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Child Welfare

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In 2013, the Child Welfare League of America published the CWLA National Blueprint for Excellence in Child Welfare (National Blueprint). The National Blueprint provides a vision for child welfare that “all children will grow up safely, in loving families and supportive communities.” Fundamental to this vision is the belief that while the formal child welfare system is accountable for its specific role as it relates to children who are at risk of or have experienced abuse or neglect, it will take the combined efforts of families, communities, other child and family systems, and the public as a whole to fully actualize the vision. The National Blueprint is intended to challenge individuals, groups, communities, and providers, inside and outside of the formal child welfare system, to understand that they play an important role in advancing improved outcomes for children and families.

The National Blueprint also serves as the foundation for all of CWLA’s work. It makes it clear that the needs of the children and families that come into contact with the formal child welfare system cannot be addressed by the child welfare system alone; the system must do its work by leveraging the knowledge and resources gained from families, communities, and other child and family serving systems. The core principles of the National Blueprint include Rights of Children; Shared Responsibility and Leadership; Engagement/Participation; Supports and Services; Quality Improvement; Workforce; Race, Ethnicity, and Culture; and Funding and Resources. In particular, the Engagement/Participation principle states, in part, that “Children, youth, and families are engaged and empowered to promote family success and build community capacity.” Also, the Supports and Services principle states that “Families, individuals, communities and systems protect children from abuse and neglect and provide an array of supports and services that help children, youth, and their
families to accomplish developmental tasks, develop protective factors and strengthen coping strategies.” To achieve this National Blueprint vision for children and youth, child welfare organizations—and in fact other child serving organizations must engage and extended family members to care for children when their adult children are not able to care for them and to ensure that these family members have the supports and services they need to effectively care for these children. This special issue of Child Welfare, “Kinship Care and Child Welfare: New Directions for Policy and Practice,” focuses on kinship families and the successes and challenges they experience, with a view toward assuring a comprehensive system of kinship care that is inclusive of all such families.

Child Welfare thanks our colleagues at University at Albany, SUNY, for their contributions to this special issue.
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The guest editors of this special issue would like to thank Catherine Kramer, a doctoral student, and Jennifer North and Cara Duffy, staff members, at the University at Albany’s School of Social Welfare for their assistance with the 2016 Kinship Summit.
From the Editor:

The Apple Tree Has Many Healthy Apples: Kinship Caregiving

Beatriz Johnson was leaving work when she received a frantic call from her daughter, Patrice: “Mom, the police are here, and they have the kids!” Patrice had struggled with substance abuse before she became a mom. Beatriz rushed to her daughter’s home. A neighbor had called the police when the children—Bobby, 6 months, and Patrick, 2—were heard crying, the door to the apartment was opened, and Patrice was found not to be at home. Child protective services were called; they waited for Patrice, and after an hour, the children were taken into custody. Beatriz knew that she was not going to let her grandsons stay in custody and immediately made a plan to take them into her home and care for them—after all, isn’t that what grandmothers did? The children were placed with Beatriz, who cared for them full-time with support; Patrice entered substance abuse treatment and worked to regain custody of her children. And so begins the process of kinship care.

Twenty years ago, when this journal first addressed Beatriz’s plight and others like hers in our special issue on kinship care (Wilson & Chipungu, 1996), the focus was on the formal placement of children with kin after the children were taken into public custody. This special issue focuses on the much larger number of kinship caregivers, who, as in Beatriz’s situation, either intervene on their own or accept the assistance of child protective authorities that facilitate informal arrangements without taking legal custody. It is the larger combined population of formal and informal kinship placements, to which the common definition of kinship care appropriately applies: “the full-time care, nurturing, and protection of a child by relatives, members of their Tribe or clan, godparents, stepparents, or other adults who have a family relationship to a child.”
There are many benefits to placing children with relatives or other kinship caregivers, such as increased stability and safety as well as the ability to maintain family connections and cultural traditions. Whether these kinship arrangements should be kept informal or brought under the formal governance of child protective authorities is a policy question with which federal and state governments continue to struggle: How can the respect owed informal kinship relationships on the basis of emotional ties and the family's cultural values best be reconciled with the formal placement requirements of legal custody, licensing, and regular surveillance of the quality of foster family homes?

Even after the public enforcement of so-called relative responsibility laws eventually ended in most western societies (Bell, 1965), cultural expectations still dictated in many regions that kin should provide for one another as a moral duty without being financially compensated. During the 20th century, these cultural expectations surrounding uncompensated kinship care began to change. The relative-payee Aid for Families with Dependent Children grant, which aided a family when a child came from an eligible household and was living in the home of a relative, was explicitly addressed in the Social Security amendments of 1962. Relatives also qualified as providers of home health aid under Medicaid. Then, in 1977, the U. S. Supreme Court ruled in *Miller v. Youakim* that relatives who met foster care licensing standards must be permitted to receive federal foster care funds and in *Moore v. City of East Cleveland* that relatives, especially grandparents, have heightened protections when they become caregivers. For years, many states were slow to add relatives to the foster care rolls and to enact supports for kinship families, but additional policy on the federal level and by some states has helped create momentum for change.

There are many perspectives and opinions about kinship care from the child welfare community and society at large. The old adage of “the apple doesn't fall from the tree” is erroneously used to denigrate
the kinship connection. But as Dr. Joseph Crumbley—a leading expert in this area—often says, “we have to dispel that myth—there are many healthy apples on the tree, too.” The benefits of kinship care for children who cannot live with their birth families, in my opinion, outweigh the concerns. Yet there are many considerations that continually arise and should be assessed.

The authors featured in this special issue on kinship care cover a wide range of issues. They are among the leading experts in the field, and their contributions will undoubtedly stimulate dialogue and discourse among many in child welfare.

Gary Mallon DSW
Senior Editor
Introduction:

**Kinship Care Policy and Practice**

(First Issue)

More than two decades ago, the Child Welfare League of America (CWLA) published *Kinship Care: A Natural Bridge* (Child Welfare League of America, 1994). The report assembled the best thinking and scholarship available at the time to address the emerging issue of kinship care in the field of child welfare. Even though the alternative care of children by extended family, tribal members, and other primary groups is deeply rooted in human evolutionary and cultural history, it was only in the last quarter of the 20th century that child welfare practitioners and policy-makers put concerted efforts into reconciling the natural-customary sources of informal kinship care with the rational-legal foundations of formal foster care. Despite some progress in reconciling the informal agency relationships of kinship solidarity and customary trust with the formal agency relationships of contractual exchange and generalized beneficence (Testa, 2013), significant challenges still remain in demarcating the boundaries between informal and formal kinship care and in ensuring that kinship caregivers, birth parents, and their children receive the support and services they need from the public child welfare system.

The purpose of this introduction is to offer a conceptual framework for addressing the challenges involved in developing a coherent set of policies and practices with respect to kinship care. The challenges span two key tensions in the public protection and care of vulnerable children. The first concerns the appropriate scope of public interest in the welfare of other people’s children: Should child welfare policy be constrained to a narrow set of functions that ensure children are adequately fed, sheltered, clothed, and protected from physical harm, or should it be unconstrained in the pursuit of a diffuse array of improvements in children’s
general well-being? The second concerns the appropriate locus of agency relationships in the protection and care of children: Should actions taken by non-parental agents on behalf of the interests in children be largely the informal responsibility of the particularistic agency relationships of extended kinship, tribal affiliation, and voluntary association, or should the universalistic agency relationships of child protective services (CPS) and court authority ultimately be held accountable for ensuring adequate safety, family permanence, and equal developmental opportunities for all vulnerable children?

An agency relationship is one in which an individual or collective agent is delegated the discretion to act on behalf of the interests of another individual or class of individuals, also known as principals (Testa & Poertner, 2010). The intersection of the two dimensions of locus of agency relationships (informal vs. formal) and scope of public interest (constrained vs. unconstrained; Sowell, 2007) frame a matrix of policy choices that, on the constrained side, range from: (A) deferring to the autonomy and discretion of informal primary groups to raise children as they deem appropriate to (B) enforcing uniform caregiving practices that uphold minimal formal standards of child protection, care, and discipline. On the unconstrained side, the choices range from: (C) redistributing resources to enable informal primary groups to raise children as best they can to (D) investing in formal agency relationships of early education, mental health services, foster homes, and adoption assistance, which can supplement or substitute for primary group relationships that don’t measure up to majority expectations.

Much of the history of child welfare in general and kinship care in particular can be interpreted as evolving from policy A, under mid-19th-century poor law doctrines of family autonomy and relative liability, to policy B, with the spread of child rescue societies and the growth of orphanages and family foster care as alternatives to in-home care in the late 19th century (Costin, 1993; Meyers, 2008). Policy C emerged during the first half of the 20th century, partly in reaction to Policy B, with the creation of mothers’ pensions and the federalization of kinship
support under Aid to (Families with) Dependent Children (Leff, 1992). Policy position D appeared around the same time with the invention of the juvenile court and accelerated after the passage of Medicaid, Title IV-E, Head Start, and other “war on poverty” programs in the 1960s.

The progression from policy choices A to D, however, has not been unidirectional. Some have likened it to the swings of a pendulum (Garwood, Phillips, Hartman, & Zigler, 1989). Backing for Policy C receded in the mid-1990s with the replacement of the Aid to Families with Dependent Children (AFDC) entitlement by time-limited Temporary Assistance to Needy Families (TANF). Support for Policy D eroded with the deinstitutionalization of foster care in the 1970s and the elimination of long-term foster care as a permanency planning goal in the late 1990s. All four policy positions continue to evolve in response to changing demographic, economic, and political conditions in the early 21st century.

Figure 1. Typology of Kinship Care

Figure 1 presents a typology of kinship care based on the cross-tabulation of the two dimensions of scope of public interest and locus of agency relationships. The 1994 CWLA report emphasized the informal-formal distinction and focused its recommendations on formal kinship care. It defined formal caregiving as child custodial relationships that are established: “… as a result of a determination by the court and the public child protective service agency that a child must be separated from his or her parents because of abuse, neglect, dependency, abandonment,
or special medical circumstances. In formal kinship care, the court places the child in the legal custody of the child welfare agency, and kin provide the full-time care, protection, and nurturing that the child needs.” (Child Welfare League of America, 1994, p. 3)

Subsequent scholarship (Testa, 2013; Denby, 2016) broadened the definition of formal kinship care to encompass legal processes that establish relatives as permanent legal guardians or adoptive parents of the child (permanent kinship care) in addition to those that establish them as temporary foster parents (public kinship care). This broadening of the definition was in keeping with earlier scholarship concerning the contrast between informal and formal adoption (Hill, 1977). Even though permanent kinship care was only tangentially addressed in the 1994 CWLA report, this report recommended that subsidized guardianship by kin be offered as a supplemental permanency option. At the time, federal kinship guardianship assistance was still being tested under IV-E waiver authority, and adoption was just beginning to be accepted as a viable permanency goal for children in kinship care (Testa, Shook, Cohen, & Woods, 1996). The subsidized guardianship recommendation was later established in law when Congress acted on research evidence from IV-E waiver demonstrations to create the kinship Guardianship Assistance Program (GAP) as part of the 2008 Fostering Connections Act (FCA).

The 1994 CWLA report defined informal kinship care as child-caring relationships that are based on a private agreement reached between a parent and alternative caregiver. In these informal arrangements, a public agent may be involved in helping family members plan for the care of the child, but the CPS agency does not take formal custody of and assume legal responsibility for the child. The 2000 Report to the Congress on Kinship Foster Care (U.S. Department of Health and Human Services, 2000) built on this distinction and separated informal kinship care into private and voluntary types in order to distinguish the special relationship that is created when child protective authorities help facilitate voluntary kinship care but do not seek court
action to obtain public custody of the child. Because CPS involvement in voluntary kinship care arrangements can range from conducting a brief home visit or background check to opening up a CPS case and providing ongoing intervention and treatment services, the typology makes a further distinction along the constrained vs. unconstrained dimension—between voluntary arrangements that experience brief CPS involvement and those that result in an open CPS case.

The 2008 FCA also included notice provisions that mandated diligent efforts in finding kin, especially grandparents, and informing of them of their custodial options. These provisions prompted the use of other formal legal mechanisms for temporarily reassigning child custodial responsibilities, such as voluntary placement agreements, parental powers of attorney, and probate court guardianship, which blur somewhat the boundary between voluntary and permanent kinship care. The blurring is illustrated by the dotted lines in Figure 1 where the separation is less distinct than the boundaries around public kinship care.

**Size of the Kinship Care Population**

The 2000 ACF report grouped voluntary kinship care together with formal kinship care under the general heading of public kinship care. Figure 1 restricts the definition of public kinship care to the formal placement of children who are court-ordered into public custody. This includes foster children who are placed into unlicensed kinship homes. Estimating the sizes of the different categories of kinship care is not simply a matter of counting noses. Kinship caregivers can occupy a multiplicity of informal and formal roles. For example, caregivers can initially occupy an informal role as a grandparent, aunt, uncle, or tribal member in private or voluntary kinship care and subsequently assume a formal role as a licensed foster parent in public kinship care; still later, caregivers can take on formal roles as adoptive parents in permanent kinship care.

At any point, children in public kinship care may be undercounted in administrative data because official records may expunge a caregiver’s
informal identity as kin after they become formal foster caregivers. Similarly, licensed foster parents who previously occupied an informal role as a relative caregiver may continue to self-identify as kin and not disclose, unless explicitly asked, their formal status as a foster parent. Further, children in permanent kinship care can also be overlooked because a caregiver’s formal role as an adoptive parent eclipses their customary kinship role. Some general population surveys skip asking relatives questions about their experiences as non-parental caregivers because they have become the legal parents of the children previously under their temporary kinship care.

Given the multiplicity of roles that kinship caregivers can occupy, the best available data about the respective sizes of the different types of kinship care come from the 2013 National Survey of Children in Nonparental Care (NSCNC). These data are analyzed in the paper by Bramlett, Radel, and Chow (this volume). At the request of the editors, the paper’s authors generated population estimates of the number of children in the different types of kinship care. They weren’t able to generate an estimate of all children in kinship care, because adopted children in permanent kinship care were, by definition, excluded from the 2013 survey. Nonetheless, the authors surmised from the 2007 National Survey of Adoptive Parents that approximately 436,000 adopted children were also previously related to their parents through kinship ties (Vandivere, Malm, & Radel, 2009)

Based on the 2013 NSCNC, the estimated number of children in public kinship care was 196,000 children in 2013. This is approximately 70% larger than the 113,065 children reported to the U.S. Department of Health and Human Services (HHS) by state child welfare agencies as living in public kinship care on September 30, 2013 (U.S. Department of Health and Human Services, 2014). The discrepancy can be accounted for by the fact that the NSCNC provides a count of children in kinship homes over the course of a two-year data collection period, whereas the federal count refers to the number in public kinship care on a single day. Children who transition to permanent
kinship care or voluntary kinship care are dropped from the federal count. Another reason for the lower HHS count is missing data. When the U.S. Congress ordered HHS to submit a report in 2011 on children placed in relative foster family homes, the agency responded that it could not provide a national estimate of the number of related children in licensed or unlicensed foster care because of missing data about kinship status in some state information systems (U.S. Department of Health and Human Services, 2011).

