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ORIGINAL PAPER

Prevention of Instability in Foster Care: A Case File Review Study

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Abstract

Background Stability in foster care is paramount, since it enables children with a history of maltreatment to experience secure attachment relationships, and decreases the risk for behavioral and emotional problems when growing up.

Objective We investigated whether foster care interventions play a role in enhancing foster placement stability, in addition to several characteristics of foster children and foster families. Our hypothesis was that foster children of female gender, relatively young at start of the placement, with less previous foster care placements, staying in kinship care, placed with siblings (if they had any) and in a foster family receiving a training to enhance the foster parents' knowledge on childhood trauma, an attachment-based video-interaction intervention or Treatment Foster Care, would experience significantly less breakdown in foster care.

Method A multilevel analysis was conducted on data from 2000 foster care placements in a 4 year period (2015–2018), concerning 1316 foster families (35.9% kin) and 1542 foster children (49.4% boys, $M^{age} = 7.54$ years).

Results The frequency of previous foster care placements (OR = 3.56) increased the risk for breakdown, and receiving the Basic Trust intervention (OR = 0.26) or Treatment Foster Care (OR = 0.11) decreased that risk. Other investigated variables were unrelated to breakdown when checked for the number of foster placements and the applied interventions.

Conclusions Foster care organizations should systematically monitor important risk factors for breakdown, in order to (timely) intervene if necessary to enhance the chances for continuity of foster care placements. Treatment seems to make a difference.

Keywords Foster care · Multilevel analysis · Breakdown · Instability · Basic Trust · Treatment Foster Care · Trauma-informed parenting

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Introduction

Most out-of-home placed children stay in foster care. In the United States, 77% of about 437.000 out-of-home placed children (AFCARS Report 2019), in England 73% of approximately 54.000 looked-after children (Department of Education 2019) and in the Netherlands 51% of almost 43.000 out-of-home placed children (CBS 2020) live in foster families. The experiences of children placed in foster care are more positive than of children in residential care (Li et al. 2019). Main reasons why children cannot grow up with their parents are inadequate parenting, such as abusive and neglectful parental behavior, often combined with parental psychopathology, delinquency and/or substance abuse (McDonald and Brook 2009; Okma-Rayzner 2006; Shaw et al. 2015). Foster children can stay in foster care for a short time or for the long-term, and in families of relatives (kinship care) or in a family recruited by a foster care organization. Kinship care has become the preferred placement option, as this provides the best guarantee for continuity of family relationships, participation in the community, and school attendance (i.e., remain in the community and attend the same school) (Barber and Delfabbro 2005; Bell and Romano 2017).

Foster children, who often have a history of maltreatment before placement, are likely to develop insecure attachment relationships (Cyr et al. 2010), which have been shown to be associated with deficiencies in socio-emotional and behavioral development (Colonnesi et al. 2011; Groh et al. 2017; Hoeve et al. 2012; Madigan et al. 2016; Spruit et al. 2020). Despite a disruption in their lives, children appear to be able to organize their behavior around the availability of new caregivers and develop secure attachment relationships with foster parents (Dozier et al. 2001). Secure attachment with foster parents may decrease the risk for emotion-regulation problems (Brumariu 2015), externalizing and internalizing problems (Madigan et al. 2016), delinquent behavior (Ryan and Testa 2005), and psychopathology (Humphreys et al. 2015). Prerequisite for developing secure relationships is stability of the foster care placement. In addition, potential negative consequences of placement instability are social and academic problems, negative self-esteem, and increased distrust in guardians and other adults (Rock et al. 2015). Therefore, the main goal of long-term foster care is continuity and decreasing the risk for disruption of the placement.

Placement instability or placement breakdown can be defined as premature ending of a foster placement (before the goals were reached) and/or moving to another foster family (Konijn et al. 2019; Oosterman et al. 2007; Rock et al. 2015). According to a recent meta-analytic review, the risk for placement instability is highest for children with behavioral problems, children who stay in non-kinship care, and children with less competent foster parents (Konijn et al. 2019). Younger age at first placement, being a girl, and placement with siblings may reduce the risk for breakdown (Konijn et al. 2019; Rock et al. 2015). A history of residential and foster care placements have been positively associated with future placement instability (Oosterman et al. 2007; Rock et al. 2015). Placement breakdown often leads to the child 'giving up', 'disconnecting', 'detaching' or 'withdrawing' from people, which is compounded by the loss of social networks and connections to school (Rock et al. 2015). However, in a meta-analysis of 42 studies published between 1990 and 2017, Konijn et al. (2019) found no significant unique effect of a history of out-of-home placements on instability of foster care. Other factors were more important.

