them in their planning. Two decisions that the worker needs to make at this point is the type of placement that the child requires and the length of care that the child needs. It is to this latter decision that this study addresses itself.

Shirley Jenkins has said that

> Some factors in the situation of individual children and families at the time children entered into care are related to the length of time children remained in care...analyses of the situation bringing a child into care can be a help in making an estimate of how long he will stay.[10]

Clearly, fragmented and unplanned long-term care is a disservice to the child. If some indicators could be found that would be predictive of long-term care and if such indicators could be utilized at the point of intake, the worker's task in planning would be greatly facilitated. Similarly obtaining indicators for short-term care would aid the worker in his planning for the child. If such a construct were found, the worker would have a scientifically sound base on which to build plans for the future of the child.

There are a number of factors which would affect the length of time that a child is in agency care. These can be broken down into three divisions. There are those factors which occur before the point of intake; those which occur between the point of intake and the point of placement; and those which occur during the time of placement. Since the purpose of this study is to test factors obtained at the point of intake to see whether or not they correlate with long or short-term care, only the first division of factors which apply will be considered.

Within this first division, there are a number of factors which would apply. The personal characteristics of the child, family conditions, peer group relationships and environmental conditions are examples of the areas that indicate the usefulness of testing. Because of the time limitations, the researchers have chosen to test only certain specific factors within the areas of the characteristics of the child and family conditions to determine whether or not there is a correlation between these factors and length of care.

The researchers have made a general hypothesis which indicates the area of study, and then followed this up with ten sub-hypotheses which give precisely the factors that will be tested and the expected correlation to length of care. This study, then, is of a descriptive and exploratory nature.

The general hypothesis states:

> A Correlation exists between the duration of care of wards of the Children's Aid Society of Winnipeg and the child's personal data and family conditions obtainable at the point of intake.

The name of the agency from which the data is obtained is identified in the general hypothesis because it is recognized that the results may only be accurate for the Winnipeg area. That is, the locale may be a significant factor. Further testing in agencies of other areas would indicate whether the findings of this report may be applied elsewhere.

Because of the time limitation it was necessary to limit the study to wards of the agency, that is, to children for whom the court has granted agency guardianship. The researchers have confined their study population to wards from the Protection Department of the Children's Aid Society of Winnipeg only, and have not considered wards from the Unmarried Mother's Department of that Agency.

For testing purposes the general hypothesis has been operationalized into the following ten sub-hypotheses. Each sub-hypothesis correlates a factor from either the personal characteristic or the family conditions area to either short-term or long-term care. Short-term care has been defined to be care one year or less, and long-term care as care longer than one year.

The sub-hypotheses are listed and a brief rationale follows each sub-hypothesis.

1. The age of a child relates directly to the duration of care.

   It is felt that the older the child, the more difficult it is for the child to adjust to a new situation. An older child has internalized values which have established his patterns of behaviour to a greater degree than those of a younger child. All other things being equal,

the older child will require a longer period for treatment than a younger child.

2. A greater percentage of male children require long-term care than do female children.

   It is known that boys tend to present more adjustment problems in the school system, have a proportionally higher rate of delinquency than girls, and exhibit more aggressive acting-out behaviour. This being the case, boys would present more problems before and during placement, which in turn would indicate the need for a longer period in care for boys.

3. A greater percentage of Indian and Metis children enter long-term care than non Indian and non Metis children.

   Because of cultural differences and the general prejudice towards Indians and Metis in a basically white society, those children have a more difficult time during placement and are subject to changes in placement and therefore require longer care. Also, the adjustment of Indian and Metis families to urban living presents even greater difficulties in rehabilitation for non-white families than white families. This affects the duration of care of children.

4. There is a positive relationship between an emotionally disturbed child and long-term care.

   Children described as emotionally disturbed are operationally defined here as those who have had a psychiatric assessment, and as such require treatment which, in most cases, would be of long-term duration.

5. A higher percentage of children whose parent(s) have been in agency care requires long-term care.

   The problems that caused the parent(s) to have been in care reoccurs with the children.

6. The length of care of children increases with the number of siblings.

   The stress on a family increases with the number of children and thus rehabilitation for the child and family requires a longer period in care.

7. The length of care of children increases with the number of siblings in care.

   It is expected that if it has been necessary for more than one child to come into Agency care, the family again would have a more difficult time to re-establish itself and children of such a family would remain in care longer.

8. The number of parents in the family is inversely related to the duration of care, i.e. the greatest percentage of children in long-term care are those with no parents, followed by those with one parent and finally by those with two parents.

   A lack of parent constitutes a deficiency in the structure of the family. This is likely to increase the problems for the child.