Despite the differences in counting methods, it is noteworthy that even under the broader NSCNC definition, children in public kinship care account for only a fraction of the total population under the full-time care of relatives. Corresponding to the different types in Figure 2, the largest category of full-time kinship care includes the 862,000 children in private kinship care (39%) with no prior CPS involvement. It is followed by an estimated 374,000 in voluntary kinship care (17%) in which there was an open or prior CPS case and another 335,000 in voluntary kinship care (15%) in which there was some other type of CPS involvement. Adding to these counts, the approximate number of adopted children whose parents were also related to the child by kinship ties (20%) elevates the total estimated number of children in all four types of private, voluntary, permanent, and public kinship care to the vicinity of 2.2 million children.
Responsibility and Accountability

The reason that the boundary between informal and formal foster care may be drawn crisply around public kinship care in Figure 1 is because federal law holds child welfare systems legally liable for the safety and general well-being of vulnerable children only when they are in the formal legal custody of government (DeShaney v. Winnebago County Department of Social Services, 1989). In spite of immunity from federal lawsuits involving children not in public custody, state child welfare systems are not entirely shielded from public accountability as collective agents of the safety and well-being of children for whom they are not legally responsible. Even though responsibility and accountability are intertwined, the two concepts are separable to some degree. While parents are responsible for the safety and well-being of their own children, they are not ordinarily accountable to the public except in the narrow sense of not violating child maltreatment laws. Conversely, child welfare systems are accountable under federal law for general rates of repeat maltreatment and the provision of in-home services even though they are not legally responsible for the safety and well-being of individual children in parental or informal kinship care.

States that fail to measure up to public accountability standards can be assessed federal financial penalties if they don’t demonstrate progress in remedying audited deficiencies. This places states in the quandary of being held accountable for child-caring practices for which they are not legally responsible. Government may seek to resolve this predicament by expanding the population of vulnerable children taken into public custody. This is a general pattern that is frequently observed in the aftermath of a child’s death due to horrendous abuse by parents or other caregivers. Conversely, government may seek to alleviate the tension by limiting public accountability only to the constrained functions of protecting the child’s safety and finding them permanent homes. This was essentially the position taken by the American Bar Association and other national organizations when they declined to adopt measures of child well-being because they lacked...
consensus on performance measures for which they already had direct responsibility (American Bar Association, National Center for State Courts & National Council of Juvenile and Family Court Judges, 2004). Striking the right balance between ensuring that private and voluntary kinship caregivers receive the support and services they need without bringing more children into the formal legal custody of the state remains one of the key challenges for public child welfare in the 21st century.

Focus of the Special Issue

The 1994 CWLA report focused on children in public kinship care. This special issue of *Child Welfare* focuses on the estimated 1.6 million children under the private and voluntary care of relatives for whom government is accountable in a general sense even if it is not directly responsible for their safety and well-being in an individual sense (A and C shaded in Figure 1). The volume also considers the smaller number in unlicensed public kinship care (the shaded half of B) for whom government is directly responsible but their caregivers face obstacles that are similar to those faced by informal caregivers (Wallace, 2016).

For most of the 20th century, American states formally excluded kinship caregivers from the licensed foster care system. Instead they supported the kinship care of dependent and neglected children under the family assistance provision of ADC/AFDC. This provision of the 1935 Social Security Act authorized federal financial participation (FFP) in assistance programs for children who were deprived of parental support and lived in a place of residence maintained informally by a relative as the children’s “own home.” The issue of whether children placed formally with kin by CPS agents could also qualify for public foster care benefits came to a head in the landmark Supreme Court ruling, *Miller v. Youakim* (1979). The state of Illinois argued that the preferred locus of alternative care rested voluntarily with extended kin and was enforceable as a family duty by denying relatives full foster care benefits even if they met formal licensing standards.
The plaintiffs countered that because kin were not legally liable for the support of related minors under modern family law, there was no legitimate grounds for arbitrarily withholding federal benefits from licensed foster parents for reasons of kinship alone. The Court concluded that responsibility for the welfare of children in public custody resided squarely with the state and ordered that equal subsidies be paid to licensed kinship caregivers the same as unrelated foster parents.

Even though the Miller decision outlawed the exclusion of licensed kinship caregivers from federally supported, public foster care, the decision still allows substantial discretion to states for excluding or including relatives in other ways. States may choose to restrict a relative’s participation in public foster care by denying federal benefits to children who previously resided in the relative’s home for six months or longer unless they are physically removed from the relative’s home. Alternatively, states can divert children who have been found to be abused or neglected to the informal custody of extended kin, with or without financial assistance. For children who need to be removed, states may either restrict placement into relative homes by requiring that their homes meet formal licensing standards or by placing children in unlicensed kinship homes that qualify for less financial assistance than what licensed foster homes can receive.

Looking forward, individual states undoubtedly will continue to rely on all four types of kinship care for the protection and care of abused and neglected children. An unresolved issue is the extent to which federal policy should promote the use of one type of kinship care over another or guarantee equal access to federally funded benefits and services regardless of kinship care type. For example, should placement into voluntary kinship care be facilitated and supported as the preferred response to child maltreatment whenever diversion is appropriate or should the majority of kinship care be incorporated into the formal system to ensure children’s equal rights to counsel, adequate financial support, and timely permanence? Should federal guardianship assistance be limited only to formal
kinship caregivers who are licensed and exit to permanent kinship care, or should an additional pathway to subsidized guardianship be carved out for unlicensed kinship caregivers and relatives who transition from informal caregiving to permanent legal guardianship? Should public resources be invested broadly in reinforcing informal kinship caregivers’ natural inclinations and capacities for promoting the well-being of their own children or should the dollars be spent on inducing formal agents of the state to take a long-term interest in and responsibility for the social, emotional, and educational well-being of children in public custody? These and other questions are addressed in the Position Paper that is included as an addendum to this double issue’s collection of articles.

**Dimensions of Formality**

Even though the simple typology illustrated in Figure 1 is handy for demarcating public responsibility, highlighting policy dilemmas, and estimating the size of the kinship care population, it is less useful for generating specific policy and practice recommendations about the appropriate scope of public interest and locus of agency relationships for ensuring the safety, permanence, and well-being of vulnerable children. Such concerns are better addressed by defining formality as an interval variable rather than a nominal one.

Drawing from the literature on informal and formal organizations (Froland, 1980; Stinchcombe, 2001), the formality of caregiving can be contrasted with informality in at least three ways. The first concerns the degree to which public interest in the welfare of children is governed by explicit rules and procedures for assessing need, determining eligibility, providing assistance, assigning responsibility, and supervising performance. This dimension of formality can vary from a narrow concern with protecting children’s safety and health to a diffuse concern with promoting children’s general well-being. The second contrast refers to the degree to which the governing abstractions are set
apart from the personal feelings, subjective biases, and power imbalances of everyday life. The third refers to the degree to which there is public accountability for the validity and integrity of agents’ actions in accomplishing the desired results.

Agency relationships that score high on all three dimensions exhibit a high degree of formality. Such relationships cluster in zone “D” of Figure 1. Even though the permanence of agency relationships is best formalized through legal guardianship and adoption of children, long-term guardianship can also be vested with collective agents that are entrusted with public responsibility for promoting the social and emotional well-being of individual children. Therapeutic foster homes and residential treatment centers for youth with emotional and behavioral challenges fall into this zone. They exhibit a high degree of formality by virtue of the collective agent’s assuming full responsibility for the well-being of the child; the governance of the agency relationship by supervisory monitoring and financial incentives that reinforce professionalism; and the agent’s ability, when called upon, to supply evidence of the validity of its actions in achieving the desired outcomes.

Highly formalized agency relationships that depart from these three criteria—for example, by ignoring children’s needs for quality care, reverting to the use of corporal punishment, employing pseudoscientific therapies, or treating children prejudicially on the basis of race, religion, or sexual orientation—constitute grounds for dismissal from the formal caregiving role. By contrast, it is highly unlikely that informal caregiving arrangements that occupy zone “A” in Figure 1 would be held to the same accountability standards regarding quality care, discipline, evidence-based practice, and favoritism. In fact, it is precisely this contrast—which according to some social theorists makes extended families, religious organizations, and other voluntary associations better equipped than formal systems for promoting children’s well-being because they are able to elicit cooperation and motivate change by drawing upon their own
cultural and social resources unlike state agencies—that must remain culturally neutral (Glazer, 1988).

Social Capital and Relational Models

The fact that similar parenting practices can elicit different societal reactions depending on whether they are expressed within the informality of private kinship care or the formality of public foster care brings into focus the different types of social capital (Portes & Sensenbrenner, 1993) and relational models (Haslam, 2004) that informal groups and formal organizations are able to draw from to motivate and regulate agency relationships on behalf of children. A key social dilemma in the regulation of agency relationships is whether agents will remain committed to the interests of their principals or defect from this expectation at the principal's expense. Informal agency relationships are able to draw from two types of social capital and relational models that are typically absent from or expressly prohibited in formal agency relationships. The first is the natural altruism and communal sharing that flows from ascribed membership in primary group solidarities rooted in kinship, tribe, religion, or ethnicity. Informal kinship care assumes that the agency dilemma of cooperation or defection is best resolved by placing vulnerable children in an agency relationship in which a member of the child's primary group can be counted on to act on behalf of the general well-being of the child as if those interests are the member's own. Formal agency relationships typically lack access to this intrinsic source of agency motivation and regulation, and federal law expressly prohibits child welfare systems from refusing or delaying foster or adoptive placements because of a child's or foster/adoptive parent's race, color, or national origin.

Intrinsically motivated relationships of kinship care eventually become vulnerable to agent defection over time unless they are fortified periodically by an extrinsic source of motivation. Traditionally, informal kinship care supplied extrinsic motivation by embedding the
child in a hierarchical relationship in which the minor owed obedience and service to an elder who bore responsibility for the protection and care of the subordinate. This second type of social capital and relational model is also limited in formal agency relationships by restrictions on the kinds of duties that can be imposed on minors and the forms of discipline that can be used to exact obedience. For example, restrictions on the use of corporal punishment is one of the limitations on caregiver authority that distinguishes formal from informal kinship care.

Up until the industrial revolution, the customary trust vested with patriarchal authorities through the institutions of indenture, apprenticeship, and domestic service met majority expectations for what was considered both necessary and appropriate for the basic care, protection, and maintenance of dependent and neglected children. With the spread of formal systems of market exchange and contractual liberty, however, patriarchal systems of foster care gradually lost legitimacy. Without the softening of authority relations that particularistic ties normally afford in extended families and close-knit communities, the agency risk increased that the patron, master, or overseer would defect from his paternalistic responsibilities and bind the minor to conditions of servitude in opposition to the child’s best interests and needs. This was one of the agency risks of public foster care under the poor laws, which private child welfare agents sought to ameliorate by bringing the alternative care of dependent, neglected, and abused children under the contractual agency relationships of licensing, certification, and boarding home subsidies.

As long as the scope of public interest in child welfare was constrained to meeting the basic needs of dependent and neglected children for food, clothing, shelter, and protection from physical harm, the foster boarding system functioned adequately enough to elicit the compliance of formal agents in meeting these expectations. But as scientific knowledge of the developmental needs of children for family permanence and trauma-informed care became widespread, the limits of
contractual agency relationships in sustaining unconstrained commitments to the well-being of the child at an affordable cost became more problematic. Contractual agency relationships worked best in meeting the temporary health and safety needs of children in highly formalized settings, such as hospitals and CPS, but long-term commitments to child well-being needed intrinsic sources of motivation to sustain the continuity of agency relationships. Agent recruitment practices in public child welfare shifted to the selection of fiduciary agents who, by virtue of their professional training and internalized values of probity and beneficence, could be counted on to look after the long-term interests of children impartially and equitably.

**Social Dilemma of Kinship Care**

The social dilemma of kinship care can be expressed in terms of lingering concerns over the adequacy of the informal agency relationships of kinship solidarity and customary trust in meeting the needs of vulnerable children for safety, permanence, and well-being. When the federal foster care program was established in the 1960s under AFDC, prevailing social work wisdom at the time was that the nuclear family form, with its breadwinner father and stay-at-home mother, was the most functional for modern society (Parsons, 1943). The prediction was that the importance and vitality of the extended family as sources of social capital and moral regulation would gradually dissipate with industrialization and the expansion of the bureaucratic welfare state (Putney, Bengston, & Wakeman, 2007).

Any lingering concerns over the continued importance and vitality of private and voluntary kinship care in meeting the permanency and well-being needs of children should be allayed by the findings presented in the first two articles in this volume. Each examines differences in the characteristics, adverse family experiences, and well-being of children in different types of kinship care. The article by Bramlett, Radel, and Chow (this volume) uses nationally representative survey data to
examine differences in kinship care along the constrained-unconstrained dimension of varying degrees of child welfare involvement.

Within informal kinship care arrangements, tests for linear trends indicate that adverse family experiences correlated with higher degrees of child welfare involvement. For example, the percentage of children who ever lived with a parent who was mentally ill rises from 17.9% for children in private kinship care to 24.3% in voluntary kinship care with other CPS involvement and 43.8% for children in voluntary kinship care with ever an open CPS case. Even though it might be expected that adverse family experiences would be most highly associated with formal kinship care, the percentage of children in public kinship care who ever lived with a mentally ill parent was nearly identical (24.2% vs. 25.4%) to the average for all children in nonpublic kinship care. Whereas CPS involvement appears responsive to higher levels of risk in informal kinship care, there appears to be no association between adverse family experiences, neighborhood violence, health conditions, and utilization of mental health services among children taken into public kinship care compared to children left in or diverted to informal kinship care. The lack of statistical association of greater formality with risk levels reinforces inklings that the decision to take a child into public kinship care is more a by-product of bureaucratic routines than a clinically informed response to child and family need.

The second article, by Wu (this volume), also allays concerns that diversion of children from the public foster care system to voluntary and private kinship care compromises the well-being of children investigated for child maltreatment. The study analyzes data from the Second National Survey of Child and Adolescent Well-Being (NSCAW II), a nationally representative sample of children investigated for child abuse or neglect. It tracks the well-being of a subsample of 654 children who were removed from parental custody and placed in public (paid) kinship care, voluntary kinship care, or private kinship care. Echoing the findings from NSCNC, the NSCAW II data also shows that caseworker assessments of the maltreatment allegations
for children in private kinship care registers less severe levels of harm and risk than the allegations for children in voluntary or public kinship care. But lower harm and risk assessments by caseworkers do not translate into lower caregiver ratings of child behavior problems. To the contrary, children in private kinship care were rated higher at baseline by their caregivers on the Child Behavior Checklist (CBCL) than children in public and voluntary kinship care. Follow-up interviews at 36 months after the close of the initial investigation, however, showed a significant decline in CBCL scores for children in private kinship care. All else equal, the average scores for both internalizing and externalizing problems registered larger declines for children retained in private kinship care compared to children who were taken into formal legal custody and placed with relatives in public kinship care.

Challenges of Informal Kinship Care

The findings from two nationally representative samples of children in kinship care provide compelling statistical evidence of the continued vitality of kinship solidarity and customary trust in safeguarding the well-being of children in non-public kinship care. There is little indication that the well-being of children who reside in or are diverted to private or voluntary kinship care would substantially improve if they instead were taken into public custody. In fact, some of the findings suggest that their well-being could possibly worsen. But these positive indications do not mean that the circumstances of children and kinship caregivers in informal care situations are devoid of challenges.

The next two contributions, by Lee, Choi, Lee, and Kramer (this volume) and by Rushovich, Murray, Woodruff, and Freeman (this volume) underscore the challenges of ensuring the well-being of children under the private or voluntary care of relatives. The former study’s analysis of survey data and administrative records indicates that a majority of children in informal kinship care had prior CPS involvement and a quarter had been previously placed in public foster care.
with non-relatives. While most of these children experienced long periods of stable kinship care, financial hardships posed a constant threat to the solidarity of kinship relationships. The strains on kinship solidarity appear to be especially acute during a child’s infancy when the demands for full-time care can drain the energies and resources of kin, especially older caregivers. On the other hand, if the caregiver-child (agency) relationship is able to survive this critical developmental period, the longer a child remains under the relative’s care the lesser is the likelihood that the kinship bond will be broken.

Focus groups conducted by Rushovich, Murray, Woodruff, and Freeman (this volume) identified high financial needs as significant constraints on the ability of caregivers to raise children as they deem appropriate. These authors describe a program of kinship navigator services delivered to caregivers who were looking after related children with no or brief CPS involvement. Because the program was voluntary and operated independently from CPS, navigator staff felt they were able to build cooperative relationships and gain the confidence of families and community partners that were normally distrustful of the power of CPS to break-up families. The staff viewed the formal system’s restriction of foster care subsidies only to children in licensed, public kinship care as an inherent injustice that inflicted financial hardship on informal caregivers. Kinship navigator staff perceived CPS workers as unwilling to take the time to explain to relatives all of the financial ramifications of taking on the care of grandchildren, nieces, and nephews where diversion from state custody to voluntary placement was sought.