The most important risk factors for placement instability—behavioral problems of foster children and less sensitive parenting—mutually affect each other. Foster children may show more problem behavior as a consequence of their history of maltreatment and insecure attachment relationships in the birth family, challenging the parenting competence of

their foster parents (Goemans et al. 2015). Also, foster parents who have problems with setting and maintaining boundaries (Crum 2010), and with reacting adequately to the emotional and developmental age of the foster child (Lipscombe et al. 2003), develop more parenting stress (Neece et al. 2012), which in turn increases behavioral difficulties in their foster children (Newton et al. 2000). Hence, parents and children who influence each other with their behavior both contribute to the (in)stability of foster care.

Timely detection of behavioral problems and the competence to respond adequately to difficult behavior are necessary conditions for addressing placement instability. Sufficient knowledge on the impact of childhood trauma and understanding why foster children may show problem behavior may enable foster parents to prevent worsening the difficulties they encounter. Foster parents who have trauma-informed attributions of children's behaviors are more likely to respond to their children in a way that helps to establish secure relationships (Kelly and Salmon 2014; Sullivan et al. 2016). Offering secure attachment experiences with emotionally available and sensitive foster parents may therefore contribute to positive development of foster children and a decrease of behavioral problems (see Zeanah et al. 2016).

Responsive and sensitive foster parents may reduce the risk for placement breakdown through their positive impact on their foster child's development (James 2004). Foster parents' sensitivity to their foster child's needs (Verhage et al. 2016) and the capacity to represent their foster child as an independent individual with own thoughts, feelings, emotions, wishes and longings (Bernier and Dozier 2003), also known as parental 'mind-mindedness' (Meins 1997), are crucial conditions for positive socio-emotional development of the children. For instance, a foster parent gave the following mind-minded description of her foster child (mind-related comments are in *italics*): 'She has been through a lot in her short life. She is a tremendous go-getter. *She sometimes feels a strong anger inside* and has temper tantrums because of that. *But she is eager to learn how to do things differently* and she really tries… However, she still is very vulnerable, especially in contact with other children… *She easily feels rejected*…' Mothers' mind-mindedness has been found to be associated with sensitive parenting and secure attachment relationships (Zeegers et al. 2017) and less maladaptive behavior (Colonnesi et al. 2019). Several interventions, aiming to enhance the sensitivity, mind-mindedness of foster parents, and secure attachment experiences have a certain impact on the child's behavioral, emotional and relational functioning (Kerr and Cossar 2014) and therefore, they may decrease instability of foster care placements.

In order to prevent foster placement instability, parenting interventions that improve foster parents' knowledge on the impact of trauma, target parenting skills and enhance the quality of foster parent–child relationship seem appropriate. Examples of these type of interventions are specific trainings for foster parents, such as Pressley Ridge's Treatment Foster Care pre-service training (Strickler et al. 2018) and the trauma-informed parenting training 'Caring for children who have experienced trauma', developed by the National Child Traumatic Stress Network (Coppens and Van Kregten 2012; Grillo and Lott 2010). This latter training aims to break the negative circle of traumatic stress, behavior problems and parenting stress by improving foster parents' knowledge on childhood trauma, their sensitivity towards the needs of their foster child, and their level of mind-mindedness. Evaluation of this training showed an increase of the foster parents' positive mind-mindedness (Konijn et al. 2020), associated with parental sensitivity (Demers et al. 2010). Also, 3 months after the last session, the number of foster children who received trauma-focused treatment had been increased and parental reported post-traumatic stress symptoms in the foster children had been reduced (Konijn et al. 2020). Two trained youth care professionals

conduct the training with groups of 10 to 12 foster parents in 8 weekly sessions of 2.5 h: (1) Introductions, (2) Types of trauma, (3) Understanding the impact of trauma, (4) Building a safe place for the children, (5) Dealing with feelings and behaviors, (6) Connections and healing, (7) Becoming an advocate for your child and (8) Taking care of yourself (Coppens and Van Kregten 2012; Grillo and Lott 2010).

