Foster care for intellectually handicapped children

A description of a program in Queensland

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Introduction

Over the past twenty years, concepts and ideas about the care of the intellectually handicapped have been changing. These changes are largely based on the principle of "normalisation" which originated in Scandinavia and in essence implies that the intellectually handicapped should experience as nearly as possible, and in keeping with their special needs and capabilities, normal community living (Nirge).[1]

Like any normal child, evidence suggests that the intellectually handicapped learn from experience and by experiencing (Nirge).[2] Their environment, therefore, must be stimulating and educational, enabling them to develop to their greatest potential. It is equally important that they have the opportunity for warm, intimate and long-lasting relationships which will offer the basic security needed for optimal personality development, an intrinsic pre-requisite for making the best use of other learning experiences.

The acceptance of this principle, as well as increased knowledge in the area of child development has led to an examination and questioning of the adequacy of traditional facilities for the intellectually handicapped. The result has been a world-wide move away from large, hospital-type institutional care towards community-based care. The desirability of such a trend has been recognised by practitioners and policy makers alike (see Queensland Health Paper 1976)[3]. The last two decades have seen the increase of community-based facilities designed to offer support and supplementary assistance to intellectually handicapped persons and their families. Such facilities include appropriate schools, day care, training and recreational centres, sheltered employment, medical care, where necessary and relief placement centres. As well as this, a Handicapped Person's Allowance has been introduced in Australia. For those persons in need of residential care, the trend has been towards the provision of community-based small family group homes, hostels, supervised boarding accommodation and private foster homes.

Foster Care for Intellectually Handicapped Children

"Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life." (U.N. Declaration of the Rights of Mentally Retarded Persons.)[4]

Foster care is one of several forms of substitute care which has emerged from recent thinking on the needs of intellectually handicapped children. Although it is recognized that there are many problems associated with this form of care, (only one of which is the fact that it does not really offer security to either the substitute parents or the child) it can offer the child who otherwise lacks adequate parental care, who cannot remain in his own home and who is not available for adoption, a "closer approximation to normal family living than other types of substitute care and is particularly suited to meet the child's developmental needs in a family-oriented society." (CWLA)[5]

For many children who are mildly or moderately retarded (WHO classification)[6] in the educable or trainable range, foster care can offer the most appropriate form of care. As Adams[7] points out,

"Foster care has many advantages for retarded children in that it forestalls separation from the community at large, offers greater chance for development along socially normal lines through day to day in-

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teraction with normal individuals and situations, and accustoms the community to relating to them. Where the natural family is intact or able to be rehabilitated, foster care keeps alive the chance of eventual reunion which is lessened when the child is banished to a facility that defines him in terms of his handicaps and is some distance from his home."

This latter point is expanded by Booth[8] when she says that, "It (foster care) can encourage the continued involvement of the natural family in the child's life and it can be a therapeutic tool towards the eventual reunion of the family group."

More specifically, Smith and Wilson[9], in studies with Downs Syndrome children, have shown the positive advantages of placement in a home environment. Their work stresses the importance of a stimulating environment in the early years of a child's development and they present evidence to show that Downs Syndrome children with this stimulation walk and talk earlier than children in less stimulating environments. They go on to point out that,

"Most institutions cannot provide this kind of constant teaching environment and stimulation and on the average, the I.Q. scores of Downs Syndrome children raised in institutions are 10 or 15 points lower than those living in a home setting."

The W. R. Black Handicapped Children's Centre

The Centre is primarily a home for intellectually handicapped children, but it also provides a day care service for children living in the community. It is maintained by the Uniting Church in Australia with the financial assistance of appropriate State and Commonwealth subsidies.

The Centre is located in a Brisbane suburb, and offers accommodation to about forty-five children, ranging in age from a few days old to seven or eight years. At the time of writing, approximately half the children were severely or profoundly intellectually handicapped requiring full-time nursing care whilst the remainder were moderately or mildly intellectually handicapped and did not require medical care on a full-time basis. Many of the children also had physical handicaps such as partial deafness, partial blindness or mild cerebral palsy.