9. When the reason for admission of the child is the physical illness of the mother, the duration of care is usually short-term.

   If the mother is incapacitated and the child needs to be cared for by an agency until the mother is well again, the child is removed only as long as the mother cannot function in the home. Since many physical illnesses are temporary in nature, it is expected that the child would require short-term care.

10. A high percentage of children of alcoholic parent(s) require long-term care.

    Alcoholism is a major factor in family discord and takes a long time to treat. Thus a child coming from this kind of home situation requires long-term care. Operationally, alcoholic parents are defined as such if mention has been made in the initial recording that drinking is a problem in the family.

FOOTNOTES

1. Declaration of the Rights of the Child, United Nations Assoc. in Canada, 329 Bloor Street West, Toronto

2. Euclid Herie and Isobel Garvie, In Search of a Way Home, Children's Aid of Winnipeg Study 1969, p.1

3. Ibid., p.12

4. Ord Matek, Differential Diagnosis for Differential Placement of Children, Child Welfare, Vol. 43, No. 7, July 1964, p.342

5. Dr. John A. Rose, "A Re-evaluation of the concept of Separation for Child Welfare", Child Welfare XLI, 1962, p.445

6. Ester Glickman, Child Placement Through Clinically Oriented Casework, New York, Columbia University Press, 1957, p.343

7. Ibid., p.344-345

8. Scott Briar, "Clinical Judgment in Foster Care Placement", Child Welfare, Vol. 42, #4, April 1963, p.161

9. E.T. Weaver, "Long-Term Foster Care, Default of Design", Child Welfare, Vol. 47, No. 6, June 1968, p.343

10. Shirley Jenkins, Duration of Foster Care: Some relevant Antecedent Variables, New York City Welfare Study, Child Welfare, Vol. 46, No. 8, October 1967, p.450

# CHAPTER II

## BACKGROUND LITERATURE

A survey of the literature in the field of child placement and care reveals that there has been very little research done to determine the relationship between the causes of substitute care and the duration of care. Scott Briar studied the clinical judgement used in foster care placement, in which he examined some of the factors affecting social workers' clinical judgments associated with the choice of foster family care or institutional care in the placement of children. He initially states that "Systematically, we know next to nothing about how the child-placement worker makes these decisions".[1] He concluded that "there appears to be a relationship between emotional disturbance and placement recommendations, although the nature and direction of this relationship are not clear,"[2] and that "workers are guided by various idiosyncratic assumptions in making inferences from diagnosis to prognosis and treatment."[3] Matek also attempted to delineate the criteria used to determine the best placement for a child's needs, whether a closed institution, a group home or a foster home. He concluded that, because of the complexity of the human personality and the uniqueness of each individual, identical handling is prohibited.[4]

Weaver, commenting on the problems in planning long-term foster care states that:

> The intensity of the problem is heightened today because of other factors which include: increased difficulty in recruiting good foster homes for long-term care; children upset by the trauma of multiple family crises--and multiple placements; in some areas, a decrease in the proportion of applications for adoption to the number of children needing adoption, and the gross disparity between the number of unplaced children and the resources for long-term foster care or adoption...insufficient personnel and insufficient funds.[5]

He goes on to question whether it would not be better to plan the long-term goals on the basis of the situation of the family and the child, as it existed immediately before or after separation as "Thorough diagnosis makes sound decisions and planning possible".[6] He then lists Kline's set of configurations of conditions which usually characterize the long-term foster care case. They include defective ego functioning in the parents which is either current or chronic which prevent the parents from adequately meeting the vital needs of the child such as care, affection, supervision, protection and training, major development or psychological problems in the child which require an indefinite period of corrective care or treatment; and an unhealthy emotional involvement in the parent-child relationship.[7]

Studies undertaken by Theis, Maas, Jenkins and Murphy relate directly to this study. Theis conducted a critical

analysis of 910 foster children who were, at the time of the study, 18 years old or over, and he found that a significant variable of length of care was the age of the child at the time of placement.[8]

