Resource Parent Willingness to Provide Care to Specific Populations

Study Overview

- A survey of resource parents was conducted to assess willingness to provide care to specific populations of children and youth as part of DCYF's ***A Family for Every Child!*** Initiative. Responses of 227 resource parents are summarized.

Key Findings

- Overall, resource parents are most willing to provide care, with minimal or no extra support to children with minor medical problems (e.g., allergies/asthma, speech problems, or overweight/obese).
- Resource parents are significantly less willing to provide care to children with behavioral or emotional problems (e.g., aggressive, psychiatric illness, behavioral challenges) compared to children with minor medical problems.
- Resource parents are significantly less willing to provide care to children with serious medical problems or disabilities (e.g., child with HIV/AIDS, who is medically fragile, or has physical handicaps) compared to children with minor medical problems.

Key Recommendations

- Making services and supports available to all resource parents who are asked to care for teens and children with emotional/behavioral or serious medical conditions will help ensure these families feel well-equipped to provide care to these populations of children.
- Inclusion of, exposure to, or interactions with "special needs" children or youth in pre-service training may increase likelihood of willingness to provide care for those populations.

Approximately 1,200 youth enter foster care placement in Rhode Island each year[1], and many of these children have special needs (e.g., emotional and behavioral problems, disabilities, special medical conditions) or demographic markers (e.g., age, sibling groups) that may impact resource parent willingness to provide a placement for them. Finding a good match for such children is a critical step in safety and permanency planning that may reduce placement disruptions,[2] increase adoptions,[3] and increase both the length of time and the number of children for whom foster parents are willing to provide care.[3,4] Research has shown that foster parents are significantly less willing to provide care for a child with behavioral or medical/health-related needs, perhaps due to concerns about additional resources and supports necessary to provide care.[5-7] Resource parents may also have concerns or preferences about providing care for youth based on age or other demographic markers, or have limited ability to provide care for multiple siblings concurrently.[8] Willingness to provide care may differ based on the type of care resource parents provide. Resource parents with intentions to adopt may be more likely to care for youth with special needs, for example.[9] Assessing willingness to provide care to children with a range of special needs is a vital step in identifying barriers to finding acceptable child placement opportunities.

This report summarizes findings of resource parent willingness to provide care to specific child populations from a Rhode Island-based resource parent survey. The survey was conducted on behalf of the Rhode Island Department of Children, Youth, and Families (DCYF) in 2014 as part of an initiative funded by the Administration for Children and Families. Two previous reports have summarized results from this survey related to resource parent experiences with the application and licensing process and their satisfaction providing care. This is the third and final planned report of survey results.

Survey Methods. Surveys were distributed electronically to 670 households, which had an active or pending license to provide foster or adoptive care and an active email address in DCYF databases. This was supplemented with an additional 136 households whose members had attended a resource parenting information session in the previous year. A total of 270 households (33.5%) completed at least a portion of the online survey. Participants included those who were licensed or seeking a license through DCYF or one of 11 private child-placing agencies (PCAs) (25% of participating resource parents were affiliated with a PCA). For purposes of this brief, the sample was limited to those respondents who had sufficiently completed relevant portions of the survey, resulting in a final sample of 227 participants for the present report.

Survey Participants. Participants ranged in age from 23 to 76 years old (mean age: 46 years). Approximately 90% were female, approximately 9% were male and 1% identified as transgender. Resource parents identified primarily as Caucasian (84%); an additional 7% identified as Hispanic, and 2% or fewer identified as being African American, Native American, Asian, bi- or multi-racial, or from other racial/ethnic backgrounds. Types of care provided are as follows (note: respondents may be providing more than one type of care): relative/kinship care (33%), non-relative foster care (38%), treatment or private agency foster care (12%), adoptive care (17%), pre-adoptive care (24%), and guardianship (7%); 9% of those surveyed were not yet licensed to provide care and 13% were not

currently providing care. Length of time respondents had been providing foster or adoptive care varied by the type of care provided: foster care (4.7 years), adoptive care (4.3 years), pre-adoptive care (3.1 years), and guardianship (1.2 years).

