McGill University

A Study to determine what variables may increase the risk of an Adolescent coming into the care of the Children's Aid Society

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Abstract

Ninety-six child protection files were scrutinized according to the Holland Complex Care Case Review Data Collection Instrument in order to verify the applicability of the instrument to determined the variables influencing social workers in the determination of bringing an adolescent in need of protection into care. Results show that school related issues seem to influence workers in determining the need to remove the child from the family. Statistical analyses indicated numerous correlations supporting the link between case complexity and the need to bring an adolescent into care.

Quatre-vingts seize filières reliées à la protection de l'enfance furent analysées utilisant l'instrument de récolte des donnés sur la complexité des cas développé par Holland afin de vérifier la capacité de l'instrument à déterminer les variables influençant le jugement du travailleur social dans la détermination du besoin d'amener un adolescent en besoin de protection en milieu d'accueil. Les résultas démontrent que les problèmes scolaires semblent influencer le travailleur social dans l`évaluation du besoin d'enlever un adolescent de son milieu familial. L'analyse inférencielle indique de nombreuses corrélations supportant un lien entre la complexité des cas et le besoin de placer un adolescent en milieu d'accueil.

1.0 Introduction

The world of child protection is deemed to be one of uncertainties. Every day hundreds of social workers perform the difficult, sometimes impossible, task of assessing, in a short period of time, the risk for children in need of protection. The political context of this demanding intervention is constantly requesting a higher level of accountability for the decision making process. As opposed to our American counterpart and even with over hundred years of existence very few reliable studies helping predict children at risk have been produced in the field of practice. A small number of instruments have been developed especially during the last decade. The legislation of the last decade has generated the Provincial risk assessment model (OACAS, 2000)

Clearly the progress made with this instrument contributes to seeing the gaps needing to be filled out, in order to better serve, this vulnerable population. The difference between the predictability of risk for children and adolescent represents a growing concern for many Children's Aid Societies and becomes an increasing focus of attention for research. Within the sub-population of young children or infants at risk, there emerges a specific set of variables that workers must use to carefully assess the situation before they articulate a professional judgement on the child's safety. Among the most common are: the young age of parent(s), the lack of existing adequate supports and resources from community or family, education and intellectual capacities and poverty.

Adolescents, on the other hand, being in transition, have started developing a more sophisticated and complex social network based on a more independent decision making process. These factors make it even a more complex task in assessing their level of risk. With an infant the assessment of risk is quasi limited to the reading of the

nurturing environment, with adolescents the immediate system is only a small piece in the puzzle. Greater risks seem to emerge from the exchange between the immediate and social environments. Risks related to relationship issues, mental health problems, school issues, substance abuse and placement breakdowns are aggravated by the lack of control over the consequences resulting from unhealthy coping mechanisms such as running away, criminal activities, living on the streets and being victimized (prostitution, drugs, etc.).

The child welfare system presents with an increasing number of youth in-care, especially between the ages of 13 and 15 years old. This presents the Children's Aid Society with new challenges. The growth of the demand clearly outweighs the capacity of the agency to respond. This phenomenon is pressuring social workers to better understand the need of bringing adolescents into care. Closely linked to safety and risk issues, the need to bring an adolescent into care is to be carefully assessed. Little if any rigorous methodology or valid instruments exist in helping child protection workers and their managers in making this decision.

The current safety assessment insists on exploring variables assessing the impact of the parents' behaviour in relation to the child's safety where as with adolescents, safety seems to revolve around their behaviour in context or in relation to their immediate and extended social environment. There is no instrument being used at Frontenac CAS in that regard. A comprehensive safety assessment tool examining adolescent level of risk would need to gather information on specific variables affecting this population. The case complexity instrument developed by Holland (1998) underlines what this research believes to be essential components allowing for a thorough assessment of this adolescent

population. Responding to the lack of instrument assessing adolescents in need of protection, social workers use their clinical judgement to determine the need of an adolescent to come into care in certain situations. This study will explore, using the Case Complexity Instrument, the best predictors that an adolescent will be more likely to come into the care of the Children's Aid Society and hope to contribute to the development of a more effective safety assessment tool.

1.1 Purpose.

The purpose of this exploratory-descriptive research is to examine variables that seem to influence child protection workers making a professional judgement on the necessity to bring an adolescent into care to ensure their safety. This objective will be reached by examining factors and dimensions contained in the Holland Complex Care Case Review Data Collection Instrument on the Children's Aid Society 1999-2000 database.

1.2 Rationale.

This research will fill a distinct void in the literature concerning the identification of variables directly related to the need of bringing an adolescent into care. The importance of being able to pre-determine if an in-care service is required for an adolescent is increasingly significant as actual resources available in the community for this particular clientele constantly decrease and opportunities to develop more in-care services for them unlikely to change in the next few years. In general, the literature examining adolescents in-care address the *de facto* situation. The commonly presented factors contributing to an adolescent in-care does not bring forward empirical evidence

allowing for possible scientific conclusions. Neither is presented possible correlations explaining their coming into care.

This study has practice implications. It attempts to systematize the use of a number of variables playing a crucial role in determining the need for an adolescent to come into care. Any of the decision-making process involved in child protection uses numerous components. One implication in this regard includes developing a more comprehensive assessment tool that is used when the worker first meets with the adolescent and their family. This would then ensure workers consistency in assessing the variables, and allow for a quicker decision-making process in determining the need to bring an adolescent into the Society's care.

Third, this study hopes to enhance theory by examining the complementarities of two situations using one measuring instrument i.e. case complexity and the need for an adolescent to come into care. The interdependence of the two: situation and concept shows the possibility of applying the contextual framework to a larger system. The increasing number of adolescents coming into care is pressuring all service levels i.e. macro (the agencies) mezzo (supervisors) and micro (social workers) to develop an instrument helping to determine the predictability of this target population to use this specialized serviced. By demonstrating the applicability of the instrument to the in-care predictability this study hopes to develop a theory linking case complexity and in-care necessity.

1.3 The Concepts

This study being highly specialized, many concepts and terms need to be clarified.

Children's Aid Society (CAS)	The agency in the Province of Ontario

	Legislated to protect children.
Community	The Society found in the City of Kingston and County of Frontenac and the agency where the respondents have been located in.
Family	The families that have come in contact with the Children's Aid Society as a result of them or someone from the community calling the Society for assistance.
Adolescent	For the purpose of this study an adolescent is either 13, 14 or 15 years of age.
School	The place where children receive their academic instruction.
Placement Type	Where the child is currently residing.
In-Care	The term used when a child is living in the Care of the Society.
Foster Home	An alternative living placement for a child who has been removed from their parents or guardian's care under a court order or Temporary Care Agreement.
Independent Living	A youth in-care of the Children's Aid Society who is living in the community with CAS support services or who may be attending College or University or in a room and board setting.
Outside Paid Resource	A supportive living setting where children live. The CAS purchase this service and place children in staff or parent model group homes.
Placement Issues	Where the child is experiencing instability in their current placement.
Status of the Child	Whether or not there is a family court order such as Crown Wardship, Society Wardship, TCA or home.

Temporary Care Agreement	A legal and voluntary agreement between the Society, the parent and the child if they are over 12 years old, which brings a child into the Society's care with the agreement that the child will return home. This is a legal document and not a court order.
Apprehension	When a child is removed from their parents or guardian's care as they are not deemed safe to remain in that person's care.
Interim Care and Custody	Once a child has been apprehended, the Society must attend Family Court to determine whether or not the CAS had cause to remove the child. The initial order to keep the child in the Society's care is known as an Interim Order.
Crown Ward with access	A legal term for a child who has been made a permanent ward of the Society who continues to have contact with their parents. attending College or University or in a room and board setting.
Society Ward	Is a child found in need of protection by Family Court and therefore are not able to return to their parents' or guardian's care for a period of time. The youth is however, not a permanent ward of the Society.
Extended Care and Maintenance	The status of youth 18 to 21 years of age who continue to reside and receive support from the Society.
Eligibility Spectrum	The tool that Children's Aid Society's in Ontario use to determine whether or not they will respond to a report made to the society. It also determines how they will respond and in what time frame.
Safety Assessment	The initial tool used when the assigned worker first meets with the family to determine the immediate safety of the children.

Risk Assessment	The standardized assessment tool used by Workers at the Children's Aid Society in order to assess current and predict future risk to children in their parent's care.
History of Abuse	The Society has verified abuse as per the Standards and guidelines of the agency. This would include sexual, physical and emotional.
Behavioural Issues	The child is assessed to have problematic behaviour issues as reported by the child, parent, community or another professional, such as substance abuse, being sexually inappropriate etc.
Health --- Physical	The child has been diagnosed with a physical health issues such as Fetal Alcohol Syndrome, sexually transmitted disease etc.
Health --- Mental/Psychological	The child has been assessed or diagnosed as having a mental health disorder such as Attention Deficit, depression, suicidal ideation etc.
Parent --- Related Issues	The parent has been assessed or diagnosed as having mental health problems, substance abuse problems, parenting capacity problems etc.
Relationship Issues	A child who is assessed as having an Attachment Disorder or having poor social skills etc.
Legal Issues	A child who has or is involved with the young offender system or continues to be involved with the family court system due to their involvement with the Society.
Placement Issues	The child is having a difficult time in their placement setting, has run away, has lived in multiple placements and is conflict with their parent and/or foster parent etc.

School-related Issues	The child has learning, social and/or academic problems at school

2.0 Theoretical Framework

Family life cycle is punctuated with conflicts. Stress is an integral part of confrontation in the daily life relationship between adolescents and their immediate support system,e.g., their family. During adolescence, the personal, family and social boundaries are being extended. Family life events, school and personal relationships are challenged. Migrating to the adult age, adolescents test their environments and establish their own personal rules and their values are modified. This ongoing identity formation generates a large amount of stress. Communication plays a crucial role in how parents and adolescents negotiate the new required boundaries. The traditional conflict resolution pattern developed by the family unit is challenged. Voicing their new beliefs, adolescents will argue a new order of things. The parents' ability to provide new boundaries and structure to facilitate growth vary (Bibby & Posterski, 1992).

Change occurring within the family system is rationalized by the family unit and problems are personalized. The adolescent is targeted as the cause of those changes and, therefore, any conflict. The adolescent is also influenced by a new set of external systems such as peers, schools or social groups. These sources counter-balance the parental authorities. Some conflicts resulting from internal and external family influences find a positive resolution. However, certain factors such as abuse, mental health problems, school problems and legal issues seem to impact on their mutual ability to effectively resolve conflicts. Unresolved conflicts cumulate, forced compromises raise defensiveness, coping capacity decreases, and individual capacity to communicate also decreases. The result, an increasing mutual inability to resolve conflict, a larger gap

between the adolescent and parent belief system and the entire responsibility for creating the problems is placed on the adolescent (Gottlieb & Saltzman-Chafetz, 1997). With time, the family unit becomes more strained creating an acute level of stress in the home environment. The adolescent's problematic behaviour correlates with the level of tension that is escalating within the family unit. Each individual family seems to define the threshold of coping. Factors such as parents' individual problems, substance abuse, marital problems, violence, finances and mental health also contribute to the conflict resolution pattern. The whole family system shifts from trying to deal with the conflict to focusing on the adolescent and their negative behaviour as being identified as 'the problem' within the family. These negative adolescent behaviours may include substance abuse, running away, truancy or by the adolescent engaging in criminal activity.