Attachment-based interventions may be used to prevent foster placement instability (Kerr and Cossar 2014) through the enhancement of parental sensitivity and mind-mindedness, parenting skills, and the quality of parent–child relationship. Examples of such interventions are Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline in Foster Care (VIPP-FC; Juffer et al. 2008; Schoemaker et al. 2020) and the Basic Trust intervention (Polderman 1998; Colonnesi et al. 2013; Zeegers et al. 2019). Basic Trust contains on average eight sessions with video-feedback for parents of children with attachment difficulties (Polderman 1998). The therapist records natural interactions between parent and child in regular settings, such as eating dinner or playing together, selects images for a recording and subsequently reviews these with the foster parents. In feedback sessions the parent–child interaction is analyzed, and the foster parents receive support and advice to strengthen their relationship with the foster child. Basic Trust teaches parents to practice a specific communication skill, that is, 'naming' the behaviors, feelings, intentions, and thoughts of the child according to a set of criteria (Polderman 1998). The 'naming' should be clear and concrete descriptions of actual behaviors and mental states of the child, neutrally verbalized, so the child becomes conscious of its experience, which is thought to enable adequate self-regulation (Schore and Schore 2008). Moreover, 'naming' communicates acceptance of the child as a person (Polderman 1998). 'Naming' is a crucial interaction principle to promote attachment security in children, to facilitate the child's ability to recognize its own feelings, thoughts and intentions, and those of others, advancing the process of mentalizing (Colonnesi et al. 2013). Several meta-analyses showed positive effects of attachment-based interventions on both maternal sensitivity and child security (Bakermans-Kranenburg et al. 2003, 2005; Facompré et al. 2018; Wright et al. 2017).

Therapeutic or Treatment Foster Care (TFC; Turner and Macdonald 2011) are other intervention models that may prevent instability of foster care placements through decreasing problem behavior in foster children. To realize behavioral change, TFC not only targets the foster child's problematic behavior, but also parenting skills of foster parents, and the foster parent–child relationship or interaction (Kerr and Cossar 2014). The TFC-model has been used to develop several programmes for foster parents, such as Multidimensional treatment foster care (Fisher and Chamberlain 2000; Fisher and Gilliam 2012), Together Facing the Challenge (Farmer et al. 2010), and KEEP (Keeping Foster and Kinship Parents Supported and Trained; Price et al. 2009). In these TFC-models, foster parents receive training in parenting skills to manage challenging behavior of their foster child. They also receive support, consultation, and supervision from professionals in their own foster home (Turner and Macdonald 2011). Foster children are trained to enhance their social and problem-solving skills, and are stimulated to show positive behavior by positive feedback from their foster parents (Fisher and Chamberlain 2000). When needed, foster children receive additional individual treatment.

TFC, as carried out in the present study, comprised the following elements (Van der Kooij and Bolle 2014). First, foster parents received the training 'Caring for children who have experienced trauma' (Coppens and Van Kregten 2012; Grillo and Lott 2010). Second, foster parents receive support tailored to their situation, targeting their parenting skills and parental sensitivity, enabling them to manage possible behavior problems of their foster child. Third, when needed, the foster children receive trauma

treatment, for some preceded by a so called Dragon Tamer Training, which prepares them to profit from trauma-focused treatment. The Dragon Tamer Training helps a group of six foster children in the age of 7 to 12 years to stabilize themselves and each other (peer support). The training contains eight two-weekly sessions of 2 h. The dragon is used as a symbol of the traumatic events that the child has experienced, and the child is given tools to tame that dragon: psycho-education, relaxation and emotion regulation skills (Schlattmann et al. 2020). Fourth, the biological parents are motivated to accept the foster care placement of their child, and to cooperate with the foster parents, which is considered to be an important condition for a stable foster care placement (Rock et al. 2015).

Several interventions have been evaluated with respect to the decrease of problem behavior in foster children and/or an increase of sensitivity and parenting skills of the foster parents (Van Andel et al. 2014), factors with a known association with foster care (in)stability (Konijn et al. 2019). As far as we know, these interventions have not been evaluated with respect to a direct relation with (in)stability of foster care placements. In the present study, we examined the association between different characteristics of foster care placements and foster children, reception of foster care interventions and foster placement instability. Our hypothesis was that foster children of female gender, who were relatively young at placement, who had less previous foster care placements, who stayed in kinship care, were placed with siblings (if they had any) and in a foster family that received additional training and/or treatment, would experience significantly less breakdown in foster care.