Willingness to provide care was assessed using a modified version of the Willingness to Foster Scale – a set of questionnaires developed to assess foster care provider willingness to foster children with either special needs or specific child characteristics (e.g., children with emotional and behavioral problems, disabilities, special medical conditions, or other characteristics such as age or sibling groups). Respondents rate their willingness to provide care based on a scale from 1 (would not be willing to foster under any circumstance) to 4 (would be willing to foster without any extra help or support). We first present willingness-to-care attitudes for each type of behavioral, medical, or other child characteristic. Next, we discuss the results of a factor analysis, which examined three general categories of child characteristics: behavioral/emotional, minor medical, and significant illness. We compared differences in mean scores across these categories based on licensure (licensed through DCYF and licensed through a private agency) and type of care provided (kinship, foster, treatment, and adoptive/pre-adoptive).

Willingness to Provide Care to Specific Populations

Table 1 summarizes the web-based resource parent survey responses for willingness to foster children with physical health/medical needs. Approximately three-quarters of resource parents indicated a willingness to care with little or no extra support for a child with allergies or asthma (76%) as well as children with speech problems (71%). Factors that were associated with difficulty finding placement (i.e., placements requiring a lot of help or not acceptable under any circumstance) include: a child who is terminally ill (83%), child who is pregnant (72.4%), child with HIV/IADS (72.7%), child or infant who is medically fragile (68.8%), child with physical handicaps (70%), child who is extremely overweight/obese (51.4%), and a child with medical needs (e.g., diabetes, epilepsy; 42.9%).

Table 1: Resource Parent Survey Willingness to Provide Care: Physical Health/Medical Needs (N= 227)

	Willing without any extra support or help (%)	Willing with a little extra support or help (%)	Willing with a LOT of extra support or help (%)	NOT willing under any circumstances (%)
Child who is terminally ill	2.8	11.7	34.1	51.4
Child who is pregnant	6.5	21.0	22.9	49.5
Child with HIV/AIDS	4.2	23.1	26.9	45.8
Child or infant who is medically fragile (medically complex)	4.1	27.1	30.3	38.5
Child with physical handicaps	5.1	24.9	39.6	30.4
Child who is extremely overweight (obese)	13.3	35.3	31.2	20.2
Child with medical needs (e.g., diabetes, epilepsy)	15.2	41.9	25.8	17.1
Child with speech problems	30.0	40.1	23.5	6.5
Child with allergies or asthma	48.6	28.5	16.4	6.5

Resource parents were also assessed on willingness to care for a child with emotional, mental health or behavioral needs (see Table 2). Approximately 40% of parents surveyed stated willingness to provide care with no or minimal extra support for a child with a learning disability. Other factors were associated with difficulty in securing placement. More than half of resource parents indicated they would be willing to provide placement only with a lot of extra help, or not under any circumstances to children with behavioral challenges (58.4%), intellectual and developmental disabilities (54.1%), or a problem forming attachments (57.9%). More than three quarters of parents would only be willing to provide placement with a lot of extra help, or not under any circumstances, to a child who was self-abusive (80.1%), aggressive (77.4%), diagnosed with a psychiatric illness (79%), or an eating disorder (71.3%).

Relevant to other initiatives in Rhode Island (e.g., Adopt Well-Being Rhode Island) is the issue of children's exposure to traumatic events and its impact on placement likelihood (see Table 3). Children with a history of sexual abuse or other serious trauma experiences were also indicated as being particularly difficult to place, with approximately 68% of respondents indicating they would need significant support or would not be willing to accept such a placement under any circumstances.

Approximately half of resource parents would be willing to provide placement without any or with a little extra support for a child who identifies as LGBTQ (57.9%) or to sibling groups (59%; see Table 4).

Finally, as indicated in Table 5, approximately three quarters of resource parents reported willingness to care for infants and young children ages 0-2 years and 3-5 years (70.3% and 67.3%, respectively). Older children, ages 12 to 18 years, were indicated most

frequently as the group resource parents would not be willing to provide care for (49.3%), with an additional 20.8% indicating they would provide care with "a lot of extra help and support."