As the conflict increases, the family system starts breaking down. The latter induces a crisis that demands the family to place blame on the individual who initiated and maintained the conflict. The family system must be maintained at all costs (Pollack & Friedman, 1969). Each family member is trying to retrieve the initial equilibrium and resists change. As 'normal family functioning' becomes threatened, each member of the system will find ways to cope with the problems. The adolescent may further resort to risk taking behaviours to escape from their problems and the conflict at home. The increase in the adolescent's behaviour continues to reinforce, to the parent, that the adolescent is in fact 'the problem'. Therefore, the parents determined that the only way to resolve the conflict and return the family system to a 'normal' level of functioning is to have the adolescent removed from their home.

Families come in contact with the Children's Aid Society for a variety of reasons. Some parents need some direction in how to link up with support services. These families are often referred to children's mental health services or to other counselling organizations. However, there is a percentage of families who are in a state of crisis when they call the Society and only see the removal of their adolescent as the only way to resolve their problems. During this crisis stage, it is essential for the assigned worker to understand the principles of crisis intervention in order to enhance social functioning and coping within the family (Rapoport, 1970 & Dixson, 1970). The objective is to reduce tension and anxiety, give hope and teach new patterns of problem solving and coping skills (Johnson, 1983). Given the age of the adolescent, one must listen to them and their parents in order to understand the family dynamics and how each part of the system is functioning, interpreting and dealing with the problems (Combs-Orme & Thomas, 1997). The importance of effective communication skills can be enhanced by focusing on building self-esteem, defining roles and rules and modeling effective communication skills (Satir, 1967). With some families, the intervention alone seems to initially be enough to prevent the adolescent from having to leave their family home. The family feels that their 'cry for help' was heard and now they can begin working on the problems within their family unit. By attending the home, one is able to have the family identify and discuss the problems and start to help the family negotiate and focus on the problems and not so much on the adolescent's behaviour (Perlman, 1970). Once the initial crisis has been alleviated, short-term family therapy may be a course of action to continue to help the parents and the adolescent resolve their conflicts and deal with the adolescent's acting out behaviour (Kelley et al., 1989). For other families, the crisis and conflict is so

intense, that it is deemed not safe for the adolescent to remain in the family home. There are situations whereby the parents 'abandon' their responsibility in order for the adolescent to be removed from their home.

Throughout this process, the gathering of information from each part of the family system and the larger ecological systems become important in understanding the influence each of them have on the parents and the adolescent's behaviour and actions (Minuchin, 1969). By understanding the roles of the internal and external systems, this helps one understand the communication patterns of the family and how each member is coping (Combs-Orme & Thomas, 1997). It is at times easy to place the blame on the adolescent during this stage as often their behaviour is quite problematic and creates stress in the family. However, it is crucial to get underneath the behaviour in order to understand the dynamics and reasons that have lead the adolescents to place themselves at risk. Within each family system, each member will take on a role. Other children may try to be very good and do everything well in order to not get into trouble. A parent may turn to drinking or staying away from the home or work late in order to avoid the problems and conflict at home. It is important to understand the roles of each member within the system to see how they are impacting on the increased conflict.

When the adolescent doesn't come into the Society's care, the family may need some outside help to get them through the difficult point. There is a positive relationship between the use of support services with families with adolescents (Richman et al., 1998). Sometimes, family members need to realize they do not have to be perfect and that some families need outside support and help. Social support can be found within the family or extended family, the community, school and peer groups. Needing outside

support seems to be perceived as negative by the parents or the adolescent (Richman et al., 1998). It is easy to focus on the family's vulnerabilities. However, social or professional supports work to enhance families' strengths and address positive actions and behaviours of the adolescent and other family members as a way to work through the conflict (Hartman, 1990). Parenting programs or brief solution counseling may both be effective in helping the parent and the adolescent better understand the phase they are going through, and strengthen the skills they already have, to resolve the conflict. As the parent and adolescent are involved with various services and systems a common goal and outcome for the family are developed (Richman et al., 1998). For some families, this type of intervention is the way for them to resolve the conflict and the adolescent is still in the home. The success of these families may be attributed to single problems and multiple services being available to them.

The families who are not able to resolve their issues and problems often need more intensive treatment and services. Each part of the system needs to be assessed to determine what course of action they require in order to reduce the conflict and hopefully return the adolescent home. Sometimes, once the adolescent is removed, the family is able to re-group in order to see what the problems are and how to resolve them. Again, it is important to look at the whole system and each part of the sub-systems. Counselling, parenting courses and other support services can effectively help the family re-organize and learn more effective coping and conflict resolution skills. The parent and adolescent must share in a 'give and take' process in order for any type of reconciliation and/or resolution to be found (Gottlieb & Saltzman-Chafetz, 1997). A comprehensive assessment again helps organize the information gathered by all parts of the system,

which in turn helps identify the needs of the family. A family genogram can assist in providing a pictorial record of the family and shed light on the family's current difficulties and patterns of behaviour (Goldenberg & Goldenberg, 1996). By drawing or mapping out the family and the ecosystems involved with a family, one can start to see where there are positive and negative relationships, tension and where there is a source of support for a family member (Minuchin, 1974). Two issues arises from this method, first, it can help identify what services can assist the family during this crisis and secondly, it shows what new services may need to be brought into the family system to help them function more effectively.

There is a percentage of families whereby the variables are so acute, the problems are so intense and the situation is so sensitive, that the case is rendered complex. No level of support is enough to maintain the adolescent with their family unit. There are times when individuals are not able to see how their behaviour and actions have impacted on the situation. Parents continue to blame the adolescent for the family's problems and the adolescent is so angry, that they cannot see any positive reason for returning to their family. A high percentage of these adolescents remain in the Society's care until they are 18 or even 21 years old and become Crown Wards of the Society. At this point, the agency's focus becomes meeting the needs of the adolescent and preparing them for independent living. The hope is that the adolescent and their parent can re-build and reconcile their relationship to some degree that allows them to have some contact (Gottlieb & Saltzman-Chafetz, 1997). Sometimes this is effective as the parent is no longer responsible for their daughter or son's actions and behaviour. This may take some

pressure off the family system, which allows the family to re-build some form of relationship.

The overall theory of this study can be stated as follows, an adolescent experiencing one or two problems is perceived as 'having a problem', and they receive support and help from their family to get through this difficult time with little to no risk of the their home placement breaking down. Whereas, an adolescent experiencing multiple problems at home, in school and within their community is often labeled as being 'a problem adolescent'. They often do not receive the support and help from their family and there is a high risk of their home placement breaking down. The parents who see their adolescent as a 'problem' are not able to differentiate between the acting out behaviour and the actual problems that the adolescent is experiencing. Thus, creating intensive conflict within the home and a breakdown of the family unit.

3.0 Literature Review

In today's society there is an increasing awareness of adolescents, their behaviour and actions. There have been several Commissions and reports conducted in an attempt to gain a better understanding of this phenomena and to try to figure out how to resolve the perceived growing problems of youth at risk in our communities (Standing Committee on Social Development, 1994). Child Welfare agencies are also dealing with an increased number of families with adolescents needing their services (OACAS, 1998). In 1993, it was reported that 2% of Ontario's children had been reported to the Children's Aid Society and were investigated due to allegations of maltreatment (Trocme, 1995). Many of these families coming in contact with the Children's Aid Society are in severe crisis and their issues and problems are quite complex (Frontenac Children' Aid Society,

1997). This study reviewed literature that examined the components of the parent-adolescent conflict and what variables may be the attributing factors that intensify the conflict resulting, in the family needing help from outside support services such as the Children's Aid Society. Research has already identified these 10 variables closely related to the phenomena this study approach. The study will present the phenomena of adolescence, scrutinize the concept of family structure in our current society and define the variables that seem to make a difference in predicting whether or not an adolescent will come into the Society's care.

3.1 The Adolescent

Adolescence is the transitional stage in human development that marks the end of childhood and the beginning of a person's move towards adulthood. It is a period of rapid change that covers approximately eight years of a person's life (Rycus & Hughes, 1998). Each young person will experience this stage differently and their feelings, thoughts and actions are unique unto themselves (Santrock, 1987). There are five key areas of development that adolescents must complete in order for them to be recognized as a healthy adult. These include physical development, cognitive development, social development, moral development and emotional development (Daniels, 1990; Paikoff et al., 1991 & White, 1989). On a daily basis, these five areas of development have significant influence on the adolescent's life (Paikoff & Brooks-Gunn, 1991).

The physical development of an adolescent is marked by a physical change in their height, weight and overall body structure. During this phase, both males and females experience an increase in hormones that contribute to the development of sex organs and secondary sex characteristics (Rycus & Hughes, 1998; Paikoff & Brooks-

Gunn, 1991). As the body is changing, so is the adolescent's ability to think at a more hypothetical level. They begin to be able to consider and calculate consequences of their thoughts, actions, events and behaviours without having actually completed the event or thought. As the adolescent matures through this phase, they become more introspective and are able to consider other people's perspectives (Rycus & Hughes, 1998). Social development evolves along with emotional and cognitive development. As the adolescent is able to operationalize their thoughts and ideas, they are able to move to a new level of intimacy with people and they develop a strong identification with their own peer group. Adolescents tend to move away from their parents' influence, the most important, to various social groups and friends having more influence on their thoughts and ideas. As the adolescent is now able to think in an abstract manner and is gaining more insight, their moral development of what is right and wrong is starting to develop. They are able to understand rules and laws and the consequences for breaking any of these rules and laws (Rycus & Hughes, 1998). The final critical stage of development is reached when the adolescent is able to define and has developed his or her own identity. During this phase, the adolescent is moving away from being only identified as a member of a family to being identified as an individual and also as a contributing member of society. This is a very important time for the adolescent as they start to sort through and assimilate the values and beliefs of society in order for them to define their own ideals and viewpoint. Sometimes, this new set of principles comes in conflict with the norms and views already established by the adolescents' family. However, this is a critical phase as the adolescent starts to further define whom they are and how they wish to be

perceived within their family, by friends and within their community (Rycus & Hughes, 1998).

During this phase, there is a normal level of conflict for the adolescent and their parents. Up to this point, the adolescent's family has most likely had the greatest amount of influence on how the adolescent thinks and perceives the world. The adolescent is now trying to move towards independence and often questions many of their parents' values and beliefs. The adolescent's friends and their group associations play a pivotal role in the further development the adolescent's self-esteem and give the adolescent a further sense of their own identity (Santrock, 1987; Bibby & Posterski, 1985). As the family unit is no longer the most important part of the adolescent's life, many parents will struggle as their adolescent moves through these five stages of development.

3.2 Today's Families

In today's Society, the term "family" no longer renders a traditional image of a mother, a father and some children. Families today are quite different and may consist of single parent families, adoptive families, blended families and childless couples (Emond, 1994; Barnhorst & Johnson, 1991). Barnhorst and Johnson (1991) reviewed the 1986 Canadian Census and found that there were 2.4 million families in Ontario and 67% of these families had at least one child. In the United States, almost 50% of all marriages will end in divorce. It has been estimated that by 1990, one-third of children under the age of 18 will have experienced parental separation and divorce and will have grown up in a non-traditional family (Johnston, et al., 1985). Barnhorst & Johnson (1991), further found of the 2.4 million families in Ontario, women headed 380, 170 households either due to divorce, separation, being widowed or being a single mother. A single father due

to the same reasons headed only 79, 395 families. In reviewing the literature, there appears to be no empirical evidence showing that the type of family structure that the adolescent originates from is a contributing factor to adolescents experiencing problems.

