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## **Assessment of foster carers: their willingness to raise children with special needs**

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### **Abstract**

A substantial part of children placed out of home in family foster care suffers severe emotional and behavioural problems. These problems can enlarge the risk of a placement breakdown: the stay of a child in a foster family comes prematurely to an end because, for instance, the foster carers are not able anymore to handle the challenging behaviour of the child. As a result the child will be replaced to another care setting. To diminish the risk of such breakdowns it is crucial to assess among prospective foster carers if they feel competent and are willing to raise children with special needs or conduct problems. As part of a research programme on the applicability of the Casey Home Assessment Protocol (CHAP) in the Netherlands prospective foster carers (N=37) were interviewed on their willingness to include children with special needs in their families. In nearly 40% of the cases the participants were 'under no circumstances' willing to admit children who had committed sexual offences or were sexually active, who used drugs or who showed cruelty to animals. Also children with an incurable illness and intellectual or physical disabilities were quite often not welcome. Offering professional help and support to foster carers increased their willingness to foster these children. Implications of the outcomes are discussed, especially regarding their significance for the matching process in family foster care.

**Keywords:** family foster care, breakdown, willingness to foster, children with special needs

## **Preface<sup>1</sup>**

This paper is an adapted version of a presentation by the authors at the 3rd International Foster Care Research Network Conference in Rorschach/St.Gallen, Switzerland (September 21-23, 2009). Three quarters of a year after this conference (July 2010) the first author died as the result of a life-threatening disease. Dr. J. Strijker – known as Piet – worked for more than two decades at the University of Groningen, Department of Special Needs Education and Youth Care – the last few years as an associate professor. He was without doubt one of the most important researchers and experts in the Netherlands on family foster care (Knorth, 2012). Themes he was engaged in were the characteristics of foster children, the assessment of problem behaviour, the matching of foster children and foster families, selection and training of foster carers, kinship foster care, (coping with) trauma in foster children, and the evaluation of programmes to support foster carers and birth parents. In addition, he did pioneering research on the phenomenon of ‘breakdowns’ in foster care. Publication of this final public presentation of Piet can (also) be considered a late tribute to a humble, very competent and inspiring colleague who passed away far too early.

## **1 Introduction**

An American journal compared family foster care in that country to an ‘open air hospital’ (Rosenfeld et al., 1997). What the authors meant was that children who go into foster care have quite a lot of, sometimes very severe, problems. They are welcomed in the families of well-meaning volunteers who have their hearts in the right place. However, examining the severity of problems among foster children, we concluded that family foster care might be considered as a ‘risky business’ (Strijker, 2009, 2010).

A considerable number of foster care placements turn out *not* to be successful or are broken off prematurely. Percentages vary – especially depending on the group of foster children investigated – from a quarter to more than half of this population (Scholte, 1995). These numbers are not only found in the Netherlands (see, for instance, Wulczyn & Chen, 2010, p. 65). Investigations of re-entry percentages (Kimberlin, Anthony, & Austin, 2009) also indicate that foster care placements do not always fulfil their initial objectives.

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<sup>1</sup> The Preface was written by the second author; the rest of the text by both authors.

In this contribution we will examine what this means for foster carers: Do they need certain skills in order to responsibly take on ‘the risk’ of being a foster family? Or more specifically: Are they prepared to take on children with special needs? What does the research tell us about this? And what does this mean for the assessment and selection of current and prospective foster carers?

Before looking at these questions, we will first provide some background information on the problems that many foster children grapple with and on possible implications for placements. We will conclude our contribution with some suggestions for future research.

## **2 Foster children: the risk of severe behavioural problems**

Figures from Dutch research show that there might be some truth in a quote from our American colleagues about an ‘open air hospital’; a study of 59 foster children in the Netherlands (Alberts, Buijs, & Hummel, 2009)<sup>2</sup> revealed that 58% of the children have (severe) emotional and/or behavioural problems.<sup>3</sup> Of these, 34% qualify for the psychiatric diagnosis of conduct disorder and 22% have serious attention deficit problems.

