THE CONCEPT OF "HARD-TO-PLACE

IMPLICATIONS FOR CHILDREN ADOLESCENTS AND FAMILIES

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Problem Statement

This paper, based on the author's dissertation, discusses several factors that impinge on and add meaning to the concept of "hard-to-place" (HTP) as applied to children and adolescents.

The author examines placement facility and child characteristics in seeking to ascertain the extent to which children might be placed in settings on the basis of some factors that transcend or interact with their individual characteristics. The field of family and children's services, to the researcher's knowledge, has not attempted a systematic assessment comparing "Hard-to-place" children with other children placed within the child-care system. (The author's dissertation examined, in addition, workers' perceptions of child characteristics comprising the label of HTP).

Placement Facility Characteristics

A contribution identifying a child as HTP concerns the placement setting's view as expressed in its admission and/or exclusion criteria. For, some facilities "admission policies are so restricting or exclusive in terms of age, sex and treatability of problem that it denies to many of the severely disturbed children who need it most." [1] As Rae-Grant points out: "the combination of behaviours most guaranteed to elicit a refusal to admit to a residential treatment setting includes persistent running, suicide attempts, fire-setting and diminished relationship capacity." [2]

Lerner suggests that children should be excluded from foster homes and hence admitted to an "institution" if the placement sought is short-term; if "hard-to-serve", [14] "difficult to manage" children, [15] "difficult to treat", [16] "'untreatable' adolescent" and "difficult to contain" [18].

Need for 'local' placement

The removal and placement of a child from his/her 'local' community may have implications for identifying a child and his/her situation as HTP. The literature suggests the positive impact of placing a child as close as feasibly possible to his/her home community and family. This view is predicated on the "geographic as well as emotional distancing from already distant parents" that can exist. [19] Johnson, in reference to the Joint Commission on the Mental Health of Children, reflects this position: ". . . the guiding principle should be that children be removed as little as possible in space, time, and life experience from their normal setting". [20] Similarly, Richter suggests that:

"institutional care . . . is regarded as detrimental because it removes the child from his/her community, his/her school, his/her employment, and especially his/her parents". [21]

Several authors stress the importance of involving the natural parent(s) in the child's treatment and/or placement. Whittaker reports findings of "impressive results" when parents have been involved in the child's residential treatment or placement. [22] Given that there are parents or a resource waiting for children upon completion of treatment or placement, Steinhauer offers the observation: ". . . those youngsters who do best in any form of treatment are those who have someone outside the treatment to go back to". [23]

By facilitating close proximity of the child to his/her community, the value of 'continuity of care' may be achieved. However, this orientation may be held in theory more than in practice. [24] In any event, it can be argued that ". . . no child functions independently of the system to which he or she belongs". [25]

The placement agency worker needs to be sufficiently close to the placement setting to maintain a child in his/her current placement, to prevent further placement breakdowns, and to facilitate involvement of the natural parent(s) (where available). Hence, in Mora's sense, a "continuous relationship" needs to be fostered amongst these linkages. [26]

Methodology

The descriptive study consisted of three components in an effort to examine various contributions to the labelling of children and adolescents as "HTP". For the purposes of this paper, the author focusses on the first two components, facility characteristics, and child characteristics. First, the study described and compared the (a) characteristics, and (b) admission and exclusion criteria of facilities in which children were placed. Second, the study examined the characteristics of children considered, for the purposes of the study, as HTP by virtue of their placement in a facility external to the community (outside the boundaries of the region) and a comparison of these characteristics with the characteristics of children considered "less HTP" in an internal facility (within the region).

Workers in this community seeking placements had, at the time of the study, several referral routes open to them. For internal placements, workers could refer directly to some foster and group homes. For residential treatment and other group homes, workers would refer through the multiagency screening group, the A.A.T.D> Team (Association of Agencies in Treatment

and Development). For external placements, workers could consult with and/or refer to the "Special Needs Committee" of A.A.T.D., or refer directly to out of region resource.