Formalization of Private and Voluntary Kinship Care

The perceived unwillingness of CPS workers to help kinship caregivers with their financial needs can be viewed as a violation of the formality of impartial administration, much like the arbitrary withholding of federal foster care benefits discriminated against kin prior to the
Youakim ruling. Many of the inequities identified by focus group participants appear to result from an absence of formality rather than too much formality. The kinship navigator services funded under the 2008 Family Connections Discretionary Grant Program (FCDGP) aimed to introduce greater formality into the process of assisting kinship caregivers in learning about, finding, and using programs and services. It also sought to promote closer collaboration between public and private agencies in ensuring that kinship families are fairly and equitably served (Catalog of Federal Domestic Assistance, 2013).

The FCDGP tacitly acknowledges that the post-WWII prediction of the steady displacement of informal by formal agency relationships is no longer a tenable assumption for social policy. The new governing abstraction is that formal systems must learn to coexist with informal solidarities. No informal agent can adequately meet the extensive responsibilities of parenting in modern society without drawing on essential goods and services provided by formal systems (Heimer & Steffen, 1998). The first task in building an effective informal-formal partnership is constructing reciprocal avenues of influence so that the public systems that are accountable for child safety, family permanence, and adolescent well-being can be better coordinated with the informal processes of parental responsibility, kin altruism, and adult authority, which make possible the achievement of broader public interests in the welfare of vulnerable children (Testa & Poertner, 2010).

Another important principle of effective partnerships is that informal relationships should not be displaced by formal agency relationships unless there is clear evidence of the superiority of greater formality in achieving desired outcomes. The use of manualized procedures, standardized checklists, and decision protocols to structure informal-formal partnerships and coordinate mutual responsibilities introduces greater formality into the interactions between primary group agents and contractual and fiduciary agents of the state. Building evidence for the superiority of formality over informality assumes a valid set of methods for evaluating the effectiveness of planned innovations.
and for monitoring the integrity of implementation by contractual and fiduciary agents accountable for effecting the intended improvements (Stinchcombe, 2001).

The article by Feldman (this volume) evaluates an informal kinship-formal agency partnership that was operated by the Children’s Home Society of New Jersey. The final phase of the program involved engaging informal caregivers in a Family Group Decision Making (FGDM) conference to formalize a plan of action and coordinate responsibilities with public agents for addressing the needs of the children and caregivers. A formative evaluation was undertaken to test the initial implementation of the program so that early problems could be spotted and corrected before the program moved into full implementation and rigorous summative evaluation (Scriven, 1997). The results indicated that initial implementation of the program was conducted in a manner consistent with its original design, but the level of program participation was much lower than projected. Even though the drop-off in participation was unanticipated, it may also be taken as welcome sign that many families are able to handle caregiving needs on their own. One of the distinguishing features of FGDM meetings compared to usual case planning is their positioning of primary group agents to lead decision making in crafting the plans and eliciting the cooperation of contractual and fiduciary agents in gaining access to the resources necessary for implementing the plan. For those families that did proceed through all phases of the intervention, the results of the formative evaluation indicated that pretest-posttest changes in parenting stress levels, family needs, and child well-being, even though not statistically distinguishable from zero change (except for health care), were all trending in the desired direction. Only the number of social supports and level of satisfaction with the supports showed no change. These promising findings support moving toward full implementation of the FGDM intervention and conducting a rigorous summative evaluation of its overall impact using comparison groups.
The article by Schmidt and Treinen (this volume) also shows high levels of self-efficacy expressed by caregivers. They reported findings from a formative evaluation of a kinship navigation program operated by Arizona's Children Association. The pretest-posttest scores, using standardized assessment measures, showed no differences in self-efficacy scores, which most likely reflected the caregivers' high scores at baseline. There were some statistically significant decreases in family needs, such as paying for utility bills, having time for self-care, and finding future care for the children. Additionally, of the youth in care, 87% remained in a stable placement and only 7% were subjects of subsequent child maltreatment investigation after case opening.

Wheeler (this volume) reports findings from a quasi-experimental evaluation of the Ohio Title IV-E Waiver Demonstration. Participating local agencies were able to use IV-E funds to hire and train kinship navigator staff and provide services, financial assistance, and material goods that would otherwise only be available to licensed foster parents under existing IV-E regulations. The pertinent findings from the Ohio study were that the target population of children in counties that implemented the kinship support intervention experienced shorter lengths of stay and more stable care than a matched sample of children in unlicensed and voluntary kinship care in comparison counties. Further, children in intervention counties experienced greater stability, achieved more timely permanence, and were less likely to experience subsequent maltreatment and re-enter foster care than a matched sample of children in non-relative foster care in comparison counties.

Building Sustainable Partnerships

Contrary to earlier predictions of the demise of extended families, recent demographic trends as well as the findings presented in this volume attest to the continued vitality and importance of kinship ties for the care of vulnerable children in modern societies. The notion that extended family care is a natural resource that should be conserved and not squandered is at the core of many of the policy implications that
contributors draw from their research. At the same time, there is general recognition of the need for a more nuanced theoretical and empirical understanding of the compatibility of the universalistic principles of formal agency relationships with particularistic ties of kinship solidarity. Of particular interest is whether formal systems of care and financial subsidies erode (“crowd-out”) the natural motivation and customary trust upon which informal kinship care is based or alternatively reinforce (“crowd-in”) motivation and trust by supporting relative’s sense of self-efficacy, parenting ability, and caregiver capacity to sustain the agency relationship (Frey, 2012).

The paper by Denby, Testa, Alford, Cross, and Brinson (this volume) helps to advance our theoretical and empirical understanding of the tradeoffs by examining the mediating and moderating factors that can help relatives manage the role strains, special needs, and financial pressures that drain caregiver resources and increase the risk for adverse childhood outcomes. An unexpected finding was that child well-being levels were rated higher by caregivers in families with incomes below $20,000 than in families with higher incomes. When compensating protective factors were considered, it was found that the lower income association with higher well-being was mediated by the higher expressed levels of attachment to the child and sense of caregiver efficacy. The authors caution, however, that the anomalous relationship could also arise from parents’ wariness of candidly disclosing problems, confidentiality assurances notwithstanding. Lower-income parents may feel a need to inflate reports of child well-being in order to avoid attracting the unwanted attention of child protective authorities. At the same time, the absence of a statistical association in the opposite direction raises doubts about the justifiability of basing foster home licensing standards on families’ meeting arbitrary socioeconomic thresholds related to family income and housing accommodations, at least where relatives are concerned. Perhaps a better approach, as the paper implies, is to test the feasibility of developing separate kinship licensing standards that invests in training caregivers in trauma-
informed care and reimburses them in a commensurate fashion. An achievement-oriented approach to licensing and reimbursement could go a long way toward reconciling the traditional belief that relatives should not expect any reward for honoring their familial obligations to kin with the modern practical need for financial support to fulfill these obligations. Demonstrating through rigorous experimentation the superiority of new licensing approaches to business as usual would satisfy the third evidence-building criterion of formality for ensuring that kinship caregivers, birth parents, and their children receive the support and services they need from public child welfare systems.

**Kinship Care Position Paper**

The Position Paper included in this double issue offers guidelines for improving the formalization of the role of public child welfare systems in supporting kinship care arrangements. In contrast to most prior scholarship on kinship care, the refereed articles in this double issue focus on the informal side of the kinship care continuum, which hasn’t received as much attention as formal foster care from researchers in the past. As argued in this introduction and reinforced by the articles, the simple dichotomy between informal and formal kinship care is much too arbitrary a distinction for generating practical recommendations that are in keeping with modern concepts of kinship care as a partnership between families and government. The convention of linking formal kinship care to states’ taking legal custody of children is an archaic legacy of 19th-century poor laws that made public assistance conditional on needy parents’ relinquishment of their rights of child custody (Marshall, 1964). The formalization of kinship care as a partnership between legally responsible caregivers and publicly accountable collective agents offers a more promising direction for redressing routine inequities that hinder responsible caregiving, such as withholding information, failing to arrange for TANF receipt, and tolerating low foster home licensure rates among kinship caregivers.
These inequities appear not to be a manifestation of too much formality but rather too little formality, which allows personal feelings, subjective biases, and power imbalances to consign children to private or voluntary kinship care because of feelings that families should look after their own, interests in cutting down on paperwork, or administrative reluctance to add more families to “the public dole.” Introducing greater formality into the routine interactions between relative caregivers and child welfare workers and auditing compliance with these standards should help shed light on the different ways state systems, for better or worse, opt to exclude or include relatives in systems of care for the protection and care of dependent, neglected, and abused children.

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References


This study uses nationally representative survey data to describe differences in characteristics, adverse family experiences, and child well-being among children in kinship care with varying levels of involvement with the child welfare system. Well-being is examined in the domains of physical and mental health, education, and permanency. Comparisons provide insight on kinship care arrangements inside and outside the child welfare system, as well as the variability among nonfoster kinship care arrangements.

Disclosure: The authors have no financial interests to disclose. This original research paper has not been published previously nor submitted elsewhere while under consideration by Child Welfare. As a secondary data analysis of a de-identified microdata set, this study is exempt from Human Subjects review; the original data collection protocols were approved by the NCHS Research Ethics Review Board as well as the Institutional Review Board at NORC at the University of Chicago.

Disclaimer: The opinions and conclusions in this study are the authors' and do not necessarily represent the views of the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation.
Once largely separate from the child welfare system, in recent decades kinship care has become an integral part of child welfare practice and is often used as a preventive alternative to foster care (i.e., voluntary kinship care), as a foster care placement (public kinship care), or as an exit destination (permanent kinship care). This complexity exists, in part, due to layers of federal statute that have evolved over time and are not entirely consistent. Since the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, child welfare agencies have been directed to consider giving preference to an adult relative over an unrelated caregiver when placing a child in foster care, provided the relative caregiver meets all relevant child protection standards (42 U.S.C. 671(a)(19)). In addition, since the 2008 Fostering Connections to Success and Increasing Adoptions Act, agencies have been required to notify adult relatives when a child is placed in foster care (42 U.S.C. 671(a)(29)). Since 2008, federal law also has provided agencies with the option to establish kinship Guardianship Assistance Programs with partial federal funding under title IV-E of the Social Security Act (42 U.S.C. 673(d); Testa, Snyder, Wu, Rolock, & Liao, 2015). Federal policy creates an inherent tension, however, as the preference for initial, temporary foster care placement with relatives is replaced by a hierarchy of permanency preferences that, if reunification with parents is not feasible, prioritizes first adoption, then placement with relatives (42 U.S.C. 675(1)). By 2014, nearly one-third of children in foster care (29%) and adopted from foster care (32%) nationally were cared for by relatives (U.S. Department of Health and Human Services, 2015). Cassanueva and colleagues found that of children living outside their parents’ home following a maltreatment investigation, an estimated 48% resided in private or voluntary kinship care (calculated from Exhibit 1 of Casanueva, Tueller, Dolan, Smith, & Ringeisen, 2012).

The tension between some kinship caregivers’ reluctance to consider adoption and the policy preference for adoption as a permanency outcome has prompted a number of policy and practice responses. As of
March 2016, 33 states and six Indian tribes have made guardianship subsidies a component of their Title IV-E permanency programs (Administration for Children and Families, 2016). Child welfare agencies have created initiatives to encourage relatives to adopt the children in their care and train caseworkers on speaking with relatives about adoption and guardianship options (Pasztor, Mayers, Petras, & Rainey, 2013). And child welfare agencies, relatives, and legal advisors have parsed the advantages and disadvantages of adoption versus guardianship (Saisan, Smith, & Segal, 2016).

Although placement preference is given to relatives, it remains unclear what nonparental living situations best support children’s development (Winokur, Holtan, & Batchelder, 2014). Children in kinship foster care have shown more positive behavioral development, mental health, and placement stability than children in nonkin foster care (Wu et al., 2015; Winokur et al., 2014). Yet, children in nonkin foster care may fare better in accessing needed services and achieving adoption (Winokur et al., 2014).

Less is known about the well-being of children in private kinship care than about children in public kinship care (Littlewood, 2015). The living arrangements of children in public kinship care and nonkin foster care are similar in that both are monitored by caseworkers and in administrative databases from which children in informal kin care are absent (Stein et al., 2014). Researchers have lamented the lack of research on informal relative care following a Child Protective Services (CPS) investigation (Stein et al., 2014). Little is known about whether children’s situations improve if they are diverted to voluntary kinship care without oversight of the child welfare agency following a CPS investigation.

This study describes differences in characteristics, adverse family experiences, and well-being among children in kinship care in the following subgroups: (1) children in public kinship care; (2) children in voluntary kinship care for whom there is a current or past open CPS case; (3) children in voluntary kinship care without an open case but the relative reports other CPS involvement (e.g., the child welfare
agency facilitated the placement); and (4) children in private kinship care with no current or past CPS involvement. We conceptualize kinship care as a continuum of arrangements, arrayed here according to decreasing level of child protective services involvement, and expect higher intensity of CPS involvement among children most at risk. However, state and local policies and practices may also influence the level of CPS involvement in less formal care arrangements.

As far as we are aware, the 2013 National Survey of Children in Nonparental Care (NSCNC) is the first population-based, nationally-representative survey of all children in nonparental care, the majority of whom are in relative care. Most surveys do not include enough cases to generate sufficient sample sizes in this rare subpopulation. While large surveys or Census data may include sufficient samples, they typically do not include relevant topical content (such as child well-being), nor the detail necessary to identify specific care types (foster, grandparent, other) or involvement with the child welfare system. Administrative foster care data cannot be used to compare foster children to children in other living arrangements and includes scant data on child well-being. Analysis of administrative data from CPS would similarly suffer from the inability to compare outcomes for children with varying levels of involvement with CPS (particularly those with none). NSCNC meets all these requirements.

Methods

Data

Data were drawn from two national surveys conducted by the National Center for Health Statistics (NCHS): the 2011–2012 National Survey of Children’s Health (NSCH), a nationally representative survey of households with children, and the 2013 NSCNC, which re-interviewed almost 1,300 households identified as nonparental care households in the NSCH, including foster care, grandparent care, and other households.
with no parents present. Both surveys were modules of NCHS’s State and Local Area Integrated Telephone Survey. NSCH was sponsored by the Health Resources and Services Administration’s Maternal and Child Health Bureau; NSCNC was sponsored by the Department of Health and Human Services’ Office of the Assistant Secretary for Planning and Evaluation, with supplemental funding from the Annie E. Casey Foundation.

NSCH was a random-digit-dial landline and cell telephone survey that interviewed 95,677 households with children throughout the United States. The NSCH sample is nationally representative of non-institutionalized children aged 0 to 17 years in the United States in 2011–2012.

NSCNC was a follow-back survey 1–2 years after the NSCH for children who lived in households with no parents present and were ages 0–16 when the NSCH was administered. Interviews were conducted with a current caregiver of the child; in some cases, this was a parent who had reunited with the child since the NSCH interview. To distinguish among relative and nonrelative foster care and informal relative care situations, respondents who identified as foster parents were asked whether they were related to the child and respondents who identified as relatives were asked whether they were the child’s foster parent.

NSCH had a 23% overall response rate (partly due to the inclusion of a cell phone sample to maximize coverage of the population), but this does not mean that three quarters of eligible households refused to participate in the survey. The response rate is low in part because it includes phone numbers that ring with no answer and for whom eligibility cannot be determined, especially among cell phone numbers. The NSCH cooperation rate among eligible households, or interview completion rate, was 51.4%. NSCNC had a 52% interview completion rate among eligible households 1–2 years later. Weighting adjustments were applied such that the population estimated by the sample of completed interviews matched that of the pool of eligible households.
demographically. This dramatically reduced estimated nonresponse bias; remaining bias in weighted estimates was smaller than sampling error. More information about NSCH and NSCNC may be found at http://www.cdc.gov/nchs/slaits.htm or by referring to the associated documentation (CDC, 2013; CDC, 2014).