Method

Data

Data was extracted from administrative electronic data client files of two Dutch Youth Care organizations that provide, alongside other types of youth and adolescent care and psychiatric services, foster care training and support of 1486 foster families in the region of Amsterdam. In the client files care providers document characteristics of the client and the care they provide: gender, date of birth, dates of beginning and ending of the foster care placement, type of foster care, interventions delivered, the way placement was ended. Also, the client files contain the foster care plan with the family history, childhood experiences, problems of the child(ren) and parents, and the goals they want to achieve with the foster care placement. In this study, we used the data of the administrative part of the client files. Within a set of conditions from the researchers, the Youth Care organizations provided the required information about a cohort of foster care placements for the analysis (see Participants). Data was made available anonymously, not reducible to persons or small groups of persons, and therefore, under current European legislation, not considered as personal data. Explicit permission to use the data for scientific research was not necessary. Participants had been informed about the use of their data for research at start of the foster care placement. At that moment, foster parents, biological parents, and children received information from the care provider that data collected during care provision could be used anonymously for scientific research to learn how to improve foster care (Spirit 2018).

Design

A multilevel model was used to investigate the association of several factors with the (in)stability in foster care placements. Data were obtained at the level of foster families (level 1) and of foster children (level 2). The (in)stability of foster care placements for foster children was nested in foster families. The dependent variable, the (in)stability of foster care, was defined as premature ending of the foster care placement (before the goals were reached) and/or moving the foster child from one to another foster family on the one-sided initiative of the foster child, foster parents or care provider, as administered by the supervising social worker.

The independent variables of the foster children were: age of the foster child at start of the placement, gender of the foster child, number of foster families the foster child stayed in (including the present one), and whether the placement was with or without siblings. The independent variables of the foster family were: type of foster care (kinship versus non-kinship foster care), the interventions received, in addition to the usual guidance of the social workers: the training 'Caring for children who have experienced trauma', the Basic Trust intervention, Treatment Foster Care, and no additional intervention. Each variable was dichotomous. The present study examined the association of foster parents' training with foster placement instability in a stand-alone version and as part of a multidimensional foster care program. The foster care as usual, which all foster parents received, was focused on grief processing in parents and child, acceptance of the foster care placement by the biological parents, parenting skills of the foster parents and positive development of the foster child. If necessary, the foster child received additional treatment.

Statistic Approach

To examine the factors associated with foster placement breakdown, a multilevel logistic regression analysis was conducted with the Statistical Package for the Social Sciences SPSS 25. All variables were dichotomous, except the foster child's age, and the number of placements foster children experienced. Because not all foster children had biological siblings staying in foster care, we created two dichotomous dummy variables for the variable 'with(out) siblings': 'with siblings' (1 = the foster child lived in a foster family together with one or more siblings, 0 = all other cases) and 'without siblings' (1 = the foster child had a sibling but did not live together with him/her in the foster family, 0 = all other cases). To examine the impact of the interventions, we created three dummy variables: Basic Trust versus no Basic Trust, TFC versus no TFC, training 'Caring for children who experienced trauma' versus no training. The breakdown variable was coded '1' when either the child moved to another foster family or the placement ended prematurely by a one-sided initiative of the foster child, foster parents or care provider. In all other cases 'breakdown' was coded as '0'. The dataset was supplemented with the number of foster families the foster child lived in during the research period. A significance level of $p < .05$ was used. Assumptions were checked, including multicollinearity, which proved not to be violated.

Results

Demographics

The study sample included 1316 foster families of whom one third was kin of the foster child, and 1542 foster children with a mean age of 7.5 years at start of the foster care placement (Table 1). One-third of the foster children was placed before their fourth birthday, almost half when they were 5 to 12 years and one in six children when they were 13 years or older. Almost 70% of the foster children stayed in one foster family, and 30% in more than one. Foster children in kinship care stayed more often in one family (82%; $M = 1.28$, range: 1–5; $SD = 0.667$) than children in other foster families (49%; $M = 1.73$, range 1–6; $SD = 0.913$) ($p = .000$; $t\ (1540) = 10.338$). Almost half of the foster children had a brother or sister who also stayed in foster care, and two-third of them stayed with their sibling in the same foster family (Table 1).