Mass conducted a follow-up study of 422 children in foster care for ten or more years. He analysed the results in order to determine the factors and conditions that differentiated such children from others in foster care, and also to check his predictions on the same children, which were made ten years before, in a previous study. He examined the relationship between long-term care and certain characteristics of the children, conditions of their families and agency procedures. He concluded that the intelligence, race, religion and the economic level of the parents were indicative of long-term care but: "none of these characteristics of the long-term care children, alone, has a strong enough relationship to long-term care to serve as a useful predictor".[9] Jenkins conducted a two year follow-up study of 891 New York City children to determine whether some factors in the situations of individual children and families, at the time the children entered foster care, were related to the length of time the children remained in care. She analysed ten variables, four of which were based on child data and were jurisdiction of case, ethnic group, religion, and age, while the remaining six referred primarily to family characteristics and were household

composition, number of children placed per family, parental participation in the decision, main reason for placement, main source of income, and type of housing. She found that factors associated with living circumstances such as type of housing and economic conditions were relevant to length of care. To be more specific--being housed in rooms and being supported by public assistance seemed to be related to short-term care. She also found that demographic variables, such as age at placement, religion, and ethnic group, were inter-related and, combined, can serve as indicators of duration of care. Reason for placement, which included such variables as physical and mental health of mother, family problems, child abuse or neglect, was particularly relevant to duration of care. However, she concluded that the results could not be generalized to every child entering care.[10]

Murphy analysed the records of 400 children taken into care during the years 1960 to 1963 by a Montreal Agency in order to predict duration of foster care. He studied many variables such as principal reason for placement as recorded by the intake worker, family background, the child's age and sex, the family's prior experience with welfare agencies, parental attitudes toward placement; the education, recent economic history, lifetime medical history, and present location of the parent; the mother's age at placement, length of time of mother's separation from the father or child, and the number of children in the family. He found that:

> Mother's age at placement of child, number of children borne and amount of separation from husband or child prior to placement are factors found related to length of stay in foster care. For children without mothers present, length of stay is related to previous separations from mother and to father's receptivity to social work intervention.[11]

It must be noted that these studies were all different in their research design, populations and methodology. Consequently, it is no wonder that their results are so dissimilar. Another important factor is that the resources available in the different communities are different from one another.

FOOTNOTES

1. Scott Briar, "Clinical Judgment in Foster Care Placements" in Child Welfare, Vol. 42, No. 4, April 1963, p.161

2. Ibid., p.165

3. Ibid., p.167

4. Ord Matek, "Differential Diagnosis for Differential Placement of Children" in Child Welfare, 1964, p.348

5. Edward T. Weaver, "Long-Term Foster Care: Default or Design? The Public Agency Responsibility" in Child Welfare, Vol. XLVII, No. 6, June 1968, p.339

6. Ibid., p.340

7. D. Kline, "The Validity of Long-Term Foster Family Care Service", Child Welfare, Vol. XLIV (1965), Page 187 in Edward Weaver, op.cit., pp.340-341

8. H. Maas, "Children in Long-Term Foster Care", Child Welfare, June 1969, p.326

9. Ibid., pp.326-327

10. Ibid., p.455

11. H.B.M. Murphy, "Predicting Duration of Foster Care", Child Welfare, Vol. XLVII, No. 2 (Feb. 1968), p.76 (pp.76-88 and 101)

# CHAPTER III

## METHOD

Having formed the general hypothesis and ten sub-hypotheses, the researchers set up a questionnaire that, when answered, would contain the necessary data to test out the sub-hypotheses. This questionnaire had a multiple choice type format which maximized uniformity in completion and interpretation. A pretest was run on 23 cases, the results evaluated and the questionnaire revised to the form shown in Appendix 'A'.

The majority of the questions on the questionnaire are self-explanatory. However, clarification is given on the following:

Question 3 - The category "non-Indian or non-Metis" was mainly white children but also included three negro children.

Question 4 - Since the records seldom, if ever, indicated whether a child had <u>not</u> had a psychiatric assessment, yet tacit information usually implied a "no" answer; the second category of this question had the unit "no or don't know". It is important to realize that the researchers were only interested in the number of children who had psychiatric assessments and therefore only the number in the "yes" category were used in this question.

Questions 7 and 8 - By agency care, the researchers were trying to determine if the siblings of the child in question were in care at the time of the court hearing or at a previous time. In care meant that the sibling was a ward or a non-ward of the agency.

Question 11 - The parent or parents were noted as having an alcoholic problem if the worker cited in the initial recordings that alcolhol was a problem for the parent or parents.

Question 16 - When a child had been a ward for one year or less, the child was deemed to have received short-term care. If the child was a ward for more than one year, the child was said to have received long-term care.

The population selected for this study was the total number of children who became wards, temporary or permanent, of the Children's Aid Society of Winnipeg during the period February 1 to September 30, 1969.

To obtain this population, the researchers used four sources within the Children's Aid Society of Winnipeg - department work sheets, the legal files, the general files and the data compilation sheets of the study "In Search of a Way Home" undertaken by Euclid Herie and Isobel Garvie. The work sheets used were a monthly summary of cases which included those that would be presented in court.