In 1998, Children's Aid Society's in Ontario served 114,132 families (Ontario Association Of Children's Aid Society's, 1998). Seven percent of these families required additional support services from the Society that included the use of a case aid, child management worker or another type of home support worker in addition to the assigned caseworker. From these families, there were 11,260 children admitted into the 52 Ontario Children's Aid Society's care. The Child Abuse and Neglect in Ontario Incidence and Characteristics Study (Trocme et al., 1995), found in their study, of the 2,447 investigations by Children's Aid Society's on children, that single mothers headed 36% of the families, 34% of the investigations found children to be living with two biological parents in the home and 19% of the children lived with one biological parent and one common law or stepparent. The research further found that a third of the children lived with parents who had problems with alcohol (13%), problems with drug abuse (7%), inter-parental violence (17%) and 13% had parents with mental health problems. Thirty-eight percent of the families were on social assistance and 18% were living in public housing (Trocme, 1995). The Child Abuse and Neglect in Ontario Incidence and Characteristics Study (Trocme et al., 1995) confirms that family structure is not a contributing factor causing the adolescent to experience difficulties but it is rather the multiplicity of social problems facing families today that seem to generate difficulties or intensify already existing family issues. Therefore, the report leads one to believe that, the family structure appears to be a contributing factor to the pre-existing problematic

family situation. At a local level, the Frontenac Children's Aid Society served 1,368 families and children and 234 children came into this Society's care (FCAS Annual Report, 1999).

Research defines what constitutes a family and defines a normal adolescence (Barnhorst & Johnson, 1991; Rycus & Hughes, 1998; Paikoff & Brooks-Gunn, 1991). In particular, the statistics are able to identify how many families come into contact with the Children's Aid Society. These are the children and their families that are in need of assistance (Hall, 1987) and meet the eligibility criteria (OACAS, 2000) for service within the Society's mandate.

3.3 Parenting Styles

The literature states the importance of understanding parenting styles in order to better approximate the understanding of parent-child conflict (Hall, 1987). Various studies claim that authoritative parenting style better suit this stage of development (Baumrind, 1978; Lamborn et al., 1991). Parental warmth, effective and fair discipline and consistency in child rearing are each associated with positive child development (Henggeler, et al., 1998). Other styles of parenting including authoritarian, permissive and neglectful, may produce extreme negative reaction leading to ongoing conflict. In fact, these styles revealed to negatively impact on the adolescent's capacity to develop a structured environment, establish clear and healthy boundaries and their ability to make healthy decisions on their own or with parental support resulting in potentially greater conflict in the family system.

Adolescence is a challenging time for most parents. Youth during this time will often challenge and question their parent's decisions and actions. Garbarino et al., (1986)

states that extreme styles of parenting are not optimal in raising children. As adolescence experiences a great deal of conflict and turmoil during this stage, authoritarian and permissive parents can create further conflict and problems. Authoritarian parents do not allow the young person to negotiate with them and they do not compromise. Permissive families have allowed the young person to be in charge and have given them little direction or guidance in order to make decisions. Youth need parents who will negotiate, compromise and set clear limits and boundaries that the adolescent perceives are fair and reasonable (Edwards & Brauburger, 1973).

3.4 Relationships

The literature states that adolescence is a stage of development where the outside influences outweigh the nuclear family authority. Studies identify peers and social groups as being the main source of external influence. The same studies also identified school as being a privileged environment for these influence to impact on the adolescent. Responding to the inner turmoil generated by this stage of development and creating an emotional unbalance, the adolescent attempts to re-establish the equilibrium by creating an artificial environment which will compensate for what they perceive their family is not able to provide to them (Bibby & Posterski, 1992; Montemayor, 1982). This socialization process is essential to bridge the adolescent in the adult world. They need to become more psychologically independent of their parents, develop relationships outside of their home, and seek their own identity (Daniels, 1990). Adolescents individuate by separating from the family while belonging in two separate groups. This transition for the adolescent and the family generates tension generally resulting in conflict. As they are increasing the gap between the two social groups, the adolescent starts to gain, among

other things, insight into inter-personal relationships (Rycus & Hughes, 1998). The literature seems to expose an equation. The more emotional problems experienced by the adolescent the greater the difficulty for the adolescent to develop a social network. When the extended social network is not developed at this stage, it is more likely for the adolescent to exhibit more symptoms related to mental health issues.

Hill (1980) suggests that continual parent-child conflict in the home leads an adolescent to reject their parents and accept the norms, values and standards of their friends. Adolescents who seemed to value their peers' approval over their parents' were reported to have higher level of conflict in the home (Edwards & Brauburger, 1973). A study of 64 adolescents with an average age of 15 years were interviewed to find out if there was a relationship between parent-adolescent conflict and the amount of time the adolescent spent alone with their parents and peers. The study found that adolescents spent significantly more free time with peers (449 minutes) as opposed to 248 minutes with parents and 241 minutes by themselves. The next step of the study found that in general adolescents experienced more conflict with their mother's (75%) than with their father's (25%). Female respondents had a slightly higher conflict rate (58.8%) than male respondents (41.2%). Eighty-five percent of all females reported having higher conflict with their mother (Montemayor, 1982). Montemayor's conclusion found that adolescence tend to spend time with their parent and peers but for quite different reasons. Time spent with parents was more tasks oriented in that the adolescent spent this time by eating, shopping and completing household chores. The adolescents' time spent with their peer group centred around entertainment, playing games and talking. The Study

confirms the existence of the two social networks being simultaneously maintained by the adolescent.

Parents struggle with understanding why friends are more important and see their relationship with their teen as moving further apart (Rutter, 1980). Kipke et al., (1997), cites Douvan & Adelson, (1966), in stating that youth increase their dependence on their friends for support and directions as opposed to turning to their families. The teen at this time is searching for loyal and trustworthy friends. They will experiment with new behaviour and groups of friends to help them develop a sense of self-worth and self-identity. This is a critical stage for the young person and a great source of conflict for them with their family (Kipke et al, 1997). When families are struggling with poor relationships they are frequently seen in child welfare, youth corrections, mental health, and other social service agencies (Combs-Orme & Thomas, 1997). The cognitive dissonance parents' experience leads them to believe that they are not the focus of the adolescent's attention any more. This makes the parent conclude that the child no longer wishes to belong to the family unit when in fact this is only a part of the developmental stage.

3.5 Parent-Adolescent Conflict

Conflict is defined as a disagreement between two or more people (Hall 1997). However, parent–adolescent conflict seems more intense than normal conflict in that it connotes greater hostility, aggression and emotions. Normal conflict occurs on a fairly regular basis and is usually resolved in an effective manner with little effort. Intense or 'acute' conflict means disagreement between the parent and adolescent coupled with strong emotions. Parent-adolescent conflict is distinguished from other forms of

interpersonal conflict by the relationship of the participants and their life goals. Conflict often arises from disagreement on family rules or family roles where different sets of expectations are confronted. That happens for instance when, parents attempt to establish guidelines in order to maintain the family's status quo and the adolescent is requesting changes in the family system to adjust to their new status (Hall, 1997; Smetana, 1998).

Conflict between an adolescent and their parents can be as a result of daily issues related to schoolwork, home chores, disobedience, choices adolescents make, social life, friends, sibling rivalry and personal hygiene to name a few (Smetana, 1989). Smetana's (1989) study of 102 families with children from grades 5 to 12 was a survey to understand what the parent and child identified as conflicts in the home. The identified issues were put into 10 categories once all the information collected was coded and organized by the researchers. The 10 categories were defined as chores, appearance, personality/behavioural style, homework and academic achievement, interpersonal relations, regulation of interpersonal activities, bedtime and curfew, health and hygiene, regulations of activities, finances and an other category. On average the children reported an average means of 4.32 conflicts whereas the mothers reported an average means of 3.62 and the fathers reported on average 3.10 conflicts within their home. This study found that most conflict between adolescents and their parents are over mundane life issues. The conflict usually occurs as a result of a gap between parental and adolescent expectations with parents citing their adolescents' personality and behavioural style being at the center of their frustrations.

Glambos and Almeida (1992) found that much of the research on parent-child conflict has some limitations in that not all studies have found difference between parent-

mother or parent-father relations and conflict. That study attempted to look at some of the gaps in the research on parent-child conflict. This longitudinal study followed 112 respondents from the time they were in grade 6 until grade 8. The parents filled out an Issues Checklist (Prinz et al., 1979) measuring conflict between the adolescent and their parent. All 5 domains (chores, appearance, politeness, finances, and substance abuse) are directly related to parent-adolescent conflict (average r = .51). According to Glambos and Almeida's study (1992) mothers and fathers reported higher conflict with their adolescent over household chores and fathers also reported higher conflict over politeness with their adolescent's. This study refuted Montemayor's (1983) study that conflict increases across early adolescences. Finance was the only domain that Glambos and Almeida found to increase over the period of their study. Inasmuch as this study found conflict to decrease with time and as the adolescent matured, research still needs to look more at what happens specifically to families that show an increase in conflict over the adolescents life as these young people may be at risk for later difficulties (Glambos & Almeida, 1992).

Research has found that there may be a link between parents' current relationship with their adolescent and how they perceived their own experience as an adolescent. A study of 121 adolescents between the age of 12 to 18 years old and their parents were asked to complete the Storm and Stress Scale (Holmbeck & Hill, 1988), Youth-Parent Conflict Scale (Prinz, 1979), Family Satisfaction Scale (Olson & Wilson, 1985) and a Depression Scale (Radloff, 1977). The researchers found that 48% of the parents described their adolescents as 'stormy and stressful'. The study also found that the parents who described their adolescents as a 'difficult time', also reported having a higher

level of current conflict with their own adolescent and were overall less satisfied with their family (Scheer & Unger, 1995). For example, a parent who had a negative experience as an adolescent might create undue tension or conflict in their family by assuming that their adolescent will have similar problems. Therefore, in better understanding how a parent reflects on their own past, may provide insight into the expectations they now have for their adolescent and explain the type of relationship they currently have with their daughter or son.

Studies have examined a number of variables that may have influence on the relationship between family functioning and delinquent behaviour. Variables such as broken homes, family cohesiveness, parental attitudes and parental discipline may all have influence on the adolescents' behaviour. One characteristic that has gained increasing attention by researchers is the level of communication between the adolescent and their parent (Masselam et al., 1990; Morrison & Zetlin, 1992; Clark & Shields, 1997). Communication is a key facet to understanding the dynamics of family relations. The family uses communication to define and redefine their relationship within the system and to organize themselves into predictable modes of behaviour. By understanding communication patterns within the family, researchers are better able to understand such things as cohesion, the decision-making processes and the rules and roles of the family unit (Galvin & Brommel, 1991; Clark & Shields, 1997). The inability to communicate effectively may lead to increased frustration, anger and even violence in the home (Gambrill, 1977). Conflict may become so severe within the family that any new learning or form of positive communication is effectively blocked creating intense and 'acute' conflict between the parent and the adolescent. During the conflict, the

literature describes a lack of any positive interactions, an increase focus on negative actions and a lack of problem solving skills by either the parent or the adolescent (Clark & Shields, 1997). Clark and Shield's study (1997) was conducted on 339 high school students between the ages of 14 to 19 years old, to determine whether or not the level of communication within a family had impact on delinquent type behaviour in an adolescent. The respondents were administered the Parent-Adolescent Communication Scale (PACS; Barnes & Olson, 1985) and a modified version of Elliott and Ageton's (1980) Self-Report Delinquency Scale. The study found that having open communication by the adolescent with either parent is significantly associated with less serious forms of delinquency ($F = 5.79$; $p < .01$ for maternal-adolescent communication and $F=4.27$; $p < .01$ for paternal-adolescent communication and no delinquent acts). Researchers further found that when adolescents experience problems communicating with their parents there was also a tendency for the adolescent to move towards more serious forms of delinquency. The study did conclude that open lines of communication between the parent and the adolescent are important in the prevention of delinquency. The second conclusion found that even when communication within the family unit is considered to be acceptable, the adolescent might still make a decision to commit a delinquent act.

