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Underserved parents, underserved youth: Considering foster parent willingness to foster substance-using adolescents ☆

Kathleen Meyers [a,*], Övgü Kaynak [a], Irene Clements [b], Elena Bresani [a], Tammy White [c]

[a] Treatment Research Institute, 600 Public Ledger Building, 150 S. Independence Mall West, Philadelphia, PA 19106, United States
[b] National Foster Parent Association, 2021 E. Hennepin Ave., #320, Minneapolis, MN 55413, United States
[c] Administration on Children, Youth and Families, U.S. Department of Health and Human Services, 1250 Maryland Ave. SW, Washington, DC 20024, United States

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ABSTRACT

Adolescents involved with foster care are five times more likely to receive a drug dependence diagnosis when compared to adolescents in the general population. Prior research has shown that substance use is often hidden from providers, negating any chance for treatment and almost guaranteeing poor post-foster care outcomes. There are virtually no studies that examine the willingness (and its determinants) to foster youth with substance abuse problems. The current study conducted a nationally-distributed survey of 752 currently licensed foster care parents that assessed willingness to foster youth overall and by type of drug used, and possible correlates of this decision (e.g., home factors, system factors, and individual foster parent factors such as ratings of perceived difficulty in fostering this population). Overall, willingness to foster a youth involved with alcohol and other drugs (AOD) was contingent upon the types of drugs used. The odds that a parent would foster an AOD-involved youth were significantly increased by being licensed as a treatment foster home, having fostered an AOD-involved youth in the past, having AOD-specific training and past agency-support when needed, and self-efficacy with respect to positive impact. Surprisingly, when religion played a large part in the decision to foster any child, the odds of willingness to foster an AOD-involved youth dropped significantly. These results suggest that a large proportion of AOD-involved youth who find themselves in the foster care system will not have foster families willing to parent them, thereby forcing placement into a variety of congregate care facilities (e.g., residential treatment facilities, group homes). Specific ways in which the system can address these issues to improve placement and permanency efforts are provided.

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1. Introduction

Each year, there are over half a million children and adolescents served in the U.S. foster care system (DHHS, 2012). When compared to the general population, youth in foster care have significantly higher lifetime rates of mood, anxiety, and behavioral disorders and of substance use disorder (White, Havalchak, Jackson, O'Brien, & Pecora, 2007). Youth involved in the foster care system are also four times more likely to have attempted suicide and almost five times more likely to receive a substance use disorder diagnosis (Pilowsky & Wu, 2006; Simms, Dubowitz, & Szilagyi, 2000; Thompson & Auslander, 2011; Vaughn, Ollie, McMillen, Scott, & Munson, 2007). In a study of homeless young adults who had been in the foster care system, Meyers, White, Whalen, and DiLorenzo (2007) found that many youth were using substances while in care, did not disclose their use for fear of placement change, and did not receive substance abuse treatment. Clearly, many youth in the foster care system and the parents who care for them experience significant challenges that can lead to placement disruption, thwart permanency efforts, and portend poor adult functioning.

A variety of initiatives attempt to improve the functional status of youth (Benson, Scales, Hamilton, & Sesma, 2006; DuBois, Holloway, Valentine, & Cooper, 2002; Ravindranath & Pittman, 2010; Roth & Brooks-Gunn, 2003; Waldfogel, Craigie, & Brooks-Gunn, 2010). However, we know little about the willingness, experiences, or needs of those expected to care for them. The limited research available indicates that many foster parents are unwilling to foster youth with mental, physical, and medical disabilities (DHHS, 1993; Downs, 1989; Kriener & Kazmerzak, 1995) and serious emotional and behavioral problems (Cox, Cherry, & Orme, 2011; Cox, Orme, & Rhodes, 2003; DHHS, 1993; Kriener & Kazmerzak, 1995). Among parents who are willing to foster these youth, characteristics of parents vary. For example, Downs (1989) found that parents who were willing to foster youth with mental disabilities had fostered more

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* Corresponding author.
E-mail address: kmeyers@tresearch.org (K. Meyers).

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children, had lower incomes, and were less educated when compared to those who were not willing. Foster parents willing to foster youth with physical disabilities were more educated, younger, more likely to be married, and more likely to be full-time homemakers. While many families are willing to discuss fostering children with emotional and behavioral problems, there are behaviors that are rated as least acceptable for bringing a youth into their home: setting fires, behaving destructively, and acting out sexually (Cox et al., 2003). Nonetheless, foster parents are willing to foster children with emotional and behavioral problems and they tend to have had fostered longer, have had fewer children removed from their home at their request, and to have been licensed to provide treatment foster care (Cox et al., 2011). In the Cox et al. (2011) study there was one item on their survey that asked about willingness to foster children using drugs or alcohol, but this item contributed to an overall willingness score and was not examined separately. To date there are no detailed data on foster parent willingness to foster youth with a past or present substance use problems despite the prevalence of this disorder among youth in care.