The children have already had to deal with a lot before being placed in a foster family. Table 1 (see below) shows a selection of the most common stressors. Using the *Parents Report of Traumatic Impact Checklist* (PRTI Checklist; Friedrich, 1997; Lamers-Winkelmann, 2003), which maps 32 potentially stressful events or experiences, we see that the foster children in this sample had experienced on average 9.3 stressors. As Table 1 shows, more than half of the foster children witnessed their parents separating and/or divorcing, shouting and/or hitting one another, and underwent one or more changes of school. In more than one-third of the cases, sexual abuse of the child was suspected, while in one-fifth of the cases it was substantiated.

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2 From the population served by three different foster care agencies in the northern part of the Netherlands 20 foster families *per agency* were selected. These families took care for at least one foster child aged 6-12 years for minimally half a year and maximally two and a half year. The foster carers were willing to cooperate with the researcher team, coordinated by the first author of this paper. In one family the data were too incomplete to be useful.

<sup>3</sup> By way of comparison: Kindler, Scheuerer-Englisch, Gabler and Köckeritz (2011, p. 208) refer to three rather big foster care studies in Germany wherein percentages of children with serious problematic behaviour („Verhaltensauffälligkeiten in einem klinisch bedeutsamen Umfang“) were found, varying between 22% and 54%.

**Table 1.** Stressors among foster children - based on the PRTI Checklist ( $N = 59$ )

Stressor	%
Parents temporarily separated	76.3
Parents shout at one another in the child's presence	71.0
Child switches to another school	62.7
Parents hit one another in the child's presence	59.3
Parents divorced	50.8
Child hit by parent	47.5
Suspected sexual abuse of the child	35.6
Parent arrested	32.2
Child shows learning difficulties	23.7
Child sexually abused	20.3

The *Trauma Symptom Checklist for Children* (TSCC; Briere, 1996) establishes how severe the consequences of these events are or the degree to which the foster child shows symptoms that are indicative of a posttraumatic stress syndrome (PTSS). The percentage of children in the clinical range on the scales of this checklist is given in the second column in Table 2. The third column shows the sum of the percentage of foster children in the clinical and borderline ranges. For the sake of conciseness, we have labelled this 'deviant'.

**Table 2.** Symptoms of posttraumatic stress among foster children - based on the TSCC ( $N = 59$ )

Scale	% clinical range	% deviant
PTS Intrusion	16.9	18.6
PTS Avoidance	25.4	26.8
PTS Arousal	37.3	47.5
<i>PTS Total</i>	28.8	37.3
Sexual concerns	8.5	13.6
Anxiety	10.2	13.6
Depression	3.4	6.8
Dissociation	8.5	17.0
Aggression	11.9	20.4

We see that almost 30% of the children in the sample score in the clinical range on the scale Posttraumatic Stress Syndrome Total (PTSS) (row five, column two). Almost half the children are restless and nervous (PTS Arousal), while over a quarter show serious avoidance behaviour. Almost one in five children is plagued by intrusive traumatic images, is dissociative and/or (highly) aggressive.

In summary, foster children normally live in families where they lack nothing in material and affective terms. At the same time, research indicates that these children quite often may have experienced stressful life events. It also shows that a posttraumatic stress disorders or severe behaviour problems are not unusual. However, considering the relative small sample size it would not be appropriate to generalise these findings.

