Placement breakdown in foster care: Reducing risks by a foster parent training program?
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Chapter 1

General Introduction
The United Nations Convention on the Rights of the Child (1989), which was ratified by the Dutch government in 1995, asserts that the family is a fundamental building block of society and the natural environment in which to bring up a child and foster their well-being (United Nations General Assembly, 1989). This implies that “Every child has a basic right and need to grow up in a safe home with a stable continuous relationship with at least one adult who is a trusted, committed parent figure” (Dozier et al., 2014, p. 219). In 2009, the United Nations adopted a resolution delineating guidelines for children who are deprived of parental care (United Nations General Assembly, 2010). The resolution states that if a child is temporarily or permanently deprived of his or her own parents or family, alternative care should be provided, preferably in a family-based setting. In the light of these recent regulations, the number of children entering foster care worldwide has grown rapidly over the last decade (Fernandez & Barth, 2010). With approximately 22,000 children (aged 0-18) living in foster care in 2014, over ten years, the number of foster children in the Netherlands has more than doubled (Foster care Netherlands, 2014).

**Background to foster care**

Policies on foster children and their legal position differ across the world. In the United States, where most studies on foster care have been conducted to date, foster care is regarded as a time-limited form of care prior to a child’s permanent placement (Maluccio, 2003). If a child is unable to return home within two years, the child will be adopted or placed with relatives who will be given custody of the child (e.g., Barth, Wulczyn, & Crea, 2004; Child Welfare League of America, 1995). Foster care in the Netherlands follows a different approach, particularly with regard to the goal and duration of placements. For one thing, foster children are rarely adopted. Furthermore, the Netherlands employs two main models of foster care in foster families: short-term and long-term foster care (Strijker, Knorth, & Knot-Dickscheit, 2008). Foster care as a short-term solution is aimed at assisting a child and/or supporting their biological parents for the purpose of reuniting the child with his or her birth family (Bastaensen & Kramer, 2012). If the child is unable to return home within one year or soon afterwards, the foster placement is supposed to become a long-term placement. This permanent planning process is often a long and less definitive process than that in the United States (Strijker & Knorth, 2007; Vedder, Veenstra, Goemans, & Van Geel, 2015). Long-term foster care can be provided until the child reaches adulthood, centering on the continuity of care and the child’s right to grow up in a stable situation (Bastaensen & Kramer, 2012). Though the exact number of children placed within both models of care is not known, approximately half of all foster children stay with their foster families for longer than two years (Foster Care Netherlands, 2014). Both short-term and long-term foster care can include kinship (placement with relatives) and non-kinship care. In the Netherlands, parental authority remains with the biological parents if they cooperate.
voluntary with the out-of-home placement. If the child’s security is seriously threatened, the biological parents can be temporarily or permanently discharged by a court of their authority, and a guardian is appointed. In such cases, custody is mostly given to a child protector from the Youth Care Agency. If the parents are permanently discharged of their authority, and the child is placed in long-term foster care, the current tendency in the Netherlands is to encourage foster parents to become the legal guardians of the child (Hermanns, 2008; Smit, van der Tillaart, & Snijdewint, 2015).

As a legal framework for youth care services for young people at risk and their families, the Dutch Youth Act (in Dutch: de Jeugdwet) aims to ensure that high-quality care and support is available to young people and their parents (Article 4.1, Ministerie van VWS, 2014). With the new Youth Act, which came into effect in January 2015, foster care in the Netherlands is expected to expand further as a more desirable alternative to residential care or treatment. The aim of the current act is that the youth care system should become be more efficient, coherent and cost-effective. A focus on community-based care, young people’s and parents’ own capacities, support from social networks and improved cooperation between professionals are intended to discourage the use of unnecessary specialized and residential services. If an out-of-home placement is unavoidable for a short or longer time period, voluntary placement with relatives, assisted by local professionals, is the preferred method. If this is not possible, foster care is seen as the most “normal” living environment, offering the child an opportunity to grow up in a family with committed foster parents capable of meeting their physical, emotional, developmental and social needs.