There is extensive literature on family violence and the impact of violence on women and children (Micucci, 1995). The Canadian Panel on Violence Against Women (1993) reported that 27% of women have experienced physical violence in their relationship by their husband or live-in boyfriend. (Goldberg et al, 1994; Canadian Panel, 1993) A Toronto study of 2,910 incidents of spousal abuse found that in almost 50% of

the incidents, children were present at the time of the violence (Leighton, 1989). Studies are showing that a growing level of violence in the home is as a result of an adolescent assaulting a parent. In a study about single mothers, 29% of them reported having been physically assaulted by one of their own children (Livingston, 1986). There is evidence showing a link between adolescent assaulting their parents and addictions (Peletier & Coutu, 1992), school problems (Paulson et al., 1990) and low self-esteem. Evidence also demonstrates a further link between assaulting a parent and witnessing violence against their mothers at an earlier stage of their development (Livingston, 1986). Other studies have indicated that an assault on a parent usually occurs in the context of the parent-adolescent conflict about responsibilities, money and privileges (Evans & Warren-Sohlberg, 1988).

Overall the literature review shows that as parent-adolescent conflict intensifies, the adolescent is targeted as the 'identified problem', the family system under intolerable tension resulting in a risk of family break down (Micucci, 1995;Lavee et al., 1987; Walsh, 1998).

3.6 Substitute Care

According to Barnhorst & Johnson (1991) the 1986 Canada Census found that there are 3.4 million children and youth between the ages of 0 to 24 years old in Ontario. Of that, approximately 1.3 million are between the ages of 10 to 19 years old. Children's Aid Society's in Ontario provided service to 114,132 families with children in 1997 (OACAS, 1998). Of the 21, 328 children who required substitute care in Ontario, 49 % of these children were over the age of 13. Fifty-seven percent of the total numbers of children in-care will more than likely not return home and will rely on the Society to provide for them as a parent until they reached the age of 21 years old. (OACAS, 1998;

MCSS, 1990). A similar situation has been observed in the United States. Barth, (1986) also found that one-fourth of the children coming into the foster care system in the states of New York and Maine were adolescents.

The Ontario Incidence Study (1995) found that of the 2, 447 investigations conducted on families and children, 6% of these children had to be placed in the care of the Children's Aid Society, due to them being assessed as being 'unsafe' to remain in their family home. The study further concluded that another 5% of the children investigated were considered to be 'at risk' to being placed in the Society's care (Trocme et al, 1995). At the conclusion of the study, 57% of the investigations were closed, 16% of the investigations were closed and re-directed for services and just over one-fourth of the cases remained open for ongoing services.

From the research, it is apparent that Children's Aid Societies are dealing with a small percentage of the total number of families in Ontario. The Incidence Study found of the total number of investigation conducted during the period of their study, 26% were completed on adolescents (Trocme, 1995). The research demonstrates that it is a fairly small percentage of adolescents and their families that the Children's Aid Society deals with on an annual basis. Barth (1986), found that the reason why most of the adolescents entered foster care, was due to behavioural problems rather than inadequacies in their homes (Bernstein, Snider & Meezan, 1975; Fanshel & Grundy, 1980; Hornby& Collins, 1981). Professionals are initially faced with the adolescent being identified as 'the problem' within the family system. The adolescent's externalizing behaviour is often the focus as to why the Children's Aid Society and other professionals have become involved with the family (Glisson, 1994).

3.7 Child Maltreatment and Impact

The Ontario Incidence Study (1995) indicates that 2% of Ontario's children had been reported to the Children's Aid Society and were investigated due to allegations of maltreatment (Trocme, 1995). The Ontario Incidence Study (1995) found that 26% of their investigations were on adolescents and that 8.89 per thousand investigations on adolescents were substantiated.

A study conducted by Manion & Wilson (1995) establishes a relationship between maltreatment and adolescent risk taking behaviour including significant deficits in behavioural adjustments. The study further demonstrates a correlation between multiple exposures to maltreatment and acuteness in the symptoms manifestation.

Manion & Wilson (1995) also found that adolescents who reported histories of maltreatment also reported a higher rate of family members having problems such as mental illness 29.8%, substance abuse 42%, maltreatment 51.9% and/or criminal offences 27.7%. Adolescents reporting history of maltreatment also reported lower family cohesion, independence and organization but a higher level of conflict than adolescent who reported no history of maltreatment. The study also found that between the two groups there was little difference in social competence however the group that experienced maltreatment obtained scores that suggested poorer self-esteem in the area of general self $t\ (133) = -2.09$ and parent relations $t\ (140) = -4.90$. Thirty three percent of the maltreatment group reported having run away from home and 41.2% reported having had suicidal thoughts compared to 11.5% of the non-maltreatment group. The adolescents reporting maltreatment also reported 24.4% had been charged with a criminal offence compared to only 11.1% of other group. In both groups there was a high

percentage of youth who never tried drugs, 61.6% of the maltreatment group and 87.3% of the non-maltreatment group. However, 16.3% of the maltreatment group respondents reported occasional drug use and 54% reported occasional alcohol use.

3.8 Stress and Self Esteem

Youngs et al's (1990) confirmatory study of Johnson's et al (1980) demonstrates that adolescents' perception of negative life event and intensity of events from family situations directly impact on the adolescent's state of mental health. Adolescents are more vulnerable to the impact of family related stress. The family environment seems to be an area of mental health predictability.

3.9 Behavioural Issues

As the adolescent's behaviour and problems increase, the adolescent begins to be identified as the 'problem' and the family, school and community are less likely to respond to any of the adolescent's positive behaviour (Micucci, 1995). As the adolescent feels less understood and not supportive by their family, they are more apt to act out in a negative way within each of the systems they come into contact with on a daily basis (Micucci, 1995). Whether the adolescent is trying to conform to the family's expectations or rebelling against their family, many internal or eternal behaviour may result. Adolescents may produce internal symptoms such as depression, suicide attempts or eating disorders. The more rebellious adolescent may resort to more external behaviours such as violence, delinquency, running away or truancy from school (Micucci, 1995).

Day's (1998) study of 203 high risk youth who between the age of 6 to 12 years old had initially come into contact with the Earlscourt children's mental health service in

Toronto due to conduct problems, found that 65.9% of males and 32.9% of females came in contact with the criminal justice system before they turned 18. These children were not just coming in contact with the police they were also having school problems whereby 42% had repeated a grade and 40% were in an alternative school program for children with behavioural problems and/or learning disabilities. They also found that 83.7% of the families involved had had contact with a social service agency and 50% had been involved with a child welfare agency (Day, 1998). The study further found that of the 11 family stressors which included financial problems, housing problems, problems with the law, alcohol problems, marital problems, parental depression, other psychiatric problems, drug abuse, family violence and CAS contact, there was a means of 2.2 out of a range of 0-8. Of the 7 school problems that included academic problems, behavioural problems in the classroom, type of classroom, repeated a grade, problems with teacher, disruptive in class and disruptive in the schoolyard found a means of 3.6 out of a range of 0-7. Peer problems included no or few positive friends or did not get along well with peers found a means of .49 out of a range of 0-2. History of physical, sexual, emotional abuse or neglect found a means of .31 out of a range of 0-3. These variables seem to have some link to the child coming into conflict with the law. Whether or not these variables preclude a child coming into conflict with the law or vice versa, there seems to be more than one variable affecting these young people. One variable in itself does not seem to be the prime reason for someone having problems, conflict or needing help.

Acuteness can also be witnessed according to the Ministry of the Attorney General statistics gathered between 1988 to1989, found that 46,109 adolescents ranging between 12 to 17 years of ages as cumulates a total of 73,671 charges before the courts.

Disregarding other problematic areas, these numbers show an average of 1.4 charges per adolescent (Barnhorst & Johnson, 1991).

Howing et al.'s (1990) research article has found in the studies they reviewed that a range from 9 to 69% of the case files or self-reporting studies found that adolescents in the criminal justice system reported having been physically abused. Tarter et al. (1984) found that 44% of the abused delinquents in their study committed violent crimes of an assaultive nature compared to only 16% of the non-abused delinquents. There have been limitations to many of these studies as a result of study's design, definition, and most are self-reporting in nature. There does appear to be a relationship between delinquency and child abuse. Patterson's study (1982) indicates that child characteristics, parental inadequacies and external stressors each play a part in shaping behavioural patterns.

3.10 Drugs and Alcohol

There appears to be a correlation between the family structure and youth's substance abuse. Jenkins and Zunguze (1998), reviewed and found that several studies have shown that youth from disruptive families are more apt to misuse substances. Their study surveyed 2,229 high school students using a 163 items measuring drug use. The study found a significant difference in patterns of substance abuse between single families or reconstituted families structures and intact families. It appears that adolescent from the former structure need more comprehensive helping strategies than the later group. The study implies that healthy family processes temper the need for multiple source of support and therefore may contribute to a lesser need for outside resources to cope or address substance abuse related issues.

It was discovered in a study completed by the Addictions Foundation of Manitoba (1997) surveying 3,528 high school students that addiction problems start at around 13 years old and are related to school and family problems. The study also showed that adolescents using substances are more likely to exhibit riskier behaviour, experience isolation and tend to deny the need for help.

3.11 Runaways

In 1988, 72% of the children missing in Canada were runaways of which 65% were repeat or habitual runaways (Daley, 1989). In the United States on any given night, there may be over one million adolescents on the run (Coco & Courtney, 1998; National Runaway Switchboard, 1993; Burgess, 1986). Fisher (1989) found in the study of 341 repeat runaways that 36% of them were victims of abuse. The study also found that 69% of the adolescents on the run were reported to have used various substances such as alcohol, marijuana and hashish. Also, 80% of the adolescents in this study had reported delinquent type behaviour such as shoplifting and stealing money. The study also found that 45% of the respondents of this study were on the run from institutions or foster care.

Coco & Courtney (1998) found in their study that young females were more likely to be homeless and they tend to engage in problematic behaviours such as vagrancy, sexual promiscuity, prostitution, and suicidal attempts. Not only was the sample engaging in problematic situations but, their original family system was highly dysfunctional. This is further seen in Schaffner (1998) qualitative study who also found themes of chronic and acute family dysfunction, physical and sexual abuse, parenting styles, neglect, abandonment and drug use as sources of conflict that resulted in the adolescent running away from home.

For the adolescent, running away is very much seen as a last dramatic resort to dealing with longstanding problems or conflicts within the family (Sharlin & Mor-Barak, 1992). Not only do they run away from home, but also from various substitute care providers such as foster homes, shelters and residential treatment facilities (Schaffner, 1998). The longer the adolescent is without the family structure or a substitute structure, the more likely they are to engage in criminal activity in order to survive (le Roux & Smith, 1988).

3.12 Children's Mental Health

According to the Ontario Association of Children's Mental Health Centres (1998), 18 percent of Ontario's children have a psychiatric disorder that equates to about 500,000 children. There are 90 children's mental health agencies in Ontario that serve 117,000 children in day and residential treatment programs on an annual basis. These are the children who have been identified by teachers as causing havoc in their classrooms and by parents who are stressed by their children's behaviour in their home. They may also have been identified through the legal system as youth in conflict with the law who seem to have extensive problems at home, in school and now within the community.