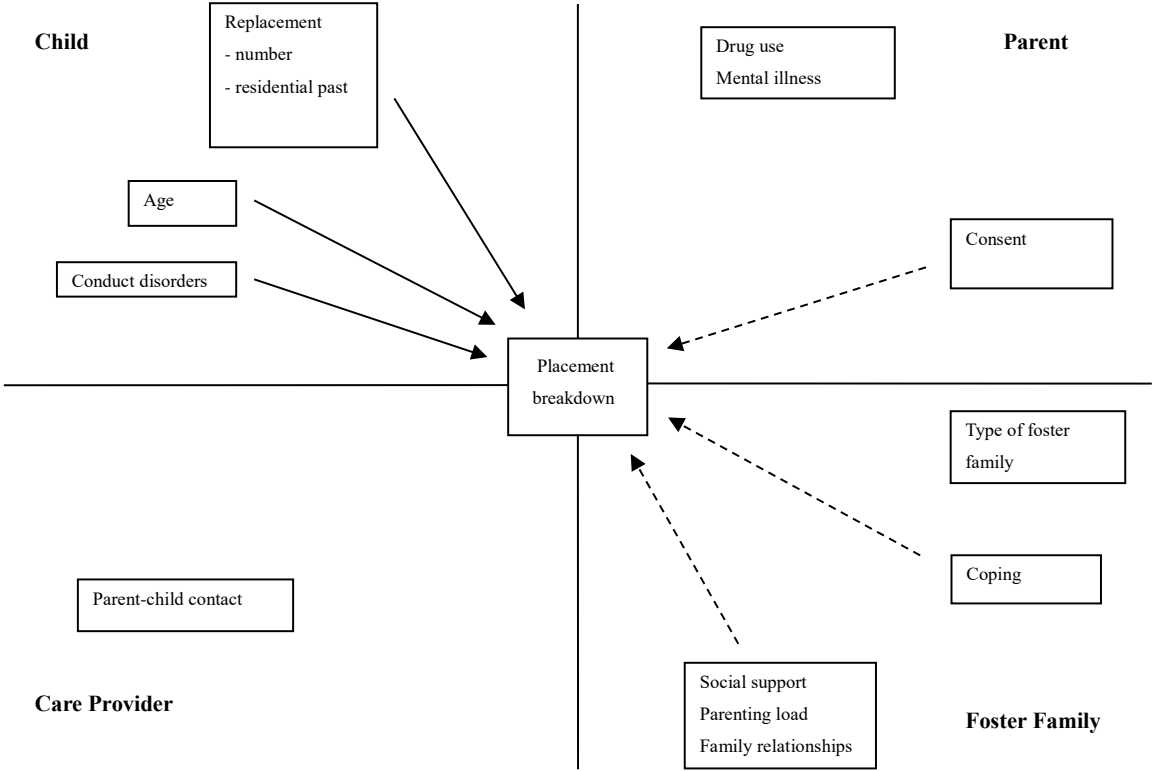
Because these children are raised by volunteers, in other words by ‘ordinary’ foster carers, we can interpret foster care as a ‘natural experiment’. This is because a child is moved from a qualitatively unfavourable environment to one that is qualitatively favourable, which entails a radical environmental change in the child’s life. The offer of a different family life should turn the tide of setbacks in the life of the foster child (Strijker, 2009). This ‘natural experiment’ should produce a favourable effect, for example, a reduction in severity of problem behaviour or resolving the posttraumatic stress syndrome. But just how well do children fare in family foster care?

### **3 Placement progress: the risk of breakdown**

Studies from the Netherlands and abroad show that to a limited degree progress is made with the severity of problem behaviour once children have lived with the foster family for 1.5 to 2 years (for instance, Van Oijen, 2009). Different Dutch studies show a more or less stabilizing trend in the severity of problem behaviour (see Strijker, 2009). Other studies claim better outcomes. For example, in an international review by Kindler, Scheuerer-Englisch, Gabler and Köckeritz (2011) the authors conclude: “In the short and medium-long term foster children as a group clearly show progress during their placement, especially regarding their behaviour at school, their development or their behaviour in de foster family. The progress is much more clear in case of a stabile compared to an unstable fostering situation (...)” (p. 221).

In our research we looked at outcomes for the factor ‘behavioural change’, one of the performance measures used in foster care in the Netherlands. Another performance indicator is the stability of the upbringing setting. This relates to the question ‘Does the child still live in the same foster family after 1.5 or 2 years or has he or she been placed elsewhere?’ Or, in other words: Has the placement broken down or does the child still live with the foster family? A great deal of research has been carried out in the Netherlands and abroad into the stability and outcomes of the foster care placements (Fernandez & Barth, 2010; Strijker, 2009).

