# Kinship Care

**May 2004**

### Definition and Incidence

Kinship care is a living arrangement in which a relative or another person who is emotionally close to a child takes on primary responsibility for raising that child (Leos-Urbel, Bess, & Geen, 1999). According to the 2000 U.S. Census, nationally, there are 4.5 million children under the age of 18 living in grandparent-maintained households, and another 1.5 million children under 18 living in other relative-maintained households (U.S. Census Bureau, 2002 as Cited in Generations United, 2003). Several types of kinship care arrangements exist: formal kinship care, informal kinship care, and legal guardianship/adoption.

Children placed into formal kinship care are under the supervision of a child welfare agency. The relative that cares for the child in formal care is a licensed foster parent, and can receive the same oversight and compensation as a foster parent caring for non-kin children. Some states utilize kin much more heavily than others and, therefore, an estimate of the number of children placed in the care of relatives varies across locale. Based on a sample of 25 states, approximately 20 percent of children entering foster care in 1997 were placed in the homes of relatives (US DHHS, 2001d). However, in some states, such as California, New York, and Illinois, the proportion of children placed with kin is markedly high; various estimates near or exceed 50 percent (Geen & Berrick, 2002; Meyer & Link, 1990; US GAO, 1999).

Many more children are placed in the home of a relative informally. In this case, the relative caregiver takes on primary care for the child outside of the auspices of the child welfare system (Harden, Clark, & Maguire, 1997). According to the National Survey of American Families (NSAF), the number of informal kinship care placements is approximately one and a half times greater than the number of formalized kin care placements (Ehrle & Geen, 2002; Ehrle, Geen, & Clark, 2001). These families are not subject to the same supervision as those in the formal foster care system; they are also not eligible for the same monetary compensation and services that formal kinship caregivers receive.

An increasingly popular option for kinship care families is legal guardianship, wherein a relative becomes the legal guardian of the relative child in their care (Testa, 2001). It has often been reported that kinship caregivers are reluctant to obtain guardianship because of the confusion that it might cause for a child in kinship care, the conflict that might arise with the child's biological parent(s), and a feeling that blood ties already existent in the relationship make legal bonds unnecessary (Barth and Berry, 1990; Thornton, 1991). However, new federal and state policies make this a more viable option for kinship caregivers (Testa, 2001). Monetary compensation or subsidized guardianship for caregivers obtaining legal guardianship, legal services available to assist kin in completing necessary paperwork, and agency support systems where kin can see others who have obtained guardianship have promoted this option among kin caregivers. As a result, the number of caregivers obtaining legal guardianship has been increasing (Testa, 2001).

### State and Federal Policy

Despite the heavy reliance on family members as substitute caregivers, state and federal policy governing the role of kin in the foster system has been slow to materialize. While much of the growth in kin care occurred in the late 1980's and early 1990's (Barth, Courtney, Berrick, & Albert, 1994; Boots & Geen, 1999, Needell et al., 2001), it was not until the 1997 Adoption and Safe Families Act (ASFA) that the federal government recognized kin care as a unique type of foster care placement (Geen & Berrick, 2002). Before this time, states developed their own policies about kinship care, with no direction by the federal government. This resulted in differing definitions of kin, large disparities in monetary compensation, and a broad array of licensure requirements, which created inconsistency across states and confusion as to the role of kinship care within the foster care system (Boots & Geen, 1999).

Through a revision of ASFA in 2002, the federal government began to establish standards for licensing and monetary compensation of kinship foster homes (Geen & Berrick, 2002). Rules set forth mandated that, in order for states to receive federal funds for kinship caregivers, "relatives must meet the same licensing/approval

standards as nonrelative foster family homes" (Leos-Urbel, Bess, & Geen, 2002, p. 48). Licensed kinship foster homes are entitled to the same foster care payments and services. However, meeting the licensing requirements can be problematic, as many families taking in relative children do not have the resources to meet family foster care regulations (Ingram, 1996). Such families are still able to take relative children into their homes informally (Ehrle, Geen, & Clark, 2001), but these caregivers are not eligible to receive foster care payments, and do not have service systems set up to meet non-monetary needs. Informal kinship caregivers may be eligible to receive grants through Temporary Assistance to Needy Families (TANF), but these are often significantly smaller than foster care payments (Leos-Urbel, Bess, & Geen, 2002). In 1999, Berrick, Needell, and Minkler reported that the difference in these payments range from only $66 to a substantial $1,653, depending upon the number and ages of children residing in the home.