Studies have found that adolescents between the ages of 14 to 15 are more likely to use mental health services than any other group of children (Rosen, Bahn, Shellow & Bower, 1965). Mitchell and Smith (1981) found of the 185 files they reviewed from a youth health care center, there were more self-referrals by adolescents between the age of 15 and 16 than any other grouping. Roughmann et al. (1982) also found a higher percentage of youth between the age of 15 to 17 years old using mental health services in Munroe County, New York.

In 1971, Finlay & Randall (1975) found that at any given time, there were approximately 300 adolescents in Toronto without adequate support services. Often due to the adolescent's behaviour, they were not able to be served in various school programs and were looked upon as untreatable by many mental health services. John et al., (1995) collected data on 1, 587 randomly selected children between the age of 6 to 16 years old by using data collected from parents, teachers and youth aged 12-16 through using a structured self-administered questionnaire. They also created a scale to measure psychiatric disorders. These items where chosen from the Child Behaviour Checklist (Achenback & Edelbrock, 1981) to represent DSM-III criteria for specific disorders. Their study looked at what factors may predict the use of mental health and social services by children 6-16 years old. What they found was that only 6.2% of the respondents had used mental health/social services. There was almost of 50/50 split between males and females in the study and 49.3% of the respondents were between the age of 12 to 16. There was fairly low correlation among the candidate's variables of age, sex, psychiatric disorder, child chronic medical problems, social impairment, school performance, maternal level of education, family dysfunction, family income and parents treated for nerves. The study noted that the highest positive correlation was between poor school performance and presence of social impairment ($r=.18$, $p<.001$) and between maternal post-secondary education and family income about $10,000 ($r=.15$, $p<.001$). Through further analysis using relative odds in stepwise logistic regression, the study found that children who had a psychiatric disorder were more likely than children without a psychiatric disorder to have a higher rate of service use when their school performance was also poor (Ors = 2.48 and 0.57, respectively). There was also a higher association

between a child using services than not using services when they are identified to have a psychiatric disorders and one of their parents are being treated for a nervous conditions (Ors = 3.09 and 1.19 respectively). The association found in the study between family income and school performance was highly associated with service use. Low-income families in the presence of poor school performance were a stronger predictor of using mental health services than low-income families and good school performance. Their findings were supported by other studies that low-income families no matter whether the child was doing well or not in school were more likely to use mental health services. The conclusion of this study found that a child having a psychiatric disorder does not in itself preclude the use of mental health services. However, the study did find that the association with service use was more correlated with prior parental use of service, low-income families and a child's school performance.

3.13 Suicide

Suicide has increased by 35% among adolescents 15 to 19 years old and it is the third leading cause of death in this age group (Cleary, 2000). This study also found an association between an adolescent being victimized in school and the risk of suicidal and/or violent behaviours. In the study, 49% of the students reported no suicidal or violent behaviour. Twelve percent reported suicidal behaviour, 11% reported both suicidal and violent behaviour and 28% reported only violent behaviour. Of the students who reported having been victimized they were 1.4 to 2.6 times greater to have suicidal or violent behaviours.

3.14 Support Services

Social support has a clear correlation in promoting and developing children and youth's ability to adapt to various issues such as reducing stress, increasing one's school grades and providing valuable support to a high risk youth and their family (Whittaker, et al., 1995). Support can be from family members, peers, school or other community organizations (Richman, Rosenfeld, & Bowen, 1998). The type of support can come in the form of listening support, emotional support and professional counselling support (Richman, Rosenfeld & Bowen, 1998). In reviewing the files, it was noted that a high percentage of the families and the adolescents had various services currently or previously involved with them. Social workers often provide services to families and children. When one reviews these files, these adolescents and their families are often being served by Children's Aid, Children's Mental Health services, Young Offender services and school. These services need to collaborate their services in order to provide the best support to the adolescent and their family. By using support as an intervention strategy to positive change, the family unit can only benefit from this approach (Richman, Rosenfeld & Bowen, 1998).

3.15 School

Every year in Ontario, 70,000 young people will drop out of school before they graduate (Barnshort & Johnson, 1991). In 1986 to 1987 the Ontario Education Statistics found that 40,000 young people will re-enter high school after having left for a period of time. Almost half of the re-entry students are over the age of 21 and about one-half of these people will in fact graduate with a diploma (Karp, 1988). Further studies have found that children in the basic (79%) and general levels (62%) are more likely to drop

out of school than students who are enrolled in advance levels (12%) of an academic program (Radwanski, 1987).

It is important to look at what factors relate to academic achievement, academic level and the drop out rate. Masselam et al. (1990) conducted a study of two groups of adolescents. The one group consisted of 40 families who had an adolescent attending an alternative school program. The other group consisted of 52 families with an adolescent in a regular school program. Both groups consisted of primarily white, upper-middle class families from northern Virginia County. The sample consisted of males and females, age 14 to 18 and that were in grades 8 to 12. The adolescents and families had to complete the Family Adaptability and Cohesion Evaluation Scales (FACES III; Olson, McCubbin, Barnes Larsen, Muxen & Wilson, 1985). They were also administered the Parent-Adolescent Communication Scale (PACS; Barnes & Olson, 1985) which is used to determine openness or freedom to exchange ideas, information and concerns between the generations, trust or honesty experienced, and the emotional tone of interactions. Of the children in the alternative school program, 62.5% of them had been suspended or repeated a grade, 45% had been on probation and 25.6% indicated some form of substance abuse, as compared in the other group, in which none of them reported these same characteristics or problems.

School performance can further be affected when an adolescent scores in the IQ range of 71 to 84, which is one standard deviation below average (Masi et al., 1998). In a qualitative study, the findings saw these young people struggling with many aspects of school due to cognitive impairment, learning disabilities, withdrawal, apathy and lack of motivation to learn. The youth often experiences low self-esteem as they struggle within

their school program and feel little success within the classroom setting (Masi et al., 1998). When a child is not feeling success at school due to learning disorders then they are two to three times more likely than the normal population to have incidence of depressive disorders (Huntington & Bender, 1993). Peck (1985) also found that 50% of the adolescents he investigated for suicide were also diagnosed with a learning disability. Weak cognitive abilities may lead the adolescents to having low self-esteem, behavioural disorders and increased feelings of frustrations, depression and anxiety within the education system, at home and in the community (Weisz et al., 1993).

3.16 Case Complexity

Holland, (1998), created a tool to diagnose cases in order to classify them. Child protection cases vary by the number of issues and their multi-dimensionality. The combination of the number of issues, frequency of issues and nature of issues seems to make emerge a scale from which the concept of complexity emerged. In developing his tool, Holland demonstrated that not all cases are equal. He was able to also demonstrate that complexity of cases should alter funding. The result of his work generated a 96 item checklist assessing case complexity within the Ontario child welfare system.

3.17 Summary

The literature review focused on parents and youth and how their behaviour and actions have affected the family. Janko, (1994), Bibby & Posterski, (1992), and Garbarino, (1986), all clearly show that there is no one family variable that will cause a youth to be at risk, or a family to be in conflict. The literature shows that there are normal and natural levels of conflict in every family. Acute conflict seems to change the families' ability to function and results in the family needing additional support services

to get through the difficult time to the extent to have to remove the adolescent from the family.

There is a great deal of research to review when it comes to looking at adolescents, their behaviour and needs. There is however, a limited amount of research specific to adolescents in-care or coming in contact with any Children's Aid Society. The research does look at the foster care system, and why children are in-care, but little research has been done around the reasons as to why 13 to 15 year olds come into care or contact with any child welfare organization. There is also limitations to the research as to what are these young person's needs and how do agencies respond to these adolescents needs. In reviewing the literature, there is extensive research on adolescents, their behaviour and actions and how this impacts and creates conflict within the home. No research has isolated one specific variable explaining adolescents experiencing problems at home, school or within their community. If no single factors were found a combination of factors seems to better explain the phenomena. Researchers exploring adolescent difficulties in families, at home or at school have exploited the symptomotology. Little effort has been deployed to understand the cause of the adolescent experiencing acute crisis situations.

The literature does not demonstrate the causality between specific factors and specific problematic behaviour. The literature however shows, that specific factor combinations generate an array of problematic behaviours. Nonetheless, no studies have yet demonstrated that specific variables or set of variables explain the probability of an adolescent coming into care.

The work done by Holland on case complexity seems to bring the beginning of an explanation as to why an adolescent is more likely to be brought into care. His 96 item checklist defines case complexity. These items correspond to the variables privileged by a social worker in assessing the need for an adolescent to come into care.

When families contact the CAS for services, child protection workers need to be able in a crisis situation to complete a comprehensive assessment on these families. The literature shows that multi-variables of issues and problems within a family unit can define how complex these troubled families are and usually come in contact with the CAS in an acute stage of crisis.

It is essential for workers to understand that the actual behaviour being portrayed by the adolescent is usually due to another variable such as abuse, neglect, school problems or family problems. Competent and comprehensive assessments are critical for effective social work intervention with dysfunctional families (Combs-Orme & Thomas, 1997).

4.0 Method

4.1 The Setting

The setting for this study is the Children's Aid Society of Kingston and Frontenac County. This provincially funded non-profit organization serves a population of 116,000 people. The mandate of the organization is defined by the *Children Family and Services Act* (2000). The Society's primary role is to investigate referrals related to child protection. Around 90 employees act in concert providing child protection services. The organization is team based and presents its intervention services on a continuum: Intake

or Assessment Services, Children and Family Services, In-care Services. Related to its primary function the Society offers diverse programs including foster care and adoption. After a referral meeting the eligibility spectrum is received at the intake services and investigation is engaged. A twelve factors assessment determines the immediate need of protection. Thereafter, and depending on the situation, a risk assessment will determine further potential risk. At this point a child protection worker will establish whether or not there is a need for the child to remain in her/his current location or environment.

4.2 The Population

The population of this study consists of teenagers experiencing intense parent-child conflict requiring intervention of the Children's Aid Society. It is practically impossible to empirically validate the actual number of teenagers that form this population because: 1) there is no national summary statistics available and, 2) many Parent-Child conflicts requiring Children's Aid Society intervention are not reported. However, for the purpose of this study, the population will be determined by the total of teenagers served by the Society during the period where the sample was collected. Between 1998 and 2000 107 teenagers were served by this agency.

4.3 Samples

The total sample had a potential of 270 subjects. The two samples were randomly selected from the Kingston CAS. The samples of this study consist of teenagers aged between 13 and15 years old that have experienced a Parent-Child conflict, have been in contact with CAS and meet the criteria for service under the Eligibility Spectrum (Ontario Association Of Children's Aid Society, 2000). The Society's computer was programmed to provide a randomized sample based on the aforementioned criteria. This

programmed categorization produced two distinct sets of samples meeting the purpose of the study: *in-care* and *at home*. Computer's commands were provided to further select potential candidates to equalize the number of female or male subjects. The samples should not be construed as statistically representative of the population. The study is not meant to be generalized to a larger population, but its method might be extended to use in a larger-scale representative study.

There are two sets of samples. The first one mainly child protection issues parent and child conflict, behavioural issues, caregiver with a problem. The second one child protection with similar characteristics but did not require in-care services.

Sample 1 (n_1) *In-care*

The first sample (n_1) is a non-probability sample that was drawn from both active and inactive client files contained in the Front-Line Database Computer System between October 1999 and October 2000 generating a total of 174 potential children *in-care* or having been in-care. Out of this number 56 subjects were between the age of 13 and 15 at the time they were apprehended or ordered into care. This randomized sample selection represents 32 percent of the in-care population of the database.

Sample 2 *At Home.*

The second sample (n_2) is a non-probability sample that was drawn from both active and inactive client files contained in the Front-Line Database Computer System between January 1996 and December 1998 generating 96 potential subjects. From this total 40 were extracted based on the criteria that these children did not come into care and were aged between 13-15. This represents 42 percent of the Society internal database.