The Centre has four major functions:

1. To provide short-term relief accommodation for children whose families require a rest period from the stresses which inevitably come from caring for an intellectually handicapped child at home, or for children who themselves require placement for therapeutic reasons.

2. To provide long-term accommodation for children whose families, for various reasons, are unable to care for them at home.

3. To provide a day care centre for children living in the community with their families.

4. To provide a foster care and adoption program for moderately and mildly intellectually handicapped children who have been placed in the care of the State and have little chance of returning to their own families in the near future or perhaps ever.

The Social Work Unit at the W. R. Black Handicapped Children's Centre

In the belief that "no child is unplaceable", that there are many moderately and mildly intellectually handicapped children residing in institutions who would benefit from foster care, and that there are families in the community who are both willing and capable of taking on the task, the Social Work Unit at the W. R. Black Handicapped Children's Centre was established in 1971 by the Department of Social Work at the University of Queensland. It was designed to provide a foster care and adoption program for the intellectually handicapped children in the Centre, and at the same time provide a field work training Unit for third and fourth year social work students at the University. During the period from September 1973 — June 1977, the University changed to a two semester system and the Unit operated with a new supervisor. During this time, it offered a four-month field placement each semester to two or three social work students. Because the supervisor did not carry a caseload and the work was carried out by the students, the Unit was operational for eight months each year, although maximally productive for only six months, allowing for an orientation period for each new group of students. During semester breaks, the supervisor followed up the current foster families, but no new work was undertaken.

The Role of the Social Work Unit

In all its activities from September 1973 to June 1977, The Unit worked in close co-operation with the staff at the Centre, the Health Department through the para-medical team at The Central Assessment Clinic which makes all admissions to the Centre and provides para-medical services to the residents, and The Department of Children's Services to whom the Unit was accountable for all action taken. Fortnightly meetings of these groups, were held to discuss the needs of individual children, their development, their families, and plans for their future. Information was shared and decisions were made jointly. As well as this the Unit was in constant two-way communication with members of staff, other involved professionals and relevant community based agencies.

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During their period of residence at the Centre the Unit, participating with the other team members,

(1) worked directly with the children, assisting them to overcome some of the effects of separation from their parents and to make constructive use of the home emvironment for their social, emotional and educational development;
(2) prepared the children for alternative arrangements for their care in the form of fostering, return to their own families, or in family group home accommodation;
(3) acquired knowledge about the individual child's emotional, social and developmental needs and patterns of behaviour in order to select and/or prepare appropriate foster parents, family group parents or biological parents, prior to the child's discharge from the Centre.
(4) maintained contact with the biological parents in order to help them come to terms with their feelings about their child's condition and placement in the home.

The family was encouraged to maintain maximum feasible contact with their child and to take as much responsibility as possible for the planning of the child's future. Every effort was made to help the family work towards restoration of their family situation where they could cope with their child at home and to facilitate a working relationship between the parents and home personnel or foster family by encouraging a team approach and joint responsibility for the child's care.

TABLE 1
The Unit's Caseload of Children in Foster Care for the period September 1973 to June 1977 (a)

IN OUT Year	No. of children placed in foster homes	No. of children transferred to Unit from Dept. of Children's Services	No. of children adopted	No. of children transferred to Dept. of Children's Services	Fostering broke down	Caseload at the end of any one period
Sept. 1973	—	—	—	—	—	18
Dec. 1973	5	—	—	4	2	17
1974	3	—	1	1	1	17
1975	2	1	2	—	2	16
1976	4	1	—	—	1	20
June 1977	1	1	—	—	—	22
TOTAL	15	3	3(b)	5	6	

(a) The Unit was responsible for the additional placement from the W. R. Black Home of:-
1. 3 children directly to adoptive parents.
2. 5 children to family group homes.
3. 2 children with their biological parents.