**Substance Abuse and Kinship Care**

Kinship care and parental substance abuse are closely intertwined. According to recent research, the primary reason for a child's separation from a parent and placement with a relative is substance abuse by a biological parent (Weinstein & Takas, 2001). In particular, maternal substance use and abuse is a recurring theme for the caregivers of children in kinship care, who often identify drugs as the catalyst for the problems in the mother's life (Cohon, Hines, Cooper, Packman, & Siggins, 2000). Various studies have also reported substance abuse as a current concern for between 25 and 80 percent of mothers whose children have been placed in kinship foster care (Benedict, Zuravin, & Stallings, 1996; Gleeson, O'Donnell, & Bonecutter, 1997).

Exposure to substance use raises a number of developmental, emotional, and psychological concerns for children. Although the long-term developmental effects of perinatal exposure to specific illegal drugs have been hotly debated, perinatal substance exposure can have developmental consequences. For example, some research has linked perinatal cocaine exposure to lower birth weights, smaller head circumference, and shorter gestational periods. In turn, each of these problems has been linked to developmental delays (Boardman, Powers, Padilla, & Hummer, 2002). However, a meta-analysis that reviewed studies on cocaine-exposed children over a 16-year period (1984-2000) and analyzed the outcomes on five dimensions: physical growth, cognition, language skills, motor skills, and behavior/attention/neurophysiology, reached a different conclusion (Frank, Augustyn, Knight, Pell, and Zuckerman, 2001). This meta-analysis found that existing research does not provide evidence of a specific negative association between cocaine and physical growth, developmental test scores, or receptive and expressive language. Furthermore, the authors suggest that what was once thought to be direct effects of cocaine exposure on child development may be the result of other drug use, such as tobacco, and/or the child's environment (Frank et al., 2001). However, a more recent study (Singer, Arendt, Minnes, Farkas, Salvator, Kirchner, and Kliegman, 2002) used measures of infant development to assess the cognitive and motor outcomes of 415 cocaine exposed and non-exposed infants from birth to 24 months. These authors concluded that the cocaine-exposed infants had twice the developmental delay during the first 2 years of life than the non-exposed infants and that this delay may lead to learning difficulties as the children move into school.

Some researchers, such as Carta et al. (2001) and Bauer & Barnett (2001), maintain that what happens in the home after birth has a greater effect on growth and development than in utero exposure to drugs. For example, inconsistent parenting may lead to the development of attachment disorders, in which a child does not develop a close bond with a caregiver. Compounding the problem of inconsistent parenting, "out-of-home placement is typically associated with a numerous disruptions in attachment relationships" (Troutman, 1999). Though children in kinship care are less likely to have a disrupted placement than children in traditional foster care situations (Mason and Gleeson, 1999); this possibility, combined with the emotional upheaval involved in moving from a biological parent's home, places substance-exposed children in kinship homes at particularly high risk. In addition, a history of parental substance abuse places these children at a greater risk for using and abusing substances themselves (Gross & McCaul, 1990; Weinstein & Takas, 2001). For example, children who resided with relatives are more likely, as adults, to use heroin and to trade sex for drugs (Benedict, Zuravin, & Stallings, 1996).