Foster Care Placements

The dataset was made up of foster care placements ($N = 2000$) that were active on 2018, December 31, or terminated in the period January 2015—December 2018, a research window of 4 years. At the end of 2018, 60% of the placements was ongoing with a mean duration of 4 years, 22% was regularly terminated in the 4 years of the research period, after a mean duration of nearly 2 years. Finally, 18% had been prematurely ended after a mean duration of 1.31 years (Table 1).

Foster Care Interventions

One in seven foster families received a foster care intervention: 132 families attended the foster parents training (6.6%), 116 received the Basic Trust intervention (5.8%) and 87 Treatment Foster Care (4.4%). Seven families received the Basic Trust intervention as well as Treatment Foster Care (0.35%), and fifteen families received the Basic Trust intervention as well as the foster parents training (0.75%). All families that received Treatment Foster Care attended also the training 'Caring for children who have experienced trauma' as this is a standard component of the treatment program. The foster families that received the Basic Trust intervention fostered children who were younger of age ($M = 4.9$ years; $SD = 3.48$) than those who attended the training ($M = 8.0$ years; $SD = 4.40$) or got Treatment Foster Care ($M = 8.5$ years; $SD = 4.07$).

Associations Between the Variables

The type of foster care (kin or no-kin), placement with(out) siblings, and the number of previous foster care placements were correlated with foster placement breakdown. Children who stayed in kinship care and were placed with siblings, experienced less breakdown than other foster children. The relation between these factors was significant but small, $r\ (1999) = -.16$, $p = .000$ and $r\ (1999) = .09$, $p = .006$, respectively. Also, the more foster placements the children experienced, the more placement breakdown occurred. This association was significant and large, $r\ (1999) = .49$, $p = .000$. Finally, two of the three interventions—Basic Trust, $r\ (1999) = -.06$, $p = .014$, and Treatment Foster Care, $r\ (1999) = -.07$,

Table 1 Descriptive statistics of the study variables

Variables	*N*	%	*M*	*SD*	Range
Foster families	1316				
Type of foster care					
Kinship care	472	35.9			
Non-relative foster care	844	64.1			
Foster children	1542				
Gender					
Boys	769	49.9			
Girls	773	50.1			
Age (in years) at start of foster care placement			7.54	4.817	0.00–19.37
0–4 years	531	34.4			
5–8 years	435	28.2			
9–12 years	321	20.8			
13–16 years	220	14.3			
17 years and older	35	2.3			
Number of foster families the foster children stayed in			1.45	0.800	1.00–6.00
Foster children that stayed in one foster family only	1069	69.3			
Foster children that stayed with more than one foster family	473	30.7			
Foster care placements	2000				
Placements of children without siblings	1089	54.4			
Placements of children with siblings	911	45.6			
Siblings placed in the same foster family	595	65.3			
Siblings placed in different foster families	316	34.7			
Duration (in years) by type of placement					
Ongoing placement (duration at 2018, 31th Dec)	1208	60.4	4.04	3.390	0.01–19.05
Regular ended of placement	434	21.7	1.90	2.333	0.03–18.05
Premature termination of placement	358	17.9	1.31	1.920	0.01–12.52
Interventions					
Training caring for children who have experienced trauma	132	6.6			
Mean age of the foster children (in years)			8.042	4.404	0.01–18.04
Basic trust intervention	116	5.8			
Mean age of the foster children (in years)			4.910	3.481	0.09–13.28
Treatment Foster Care (incl. Training Caring for children who have experienced trauma)	87	4.4			
Mean age of the foster children (in years)			8.516	4.073	0.01–17.40
No interventions	1696	84.8			
Mean age of the foster children (in years)			7.988	4.979	0.00–19.37

N number, % percentage, *M* mean, *SD* standard deviation

$p = .001$—showed significant negative correlations with breakdown. This may indicate that these interventions play a role in preventing foster placement breakdown.