We listed the key factors from various Dutch studies that appear to be associated with placement outcome, i.e. placement breakdown (Bastiaensen, 2001; Scholte, 1995; Strijker, Knorth, & Knot-Dickscheit, 2008; Strijker & Van de Loo, 2010; Strijker, Van Oijen, & Knot-Dickscheit, 2011; Strijker & Zandberg, 2005; Strijker, Zandberg, & Van der Meulen, 2002). We then represented the factors in four *conceptual squares*: Child, Parent, Foster Family and Care Provider (see Figure 1). The factors are shown in text blocks in each square. For example, the Child square contains three text blocks: conduct disorders, age, and replacement. The Replacement factor is then broken down into number of replacements and residential past. The Replacement factor is then broken down into number of replacements and residential past. A solid arrow pointing to Placement Breakdown means that most studies showed a significant correlation between the factor in question and placement outcome. A dotted arrow means that some studies showed a correlation while others did not. No arrow means that very little research, sometimes no more than a single study, has been conducted into the link with placement outcome.



**Figure 1.** Factors associated with the risk of a placement breakdown in foster care

This figure shows clearly that the factors in the Child square influence placement outcome, i.e. placement breakdown, and that most research is done in this area. The relationship is as follows:

- For *conduct disorders*: the more serious the problem behaviour, the greater the probability that the placement will break down.
- For *age*: older children are at greater risk of placement breakdown.
- For *replacement*: the more replacements the child experiences, the higher the risk that the current placement will also break down and be followed by another. The same holds true for having been in residential care: if so, the risk of breakdown is higher.

As we have already put forward, different Dutch studies have demonstrated these correlations (for an overview, see Strijker, 2009).

We would like to focus now on the main topic of our contribution: assessing current and prospective foster carers. So let us turn our attention to the Foster Family square.

#### **4 Assessment of foster carers**

We can see that there are three blocks of factors, two of which have a dotted arrow pointing to placement breakdown. This means that there is a possible correlation between these characteristics of the foster family and placement outcome; some studies have demonstrated this link while others have not. The factors in the figure are Type of Foster Family, Coping, Social Support, Parenting Load, and Family Relationships.

First something about the Type of Foster Family – in other words, is it a kinship foster family or a non-relative foster family. The research literature suggests that placement in a kinship foster family can ensure greater stability of upbringing than placement in a non-relative foster family (Leslie, Landsverk, Horton, Ganger, & Newton, 2000; Strijker & Knorth, 2007a, 2007b). Although the type of foster family is frequently mentioned in the literature as an influential factor, evidence to support this in the Netherlands is still thin. A recent Dutch study found that kinship foster families had a greater probability of placement breakdown for children with an intellectual disability; kinship foster families were shown to offer these children a less stable upbringing setting (Strijker & Van de Loo, 2010).

The type of foster family will not be an important selection criterion when it comes to assessing prospective foster families. This is because assessment is primarily concerned with



the psychological and pedagogical characteristics of these families (Knorth, 1997; Strijker, 2009). The relevant factors in the figure are:

- coping: the ability to deal with tension and stress;
- social support: the availability and quality of social support for the foster family;
- parenting load: the extent to which and how foster carers feel responsible for their upbringing task;
- family relationships: the closeness of family relationships, and in particular the cohesion between the family members.

Research in the Netherlands shows that better coping skills, more social support, lower parenting load, and close family relationships are associated with a reduced risk of placement breakdown (for an overview, see Strijker, 2009). We should point out, however, that these findings often come from studies involving small samples, although standardized measures have been used in each instance.

Internationally, even fewer studies appear to have been conducted using standardized instruments than in the Netherlands. The international research literature nevertheless often stresses the importance of standardized tools for assessing placement progress in foster families as psychological and pedagogical settings. A quote from an American journal speaks volumes: ‘For years there has been a strong and growing need for standardized reliable and valid assessment tools to use when judging the potential success of family foster care applicants. However, these tools do not exist. This is a remarkable gap in our knowledge given the millions of vulnerable children placed in family foster care over the last century’ (*Foster Family Forum*, 2003, p. 2).