Given the high rates of substance use in this population, it is important to ascertain the willingness of foster care parents to foster these youth, whether such willingness differs by type of drug used, and whether the home itself, the system, or individual foster parent factors influence overall willingness. In this way, informed placements could be made (e.g., foster parent–child matching) to maximize well-being for the youth and the home and to help ensure permanency. As part of our Parents Translational Research Center, a NIDA-funded Center designed to assist all types of families caring for a substance-involved youth, the main objective of this study was to ascertain the willingness of current U.S. foster care parents to foster alcohol or other drug (AOD)-involved youth and to identify possible determinants for willingness (or unwillingness). To the best of our knowledge, this study is the first to assess adolescent AOD-related issues among currently licensed foster care parents.

2. Method

2.1. Survey design

A survey was developed in collaboration with the National Foster Parent Association (NFPA) in order to assess foster parent willingness to foster AOD youth and to understand what factors may influence foster parent willingness. An initial version of the survey was drafted by study investigators with input from local and state foster care consultants, from previous work on fostering youth with special needs including emotional and behavioral difficulties (Cox et al., 2003; Downs, 1989; Kriener & Kazmerzak, 1995; Rork & McNeil, 2011; Storer, Barkan, Sherman, Haggerty, & Mattos, 2012), and from our previous work with homeless youth who had aged-out of care and were using drugs (Meyers et al., 2007). The survey was then vetted by NFPA executive board members, including former and current foster parents. Adapted methods of cognitive testing were used to increase the probability that questions would be understood in the manner intended (Jobe & Mingay, 1989; Tourangeau, 1984). For example, we asked NFPA executive board members to review the survey and provide detailed information on question representativeness, wording, meaning, and difficulty. We asked for suggestions on how to better word questions that were difficult to understand. All information was reviewed, refinements were made, and the survey was re-distributed for additional feedback. The second round of feedback was reviewed and final revisions were made to the survey. The final survey consisted of 145 multiple choice and fill-in questions. Domains covered included: 1) demographic and background characteristics (e.g., age, employment status, highest degree of school completed, marital status, race/ethnicity); 2) licensure type (e.g., foster family, therapeutic foster care); 3) provision of care (e.g., number of years fostering, number of children typically fostered at one time); 4) experience with children with disabilities and/or disorders (e.g., physical, mental health, AOD); 5) experience and training related specifically to fostering children with AOD issues; and 6) past and future willingness to foster youth using AOD. The Treatment Research Institute's Institutional Review Board reviewed and approved all methods and procedures before recruitment began.

2.2. Participant recruitment

All aspects of participant recruitment and survey completion were performed virtually. Participants were recruited to take part in the survey through the NFPA's virtual network. An email with a description of and a link to the online survey was distributed to 32 state foster parent associations. Parents were eligible for participation if they: 1) were a current certified/licensed foster parent; 2) had a history of fostering an adolescent (12–18 years old); 3) were English-speaking and literate; 4) were the primary caregiver to foster child/ren; and 5) were not a kinship care only foster parent. Due to placement agency privacy laws, there was no way to track the exact number of parents who received and opened the email. It is estimated that the state foster parent associations represent about 60,000 foster families. However, only a fraction of these families would qualify because they do not foster adolescents. Additionally, many members of the NFPA network were not eligible to participate in the survey because they did not have a foster child currently in the home. Throughout active enrollment, the survey was advertised through the NFPA's website and other social media sites. After seven weeks of active enrollment, the final sample consisted of 752 currently-licensed foster parents from across the U.S. with representation from all 50 states and the District of Columbia.

2.3. Survey questions

Parents were asked about various foster and AOD-specific factors that could influence their willingness to foster AOD youth. Parents indicated whether they would be willing to foster youth using various types of drugs including alcohol, marijuana/cannabis, prescription drugs without a prescription, inhalants, synthetic/designer drugs, methamphetamines, cocaine, heroin, and PCP. A dichotomous variable indicating overall willingness to foster AOD youth was created. If foster parents responded “yes” to one or more drug, willingness = 1; if they responded “no” to all of the drugs, willingness = 0. In order to understand influence related to willingness to foster AOD youth within the context of the foster care model, factors were organized into three levels: home, systems, and individual.

At the home level, parents reported the number of years they had been fostering, the number of other non-foster children currently in the home, the number of children typically fostered, and whether they had fostered an AOD youth in their home in the past (yes or no). Parents also reported on type of foster home (i.e., regular, treatment, primary medical needs, other specialized, or group). The treatment home variable was divided into two categories: treatment, group treatment, or specialized (1) vs. regular, group regular, or primary medical needs (0).

At the systems (i.e., agency) level, parents reported number of trainings attended specific to AOD youth and what kind of support they had access to when needed. AOD-specific training, respite relief, and agency support were all dichotomized into yes and no categories.

At the individual level, parents reported on the impact of religion on their decision to foster, self-efficacy related to fostering an AOD youth, and their personal experiences related to AOD addiction and recovery. Impact of religion was divided into two categories: religion played a large part in their decision to foster (1) vs. religion played a small or no part in their decision to foster (0). Experience fostering an AOD youth in the past was dichotomized into yes and no categories.

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