Only the names of those children who became wards, temporary or permanent, during the stated period were used. The legal files contained transcripts of the court hearing and file cards which summarized the transcript information and also recorded any subsequent extensions of wardship. The names obtained from the work sheets were checked out in the legal files and those children thus confirmed as having become wards of the agency comprised the total population for the study. The data compilation sheets used by Mr. Herie and Mrs. Garvie consisted of a questionnaire applied to all children who came into care during the period of June 1968 to September 1969.

Work sheets have been kept as far back as February 1969. In order to make use of both the work sheets and the data compilation carried out by Mr. Herie and Mrs. Garvie, the researchers decided that their study period would be the eight month period from February 1 to September 30, 1969.

Answers to many of the questions of the researcher's questionnaire could be obtained from the data compiled from the study "In Search of a Way Home" with the remaining answers collected from the general files. The general files included intake information, case records, doctors' reports, correspondence and any other written documents pertinent to the case. In a few cases, the data sheet of Herie and Garvie's study could not be found and the information was gleaned from the general files.

In both the Protection and Unmarried Parents' departments, there were children who became wards of the Agency. If both groups were to be considered in this study, the factors specific to each group would require separate analyses. To avoid distortion of results, the researchers, because of the time limitation, chose to study only those children who became wards through the Protection Service Department.

The total population of protection cases during this eight month time period was 154. Data was obtained for 136 cases which is 88 per cent of the total population. Data was not obtainable for the remainder because in some cases the information given was not complete, and in other cases it was not possible to determine which worker had the file required. The number of cases for which complete data were obtained was deemed by the researchers to be a sufficient number to test the given sub-hypotheses.

A coding system was set up in the following way. Each question had from two to eleven possible answers. The digit to the left of the decimal point corresponded to the question number of the questionnaire. The digit or digits to the right of the decimal point indicated the alternate answer accurate for that question. For example, question number two had two possible answers. They were 2.1 or 2.2. Again, question number ten had eleven possible answers. They were 10.1, 10.2 ... 10.11. Thus, every possible answer was given a code number which facilitated identification and tabulation. The

data collected, using this code, was recorded on a master sheet. These results were then illustrated in table form as shown in Chapter IV.

## LIMITATIONS

This study was limited to the information from only one child caring agency, the Children's Aid Society of Winnipeg.

Within the study, the data obtained from family files is limited to the recording by the worker who might have a bias that distorts the accuracy of the data. In certain situations, information was drawn from the recording of several workers who may vary in their emphasis and approach. For instance, the question on use of alcohol by either or both parents constituting a problem was data required. This information is dependent on the worker's judgment and attitude to alcohol as a problem.

No clients were interviewed to confirm information. Since the information was not given originally with the intent of research, the client himself may have intentionally or unintentionally given inaccurate or incomplete information.

It is noted that the study is limited by the fact that the clientele came from a particular urban area. Although the results obtained from this study might be true for a rural setting or another urban area, generalizing the results would not be valid without qualification.

It is recognized that the time period of the study is rather limited. In order to complete the study in the time allocated, the researchers confined their study to the eight month period, which has an effect upon the degree of reliability of the study.

# CHAPTER IV

## ANALYSIS

In Chapter I, the general hypothesis was stated as follows: There is a correlation between the duration of care of wards of The Children's Aid Society of Winnipeg and the child's personal data and his family conditions as obtained from the intake data. Chapter I also contained the ten sub-hypotheses that would be tested to determine the validity of the above stated general hypothesis.

This chapter gives the results of the tests in table form. In Table III, a chi-square test indicated that the results were significant at .02 level.

There were a total of 136 children considered in this study. However, in some cases, information was not obtainable. When this occurred, a statement has been included, giving the number of cases absent and the reason for omission. For example, when the child's race was considered, the results illustrated in Table III indicate that there were seven cases in which the race was not stated in the intake data.

One of the most interesting additional findings was the observation that approximately twice as many children required long-term care as opposed to short-term care during this period.

This suggests either that the arbitrary definitions of short and long-term care were not suitable for the population studied, or that the Agency used other alternatives to application for wardship such as homemaker services, day care services and non-ward agreements when it was perceived that the duration of care indicated was short-term.

TABLE I

AGE OF CHILDREN AND LENGTH OF CARE

| Ages | 0-2 | 3-5 | 6-8 | 9-11 | 12-14 | 15-17 | 17+ | Total |
|---|---|---|---|---|---|---|---|---|
| Short-Term Care | 11 | 9 | 9 | 8 | 6 | 3 | 0 | 46 |
| Long-Term Care | 20 | 20 | 17 | 14 | 10 | 5 | 4 | 90 |
| Total | 31 | 29 | 26 | 22 | 16 | 8 | 4 | 136 |
| Percent in Long-Term Care | 65 | 69 | 66 | 64 | 63 | 63 | 100 | |

It was noted that in all seven age groups the percentage of children in long-term care is consistently higher than the percentage of children in short-term care. The range of the percentages of children in long-term care is from 63 per cent to 69 per cent with one exception. There were only four children 18 years and over, and all (100 per cent) of these children were in long-term care. However, in this grouping and in the 15 - 17 age group, the number of children was insufficient for a meaningful analysis.