(b) These 3 children were firstly fostered and subsequently adopted.

The Foster Care Program

In September 1973, the Unit Supervisor and students inherited a caseload of 18 children in foster care, placed either by the previous Unit Supervisor and students or The Department of Children's Services. Between September 1973 and June 1977, the Unit placed an additional 15 children from the W. R. Black Centre with foster families in the community. Three cases were transferred to the Unit from The Department of children's Services during that period, and a caseload ranging between sixteen and twenty-two foster children was carried at any one time. (Table 1)

It is interesting to note that out of a total caseload of 39*, there were 6 breakdowns. This represents a breakdown rate of 15%; in other words, 6 out of 7 placements had not broken down up to June, 1977.

The reasons for the six breakdowns varied. Of the first three children who were placed prior to September, 1973, the first child was hyperactive and perceived by the foster parents as uncontrollable and disruptive to the family. She returned to the Centre and was then fostered successfully to another family. The second child was completely withdrawn and displayed little if any emotion at all, a reaction not anticipated by the staff at the Centre. He also returned to the Centre and was then placed in a family group home. In the third case, the child was severely battered by the foster mother and was removed from the home. He was transferred directly to a family group home.

The other three cases were placed by the Unit after September 1973. With the first case, the Unit underestimated the severity of the disabilities of the child. He was readmitted to W. R. Black and died soon after. With the second case, a poor assessment of the foster parents' marital stability was made in that they separated three weeks after placement. The child was transferred to a family group home. The final placement broke down when the foster mother had to be

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hospitalised for a major operation and the father faced a financial crisis in his business. The child was transferred to a family group home and subsequently fostered to another family.

* (18 children who were in placement prior to September 1973, 15 placed by the Unit during the period under review, 3 transferred from The Department of Children's Services and 3 placed directly from the W. R. Black Centre with adoptive parents)

The degree of handicap suffered by the children on the caseload at June 1977, varied widely from normal intelligence through to moderately and severely intellectually handicapped. As well as this many of the children also had physical handicaps. (Table 2).

At the time of placement, all except one were assessed as having some degree of intellectual handicap in that they manifested a developmental lag or delay in achieving the expected stages of motor, social or intellectual functioning and were seen as ultimately requiring educational facilities more highly specialised than those required by "normal" children (Volard)[10]. However, eight children subsequently proved not to be intellectually handicapped at all, some were less intellectually handicapped and others were more severely intellectually handicapped than was assumed at the time of placement.

Psychological assessments were available in all but two cases and all the children were medically assessed prior to placement. It is important to stress, however, that there are influencing factors which made it impossible to be precise about each child's intellectual handicap and predict his potential development. Firstly, the children under discussion lived for a portion of

TABLE 2

A description of the Unit's Caseload at 1.6.77

Child No.	Sex	Date of Placement	Age at Placement Yrs.	Age at Placement Mths.	Intellectual Handicap at Placement*	Physical Handicap at Placement	Parent Contact	Adopt. Consent
1	M	28.07.71	3	3	Query mild (no psychological assessment)	Speech defect	No	Yes
2	M	18.09.71	0	2	Functioning within normal limits	Webbed fingers	No	Yes
3	F	21.10.71	0	7	Query mild (no psychological assessment)	Nil	No	No
4	M	03.08.71	2	1	Mild, speech lag, tantrums	Nil	No	No
5	M	22.09.72	3	1	Mild	Cerebral Palsy, Heart Murmur	No	Yes
6	M	01.02.73	6	0	Moderate/ severe	Severe loss of vision	No	No
7	F	15.01.73	4	3	Moderate	Severe loss of vision	No	Yes
8	F	19.04.73	0	9	Mild	Squint	No	Yes
9	F	15.12.73	2	1	Moderate	Severely deaf	No	Yes
10	F	22.09.73	5	0	Moderate/ severe, hyperactive	Nil	No	Yes
11	M	16.12.73	6	3	Moderate/ severe	Cleft palate, hare lip	No	Yes

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their lives in an institutional setting and had been separated from their parents for varying lengths of time. They therefore were likely to have suffered some degree of emotional deprivation, which added a complicating factor to the assessment of their intellectual handicap. Secondly, many of the children were only a few months old when placed in foster care, making assessments very tentative.