**Characteristics of Caregivers**

Testa and Slack (2002) characterize the relationship in a kin care household as a *gift relationship*; that is, the caregiver's willingness to look after their kin is motivated by factors other than self-interest. Indeed, the demographics of kin caregivers tend to support this assertion. As Ehrle and Geen (2002) note, "research has consistently shown that relative caregivers are more likely to be single, poorer, older, and have less formal education than non-kin foster parents." A survey of 246 kin care providers and 354 non-relative foster care providers in California found that kin tend to be significantly older, more often single, employed outside of the home, have less formal education, more health problems and less income than do traditional foster parents (Berrick, Barth,

& Needell, 1994). Nearly two-thirds of relative caretakers across the country are grandparents (Harden, Clark, & Maguire, 1997), which may explain the older age and high rate of health problems among kinship caregivers. Additionally, it can be ascertained that a relatively high number of these grandparent caretakers are grandmothers, as 85 percent of single kin caregivers are female (Harden, Clark, & Maguire, 1997). In a sample of 1,095 kin care providers taken from the NSAF, it was found that 41 percent of kin caregivers lived below the federal poverty level and 36 percent had less than a high school degree (Ehrle, Geen, & Clark, 2001). Perhaps even more salient, relative caregivers have an income that is less than two-thirds the income of non-relative caregivers (Brooks & Barth, 1998).

Caring for grandchildren, especially in light of the demographic characteristics of many kin caregivers as described above, is a source of stress. Added to this, the introduction of kin into care may occur suddenly, as in the case of incarceration of the mother or removal by Child Protective Services, and kin caretakers are often less prepared than non-relative foster parents to take on caretaking responsibilities (Kelley, Whitley, Sipe, & Yorker, 2000). In a self-selected sample of 102 grandmothers and great-grandmothers caring for kin, 28.4 percent reported a psychological distress score in the clinical range as measured by the Brief Symptom Inventory (BSI; Kelley et al., 2000), a test which has shown internal consistency and test-retest reliability (Derogatis, 1993). Grandparent caregivers have also rated themselves 1.69 times more psychologically distressed than the normative non-psychiatric female (Kelley et al., 2000). However, several circumstantial factors do appear to be at play: 41 percent of the psychological distress felt by grandparent caregivers can be accounted for by a self-reported lack of resources, social support and good physical health (Kelley et al., 2000). Kelley et al. (2000) also found that the mental health of relatives is often adversely affected by assuming full-time caregiving responsibility for their kin. This emotional and psychological strain is, in turn, associated with poor parenting and family functioning.

Despite the disadvantages and difficulties faced by these caregivers, kin are more likely to care for large sibling groups (Berrick, Barth, & Needell, 1994). In fact, more than three children live in 19 percent of kin care households (Ehrle, Geen, & Clark, 2001). Further, children in the care of kin are likely to remain in care for longer periods than those in non-relative care (Berrick, 1998). This is especially troubling because, as a child in kinship care gets older, (s)he is more likely to have a disrupted placement and is, furthermore, more likely to be moved from relative care into non-relative care (Testa & Slack, 2002). Despite this finding, federal policy specifically waives permanency requirements for children residing with kin while encouraging, in the case of non-relative foster care, permanent placements through adoption and legal guardianship (Geen & Berrick, 2002).

**Child Characteristics**

Demographically, Latino and Hispanic children are more likely to reside in kinship care (Jones, Chipungu, & Hutton, 2003), and the increasing reliance on kinship care arrangements by the child welfare system utilizes family patterns common within African American, Latino, and other populations over-represented in the foster care system nationwide (Brown, Cohon, and Wheeler, 2002; Schwartz, 1993). For example, within the African American community, there has been a long tradition of flexible and adaptive families and family roles that extend to both relatives and non-kin (Chatters, Taylor, & Jayakody, 1994). An important function of this extended network is to protect children from family instability and the loss of parents (Brown, Cohon, & Wheeler, 2002). Although it has received particular attention in the literature, this flexibility and fluidity in familial relationships is not exclusive to African American families. In fact, Bengston (2001, in Brown, Cohon, & Wheeler, 2002) suggests that, "contemporary social factors that impact all families, including, for example, growing marital instability and divorce, make extended kin in all families critical to socialization, nurturance, and other 'essential family functions.'"

Like their caregivers, children in relative care face a number of challenges. Chipman, Wells, and Johnson (2002) found that "when compared to normative samples, children in kinship care still have significantly more problems than children in the general population." A non-random sample of 798 children in San Diego found that the prevalence of developmental delay for both kin and non-kin foster children was between 19.8 and 28 percent, much higher than in the general population, where the prevalence is between 4 and 10 percent (Leslie et al, 2002). Perhaps most startling, while eight percent of the general child population faces three or more socioeconomic risks concurrently (such as poverty or a caretaker with less than a high school degree), over twenty percent of children in kinship care can be placed in this category (Ehrle, Geen, & Clark, 2001). These children are also "more likely to have health problems such as: higher rates of asthma, weakened immune system, poor eating habits, poor sleeping patterns, physical disabilities, and hyperactivity" (Jones, Chipungu, & Hutton, 2003).