Instruments

The researcher used two structured, pre-coded questionnaires to obtain the characteristics of the facilities in which the children were placed and a description of the child characteristics. For the facilities, the instrument derived its items from the Special Needs Committee report of the A.A.T.D. Team [27] and from the Province of Ontario's Directory of Children's Services. For the child characteristics questionnaire, items were derived from several sources [28], selected behavioural items from two existing instruments which the researcher assumed would be available in the children's case records [29], and items from the researcher's practice experience.

Study Sample

The study population of placement facilities comprised 72 settings (40 internal, 32 external). The researcher identified the current placement facility in which a child resided as the child's "present placement facility".

The study population for the second component consisted of 102 children (51 internal, 51 external). All children placed out of the community (51 external) by or through each of the following agencies: the Catholic Children's Aid Society (C.C.A.S.), the Children's Aid Society (C.A.S.), the Probation and After-Care Office (P.A.C.O.) and the "Special Needs Committee" (S.N.C.) of the A.A>T.D. Team during the 12 month period from January 1, 1982 to December 31, 1982 were included in the study. For comparison purposes, the researcher randomly selected a similar number of children from the total number of children placed within the community (51 internal).

Data Collection

For the 72 placement facilities, the researcher obtained a description of each facility's characteristics with the Facilities questionnaire from the following data sources: the Province of Ontario's Directory of Children's Services, the respective agency files describing the settings not listed in the Directory, agency placement resources staff responsible for specific facilities (when data, particularly specific behavioural exclusion criteria, were not reported in the agencies' facilities files), and several senior Ministry of Community and Social Services personnel to obtain unreported data, especially per diem rates for 1982.

The case records within each of the four respective agencies responsible for placement of children were the data sources for the internal and external child characteristics. The researcher obtained from these agencies a list of children placed externally during the study period. Second, the researcher randomly selected a comparable number of internal children from a list supplied by the agencies of all children placed internally. Each child's case record was coded with a "child identification number". The researcher examined a sample of the children's case records to pre-test the child characteristics questionnaire. Subsequently, the researcher completed the questionnaire based on data reported in each case record listed on the internal and external children's lists.

Data Analysis

The researcher computed frequencies, corrected any coding and/or punching errors, and computed descriptive statistics for variables in each of the Facility and Child study components. The researcher compared the internal with the external facilities concerning each placement facility characteristic with chi-square and t-test statistics, where appropriate. Similarly, the researcher compared the internal with the external child characteristics on an item by item basis using chi-square and t-test statistics, where appropriate.

Results

Placement Facilities

The characteristic of placement size distinguished the internal from the external facilities. Thus, the variables of placement type, bed capacity, bed-staff ratio, and resident staff type, suggest that external facilities were larger than internal facilities.

Group homes were the most frequent type of external setting, 65.6%; whereas foster homes predominated internal settings, 60%. The largest proportion of external facilities, 46.9%, contained 5 to 10 beds; alternatively, the largest proportion of internal facilities, 82.5%, contained 1 to 4 beds.

External settings had a larger mean bed-staff ratio (internal, 1.38; external, 1.84) and contained a greater mean number of resident staff (internal, 3.64; external, 16.9). Similarly, external settings employed more specific types of resident staff--child care workers, social workers, administrators, teachers, nurses, and recreation staff--than internal settings.

Presumably, per diem cost is a characteristic related to

facility size. External settings were two and one-half times as expensive to operate as internal settings as indicated by the mean per diem cost in dollars (internal, 23.22; external, 56.56).

The above findings could suggest that external settings possess a greater degree of restrictiveness than internal facilities concerning the management of children and adolescents as reflected in size and type of setting.

Several behavioural, sex, and age facility admission/exclusion criteria, distinguished internal from external facilities. The behaviours most likely to exclude a child from an internal placement rather than an external placement were delinquent or'acting-out' behaviours (e.g., fire setting, destruction of physical property, stealing from other homes or shoplifting). Behavioural exclusionary criteria included under the category of "issues surrounding the child" (frequent running, assaultive-difficult to manage child, and a history of placement breakdowns) were more likely to exclude a child from an internal than from an external setting (see Tables 1, 2, and 3). One can suggest that the items presented in Tables 2 and 3 are characteristic of 'delinquent' or 'acting-out' behaviours.