#### *4.1 Casey Home Assessment Protocol*

With this statement, the University of Tennessee launched the development of three test batteries for assessing foster carers. One of these is the CHAP, which stands for *Casey Home Assessment Protocol* (Orme et al., 2006). Casey is a national foster-care provider in the USA. As of 2009, the CHAP comprises 19 scales.<sup>4</sup> What is special about many of these instruments is that they were developed specifically for family foster care. A lot of research has been

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<sup>4</sup> The CHAP-user’s manual can be downloaded at:  
[https://www.researchgate.net/publication/291680440\\_Casey\\_Home\\_Assessment\\_Protocol\\_CHAP\\_User%27s\\_manual\\_2nd\\_ed](https://www.researchgate.net/publication/291680440_Casey_Home_Assessment_Protocol_CHAP_User%27s_manual_2nd_ed)

conducted using tools that were only designed to identify families with a problem – in other words, to distinguish between non-clinical and clinical families. The question is whether instruments of this type are suitable for assessing prospective foster carers. They were designed to establish whether families belong to the clinical group. The assessment of foster carers needs to address other questions, such as (1) what their parenting skills include, and (2) which foster child might fit within a particular family. These questions cannot be answered very well using existing instruments. However, the CHAP-scales do offer potential.

A study was launched in 2004 into CHAP's applicability within the Netherlands. Eleven CHAP-scales were selected, in particular those relating to foster care practice itself rather than foster carer characteristics. The study took three years and was conducted among 'licensed family foster carers' (i.e. foster carers who have undergone a preparatory programme and who have received the care provider's approval to foster, based on specified criteria).

Because the first results with the CHAP were promising (Jongeling, 2005; Strijker, 2006), we subjected the CHAP to a further review (Feikens & Mensinga, 2007). The different sub-studies showed that:

- there were too many scales in terms of number and scope;
- some scales were too long;
- in terms of content – and this was the most important point – they were not always applicable to Dutch foster care (e.g., the items on adoption do not go with foster care in the Netherlands because it is virtually impossible to adopt a foster child in our country).

We revised the scales together with the Recruitment, Selection and Matching Department of a large care provider. The revised scales were then submitted to a group of prospective foster carers, all of whom had taken part in the STAP training programme, designed to prepare prospective foster carers for the arrival of a foster child.<sup>5</sup> The items were finalised with the help of suggestions from the training group. The following scales were selected and adapted:

1. Reasons for Fostering scale;
2. Receptivity to Birth Family Connections scale;
3. Foster Parent Role Performance scale (with the subscales 'child-centred' and 'willingness to cooperate with the institution');

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<sup>5</sup> The STAP programme - STAP literally means Cooperation Team Spirit Prospective Foster Parents - is based on the North-American MAPP programme (Model Approach to Partnership in Parenting; see Pasztor, 1985; see also Herczog, Van Pagée & Pasztor, 2001; Knorth, 1997).

4. Short Hardiness scale (with the subscales ‘commitment’, ‘control’, and ‘challenge’)
5. Willingness to Foster scale (see below);
6. Child Memories of Foster Parent scale (with the subscales ‘safe memories’, ‘avoidance memories’, and ‘ambivalent memories’).

This last scale is not part of the original CHAP but was added by us at a later stage. The outcomes on this scale indicate a certain type of attachment for the foster carer (Röwekamp, 2009).

#### 4.2 *Foster carers’ willingness to foster*

The ‘Willingness to Foster’ scale addressed the question of the extent to which foster carers are willing to accept children with different types of problems into their family without outside help or support. The scale comprises three subscales that relate to special characteristics of children, namely ‘problem behaviour’, ‘disabilities or handicap’, and ‘other culture, race or religion’.

Our research<sup>6</sup> showed that foster carers are more willing to take children with severe problem behaviour into their family

- 1) if they expect more help and support from their surroundings, in particular from family members;
- 2) if they believe that their family is functioning well.