**Statistical Analysis**

Weighted estimates were calculated using SUDAAN (RTI, 2008) to account for complex sample design. Four subgroups of children were compared on well-being outcomes: those in public kinship care, and three subgroups of children in nonpublic kinship care; (1) those in voluntary kinship care for whom there had ever been an open CPS case; (2) those in voluntary kinship care without an open case but with other CPS involvement in the placement (a background check or home visit or CPS had arranged for the child’s placement); and (3) children in private kinship care with no CPS involvement. Excluding from the analytic sample children not in relative care, the sample size of 1,298 is reduced to 1,122.

Demographic and socioeconomic characteristics, adverse family experiences, and child well-being (health, academics, and permanence) were compared between children in public and nonpublic kinship care. Linear and curvilinear (quadratic) trend tests were performed among the nonpublic children across the three ordinal categories of CPS involvement. The significance of public/nonpublic differences or trends across categories of CPS involvement was evaluated at the 0.05 level.

**Measures**

In addition to child demographics (age, sex, and race/ethnicity), sociodemographic characteristics examined include household income relative to Federal Poverty Level and caregiver age.

We examined seven adverse family experiences (AFEs): whether the child had (1) experienced a parent’s death, (2) experienced parents’
divorce or separation, (3) experienced parental incarceration, (4) witnessed violence in the home, (5) experienced or witnessed violence in the neighborhood, (6) lived with a mentally ill person, or (7) lived with someone who had a problem with drugs or alcohol.

Child health is measured by indicators of overall health (excellent/very good versus good/fair/poor); whether the child has any mental health conditions (ADHD, learning disability, depression, anxiety, behavior/conduct disorder, autism, developmental delay, intellectual disability, cerebral palsy, speech problems, or Tourette's syndrome) or any physical conditions (asthma, diabetes, epilepsy, hearing problems, vision problems, bone/joint/muscle problems, or brain injury); whether the child received mental health care in the previous year; and whether the child has special health care needs (SHCN) (any of five health care consequences resulting from a chronic health condition: (1) need for prescription medications; (2) need for specialized therapies; (3) need for more health care services than most children the same age; (4) treatment for a behavioral, developmental or emotional problem; and/or (5) activity limitation).

Academic well-being indicators include whether the child has an Individualized Family Service Plan (children under age 6) or an Individualized Education Program (ages 6+) (IFSP/IEP); whether the child is engaged in school (i.e., the child cares about school and does all required homework); whether the child repeated any grades; and math and reading/writing performance (excellent/very good versus good/fair/poor).

Indicators of permanence include whether the child lived with the caregiver since birth, whether the child lives all/most of the time with the caregiver, whether the caregiver feels the child is likely to live with them until grown, whether the caregiver has legal custody, and whether the caregiver has or intends to adopt the child.

Child sex, race/ethnicity, overall health, chronic conditions, SHCN, AFEs, IFSP/IEP, school engagement, and grade repetition are drawn from NSCH. Values may have changed between surveys.
Table 1. Demographic and Socioeconomic Characteristics by Kin Care Type and Child Protective Services (CPS) Involvement

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Informal (Nonpublic) Kinship Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public Kinship Care</td>
</tr>
<tr>
<td>Child</td>
<td>Percent (standard error)</td>
</tr>
<tr>
<td>Age: 1-8 years</td>
<td>34.5 (9.79)</td>
</tr>
<tr>
<td>9-12</td>
<td>12.8 (4.41)</td>
</tr>
<tr>
<td>13-17</td>
<td>52.7 (10.39)</td>
</tr>
<tr>
<td>Sex: Male</td>
<td>59.5 (9.95)</td>
</tr>
<tr>
<td>Female</td>
<td>40.5 (9.95)</td>
</tr>
<tr>
<td>Race/ethnicity: Hispanic</td>
<td>16.1 (8.38)</td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>40.3 (9.67)</td>
</tr>
<tr>
<td>Non-Hispanic black</td>
<td>32.4 (10.37)</td>
</tr>
<tr>
<td>Non-Hispanic other</td>
<td>11.1 (4.12)</td>
</tr>
<tr>
<td>Household</td>
<td></td>
</tr>
<tr>
<td>Federal Poverty Level: 0-50%</td>
<td>23.9 (9.72)</td>
</tr>
<tr>
<td>50-100%</td>
<td>19.5 (9.08)</td>
</tr>
<tr>
<td>100-200%</td>
<td>38.1 (10.05)</td>
</tr>
<tr>
<td>200-400%</td>
<td>16.0 (6.24)</td>
</tr>
<tr>
<td>&gt;400%</td>
<td>1.8 (1.00)</td>
</tr>
<tr>
<td>Caregiver</td>
<td></td>
</tr>
<tr>
<td>Age: &lt;55 years</td>
<td>36.4 (9.90)</td>
</tr>
<tr>
<td>55-59</td>
<td>21.0 (7.28)</td>
</tr>
<tr>
<td>60-64</td>
<td>19.1 (8.99)</td>
</tr>
<tr>
<td>65-69</td>
<td>18.0 (9.08)</td>
</tr>
<tr>
<td>70+</td>
<td>4.2 (2.05)</td>
</tr>
</tbody>
</table>

Source: National Survey of Children’s Health 2011-2012 & National Survey of Children in Nonparental Care 2013; *Estimate differs at the 0.05 level from that of Public Kinship Care; ± Quadratic trend by level of CPS involvement is significant at the 0.05 level.
(e.g., a child may have lost a diagnosis and no longer be considered to have a health condition) and events that occurred between surveys would not be included (e.g., a grade repeated after the NSCH interview would not be identified). Academic measures from NSCH are not available for children younger than 6 in 2011–2012. The remaining covariates are drawn from NSCNC.

Results

Of children in nonparental relative care, an estimated 11.1% were in public kinship care, 21.1% were in voluntary kinship care and had an open CPS case (“Open case”), 19% were in voluntary kinship care without an open case but with other CPS involvement in the child's placement (“Other CPS”), and 49% were in private kinship care without CPS involvement (“No CPS”).

Table 1 shows demographic and socioeconomic characteristics. Children in public kinship care were less likely than children in nonpublic kinship care to be ages 9–12, in the highest income category, or to have a caregiver aged 70+ years. Quadratic trend tests show parabolic associations in which children in the Other-CPS group are least likely to be Hispanic, most likely to be non-Hispanic Black, and more likely to have caregivers aged 55–59 and less likely under age 55.

Table 2 shows AFEs that may have precipitated the child's entry into nonparental care. None showed a significant difference between foster and nonfoster children, but 5 of the 7 showed a significant linear trend among the private and voluntary kinship care groups in which higher prevalence is associated with more CPS involvement. Although the linear trend was not significant and differences were smaller, the remaining adverse experiences (parental divorce/separation and parental death) also showed the highest prevalence for children with the most CPS involvement.

Some Table 2 estimates, and differences are large. Seventy percent of children with an open case had lived with someone who had a problem
Table 2. Adverse Family Experiences by Kin Care Type and Child Protective Services (CPS) Involvement

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Informal (Nonpublic) Kinship Care</th>
<th>Public Kinship Care</th>
<th>All Nonpublic Kinship Care</th>
<th>Voluntary kinship care, ever an Open CPS case</th>
<th>Voluntary kinship care, no open case, but other CPS involvement</th>
<th>Private Kinship Care, No CPS involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever lived with a parent who got divorced or separated</td>
<td>43.0 (10.16)</td>
<td>47.7 (3.98)</td>
<td>53.2 (8.33)</td>
<td>45.5 (6.81)</td>
<td>46.1 (5.59)</td>
<td></td>
</tr>
<tr>
<td>Ever lived with a parent who died</td>
<td>11.7 (4.15)</td>
<td>18.3 (2.57)</td>
<td>19.6 (5.89)</td>
<td>18.3 (4.79)</td>
<td>17.8 (3.41)</td>
<td></td>
</tr>
<tr>
<td>Ever lived with a parent who was incarcerated</td>
<td>49.6 (10.58)</td>
<td>37.8 (3.77)</td>
<td>62.9 (7.06)†</td>
<td>32.9 (6.22)†</td>
<td>28.9 (5.35)†</td>
<td></td>
</tr>
<tr>
<td>Ever lived with anyone who was mentally ill</td>
<td>24.2 (7.42)</td>
<td>25.4 (3.55)</td>
<td>43.8 (7.80)†</td>
<td>24.3 (5.33)†</td>
<td>17.9 (5.04)†</td>
<td></td>
</tr>
<tr>
<td>Ever lived with anyone who had drug/alcohol problems</td>
<td>50.0 (10.56)</td>
<td>47.2 (4.03)</td>
<td>70.2 (9.25)†</td>
<td>42.9 (6.63)†</td>
<td>38.9 (5.47)†</td>
<td></td>
</tr>
<tr>
<td>Ever witnessed violence in home</td>
<td>25.1 (7.25)</td>
<td>31.3 (3.79)</td>
<td>54.4 (8.27)†</td>
<td>20.8 (5.00)†</td>
<td>25.4 (5.23)†</td>
<td></td>
</tr>
<tr>
<td>Ever the victim of violence or witnessed violence in neighborhood</td>
<td>20.6 (6.87)</td>
<td>23.2 (3.02)</td>
<td>39.2 (7.69)†</td>
<td>24.5 (6.94)†</td>
<td>15.7 (3.23)†</td>
<td></td>
</tr>
</tbody>
</table>

Source: National Survey of Children’s Health 2011-2012 & National Survey of Children in Nonparental Care 2013; †Linear trend by level of CPS involvement is significant at the 0.05 level.

with drugs or alcohol and 63% experienced parental incarceration. The incidences of incarceration and witnessing violence in the home were roughly twice as likely among children with an open case as among other nonpublic groups. Other adverse experiences with significant linear trends showed similar patterns of differences almost as large.

Table 3 shows health conditions, special health care needs, and receipt of mental health care. Physical and mental health conditions show a
Table 3. Health Characteristics by Kin Care Type and Child Protective Services (CPS) Involvement

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Informal (Nonpublic) Kinship Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public Kinship Care</td>
</tr>
<tr>
<td>Overall health Excellent/very good</td>
<td>70.7 (10.60)</td>
</tr>
<tr>
<td>No mental health conditions</td>
<td>71.3 (9.85)</td>
</tr>
<tr>
<td>1 mental condition</td>
<td>11.5 (8.50)</td>
</tr>
<tr>
<td>2+ mental conditions</td>
<td>17.1 (6.84)</td>
</tr>
<tr>
<td>No physical conditions</td>
<td>75.1 (9.90)</td>
</tr>
<tr>
<td>1 physical condition</td>
<td>22.2 (9.86)</td>
</tr>
<tr>
<td>2+ physical conditions</td>
<td>2.8 (2.06)</td>
</tr>
<tr>
<td>Special health care needs</td>
<td>30.6 (9.58)</td>
</tr>
<tr>
<td>Received mental health care in previous year</td>
<td>29.1 (9.33)</td>
</tr>
</tbody>
</table>

Source: National Survey of Children’s Health 2011-2012 & National Survey of Children in Nonparental Care 2013; †Linear trend by level of CPS involvement is significant at the 0.05 level.

There is a significant pattern of more conditions with more CPS involvement, or a greater likelihood of zero conditions with less CPS involvement. SHCN and mental health care also follow a pattern of higher estimates with more CPS involvement. SHCN and mental health care were particularly high among children with an open case, who had SHCN at twice or more than twice the rate of foster children and voluntary kinship care children, respectively. More than half of the children with an open case had received mental health care, and more than 60% had SHCN.
Table 4. Academic and Permanence Characteristics by Kin Care Type and Child Protective Services (CPS) Involvement

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Informal (Nonpublic) Kinship Care</th>
<th>Public Kinship Care</th>
<th>All Nonpublic Kinship Care</th>
<th>Voluntary kinship care, ever an Open CPS case</th>
<th>Voluntary kinship care, no open case, but other CPS involvement</th>
<th>Private Kinship Care, No CPS involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Academic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has IFSP (ages 0-5) / IEP (6-17)</td>
<td>10.2 (4.76)</td>
<td>15.5 (2.41)</td>
<td>27.7 (7.38)†</td>
<td>20.1 (5.45)†</td>
<td>8.4 (1.70)†</td>
<td></td>
</tr>
<tr>
<td>Is engaged in school (6-17)</td>
<td>76.9 (10.64)</td>
<td>66.0 (4.54)</td>
<td>55.5 (11.61)</td>
<td>54.1 (8.13)</td>
<td>74.9 (4.80)</td>
<td></td>
</tr>
<tr>
<td>Cares about school (6-17)</td>
<td>89.7 (4.48)</td>
<td>75.6 (4.38)*</td>
<td>59.8 (12.08)</td>
<td>76.8 (7.61)</td>
<td>81.2 (4.57)</td>
<td></td>
</tr>
<tr>
<td>Does all homework (6-17)</td>
<td>80.7 (10.68)</td>
<td>75.6 (3.73)</td>
<td>74.9 (8.83)</td>
<td>65.8 (7.82)</td>
<td>79.9 (4.51)</td>
<td></td>
</tr>
<tr>
<td>Repeated any grades (6-17)</td>
<td>29.2 (12.04)</td>
<td>22.2 (4.20)</td>
<td>39.2 (11.98)†</td>
<td>28.1 (7.93)†</td>
<td>13.1 (3.41)†</td>
<td></td>
</tr>
<tr>
<td>Excellent/Very good reading/writing</td>
<td>64.0 (9.65)</td>
<td>62.0 (4.12)</td>
<td>48.1 (8.85)</td>
<td>59.6 (7.42)</td>
<td>68.7 (5.84)</td>
<td></td>
</tr>
<tr>
<td>Excellent/Very good math</td>
<td>58.5 (10.64)</td>
<td>46.1 (3.94)</td>
<td>32.8 (7.10)</td>
<td>47.1 (7.26)</td>
<td>51.3 (6.03)</td>
<td></td>
</tr>
<tr>
<td><strong>Permanence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lived with caregiver since birth</td>
<td>17.5 (8.66)</td>
<td>17.8 (2.64)</td>
<td>10.8 (4.56)±</td>
<td>32.1 (7.05)±</td>
<td>15.3 (2.91)±</td>
<td></td>
</tr>
<tr>
<td>Lives all/most of time here</td>
<td>99.9 (0.13)</td>
<td>96.5 (0.96)*</td>
<td>97.9 (1.10)±</td>
<td>99.2 (0.60)±</td>
<td>94.7 (1.68)</td>
<td></td>
</tr>
<tr>
<td>Will live here until grown</td>
<td>72.5 (11.23)</td>
<td>87.5 (3.63)</td>
<td>97.5 (1.20)±</td>
<td>97.3 (1.44)±</td>
<td>79.2 (6.10)</td>
<td></td>
</tr>
<tr>
<td>Caregiver has formal/ legal custody</td>
<td>75.1 (10.41)</td>
<td>73.5 (3.80)</td>
<td>91.4 (3.19)±</td>
<td>88.8 (5.31)±</td>
<td>57.4 (5.91)</td>
<td></td>
</tr>
<tr>
<td>Child was adopted between surveys</td>
<td>7.4 (4.03)</td>
<td>8.1 (1.28)</td>
<td>11.5 (3.19)†</td>
<td>13.5 (3.51)†</td>
<td>3.9 (1.20)†</td>
<td></td>
</tr>
<tr>
<td>Caregiver has plans to adopt</td>
<td>31.0 (9.68)</td>
<td>23.6 (4.11)</td>
<td>35.5 (9.97)†</td>
<td>31.1 (7.65)†</td>
<td>14.3 (4.07)†</td>
<td></td>
</tr>
<tr>
<td>Not adopted, no plans to adopt</td>
<td>61.6 (9.91)</td>
<td>68.3 (4.05)</td>
<td>53.0 (8.99)†</td>
<td>55.1 (7.19)†</td>
<td>81.8 (4.18)†</td>
<td></td>
</tr>
</tbody>
</table>

Source: National Survey of Children's Health 2011–2012 & National Survey of Children in Nonparental Care 2013; *Estimate differs at the 0.05 level from that of Public Kinship Care; †Linear trend by level of CPS involvement is significant at the 0.05 level; ± Quadratic trend by level of CPS involvement is significant at the 0.05 level.
Table 4 shows academics and permanence. There were few significant public/nonpublic differences, but many indicators showed a linear trend across nonpublic categories. Significant academic measures (IFSP/IEP and grade repetition) showed a pattern of more favorable outcomes for children with less CPS involvement—and although the trends were not significant at the conventional level, most other measures of school engagement and academic performance were consistent with this pattern. These findings suggest that children in private kinship care tend to have better academic outcomes than children in other types of informal care. But while their academic outcomes may have been better, their permanency outcomes were worse: Those with less CPS involvement were less likely to have been adopted or to have caregivers with adoption plans. Quadratic trend tests suggest that the likelihood that the child will live with the caregiver until grown or that the caregiver has custody are L-shaped associations in which children with no CPS involvement are much less likely than the other two groups to achieve these permanence indicators. Only 57% of children in voluntary kinship care had caregivers with legal custody, compared with about 90% of the other nonfoster groups.