TABLE 1

EXCLUSION CRITERIA:
MEAN NUMBER OF DELINQUENT BEHAVIOURS EXCLUDED

Internal (n = 40)	External (n = 32)
1.78	.81

$t = 3.02$, $p < .01$

TABLE 2

EXCLUSION CRITERIA:
NUMBER OF FACILITIES EXCLUDING DELINQUENT BEHAVIOURS

	Internal (n = 40)	External (n = 32)	x^2	df	
Sets fires	22 (55.0%)	9 (28.1%)	5.237	1	*
Destructive of physical property	15 (37.5%)	5 (15.6%)	4.240	1	*
Steals from other homes, shoplifts	11 (27.5%)	0	10.386	1	**

* $p < .05$
** $p < .001$

TABLE 3

EXCLUSION CRITERIA: NUMBER OF FACILITIES EXCLUDING BEHAVIOURAL "ISSUES SURROUNDING CHILD"

	Internal (n = 40)	External (n = 32)	x^2	df	
Frequent running	10 (25.0%)	2 (6.3%)	4.50	1	*
Assault-difficult to manage child	19 (47.5%)	7 (21.9%)	5.059	1	*
Placement breakdowns	6 (15.0%)	0		X^2 invalid	

* $p < .05$

The exclusionary criteria of epilepsy ("controlled epilepsy" or "controlled epilepsy with odd seizures') more likely excluded children from internal than from external facilities. However, the exclusionary criteria of the child not being able to feed or dress his/herself more likely excluded children from external than from internal settings, a finding, presumably, age-related.

Internal settings were more likely to accept only females for admission (23%), while external settings were more likely to accept only males (38%).

Concerning age, a greater proportion of internal (48%), than external settings (6%), reported accepting children under the age of 12. In contrast, a greater proportion of external (50%) compared to internal facilities (43%) indicated accepting children 12 years of age and over. Further, more external (44%) compared to internal facilities (10%) indicated no age admission restriction. Thus, external settings more likely accepted the older child.

Given the above features distinguishing the external from the internal settings, a majority (73%) of the behavioural exclusion criteria did not distinguish internal from external facilities. This observation suggests that external and internal settings in this study, possess a number of similar behavioural exclusionary criteria. Further, the behavioural exclusion criteria distinguishing internal from external settings suggest

that external facilities were more likely to accept the child who was troublesome or bothersome to others; while the criteria which did not distinguish the facilities are characteristic of a child who is troubled. (e.g., "sensory impairment", "diabetes", "self-harm").

Child Characteristics

The findings below compare HTP (external) with less HTP (internal) children according to the categories of variables: (1) demographics, (2) placements, (3) agency involvement, (4) school issues, and (5) behaviours.

1. Demographics

The 102 study population of children (51 internal, 51 external) consisted of 40.2% females and 59.8% males. The less HTP sample of children included 45.1% females and 54.9% males. while the HTP sample of children included 35.3% females and 64.7% males. (This difference was not statistically significant). The children's mean age was slightly more than 12 and one half years of age (12.76 years). There was a significant difference in the mean age of less HTP children (11.4 years) compared to HTP children (14.2 years), the latter being older.

A HTP child's father's most likely occupation was that of a labourer (20%); whereas, the less HTP child's father was more likely to be unemployed (20%). Further, the HTP child was more likely than the less HTP child to be governed by the more restrictive guardianship statuses of either Crown (29.4%) [30] or Society (43.1%) [31] wardship.. The less HTP child's most frequent wardship status was as a Voluntary non-ward (care agreement) (56.9%). [32]

2. Placements

The type of placement in which the children resided at the time of the study and number of previous placements experienced by the children, distinguished the HTP from the les HTP group. The HTP child's placement more likely was a group home (external, 74.5%; internal, 15.7%) or secondly, a residential treatment centre (external, 11.8%; internal, 5.9%). The HTP child experienced two times the total mean number of previous placements than did the

less HTP child. Specifically, the HTP child experienced more previous placements in both reception-detention/assessment emergency homes and observation & detention homes) and longer term facilities (group homes, correction group homes, special foster homes, and residential treatment centres) than did the less HTP child (see Table 4).