The Fostering Process

In keeping with the philosophy of others in the field, such as Donley[11] and Booth[12], the Unit's program was based on the practice of a team approach to foster care and the belief that such a program for intellectually handicapped children should provide expertise in the understanding and management of the intellectually handicapped child. The Unit, together with allied specialist agencies, worked with the foster family and the biological parents (where they were involved) for the benefit of the child, sharing equally the responsibility for the child's welfare. All team members were recognised as colleagues, each with a specialist contribution to make which was acknowledged and respected.

The fostering process can be seen as having four phases:

1. Recruitment
2. Education, counselling and selection
3. Placement
4. Follow up.

Recruitment

During the period from September 1973 to June 1977 the supervisor and students at the Social Work Unit became increasingly aware of the difficulties involved in recruiting foster parents for the intellectually handicapped children in the Centre. Throughout this time, a great deal of effort was invested in planning and carrying out recruiting

TABLE 2 (continued)

12	F	15.12.73	4	7	Mild, severe speech lag	Nil	No	No
13	M	31.10.73	2	7	Mild, compulsive eater, tantrums	Flat feet	No	Yes
14	M	28.01.74	3	2	Moderate/ mild	Cleft palate	No	Yes
15	F	31.07.74	3	5	Downs Syndrome, moderate	Nil	No	No
16	M	17.07.75	2	6	Moderate/ severe, Hyperactive	Mild cerebral palsy	No	No
17	M	17.10.75	3	5	Downs Syndrome, Moderate	Nil	No	No
18	M	16.01.76	9	9	Hydrocephalus, Moderate	Cerebral palsy	No	No
19	F	05.11.76	0	6	Downs Syndrome, Moderate	Nil	No	Yes
20	M	09.08.76	3	4	Downs Syndrome, Moderate	Poor balance/ muscle tone/& motor co-ordination	No	No
21	M	11.02.77	0	3	Microcephalus, query moderate	Clicky hips	No	Yes
22	F	19.03.77	1	4	Downs Syndrome	Minor cleft palate	Yes	No

* WHO classifications — see The Senate Standing Committee Report on Mentally and Physically Handicapped Persons in Australia, 1971, Parliamentary Paper No. 45, p.2.

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campaigns, i.e., attempts were made to interest and educate people in the task of fostering intellectually handicapped children.

In 1974 and 1975, regular publicity was carried out throughout each year and the following media were utilized.

1. **Newspapers.** There were three articles in the daily press and three consecutive articles in a local paper in 1974. There were two articles in the daily press and one in a local paper in 1975.

2. **Women's magazines.** There was one article in the Australian Women's Weekly in 1974. There was one article in Woman's Day in 1975.

3. **Radio.** There was participation in one daytime and one evening "talk-back" program in 1974 and in two daytime "talkback" programs in 1975.

4. **Television.** There was one ten minute segment on "This Day Tonight" current affairs program and one interview on a daytime show in 1974.

5. **Pamphlets.** In 1974, pamphlets outlining the foster care program were sent to all dentists and doctors (excluding psychiatrists) in the Brisbane metropolitan area, to be placed in waiting rooms. Pamphlets were distributed at the Brisbane Exhibition and the Home Show in 1975.

6. **Information booths.** Three information booths, at three different shopping complexes in Brisbane, were manned in 1975.

As well as this, the students spoke at two church auxiliary meetings, two Rotary group meetings and two Foster Parent Association meetings, and the supervisor spoke at a public meeting held during "Child Care Week" in Brisbane in 1974. In 1975, the students spoke at one church auxiliary meeting, one Rotary group meeting, two Foster Parent Association meetings and one school parent's meeting.

