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

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Abstract

A substantial number of children placed out of home in family foster care suffer severe emotional and behavioural problems. These problems can increase the risk of placement breakdown, where a child's stay with a foster family comes prematurely to an end because, for instance, the foster carers are no longer able to handle the child's challenging behaviour. As a result, the child will be moved to another care environment. To reduce the risk of such breakdowns, it is crucial to assess prospective foster carers on whether 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 about their willingness to include children with special needs in their families. In nearly 40% of cases the participants were 'under no circumstances' willing to admit into their families children who had committed sexual offences or were sexually active, who used drugs or who showed cruelty to animals. Children with incurable illnesses or intellectual or physical disabilities were also quite often not welcome. Offering professional help and support to foster carers increased their willingness to foster these children. The 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[1]

This paper is an adapted version of a presentation by the authors at the third International Foster Care Research Network Conference in Rorschach/St Gallen, Switzerland (21-23 September 2009). Nine months after this conference (July 2010), the first author died after a period of illness. Dr J. Strijker – known as Piet – worked for more than twenty years 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 in family foster care (Knorth, 2012). The areas he was engaged in included describing the characteristics of foster children, the assessment of problem behaviour, the matching of foster children and foster families, the 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 into the phenomenon of 'breakdowns' in foster care. The publication here of Piet's final public presentation can also be considered a late tribute to a humble, very competent and inspiring colleague who passed away before his time.

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 enter foster care have quite a lot of problems, some of them very severe. They are welcomed into the families of well-meaning volunteers who have their hearts in the right place. However, examining the severity of the problems common among foster children, we concluded that family foster care might be considered 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).

Such high 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.

In this contribution we will examine what this means for foster carers: do they need certain skills to take on 'the risk' of being a foster family in a responsible way? Or more specifically, are they prepared to take on children with special needs? What does 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.

1 The preface was written by the second author; the rest of the text by both authors

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 moves 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

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)[2] revealed that 58% of the children have severe emotional and/or behavioural problems.[3] Of these, 34% met the criteria for a psychiatric diagnosis of conduct disorder and 22% had serious attention deficit problems.

Children have already had to deal with a lot before being placed with a foster family. Table 1 shows a selection of the most common stressors. Using the *Parents Report of Traumatic Impact Checklist* (PRTI Checklist; Friedrich, 1997; Lamers-Winkelman, 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, shouting or hitting one another, and underwent one or more changes of school. In more than one-third of cases, sexual abuse of the child was suspected, while in one-fifth of cases it was substantiated.

2 Twenty foster families per agency were selected from the population served by three different foster care agencies in the northern Netherlands. These families cared for at least one foster child aged 6-12 years for at least six months and at most two and a half years. The foster carers agreed to cooperate with the research team, coordinated by the first author of this paper. The data for one family were too incomplete to be useful.

3 By way of comparison: Kindler, Scheuerer-Englisch, Gabler and Köckeritz (2011, p. 208) refer to three rather large foster care studies in Germany where between 22% and 54% of children were found to display serious problematic behaviour ('Verhaltensauffälligkeiten in einem klinisch bedeutsamen Umfang').

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
PTS Total	*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

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 indicative of posttraumatic stress syndrome (PTSS). The second column of table 2 presents the percentages of children in the clinical range on this checklist's scales. 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'.

We see that almost 30% of the children in the sample score in the clinical range on the Posttraumatic Stress Syndrome Total scale (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 or 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 may quite often have experienced stressful life events. It also shows that posttraumatic stress disorders or severe behaviour problems are not unusual. However, considering the relatively 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 the severity of problem behaviour or resolution of the posttraumatic stress syndrome. But just how well do children fare in family foster care?

Placement progress: the risk of breakdown

Studies from the Netherlands and abroad show that limited progress is made with the severity of problem behaviour once children have lived with a foster family for 1.5 to 2 years (for instance, Van Oijen, 2009). Various 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, an international review by Kindler, Scheuerer-Englisch, Gabler and Köckeritz (2011) concludes: '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 stable compared to an unstable fostering situation [...]' (p. 221).

Our research considered the outcomes of the 'behavioural change' factor, 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?' 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 foster care placements (Fernandez & Barth, 2010; Strijker, 2009).

We listed the key factors from various Dutch studies which appear to be associated with placement outcomes, i.e. placement breakdown (Bastiaensen, 2001; Scholte, 1995; Strijker, Knorth, & Knot-Dickscheit,

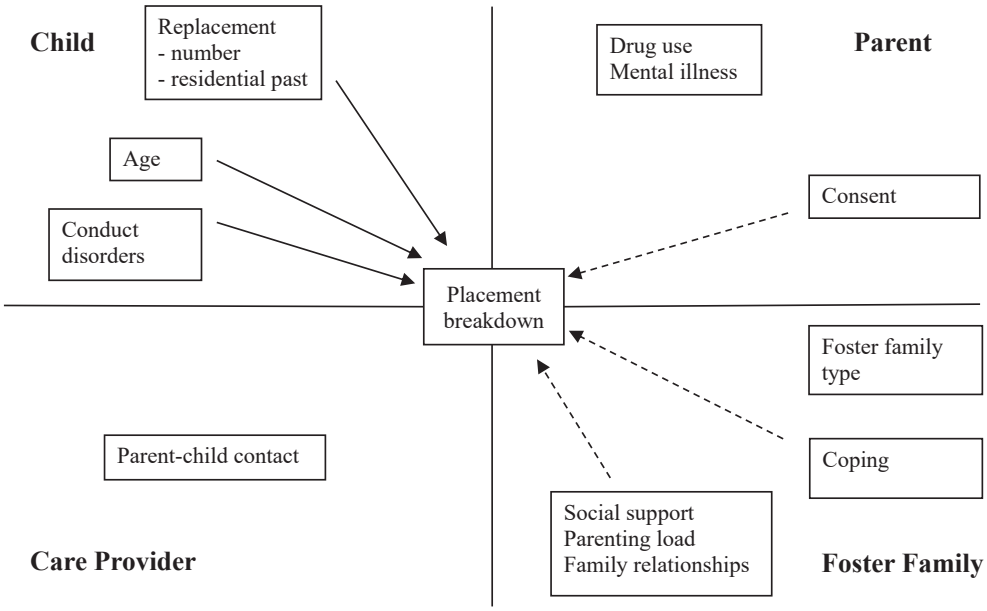

Figure 1. Factors associated with the risk of a placement breakdown in foster care

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. 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.