If one divides the age groupings in half, age 8 and under as against age 9 to 17 and over, it is noted that 67 per cent of the younger group require long-term care and 63 per cent of the older age group require long-term care.

The sub-hypothesis in which it was stated that the older the child is at intake the greater the probability that he will remain in long-term care, is not supported by Table I. The fact that all four of the children coming into care at age 18 and over suggested that there was a high probability that children who came into care at that age remained in long-term care. However, the number of children was too few to be conclusive.

Very few children over age fourteen became wards of the agency. This suggests that the Agency may not have had adequate placement resources available for this age group. Another possible explanation is the fact that Winnipeg Family Court becomes directly involved with children over twelve years of age who commit a delinquent act. There is also the real possibility for themselves at an earlier age than ever before.

TABLE II

RELATIONSHIP BETWEEN SEX AND DURATION OF CARE

| | Male | Female | Total |
|---|---|---|---|
| Short-Term Care | 29 | 17 | 46 |
| Long-Term Care | 45 | 45 | 90 |
| Total | 74 | 62 | 136 |
| Percent in Long-Term Care | 62 | 73 | |

Table II does not support the sub-hypothesis that more boys than girls remain in long-term care, as there is a higher percentage of girls (73 per cent) than boys (62 per cent) in long-term care. It is noted that there was a greater total number of boys, 74, as compared to the total number of girls, 62, that required care.

The chi-square value is at a level of significance of 0.20. The results do suggest that more girls than boys tend to remain in long-term care. Although the findings are the opposite to the expected results, they tend to support the main hypothesis. Further research in this area is suggested and the relationship between age and sex together to duration of care is also worthy of investigation.

TABLE III

RACE AND DURATION OF CARE

| | Indian and Metis | Non Indian and Non Metis | Total |
|---|---|---|---|
| Short-Term Care | 10 | 33 | 43 |
| Long-Term Care | 38 | 48 | 86 |
| Total | 48 | 81 | 129* |
| Percent in Long-Term Care | 79 | 59 | |

*Race of child was not obtainable for 7 children $X^2 = 5.4$

Table III supports the sub-hypothesis that a greater percentage of Indian and Metis children require long-term care than non Indian and non Metis children. The percentage of

Indian and Metis children in the total population studied was 37 per cent (48). The results show that 79 per cent (33) of these 48 children were in long-term care, while 59 per cent (48) of the non Indian and non Metis children (81) were in long-term care. This result was significant at the .02 level using the chi-square test. Although the Indian and Metis population in Winnipeg is less than 10 per cent, 37 per cent of the children in care were Indian and Metis.

TABLE IV

EMOTIONAL DISTURBANCE AND LENGTH OF CARE

| | Emotionally Disturbed Children | Per Cent |
|---|---|---|
| Short-Term Care | 5 | 55 |
| Long-Term Care | 4 | 45 |
| Total | 9 | 100 |

The results in Table IV do not support the sub-hypothesis that emotionally disturbed children will experience long-term rather than short-term care. There were only nine emotionally disturbed children as identified at the point of intake out of a total of 136 children; five were in short-term care and four were in long-term care. This number is too small to formulate any conclusions from the results. It is believed that many more than the nine children found were, in fact, emotionally disturbed as it was noticed in the collection of data, that several children received psychiatric assessments following intake.

TABLE V

PARENTS AS FORMER AGENCY WARDS AND DURATION OF CARE

| Duration of Care | Parents as Former Wards | | | | |
|---|---|---|---|---|---|
| | Both | Mother | Father | Not Known | Total |
| Short-Term | 0 | 2 | 2 | 42 | 46 |
| Long-Term | 0 | 11 | 1 | 78 | 90 |
| Total | 0 | 13 | 3 | 120 | 136 |
| Per Cent in Long-Term | 0 | 85 | 33 | | |

Table V partially supports the sub-hypothesis that a high percentage of children whose parent(s) have been in agency care require long-term care. There was no record in the intake data to show that both parents were former agency wards. Of the thirteen children whose mothers were former agency wards, eleven (85 per cent) were in long-term care. This result agrees with the hypothesis. Two of the three children whose fathers were formerly wards were in short-term care. This number of children, 3, which is 2 per cent of the total population, is too small to be considered conclusive.