4.4 Procedure

The Holland Complex Care Case Review Data Collection Instrument developed by Patrick Holland (1998) was used for this study. The checklist instrument totalize 98 items grouped into nine dimensions. The instruments reliability has not been established. Ninety-two items were selected for the purpose of this research. Case weight, degree of risk, amount of time regularly committed per month, amount of case activity per month and total case weighting were rejected based on the absence of data from the files. Selected clients' files were manually examined and information related to the 92 items from non-standardized instrument was extracted. Only one reader executed the reading of the files to minimize biases, increase internal validity avoiding judgement diversity. Data collected were compiled, computed and analyzed using SPSS version 10 a.

4.5 The Instrument

The instrument presents 6 demographic-items, 9 dimensions and one 'other' category (Appendix A).

4.6 Description

Demographics. This included: Age, Status of child, placement type, Sex, new admission or re-admission

History of Abuse. This refers to the following items: child has been physically abused, child has been sexually abused, child has been emotionally abused, child has been neglected/ developmentally, child has been neglected-medically, child has experience abandonment, child was a victim of abuse while in foster care,

Behavioural Issues. This implies: child abuses alcohol, or non prescription drugs, child is abusive toward other children, child has been a fire-setter, child has previously

sexually molested other children, child engages in sexually inappropriate activities or exercises poor judgement in this area, child's behaviour are precipitating calls from the community.

Health- Physical. This consists of child is physically disabled, child suffers from foetal alcohol syndrome, child is "medically fragile", child has suffered a traumatic brain injury, child suffers, or has suffered, from sexually transmitted disease, child is suffering from a life-threatening illness or disease, child is anorexic or bulimic, child is on prescribed medication that must be monitored closely.

Health – Mental/Psychological. This involves: child exhibits symptoms suggestive of ADHD/ADD, child exhibits symptoms suggestive of a behaviour disorder, child has been diagnosed as autistic, child is developmentally disabled, child threatens or has attempted suicide, child is self mutilating, child is a bed-wetter, and encopretic or smears faeces, child has tortured or harmed animals, child shows no remorse for his/her hurtful or criminal acts, child has been found responsible for a serious offence (e.g. murder), child displays behaviours consistent with poor self-esteem, child's sibling or 'significant friend or relative' is suffering from a life threatening disease or illness, child has been diagnosed as suffering from a dual-diagnosis disorder.

Parent – Related Issues. This refers to: child has witness violence directed toward a sibling or parent, by a parent or caregiver, in his/her own home on more than one occasion, parent is suffering from a life threatening illness or disease, custody or access presents conflict for the child (e.g. parent doesn't visit, or visit regularly, or there is open conflict between the parents over custody), child's parent is suffering from a mental health disorder, child demonstrates fear of a parent with whom he/she has required

access, poverty in the child's family is an issue of concern for the child, the child's parent lacks the capacity to assume parental responsibility ('or parent child conflict if not in-care' was added, child's parent is abusing/has abused alcohol or drugs, parent has been diagnosed as having an untreatable character disorder, parent has unresolved issues related to their abuse has a child that are negatively impacting upon the treatment needs of their child while he/she is in-care, parent is in conflict with the CAS intervention or treatment plan, parent is in direct conflict with the child foster parent while the child is in-care.

Relationship Issues. This means: child is abusive toward children, child displays indications of an attachment or bonding disorder, child displays poor social skills, child is manipulative in his/her dealing with peers, child displays confusion about their gender identify, child identifies him/herself has a homosexual, child is experiencing scapegoat or racism at home, placement, school or in the community.

Legal Issues. This includes: child is ('or has been subject' was added) subject to an order under the YOA and Child is subject to an order from family court and another (or more) court hearings are likely to affect his/her status and placement.

Placement Issues. This comprises: Child has stolen from others within a foster or group home residential setting, child has been in more than two placements with respect to his/her current admission to care, child has been admitted to care more than once, or has experienced a number of changes in primary caregiver during his/her life, child has run away from home or from his/her placement(s) while in-care, child has not experienced stability in their place of residence, child is a placement outside his/her home community, child is in conflict with their foster parents (or 'conflict with parent if not in-

care' was added), child is in conflict with other children in their placement, child is inappropriately placed (i.e. it is in the worker's judgement that the placement does not match the child's needs), child requires in-home one-to-one support in order to sustain their placement, frequent scheduling problems encountered in facilitating access visits, significant time invested in arranging relief placements for child.

School – Related Issues. This contains: child has symptoms suggestive of a learning disorder, child is experiencing academic problem at school, child is experiencing social problems at school, child presents management problems at school and requires in-school one-to-one support

The instrument was adapted for research purposes. The items under the 'other' category from the original version were redistributed in the already existing dimensions as indicated in the figure 1.

Figure 1 Items Dimensions or Category

Child is pregnant	Demographic
Child has a sibling at home	Demographic
Child has a sibling in-care	Demographic
Child's race, religion or culture precipitates conflicts or stress for the child	Relationship issues
Child is native Canadian	Demographic
Child grew up in an environment where criminal activities were socially acceptable	Parent related issues
Child has needs that cannot be addressed because of lack of placement, treatment of environmental resources (e.g. waiting list or lack of a need resources in the community)	Behaviour Issues
Child is oppositional to CAS intervention or treatment	Behavioural
Access visits by the child his/her parents or siblings are required to be supervised	Relationship issues
Child is a parent caring for a child while both are in-care	Relationship
Child is involved in a number of program, the shear number of which creates	Behavioural Issues

confusion or conflict for the child	
Child participation in placement review, case planning legal or treatment conferences is judged to precipitate conflict or confusion for the child rather than a sense of control	Behavioural issues
Child placed with "part" racial match	Demographic
Child place together with sibling	Demographic
Child exhibits bizarre behaviours – FP's anxiety requires labour intensive support	Behaviour Issues
Child has been physically abusive toward parent	Behaviour

4.7 Reliability and Validity.

The instrument has no reliability and validity established, however when the sample size is sufficient in the future, the psychometric properties of the instrument would be scrutinized.

4.8 Limitation

This study presents some limitations.

1) The two samples come from different time frames. The time frames are relatively closed and, therefore, it is believed to be a major limitation as different sets of policies and different legislation succeeded.
2) Not all files were complete in their recordings. Some information related to some items could be missing.
3) Different workers completed their assessments and recordings. Different styles and observations may indicate different information.
4) Different level of experience of the different workers. A more experience worker may underline many different factors. Therefore, information gathering may vary considerably.

4.9 Ethics and Confidentiality

To protect the identity of the subjects, codes were assigned to replace names. Data allowing possible identification such as location and number of siblings were eliminated or not used.

5.0 Results and Discussion

5.1 Descriptive Analysis

Demographics

The age of the respondents ranged between 13 and 15 years old. Almost thirty nine percent of the respondents were 15 years of age, 37.5 were 14 years old and 24 percent were 13. Sixty percent of the respondents were female and 40% were male. The files did not indicate any female subjects being pregnant. There was no indication of any subject having a native background. Twelve percent of the sample had a sibling in-care where as 76% had a sibling still in the home.

Forty two percent of the total sample had never been in-care before and the remaining 58 percent was divided as followed: 32.3% being admitted in-care for the first time and 26% having been re-admitted into care.

Of the 40 percent of subjects who never been in-care of the Society, this group identifies home as being their primary placement. Eighteen percent of the sample is living in CAS approved foster homes, 15 % are living in outside paid resources and the remaining 28% were living with extended family or on independent living.

Forty two percent of the sample was residing at home or with extended family, 29 percent were Crown Ward with Access, 14 % were Society Wards, 2% were under an Interim care and Custody Order, 6% were in-care under a temporary care agreement and 7 % of the sample were classified as Extended Care and Maintenance. Table 1 shows the distribution of gender between the In-care and In Home groups.

Table 1

Gender of the Subjects for the In-care and In Home Groups

Group		Frequency	Percent	Valid Percent	Cumulative Percent
In-care	Male	25	44.6	44.6	44.6
	Female	31	55.4	55.4	100.0
	Total	56	100.0	100.0	
In Home	Male	13	32.5	32.5	32.5
	Female	27	67.5	67.5	100.0
	Total	40	100.0	100.0	

Table 2 shows the total score for the two groups. The In-care group shows the highest score of the two groups. History of abuse, relationship issues and placement issues ranked the three highest score.

Table 2

Total Score for the In Home and In-care Groups for each Dimension

	In-Care		At Home	
	None or One Frequency (Percentage)	Two and more Frequency (Percentage)	None or One Frequency (Percentage)	Two and more Frequency (Percentage)
History of Abuse	19 (33.9)	37 (66.1)	29 (72.5)	11 (27.5)
Behavioural issues	27 (48.2)	29 (51.8)	31 (77.5)	9 (22.5)
Health – Physical	36 (64.3)	20 (35.7)	38 (95.0)	2 (5.0)
Health – Mental/Psychological	25 (44.6)	31 (55.4)	31 (77.5)	9 (22.5)
Parent related issues	23 (41.1)	33 (58.9)	28 (70.0)	12 (30.0)
Relationship Issues	22 (39.3)	34 (60.7)	33 (82.5)	7 (17.5)
Legal issues	24 (42.9)	32 (57.1)	27 (67.5)	13 (32.5)
Placement Issues	22 (39.3)	34 (60.7)	36 (90.0)	4 (10.0)
School related issues	34 (60.7)	22 (39.3)	28 (70.0)	12 (30.0)

Table 3 shows the means scores for each dimension (categories of factors). The two groups presents a distinct different in the factor profile. The means scores of In-care

group represents the double of almost all the In Home group means scores. Placement issues ranks first as a dimension for the In-care group with a means of 3.42 followed with Parental issues with a means of 3.12. Parental issues ranks first for the In Home group with a means of 1.97 closely followed by Mental Health (1.80) and School related (1.75) issues. To be noted, none of the dimensions of the In Home group is above a means of 2 while only three dimensions of the In-care group is below the same mark.

Table 3

Means Score for each Dimension for In Home and In-care Groups

In-care N = 56 In Home N = 40	Mean	Median	Mode	Std. Deviation
History of Abuse				
In-care	2.12	2.00	3.00	1.19
In Home	.80	.50	.00	.91
Behavioural Issues				
In-care	1.60	2.00	.00	1.39
In Home	.87	1.00	.00	.88
Health Physical Issues				
In-care	.39	.00	.00	.56
In Home	.12	.00	.00	.56
Mental/Psychological Health Issues				
In-care	2.92	3.00	2.00	1.70
In Home	1.80	2.00	2.00	1.06
Parental Issues				
In-care	3.12	3.00	2.00	1.59
In Home	1.97	2.00	2.00	.99
Relationship Issues				
In-care	2.00	2.00	2.00	1.38
In Home	.75	1.00	.00	.80
Legal Issues				
In-care	.76	1.00	.00	.76
In Home	.32	.00	.00	.47
Placement Issues				
In-care	3.42	3.00	2.00	2.14
In Home	1.65	2.00	1.00	.66
School-related Issues				
In-care	2.25	2.00	2.00	1.22
In Home	1.75	2.00	2.00	1.05

History of Abuse

The comparison of group means regarding the history of abuse reveals that the means of this factor decrease with age indicating male subjects of In-care 13 years of age are more likely to score higher in that dimension than male of 14 and 15 years old. The opposite is observed for females. Fourteen and fifteen years old female subjects have similar scores as thirteen years old male. Age does not seem to be a factor influencing the means for female in this category. All subjects of the In Home group shows a means lower than 1 except for female subject age fourteen indicating history of abuse being less predominant for this category.

