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

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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

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ways in which the system can address these issues to improve placement and permanency efforts is provided.

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 (DHHS, 1993; Cox, Cherry, & Orme, 2011; Cox, Orme, & Rhodes, 2003; 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 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 children; 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 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. Self-efficacy variables included: confidence in dealing with the behaviors of an AOD youth (very confident vs. not at all confident), difficulty in dealing with the behaviors of an AOD youth (very difficult vs. not at all difficult), and confidence in having a positive effect on AOD youth (very confident vs. not at all confident). Parents also reported on their personal experiences with AOD recovery and/or addiction. This variable included: parents who were currently in recovery, parents who knew someone in recovery or parents who knew someone struggling with addiction.

Parents were asked more extensively about their experiences fostering children and adolescents with disabilities and disorders. If a disorder or disability was selected (N=708), parents then indicated how helpful their placement agency was when they fostered a child or adolescent with that specific disorder or disability (very helpful vs. not at all helpful), how easy it was to get services for a child or adolescent with that specific disorder or disability (very easy vs. not at all easy), whether the parent attended a disorder or disability-specific training (yes or no), and whether the parent had to request a placement change because they were not getting the help needed with a child or adolescent with that specific disorder or disability (yes or no).

2.4. Analytical Plan

Statistical assumptions were met prior to conducting analyses (e.g., univariate and multivariate outliers, normality, multicollinearity). Parents could refuse to answer any question, but there was no evidence of any systematic bias in responses. No one item had more than 2% missing data (range of 0–15 missing data points by item) which is well below the 5% standard and was treated as random (Tabachnick & Fidell, 2007). Descriptives (frequencies, means and standard deviations where appropriate) of general, foster, and AOD-specific characteristics were generated. Chi-Square tests for independence (with Yates Continuity Correction) were used to determine differences between parents who had fostered youth with a substance use problem in the past when compared to parents who had not. Logistic regression models were used in order to examine bivariate and multivariate associations with the dichotomous dependent variable: willingness to foster AOD-involved youth. In order to control for Type I errors due to the number of bivariate logistic regression analyses performed, a Bonferroni adjustment was used to assess significance ($p < .004$). Multivariate logistic regression controlled for foster parent gender (male vs. female), age, and race (white vs. non-white) in the first block and entered category variables simultaneously in the second block. An alpha level of $p < .05$ was used to assess significance and the Hosmer-Lemeshow goodness-of-fit statistic was calculated to assess model fit.

3. Results

3.1. Demographics

Parents who completed the survey were an average of 46.60 years old (SD=10.55), predominately female (86%), white (81%), and well-educated (41% with more than a high school degree). The majority (75%) of parents maintained a full or part-time job in addition to their work as a foster parent. Seventy-five percent lived with a spouse or partner. Parents

had been fostering for an average of 8.25 years ($SD=7.16$) and typically fostered two or more children or adolescents at a time ($M=2.45$, $SD=1.25$). Parents typically had at least one other non-foster child in the home ($M=1.64$, $SD=1.63$). Twenty-two percent were licensed as treatment or specialized foster homes. Over half (52%) of parents received help from their placement agencies when needed with 38% receiving respite relief when needed. Forty-four percent claimed that religion played a large part in their decision to foster. The majority of parents (68%) had some kind of personal experience with addiction, whether they were in recovery themselves, or whether they knew someone in recovery or currently struggling with addiction.

3.2. Experience with special populations

Regardless of whether parents were ever licensed as treatment foster care parents, many had a history of fostering youth with special needs. As seen in Table 1, participating foster parents had fostered children with behavioral disorders (81%), developmental disabilities (49%), medical needs (18%), mood disorder (76%), physical disabilities (15%), and substance use problems (40%). Hence, this group of parents was not naïve to the tasks of fostering youth with a variety of developmental, medical or behavioral health challenges. By special population fostered, between 54 and 78% of parents had received disorder/disability-specific trainings, agency assistance when needed, and treatment on demand when indicated (Table 1 for exact percentages by group). Across disorders/disabilities, between 5 and 72% of foster parents had requested at least one placement change in the past because they were not getting the help they needed from their agency when dealing with a child with special needs.

