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Pilot randomized controlled trial of foster parent training: A mixed-methods evaluation of parent and child outcomes

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ABSTRACT

Many foster parents are challenged by the social-emotional consequences of children in foster care who have experienced childhood trauma. In this project, we provided foster parents with a trauma-informed, evidence-based parenting program (Incredible Years; IY) and assessed its impact on child behavior, foster parent stress and attitudes, and perceived effect on parenting. Foster parents of children aged 2–7 yrs. were randomly assigned to IY intervention or control groups. We assessed pre-post child behavior, parenting stress, and parental attitudes. A subset of intervention foster parents completed post-intervention focus groups and in-depth interviews. Main themes from qualitative data (3 focus groups; 5 interviews; total n = 12) revealed that IY foster parents perceived changes in their parenting that they attributed to the peer support, new perspectives on the value of play, and specific tools that enhanced parenting skills. These parenting skills improved family relations and were sustained over time. Quantitative data, however, did not as strongly support program effectiveness. Between the IY (n = 16) and control (n = 17) groups, foster parents were less likely to perceive their foster child in need of mental health treatment (p = 0.002), and changed their perception of their child's role in the family (p = 0.03). No between group differences were found for measures of child behavior or parent stress. Overall, these results suggest that trauma-informed IY for foster parents may provide unique peer support and increased confidence needed to implement strategies that can improve intra-family relations. Further research is needed to verify whether and how these relations are improved.

1. Introduction

Children in foster care represent a particularly vulnerable population, with high rates of medical, developmental, and mental health needs when compared to children in the general population (Jee et al., 2010, 2006). When entering foster care, children may have the opportunity to improve outcomes if they are provided an enriched and stable environment with a supportive caregiver (Conn, Szilagyi, Jee, Blumkin, & Szilagyi, 2015; Horwitz, Balestracci, & Simms, 2001). Yet for children with pre-existing behavioral problems foster care placement, particularly when it is insecure, may worsen these problems (Aarons et al., 2010).

The quality and stability of the foster placement has been consistently associated with more positive developmental, educational, physiological, and emotional/behavioral outcomes (Bernard, Butzin-Dozier, Rittenhouse, & Dozier, 2010; Horwitz et al., 2001). Yet, many foster parents report feeling unprepared or unwilling to manage the emotional and behavioral problems that are most often present among children entering foster care (Cox, Orme, & Rhodes, 2003; Jee, Salter, Gonka, & Chin, 2014). Given low rates of treatment utilization in foster care, foster parents are often in the position of primary therapeutic agent for children in their care (Orme & Buehler, 2001). Further, foster parents have been called upon to manage increasingly difficult emotional and behavioral problems (Conn et al., 2013) in the absence of formal behavior management training or specialized support (Puddy & Jackson, 2003). Hence, child outcomes in foster care may be best

Abbreviations: IY, Incredible years; CBCL, Child behavior checklist; PSI-SF, Parenting stress index-short form; AAPI-2, Adult-adolescent parenting inventory-2

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understood from a social learning theory perspective that considers the relationship between foster parent and child as a key factor.

Children enter foster care with complex emotional needs and may have learned poor patterns for managing negative emotion in their families of origin. To navigate the traumatic experience of separation successfully, these children require foster parents who can be nurturing and empathetic, as well as establish new behavioral patterns. Thus, foster parents are faced with the difficult task of providing a safe environment, encouraging emotional regulation, and setting limits on behavior, all within a stressful parenting environment. This requires not only knowledge of parenting skills, but strong interpersonal skills and support to parent children with emotional and behavioral problems within a social service system. First, foster parents must have the emotional capacity to deal with traumatized children's strong emotions and emotional dysregulation. Parenting a child with social-emotional problems increases parental stress which, in turn, increases the risk for poor parenting and subsequent child behavior problems (Neece, Green, & Baker, 2012). To mitigate the negative impact of parenting stress, foster parents need emotional support (MacGregor, Rodger, Cummings, & Leschied, 2006). Foster parents must also have the interpersonal skillset to manage parenting challegnes even when they may have limited health histories and access to information. For instance, foster parents may have limited communication with caseworkers and may lack information about the child's mental and physical health needs and services; however, they are often in required to seek out and coordinate necessary services for the child in care (Pasztor, Hollinger, Inkelas, & Halfon, 2006), even when they have limited voice in decisions about the child's care or custody. Finally, foster parents may benefit from knowledge of trauma and the impact on children's development, including neurobiological changes and socioemotional developmental impacts.