The functioning of foster children

Notwithstanding individual differences, studies from across the world have clearly shown that in general, foster children experience substantially higher levels of behavioral, emotional and relational problems than children in the general population (Burns et al., 2004; Landsverk, Burns, Stambaugh, & Reutz, 2006). Moreover, it appears that the initial severity of problems presented by children entering foster care is increasing (Haugaard & Hazan, 2002). A recent meta-analysis on the development of foster children also showed that on average, these children did not improve with respect to adaptive functioning, and the intensity of internalizing and externalizing behavior problems during their stay in foster care (Goemans, Van Geel, & Vedder, 2015). The risk of negative developmental outcomes seems to persist in adulthood. Adults who were raised in foster families, tend to have more problems in various areas of life – such as psychological and social functioning, education, employment and delinquency – compared to their peers in the general population (Dumaret, Coppel-Batsch, & Couraud, 1997; Pecora et al., 2006; Vinnerljung, Hjern, & Lindblad, 2006).

The origins of mental health problems in foster children may be attributed to the characteristics of the foster child, the functioning of the biological and foster family or...
the wider environment. Sameroff’s (2009) transactional model provides a theoretical framework for understanding the complex interplay between the proximal (e.g., parent-child interaction) and distal (e.g., dispositional characteristics of parents) factors responsible for the development of children. Central to this model is an emphasis on bidirectional relations and the interdependence of children and their social environment. The mental health problems of foster children are often related to a complex history of cumulative stressful and traumatic experiences, such as abuse, neglect and inadequate parenting prior to the out-of-home placement (Leathers, 2002; Oswald, Heil, & Goldbeck, 2010). Due to this history and their separation from their primary caregivers, foster children often have difficulties forming secure attachment relationships with foster parents (Van den Dries, Juffer, Van Ijzendoorn, & Bakermans-Kranenburg, 2009). Their subsequent life and juridical prospects often remain unclear for a lengthy period, which in turn may have an additional negative effect on the child (Van den Bergh & Weterings, 2007). The child needs to re-establish their relationship with their biological parents and form a new relationship with their foster parents. In this process, it is often assumed that the child feels torn between their biological and foster parents, which negatively affects the child’s well-being (Leathers, 2003). The child’s ensuing difficult behavior may lead to negative feelings, behaviors and expectations on the part of the foster parents, which in turn may reinforce negative behaviors, feelings and expectations in the child and vice versa. In this way, the accumulation of risk factors destabilizes functional child-rearing processes and negatively influences children’s developmental outcomes (e.g., Hermanns, 1998; Sameroff, 2009).

Foster placement breakdown

Many foster children move repeatedly from home to home (Barth et al., 2007). In the Netherlands, a third of all foster children experience two or more placements (Strijker et al., 2008). Achieving a stable, permanent foster care arrangement appears to be a relatively complicated process. For 20-50% of children placed in long-term foster care the planned stay in their foster family ends prematurely (Minty, 1999). The disruption of a foster placement increases the risk of consecutive unstable placements (Newton, Litrownik, & Landsverk, 2000; Rubin, O’Reilly, Luan, & Localio, 2007) and has an additional negative impact on the developmental outcomes of foster children (Aarons et al., 2010; Herrenkohl, Herrenkohl, & Egolf, 2003). Enhancing placement stability is thus of critical importance for improving foster children’s developmental outcomes. Research that focuses on risk and the protective factors associated with placement stability has distinguished important proximal and distal factors. A meta-analysis by Oosterman, Schuengel, Slot, Bullens, and Doreleijers (2007) has shown that among other risk factors (e.g., older age at placement, a history of residential care and number of previous placements), behavioral problems are a robust predictor of foster placement breakdown. Behavioral problems on the part of the child can
upset interactions between the foster parent and the child and can form a burden for foster parents. Indeed, foster parents appear to experience higher levels of parental stress than other parents (Bastiaensen, 2001). A Flemish study has shown that behavioral problems have a direct negative impact on parental stress levels and lead to less effective parenting (Vanderfaeillie, Holen, Vanschoonlandt, Robberechts, & Stroobants, 2012). If there is a fall in the foster parents’ sense of parental competence, parenting stress levels can rise even further and this may in turn negatively affect the child’s behavior (Jones & Prinz, 2005). In this way, coercive cycles can develop and add to the risk of placement disruption.