Foster children who were placed together with their sibling lived more often in kinship care than in foster families recruited by the foster care organization, $r\ (1999) = .20$, $p = .000$. Foster children with a history of more placements lived more often in non-kinship foster families than in kinship care and less often together with their siblings, $r\ (1999) = -\ .30$,

$p = .000$ and $r\ (1999) = -.13$, $p = .000$, respectively. The training 'Caring for children who have experienced trauma' and Basic Trust were delivered more often to non-kinship than kinship foster families, and to foster families that cared for one foster child and not siblings, $r\ (1999) = -.17$, $p = .000$ and $r\ (910) = -.07$, $p = .049$, respectively. Treatment Foster Care showed no association with the type of foster care nor the care for siblings. Finally, the training for foster parents was often delivered to the same families as those receiving Basic Trust or Treatment Foster Care, $r\ (1999) = .06$, $p = .005$ and $r\ (1999) = .06$, $p = .006$, respectively. Treatment Foster Care and Basic Trust, however, were not often given to the same foster families.

Foster Placement (In)stability

The results of the multilevel logistic regression analyses are reported in Table 2. Foster placement (in)stability was found to be significantly associated with the number of foster families where the foster child had stayed, $b = 1.27$ and OR = 3.56, $p = .000$, and receiving the Basic Trust intervention, $b = -1.33$ and OR = 0.26, $p = .001$, and Treatment Foster Care $b = -2.19$ and OR = 0.11, $p = .000$. The age and gender of the foster child, placement with(out) siblings and the type of foster care (kin or no-kinship care) did not have a unique contribution to the (in)stability of foster care placements. Finally, the stand-alone version of the training 'Caring for children who have experienced trauma' was not significantly associated with (in)stability of foster care.

Discussion

In the present study, we examined the contribution of several factors to placement instability in foster care, and whether foster care interventions can play a role in preventing foster care breakdown. Our results showed that a higher frequency of foster care placements was associated with breakdown or instability in foster care. The odds for breakdown of every next foster care placement was 3.6 times higher than for the first one. The results also indicated that foster care interventions might play a role in the prevention of foster care instability. The odds that a foster care placement ended up in breakdown in foster families that received the Basic Trust intervention were 26% smaller, and for those who received Treatment Foster Care 11% smaller than in foster families that received no additional intervention. The training 'Caring for children who have experienced trauma' in the stand-alone version was not significantly associated with placement stability. As mentioned before, this training was also an element of Treatment Foster Care, and possibly, in that context, contributed to decreasing the risk for breakdown. Finally, also gender and age of the foster child, the type of foster care (kin or no kinship), and placement with(out) siblings were not significantly associated with placement (in)stability.

The finding that the number of previous placements was associated with placement instability is not in line with a recent meta-analysis of foster care instability (Konijn et al. 2019). However, their study was not limited to the history of foster care placements but considered all prior out-of-home placements, including residential care. The combination of these findings could indicate that foster care instability was mainly determined by prior placements in foster care, and less by those in residential care. However, this is contradicted by the meta-analysis of Oosterman et al. (2007) and the review of Rock et al. (2015), which found a positive association between placement breakdown and a

Table 2 Multilevel logistic regression analysis: predictors of foster care placement breakdown

Predictors	*b*	SE	*t*	*p*	*OR*	95% confidence interval for *OR*	
						Lower	Upper
Foster care versus kinship care	− 0.276	0.1707	− 1.619	.106	0.759	0.543	1.06
Age of foster child at start placement	0.021	0.0161	1.287	.198	1.021	0.989	1.054
Gender of the foster child (1 = boy. 2 = girl)	− 0.018	0.1510	− 0.117	.907	0.982	0.731	1.321
Number of foster families the foster child stayed in	1.270	0.0787	16.127**	.000	3.561	3.051	4.155
Placement							
Without siblings	0.253	0.2001	1.263	.207	1.288	0.870	1.907
With siblings	− 0.040	0.1850	− 0.217	.828	0.961	0.668	1.381
Intervention							
Training 'Caring for children who have experienced trauma'	− 0.351	0.3385	− 1.037	.300	0.704	0.362	1.367
Basic Trust intervention	− 1.333	0.3841	− 3.472**	.001	0.264	0.124	0.56
Treatment Foster Care	− 2.188	0.5564	− 3.933**	.000	0.112	0.038	0.334

b unstandardized regression coefficient, *SE* standard error, *OR* odds ratio

*$p < .05$; **$p < .01$

history of residential care. Konijn et al. (2019) did not find sufficient studies to examine the potential moderating effect of the type of previous placements, that is, residential placement(s) versus foster care. More research is needed on the relation between the history of out-of-home care and placement instability.