Foster carers with better family functioning are also more prepared to take in children of another race, religion or culture. Finally, we found that foster carers are more prepared to accept children with disabilities or a handicap if they expect more support from their environment, especially from family members. However, they are less willing to do so if the foster carer believes that the family is functioning well. This last point is surprising. It could mean that respondents feel less well-equipped to take on a (physically and/or mentally) handicapped child than a child with psychosocial problems.

Adding to the plausibility of the results is the fact that virtually the same variables emerge that were also associated with placement breakdown, namely ‘social support’ and ‘family relationships’.

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6 The sample in this study consisted of all prospective foster carers (N female = 37, N male = 35) who were in the first half of 2009 registered as such in the database of the main foster care agency in the Dutch northern province Drenthe. All of them had successfully taken part in the regional STAP training programme (cf. note 4).

A closer look at the reasons for not wanting to take on children reveals the following. Table 3 shows what type of foster child with behavioural problems *prospective* foster carers *do not want* to be placed in their family.<sup>7</sup>

Almost 57% of prospective foster carers want under no circumstances to take into their family a child who has committed a sexual offence; 32% say ‘perhaps’ but only with a great deal of help and support. The table shows that the following types of children are not very ‘popular’: children with deviant sexual behaviour, children who use stimulants (drugs, smoking, alcohol), and children with delinquent and aggressive behaviour (cruelty to animals, stealing, destructive behaviour, swearing). In short, foster families prefer not to accept children with (severe) externalising problem behaviour.

**Table 3.** Willingness of prospective foster carers to take on a foster child with a particular type of problem behaviour (N = 37)

Willingness	No, under no circumstances	Perhaps, with considerable help and support	Probably, with a little help and support	Yes, without help and support
<b>Type of problem behaviour</b>				
Sexual offences	56.8	32.4	8.1	2.7
Drugs	48.6	40.5	10.8	0
Cruelty to animals	45.9	29.7	18.9	5.4
Sexually active	37.8	35.1	24.3	2.7
Inappropriate sexual behav.	29.7	48.6	21.6	0
Smoking	29.7	10.8	35.1	24.3
Alcohol use	27.0	24.3	37.8	10.8
Stealing	10.8	48.6	35.1	5.4
Depression	13.5	35.5	45.9	5.4
Destructive behaviour	8.1	45.9	37.8	8.1
Swearing	5.4	10.8	54.1	29.7

Children with disabilities and illnesses are also not very popular, as the following table 4 shows.

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<sup>7</sup> Results were derived from the female part of the sample (n = 37).

**Table 4.** Willingness of prospective foster carers to admit a foster child with a particular type of disability or illness into the family ( $N = 37$ )

Type of disability or illness	Willingness	No, under no circumstances	Perhaps, with considerable help and support	Probably, with a little help and support	Yes, without help and support
Incurable illness		40.5	21.6	27.0	10.8
Intellectual disability		35.1	35.1	21.6	8.1
Physical disability		29.7	37.8	21.6	10.8
Pregnant		27.0	24.3	29.7	18.0
Eating disorder		18.9	35.1	40.5	5.4
In need of medical care		16.2	27.0	43.2	13.5
Sexually abused		13.5	29.7	51.4	5.4
Unable to bond		10.8	21.6	45.9	21.6
Physically abused		0	24.3	51.4	18.9
Overweight		0	21.6	48.6	29.7

If we look at the percentages of children who have been physically abused, sexually abused or who cannot form emotional bonds with others, we see that some 43% of prospective foster carers (the sum of the first two columns) are unwilling or barely willing to accept into their foster family a child who has been *sexually abused*. For children who have been *physically abused* this percentage is about 24%, and for children who *cannot bond* with others about 32%.

**Table 5.** Distribution of type of problem in foster care population and willingness to foster ( $N = 37$ )

Problem	% in foster care population <sup>1</sup>	% willingness to foster, without help and support
Sexually abused	14	5.4
Physically abused	24	18.9
Unable to bond, i.e. attachment disorder	14	21.6

<sup>1</sup> Source: Strijker and Knorth (2009).

The number of foster children who have been *sexually abused* in the foster care population is estimated at 14% (Strijker & Knorth, 2009, p. 424). The number of prospective foster carers who are prepared to take on children with this type of problem without additional help and support comes to 5.4% (see the final column in Table 5).