Apart from one press article in 1974 when 10 telephone inquiries were received, none of these efforts yielded more than three or four inquiries. In 1974, only one of the foster placements made was directly attributable to the recruiting campaign and in 1975 neither of the two foster families were recruited from these sources.

During April and May 1976 and in March and April, 1977, the Unit conducted an intensive media campaign as a build up and public invitation to a workshop for interested families and intending applicants. In 1976, 41 people representing 25 families attended the workshop from which one family fostered a Downs Syndrome child within six months and another family fostered some three months later. In 1977 the media campaign included five appearances on "talk-back" radio, appearances on one daytime and one evening television program and some limited coverage in newspapers (one daily, one widely circulated local paper in two consecutive weeks, and an article in the Catholic Leader). The Foster Parent Association (Qld.) also publicised the workshop in their newsletter.

The immediate response was encouraging; but many who responded subsequently failed to attend the workshop and only two families pursued the idea and embarked on the education phase. It is possible that one placement will be made in 1977 which is directly attributable to the workshop and its preceding publicity — Table 3 indicates the sources used in the 1977 media campaign, the number of responses to each and the numbers who attended the workshop.

Although these figures illustrate the difficulty the Unit had in recruiting suitable foster parent applicants, it is hard to gauge the general effect of raising community consciousness to the needs of intellectually handicapped children and the fostering program. Hopefully, it contributed to the overall education process that must take place if community attitudes to the intellectually handicapped are to become more accepting. Thus, if the fostering program did not benefit directly, then a second purpose may have been served.

TABLE 3

Attendance at Workshop Attributable to different media, 1977.

SOURCE	INITIAL RESPONSE	ATTENDED WORKSHOP
Radio	7	4
T.V.	0	0
Newspaper	6	1
F.P.A.Q. Newsletter	3	3
TOTAL	16	8

Education, Counselling and Selection

The length and intensity of this phase varied according to applicants' experience and knowledge about both foster care and children with intellectual and physical handicaps. In keeping with the Unit's philosophy of a team approach to foster care, this phase was seen as a mutual education time leading to a decision by the applicants as to whether they wished to embark on the fostering task, and a decision by the applicants and the Unit that they

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could work together as team members with the biological family (where they were involved) and other community based agencies and professionals, for the benefit of the child.

During this phase, the applicant family participated in discussions either in groups where there were other families interested, or independently. When group meetings were held, the family was seen independently as well. Three consecutive group meetings were held where applicants had the opportunity to talk with psychologists from The Central Assessment Clinic, staff from the Unit and W. R. Black, and experts on fostering from the Department of Children's Services. Concurrently with the meetings, applicants were encouraged to observe intellectually handicapped children at schools for sub-normal children, visit families currently fostering intellectually handicapped children, visit the children in the W. R. Black Centre, and read as widely as possible in the area. The Unit had a range of phamphlets and articles available for this purpose.

As well as facilitating the educative process, the Unit had a counselling role. All families were visited at least three times in their homes. At these interviews applicants were encouraged to assess their own circumstances and feelings relating to foster care of intellectually handicapped children and to discuss any issues that may have arisen in group meetings, or concerns they may have had relating to the task. At the same time, the Unit aimed to learn as much as it could about the family. This was in order to select in an informed way a child which would benefit from being with a particular family and fit into that family's framework. Once a decision had been made to the satisfaction of both the Unit and the family, an assessment report was submitted to The Department of Children's Services for approval of that family as potential foster parents. (All fostering is carried out by the Department in Queensland). The applicant then made an official application to the Department and carried out other official requirements.

