fostering and the retarded

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SYNOPSIS

Foster care has long been overlooked as a viable alternative in the range of services to the retarded child and his family.

At a time when a number of agencies are planning developments into this area, this article discusses some of the underlying principles and conditions for a successful programme.

Foster care is one of the range of alternatives which should be available in any comprehensive programme of services to the retarded child and his family. Whilst we would probably all agree that the priority for the child is care in his own family, every child has the even more fundamental right to be cared for by people who value and want him. People who will provide the warmth and loving nurturance which will allow him to develop his full potential as an individual. It is apparent that not every family can face the reality of a defective child in a way which will meet these requirements. In these cases the enforced maintenance of the caring relationship may have severe consequences, both for the child's development and for the well-being and stability of the entire family group.

For some of these families the rejection of the child may be so complete that consent for adoption may be the answer. For others, a period in foster care may provide the emotional relief necessary to obtain a clearer perspective on the child, his limitations and their own capacities for dealing with these. In other situations it may afford the family with a recuperative period, sufficient to sustain them during the following months of the child's care.

Advantages and disadvantages

Foster care is designed to supplement rather than supplant the role of the child's own family. Unlike adoption, foster care does not transfer the legal rights and responsibilities for the child from the natural parents to the substitute parent figures. The more "informal" nature of foster relationships carries both advantages and disadvantages for the parties involved:

1. Certainly it makes fostering a more flexible service. Placements can be tailored to the individual needs of the child and his family, lasting from a few days to years.

2. It can encourage the continued involvement of the natural family in the child's life, and

3. It can be a therapeutic tool towards the eventual reunion of the family group.

To many parents, however, foster care is the most threatening form of substitute care. Many would prefer their child to be placed in an institution rather than accept the prospect that another family can cope where they have been unsuccessful.

From the child's point of view foster care affords him with the benefits of individualised care and attention, but it cannot offer the assurance of permanency in relationships and continuity in environment — factors which are fundamental to every child's secure and normal personality development; factors which are especially relevant for the retarded child.

Risks in foster care

Risks to the security of foster placements derive from two major sources. Firstly, the right of foster parents to opt-out of the relationship at any time. Practice has shown that foster parents are more likely to request the removal of the child if they feel that they are not coping with his problems and consider that their own family life is being disrupted too much. Secondly, the option of the natural parents to request return of the child to their care. Whilst successful reunion of the family is the primary goal of all foster care, it is apparent that timing and preparation will influence the likely success of that reunion. Parents are often not the best judge of the most propitious time for the removal of their child from the foster home.

Because of these characteristics fostering cannot provide a realistic solution for the child's permanent care.

It is imperative, therefore, that for those children who can be coped with in a family setting, arrangements to ensure long term security and continuity are built into the placement programme.

For this purpose it is important that counselling and other support services are available to natural parents. Services which will help them work through the feelings and problems which have inter-

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fered with their parenting role, whilst encouraging them to maintain regular contact with the child in foster care. After a maximum of approximately two years some decision regarding their future involvement with the child should be taken. Excluding those cases which may subsequently require institutionalisation, and others, particularly the adolescent group who may be more suitably placed in a peer group setting, the parents' decision would be either the anticipated return of the child to their care, or a termination of the relationship by consenting to the child's adoption — ideally adoption by the foster family.

Foster home or institution?

Foster care has several distinct advantages over institutional care for the child who cannot live in his own home. According to Beatrice Garrett, in her paper "Foster Family Services for Mentally Retarded Children", these advantages include the fact that "the child is functioning within the community; it offers a chance for the child's development along socially normal lines through day to day interaction with normal individuals and situations; and it accustoms the community to the presence of the mentally retarded".

In theoretical terms at least, the range of mentally retarded children who can be catered for in foster care is large. Quoting again from Garrett, "They may be in early infancy or late adolescence, passive in temperament or hyperactive and hostile, in good physical condition or handicapped by complicated physical defects or medical problems. Their retardation may be regarded as profound, severe, moderate or border-line. They may look strange or be normal in appearance. In many children the retardation may stem from deprivation rather than organic impairment".

Now, I would like to look a little further at these broad parameters and review them in the light of local experience. A study completed in 1974 by Farrell and Wysoke, 5th year medical students at the University of Western Australia, reviewed a study population of 65 children who were registered on State Departmental files in March 1974 as being currently fostered, and who on psychological testing had been shown to be mentally deficient. They compared this group with a control population of 65 randomly selected State Wards, presently in foster care. Included in their study was a group of 19 children who, though also registered with the Mental Deficiency Unit, were shown on testing to be not mentally deficient.

Whilst no statistical difference was determined for the number of foster placements made in each group, the trend was in the expected direction — the study group having 120 fosterings, the control group 101 fosterings and the not mentally deficient group 35 foster placements.

The groups were also tested according to age and level of retardation. In analysis the only group which was significantly more at risk for foster breakdown were those children in the border-line mentally deficient group. This tested at the 0.02 level of significance.

The researchers hypothesised that the difference in the number of fosterings in the border-line group may be due to factors such as:

1. The greater the degree of deficiency, the more likely is the child to be placed in an institution rather than foster care.
2. The care which is taken on choosing foster parents may vary with the degree of mental deficiency.
3. A large number of the border-line group will have environmental deprivation in the actiology of their deficiency and this factor may produce a larger number of associated behaviour problems.

A more comprehensive analysis of the risk of fostering breakdown for the retarded child would need to include in the study sample those children who are no longer in foster care because of successive breakdowns — and others who have been deprived of this form of care because of insufficient resources. Numbers of these children in Western Australia would be found in voluntary child care institutions, Mental Health Department facilities, and within the Community Welfare Department's institutions for the temporary care and assessment of wards, or treatment centres for offending wards.