**Giving effective supporting to foster parents**

Raising a foster child with a traumatic history and/or complicated behavioral problems clearly presents a challenge to foster parents, meaning that they need professional and effective support. Although a growing number of studies has investigated a wide variety of intervention programs for foster parents over the past three decades, various meta-analyses and reviews (e.g., Dorsey et al., 2008; Turner, Macdonald, & Dennis, 2009; Macdonald & Turner, 2008) underline the fact that we still lack a comprehensive understanding of which intervention(s) in what are often complex foster care settings work best, and for whom. Standard parenting interventions often seem to be too ‘light’ for foster parents, as they are relatively short and not tailored to foster parents’ particular needs (Dorsey et al., 2008; Turner et al., 2009). Compared to standard services, more intensive and specialized interventions for foster parents (e.g., Attachment Based Catchup, (Multi) Treatment Foster Care, Keeping Foster Parents Trained and Supported) show more promising results on parenting and child behavior (Dorsey et al., 2008; Leve et al., 2012). However, the evidence is less robust than is usually claimed (Macdonald & Turner, 2008). Many studies show substantial methodological limitations (e.g., failing to follow stringent randomization procedures or including control groups, using single parents-reports), thereby undermining the validity and reliability of their results (Rork & McNeil, 2011). Rigorous longitudinal empirical studies are needed that use more than one foster-parent report, valid assessment measures, and intervention programs that have been empirically derived and which include treatment integrity checks to ensure that the program is being carried out in a systematic and replicable manner.

**Parent Management Training Oregon**

At first sight, Parent Management Training Oregon (PMTO) seems a promising intervention program for effectively supporting foster parents (of children aged 4-12). The aim of PMTO is to enhance parenting skills and thereby reduce severe child behavioral problems (Patterson, 2005a). PMTO is an intensive, individual and relatively long training program,
and thus expected to serve the specific needs of foster parents better than standard foster parenting programs. PMTO has already been implemented in various regions in the Netherlands in both regular youth care services and in foster care. Therapists are supervised very intensively to ensure program integrity. Internationally, PMTO has been investigated in several international clinical and prevention samples and across a broad range of families (traditional families, stepfamilies, single parents and ethnic minorities; Bullard et al., 2010; DeGarmo & Forgatch, 2005; Forgatch, DeGarmo, & Beldavs, 2005a; Martinez & Forgatch, 2001; Ogden & Hagen, 2008; Patterson, Chamberlain, & Reid, 1982), but not yet in a foster care population. PMTO has been proven to be effective in improving parenting skills and reducing child behavior problems directly after treatment (DeGarmo & Forgatch, 2005; Forgatch & DeGarmo, 1999; Martinez & Eddy, 2005; Ogden & Hagen, 2008), as well as in follow-up periods (Bullard et al., 2010; DeGarmo, Patterson, & Forgatch, 2004; Hagen, Ogden, & Bjørnebekk, 2011; Patterson, Forgatch, & DeGarmo, 2010). A recent randomized controlled trial on the effectiveness of PMTO in regular families in Dutch youth care showed that PMTO was as effective as care as usual in reducing children’s externalizing behavioral problems (Thijssen, 2016). Considering that interventions designed for general populations or studied on their efficacy under tightly controlled study conditions, cannot directly be transferred to foster care settings, it has yet to be proven whether PMTO is effective for Dutch foster parents. Similarly, it is not yet known whether PMTO is more effective or adds value to care as usual, including regular foster care assistance as well as more specialized interventions.

**The challenges of conducting research in foster care settings**

“Real world” foster care is a rather complicated setting in which to undertake empirical research. Response rates are generally low (e.g., Murray, 2005). In practice, given the relatively powerless position of foster children, the role of their gatekeepers is particularly important. Gatekeepers are those “with the power to grant or withhold access to people or situations to the purpose of research” (Burgess, 1984, p. 48). Many foster children are surrounded by a frequently-changing array of people who act as gatekeepers, including foster parents, birth parents, guardians from youth care agencies, supervisors from the foster care institutions and other professionals or relatives. These gatekeepers often have the legal right and responsibility to safeguard the well-being of the foster child and the duty to take the child’s perspective into account, meaning that decisions have to be made in consultation with all these gatekeepers (Murray, 2005). This seriously challenges the researchers’ ability to conduct research trials with the required response rates and inclusion targets, often within a tight time frame. In many cases, concerned parents, relatives and professionals do not agree, or even have conflicting opinions, on what is
best for the foster child, making it rather complicated for researchers to secure common agreement for participation in research.

Moreover, in the Netherlands, more intensive forms of support or specialized intervention programs for foster parents in addition to regular foster care assistance are not implemented at a national level. In practice, each of the 28 regional foster care institutions makes its own decisions, which has led to a wide variety of intervention programs, ranging from low to high intensity, with or without evidence-based foundations. Even if sound methodological designs are employed, this variety complicates the task of proving the relative efficacy of a specific intervention program compared to a wide range of standard care approaches.