**Discussion**

When children do not live with parents, a connection critical to healthy development has been disrupted. Other family members frequently step in to fill the parental role, independently or in partnership with a child welfare agency. In recent decades, perceptions and policies have been evolving about the appropriate role and level of child welfare involvement when relatives care for children due to parents’ absence or incapacity (Hegar & Scannapieco, 2005; Allen, DeVooqht, & Geen, 2008). This study advances this discussion by comparing the well-being of children in kinship care with varying levels of child welfare involvement.

We found that children with current or former open CPS cases, but who were not in foster care at the time of the survey, had particularly
high rates of SHCN and mental health care compared with children in nonfoster relative care with less CPS involvement. It is possible that some children with health problems have open cases in part because the caregiver needed additional support for the child’s needs (Child Welfare Information Gateway, 2014).

Many adverse family experiences were increasingly likely with greater CPS involvement: violence in the home or neighborhood or having lived with the mentally ill, struggles with addiction, or parents who were incarcerated. Most were almost twice as prevalent among the children with an open case as among other nonfoster groups.

Because CPS cases could have occurred at any time, it is likely that some children with an open case were investigated by CPS, spent time in foster care, and were later discharged to relatives. Nationally, 16% of children exiting foster care in 2014 lived with relatives or guardians following discharge (U.S. Department of Health and Human Services, 2015). Discharge from foster care to private kinship care typically involves cessation of monitoring by CPS. Children who had an open CPS case may be particularly vulnerable given the frequency with which they have SHCN and receive mental health care. While post-reunification services for parents have received considerable attention (Child Welfare Information Gateway, 2012) and post-adoption services have also been discussed (Smith, 2014; Zosky, Howard, Smith, Howard, & Shelvin, 2005), there has been less discussion in the child welfare field about post-permanency services for kinship caregivers.

Just under half of children in kinship care are not involved with the child welfare system at all, according to their caregivers. These children are absent from child welfare administrative databases and are invisible in most surveys. NSCNC affords an opportunity to examine well-being and permanency outcomes in a comparative analysis including this subgroup. We found that these children tended to have better health and academic outcomes than other nonfoster groups, but they also tended to have poorer prospects for permanence.
The concept of “permanence” is complex and is viewed differently by various parties within and outside the child welfare system. Thompson and Greeson (2015) differentiate between legal permanence—i.e., the attainment of a court-sanctioned legal status according to the hierarchy defined in federal law, and relational permanence, meaning the subjective experience of a long-term emotional and social connection to one or more caring adults. Many relative caregivers think of the child as “already family” and report that as a reason for not considering adoption (Berrick, Barth, & Needell, 1994; Bramlett & Radel, 2016). Legal custody may not be seen as necessary given the family bond. However, children without CPS involvement did not just show lower rates of adoption or custody—they also had lower caregivers’ expectations that the living situation would last throughout childhood, perhaps indicating a hope for reunification with parents. Researchers have suggested that children in relative care need definitions of permanence that work for their particular situation and strategies to achieve permanence should be differentially targeted to specific subgroups (Yampolskaya, Sharrock, Armstrong, Strozier, & Swanke, 2014).

For informal relative caregivers for whom adoption and custody are less likely, accessing support services for the child can be difficult. Grandparent caregivers are often ineligible for certain financial supports because they lack status as foster parents or formal caregivers (Fruhauf, Pevney, & Bundy-Fazioli, 2015), but might be eligible for subsidies and Medicaid benefits if they adopted or established a subsidized guardianship. Health care for the child can be complicated when there is “difficulty identifying who has the authority to consent for health care on behalf of the child” (Szilagyi et al., 2015, p. e1133). There is often a poor fit between services and families’ needs because policies were designed without consideration for nonstandard family status (Annie E. Casey Foundation, 2012). Not surprisingly, then, “kinship caregivers receive far fewer support services than nonkinship foster caregivers” (Stein et al., 2014, p. 560).
Limitations

Findings from NSCH and NSCNC are based on caregivers’ experiences and perceptions. Information provided about health status and health care was not verified with health professionals. Information about CPS involvement was not verified with child welfare agencies. Sampling weights were adjusted to minimize nonresponse bias and evidence suggests that remaining estimated biases tend to be smaller than sampling error (CDC, 2014), but because bias can only be estimated, the low overall response rate means that bias resulting from nonresponse cannot be completely ruled out.

That 75% of children in public kinship care were reported to be in the legal custody of their relative foster parents, when formal foster care usually means that the state retains formal custody, might indicate that custody was poorly understood by respondents—most of whom are grandparents—as distinct from having the child placed in their care. The question asked about a “formal or legal agreement about custody or guardianship for [the child]” and help text was provided (if necessary) to define custody as the legal right to make decisions for the child and to indicate that it may be conferred on a relative by a court. Custody status was not verified with child welfare agencies. It is possible that for some, custody was transferred between surveys. However, this limitation is less likely to affect comparisons among the nonpublic kinship care groups, and other measures of permanence, such as adoption and expectations for the future, showed similar patterns as for custody.

Despite these limitations, the authors know of no other data source that includes a population-based national sample of children in relative care, can identify the subgroups analyzed here, and includes survey content directly relevant to this population.

Conclusion

Relative care is an essential component of the safety net for children whose parents cannot care for them. Relatives are frequently sought by
child welfare agencies as placement resources, particularly since the implementation of the 2008 Fostering Connections to Success and Increasing Adoptions Act’s requirement that agencies notify relatives of children’s placement in foster care. We found that just under half of kinship care is arranged privately among parents and relatives—i.e., it occurs outside the context of formal foster care, without child protective services involvement. This does not mean, however, that children in voluntary kinship care have not faced serious adversity; a sizeable proportion have experienced disruption and adverse family experiences.

Children with current or former CPS cases tended to have poorer health and academic outcomes than other children in nonpublic kinship care and may be particularly vulnerable given the frequency with which they have special health care needs. Aftercare services for children and youth discharged to relatives have received less attention than post-permanency services to support reunification and adoption. Understanding the long-term well-being of children who exit foster care across discharge destinations could benefit from further research.

That more than 40% of caregivers without CPS involvement lack custody may indicate a vulnerability regarding legal permanence. Such children do not have institutional advocates for permanency since they are not engaged with child welfare agencies or courts and relative caregivers may see little need for legal permanence. Yet the lack of legal guardianship may leave children vulnerable in the long term, either from a troubled parent who retains legal custody or from instability if the current caregiver cannot provide a stable home or adequate access to supports and services.
References


The Relationship between Kinship Diversion and Child Behavior Problems

Qi Wu  
*Arizona State University*

This study examines the relationship between kinship diversion and child behavior problems. Using data from Waves 1 and 3 of NSCAW II, the analysis conducts ordinary least square (OLS) regression analysis controlling for the Wave 1 outcome based on the multiple imputed data files using the NSCAW II weights. Results suggest that kinship diversion does not adversely affect the well-being of children and that private kinship care is associated with significantly greater declines in child behavior problems.
With the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (1996), kinship care was given priority as a preferred placement option among child welfare professionals (Harris & Skyles, 2012). In 2014, an estimated 415,129 children were in foster care, of which 29% were placed with kinship caregivers (U.S. Department of Health and Human Services [USDHHS], 2015). The variety of kinship care arrangements include public kinship care, private kinship care, and voluntary kinship care, with the primary difference being the legal relationship between the child and caregivers. In cases of public kinship care, the courts have awarded legal custody of the child to the state and the child is placed with kin through the foster care system. Caregivers in public kinship care receive payments from the child welfare system (CWS) if they are licensed or approved as foster parents. Private kinship care refers to private arrangements in which legal custody remains with the birth parents and care arrangements are made without involvement of the child welfare agency or the juvenile court system (Child Welfare Information Gateway, 2010). The third type, voluntary kinship care, usually occurs when the CWS has initiated the removal and facilitated voluntary placement of the child with kin but the legal custody of the child remains with the biological parents (Malm & Geen, 2003). Kinship diversion occurs when children who were diverted from the formal CWS are placed in private or voluntary kinship care. Diverted kin caregivers do not receive foster care payments from the system (Annie E. Casey Foundation [AECF], 2013). Recent U.S. Census data show that only 4% of the more than 2.7 million children in kinship care arrangements are living in public kinship care (AECF, 2012), whereas the other 96% of children in kinship arrangements are outside the oversight of the public foster care system. Given the lack of formal monitoring for children who are outside of the public system, this study aims to examine the relationship between kinship diversion and child behavior problems.

As mandated by the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351), when a child welfare agency
determines that an out-of-home placement is required for a child’s safety, the agency must make efforts to first contact kin when making decisions about such placements (Gibson & Rinkel, 2012). The information conveyed in this initial contact is crucial because the child’s relatives might not be aware of the legal and financial repercussions of serving as voluntary kin caregivers versus licensed foster parents. No guidelines or standardized criteria exist regarding what information CWS agencies should provide to relatives of children needing out-of-home placement. Thus, agencies have great flexibility in choosing what information to provide relatives regarding their choices of being voluntary kinship caregivers or licensed foster parents. In addition, the way in which information is provided can also create problems and misunderstandings. For example, although many relatives might not be familiar with kinship care and might be contacted in the aftermath of a family crisis, many local agencies and caseworkers provide information about kinship care through informal, verbal communication instead of formal, written information, which likely leaves potential kin caregivers with a poor understanding about their choices and options (Wallace & Lee, 2013). Some caseworkers even dissuade relatives from becoming foster parents by emphasizing the drawbacks of involving the CWS (Wallace & Lee, 2013).

Once relatives are informed about public kinship care, kinship diversion can be attractive to them because it does not require removing legal custody from parents and does not have the complications of CWS or court involvement (AECF, 2013). Additionally, the informal arrangement allows for one or both of the child’s birth parents to live in the same home as the child or to have regular contact with the child and/or caregivers (Washington et al., 2014). Having close contact with parents in diverted kinship care helps to preserve the customary family role relationships; preserve a child’s identity; ease the child’s transition to another home; and maintain close relationship with parents, siblings, and relatives (Groza et al., 2011). Kinship diversion is also an attractive option for caseworkers and states because the cost of maintenance and
administration are considerably lower than the costs associated with a child entering the foster care system (Wallance & Lee, 2013). A study in New York conducted in 2010 noted the average annual cost of routine foster care was $21,535 per child as compared with $6,490 per child in informal kinship care (which includes funds provided through a Temporary Assistance to Needy Families [TANF] child-only grant [Wallace, 2011]). Therefore, many states allow caseworkers to divert children from the foster care system even if the child was removed from the home through an abuse or neglect investigation (Jantz, Geen, Bess, Andrews Scarscella, & Russell, 2002).

Despite the appeal of informal kinship care arrangements, there is ongoing debate among child welfare professionals regarding whether kinship diversion should be given preference as a placement option when a child needs to be removed from the home of origin. Some child welfare professionals have expressed concerns that current kinship diversion policies deny kin caregivers access to financial support and services for the child and family. As noted above, when children are diverted from the CWS, the kinship caregivers are not eligible to receive foster care reimbursement or payment for providing care. At best, private and voluntary kin caregivers who struggle with the costs of raising the child might qualify for much lower financial assistance under the TANF program. In addition, kinship diversion placements (i.e., private and voluntary kinship care) are not supported or monitored by the CWS and the agency does not engage in permanency planning for children in kinship diversion care (Ehrle & Geen, 2002; Ehrle, Geen, & Main, 2003). The absence of formal monitoring or tracking of kinship diversion means no estimates are available on the prevalence of maltreatment in diverted kinship care (Font, 2015) and no data are available on the well-being outcomes of children diverted from foster care. Without such monitoring or tracking, CWS cannot evaluate the well-being outcomes of the diverted children. Lacking necessary child protective services such as the training of parenting skills, kin caregivers may not know whether the child has
behavior problems and how to address these problems. Thus, children in diverted kinship care may have different well-being outcomes than children in public kinship care. In addition, the well-being of children in kinship diversion is a critical issue because the caregiver’s lack of legal standing as guardian means these caregivers often have difficulty enrolling the children in school, obtaining medical care or medical records, and having access to a host of other things for which a parent’s permission is required. Given the potential vulnerability of children in kinship diversion care, critical questions regarding the well-being of these children warrant an exploration of the policies and practices associated with kinship diversion and an examination of the association between kinship diversion and children’s well-being outcomes.

Some researchers have examined the public kinship care, voluntary kinship care, or private kinship care population in isolation. However, a significant knowledge gap remains regarding the differences between children in these three types of kinship care and the effect of placement type on child outcomes (Cuddeback, 2004). In part, this gap remains because researchers interested in this area have encountered substantial difficulty in obtaining a representative sample (Strozier & Krisman, 2007). In addition, even though kinship diversion might be initiated for many of the same reasons as public kinship care, the different experiences due to placement types might lead to different child results. Even in cases in which the allegations of child maltreatment are substantiated, children are still more likely to be diverted. However, few studies have compared the outcomes of children in public kinship care with children diverted to private or voluntary kinship care following a substantiated allegation of maltreatment. Because the data used in this paper cannot distinguish whether the state has formal legal custody of the child, kinship diversion in this study refers to children who are diverted from paid kinship care into unpaid kinship care (i.e., voluntary or private kinship care). To address the research gaps noted above, the current study tested the following null hypothesis: Children who are removed
from their home of origin following a substantiated maltreatment allegation and diverted into unpaid kinship care are at no higher risk of child behavior problems than similar children formally placed in paid kinship care. By comparing these groups of children, this study provides a better understanding about the relationship between kinship diversion and child well-being outcomes.

Method

Data
This study uses data from Waves 1 and 3 of the Second National Survey of Child and Adolescent Well-being (NSCAW II). The NSCAW II data include 5,872 children whose ages ranged from birth to 17.5 years, who had contact with the child welfare system within a 15-month period that began in February 2008. These children were selected from 81 primary sampling units in 30 states that agreed to participate in the NSCAW study. The Wave 1 data were collected through interviews with children, parents, nonparent caregivers, teachers, and caseworkers beginning in March 2008 and ending in September 2009. For Wave 3, children and families were re-interviewed approximately 36 months after the close of the NSCAW II baseline investigation, which began in June 2011. The NSCAW II covers a range of child welfare topics such as the extent of service use and the needs of children who come in contact with the child welfare system. In addition, the survey examines child safety, well-being, and interventions or services. The sample included both cases that received ongoing services and cases that did not receive services. A case might show no services were received for reasons such as the maltreatment allegations were not substantiated or the family was not mandated to receive services. When an investigation involved multiple children in a family, NSCAW randomly selected one child as the study child and collected data for only that child.
Sample

The sample used in this analysis includes children involved in a child welfare services investigation who were removed from the home and placed in public (paid) kinship care, voluntary kinship care, or private kinship care. Because diverting children from public kinship care may affect decisions to substantiate maltreatment allegations, the analysis included only cases with substantiated allegations of child abuse or neglect. Because NSCAW weights were used in the analysis, cases were deleted if they were missing values for the NSCAW weights variable. The final sample included 654 children who were living in kinship arrangements following a substantiated maltreatment report at Wave 1. Among these 654 children, 294 children were classified as living in public (paid) kinship care, 273 children in voluntary kinship care, and 87 children in private kinship care.