The number of foster children who have been *physically abused* is estimated at 24%; the number of foster carers who are willing to accept a physically abused child into their family without help and support comes to about 19%.

An estimated 14% of children in the foster care population have an *attachment disorder*. In this survey, slightly more than 21% of the respondents were willing to take children with this type of problem into their family without help and support.

We also investigated which variables were associated with willingness to take certain types of children into the foster family. Correlational analyses gave the following links. The degree of preparedness to accept children with severe problem behaviour *without help and support* is positively associated with the level of commitment and control (CHAP-scale 4), and negatively associated with avoidance of childhood memories and ambivalent childhood memories (CHAP-scale 6) ( $p < .05$ ). In other words, foster carers with a high degree of commitment towards foster children, who like to make plans in advance and to maintain control, and who have few or no ‘unsafe’ memories of their own childhood are more willing to take on children with severe problem behaviour. Almost the same correlations apply to children with disabilities: prospective foster carers who are committed and in control, and who have few or no avoidance memories of their own childhood, are more willing to take on children with a disability or illness ( $p < .05$ ).

## **5 Discussion and conclusion**

Our main finding is that children with (severe) externalising behaviour problems, disabilities or diseases are not very popular as foster child; percentages roughly vary between 25 – 50% of the foster carers who declare *under no circumstances* to be willing to take up a child with these special needs in their family. Foster carers who are very committed towards vulnerable children, who like to plan and to be in control, and who do not have negative memories of their own childhood seem to be much more willing to welcome these children in their homes, even if external support or help is lacking. If foster carers were offered help and support they were more often willing to accept a child with special needs.

Although slightly different in terms of included items in their Willingness to Foster scale, the University of Tennessee team (Cox, Orme, & Rhodes, 2003, p. 37) also concluded in a sample of 142 applicants that children with (severe) externalising behaviour problems

(like setting fires, destructive behaviour, sexually acting out, lying or stealing) and/or psychiatric symptoms (like head banging, self-destructive behaviour) are the ‘least acceptable’ for prospective foster carers. Comparable with our findings the applicants with more resources (like social support from family, friends and/or helping professionals) were more willing to foster children with emotional or behavioural problems.

A limitation of our study is the relatively small sample size and the regionality of the survey. Although the recruitment with the service provider was not encumbered by selection bias – all candidates on the waiting in a certain period of time were included – a broader sample could inform us, for instance, on the impact of regional or cultural differences. Additional research could also encompass data on psychological and pedagogical characteristics of applicants to further deepen the insight in motives and practices of prospective foster families.

What can be concluded in terms of practical or research implications? A first conclusion is that there are imbalances in the ‘market of supply and demand’. There is a mismatch between the wishes of prospective foster carers and the ‘availability’ of different types of foster children. Many foster carers who are willing to take up a child with special needs do need additional help and support. In this way it is hoped for that all children with a particular kind of problem can nevertheless be placed in a foster family. The figure we presented shows that severe externalising problem behaviour increases the risk of a placement breakdown. With additional help and support, the breakdown of a foster care placement could perhaps be avoided. To be able to demonstrate such a result, more research is needed into the relationship between the deployment of additional assistance and placement outcomes. It should however be pointed out that, if such a relationship would be empirically substantiated, there is no guarantee that additional help and support actually will be forthcoming from care providers; the reality in the Netherlands is that care providers often lack financial resources to provide it.

A second conclusion is that the scale under study here might be of some help during the matching process. This is because the results clearly indicate for what kind of children it seems to be difficult or impossible to find a place within a foster family. If a family strongly resists the admission of a child with special needs matching professionals will be urged to find other solutions. But how does that work in practice? It would be advisable to enlarge the focus of research here and to include in a research programme the whole process of matching and decision-making in family foster care, specifically to identify the factors that impact the placement process itself. In the last couple of years such a programme has been started up at

the University of Groningen. First results are coming forward (Zeijlmans, López, Grietens, & Knorth, 2017, 2018).

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