Specialised foster programmes

It is my firm view that, whilst a foster service is a vital support to this client group, it is unrealistic to expect these children to be fitted successfully into any system of foster care primarily designed as a resource for relatively normal children, who for reasons of neglect or other family breakdown are to be placed in substitute care.

The experiences of my Department support the findings of Garrett, Dinnage and Kellmer Pringle and others, which suggests that what is needed is a programme of specialist foster care. A programme in which foster parents are viewed as colleagues to the professionals involved, and their understanding of, and skills for, the management of the retarded child are developed through a comprehensive training programme. Such people will not be successfully recruited without reasonable financial incentive. It is unreasonable to expect private families to extend themselves to the care of these children simply "for the love of it". A further major factor which I see as necessary to the establishment of such a programme, is the provision of sufficient staff resources to ensure that professional help and advice is readily available to foster parents. The attitude that once a child is placed, the family should be left alone to "get on with it", has no place in any scheme of specialist care.

It is the degree to which these factors are present in any foster programme, which I feel will determine its limits as a realistic resource for the more severely handicapped categories of children.

Conclusions

Successfully developed, it is likely that foster care can provide some solutions to the number of issues involved in retardation — it may maximise the child's potential by providing him with care in a family group where he is wanted and valued. It can provide relief for parents for holiday periods; during the initial crisis and stressful ambivalent period; or it may provide a longer term alternative whilst including provision for continued contact between the child and his natural parents. Finally it can educate the com-

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munity and increase their tolerance for the handicapped person by maintaining the child in their midst.

Foster care cannot assure the child of permanency and security in his placement and personal relationships. Because of this it should not be viewed out of its proper context as one alternative in the range of services necessary to this group. Others include supports for care within the natural family, group homes, hostels and institutional placement.

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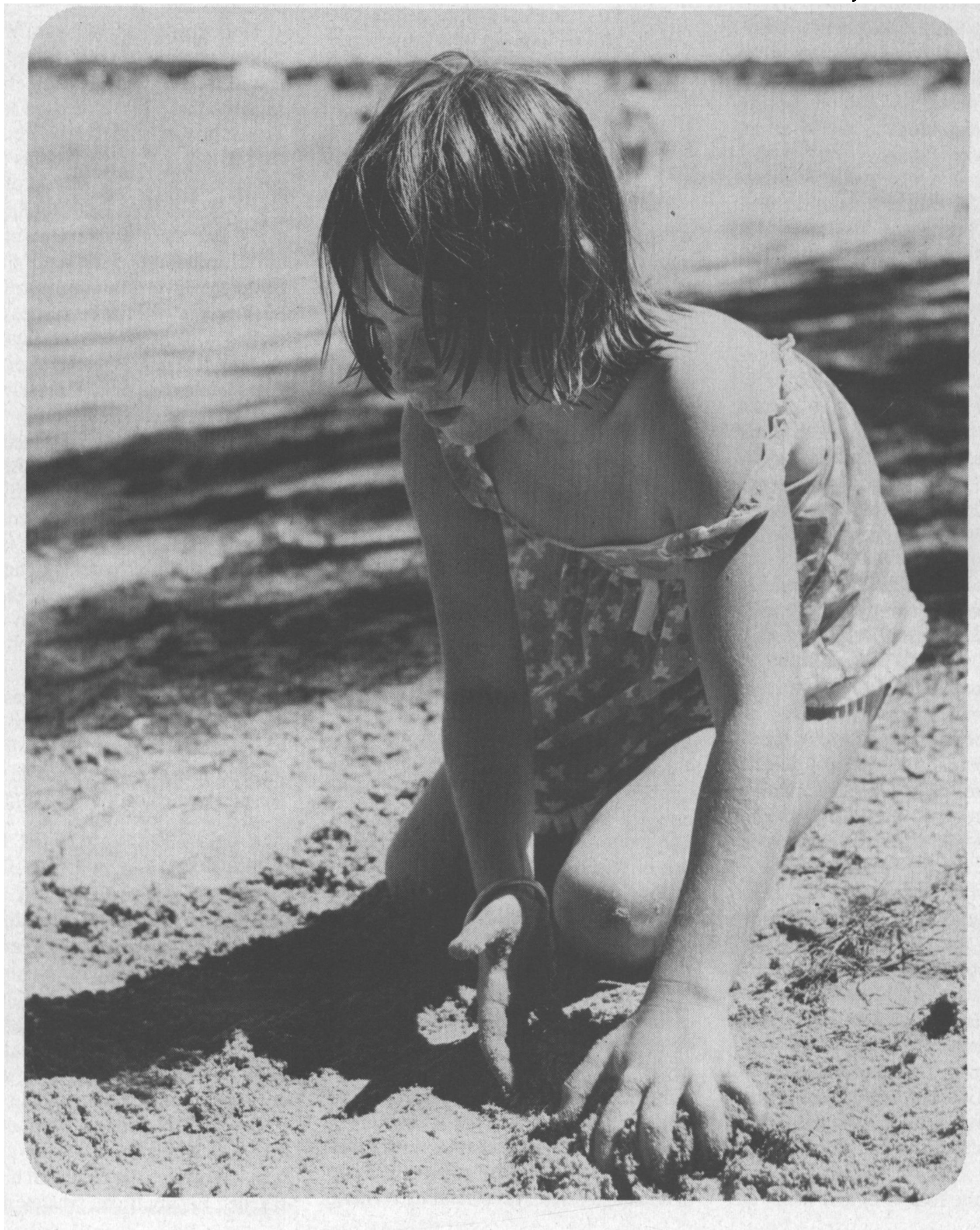

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