In 88 per cent of the total population, there was no reference made to whether or not either or both parents had been wards of an agency.

TABLE VI A

NUMBER OF SIBLINGS AND DURATION OF CARE

| Length of Care | Number of Siblings | | | | |
|---|---|---|---|---|---|
| | 0-1 | 2-3 | 4-5 | 6+ | Total |
| Short-Term | 3 | 20 | 9 | 14 | 46 |
| Long-Term | 3 | 39 | 29 | 19 | 90 |
| Total | 6 | 59 | 38 | 33 | 136 |
| Per Cent in Long-Term Care | 50 | 66 | 76 | 58 | |

To study the relationship of the number of siblings to the duration of care, four groupings were selected. It is noted that only six children with one or less siblings were in care, and the sibling group with the largest number of children in care was in the two to three sibling category (59) or 44 per cent of the total population of 136. As shown in Table VI A, 50 per cent of the children with one or less siblings, 66 per cent in the two to three sibling group and 76 per cent of the children in the four to five sibling group were in long-term care. This pattern changes, however, with children with six or more siblings as only 58 per cent are in long-term care.

An explanation for this reduction might be that for large families, older siblings learn to share responsibilities with parents in taking care of the younger children thus reducing

the stress in the family. The possibility that the agency may have used alternatives such as homemaker services, which would be less expensive, also seems likely.

Although the results appear to partially support the hypothesis, the fact that there were only six children with one or no siblings suggests that further research with a larger sample is indicated.

TABLE VI B

FAMILIES WITH VARYING NUMBER OF SIBLINGS AND DURATION OF CARE

| Number of Siblings | Number of Families | | | | |
|---|---|---|---|---|---|
| | 0-1 | 2-3 | 4-5 | 6+ | Total |
| Short-Term Care | 3 | 9 | 3 | 5 | 20 |
| Long-Term Care | 3 | 21 | 16 | 7 | 47 |
| Total | 6 | 30 | 19 | 12 | 67 |
| Per Cent in Long-Term Care | 50 | 70 | 84 | 58 | |

To analyse sub-hypothesis VI it was felt helpful to consider along with the number of siblings of a child, the number of families whose children were involved in agency care. Table VI B illustrates the findings related to families and duration of care.

In Table VI B when the number of families with varying number of siblings is compared with the duration of care, a

similar pattern as in Table VI A is observed. Of the 67 families involved, 47 (70 per cent) had children in long-term care.

Fifty per cent of the families with 0-1 siblings, 70 per cent of the families with 2-3 siblings, and 84 percent of the families with 4-5 siblings had children in long-term care. The ascending pattern again reverses when the families had six or more siblings as only 58 per cent had children in long-term care.

TABLE VII A

NUMBER OF SIBLINGS IN CARE AND DURATION OF CARE

| Duration of Care | Number of Siblings | | | | | |
|---|---|---|---|---|---|---|
| | None | 1 | 2 | 3 | 4/ | Total |
| Short-Term | 9 | 12 | 9 | 6 | 7 | 43 |
| Long-Term | 19 | 22 | 18 | 17 | 14 | 90 |
| Total | 28 | 34 | 27 | 23 | 21 | 133* |
| Per Cent in Long-Term Care | 68 | 65 | 67 | 74 | 67 | |

*For 3 children, the number of siblings was not indicated.

The results of Tables VII A and VII B do not support the sub-hypothesis that the more siblings there are in care, the longer will be the duration of a child's care. The results of Table VII A, which correlates the number of siblings in care with the duration of care, show that 68 per cent (19) of the children with no sibling in care, are in long-term care.

The percentages of the children with one, two and four siblings are 65, 67 and 67 respectively. There is a higher percentage (74) of children in care with three siblings.

TABLE VII B

NUMBER OF FAMILIES AND DURATION OF CARE

| Number of Siblings | Number of Families | | | | | |
|---|---|---|---|---|---|---|
| | None | 1 | 2 | 3 | 4+ | Total |
| Short-Term Care | 9 | 8 | 4 | 3 | 3 | 27 |
| Long-Term Care | 19 | 17 | 6 | 6 | 2 | 50 |
| Total | 28 | 25 | 10 | 9 | 5 | 77 |
| Percent in Long-Term Care | 66 | 68 | 60 | 67 | 40 | |

In Table VII B, families with varying numbers of siblings in care are correlated with the duration of care. The results show that 66 per cent of the families with no sibling, 68 per cent of the families with one sibling, 60 per cent of the families with two siblings and 67 per cent of the families with three siblings in care, have children in long-term care. Although the percentage drops sharply to 40 in the next column, it is observed that the number of families with four or more children in care are only five. This number is too small to make any definite conclusions. 70 per cent (55) of the children in care come from families with one or no siblings.