Table 2. Resource Parent Survey: Children with Behavioral and/or Mental Health Needs (N=227)

	Willing without any extra support or help (%)	Willing with a little extra support or help (%)	Willing with a LOT of extra support or help (%)	NOT willing under any circumstances (%)
Child who is aggressive	2.3	20.3	30.9	46.5
Child who is self-abusive	1.4	18.5	38.9	41.2
Child with psychiatric illness	3.7	17.2	38.1	40.9
Child who has an eating disorder (anorexia, bulimia, etc.)	4.6	24.1	38.4	32.9
Child with behavioral challenges	6.5	35.2	36.6	21.8
Child with intellectual and developmental disabilities	7.8	38.1	33.9	20.2
Child who has problems forming attachments	11.1	31.0	38.0	19.9
Child with attention-deficit/hyperactivity disorder	20.6	38.8	27.1	13.6
Child with a learning disability	15.0	48.4	26.8	9.9

Table 3. Resource Parent Survey: Trauma History (N= 227)

	Willing without any extra support or help (%)	Willing with a little extra support or help (%)	Willing with a LOT of extra support or help (%)	NOT willing under any circumstances (%)
Child who has been sexually abused	5.5	26.3	39.2	29.0
Child with serious trauma history	4.2	27.3	45.8	22.7
Infant who has been exposed to alcohol or drugs in vitro	20.6	40.8	25.7	12.8
Child who has been physically abused	19.0	41.7	28.2	11.1

Table 4: Resource Parent Survey: Other Child Characteristics (N= 227)

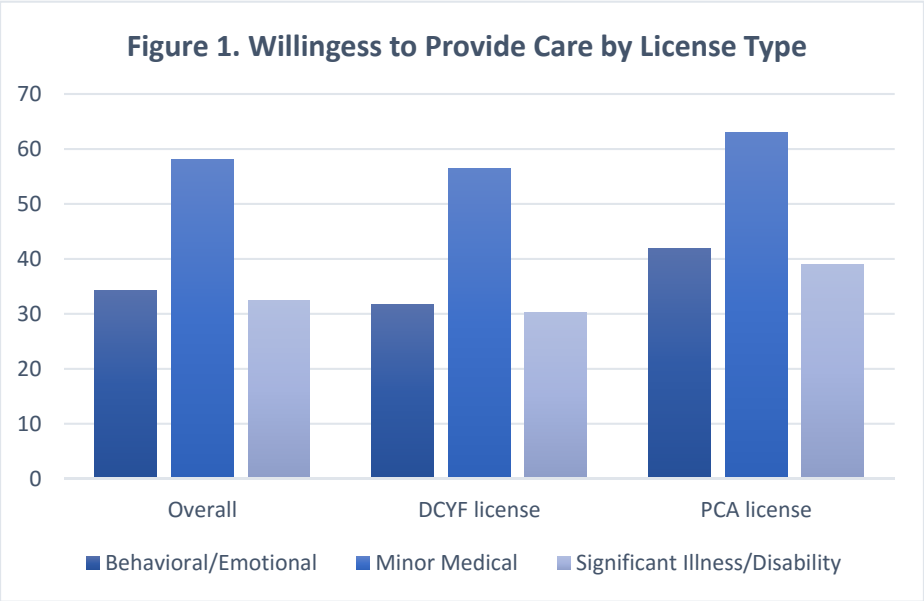
	Willing without any extra support or help (%)	Willing with a little extra support or help (%)	Willing with a LOT of extra support or help (%)	NOT willing under any circumstances (%)
Child who identifies as LGBTQ (lesbian, gay, bisexual, transgender, questioning)	29.4	28.5	17.8	24.3
Sibling Groups	29.5	29.5	22.2	18.8

Table 5: Resource Parent Survey: Child Age Groups (N= 227)