Nonetheless, existing literature has associated placing children with relatives with several benefits. Keeping children within their extended family may reduce the stigma and trauma of separation from parents and family

(Ehrle and Geen, 2002; Brooks 1999). Children placed with relatives are more likely to have contact with siblings and parents than those in traditional foster care (Ehrle and Geen, 2002), and placements with kin are less likely to disrupt and tend to last longer than non-kin placements (Mason and Gleeson, 1999). Research also suggests that children residing in kinship care have fewer behavioral, educational, and mental health problems than children residing in non-relative foster care. For example, a 1988 sample of 990 adolescents in foster care in Los Angeles County found that those in kinship care were reported by their caseworkers to have significantly fewer mental health problems and significantly higher levels of functioning, as measured thorough the absence of educational, mental health or behavioral problems, than those adolescents in non-relative family foster care (Iglehart, 1994).

**Services**

Despite findings that children in kinship care do have developmental, emotional, and physical difficulties, kin caregivers self-report significantly fewer number of contacts with social service agencies and workers than do their non-kin foster care counterparts (Brooks & Barth, 1998). Supporting this assertion, significant differences have been found between social worker visits to kinship care homes and family foster homes, with adolescents in kinship care homes receiving an average 2.4 visits less per year than adolescents living with non-kin caretakers (Iglehart, 1994). Voluntary kinship caregivers are not provided with services through the foster care system; they must seek out accessible and affordable community services on their own which can be a daunting undertaking (McLean & Thomas, 1996).

However, as kinship care becomes a more popular option for children who cannot remain in the home of a parent, services designed specifically for relative caregivers and the children in their care are becoming increasingly available. For example, the U.S. Department of Health and Human Services' Children's Bureau funds nine relative caregiver projects that receive funding through the Abandoned Infants Assistance program (National Abandoned Infants Assistance Resource Center, 2004). Among other things, these relative caregiver services provide outreach, counseling, respite care, support groups, case management, and legal services. In addition, several national organizations have developed information, curricula, and support services for service providers and caregivers working with children in relative care, including Generations United (http://www.gu.org), Casey Family Programs (http://www.casey.org), Children of Alcoholics Foundations (http://www.coaf.org), and the Child Welfare League of America (http://cwla.org).

**Conclusion**

Overall, it is difficult to enumerate, and subsequently compare, the positives and negatives of kinship care as conclusions vary across measures. Depending upon the variable assessed, we find children in kinship care at the same time better off, the same as, or worse off than children in non-relative foster care. While placing children with kinship caregivers does seem to minimize both adjustment difficulties and placement instability (Iglehart, 1994; Ingram, 1996), placement with kin also often relegates children to homes with higher socioeconomic risk (Berrick, Barth, & Needell, 1994; Ehrle, Geen, & Clark, 2001).

As state and federal government rely more heavily on kin to care for children who cannot remain in the home of their biological parents, it is important to recognize the special needs of kinship caregivers and tailor systems which suit their unique situations. The studies mentioned above, which look at the demographic characteristics of caregivers provide some insight into the needs of this population and of the children in their care. For example, providing the options of legal guardianship and adoption, as well as the creation of services tailored specifically to kinship caregivers, seems to be a good start in creating much needed systems of legitimacy and support. However, the little information available on the outcomes of children in kinship care, combined with the lack of information on the utilization and utility of kinship specific programs, begs for further research. The dearth of information on children's perceptions of their kinship care placements also seems problematic. It is important to create an environment - on the policy, service, and personal level - where these children can grow within family structure suited to their needs and equipped with the resources to care for them properly.

**Reference List**


Barth, R.P., Courtney, M., Berrick, J.D., & Albert, V. (1994). *From child abuse to permanency planning: Child welfare services, pathways and placements.* Hawthorne, NY: Aldine de Gruyter.