Notably, it is possible that the kinship care placements were changed between Wave 1 and Wave 3 or more than one caregiver provided ratings about the child’s change on outcomes between the two waves. Without controlling for this rater effect, the results might be biased. To avoid possible bias, a sensitivity analysis was conducted with a subsample of 285 children who had the same caregiver at Wave 1 and Wave 3. By changing the values of independent variables, sensitive analysis examines how robust the original results are. Among this subsample, 124 children were in voluntary kinship care, 118 children were in public kinship care, and 43 children were in private kinship care.

Measures

Dependent Variables

Child Behavior Problems

Children’s behavioral problems are measured using the Child Behavior Checklist (CBCL) for two age cohorts: the CBCL for ages 1.5 to 5
years (Achenbach, 1991) and CBCL for ages 6 to 18 years (Achenbach & Rescorla, 2000). The CBCL is a widely used caregiver-report questionnaire that identifies problem behavior by asking the primary caregiver to rate various aspects of the child’s behavioral, emotional, and social performance. The CBCL includes internalizing behaviors (e.g., depressive, anxious, and over-control of emotions) and externalizing behaviors (e.g., aggressive, noncompliant, and lack of emotional control). Responses are recorded on a 3-point Likert scale to indicate how accurately the statement describes the child (i.e., not true = 0, somewhat or sometimes true = 1, and very true or often true = 2). Based on the caregiver assessment, an internalizing score, externalizing score, and total score were calculated, with higher scores indicating a greater severity of behavioral problems. If a child has the total score that is lower than 65, he or she is in the normal range of functioning (Achenbach & Ruffle, 2000).

Independent Variables

Types of Kinship Care

Two existing variables in NACSAW II were used to identify children who were diverted from public kinship care and classify them into two categories of unpaid kinship care. The first variable asked whether the caregivers were currently receiving financial supports from CWS. If they answered “no,” a second variable asked whether social workers helped arrange the kinship placement. A categorical variable with three categories was generated: public kinship care if the caregivers were currently receiving financial supports; voluntary kinship care if the caregivers were not receiving financial supports but social workers helped arrange the kinship placement; and private kinship care if the caregivers received neither financial support or help in arranging the placement. Then two dichotomous variables were generated based on these three categories for the analysis, which indicated whether the child
was diverted from public kinship care (the comparison category) into voluntary or private kinship care.

**Maltreatment Types**

The information about child maltreatment types was collected from caseworker reports. First, all forms of maltreatment in the allegation were identified, and then the most serious type of maltreatment was determined by caseworkers using the Modified Maltreatment Classification System (English & LONGSCAN, 1997). The NSCAW II data provides 10 categories of maltreatment. For the purposes of this study, the categories for the most severe forms of maltreatment were collapsed into the following seven maltreatment types: physical abuse; physical neglect (failure to provide for the child); supervisory neglect (failure to supervise the child); sexual abuse; domestic violence; substance-exposed infant; and parental substance abuse or other type of abuse. A dichotomous variable was created for each of the seven maltreatment types.

**Demographic Characteristics and Caseworker Assessment**

The child demographic characteristics used in the analysis included age, gender, race, and primary special needs or behavior problems. Caregiver demographic characteristics included race, marital status, employment status, poverty, and the number of children in the household. Demographic information also included the caseworker's characteristics, such as age, race, gender, education, work history (i.e., years of child protective work), and the frequency of contact with his or her supervisor. In terms of caseworker assessment, caseworkers reported their perception of the extent of harm experienced by the child and the perceived extent of risk to the child; this caseworker assessment used 4-point Likert-type scale items. Dichotomous variables were generated, with 1 indicating *moderate or severe level*, and 0 indicating *none or mild level*. 
**Analytic Approach**

A descriptive analysis was conducted to summarize the characteristics of children, caregivers, and caseworkers. A diagnostic check for the ordinary least squares (OLS) regression analysis such as the Q-Q plot and the kernel density plot were conducted to examine whether the dependent variable was normally distributed. Then ordinary least squares (OLS) regression models were conducted to examine the relationship between kinship diversion and child behavior problems. The measures of Wave 1 outcome were controlled as well as other covariates when predicting the outcomes at Wave 3. Using the analysis of covariance approach to control for baseline levels of outcomes helps to reduce possible bias (Morgan & Winship, 2007).

The analysis sample has missing values for the variables of interests. The missing data pattern and mechanisms were explored by examining whether values of the variables in the dataset predicted missing values on other variables, which was consistent with the missing at random (MAR) assumption. Thus, the multiple imputation by chained equations (MICE) procedure was conducted to impute missing values. Ten imputed files were generated after using MICE. For each imputed file, the variables with missing values were treated as dependent variables whereas the other variables were controlled in a series of regression models using chained equations (Stuart, Azur, Frangakis, & Leaf, 2009). Based on the imputed data, statistical analysis was conducted separately in each imputed file, and then a single set or results were aggregated using Rubin’s rule (Little & Rubin, 2002).

Multiple-rater ratings are increasingly used in longitudinal research and the rater effects are sometimes overlooked in practice (Guo & Bollen, 2013). The NSCAW II also has the issue of rater effects because different caregivers might report the child behavior problems at Wave 3. To control for this possible measurement error, a sensitivity analysis was conducted using a subsample of children who had the same caregiver at Wave 1 and 3. Therefore, using the same control
variables, OLS regression analyses were conducted in this subsample to predict child behavior problems.

The NSCAW II research design is an unequally weighted, stratified, clustered multi-stage sampling design. The complex NSCAW weights reflect the probabilities of selection at each stage of sampling, and these weights were used in all analyses to adjust for nonresponse and undercoverage. Moreover, use of the weights ensured that the results would provide approximately unbiased estimates of population parameters. All statistical analyses were conducted in Stata 14.

Results

Table 1 presents the weighted baseline sample descriptive statistics for both the entire sample and the subsample used for the sensitivity analysis (i.e., had same caregivers at Wave 1 and 3). For the entire sample, about 28.91% of children were in private kinship care, and 34.18% of children were in voluntary kinship care. The remaining 36.92% (not shown) were in public (paid) kinship care. The sample had more boys (59.55%) than girls (40.45%). The average age of the children was 6.3 years old. Children in the sample had diverse races: 39.02% were White, 29.34% were Black, 28.32% were Hispanic, and 3.32% were other races/ethnicities. About 29.12% of children had a disability. The most frequent abuse type was neglect - lack of supervision (26.04%), and the least frequent type was sexual abuse (4.01%). In terms of caregivers’ characteristics, about half of the caregivers were White (47.84%). Less than half of the caregiver sample was married (44.12%) and 41.39% was living beneath 100% of the poverty line. Half of caregivers were employed. The average number of children in a household was two.

For caseworkers, 41.62% of the sample was younger than 35 years old. The majority of the caseworkers were female (84.24%) and had a bachelor’s degree or less (23.09%). Slightly more than half of the caseworkers were White (51.87%). On average, the caseworkers had been working in the child welfare field 6.41 years. The average length of caseworkers’ contact with supervisor was 7.53 months. According to
Table 1. Baseline Sample Descriptive Statistics Based on 10 Imputed Files

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total sample (N = 654)</th>
<th>Paid kinship care (n = 294)</th>
<th>Private kinship care (n = 87)</th>
<th>Voluntary kinship care (n = 273)</th>
<th>Subsample with same caregivers at Wave 1 &amp; Wave 3 (n = 285)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% or Mean SE</td>
<td>% or Mean SE</td>
<td>% or Mean SE</td>
<td>% or Mean SE</td>
<td>% or Mean SE</td>
</tr>
<tr>
<td><strong>Kinship Diversion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private kinship care</td>
<td>28.91 0.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary kinship care</td>
<td>34.18 0.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internalizing score at Wave 1</td>
<td>53.77 0.93</td>
<td>52 0.99</td>
<td>57.07 1.92</td>
<td>52.87 1.34</td>
<td>52.69 1.3</td>
</tr>
<tr>
<td>Externalizing score at Wave 1</td>
<td>52.9 0.94</td>
<td>50.48 1.02</td>
<td>56.67 1.94</td>
<td>52.31 1.27</td>
<td>51.55 1.19</td>
</tr>
<tr>
<td>Total score at Wave 1</td>
<td>53.74 0.95</td>
<td>51.49 1</td>
<td>57.42 2.03</td>
<td>53.07 1.4</td>
<td>52.47 1.36</td>
</tr>
<tr>
<td><strong>Child</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female child</td>
<td>40.45 0.04</td>
<td>48.15 0.07</td>
<td>29.72 0.07</td>
<td>41.22 0.07</td>
<td>41.11 0.07</td>
</tr>
<tr>
<td>Child age</td>
<td>6.3 0.55</td>
<td>5.25 0.42</td>
<td>9.15 0.79</td>
<td>5.03 0.61</td>
<td>4.88 0.4</td>
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<td>Child race</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>39.02 0.06</td>
<td>37.01 0.09</td>
<td>35.6 0.09</td>
<td>44.1 0.08</td>
<td>36.08 0.1</td>
</tr>
<tr>
<td>Black</td>
<td>29.34 0.05</td>
<td>26.03 0.06</td>
<td>27.3 0.09</td>
<td>34.64 0.09</td>
<td>36.08 0.09</td>
</tr>
<tr>
<td>Hispanic</td>
<td>28.32 0.05</td>
<td>30.91 0.07</td>
<td>35.26 0.1</td>
<td>19.64 0.07</td>
<td>24.86 0.07</td>
</tr>
<tr>
<td>Others</td>
<td>3.32 0.01</td>
<td>6.06 0.02</td>
<td>1.83 0.02</td>
<td>1.62 0.01</td>
<td>2.98 0.01</td>
</tr>
<tr>
<td>Child disability</td>
<td>29.12 0.05</td>
<td>23.1 0.06</td>
<td>45.78 0.12</td>
<td>21.55 0.06</td>
<td>28.98 0.07</td>
</tr>
<tr>
<td><strong>Abuse type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical abuse</td>
<td>8.79 0.03</td>
<td>8.81 0.05</td>
<td>4.19 0.05</td>
<td>12.65 0.03</td>
<td>8.71 0.05</td>
</tr>
<tr>
<td>Neglect – failure to provide</td>
<td>9.84 0.03</td>
<td>14.66 0.04</td>
<td>8.62 0.06</td>
<td>5.67 0.02</td>
<td>9.82 0.04</td>
</tr>
<tr>
<td>Neglect – lack of supervision</td>
<td>26.04 0.05</td>
<td>20.7 0.07</td>
<td>30.74 0.12</td>
<td>27.83 0.08</td>
<td>16.56 0.05</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>4.01 0.02</td>
<td>4.6 0.03</td>
<td>3.3 0.02</td>
<td>3.96 0.02</td>
<td>3.75 0.03</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>6.31 0.02</td>
<td>5.71 0.02</td>
<td>5.38 0.03</td>
<td>7.74 0.03</td>
<td>4.73 0.02</td>
</tr>
<tr>
<td>Exposed infant</td>
<td>4.16 0.01</td>
<td>5.46 0.02</td>
<td>0.87 0.01</td>
<td>5.54 0.01</td>
<td>5.29 0.01</td>
</tr>
<tr>
<td>Parental substance abuse</td>
<td>20.66 0.04</td>
<td>19.68 0.06</td>
<td>15.18 0.07</td>
<td>26.36 0.06</td>
<td>24.62 0.07</td>
</tr>
<tr>
<td>Other abuse types</td>
<td>20.19 0.06</td>
<td>20.37 0.09</td>
<td>31.72 0.09</td>
<td>10.24 0.04</td>
<td>26.52 0.09</td>
</tr>
</tbody>
</table>

Notes: SEs were estimated by aggregating 10 imputation files using Rubin's rule.
Table 1. Baseline Sample Descriptive Statistics Based on 10 Imputed Files  
— Continued —

| Variables                     | Total sample  
|                               | \(N = 654\) | Total sample  
|                               | \(N = 294\) | Total sample  
|                               | \(N = 87\)  | Subsample with  
|                               |             | same caregivers  
|                               |             | at Wave 1 & Wave 3 \(n = 285\) |
| Caregiver                     |             |             |             |             |
| Caregiver race                |             |             |             |             |
| White                         | 47.84 0.06  | 46.11 0.09  | 46.89 0.09  | 50.51 0.07  | 42.85 0.09 |
| Black                         | 25.2 0.05   | 24.54 0.05  | 23.76 0.09  | 27.13 0.07  | 29.08 0.07 |
| Hispanic                      | 21.68 0.05  | 24.01 0.07  | 20.83 0.08  | 19.87 0.07  | 20.17 0.07 |
| Others                        | 5.29 0.01   | 5.34 0.02   | 0.09 0.04   | 2.49 0.06   | 7.9 0.03   |
| Married                       | 44.12 0.05  | 46.63 0.08  | 36.18 0.09  | 48.11 0.06  | 46.2 0.06  |
| Employment                    | 50.42 0.06  | 42.39 0.08  | 56.48 0.09  | 53.96 0.08  | 42.87 0.09 |
| \(< = 100\% poverty line\)   | 41.39 0.05  | 38.35 0.08  | 52.81 0.1   | 35 0.06    | 49.44 0.06 |
| Number of children in household | 2.42 0.15            | 2.47 0.19            | 2.74 0.3            | 2.11 0.15            | 2.5 0.16            |
| Caseworker                    |             |             |             |             |
| Younger than 35 years         | 41.62 0.06  | 31.41 0.09  | 54.8 0.09   | 41.51 0.08  | 46.52 0.09 |
| Female caseworker             | 84.24 0.04  | 81.12 0.07  | 88.59 0.06  | 83.93 0.05  | 83.43 0.06 |
| Caseworker race               |             |             |             |             |
| White                         | 51.87 0.06  | 47.65 0.08  | 50.58 0.11  | 57.51 0.09  | 58.74 0.1  |
| Black                         | 27.03 0.05  | 27.81 0.07  | 27.7 0.09   | 25.63 0.08  | 20.68 0.06 |
| Hispanic                      | 13.01 0.04  | 13.34 0.05  | 14.17 0.07  | 11.67 0.05  | 16.15 0.08 |
| Others                        | 8.09 0.03   | 11.2 0.05   | 7.55 0.02   | 5.2 0.03    | 4.43 0.03  |
| Master’s or higher educational degree | 23.09 0.04            | 28.76 0.07            | 26.58 0.08            | 14.03 0.03            | 24.42 0.06 |
| Years of child welfare work   | 6.41 0.59   | 7.76 1.17   | 4.95 0.87   | 6.19 0.59   | 6.35 1.06  |
| Numbers of contacts with      |             |             |             |             |
| supervisor per month          | 7.53 0.96   | 6.62 1.21   | 8.57 2.13   | 7.63 1.34   | 8.54 2.08  |
| Assessment: moderate or severe level of harm to child | 60.97 0.06 | 73.46 0.09 | 33.79 0.09 | 70.48 0.08 | 62.72 0.08 |
| Assessment: moderate or severe level of severity of risk | 78.84 0.05 | 85.38 0.08 | 55.28 0.12 | 91.71 0.03 | 77.06 0.08 |

Notes: SEs were estimated by aggregating 10 imputation files using Rubin’s rule.
caseworkers’ assessments, 60.97% of maltreatment allegations posed a moderate to severe level of harm to the child, and 78.84% of children had a moderate or severe level of severity of risk. In terms of the outcome measure at Wave 1, the average internalizing score was 53.77, externalizing score was 52.9, and total score was 53.74. The sample descriptive statistics of the subsamples that have same caregivers for both Wave 1 and 3 was similar to the one of entire sample (See Table 1).