Placement

Once approval had been given by the Department, and where the Unit was able to select a potentially suitable child for the family, a "getting-to-know-you" time was undertaken. During this period, a gradual build up in the relationship between the child and the foster parents was attempted, starting with visits to W. R. Black, leading to outings and then perhaps to weekends at the foster parents' home. The length of this time varied according to individual circumstances, such as the age of the child, and the accessibility of W. R. Black for the family to visit the child.

When a placement became imminent, the foster family was introduced to the biological family if they were involved and, in conjunction with the Unit, appropriate arrangements were worked out for the biological family to visit and maintain contact with their child and to remain involved in its development and in the planning of its future. In reality, very few of the children who were placed by the Unit had interested biological parents who maintained contact with them. Most of the placements were seen as long-term or deferred adoption. Twelve of the children out of the twenty-two on the caseload at June 1977 in fact, had adoption consents, and it was anticipated that most of these would eventually be adopted by their foster family.

This "getting-to-know-you" time was seen by the Unit as a most important one for both the child and the family. Needless to say, the outcome of a placement is never predictable. However, the Unit had to be as certain as possible that the placement would be beneficial for the child and that the family would be able to meet its needs. Likewise, the family needed to be as sure as possible that they would be able to cope with the child and that it would fit into their family situation. A broken placement adversely affects all concerned, most of all the child.

Follow up

After placement, the Unit maintained close contact with the foster family. Regular visits were made (usually once a month) and there was an attempt to build up a firm working relationship with the family, a practice seen as important to the notion of shared task and responsibility.

The task of fostering an intellectually handicapped child is a demanding one, both physically and psychologically and foster parents cannot be expected to carry it out unless adequate resources and backup services are provided to assist them. The Unit therefore tried to be available to them whenever needed. The Unit offered support and counselling and directed the families to appropriate resources in the community.

A strong community based support system is necessary to operate alongside such a foster care program; facilities such as day care, special schools, relief placement and holiday accommodation are needed to the same extent by foster families as they are by families who are maintaining their own intellectually handicapped child at home (Q.C.O.S.S.)[13].

The Unit and the families relied very heavily on the assistance and co-operation of various agencies and professionals in the community.

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The Health Department, through The Central Assessment Clinic, provided support by offering psychological assessments and developing behaviour and environmental programs for the children, where necessary. As well, they offered advice on management problems, and the services of other paramedical personnel such as occupational thereapists, physiotherapists and speech therapists. The Department of Children's Services assisted families with matters relating to foster care and provided a fostering allowance and assistance with clothing, extra travelling expenses, etc. Some foster families received the Handicapped Person's Allowance which helped meet the added costs of maintaining an intellectually handicapped child.

Day care and relief placement were available at W. R. Black if the parents felt they needed a break or were going away on holiday and the Unit also had a valuable, if small, pool of families for relief purposes. Many of the children were attending special schools in the community and the Unit liaised with these, offering information about the child's background, and the nature of its handicap and behavioural problems, if any. Where a child was attending normal pre-school (which was encouraged), the Unit offered any assistance possible, and where necessary, a psychologist was available through the Central Assessment Clinic to interpret the child's behaviour and needs and offer advice.

Conclusion

At the time of writing, the success of the Social Work Unit's foster care program is still to be shown. The children have been in placement for a relatively short time (the longest is six years) and many hurdles have yet to be overcome, particularly as the children approach adolescence and adulthood when decisions relating to their employment, accommodation and sexuality will have to be made. Problems such as the recruitment of suitable foster parents and the paucity of community based services, need further investigation and many of the techniques and methods used at the Unit need to be evaluated in the light of experience.

What has been shown is that intellectually handicapped children are placeable, and that there are altruistic people in the community who are willing to offer such children warm, intimate and longlasting relationships in their homes, and give them the time and individual attention that is necessary if their developmental needs are to be met.

Foster care is gradually becoming more recognised as an appropriate form of substitute care for intellectually handicapped children and it is hoped that, in the light of the Unit's experience, other agencies might be encouraged to establish specialist sections to develop foster care and adoption programs for such children.

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