Treatment Foster Care, focusing on changing problem behavioral in a foster child by enhancing parenting skills of foster parents, and the quality of the foster parent–child relationship or interaction (Kerr and Cossar 2014) showed a positive association with stabilization of foster care placements. As problem behavior of foster children is the most important risk factor for placement breakdown (Konijn et al. 2019), this is not a surprising result. Additionally, the foster children in our study received, if needed, a preparatory program for enhancing motivation for treatment and, thereafter, also trauma-focused treatment. The foster parents received the training 'Caring for children who have experienced trauma' (Coppens and Van Kregten 2012) in this context of treatment and support. Whether the program as a whole or particular treatment components, such as this training, contributed to the prevention of breakdown, could not be examined because these data were not available.

Although shorter and less intensive, the Basic Trust intervention seems to have an equally positive impact on the stability of foster care placements compared to TFC. Basic Trust is focused on increasing parental mentalization and the quality of the parent–child relationship by means of video-feedback training (Colonnesi et al. 2013; Polderman 1998; Zeegers et al. 2019), which have shown positive effects on both sensitive parenting and child security (Facompré et al. 2018; Wright et al. 2017). Forming positive personal relationships not only seems important for stability of the foster care placement, but also for positively transitioning from foster care (Rouse et al. 2020). In addition to video-feedback, psycho-education is used to inform (foster) parents about the meaning of their child's symptoms from an attachment perspective, and advice is provided for dealing with their child's attachment difficulties. As suboptimal parenting skills have been proven one of the most important factors related to placement instability, the positive impact may not come as a surprise. However, the equal positive impact of the Basic Trust intervention compared to the more intensive and longer lasting TFC is not yet clear. In our study, we were unable to include (valid and reliable) information on the degree of emotional and behavioral problems of the foster children. It is plausible to suggest that TFC is provided to foster families with foster children with the most severe problems, whereas the Basic Trust intervention could have been applied to foster families with first foster care placements, and probably less severe problems of the foster children. This possibility is supported by the younger age of the foster children in the families that received the Basic Trust intervention.

The training 'Caring for children who have experienced trauma' for foster parents was, according to our findings, not significantly associated with foster care stability. Reducing the potential behavioral problems of foster children and/or enhancing the foster parent–child relationship probably needs a more intensive or interactive intervention. Gurney-Smith et al. (2010) came to the same conclusion in the evaluation of Fostering Attachments Group in the United Kingdom (Golding 2007), a group intervention based on social learning and attachment theory to enhance the parenting of looked after children who have emotional and behavioral difficulties. This intervention provided the foster parents with a greater understanding of the child's needs, but had limited impact on the child's behavior (Gurney-Smith et al. 2010). As already mentioned, this training was also an element in Treatment Foster Care, and apparently more effective in preventing breakdown if combined with support for foster parents and treatment of foster children. Although our study indicated a positive association between TFC and stability, we could

not examine what the role of the foster parents training or the other elements of the treatment program were. More in-depth research is needed to verify this.

Simple correlation analysis showed that placement in kinship care was negatively associated with foster care breakdown, which is in line with a series of recent reviews and meta-analyses (Bell and Romano 2017; Konijn et al. 2019; Rock et al. 2015; Winokur et al. 2014). However, the protective effect of kinship placement seems to disappear in multivariate analysis. The number of previous foster care placements and delivery of (effective) treatment, which were significant moderators in the logistic regression analysis, could be narrowing down the difference in risk of placement breakdown between kinship and non-kinship foster care families. Notably, non-kinship families received Treatment Foster Care and the Basic Trust intervention more often than kinship families. This may explain why the multilevel analysis did not show a significant contribution of the type of foster care to breakdown, whereas non-kinship families received more often the interventions that had been proven effective for diminishing instability. Therefore, we conducted a post hoc multivariate analysis without the variable 'number of foster care placements' in the model to check if treatment (Basic Trust and TFC) would diminish the risk for the type of foster care placement. However, this was not the case. Besides treatment, in this multivariate model kinship care was a significant and unique moderator of foster care stability. Thus, treatment does not take away the risk of being placed in a non-kinship family.