Chi-Square tests for independence indicated that there were some differences between parents who had fostered youth with a substance use problem in the past when compared to parents who had not. Fostering youth with a substance use problem in the past was associated with having personal experiences with addiction [$\chi^2(1, n=752) = 5.94, p=.01$; $OR=1.50$] and willingness to foster an AOD-involved youth in the future [$\chi^2(1, n=738) = 51.14, p<.001$; $OR=3.25$]. It was also associated with being a licensed treatment home [$\chi^2(1, n=750) = 9.06, p=.003$; $OR=1.72$] and attending AOD-specific trainings in the past [$\chi^2(1, n=752) = 28.51, p<.001$; $OR=2.38$]. In terms of self-efficacy related to fostering AOD-involved youth, fostering youth with substance use disorders in the past was associated with confidence in dealing with behaviors [$\chi^2(1, n=745) = 54.15, p<.001$; $OR=3.53$] and believing they would have a positive effect [$\chi^2(1, n=746) = 22.88, p<.001$; $OR=2.64$]. Not fostering youth with substance use disorders in the past was associated with believing it would be very difficult to foster AOD-involved youth [$\chi^2(1, n=748) = 11.99, p=.001$; $OR=.58$].

3.3. Willingness to foster AOD-involved youth

Overall, willingness to foster an AOD-involved youth was contingent upon the types of drugs used. Approximately half would foster a youth who was drinking (53%) and/or using marijuana (46%) but willingness dropped significantly if a youth was using pills (33%), inhalants (28%), synthetic designer drugs like synthetic marijuana and bath salts (18%), cocaine (14%), methamphetamines (14%), heroin (11%), or PCP (10%). When parents were

asked what they would need to take a child who was using AOD, over half would need system-level assistance including immediate treatment for the youth when needed (63%), in-home assistance when needed (59%) and an increased rate for fostering (51%). The need for additional trainings was endorsed by 50% of the parents with 31% wanting them to be delivered in their home. Finally, 40% would need available and reliable respite care, and 44% would want contact with and support from other parents who had some experience fostering AOD youth. When asked whether they felt prepared to foster these youth such that they would have a positive impact (i.e., their self-efficacy), 16% of parents felt very confident in their ability to deal with the behaviors of AOD youth, 29% felt very confident in having a positive effect on AOD youth, and 45% felt that it would be very difficult to deal with drug-using behaviors.

3.4. Predictors of willingness to foster AOD-involved youth

To determine what contributed to willingness to foster AOD-involved youth, variables were grouped into one of three categories to assure that contributors related to the foster home, the overall system, and the individual parent could be explored. Table 2 presents the results from a series of logistic regressions (unstandardized logistic coefficients, standard error, odds ratios, and confidence intervals). Our first step was to establish a link between the three categories of parent variables and willingness to foster AOD-involved youth. Six variables significantly predicted willingness to foster AOD-involved youth with each category of contributor represented ($p < .004$ due to Bonferroni adjustment). Within the home factors, treatment home significantly predicted willingness; the odds of being a treatment certified parent or a treatment or specialized home were two times as great for parents who would take a youth using AOD (OR=2.04) as for parents who would not; the odds of being a parent who had fostered an AOD-involved youth in the past were three times as great (OR=3.25). Within the agency factors, the odds of having received AOD-specific training in the past were almost twice as great for parents who would take a youth using AOD (OR=1.87) as for parents who would not. Within the individual factors, three variables were predictive with all three relating to self-efficacy. The odds of being more confident in dealing with the behaviors of an AOD-involved youth were almost six times as great for parents willing to foster such a youth (OR=5.95) as for parents who would not. Similarly, the odds of being more confident in having a positive effect on an AOD-involved youth were over five times as great for parents willing to foster such a youth (OR=5.15) and parents who felt the behaviors of an AOD-involved youth would be very difficult to deal with were two-fifths as likely to foster one (OR=.41).

Multivariate logistic regression was used to determine how well these categories of variables predicted willingness to foster AOD-involved youth and in particular, which variables overall were the best predictors of willingness (Table 3). Similar to the bivariate results, variables having the most effect on willingness to foster spanned all three categories. Within the home factors, fostering an AOD-involved youth in the past remained a significant predictor (OR=2.23). With respect to agency factors, the odds of being able to get placement agency support when needed in the past were one and a half times as great for parents willing to foster an AOD-involved youth (OR=1.55) as for parents who would not. And with respect to individual factors, three variables were significant. As seen in the bivariate model,

self-efficacy variables remained significant. Confidence in dealing with behaviors (OR=3.54) and confidence in having a positive effect (OR=2.08) both significantly predicted willingness. Additionally, parents who reported that religion played a large part in their decision to foster were three-fifths as likely to foster an AOD-involved youth (OR=.61).