Behavioural Issues

Behavioural issues seem to greatly affect In-care male subjects across the age range 13 to 15 with a means of 2.00. At the age of fourteen a slight decrease (1.41) is recorded compared to fifteen (1.88). Female In-care subjects seem to experience consistent behavioural difficulties until the age of 15 where the means dropped from 1.85 to 1.08. In Home male subjects age fourteen seem to experience more behavioural difficulties with a means if 1.67 than they did at the age of 13 (.50) and 15 (1.25). In Home Females seem to be the group that registers the lowest impact of behavioural related issues with an average means at .72.

No significant means were recorded for Physical Health related issues.

Mental/Psychological Health related issues

Across the age range male In-care subjects have a steady means score of 2.80 regarding mental health issues. Their In Home counterpart scored 1.67 at the age of 13, 2.67 at the age of 14 and slightly decreases at 1.75 at the age of 15. Fourteen year old In-

care female subjects show a means at 3.85 compared to 2.34 and 2.84 for the age of 13 and 15. This means significantly decrease for the female In Home group with a means ranging from 1.16 to 1.84 for the age of 13 and 15.

Parental Related Issues

This factor once again splits the two groups. In-care male and female subjects of all age groups have a means ranging from 2.92 to 3.50 indicating experiencing an important amount of parental related issues compared to the In Home male and female subjects who share a means of 1.5 to 2.18. The only pattern recorded seems to be the "Factor Fourteen". The 14 years old detain the pick of the means of all groups.

Relationship Related Issues

In-care male subjects seem to increasingly experience relationship difficulties as they progress in age going from a means of 1.37 to 1.75 to 3.01. It appears different for the In Home male group who demonstrate a more stable means in that area .82. The In-care female group also experience an increase in relationship difficulty however with less intensity or acuteness ranging from 1.58 to 2.50 than their In-care counterpart. The In Home female subjects seem to experience the lowest degree of difficulty with relationship with an average means of .60.

Legal Related Issues

In-care male subjects of the age of fourteen seem to have the highest means (1.67) referring to legal issues. Males In Home also has the highest means (1.00). No significant means recorded for In-care and In Home female subjects across all group age.

Placement Related Issues

In-care thirteen years old male subjects record the highest placement related issues with 4.40, followed by 15 years old at 3.50 and by fourteen years of age at 2.91. In-care female subjects seem to experience less placement related issues as they advance in age going from 4.16 to 3.84 to 2.66. In Home male subjects seem to experience a similar pattern as their counterpart In-care. The difference between in-care and in home means appears important with a gap of 50% in between. In Home Female subjects represent the most stable group with an average means of 1.63.

School Related Issues

In-care male subjects seem to experience less school related issues as they advance in age with 3.00 at age 13, 2.16 at age 14 and 1.62 at age 15. However, In Home male subject seem to follow the exact opposite pattern. School related issues seem to increase with age 1.66 at age 13, 1.50 at age 14 and 2.66 at age 15.In-care female subjects follow the same pattern as the In-care male subject with a means of 3.00 at the age of 13, 2.46 at the age 14 and 1.83 at the age of 15. In Home female subjects show little variance in the means across all age with a means of .83 at the age of 13, .83 at the age of 14 and .70 at the age of 15.

5.2 Other statistical analysis

In order to examine the extent to which certain factors influence the professional judgement of workers in determining the need to bring an adolescent into care and to isolate main factors related to the determination of the need, a non-parametric test was performed namely spearman rho correlation test. Table 4 shows the results.

Table 4

Child *In-care* and *In Home* Correlation Matrix of Dimensions

Group			Behavioural Issues	Health Physical	Mental Psy. Issues	Parental Issues	Relationship issues	Legal Issues	Placement Issues	School Related Issues
In-care N = 56	Behavioural Issues	Pearson Correlation								
		Sig. (2-tailed)								
	Health Physical	Pearson Correlation	-.031							
		Sig. (2-tailed)	.818							
	Mental/Psychological Issues	Pearson Correlation	.423	.201						
		Sig. (2-tailed)	.001	.138						
	Parent-related Issues	Pearson Correlation	.063	.188	.050					
		Sig. (2-tailed)	.644	.166	.714					
	Relationship Issues	Pearson Correlation	.459	-.093	.354	.057				
		Sig. (2-tailed)	.000	.494	.008	.674				
	Legal Issues	Pearson Correlation	.357	-.080	.351	.129	.343			
		Sig. (2-tailed)	.007	.556	.008	.344	.010			
	Placement Related Issues	Pearson Correlation	.512	.054	.446	.249	.360	.495		
		Sig. (2-tailed)	.000	.694	.001	.064	.006	.000		
	School Related Issues	Pearson Correlation	.398	.040	.488	.142	.449	.316	.477	
		Sig. (2-tailed)	.002	.772	.000	.297	.001	.018	.000	
In Home N = 40	Behavioural Issues	Pearson Correlation								
		Sig. (2-tailed)								
	Health Physical	Pearson Correlation	-.226							
		Sig. (2-tailed)	.161							
	Mental/Psychological Issues	Pearson Correlation	.272	.000						
		Sig. (2-tailed)	.089	1.000						
	Parent-related Issues	Pearson Correlation	.084	-.176	-.221					
		Sig. (2-tailed)	.608	.276	.170					

Relationship Issues	Pearson Correlation	.207	-.042	.089	.119			
	Sig. (2-tailed)	.201	.796	.584	.465			
Legal Issues	Pearson Correlation	.283	-.156	.182	.072	.217		
	Sig. (2-tailed)	.077	.337	.260	.660	.178		
Placement Related Issues	Pearson Correlation	.362	-.086	.189	.219	.168	.453	
	Sig. (2-tailed)	.022	.598	.244	.175	.301	.003	
School Related Issues	Pearson Correlation	.186	.011	.182	-.176	.435	.371	.055
	Sig. (2-tailed)	.251	.947	.261	.277	.005	.018	.736

** Correlation is significant at the 0.01 level (2-tailed).
Correlation is significant at the 0.05 level (2-tailed).

Table 4 shows an increase of behavioural issues, relationship issues, placement issues and school issues as the number of mental health issues increase for the subjects of the In-care group. The same subjects seem to experience more relationship related issues as they experience placement and school related issues. The In Home and In-care groups share similar pattern of experiencing legal related issues affecting placement. The In-care group presents numerous inter-related difficulties whereas the In Home group seems to experience more difficulties related to placement when they experience legal difficulties or school related difficulties when experiencing relationship difficulties. No other correlation has been established for the In Home group. This confirms that In-care group present more complex profile as it refers to the instrument used for this study. The next step consisted in splitting the groups based on gender to seen if different patterns further existed between male and female In-care and In Home groups. Table 5 show the results.

Table 5

Correlations Matrix of the Nine Dimensions of the Holland Modified Instrument

Gender of the Child Male N = 25		Behav.	Health	Mental	Parental	Relation.	Legal	Placem.	School
Behavioural Issues	Pearson Correlation								
	Sig. (2-tailed)								
Health Physical Issues	Pearson Correlation	-.193							
	Sig. (2-tailed)	.356							
Mental Psy. Issues	Pearson Correlation	.367	.014						
	Sig. (2-tailed)	.071	.945						
Parental Issues	Pearson Correlation	-.020	.303	.039					
	Sig. (2-tailed)	.925	.141	.854					
Relationship Issues	Pearson Correlation	.384	-.234	.372	.084				
	Sig. (2-tailed)	.058	.260	.067	.689				
Legal Issues	Pearson Correlation	.218	.039	.473	.104	.440			
	Sig. (2-tailed)	.296	.854	.017	.620	.028			
Placement Issues	Pearson Correlation	.322	.015	.463	.174	.299	.358		
	Sig. (2-tailed)	.116	.943	.020	.405	.147	.079		
School Related Issues	Pearson Correlation	.409	-.162	.610	.219	.537	.295	.636	
	Sig. (2-tailed)	.043	.439	.001	.293	.006	.152	.001	
Female N=31									
Behavioural Issues	Pearson Correlation								
	Sig. (2-tailed)								
Health Physical Issues	Pearson Correlation	.070							
	Sig. (2-tailed)	.708							
Mental Psy. Issues	Pearson Correlation	.481	.280						
	Sig. (2-tailed)	.006	.127						

Parental Issues	Pearson Correlation	.124	.122	.076					
	Sig. (2-tailed)	.505	.514	.685					
Relationship Issues	Pearson Correlation	.530	-.010	.339	.045				
	Sig. (2-tailed)	.002	.957	.062	.812				
Legal Issues	Pearson Correlation	.474	-.148	.366	.129	.310			
	Sig. (2-tailed)	.007	.428	.043	.488	.089	.		
Placement Issues	Pearson Correlation	.675	.081	.454	.320	.416	.659		
	Sig. (2-tailed)	.000	.665	.010	.079	.020	.000		
School Related Issues	Pearson Correlation	.399	.171	.417	.083	.366	.385	.329	
	Sig. (2-tailed)	.026	.357	.020	.659	.043	.032	.071	.

Male in Home N = 13

Behavioural Issues	Pearson Correlation								
	Sig. (2-tailed)								
Health Physical Issues	Pearson Correlation	.	.	.	.	.	.	.	.
	Sig. (2-tailed)	.	.	.	.	.	.	.	.
Mental Psy. Issues	Pearson Correlation	.602	.						
	Sig. (2-tailed)	.030	.						
Parental Issues	Pearson Correlation	.125	.	-.344					
	Sig. (2-tailed)	.684	.	.250					
Relationship Issues	Pearson Correlation	.107	.	.226					
	Sig. (2-tailed)	.728	.	.457					
Legal Issues	Pearson Correlation	.590	.	.198	.197	.259			
	Sig. (2-tailed)	.034	.	.517	.520	.393			
Placement Issues	Pearson Correlation	.314	.	.066	.471	.455	.570		
	Sig. (2-tailed)	.296	.	.829	.104	.119	.042		
School Related Issues	Pearson Correlation	.179	.	.359	-.268	.699	.411	.138	
	Sig. (2-tailed)	.560	.	.229	.376	.008	.164	.653	.

Female In Home N = 27									
Behavioural Issues	Pearson Correlation								
	Sig. (2-tailed)								
Health Physical Issues	Pearson Correlation	-.250							
	Sig. (2-tailed)	.209							
Mental Psy. Issues	Pearson Correlation	.110	.016						
	Sig. (2-tailed)	.584	.935						
Parental Issues	Pearson Correlation	.069	-.197	-.181					
	Sig. (2-tailed)	.731	.324	.366					
Relationship Issues	Pearson Correlation	.238	.003	-.046	.182				
	Sig. (2-tailed)	.231	.988	.819	.362				
Legal Issues	Pearson Correlation	.121	-.164	.153	.020	.106			
	Sig. (2-tailed)	.547	.414	.447	.919	.600			
Placement Issues	Pearson Correlation	.389	-.111	.258	.138	.027	.423		
	Sig. (2-tailed)	.045	.582	.193	.491	.893	.028		
School Related Issues	Pearson Correlation	.183	.026	.070	-.147	.255	.340	.018	
	Sig. (2-tailed)	.361	.896	.728	.465	.199	.082	.928	.

* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).
. a Cannot be computed because at least one of the variables is constant.

Table 5 show the different correlations obtained for the four sub-groups. Male In-care seems to experience more mental health related issue, relationship issues and placement issues as they experience an increase of school problems. Female In-care seems to experience more mental health; relationship, legal and placement relate issues as their behavioural problems increase. Except for males experiencing school problems as they increasingly experience behavioural related issues, no other correlation is recorded for the male or female In Home groups.