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 explained, various 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.

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 the placement outcome. Some studies have demonstrated this link while others have not. The factors in the figure are Foster Family Type, Coping, Social Support, Parenting Load and Family Relationships.

First something about the Foster Family Type – 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 remains scarce. A recent Dutch study found that placement breakdown for children with an intellectual disability was more likely with kinship foster families, and 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 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 the way foster carers feel responsible for their upbringing tasks
- family relationships: the closeness of family relationships, particularly the cohesion between family members.

Research in the Netherlands has shown that better coping skills, more social support, lower parenting load and closer 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 every instance.

More studies appear to have been conducted using standardized instruments in the Netherlands than elsewhere. 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).

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.[4] What is special about many of these instruments is that they were developed specifically for family foster care. A lot of research has been 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 particularly well using existing instruments. However, the CHAP scales do offer potential.

A study was launched in 2004 into CHAP's applicability within the Netherlands. Elev-

4 The CHAP user's manual can be downloaded from: https://www.researchgate.net/publication/291680440_Casey_Home_Assessment_Protocol_CHAP_User%27s_manual_2nd_ed

en 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 completed a preparatory programme and who have received the care provider's approval to foster, based on specified criteria).

Because the early results with CHAP were promising (Jongeling, 2005; Strijker, 2006), we subjected CHAP to a further review (Feikens & Mensinga, 2007). The different sub-studies demonstrated 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 did not fit with foster care in the Netherlands because it is virtually impossible to adopt a foster child in our country).

We revised the scales in partnership 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.[5] The items were finalized 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')
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 in the foster carer (Röwekamp, 2009).

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 which relate to the special characteristics of the children, namely 'problem behaviour', 'disabilities or handicap' and 'other culture, race or religion'.

5 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).

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

Willingness / Type of problem behaviour	No, under no circumstances	Perhaps, with considerable help and support	Probably, with a little help and support	Yes, without help and support
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 behaviour	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

Our research[6] showed that foster carers are more willing to take children with severe problem behaviour into their families

1. if they expect more help and support from their surroundings, in particular from family members
2. if they believe that their family functions well.

Foster carers with better functioning families are also better 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 functions well. This last point is surprising. It could mean that respondents feel less well-equipped to take on a physically 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 emerged as were also associated with placement breakdown, namely 'social support' and 'family relationships'.

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 be-

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

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

Willingness / Type of disability or illness	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

havioural problems *prospective* foster carers *do not want* to be placed in their families.[7]

Almost 57% of prospective foster carers would under no circumstances accept a child who has committed a sexual offence into their families; 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 externalizing problem behaviour.

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

If we consider 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%.

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

The number of foster children who have been *physically abused* is estimated at 24%; the proportion of foster carers who are willing to accept a physically abused child into

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

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

Problem	% in foster care population[1]	% 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

[1] Source: Strijker and Knorth (2009).

their family without help and support is around 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 a foster family. Correlational analyses provided 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 childhoods 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 childhoods, are more willing to take on children with a disability or illness (p <.05).

Discussion and conclusion

Our main finding is that children with severe externalizing behaviour problems, disabilities or diseases are not very popular as foster children; roughly 25-50% of foster carers declare that they would *under no circumstances* be willing to take on a child with such special needs in their families. Foster carers who are very committed to vulnerable children, who like to plan and to be in control, and who do not have negative memories of their own childhoods seem to be much more willing to welcome these children in their homes, even if external support or help is lacking. Where foster carers were offered help and support they were more often willing to accept children with special needs.

Although slightly different in terms of items included 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 externalizing be-

haviour problems (such as setting fires, destructive behaviour, sexually acting out, lying or stealing) or psychiatric symptoms (such as head-banging or other self-destructive behaviour) are the 'least acceptable' for prospective foster carers. Comparable with our findings, the applicants with more resources (such as social support from family, friends 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 from the service provider was not encumbered by selection bias – all the candidates on the waiting list in a given period were included – a broader sample could have informed us, for instance, about the impact of regional or cultural differences. Additional research could also encompass data on psychological and pedagogical characteristics of applicants to further deepen our understanding of the 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 on a child with special needs do need additional help and support. We therefore hope that all children with a particular kind of problem can nevertheless be placed in a foster family. The figures we present show that severe externalizing problem behaviours increase the risk of 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 were empirically substantiated, there is no guarantee that additional help and support would actually be forthcoming from care providers: the reality in the Netherlands is that care providers often lack the 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 which types of children it appears to be difficult or impossible to find places for within a foster family. If a family strongly resists the admission of a child with special needs, matching professionals should find other solutions. But how does that work in practice? It would be advisable to enlarge the focus of the research here and to include the whole process of matching and decision-making in family foster care in a research programme, specifically to identify the factors which have an impact on the placement process itself. In the last couple of years just such a programme has been started at the University of Groningen. Early results are already emerging (Zeijlmans, López, Grietens & Knorth, 2017, 2018).

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