TABLE 4

TOTAL MEAN NUMBER OF PREVIOUS PLACEMENTS

	Internal (n = 51)	External (n = 51)	t	
All previous placements	2.549	5.31	4.44	**
Reception-detention	.45	2.196	5.61	**
Longer term	2.098	3.117	2.12	*

* $p < .05$
** $p < .001$

The researcher was interested in examining if some HTP children had entered directly the types of placements typical of external facilities. Hence, he examined if HTP children had not been placed in foster homes prior to their present placement. Thus, 45% of HTP (in contrast to 71% of less HTP) children had never been in a foster home. Therefore, one can suggest that slightly less than half of the HTP children had entered directly into facilities typical of external settings.

3. Agency Involvement

The HTP children were reported to have had more involvement with "secondary-care" level agencies (e.g., outpatient mental health clinics, Probation and AFter-CAre, the multi-agency A.A.T.D. Team, and the Courts). Hence, a feature of HTP children concerns their situations being perceived as more problematic.

4. School Issues

The HTP child was more likely than the less HTP child to have experienced academic difficulties as reflected in enrollment in a vocational school and/or a history of attendance in a special education class. (Although, the difference in type of school attended, in part, can be accounted for by the HTP group being older.)

5. Behaviours

The HTP child exhibited more problematic reported behaviours than did the less HTP child under the behavioural categories of cognitive, peer, defiance, delinquent, self-harm, borderline, school, sexual, and miscellaneous (see Table 5).

Specifically, the HTP child was more likely to have dull, normal, or borderline intelligence, not to get along with other children, to lack impulse control, to mutilate him/herself, to lack self-esteem, to lie, to disrupt the classroom, to engage in sex play with others, to have committed a sex offense, and to have engaged in a number of delinquent behaviours (e.g., instigating arguments, starting fights, running, assaulting adults, stealing, committing break and enter, possessing a dangerous weapon, robbery or theft, setting fires, and/or being involved with a delinquent gang).

Although a majority of the behavioural items reported, (77%), did not distinguish the two groups of children, HTP child tended to exhibit these behaviours more frequently; however, this does not mean that any given one was typical.

TABLE 5

TOTAL MEAN NUMBER OF BEHAVIORS

	Internal (n = 51)	External (n = 51)	t
Cognitive	.882	1.275	2.07 *
Peer	.314	.686	2.72 **
Defiance	.529	.922	2.51 **
Delinquent	1.784	4.471	5.92 ***
Self-harm	.059	.294	3.03 **
Borderline	.843	1.333	2.14 *
School	.745	1.078	1.97 *
Sexual	.098	.431	3.51 ***
Miscellaneous	.098	.255	2.10 *

* $p < .05$
** $p < .01$
*** $p < .001$

Summary and Conclusions

The findings suggest that a pattern emerged between the two components of the study in describing the features associated with the label of "hard-to-place" (HTP) as applied to children and adolescents. First, the placement facilities dealing with the child accept the adolescent exhibiting 'acting-out', 'delinquent', 'troublesome' behaviours. Secondly, a profile of the HTP child suggests that s/he is an adolescent who exhibits 'acting-out', 'delinquent', 'troublesome' behaviours.

Since external facilities are larger and contain more resident staff, these settings could be perceived as more restrictive and hence more likely suited to managing the HTP child than internal facilities. Further, not only can one consider the facilities as being restrictive, but also the HTP child receives the most restrictive wardship statuses--society and crown.

In addition, one can conclude that both workers responsible for placing children and smaller facilities, for example foster homes, in dealing with the 'acting-out', 'delinquent' adolescent find his/her behaviour sufficiently unacceptable or intolerable and hence consider the child and his/her situation too difficult with which to cope. As a result, placement in and acceptance by a larger, external setting might be perceived as a more likely way of managing the child than placement in an internal setting.

Policy Implications

This study did not investigate the extent to which availability of placements impacted on a child being placed externally. Thus, a possible contributing factor related to the placement of children and adolescents external to their local community could have been the lack of vacancies in internal placement facilities. One can speculate that is workers were faced with a lack of internal placement vacancies, they would be forced to seek external placements for children in their care.

Further, the external settings predominantly were in rural or sparsely populated areas of the province. Hence, are some external placement settings sought for their being located in rural communities? Do placing workers perceive and/or is there the reality that these rural facilities are more "effective" in managing and treating the HTP child?