In the definition of "children in care", the authors did not distinguish between the children who were in care prior to or at the point of intake.

TABLE VIII

NUMBER OF PARENTS AND LENGTH OF CARE

| Length of Care | Parents Present | | | | |
|---|---|---|---|---|---|
| | Both | Mother | Father | Other* | Total |
| Short-Term | 21 | 17 | 0 | 7 | 45 |
| Long-Term | 31 | 36 | 9 | 7 | 83 |
| Total | 52 | 53 | 9 | 14 | 128 |
| Per Cent of Long-Term Care | 60 | 68 | 100 | 50 | |

*Other is relatives, former foster parents and friends.

The results of Table VIII partially support the sub-hypothesis that the number of parents in the family is inversely related to the duration of care. It is shown that with both parents present in the home, 60 per cent (31) of the children remain in long-term care, while with the mother alone present, 68 per cent (36) of the children are in long-term care, and with the father alone present, 100 per cent of the children (9) are in long-term care. These results are in the expected direction. It appears that fathers are less efficient as single parents than mothers. This may be due to cultural norm in which the father sees himself as the bread-winner and not the custodian of the home and the child. However, in the absence of the natural parents, 50 per cent (7) of the children are in long-term care, which was contrary to expectations.

It is also interesting to note that when the child had a single parent, it was usually the mother. In this study, there were approximately six times as many mothers looking after children as there were fathers.

TABLE IX

PHYSICAL ILLNESS OF MOTHER AND DURATION OF CARE

| Duration of Care | Number of Children in Care | Per Cent |
|---|---|---|
| Short-Term | 7 | 70 |
| Long-Term | 3 | 30 |
| Total | 10 | 100 |

The sub-hypothesis states that when a child is taken into care because of the physical illness of the mother, the duration of care is usually short-term. As Table IX shows, 70 per cent (7) of the children were in short-term care while 30 per cent (3) were in long-term care. The results support the sub-hypothesis, however, the number of children (10) involved is only 7 per cent of the total population.

These ten children were only from four families. The three children in long-term care were the children of one mother and the seven children in short-term care were the children of three mothers. Because only four families were involved, a meaningful analysis could not be undertaken.

The fact that very few children become wards of the Agency because of the mother's illness, suggests that the Agency used alternative means of assistance such as homemaker services to handle the problem...Quite properly, illness of a mother should not under ordinary circumstances be considered a neglect situation.

TABLE X

ALCOHOLISM OF PARENTS AND LENGTH OF CARE

| Duration of Care | Alcoholism of Parents | | | | |
|---|---|---|---|---|---|
| | Both | Mother | Father | Not Known | Total |
| Short-Term | 8 | 10 | 10 | 18 | 46 |
| Long-Term | 26 | 22 | 10 | 32 | 90 |
| Total | 34 | 32 | 20 | 50* | 136 |
| Per Cent of Long-Term Care | 76 | 69 | 50 | | |

*In 50 cases, no information was given about alcoholism as a parental problem.

The results of Table X partially supports the sub-hypothesis that a high percentage of children of alcoholic parents require long-term care. The data show that when both parents are alcoholic, 76 per cent (26) require long-term care. This percentage is higher than when the mother alone (69 per cent) or the father alone (50 per cent) is alcoholic. This result agrees with the hypothesis.

As seen above, alcoholism of both parents seems to indicate that the child will probably enter long-term care. This is

expected as the parents would be unable to care for a child properly. The degree of neglect would be a function of the extent of the alcoholic problem.

An unexpected finding is that when the father alone is alcoholic, the probability of long-term care is less than that expected by chance.

Almost two-thirds of the children studied had parent(s) with an alcoholic problem. This supports the view that alcoholism is the major drug problem in our society and demands greater attention.

# CHAPTER V

## CONCLUSIONS

The results of this research project contribute to the knowledge about variables likely to be related to duration of care. The view that there are factors obtainable at intake that may serve as guidelines to indicate duration of care is given a small boost by this study. It was found that the characteristic race showed a strong association with length of care. Other factors suggested a correlation with duration but the results were inconclusive. In this category were sex, number of siblings, number of parents, parents who had been wards of an agency and alcoholism of both parents. Only two factors, the age of the child and the number of siblings in care, appeared to be independent of the duration of care.

Although the process of determining the kinds of criteria that go into the placement decision seems to be painfully slow; research needs to be continued until it is discovered empirically what kind and what length of care suits what child. The characteristics tested in this study which indicated a correlation or suggested a correlation with duration of care should be further researched. In addition, combinations of factors should be tested to discover whether or not the inter-relationship of some factors may prove together to be indicators of duration. And finally, other factors, not studied in this project but obtainable at intake, should be tested.