Konijn et al. (2019) and Rock et al. (2015) reported that placement with their brother(s) and/or sister(s) may prevent placement breakdown for foster children. This is plausible, because the relationship between siblings in foster care is often the most viable ongoing relationship available to the child, and may be critical to their sense of connection, emotional support, and continuity (Kothari et al. 2017). However, our finding that placement with(out) siblings was associated with placement (in)stability in simple correlation analysis, disappeared in the multivariate analysis. Siblings in our study more often lived in kinship care, experienced less previous foster care placements, and lived more often in foster families that received the Basic Trust intervention, which were all significant moderators of foster care breakdown. This may explain why 'placement with siblings' showed no added value to foster care instability in the multivariate analysis. In the post hoc multivariate analysis without the number of foster care placements, staying with siblings was a trend-significant predictor of stability. So, the protective effect of placement with siblings was probably diminished by placement in kinship or non-kinship care, although treatment may also have increased the protective function of placement with siblings.

Boys and children of older age at start of the placement have been shown to experience more instability in foster care placements (Konijn et al. 2019; Rock et al. 2015). Boys often show more behavioral problems than girls, which is the strongest factor associated with instability in foster care. These behavioral problems can become more persistent in adolescents who look for more psychological autonomy, which both challenge the stability of the foster care placement (Berridge 1997). Our finding that neither gender nor age at the start of the placement was associated with breakdown is not in line with previous research findings. In our study, older children at the start of placement and girls more often received kinship care, and girls more often stayed in foster families receiving the Basic Trust intervention. It is plausible to suggest that staying with kin and receiving effective treatment, both significantly associated with placement stability, did reduce the negative impact of male gender and older age at placement on stability.

Limitations

Although this study using data from daily youth care practice is highly socially relevant, some important limitations should be mentioned. First, data were derived from only two organizations in the same region of the Netherlands, so the generalization of the outcomes is uncertain. Secondly, data were extracted from the client file administration of youth care organizations, and the analysis was therefore limited to the variables recorded by the social workers. Some important factors, such as information on foster children's problem behavior—the most important risk factor for instability of foster care placements—were not recorded in the administrative part of the used case files. Unavailability of data on the foster child's behavior precluded examination of the impact of this factor on the positive association between the applied interventions and foster care stability. Thirdly, we missed information on the specific treatment components of the foster care as usual and the interventions that were carried out in this study as well as treatment integrity. Therefore, we could not examine which treatment components may have contributed most to possible intervention effects. For instance, the role of the training 'Caring for children who experienced trauma' in foster placement stability could not be established. In addition, the contribution of the Dragon Tamer Training for young foster children to the positive intervention effect of TFC could not be checked. This information is crucial for further development of foster care practice. Fourth, this study was a retrospective investigation. Prospective (quasi-)experimental research is necessary to examine whether attachment-based treatment or treatment foster care can reduce foster care placement instability, and under what conditions and for whom effects may be largest from the perspective of personalized treatment, since findings of our study suggest that treatment can make a difference.

Conclusions

Stability of foster care is important. A positive and secure relationship with their foster parents may protect them from developing behavioral, emotional, and academic problems. The analyses we conducted on data from daily youth care practice did contribute to the knowledge on factors that may threaten, or alternatively, enhance the stability of foster care placements.

Success of the first foster care placement is crucial. When the first placement ends prematurely, the likelihood that the next placement will end in a breakdown is three and a half times greater than that of the previous one. There seem to be promising interventions to reduce the chance of a breakdown. According to our results, an attachment-based video-feedback intervention and Treatment Foster Care models may contribute to stability of the foster care placements. Apparently, this kind of interventions may protect against foster care breakdown, although placement in kinship care seems to be an additional protective factor. A recent meta-analysis showed that TFC clearly has added value compared to other types of out-of-home care for youth with complex problems (Gutterswijk et al. 2020). This underlines the importance of implementing available evidence-based interventions for foster parents and their children to enhance the continuity of relationships. Therefore, we recommend that foster care organizations systematically monitor important risk factors for breakdown, such as disturbed or insecure attachment relationships, behavioral and emotional problems in foster children, parenting competence of foster parents,

and difficulties in the foster parent-foster child relationship, in order to (timely) intervene if necessary. Notably, there is some preliminary evidence showing that treatment models like Basic Trust and Treatment Foster Care may enhance the chances for continuity of foster care placements.

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