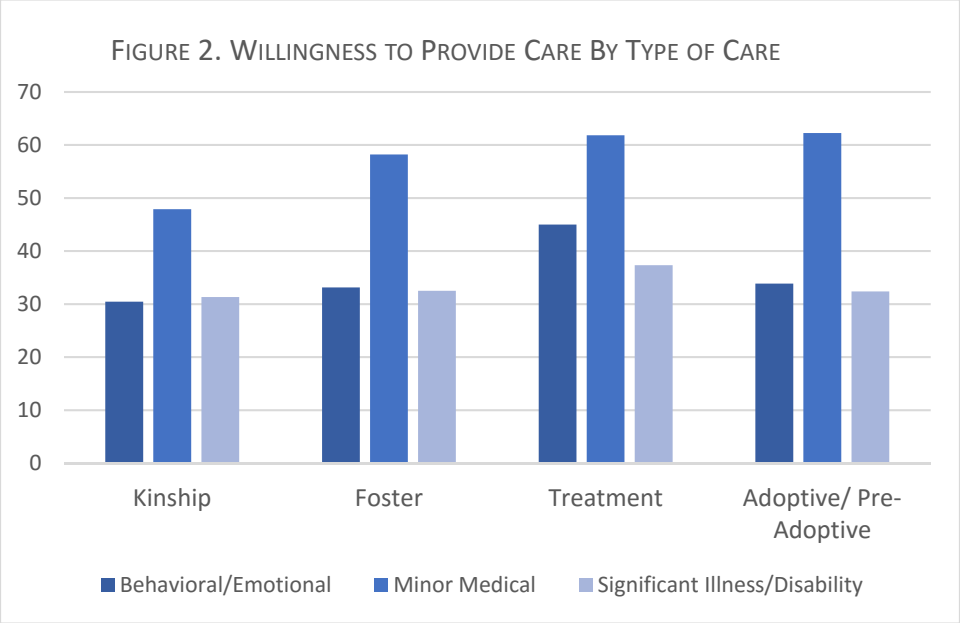
	Willing without any extra support or help (%)	Willing with a little extra support or help (%)	Willing with a LOT of extra support or help (%)	NOT willing under any circumstances (%)
Newborn – 2 years (infants / toddlers)	54.7	15.6	9.4	20.3
3- 5 years (pre-school)	45.5	21.8	12.8	19.9
6-11 years (elementary school)	27.3	27.3	18.7	26.8
12-18 years (teens)	12.1	17.9	20.8	49.3

Willingness to Provide Care Based on Child and Resource Parent Characteristics

Three scales were calculated to reflect resource parent willingness to care for youth with specific types of care-related needs including ***behavioral/emotional problems*** (e.g., aggressive, psychiatric illness, behavioral challenges), ***minor medical problems*** (e.g., allergies/asthma, speech problems or overweight/obese), or ***significant illness or disability*** (e.g., child with HIV/AIDS, is medically fragile, or with physical handicaps). Scores ranged from 0-100 with higher scores indicating greater willingness to provide care to children within this domain. As shown in Figure 1, resource parents were most willing to care for children with minor medical concerns (Mean=58.0), and were less willing to provide care to children with behavioral/ emotional problems (Mean=34.3; t=17.6, p<.001) or children with significant illness or disability (Mean=32.3; t=19.3, p<.001). Willingness to provide care for youth with behavioral/emotional or significant illness/ disability did not differ statistically.



Two sets of comparisons were made based on type of resource parenting provided. The first (also depicted in Figure 1) examined willingness to provide care based on whether resource parents were licensed through DCYF or a PCA. There were no statistically significant differences between PCA-licensed and DCYF-licensed respondents on willingness to provide care to children with minor medical issues. However, PCA-licensed resource parents were more willing than DCYF-licensed resource parents to provide care to children with behavioral/emotional problems (Mean=41.9 vs. Mean=31.6; t = -3.19, p<.01). PCA-licensed resource parents also had higher ratings of willingness to provide care to children with serious illness or disability (Mean=39.0 vs. Mean=30.2; t=-2.55, p<.01).