Table 1 also shows the baseline descriptive statistics for the sample in public kinship care, private kinship care, and voluntary kinship care. Children in private kinship care had higher internalizing, externalizing, and total scores regarding child behavior problems than children in paid or voluntary kinship care. However, the assessments showed that the maltreatment allegations for children in private kinship care had less severe levels of harm or risk than the allegations for children in public or voluntary kinship care. In addition, Figure 1 shows the changes of the mean values of child behavior problems for children in different kinship care groups from Wave 1 to Wave 3. The means of behavior problem scores were increased from Wave 1 to Wave 3 for children in paid and voluntary kinship care. For children in private kinship care, the means of behavior problems scores decreased from Wave 1 to Wave 3.

**Results Based on the Entire Sample**

Table 2 shows the results from the OLS regression controlling for Wave 1 outcome based on the entire sample. All things being equal, the average CBCL internalizing score decline from Wave 1 to Wave 3 for children who were diverted into private kinship care was greater than the score decline of children in paid kinship care by 3.96 points. ($\beta = -3.96, p < 0.05$). The average externalizing score decline for children who were diverted into private kinship care was greater than the ones for children in paid kinship care by 4.77 points ($\beta = -4.77, p < 0.05$). The average total score decline for children who were diverted into private kinship care was greater than the ones for children in paid
kinship care by 5.72 points ($\beta = -5.72, p < 0.01$). All of these associations between private kinship care and child behavior problems were statistically significant. Voluntary kinship care was associated with the increase of CBCL internalizing scores, and the decrease of externalizing scores and total scores, but these finding did not reach statistical significance.

Some covariates also have significant predicting impacts on child behavior problems. For example, other things being equal, children who experienced domestic violence had CBCL externalizing score that were 7.52 points lower than children experienced physical abuse ($\beta = -7.52, p < 0.05$). Children with Hispanic caregivers had externalizing scores that were 7.13 points lower than children with Black caregivers ($\beta = -7.13, p < 0.05$). In addition, characteristics of children and caregivers did not have any significant impacts on both CBCL internalizing score and total score. Characteristics of caseworkers did not have significant impacts on child behavior problems.

Figure 1. Child Behavior Problem Mean Scores for Paid, Private, and Voluntary Kinship Care and Wave 1 & 3

Note: The mean values were estimated by aggregating 10 imputation files using Rubin’s rule.
Table 2. Estimated Results from OLS Regression Controlling for the Wave 1 Outcome for the Entire Sample

<table>
<thead>
<tr>
<th>Covariate</th>
<th>Child Behavior Problem at Wave 3 (N = 654)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Internalizing Score</td>
<td>Externalizing Score</td>
<td>Total Score</td>
<td></td>
</tr>
<tr>
<td>Kinship Diversion (Paid kinship care)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private kinship care</td>
<td>-3.96 (1.76) *</td>
<td>-4.77 (1.89) *</td>
<td>-5.72 (1.91) **</td>
<td></td>
</tr>
<tr>
<td>Voluntary kinship care</td>
<td>0.77 (1.47)</td>
<td>-1.79 (1.38)</td>
<td>-1.35 (1.53)</td>
<td></td>
</tr>
<tr>
<td>Internalizing score at Wave 1</td>
<td>0.4 (0.08) ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Externalizing score at Wave 1</td>
<td>0.39 (0.07) ***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total score at wave 1</td>
<td></td>
<td>0.41 (0.08) ***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female child</td>
<td>-1.57 (1.44)</td>
<td>-1.36 (1.47)</td>
<td>-1.43 (1.54)</td>
<td></td>
</tr>
<tr>
<td>Child age</td>
<td>-0.15 (0.21)</td>
<td>-0.004 (0.21)</td>
<td>-0.06 (0.235)</td>
<td></td>
</tr>
<tr>
<td>Child race (Black)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>3.38 (2.80)</td>
<td>-0.29 (2.79)</td>
<td>0.70 (2.92)</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>-3.86 (2.63)</td>
<td>0.97 (2.83)</td>
<td>-0.39 (2.81)</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>1.99 (4.09)</td>
<td>4.67 (4.49)</td>
<td>3.00 (4.39)</td>
<td></td>
</tr>
<tr>
<td>Child disability</td>
<td>-0.13 (2.7)</td>
<td>1.75 (2.11)</td>
<td>1.78 (2.53)</td>
<td></td>
</tr>
<tr>
<td>Abuse type (Physical abuse)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neglect-failure to provide</td>
<td>2.26 (3.74)</td>
<td>-1.58 (3.38)</td>
<td>1.97 (3.87)</td>
<td></td>
</tr>
<tr>
<td>Neglect-lack of supervision</td>
<td>1.07 (3.04)</td>
<td>1.65 (2.8)</td>
<td>4.06 (3.24)</td>
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</tr>
<tr>
<td>Sexual abuse</td>
<td>2.49 (4.16)</td>
<td>-0.88 (3.58)</td>
<td>1.54 (3.94)</td>
<td></td>
</tr>
<tr>
<td>Domestic violence</td>
<td>-4.93 (3.40)</td>
<td>-7.52 (3.01) *</td>
<td>-5.36 (3.28)</td>
<td></td>
</tr>
<tr>
<td>Exposed infant</td>
<td>-0.46 (3.26)</td>
<td>3.02 (3.13)</td>
<td>2.46 (3.3)</td>
<td></td>
</tr>
<tr>
<td>Parental substance abuse</td>
<td>-1.30 (3.44)</td>
<td>-2.76 (3.25)</td>
<td>-2.13 (3.48)</td>
<td></td>
</tr>
<tr>
<td>Other abuse types</td>
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<td>-0.63 (3.75)</td>
<td>0.66 (4.27)</td>
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</tr>
<tr>
<td>Caregiver</td>
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</tr>
<tr>
<td>Caregiver race (Black)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>3.38 (2.8)</td>
<td>-0.32 (2.98)</td>
<td>-0.13 (3.00)</td>
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</tr>
<tr>
<td>Hispanic</td>
<td>-3.86 (2.63)</td>
<td>-7.13 (3.34)</td>
<td>-3.23 (3.11)</td>
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</tr>
<tr>
<td>Others</td>
<td>1.99 (4.09)</td>
<td>-5.11 (4.38)</td>
<td>-2.31 (4.08)</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>-1.39 (2.15)</td>
<td>-1.8 (1.6)</td>
<td>-2.16 (2.07)</td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td>-0.82 (1.7)</td>
<td>1.32 (1.61)</td>
<td>0.26 (1.82)</td>
<td></td>
</tr>
<tr>
<td>&lt; = 100% poverty line</td>
<td>-0.04 (2.00)</td>
<td>2.17 (1.63)</td>
<td>0.40 (2.05)</td>
<td></td>
</tr>
<tr>
<td>Number of children in household</td>
<td>-0.25 (0.59)</td>
<td>-0.25 (0.53)</td>
<td>-0.41 (0.6)</td>
<td></td>
</tr>
<tr>
<td>Caseworker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger than 35 years</td>
<td>-0.32 (1.732)</td>
<td>1.78 (2.06)</td>
<td>1.49 (1.93)</td>
<td></td>
</tr>
<tr>
<td>Female caseworker</td>
<td>0.96 (1.79)</td>
<td>-0.23 (1.96)</td>
<td>1.03 (2.03)</td>
<td></td>
</tr>
<tr>
<td>Caseworker race (Black)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>-4.24 (2.18) β</td>
<td>2.64 (1.86)</td>
<td>-3.42 (2.33)</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>-0.3 (2.15)</td>
<td>-0.71 (2.19)</td>
<td>-0.52 (2.31)</td>
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</tr>
<tr>
<td>Others</td>
<td>8.38 (4.36) β</td>
<td>5.23 (3.62)</td>
<td>8.33 (4.49) β</td>
<td></td>
</tr>
<tr>
<td>Master’s degree or higher education</td>
<td>-0.93 (1.59)</td>
<td>-0.95 (1.64)</td>
<td>-0.85 (1.72)</td>
<td></td>
</tr>
<tr>
<td>Years of child welfare work</td>
<td>0.07 (0.12)</td>
<td>-0.02 (0.14)</td>
<td>0.03 (0.14)</td>
<td></td>
</tr>
<tr>
<td>Numbers of contacts with supervisor per month</td>
<td>-0.12 (0.08)</td>
<td>-0.03 (0.08)</td>
<td>-0.12 (0.08)</td>
<td></td>
</tr>
<tr>
<td>Assessment: moderate or severe level of harm to child</td>
<td>-2.36 (2.6)</td>
<td>-1.76 (2.23)</td>
<td>-3.57 (2.69)</td>
<td></td>
</tr>
<tr>
<td>Assessment: moderate or severe level of risk</td>
<td>-1.28 (3.81)</td>
<td>-0.004 (3.54)</td>
<td>0.88 (4.12)</td>
<td></td>
</tr>
</tbody>
</table>

Notes: SEs were estimated by aggregating 10 imputation files using Rubin’s rule.
Main Results Based on the Subsample

Results in Table 3 based on the subsample that have same caregivers between Wave 1 and 3 showed consistent direction of the regression coefficients of kinship diversion on child behavior problems. However, the association between private kinship care and CBCL internalizing score was not statistically significant. Other things being equal, the average total score decline for children who were diverted into private kinship care was greater than the ones for children in paid kinship care by 5.74 points. ($\beta = -5.74, p < 0.05$). Children who were in private kinship care or voluntary kinship care had marginally significant negative association with externalizing score ($\beta = -4.11, p < 0.1; \beta = -3.04, p < 0.1$, respectively).

In sum, both the entire sample analysis and the sub-sample analysis got the same results in terms of the direction of association between kinship diversion and child behavior problems. However, the significance levels differed due to the differences in statistical power. For example, private kinship care had significant association with child’s internalizing, externalizing, and total score for the entire sample, but it

### Table 3. Estimated Results from OLS Regression Controlling for the Wave 1 Outcome for the Subsample that Having Same Caregivers in Both Wave 1 and Wave 3

<table>
<thead>
<tr>
<th>Covariate</th>
<th>Child Behavior Problem at Wave 3 ($n = 285$)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Internalizing Score</td>
</tr>
<tr>
<td>Kinship Diversion (Paid kinship care)</td>
<td></td>
</tr>
<tr>
<td>Private kinship care</td>
<td>-3.30 (2.15)</td>
</tr>
<tr>
<td>Voluntary kinship care</td>
<td>0.11 (1.67)</td>
</tr>
<tr>
<td>Internalizing score at Wave 1</td>
<td>0.5 (0.07) ***</td>
</tr>
<tr>
<td>Externalizing score at Wave 1</td>
<td></td>
</tr>
<tr>
<td>Total score at Wave 1</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:** Reference group in parentheses in column 1. SEs in parentheses from column 2 to 10. Same covariates were used as Table 2. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$, $\beta < 0.1$. 

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**Wu Child Welfare**

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only had a statistically significant association with child total score at the 0.05 level for the smaller-sized sample that have same caregivers at both Wave 1 and 3. Therefore, conducting this sensitive analysis is very important to better understanding the possible measurement errors in the ratings.

Discussion

Over the past three decades, kinship care has been used increasingly as an option when a child has to be removed from his or her home of origin. The majority of kinship care is provided by unpaid relative caregivers through private kinship care and voluntary kinship care arrangements that are instigated by Child Protective Services and are known collectively as kinship diversion care because the child is diverted from public foster care (paid). For the children who have substantiated allegation of maltreatment, the different types of out-of-home placements can substantially affect the child’s experiences and development given the different levels of CWS involvement, leading to important differences in child outcomes. When children are diverted from the CWS, they are not monitored by CWS and most are not eligible to receive financial support or CWS support services. To examine the concerns of child welfare researchers and practitioners, this study explored the relationship between kinship diversion and child behavior problems.

In terms of this study’s research hypothesis, the results not only suggest that kinship diversion does not adversely affect the well-being of children but also that private kinship care is associated with significantly greater child behavior problems decline. One possible explanation for this finding is consistent with the reasoning of those who support kinship diversion: Kinship diversion keeps children outside the CWS, which might benefit child through less interference and disruption in their lives. For example, kinship diversion does not entail prohibition of contact between the children and their parents. As a
result, children in kinship diversion care are more likely than children in foster care to have closer or more frequent contact with their biological parents (Gleeson & Seryak, 2010; Goodman, 2003). Fostering a close relationship with their parents is beneficial to these children, and might help the children to recover from the possible behavioral or emotional problems they have experienced, further contributing to good child outcomes.

Nevertheless, the lack of services and financial support in kinship diversion care does not always translate to “true beneficial effects” on child well-being. The salutatory effects of kinship diversion could also be attributable to unobserved selection bias that diverts “better functioning” children from public kinship care. Many children who have been diverted to unpaid kinship care have not been maltreated but needed to be placed in care because of parental illness or death; however, these circumstances might not have affected their well-being or functioning. Relatives might be more likely to agree to take care of children who have better functioning. For example, if a child does not have serious behavior problems, it is easier for caregivers to take care of them. Although the descriptive data in this study showed that children in private kinship care had higher mean scores for behavior problems than children in paid kinship care at baseline, it is possible that diverted children have better outcomes in terms of other un-measured well-being functions at baseline. It is also possible that children may be more likely to be diverted into a better functioning family, which has more positive impacts on child outcomes. Therefore, given that possible unmeasured selection bias in kinship diversion was not controlled for in the analyses, the results do not support a conclusion that kinship diversion has beneficial effects on child well-being—although the study results do suggest children in private kinship care have greater behavioral problems decline from Wave 1 to Wave 3 than children in public kinship care.

This study makes a meaningful contribution toward filling the knowledge gap around kinship care and the association between forms
of kinship care and child well-being outcomes. Confidence in the results is strengthened because the sensitivity analysis was conducted using data from same caregivers in both waves. However, the study has limitations that must be acknowledged and considered when interpreting the findings.

First, as mentioned, this study did not control for unobserved selection bias. It is possible that children in paid kinship care and children in unpaid kinship care might differ in other aspects than what could be measured. For example, children with better functioning might be more likely to be diverted into private kinship arrangements. If diverted children have fewer behavior problems than children who enter the foster care system, it is a challenge to conclude that kinship diversion has beneficial effects on the decreased rate of children with behavioral problems. Second, without using a more rigorous statistical method for the analyses, it is difficult to establish a causal relationship between kinship diversion and child outcomes. Thus, the results support only an association between kinship diversion and child outcomes. Third, kinship diversion was measured by only two items: whether caregivers received financial support from the CWS, and whether social workers helped to arrange the placement. Whereas kinship diversion is a complex process, using only two items to measure the effects of kinship diversion might lead to construct bias. Last, the analysis was limited in terms of the choices of control variables used in the statistical models given the limitations of using NSCAW II data. For example, this analysis cannot control for the characteristics of the child’s biological parents, the characteristics of child welfare agencies, and the effects of policy and laws on the use of kinship diversion. Future studies should address these limitations. For example, more variables should be collected to measure kinship diversion, enabling the studies to better capture the characteristics of kinship diversion. Researchers seeking to examine the causal effects of kinship diversion on child outcomes will need to use a more rigorous analytic method such as propensity score analysis or instrumental variable approach. In addition, future efforts
should examine a wider range of child outcomes, including cognitive skills, peer relationships, mental health outcomes, and academic performance, to provide a better and nuanced understanding of how diversion to unpaid kinship care affects the well-being outcomes of children.