It may be necessary to place the HTP child outside, and hence extricated from his/her local community since workers may perceive an external placement setting as having a greater likelihood of being geographically distant and qualitatively distinct from an urban facility. One might assume that delin-

quent, 'acting-out' activities (theft, shop-lifting, running) would be available and accessible more readily in an urban environment than in a rural, geographically distant one.

If society wishes to ensure that children and adolescents remain in close proximity to their home community and hence, close to their significant others, an important question meeds to be asked. Although internal facilities are distinct from external facilities with respect to facility type, admission/exclusion criteria, resident staff type, bed capacity, and per diem cost, would it be desirable for similar types of facilities to exist within the local community as are available outside the community? Thus, children would be afforded the opportunity of residing in the 'local' community respecting and supporting the'need for local placement', 'continuity of care', and 'least intrusive alternative' principles.

Alternatively, if the assumption is correct that the main characteristics distinguishing internal from external facilities are facility type, size, and per diem cost, it may be appropriate for the local community to develop enhancements of existing internal facilities, rather than create new settings. Further, one can consider the extent to which some, if not many, placement in external settings should continue to be used by local (internal)agencies responsible for placing childr3en as opposed to developing and placing children in internal settings.

The fact that external facilities were more expensive to operate than internal facilities should be of interest, if not concern, to agencies responsible for placement of children, government officials and funding sources (the Ministry of Community and Social Services), clients, and the public. Although the study examined only per diem cost, there are presumably other costs borne by agencies and client. For example, when children reside in geographically distant facilities, agency workers and families spend time traveling between the local community and the placement resource. The emotional and psychological costs experienced by families and guardians (and possible by workers who are already over-extended with large case-loads) who are geographically distant from the child need to be considered. It may be that the needs of the HTP child can be met only by more expensive and larger external settings. However, could some of the HTP children have been managed and maintained within placements at a considerable reduction in the above costs?

External placement of children might be associated with the extent which local placing agencies and workers are dissatisfied with the services provided by internal placement settings. For example, the relatively restrictive admission/exclusion criteria of and the potentially unwitting administrative barriers erected by internal settings to the admission process and procedures, particularly when admission to an internal residential treatment

centre or an internal group home must be screened through a multi-agency team, could prevent workers from considering a local placement.

The above factors suggest a few speculations as possible rationale accounting for placing some children and adolescents outside their local community. The discussion suggests that the label of "hard-to-place" might be applied to children for reasons in addition to a child's characteristics or behaviours. Further, the findings of this study have potential policy implications with respect to the placement of "hard-to-place" children.

REFERENCES

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1. D. Finlay and D. Randall, "Treating the "'Untreatable' Adolescent," Canada's Mental Health, 23 (September 1975), pp. 3-7.

2. N. I. Rae-Grant, "Arresting the Vicious Cycle: Care and Treatment of Adolescent Displaying the Ovinnik Syndrome," Canadian Psychiatric Association Journal, 23 (1978), pp. SS-22-SS-40.

3. S. Lerner, "The Diagnostic Basis of Institutional Care for Children," Social Casework, 33 (1952), pp. 105-111.

4. L. Lowenstein, "Residential Care for Problem Children--Are We all Going Wrong?," Social Work Today, 9, 23 (1978), pp. 11-14.

5. M.F. Mayer, L.H. Richman, E.A. Balcerzak, Group Care of Children: Crossroads and Transitions (New York: Child Welfare League of America , 1977).

6. Ibid., p. 60

7. P. Lerman, Deinstitutionalization and the Welfare State (New Brunswick, New Jersey: Rutgers University Press, 1982).

8. Ibid, p. 3

9. Ontario, Ministry of Community and Social Services, Report on the Hard-to-Serve Children in Ontario, (December), 1981; P. Barker, "The 'Impossible' Child: Some Approaches to Treatment". Canadian Psychiatric Association Journal, 23 (1978) pp. SS 1-SS-21; Rae-Grant, op. cit.; P. D. Steinhauer, "The Laidlaw Workshop on the 'Impossible' Child": An Overview," Canadian Psychiatric Association Journal, 23, (1978) pp. SS-61-SS-74; M.Q. Warren, "The 'Impossible' Child, the Difficult Child, and Other Assorted Delinquents: Etiology, Characteristics, and Incidence", Canadian Psychiatric Association Journal, 23, (1978) pp. SS-41-SS-60.