4. Discussion

These results suggest that a large proportion of AOD-involved youth who find themselves in the foster care system do 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). Living in such facilities as a result of few placement alternatives (rather than as a result of clinical necessity) very likely removes these youth from settings they will undoubtedly return to when they age out of care. This will at best obstruct and at worst negate a variety of permanency efforts and linkages to pro-social activities, peers, and supportive adults, all of which are critical to their ongoing recovery and overall success (Kriener & Kazmerzak, 1995).

Factors related to willingness to foster substance-involved youth fell within three categories at the bivariate and multivariate levels: the foster home, the overall system, and the individual parent. Not surprisingly, being a foster parent whose home was licensed as a treatment foster care home (also known as therapeutic foster care) as well as being a foster parent who had a prior history of fostering substance-using youth significantly increased the odds that they would be willing to have substance-using youth in their future care. These parents undoubtedly felt better equipped to care for substance-using youth as a result of their prior (and presumed future) treatment foster care training and supervision and/or as a result of their parenting history with such youth. This latter variable remained significant in the multivariate model and at first glance suggests that recruiting parents with an AOD fostering history to foster more of these youth is indicated. While this is certainly one potential way to proceed, it will do little to increase the pool of foster parents for this population. Developing programs where parents with an AOD fostering history recruit, mentor, and support parents new to fostering this population should not only increase the number of parents willing to foster these youth, but also may sustain both the mentors and the new parents in the fostering process. This approach is supported by the fact that: 1) almost half of participating parents (44%) would want contact with other parents who had some experience fostering AOD youth if they were to consider fostering this population; and 2) parents suggested having ongoing access to parents with such experience would be necessary for recruitment and retention of such parents.

It was surprising that the presence of other children in the home was unrelated to willingness to foster substance abusing youth. In a study on building connectedness between foster parents and the teenagers in their care, foster parents were concerned that problem behavior of youth in their care would negatively influence their biological children (Storer et al., 2012). Also, anecdotally, individuals working within various child welfare systems have reported that parents would be less likely to take a youth with AOD problems into their home if biological children were living there. It was also surprising that the typical number

of foster children in a home was also unrelated to willingness to foster AOD-involved youth given research that shows that overcrowding in foster homes (generally 3 or more foster children) lowers the threshold for problem behavior and increases the risk for placement instability (Noonan, Rubin, Mekonnen, Zlotnik, & O'Reilly, 2009). Data from this study did not support either of the previous research findings or the anecdotal reports.

When one considers the role of placement agencies in parental decisions to foster AOD-involved youth the results are not surprising: having had a history of AOD-specific trainings and having had positive experiences with placement agency(ies) when needed significantly increased the odds of willingness to foster. In other words, we can increase the odds that parents will foster these youth if the system and placement agencies prepare them specifically for this population of youth and if they provide assistance, guidance, and support when needed. Unfortunately this is not always standard practice. As shown above, 28% of parents with a history of fostering this population reported that their agency was not helpful when they were experiencing problems with these youth. At a most basic level, caseworkers may have been unprepared to provide guidance to foster families of substance-using teenagers and they too may benefit from courses/trainings on adolescent substance abuse during their initial training and ongoing continuing education. Although there are generally a required number of hours of continuing education for ongoing licensure, the content of the continuing education hours is largely unspecified in many fields. Adding adolescent substance abuse training requirements could enhance knowledge and skill sets that could ultimately assist foster parents and youth.

In addition to reporting a lack of agency support, 39% of the parents reported having never received training specific to this disorder. Skill-based training that arms foster parents with the ability to have a positive impact on these youth and thereby increases parental self-efficacy would be most advantageous for, as reported; self-efficacy significantly increased the odds that a parent would be willing to foster these youth. Noonan et al. (2009) recommend that State Medicaid plans be amended in order to finance therapeutic parenting interventions and staff training so that foster parents can mitigate behavior problems. Increasing the number of homes without attention to training and support will do little to increase the number of families who will take and keep AOD-involved youth in their care. Preparation and support for foster parents, and especially for those who foster more challenging cases, is needed to maximize placement stability and positive household functioning.