Bauer, A. & Barnett, D. (2001). Infants at risk: Marker variables related to the early lives of children. Journal of Children and Poverty, 7(2), 121-134.

Benedict, M.I., Zuravin, S., & Stallings, R.Y. (1994). A comparison of kinship foster homes and foster homes: Implications for kinship foster care as family preservation. *Children and Youth Services Review,* 16(1-2), 33-64.

Berrick, J.D. (1998). When children cannot remain home: Foster family care and kinship care. *Protecting Children from Abuse and Neglect,* 8(1), 72-87.

Berrick, J.D., Barth, R.P., & Needell, B. (1994). A comparison of kinship foster homes and foster homes: Implications for kinship foster care as family preservation. *Children and Youth Services Review,* 16(1-2), 33-64.

Berrick, J.D., Needell, B., & Minkler, M. (1999). The policy implications of welfare reform for older caregivers, kinship care, and family configuration. *Children and Youth Services Review,* 21(9/10), 843-864.

Boardman, J., Powers, D., Padilla, Y. & Hummer, R. (2002). Low birth weight, social factors, and the development outcomes among children in the United States. Demography, 39(2), 353-373.

Boots, S.W. & Geen, R. (1999). *Family care or foster care? How state policies effect kinship caregivers.* Washington DC: The Urban Institute.

Brooks, D. (1999, winter). Kinship care and substance-exposed children. *The Source,* 9 (1), 1-2, 20-21.

Brooks, D. & Barth, R.P. (1998). Characteristics and outcomes of drug-exposed and non drug-exposed children in kinship and non-relative foster care. *Children and youth services review,* 20(6), 475-501.

Brown, S., Cohon, D., & Wheeler, R. (2002). African American extended families and kinship care: How relevant is the foster care model to kinship care. *Children and Youth Services Review,* 24 (1/2), 53-77.

Carta, J., Atwater, J., Greenwood, C., McConnell, S., McEvoy, M. & Williams, R. (2001). Effects of cumulative prenatal substance exposure and environmental risks on children's developmental trajectories. Journal of Clinical Child Psychology, 30(3), 327-337.

Chatters, L., Taylor, R., & Jayakody, R. (1994). Fictive kinship relations in black extended families. *Journal of Comparative Family Studies,* 25 (3), 297-313.

Cohon, D., Hines, L., Cooper, B.A., Packman, W., & Siggins, E. (2000). Stuart foundation kin caregiver study: Final report. San Francisco, CA: Edgewood Center for Children and Families.

Derogatis, L.R. (1993). Brief Symptom Inventory manual. Towson, MD: Clinical Psychometric Research.

Ehrle, J. & Geen, R. (2002). Kin and non-kin foster care – Findings from a national survey. *Children and Youth Services Review,* 24(1/2), 15-35.

Ehrle, J., Geen, R., & Clark, R.L. (2001). *Children cared for by relatives: Who are they and how are they faring?* Washington, DC: Urban Institute.

Frank, D., Augustyn, M., Knight, W., Pell, T., Zuckerman, B. (2001). Growth, development and behavior in early childhood following prenatal cocaine exposure: A systematic review. JAMA, 285, 1613-1625.

Geen, R., & Berrick, J.D. (2002). Kinship care: An evolving service delivery option. *Children and Youth Services Review,* 24(1/2), 1-14.

Generations United (2003). A guide to the national family caregiver support program and its inclusion of grandparents and other relatives raising children. Washington DC: Generations United. Available at http://www.gu.org/Files/GU-Guide%20April%2004.pdf.

Gleeson, J., O'Donnell, J., & Bonecutter, F.J. (1997). Understanding the complexity of practice in kinship foster care. *Child Welfare,* 76(6), 801-826.

Gross, J. & McCaul, M.E. (1990). A comparison of drug use and adjustment in urban adolescent children of substance abusers. *The International Journal of the Addictions,* 25(4), 495-511.

Harden, A.W., Clark, R.L., & Maguire, K. (1997). Formal and informal kinship care: Executive summary. Office of the Assistant Secretary for Planning and Evaluation, United States Department of Health and Human Services. Washington DC: DHHS.