10. M. Aldridge, P. Cautley, and D. Lichstein, Guidelines for Placement Workers (Madison, Wisconsin: Centre for Social Services, University of Wisconsin, December 1974).

11. H.C. Hornby, M.I. Collins, "Teenagers in Foster Care: the Forgotten Majority," Children and Youth Services, 3 (1-2), (1981) pp. 7-20.

12. Mayer et al., op. cit.

13. N. Hobbs, The Futures of Children (San Francisco: Jossey-Bass Publishers, 1975); Ontario, Ministry of Community and Social Services, Foster Care: Proposed Standards and Guidelines for Agencies Placing Children, (October), 1981.

14. Ontario, op. cit. (December)

15. H. MacDonald, L. Brigham, T. Finch, Children Placed Outside Hamilton-Wentworth During 1980: a Project of the Special Needs Committee of the A.A.T.D. Team. hamilton, Ontario: (October) 1981, (unpublished report); J.S. Rubenstein, J. A. Armentrout, S. Levin, and D. Herald, "The Parent-Therapist Program: Alternate Care for Emotionally Disturbed Children," American Journal of Orthopsychiatry, 48, 4 (1978) pp. 654-662.

16. Rae-Grant, op. cit.; M. Stambler and A.Z.Mutter, "The Institution as Family: Creating a 'Holding Environment' for Treating Disorders of the Self in Children and Parents from Multiproblem Families," Psychiatric Clinics of North America, 4, 3, (1981) pp. 549-560.

17. D. Finlay and D. Randall, op. cit.

18. S. Wolkind, and G. Renton, "Psychiatric Disorders in Children in Long-Term Residential Care: a Follow-Up Study," British Journal of Psychiatry, 135, (August 1979) pp. 129-135.

19. Rae-Grant, op. cit., p. SS-24

20. S. Johnson, "Residential Treatment for Emotionally Disturbed Children and Adolescents: A Review of the Literature," Canada's Mental Health, 30, 1, (1982) p. 6.

21. P. E. Richter, "A Group Home Program in a Family Agency," Social Casework, 58, 5, (1977) p. 260.

22. J. K. Whittaker, Caring for troubled children (San Francisco: Jossey-Bass Publishers, 1979), p. 7.

23. P. D. Steinhauer, op. cit., p. SS-69

24. Rae-Grant, op. cit.

25. P. Barker, "Residential Treatment for disturbed Children: Its Place in the '80s," Canadian Journal of Psychiatry, 27, 8, (1982) p. 637.

26. G. Mora, "Foster Families for Emotionally Disturbed Children." Child Welfare, 41, 3, (1962) p. 106.

27. MacDonald et al., 1981.

28. MacDonald et al., op. cit.; Ontario, (December) 1981, op. cit.

29. T.M. Achenbach, and C.S. Edelbrock, "The Child Behavior Profile: II. Boys Aged 12-16 and Girls Aged 6-11 and 12-16," Journal of Consulting and Clinical Psychology, 47, 2, (1979) pp. 223-233; E.F. Borgatta, and D. Fanschel, "The 'Child Behavior Characteristics (CBC)' Form: Revised Age-Specific Forms," Multivariate Behavioral Research, 5 (January 1970) pp. 49-81.

30. A Crown or permanent wardship commits the child to the care and custody of the Society (a Children's Aid Society) until the wardship is terminated or expires (e.g. child's marriage, 18th birthday, adoption, or determination by the court) Ontario, Ministry of Community and Social Services, An Act Respecting the Protection and Well-Being of Children and their Families, 1984, p. 51.

31. A Society or temporary wardship commits the child to the care and custody of the Society for a specified period not exceeding twelve months, Ibid.

32. Under a voluntary non-ward or voluntary care agreement a person(s) with legal custody of the child voluntarily and temporarily seeks and agrees to place the child into the care and custody of a children's aid society for a period of time not to exceed twelve months, Ibid, pp. 49-50.