5.3 Limitations

There are some limitations to this study. The most significant was the sample size, which was small, according to research standards, and, therefore, prevents inferring overt generalizations. Also the latter prevented for testing the questionnaire in order to meet the requirement of reliability and validity. Therefore, the reliability and validity of the questionnaire is thus suspect until scrutinized with a larger sample size.

The nature of the study i.e. exploratory-descriptive can also be partially held accountable for the limited comparative studies to confirm or contradict the results obtained. The nature of the study is not exclusively responsible for this situation, the uniqueness of this study also contributed.

6.0 Impact on the Profession Of Social Work

The literature shows that there has been a dramatic increase in adolescents coming into and staying in-care of Children's Aid Society's across Ontario. From this study, it is apparent that most adolescents are in-care as a result of having problematic and multiple behavioural issues. For social workers and child protection workers who work with this population, they must understand the problems facing parents and adolescents today. Social workers and child protection workers working with these families need to gather information from each member of the family system and from the other systems that are impacting on the family in order to complete a comprehensive assessment. Research has demonstrated that in addition to an assessment, the use of standardized instruments should also be used with the family to complete a thorough assessment. In order to be effective with these families, workers must have an understanding of what variables are impacting on the family and what relationship these variables may have on each other.

The difference in the role for the child protection worker is that when meeting with these families they must also assess for the potential risk of an adolescent coming into the Society's care. The protection worker has to use the tools that are currently in place to assess risk to children. The problem is with respect to adolescents- these tools do not seem to fully capture the potential risk that the adolescent is at with respect to their home and community. The safety assessment does not look at how the adolescent's behaviour and actions place them at a different level of risk to that of a young child.

This study found that multiple issues seem to lead a worker to believe that it is necessary for an adolescent to come into care assuming the inability of the parent to deal with multiple issues. The study also found that school related issue is the prime indicator for a worker to decide on the need to bring the adolescent into care. It is believed that the functionality, the ability to remain in the family is directly correlated with the adolescents' capacity to remain functional in the school system.

For a social worker acting as a child protection worker, this implies the need to assess the adolescent's ability to remain in the school system as a way to estimate their capacity to deal with complex problems and the need for the worker to closely work with school specialist in monitoring social functioning. Every Children's Aid Society in Ontario uses a standardized tool to assess children's immediate safety. The Safety Assessment has 11 factors that assist the child protection workers in determining risk to a child (Ontario Association Of Children's Aid Society, 2000). The twelfth factor of the assessment is blank and called 'other'. Therefore, when assessing an adolescent and their family, the twelfth factor needs to focus on 'school related issues' as this will be the most

important variable that predicts whether or not the adolescent comes into the Society's care.

7.0 Conclusion

This study responds to the research question that there are variables predicting an adolescent coming into the Society's care. Holland's tool can be used to assess the possibility of an adolescent coming into care. It appears that case complexity equates the necessity of an adolescent coming into care. The same variables that Holland examined to assess complexity, seem to generate a profile of an adolescent in need of being removed from their immediate environment.

It was not surprising to observe that multiple and complex issues would bring an adolescent into care. The study in fact confirms the field practitioners' observations. At the onset of this research and in having worked with a number of adolescents and their families, child protection workers tend to focus on parent-related issues and the adolescents acting out and negative behaviour. The child protection worker assesses the adolescent's safety with respect to the 11 factors found in the Safety Assessment and the 22 factors found in the Risk Assessment tool (Ontario Association Of Children's Aid Society, 2000). Both of these tools tend to focus on the parents capacity to meet the child's needs and how the parenting is functioning.

What is surprising for me, is the variable 'school related issues' being the best predictor of an adolescent coming into care. In my experience, this variable has not been identified as a child protection concern and it is certainly not the focus of the assessment tools that the child protection worker uses in assessing risk to children. School functioning and school related issues have been seen by the child welfare system as the

educational systems responsibility and not seen as a child protection concern especially when the child is over 13 years old. School related issues are generally only labeled as a contributing factor in determining whether or not an adolescent will come into the Society's care. When in fact, child protection workers need to focus on how the adolescent is coping and functioning in school as it is the prime issue in understanding how the adolescent is functioning at home, in school and in their community. Therefore, if an adolescent has problems, but is functioning well in school, both academically and socially, they will more than likely not be at risk for coming into the Society's care. However, if a 14 year old adolescent is failing and struggling at school, they will more than likely be exhibiting other negative behaviours, which will lead to increased conflict in the home and a higher risk for them coming into the Society's care. The outcome of this study clearly shows that child protection workers will need to shift their focus when they first come in contact with an adolescent and their family in order to develop a comprehensive and accurate assessment of the adolescent's needs.

Further research needs to address the transition adolescents make between the ages of 13 to 15 and how schools help them to mange those transitions. We also need to better understand how to strengthen parents' coping mechanisms and their ability to understand adolescent development. There is also a need to develop a program that addresses parenting adolescents combined with an adolescent support system.

Further studies need also to scrutinize why adolescent at the age of 14, represent a greater risk for coming into the Society's care.

In understanding family complexity, Children's Aid Society workers will be better able to assess and develop services plans to assist the families and adolescents that come in contact with the Society.

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	Complex Care Case Review						
	Children in Care						
	Data Collection Instrument						
			Identity of Child				
			1	2	3	4	5
Variables	Worker Name	1					
	Age of child (e.g. Less than one (-1), 12 years (12), etc.	2					
	Status of child (cw/cwa/sw/ico/tca/sna/ap/oswap/ecm)	3					
	Placement type (fh/opi/hosp/oth(e.g. Independent living)	4					
	Gender (M) or (F)	5					
	New admission (N) or Readmission (R)	6					
History of Abuse	Child has been physically abused	7					
	Child has been sexually abused	8					
	Child has been emotionally abused	9					
	Child has been neglected - developmentally	10					
	Child has been neglected - medically	11					
	Child has experienced abandonment	12					
	Child was a victim of abuse while in foster care	13					
Behavioural Issues	Child abuses alcohol or non-prescription drugs	14					
	Child is abusive towards other children	15					
	Child has been a fire-setter	16					
	Child has previously sexually molested other children	17					

	Child engages in sexually inappropriate activities or exercises poor judgement in this area	18					
	Child's behaviours are precipitating calls from the community	19					
Health - Physical	Child is physically disabled	20					
	Child suffers from Foetal Alcohol Syndrome	21					
	Child is "medically fragile"	22					
	Child has suffered a traumatic brain injury	23					
	Child suffers, or has suffered, from a sexually transmitted disease	24					
	Child is suffering from a life-threatening illness or disease	25					
	Child is anorexic or bulimic	26					
	Child is on prescribed medication that must be monitored closely	27					
Health - Mental/psychological	Child exhibits symptoms suggesting mental ill-health	28					
	Child exhibits symptoms suggestive of ADHD	29					
	Child exhibits symptoms suggestive of a behaviour disorder	30					
	Child has been diagnosed as autistic	31					
	Child is developmentally disabled	32					
	Child threatens or has attempted suicide	33					
	Child is self-mutilating	34					
	Child is a bed-wetter, encopretic or smears faeces	35					
	Child has tortured or harmed animals	36					
	Child shows no remorse for his/her hurtful or criminal acts	37					
	Child has been found responsible for a serious offense (e.g. murder)	38					
	Child displays behaviours consistent with poor self-esteem	39					
	Child's sibling or 'significant friend or relative' is suffering from a life-threatening disease or illness	40					
	Child has been diagnosed as suffering from a dual-diagnosis disorder	41					

Parent - related Issues	Child has witnessed violence directed towards a sibling or parent, by a parent or caregiver, in his/her own home on more than one occasion	42					
	Parent is suffering from a life-threatening illness or disease	43					
	Custody or access presents conflict for the child (e.g. parent doesn't visit, or visit regularly, or there is open conflict between the parents over custody)	44					
	Child's parent is suffering from a mental health disorder	45					
	Child demonstrates fear of a parent with whom he/she has required access	46					
	Poverty in the child's family is an issue of concern for the child	47					
	The child's parent lacks the capacity to assume parental responsibility	48					
	Child's parent is abusing/has abused alcohol or drugs	49					
	Parent has been diagnosed as having an untreatable character disorder	50					
	Parent has unresolved issues relating to their abuse as a child that are negatively impacting upon the treatment needs of their child while he/she is in care	51					
	Parent is in conflict with the CAS intervention or treatment plan	52					
	Parent is in direct conflict with the child's foster parent while child is in care	53					
Relationship Issues	Child is abusive towards other children	54					
	Child displays indications of an attachment or bonding disorder	55					
	Child displays poor social skills	56					
	Child is manipulative in his/her dealings with peers	57					
	Child displays confusion about their gender identity	58					
	Child identifies him/herself as a homosexual	59					
	Child is experiencing scapegoating or racism at home, placement,school or in the community	60					

Legal Issues	Child is subject to an order under the YOA	61					
	Child is subject to an order from Family court and another (or more) court hearings are likely to affect his/her status and placement	62					
Placement Issues	Child has stolen from others within a foster or group home residential setting	63					
	Child has been in more than two placements with respect to his/her current admission to care	64					
	Child has been admitted to care more than once, or has experienced a number of changes in primary caregiver during his/her life	65					
	Child has AWOL'd from home or from his/her placement(s) while in care	66					
	Child has not experienced stability in their place of residence	67					
	Child is in a placement outside his/her home community	68					
	Child is in conflict with their foster parents	69					
	Child is in conflict with other children in their placement	70					
	Child is inappropriately placed (i.e. It is the worker's judgement that the placement does not match the child's needs)	71					
	Child requires in-home one-to-one support in order to sustain their placement	72					
	Frequent scheduling problems encountered in facilitating access visits	73					
	Significant time invested in arranging relief placements for child	74					
School-related Issues	Child has symptoms suggestive of a learning disorder	75					
	Child is experiencing academic problems at school	76					
	Child is experiencing social problems at school	77					
	Child presents management problems at school and requires in-school one-to-one support	78					
Other	Child is pregnant	79					
	Child has a sibling at home	80					

	Child has a sibling in care	81					
	Child's race, religion or culture precipitates conflicts or stress for the child	82					
	Child is a Native Canadian	83					
	Child grew up in an environment where criminal activities were socially acceptable	84					
	Child has needs that cannot be addressed because of a lack of placement, treatment or environmental resources (e.g. waiting lists or a lack of a needed resource in the community)	85					
	Child is oppositional to CAS intervention or treatment	86					
	Access visits by the child with his/her parents or siblings are required to be supervised	87					
	Child is a parent caring for a child while both are in care	88					
	Child is involved in a number of programs, the shear number of which creates confusion or conflict for the child	89					
	Child's participation in placement review, case planning, legal or treatment conferences is judged to precipitate conflict or confusion for the child rather than a sense of control	90					
	Child placed with "Part" racial match	91					
	Child Placed together with sibling	92					
	Child exhibits bizarre behaviours - FP's anxiety requires labour intensive support	93					
	Child has been physically abusive towards parent	91					
	Case Weighting Calculation (add above, except for variables)	92					
	Number of characteristics present	93					

	Degree of risk ("risk" is defined as an imminent threat to the child's physical or emotional well-being) low risk = 1, medium risk = 2, high risk = 3	94					
	Amount of time regularly committed per month - Less than 3 hours = 1, over 3 but less than 6 hours = 2, over 6 hours = 3	95					
	Amount of case activity per month - less than 3 contacts/activities = 1, more than 3 but 6 or less = 2, over 6 contacts/activities = 3	96					
		97					
	Total Case Weighting	98					
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