The second set of comparisons contrasted willingness based on the type of care a resource parent provided. Resource parents could select multiple types of care provided, and we assigned respondents to a specific type of care in the following ranked order: Adoptive/pre-adoptive, treatment, kinship, or foster care. Differences were found in willingness to provide care to children with minor medical needs by type of care provided (F=4.58, 3, p<0.01). Resource parents providing kinship care had lower mean scores (Mean=47.9) compared to those providing adoptive/pre-adoptive care (Mean=62.3; p<0.01) and treatment foster care (Mean 61.8; p<.10). Kinship providers also reported less willingness to care for children with behavioral or emotional needs (Mean=30.5) than treatment care providers (Mean=45.0; p=.04). Other differences between groups on willingness to provide care for children and youth with behavioral/emotional issues and significant illness/disability did not reach statistical significance.

Taken together, these patterns of findings suggest possible bases for group differences in willingness to provide care based on child or youth needs. One possible explanation for these licensing organization differences is that most PCA families are designated as "treatment-level providers." This designation may elicit a greater willingness to provide care for youth with significant medical and/or behavioral needs than one might find among providers who are not designated as such—as was borne out in the second set of

comparisons. However, given the "treatment" designation, it is potentially concerning that rates of willingness to provide care for populations with medical or behavioral health needs are not higher among PCA-licensed providers or among those who identifid as treatment foster care providers. Similarly, given that almost all kinship care providers are licensed directly by DCYF, the reduced willingness of this group to provide care to youth with special behavioral or medical needs may help explain some of the differences observed between PCA- and DCYF-licensed providers.

Another possible explanation for the differences between PCA-licensed families and DCYF-licensed families is the greater availability of supports enjoyed by all PCA families and higher standard foster board rates received by families licensed through all but one PCA in Rhode Island[a]. This explanation is somewhat undercut by previously reported results indicating no differences in satisfaction with services and supports among PCA-licensed families and DCYF-licensed families (see previous brief: *Satisfaction with Resource Parenting, Services, and Supports and Interest in Continuing*), although it is possible that greater *availability* of supports leads to higher willingness of PCA families to provide care for challenging populations of children and youth, even if their reported *satisfaction* with services and supports is no higher than that of DCYF families. Other possible explanations may include socio-demographic differences between DCYF and PCA families, or different histories of placement experiences, which could impact willingness to provide care for children with higher needs. More research is needed to test these hypotheses.

Summary & Recommendations

Resource parent survey results suggest some areas where targeted recruitment efforts for resource parents may be necessary. Children with significant behavioral or medical conditions, as well as older children and adolescents, are at greatest risk of not finding an appropriate foster home placement setting or requiring significant services and supports to help maintain stable placements when located. The placement of older children and adolescents is particularly critical, since this group represents a significant segment of the child welfare population and frequently ends up in congregate care placements either as a result of potential behavioral issues or due to lack of suitable foster home settings. While children with significant behavioral or medical needs represent a smaller proportion of the overall child welfare population, it is also apparent that there need to be greater efforts to recruit, train, and support foster and adoptive care providers who are prepared and willing to meet the unique challenges of caring for children with these service needs.

Increasing openness of resource parents to providing care for children and youth with demographic, behavioral, medical, or other factors that reduce providers' willingness to accept a placement may require a number of steps. First, a central implication of these results is that prospective resource parents may require additional supports in order to consider such placements. Supports could include additional services to help resource parents address issues related to behavioral, medical, or related child and youth needs. Providing care for some youth (e.g., older youth, sibling groups) may also place additional financial burden on resource parent households that could be alleviated through incentives or subsidies to reduce reluctance to provide care in such circumstances.[9] Finally, others have suggested that providing opportunities for direct contact with youth representing difficult-to-place populations during training could also increase willingness to provide care.[9] With the dissemination of TIPS-MAPP as a universal pre-service training requirement across the state, there may be opportunities to host sessions involving youth who are older (e.g., ages 12-17), have medical needs, identified disabilities, or other such characteristics, and facilitate positive interactions as a way to increase prospective resource parents' familiarity with, and potential interest in providing care for, these populations of youth.

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[a] Foster board rates of Children's Friend and Service families are the same as the rates received by DCYF families.