Iglehart, A. P. (1994). Kinship foster care: Placement, service, and outcome issues. *Children & Youth Services Review,* 16(1-2), 107-122.

Ingram, C. (1996). Kinship care: From last resort to first choice. *Child Welfare,* 75(5), 550-566.

Jones, E., Chipungu, S., & Hutton, S. (2003). *The Kinship Report: Assessing the Needs of Relative Caregivers and the Children in Their Care.* Seattle: Casey Family Programs.

Kelley, S.J., Whitley, D., Sipe, T.A., & Yorker, B.C. (2000). Psychological distress in grandmother kinship care providers: The role of resources, social support, and physical health. *Child Abuse & Neglect,* 24(3), 311-321.

Leos-Urbel, J., Bess, R., & Geen, R. (1999). *State policies for assessing and supporting kinship foster parents.* Washington DC: The Urban Institute.

Leslie, L.K., Gordon, J.N., Ganger, W., & Gist, K. (2002). Developmental delay in young children in child welfare by initial placement type. *Infant Mental Health Journal,* 23(5), 496-516.

Mason, S. & Gleeson, J.P. (1999). Adoption and subsidized guardianship as permanency options in kinship foster care: Barriers and facilitating conditions. In Gleeson, J. P. & Hairston, C. F. (Eds.), *Kinship care: Improving practice through research.* Washington, DC: CWLA Press.

McLean, B., & Thomas, R. (1996). Informal and formal kinship care populations: A study in contrasts. *Child Welfare,* 75(5), 489-505.

Meyer, B.S. & Link, M.K. (1990). *Kinship foster care: The double-edged dilemma.* Rochester, NY: Task Force on Permanency Planning for Foster Children.

National Abandoned Infants Assistance Resource Center (2004). *Directory of AIA programs*. Berkeley, CA: Author.

Needell, B., Webster, D., Cuccaro-Alamin, S., Armijo, M., Lee, S., & Brookhart, A. (2001). *Performance indicators of child welfare services in California.* Retrieved from http://cssr.berkeley.edu.

Schwartz, M. (1993). *Reinventing guardianship: Subsidized guardianship, co-guardians and child welfare.* New York, NY: Vera Institute of Justice.

Singer, L., Arendt, R., Minnes, S., Farkas, K., Salvator, A., Kirchner, L. & Kliegman, R. (2002). Cognitive and motor outcomes of cocaine-exposed infants. JAMA, 287, 1952-1960.

Testa, M.F. (2001). Kinship care and permanency. *Journal of social services research*, 28(1), 25-43.

Testa, M.F. & Slack, K.S. (2002). The gift of kinship foster care. *Children and Youth Services Review,* 24(1/2), 79-108.

Thornton, J.L. (1991). Special report: Permanency planning for children in kinship foster homes. *Child welfare*, 70(5), 593-601.

Troutman, B. (1999). Infants placed in out-of-home care: Implications for attachment. *The Source*, 9(3), 12-15.

United States Department of Health and Human Services (2001d). *Foster care and adoption statistics current reports*. Washington DC: Author. http://www.acf.dhhs.gov/programs/cb/dis/tables/index.htm

United States General Accounting Office (1999). *Foster care: Kinship care quality and permanency issues.* Washington DC: Author.

Weinstein, N. & Takas, M. (2001). *The ties that bind: Parental substance abuse and kinship care.* Phoenix House: Children of Alcoholics Foundation.

National Abandoned Infants Assistance Resource Center
University of California, Berkeley
1950 Addison Street, Suite 104 #7402
Berkeley, CA 94720-7402
Phone: (510) 643-8390 Fax: (510) 643-7019
http://aia.berkeley.edu
*A service of the Children's Bureau*

The publication of this fact sheet was made possible by grant #90-CB-0126 from the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, US Department of Health and Human Services. The contents are solely the responsibility of the authors and do not represent the official views or policies of the funding agency. Publication does not in any way constitute an endorsement by the Department of Health and Human Services. Readers are encouraged to copy and share this material, but please credit the National AIA Resource Center.