Research in this area would be facilitated if a better operational definition for emotional disturbance was found. Not only would a more encompassing operational definition make possible a study of this variable with duration of care but it would also advance, in general, the study of emotionally disturbed children.

There is an ever increasing number of children requiring agency care, many of them long-term which demands that knowledge about the factors which affect the placement decision be further researched. Although the results of such research are often discouraging, the best and most creative efforts are needed to continue the search for the empirical knowledge required. The well being of some children depends upon it.

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# APPENDIX

## QUESTIONNAIRE AND CODING OF DATA

1. AGE OF CHILD

| | |
|---|---|
| 0 - 3 years | 1.1 |
| 3 - 5 | 1.2 |
| 6 - 8 | 1.3 |
| 9 - 11 | 1.4 |
| 12 - 14 | 1.5 |
| 15 - 17 | 1.6 |
| ≠17 | 1.7 |

2. SEX OF CHILD

| | |
|---|---|
| Male | 2.1 |
| Female | 2.2 |

3. RACE OF CHILD

| | |
|---|---|
| Treaty | 3.1 |
| Non-Treaty | 3.2 |
| Metis | 3.3 |
| White | 3.4 |

4. HAS THE CHILD RECEIVED PSYCHIATRIC ASSESSMENT?

| | |
|---|---|
| Yes | 4.1 |
| No or Don't Know | 4.2 |

5. NUMBER OF <u>OLDER</u> SIBLINGS IN THE FAMILY

| | |
|---|---|
| None | 5.1 |
| 1 - 3 | 5.2 |
| 4 - 6 | 5.3 |
| ≠6 | 5.4 |

6. NUMBER OF <u>YOUNGER</u> SIBLINGS IN THE FAMILY

| | |
|---|---|
| None | 6.1 |
| 1 - 3 | 6.2 |
| 4 - 6 | 6.3 |
| ≠6 | 6.4 |

7. NUMBER OF <u>OLDER</u> SIBLINGS IN AGENCY CARE

| | |
|---|---|
| None | 7.1 |
| 1 | 7.2 |
| 2 | 7.3 |
| 3 | 7.4 |
| 4 | 7.5 |

8. NUMBER OF <u>YOUNGER</u> SIBLINGS IN AGENCY CARE

| | |
|---|---|
| None | 8.1 |
| 1 | 8.2 |
| 2 | 8.3 |
| 3 | 8.4 |
| 4 | 8.5 |

9. WITH WHOM WAS CHILD LIVING AT ADMISSION TO CARE?

| | |
|---|---|
| Both Parents | 9.1 |
| Mother | 9.2 |
| Father | 9.3 |
| Other | 9.4 |
| Don't Know | 9.5 |

10. PRIMARY REASON FOR ADMISSION TO CARE

| | | |
|---|---|---|
| a) | Death of Parents | 10.1 |
| b) | Hospitalization of Parent(s) | 10.2 |
| c) | Child Abandoned or Deserted | 10.3 |
| d) | Battered Child | 10.4 |
| e) | Juvenile Delinquency | 10.5 |
| f) | Child Requiring Institutional Care | 10.6 |
| g) | Child for whom the Parent(s) Refused or Neglected to Provide Medical Care | 10.7 |
| h) | Parent(s) Unable or Unwilling to Cope with an Incorrigible Child | 10.8 |
| i) | Child Refusing to Return Home | 10.9 |
| j) | Inadequate Housing | 10.10 |
| k) | Parent(s) Relinquishing the Child for Adoption | 10.11 |
| l) | Other | 10.12 |

11. DO PARENT(S) HAVE AN ALCOHOLIC PROBLEM?

| | |
|---|---|
| Both | 11.1 |
| Mother | 11.2 |
| Father | 11.3 |
| Neither or Don't Know | 11.4 |

12. HAVE PARENT(S) BEEN A WARD OF THE AGENCY?

| | |
|---|---|
| Both | 12.1 |
| Mother | 12.2 |
| Father | 12.3 |
| Neither or Don't Know | 12.4 |

13. MARITAL STATUS OF PARENT(S)

| | |
|---|---|
| Single | 13.1 |
| Married | 13.2 |
| Divorced | 13.3 |
| Separated | 13.4 |
| Common Law | 13.5 |

14. LENGTH OF TIME FROM COURT HEARING TO DISCHARGE OF CHILD

| | |
|---|---|
| One Year or Less | 14.1 |
| Greater than One Year | 14.2 |