While three individual factors increased or decreased the odds that a parent would be willing to foster, the most disconcerting finding was the relationship between religion and willingness to foster. As reported above, the odds that a parent would be willing to foster AOD-involved youth significantly decreased when religion played a role in fostering decisions. A review of these results with the NFPA suggests that this finding, coupled with relatively low overall percentage of families in general who were willing to foster these youth, suggests that despite tremendous gains in establishing substance abuse as a biological disorder similar to other chronic health conditions (McLellan, Lewis, O'Brien, & Kleber, 2000) there remains tremendous stigma with respect to AOD involvement. Fueled by many things (e.g., lack of knowledge, media-focused negative attention), addressing stigma

through sophisticated public information campaigns and educational programs will be critical if we are to increase the number of parents willing to open their homes to youth who may be struggling with substance use.

4.1. Policy and Practice Implications

There is much to be done to improve the life chances of youth in foster care with substance use disorders. At the macro level, addressing stigma will be critical so that the general public have an unbiased and accurate picture of this disease upon which the decision to foster these youth can be made. At a systems level, re-thinking how shrinking budgets are spent is critical. While treatment foster care homes (therapeutic foster care) may be more expensive than non-treatment homes, they cost much less than congregate care facilities. Increasing the number of these homes (and possibly the payment rate) has the potential to go a long way in keeping these youth in less restrictive community environments and in reducing expensive congregate care costs. Adolescent substance-abuse related trainings as well as parent-to-parent mentoring programs will be needed to equip these foster parents with the skill set, confidence, and supports needed to effectively parent these teens. Additionally, utilizing any of the evidence-based family treatments (e.g., Functional Family Therapy, Multi-dimensional Family Therapy) in these homes has the potential to improve the family's functioning (if needed) as well as reduce substance use (and maintain reductions) among these teenagers (Waldron, 1997; Waldron & Slesnick, 1998). Preparing caseworkers to be an active part of the youth's team especially when challenges occur will be critical to placement and foster parent stability. Additional research will be needed to assess the needs of child welfare staff with respect to recognizing signs and symptoms of drug use, understanding treatment needs and the chronicity of the disorder, and providing support to foster parents when needed. Careful consideration and possible specification of both the format (e.g., workshops, conferences, on-line courses, reading articles or books) and content of continuing education requirements may be called for.

4. 2. Limitations

This is the first study that assessed the degree to which foster care parents throughout the U.S. would be willing to foster AOD-involved youth and to obtain their input into what could be done to enhance such willingness. These results coupled with the fact that we obtained information directly from the people who will be asked to foster these youth [something that tends to be overlooked when designing effective interventions (Rork & McNeil, 2011)] is an important contribution to the literature. This study is not, however, without limitations. Although the sample size was large and nationally distributed, the majority of the sample was Caucasian with more than a high school degree. Whether these results will generalize to a different demographic is unknown. Furthermore, while participants came from each region of the country, some states (and therefore regions) were more represented than others (e.g., Iowa versus New York). This was largely due to local child welfare officials who re-posted the call for participants on their website.

Summary

In sum, without a call to action, many teenagers in the foster care system who use alcohol and other drugs will be without foster care homes condemning them to more restrictive

environments than necessary, typically outside the area they will undoubtedly return to after they leave the system. The system can improve youth prospects by developing parent-to-parent mentoring, respite, and support programs, increasing the number of treatment foster care slots, developing skill-based trainings that foster self-efficacy, and being responsive when problems arise. Finally, aggressively addressing stigma and challenging the media to provide a balanced and science-based view of addiction is critical to change public opinion, expand living options, and improve the permanency, health, and well-being outcomes of these youth.

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Highlights

- Substance-using youth in foster care have few families willing to parent them.
- Willingness to foster youth ranged from 53% (uses alcohol) to 10% (uses PCP).
- Odds increased if homes were therapeutic and support was received when needed.
- Odds increased if parents had specific trainings and felt able to deal with issues.
- Therapeutic homes, agency responsiveness, and skill building trainings are needed.

Table 1

Foster parent experiences fostering children and adolescents with disabilities and disorders

Type of disability or disorder	Agency helpful	Ease of obtaining services	Disability/Disorder specific training	Placement change
Behavioral disorder (<i>N</i> =612)	68%	63%	75%	61%
Developmental disability (<i>N</i> =366)	73%	62%	67%	28%
Medical disability (<i>N</i> =135)	77%	76%	64%	5%
Mood disorder (<i>N</i> =571)	70%	63%	69%	72%
Physical disability (<i>N</i> =112)	78%	75%	54%	5%
Substance use disorder (<i>N</i> =302)	72%	60%	61%	25%

Note. Agency very or somewhat helpful. Obtaining treatment through agency very or somewhat easy. Received training in the past. Requested a placement change in the past.