The importance of rigorous effectiveness studies and prerequisites

Considering the intensive demands of foster parents in raising foster children, foster parents require support from intervention programs with proven efficacy. This will strengthen the professional quality of Dutch foster care. A Randomized Controlled Trial (RCT) is considered the gold standard for evaluating intervention effectiveness, since it uses a systematic methodology that allows comparisons between groups and can yield unbiased estimates of effect sizes (Shadish, Stark, & Steiner, 2008). Few RCTs have been undertaken in foster care however, especially in Dutch foster care. The complications of undertaking research in foster care settings, as described above, are even greater when one is doing an RCT. There are a number of challenges. First, it is difficult to undertake an RCT due to the formalities around the randomization process. Parents need to consent in advance to be allocated to either an intensive intervention or the ‘care as usual’ to which they are accustomed; something that not all parents can be easily persuaded to do. Second, in general, the interventions investigated in RCTs have high drop-out rates, especially when longitudinal study designs are used (Ingoldsby, 2010). Having to take a lot of tests or make frequent in-person visits tends to reduce retention, especially in participants who are already considered to be burdened (Ingoldsby, 2010). In addition, though not RCT-specific, when conducting longitudinal studies in foster care settings, there is a real probability that the placement is disrupted during the study period. Third, professionals are often reluctant to withhold help from foster parents (in the case of parents randomized to the control group) if it is felt they need it. Although the reason for conducting an RCT is that we do not know whether the intervention under study will actually help, harm or have no effect, most professionals are convinced that such interventions are helpful and therefore cannot be refused as a consequence of randomization (Shadish, Cook, & Campbell, 2001). Finally, youth health care professionals have heavy case-loads. Despite the best of intentions at the start of an applied study project, it is very hard for them to comply continuously with the high administrative standards of sound empirical research. Overcoming these challenges
as effectively as possible requires having a dedicated research coordinator localized in the participating foster care institutions. A coordinator can improve and maintain the motivation of foster parents and professionals to participate in the RCT and decrease the bureaucratic burden of an RCT as much as possible.

**Thesis aim and outline**

The central aim of this thesis is to investigate possible mechanisms for and solutions to decrease the risk of placement breakdown for foster children in long-term foster care. We divided this complex undertaking in three steps: 1) gaining insight into the well-being and mental health of Dutch foster children and related risk factors; 2) examining placement stability in the Netherlands and the predictive role played by related risk factors; and 3) investigating the effectiveness of PMTO in long-term foster families with foster children with severe behavioral problems, by conducting a randomized controlled trial in a real world foster care setting in the Netherlands.

In the following chapter, this thesis describes the results of four separate empirical studies. *Chapter 2* reports the results of a survey study on the well-being of Dutch foster children from their own perspective \((n = 59)\). We examine how this is related to their relationships with their foster parents and their biological parents. *Chapter 3* describes the prevalence of mental health problems among Dutch foster children and the impact on their foster parents, the related risk factors and the influence of risk accumulation. These results are based on a cross-sectional study among foster parents \((n = 239)\). *Chapter 4* reports on the percentage of placement breakdowns and the predictive value of various risk and protective factors. We applied a retrospective study design with a large time frame using case files from two Dutch foster care organizations \((n = 169)\). Chapters 5 and 6 concern reports from a study into the effectiveness of PMTO in helping foster parents to handle disruptive child behaviors, with the ultimate aim of improving placement stability. Using a longitudinal RCT design \((n = 46 \text{ families PMTO and } n = 40 \text{ families care as usual})\), we investigated whether PMTO improves foster parents’ parenting practices, and reduces parental stress and child behavioral problems. *Chapter 5* reports pretest-posttest effects and variables moderating the potential effect. *Chapter 6* describes the follow-up outcomes and the predictive role of intervention non-specific variables. *Chapter 7* presents a summary of the results of the four studies, followed by a general discussion and main conclusion.

Chapters 3, 5 and 6 can be read as separate reports on data derived from the same study. The sample of the study described in Chapter 3 was retrieved from the screening data that we used to target the RCT sample (Chapter 5 and 6), sections of these three chapters may overlap. Chapters 2 and 4 concern independent study samples.