Thus, foster parent specific training is a necessary starting point to providing foster parents with the knowledge, skills, and support needed to manage child emotional and behavioral problems and develop positive parent-child relationships (Buehler, Rhodes, Orme, & Cuddeback, 2006; Cox et al., 2003). Indeed, some have found improved parenting skills and/or child outcomes as a result of foster parenting programs (Chamberlain, Moreland, & Reid, 1992; Price et al., 2008). However, the unique aspects of parent training that contribute to effectiveness for fosterparents are unknown. Nilsen (2007) reported positive outcomes using the school-aged IY parent training program, augmented to provide foster parent specific support. It is possible that addressing the unique needs of foster parents is an important component of successful foster parent training.

Pediatric offices have become increasingly important places to address child social-emotional needs. Despite their need for care coordination and intensive mental health care, many children in foster care instead experience discontinuity of primary care, episodic use of emergency health services (Jee, Antonucci, Aida, Szilagyi, & Szilagyi, 2005; Rubin, Alessandrini, Feudtner, Localio, & Hadley, 2004), and gaps in receipt of mental health services (Hurlburt et al., 2004; Leslie et al., 2005; Stahmer et al., 2005). These problems are compounded by their frequent exit and re-entry into foster care with accumulating health and social-emotional problems that are not systematically assessed by care providers (Leslie et al., 2003). Thus, children in foster care are a high-risk group that frequently falls through the cracks of the healthcare system. The delivery of psychological services in primary care may improve utilization of psychological services through increased access to care and decreased stigma. Enhancing parental competence and knowledge is a critical component of pediatric care, particularly with respect to child behavior problems (Hart, Kelleher, Drotar, & Scholle, 2007). Hence, pediatric provider support and knowledge about parenting programs can support a parent's willingness to engage in parenting education, while de-stigmatizing those who seek this resource.

Our project, introduced in the context of a pediatric medical home, had the following aims: (1) To determine the impact of a foster care parenting program on child behavior, and foster parent stress and parenting attitudes; (2) To understand foster parent satisfaction and perceived effectiveness of a foster care parenting program, and (3) To understand what specific factors contribute to the immediate and sustained impact on parenting skills of a foster care parenting program. Our quantitative hypothesis was that foster parents who completed IY training would demonstrate improvements in measures of parenting stress and attitude and child behavior compared to those who did not receive training. Qualitative analysis was exploratory, and intended to generate hypothesis regarding what contributes to effective foster parent training.

2. Materials/methods

The Commissioner of the Department of Human Services provided consent for children to participate in this study. Foster parents provided consent for their own participation. The University of Rochester Research Subjects Review Board approved the study.

2.1. Participants

2.1.1. Foster parents

2.1.1.1. Quantitative. We received a list of all foster parents of children aged 2–7 years in family-based foster care in Monroe County, NY. All English speaking foster parents caring for a child in the targeted age range at the time of baseline data collection were eligible to participate. We were initially provided a list with 118 foster families. We randomly assigned families on this list as eligible for recruitment into the intervention or control group. From those foster families that were initially eligible for recruitment into the intervention group (N = 60), 34 were ultimately exceluded (11 did not meet study criteria; 23 declined participation). Of the 26 foster families who initially agreed to participate, 7 did not show for study procedures. Our final intervention group consisted of 19 foster families. From those foster families that were initially eligible for recruitment into the control group (N = 58), 33 were ultimately exceluded (11 did not meet study criteria; 22 declined participation). Of the 25 foster families who initially agreed to participate, 6 did not show for study procedures. Our final control group consisted of 19 foster families. Fig. 1 displays the flow of participants through the trial, including reasons for exclusion and withdrawal.

2.1.1.2. Assessment. Intervention group parents completed screening measures at the first and last group meetings (13 weeks). Control group participants completed screening measures the same month as the intervention group start and end date. The mean time between screening for the control group was 15.3 (2.6 SD) weeks. All participants received $60 for the completion of screening forms- $30 post completion for each of the baseline and follow-up measures. Foster parents in the intervention group also received full credit for the annual foster parent continuing education required by the county.

2.1.1.3. Intervention attendance. Foster parents in the intervention group (total N = 16; cohort one n = 7; cohort two n = 6; cohort three n = 3) attended from 6 to 13 classes, with an average of 10.44 (2.25 SD) classes attended. A total of five foster parents attended < 75% of the total sessions (cohort one n = 3; cohort two n = 1; cohort three n = 1).

2.1.1.4. Focus groups. Of the 16 intervention group participants, we successfully recruited 75% to participate in focus groups (N = 12; cohort one n = 4; cohort two n = 5; cohort three n = 3). At the last intervention session, foster parents were asked if they would like to return the following week to participate in a follow-up focus group. Child care was provided for this group also. Because the focus group