Table 2

Results from Bivariate Logistic Regression analyses estimating predictors of willingness to foster AOD-involved youth

Independent variable	<i>B</i>	<i>SE</i>	<i>OR</i>	[95% CI]
Home factors				
Treatment home ^a	0.71*	0.19	2.04	[1.39, 3.00]
Number of years fostering	0.03	0.01	1.03	[1.00, 1.05]
Number of other non-foster children in the home	-0.14	0.16	0.87	[0.63, 1.20]
Number of children typically fostered	0.17	0.06	1.19	[1.05, 1.35]
Fostered AOD youth in the past ^b	1.18*	0.17	3.25	[2.35, 4.51]
Agency factors				
Respite relief when needed ^b	0.12	0.16	1.13	[0.83, 1.53]
Agency support when needed ^b	0.39	0.15	1.48	[1.10, 2.00]
AOD-specific training in the past ^b	0.63*	0.16	1.87	[1.38, 2.54]
Individual factors				
Religion played a part in decision to foster ^c	-0.41	0.15	0.67	[0.49, 0.90]
Confidence in dealing with the behaviors of AOD youth ^d	1.78*	0.17	5.95	[4.27, 8.31]
Believe it will be difficult to deal with the behaviors of AOD youth ^e	-0.90*	0.15	0.41	[0.30, 0.55]
Confidence in having a positive effect on AOD youth ^d	1.64*	0.20	5.15	[3.47, 7.64]
Are in recovery or know someone in recovery ^b	0.14	0.16	1.16	[0.84, 1.59]

Note. Total sample sizes ranged from 724 to 738 because of missing data.

^aTreatment/therapeutic or specialized care = 1; Regular or primary medical needs = 0.

^bYes = 1; No = 0.

^cLarge part = 1; Small or no part = 0.

^dSomewhat or very confident = 1; Not at all confident = 0.

^eSomewhat or very difficult = 1; Not at all difficult = 0

* p<.004; A Bonferroni adjustment to the alpha level was utilized to control for Type I errors

Table 3

Results from Hierarchical Logistic Regression model predicting willingness to foster AOD-involved youth ($N=691$)

Independent variable	<i>B</i>	<i>SE</i>	<i>OR</i>	[95% CI]
Home factors				
Treatment home ^a	0.21	0.24	1.23	[0.78, 1.96]
Number of years fostering	-0.01	0.24	0.99	[0.97, 1.02]
Number of other non-foster children in the home	-0.24	0.01	0.77	[0.53, 1.17]
Number of children typically fostered	0.01	0.20	1.10	[0.94, 1.29]
Fostered AOD youth in the past ^b	0.80***	0.20	2.23	[1.50, 3.32]
Agency factors				
Respite relief when needed ^b	0.14	0.19	1.15	[0.78, 1.68]
Agency support when needed ^b	0.44*	0.19	1.55	[1.08, 2.24]
AOD-specific training in the past ^b	0.09	0.20	1.10	[0.75, 1.62]
Individual factors				
Religion played a part in decision to foster ^c	-0.49**	0.18	0.61	[0.43, 0.88]
Confidence in dealing with the behaviors of AOD youth ^d	1.26***	0.22	3.54	[2.29, 5.47]
Believe it will be difficult to deal with the behaviors of AOD youth ^e	-0.33	0.19	0.72	[0.50, 1.04]
Confidence in having a positive effect on AOD youth ^d	0.73**	0.26	2.08	[1.26, 3.45]
Are in recovery or know someone in recovery ^b	-0.15	0.20	0.86	[0.58, 1.28]

Note: Goodness of fit χ^2 (Hosmer-Lemeshow) = 3.66, 8 df, $p = .887$. Model controlled for parent gender, race, and education.

^aTreatment/therapeutic or specialized care = 1; Regular or primary medical needs = 0.

^bYes = 1; No = 0.

^cLarge part = 1; Small or no part = 0.

^dSomewhat or very confident = 1; Not at all confident = 0.

^eSomewhat or very difficult = 1; Not at all difficult = 0

* $p < .05$.

** $p < .01$.

*** $p < .001$