**Implications for Practice and Policy**

This study has important implications for child welfare practice and policy. Children with histories of substantiated child maltreatment might have a different life trajectory and outcome if they had experienced a different type of out-of-home placement. On one hand, behavioral or emotional problems caused by removal of the child from the home of origin and subsequent placement in the CWS could explain why children in private kinship care showed greater behavior problems decline. Child welfare professionals should direct efforts toward developing interventions to reduce the negative impacts of involvement in the CWS. On the other hand, even though children diverted to unpaid kinship care might not have negative experiences of being in the system, these children need follow-up services and supports to ensure children diverted to unpaid kinship care have good well-being and health outcomes. Although this study did not find adverse effects of kinship diversion on child behavior problems, the children diverted away from formal systems that provide ongoing monitoring represent a highly vulnerable group of children. Therefore, paying attention to the diverted children and providing needed services to the children and their kin caregivers will be helpful in terms of family function and child development.

Although basic guidelines may be available to help guide decisions about placing children in out-of-home placement and kinship care, in many cases the decision to divert a child from foster care through kinship diversion was a subjective decision made by caseworkers. The difficulty of developing policy to address the challenges of diverted children and kin caregivers is compounded by the lack of federal guidelines and
criteria to govern kinship diversion. A clear need exists for policy-makers to create uniform criteria of kinship diversion, providing case-workers with consistent guidance when making decisions about child placements. Such policy is an important first step in ensuring children and caregivers’ access to services, including social, emotional, and financial supports.

Policy-makers face multiple dilemmas related to kinship diversion such as how to balance limited financial resources and still provide the range of supports needed by children and kin caregivers. In addition, policy-makers must grapple with rectifying the situation created by policy that made kinship care a preferred placement because of its lower costs—reduced costs that were achieved by ignoring the needs for social and financial support of the children and caregivers living in private kinship care arrangements. Beyond financial matters, policy-makers are also faced with the challenge of creating policy that can help to better meet the social and emotional needs of kin caregivers. Therefore, more research and evaluation studies are needed to focus kinship diversion, to provide policy-makers with the data needed to address these issues, and to inform the development of policies that better meet the needs of children and their kin caregivers.

References


Placement Stability of Children in Informal Kinship Care: Age, Poverty, and Involvement in the Child Welfare System

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This study examines the characteristics of children and their caregivers, the extent of children’s prior involvement in the child welfare system, and the factors associated with placement instability in informal kinship care. A survey of kinship caregivers and child welfare administrative records were used to answer these questions. The study sample includes 321 children who were living with caregivers at the time of the initial survey. Caregivers had a wide range of ages and one third of them live below the poverty line. Two thirds of children had prior CPS involvement and one quarter had been placed in foster care before moving in with current kin caregivers. The GEE model indicates that the child under age of 1 was far more likely to enter non-kinship foster care within one-year period and older age of caregivers was a stabilizing factor. Findings indicate that maltreated children move in and out of the child welfare system. Child welfare workers need to inform caregivers of the option to become licensed kin foster caregivers instead of asking them to take children “voluntarily.” Informal kinship placement of children should merit further examination as a child welfare service and deserves recognition, financial assistance, and support services.

**Acknowledgements:** This study is funded by a Children’s Bureau grant awarded to the New York State Kinship Navigator program (90CF0050) and a Children’s Bureau grant awarded to Dr. Lee (HHS#: 90CA1819-01-00). We would like to thank Ms. Joanne Ruppel and Dr. Yufan Huang of the New York State Office of Children and Family Services and many staff members in the demonstration counties for their assistance with the child welfare records. Most of all, we would like to express our deep gratitude to kinship caregivers in the study who generously shared their experience.
Approximately 2.3 million children in the United States, or about 3% of all children, live in kinship care (Radel, Bramlett, Chow, & Waters, 2016; AECF, 2012). The Child Welfare League of American (CWLA) defines kinship care as the “full-time nurturing and protection of children who must be separated from their parents by relatives, members of tribes or clans, godparents, step-parents or other adults who have a kinship bond with a child” (CWLA, 1994, p. 2). In the past decade, the number of children living in kinship care grew by 18% (AECF, 2012). This increase was due in part to child welfare agencies across the United States increasingly turning to relatives and other kin as a preferred out-of-home care option. However, only about 5% of all children living with kin are in public kinship care (AECF, 2012). The majority of children living with kin are placed “informally,” meaning the arrangement was made voluntarily with the involvement of child welfare services or privately between parents and caregivers (Billing, Ehrle & Kortenkamp, 2002; Geen, 2004; AECF, 2012; Wallace & Lee 2013; CWIG, 2016; Walsh, 2013).

In this discussion, “kinship care” will refer broadly to the care of children by relatives or others to whom a kinship relationship is ascribed, while “public kinship care” refers exclusively to the out-of-home care arrangement in which a child welfare agency assumes the custody of children and places the child with kin with or without a subsidy. “Informal kinship care” refers to both private and voluntary kinship care arrangements made outside of the formal foster care system. Additionally, formal foster care includes both public kinship care and public foster care with nonrelative foster parents.1

1 The use of the terms “formal and informal kinship care” has not been consistent in the literature. The 1996 special issue of Child Welfare on kinship care drew the following distinction: “Kinship care is typically categorized in one of two ways: informal and formal. Children may be parented by kin as an informal arrangement when the family decides…. Although a social worker may sometimes be involved in helping family members plan for the child, in informal arrangements, a child welfare agency does not assume legal custody of, or responsibility for the child.” (Wilson & Chipungu, 1996, p. 388). Other scholars use payment to draw the distinction. For example, informal kinship care refers to an out-of-home care setting where children are living with non-parental caregivers without any financial support (Bavier, 2011). The Children's Bureau (CWIG, 2016) defines informal kinship care as arrangements made without the court and child welfare agency oversight. A study using a large sample of children who had been subject to a child maltreatment investigation (Stein et al., 2014) differentiates informal kinship care from formal kinship foster care by its lack of support and licensing requirement by the child welfare system. Recognizing these differences in terminology, this paper uses the typology on kinship care offered in the Introduction to this volume.
While considerable research exists on children in public kinship care, less is known about children in private and voluntary kinship care. Studies examining the well-being of children in informal kinship care find that these children may have similar risk factors as those in formal foster care and may experience maltreatment (Billing et al., 2002; Bavier, 2011; Kelley, Whitely & Campos, 2011; Stein et al., 2014). There is limited understanding, however, of the extent to which children in informal kinship care were ever involved with the public child welfare system. Furthermore, no studies to date have examined which child and caregiver characteristics influence the stability of informal kinship care.

To address these gaps, this study aims to answer the following questions: (1) What are the characteristics of children and their kinship caregivers in informal kinship care?; (2) To what extent were these children involved in the formal child welfare system before moving in with their kin?; and (3) What characteristics of children and their caregivers affect placement stability outcomes in informal kinship care? Based on matched data from surveys of kin caregivers at baseline and at a one-year follow-up and the child welfare administrative records of children in their care, this study examines these questions and offers practice and policy recommendations. This research is uniquely positioned to provide a profile of children in kinship care, many of whom have been subject to child maltreatment investigations, and to create an understanding of the stability of informal out-of-home care arrangements.

Literature

Reasons for Entering Informal Kinship Care

While evidence is limited, studies suggest that children are often placed with kin outside of the formal foster care system after a child maltreatment investigation (Gleeson et al., 2009; Park & Helton, 2010; Walsh, 2013; Stein et al., 2014). Parental neglect due to mental health, incarceration, or substance abuse are the primary reasons that children could not stay with their parents (Davis-Sowers, 2012; Kelley et al.,
Informal kinship care involves multiple pathways where a parent may have privately arranged placement with another relative or a child welfare agency may have asked kin to voluntarily take the children (Gleeson et al., 2009). Additional pathways into informal kinship care can include military deployment and death of parents (Goodman, Potts, Pasztor, & Scorzo, 2004).

Kinship caregivers are often motivated to keep children within the family and out of the formal foster care system (Gleeson et al., 2009). Additionally, Child Protective Services (CPS) rely on kin to divert children from entering the formal foster care system (Wallace & Lee, 2013). The extent to which children in informal kinship care have a prior history of involvement with CPS remains largely unexplored, mainly because these children fall between CPS and other child-placing entities (Gibbs, Kaster, Bir, Duncan, & Hooever, 2006).

**Characteristics of Kinship Families and Caregivers**

There is ample evidence of the economic hardships of kinship family households (Gibbs et al., 2006; Yancura, 2013). It is estimated that 38% of all kinship families live below the federal poverty line (AECF, 2012). Kinship households headed by grandmothers are particularly at risk, as 48% of children living in these households live in poverty (Baker & Muchtler, 2010). While kinship family households are more likely to experience financial hardship than non-relative foster homes or single-parent households, they are also less likely to receive assistance or support (Stein et al., 2014). Studies on informal kinship families also indicate these families experience a high level of economic hardship. In fact, some suggest that informal kinship caregivers have as great or greater needs than formal kinship caregivers and foster parents. Typically, these families have less education and fewer resources than unrelated foster caregivers (Bavier, 2011; Stein et al., 2014).

Kinship caregivers themselves tend to have greater physical, mental, and emotional needs than birth families or foster parents (Billing et al., 2002; Baker & Mutchler, 2010; Harentt et al., 2014). In
particular, informal caregivers are in poorer health compared to kin or non-relative foster care providers (Stein et al., 2014). They have high levels of stress, limited resources, and lack supportive services, all of which exacerbate the stress of caring for children who have likely experienced trauma (Denby, Brinson, Cross, & Bowmer, 2015; Minkler & Fuller-Thompson, 1999). Kin caregivers are at a greater risk of experiencing health problems and depression once they take on caregiving responsibilities (Garcia et al., 2015).

**Benefits of Kinship Care**

Most studies comparing outcomes of children in out-of-home care settings suggest that kinship care offers many advantages compared to non-relative foster care (Cuddeback, 2004; Rubin et al., 2004; Winokur et al., 2014). For example, children in public kinship care are less likely to have behavioral issues (Rubin et al., 2004) or mental health disorders (Winokur et al., 2014), and are less likely to experience new incidents of abuse (Jonson-Reid, 2003).

Children in public kinship care also have fewer placement disruptions (Connell et al., 2006; Rosenthal & Villegas, 2011; Webster, Barth & Needell, 2000) and lower rates of reentry into out-of-home care settings after discharge from public foster care (Needell, Webster, Barth, Armijo, & Fox, 1998). They are also more likely to be reunified with their biological parents than those in non-relative foster care (Winokur et al., 2008).

However, recent studies raise questions regarding whether the better outcomes associated with public kinship care are in fact due to other characteristics (Anderson & Fallesen, 2015; Grogan-Kaylor, 2000; Koh, Rolock, Cross & Eblen-Manning, 2014; Font, 2015). Scholars have noted significant differences in the characteristics of children who enter public kinship care and those who enter non-relative foster care. For example, a California study found that children who were separated from their parents due to neglect were more likely to be placed in kinship care than children separated for physical or sexual abuse allegations.
(Grogan-Kaylor, 2000). Font (2015) also suggested that kinship care was more likely to involve children who had a history of neglect rather than sexual abuse, compared to non-relative foster care settings. These studies suggest that better kinship outcomes may be related to the less severe separation circumstances of children in kinship care compared to non-relative foster care.

**Predictors for Placement Stability in Foster Care**

Several factors are associated with placement stability in foster care settings, including a child's age at the time of placement, placement history, and length of stay in the current care setting. An older age at the time of placement is positively associated with placement disruption and instability (Webster et al., 2000; Oosterman, Schueugel, Slot, Bullens, & Doreleijers, 2007), particularly for those children between the ages of 12 and 15 (Rosenthal & Villegas, 2011).

Placement history and length of stay are also associated with placement stability. A meta-analysis found that children with a history of foster care placements were more likely to experience placement instability (Oosterman et al., 2007). The study also indicated that length of stay in a foster care setting was related to placement disruption and that the placement disruption rate was highest in the first six months after placement. Kinship placements are more stable than non-relative foster placements (Testa, 2002) and children who spent more time with kinship caregivers had a decreased likelihood of having multiple moves over an 18-month period (Koh et al., 2014).

**Methods**

**Study Setting and Participant Recruitment**

This study was part of a federal kinship navigator demonstration project to improve the well-being of children and their caregivers in informal kinship care. The goal of the project was to improve collaboration
between child welfare services and kinship navigator services. As part of this goal, the project was mandated to examine children’s well-being through state administrative child welfare records. Given the difficulty of identifying the informal care population, the study relied on both public and community sources to identify and recruit participants. Public child welfare and temporary assistance workers, as well as community-agency workers, utilized a simple one-page form vetted by all involved kinship service organizations to identify participant caregivers and ask for permission to be contacted. Once workers received the caregivers’ written permissions, the forms were transmitted to the kinship navigator program and to the research team.

To be eligible for the study, the primary kinship caregivers and the children in their care had to reside in one of five counties in a northeastern state at the time of study participation; provide full-time care to children in their own households without the biological parent(s) present; and could not receive foster care payments. A member of the research staff contacted prospective participants by telephone and asked for additional oral consent for participation in the study. The study was approved by the research team’s Institutional Review Board.

**Data Sources**

**Survey**

Immediately following the written and oral consent procedures, a first survey, lasting approximately 35 to 45 minutes, was conducted over the phone. The survey questions included demographic information of kin caregivers, household incomes, and the dates and reasons for children’s placement with kin. Detailed information on children, including gender, age, and birthdates, was also collected for the purpose of matching administrative records. The first survey also collected data on the perceived health and emotional well-being of caregivers and the physical and emotional health of children (only for ages 2 and over).
Out of 354 caregivers initially approached, 303 caregivers agreed to participate in the study and subsequently completed the baseline survey that included information on 455 children. One year after the first interviews, the caregivers were approached again to complete a follow-up survey by mail, online, or over the phone. The study was able to retain 72% of the caregivers at the one-year follow-up.

**Child Welfare Administrative Records**

Using the child’s demographic information from the survey, each of the 455 children were matched with state administrative records from CPS and foster care services. The child-level data contained any records associated with the child, including allegations and dates of CPS investigative reports and dates of foster care entry and exit. The records were extracted to the date of the one-year follow-up survey.

**Measures**

**Child Age and Caregiver Age**

The ages of the caregivers and the children at the time of the survey interview were calculated by dividing the difference between the survey interview date and the caregiver’s and the child’s birth date, and then converting that number into years and days. Ages were used as continuous variables.

**Household Income**

Caregivers reported their household income by selecting one of several income brackets. First, researchers recoded them into three groups based on the federal poverty guidelines and the U.S. median household income in the 2010 census: under $20,000; between $20,000 and
$50,000; and over $50,000. Therefore, this categorical variable indicates whether the families’ household income was below the poverty threshold, above the median income, or in-between, for the average kinship household size of three. In the analysis a household income greater than $50,000 was used as the referent.

**Prior CPS Records**

The number of prior CPS records was calculated based on the child move-in date with the current kinship caregiver and the dates of CPS reports. Reports made before the child move-in date were counted as prior records. This information was used as a dichotomous variable: if a child had at least one prior CPS record before the kinship placement, it was coded as 1; otherwise 0.

**Prior Foster Care Records**

The number of prior foster care placement episodes was calculated based on the same logic as the calculation for prior CPS records. This information was used as a dichotomous variable: If a child had at least one prior foster care episode before the kinship placement, it was coded as 1; otherwise, it was coded as 0.

**Infant at Date of Move-In**

The age of each child was calculated based on when the child moved in with the current kin caregiver. Age was first created using the caregiver’s report on the child’s move-in date and the child’s date of birth. This variable was coded as a dichotomous variable, since the data included a wide range of move-in ages, with a disproportionately high number of infants at the time of placement. Therefore, if a child was placed in the kinship setting during infancy (at the age of one or under), it was coded as 1; otherwise, 0.
**Time Spent with Kin**

The duration of the child’s stay with the kinship caregiver was calculated by dividing the difference between the child’s move-in date and the survey interview date into 365.25 (days) increments. The calculated duration was used after a log transformation for improving normality in the analysis model.

**Caregiver-Perceived Well-Being**

Caregiver-perceived well-being was measured using the sum of two survey questions. One item asked caregivers about their perceptions of their health in general, and the other item asked about their perceptions of their overall mental and emotional health. Original responses ranged from 1 = poor to 5 = excellent. Researchers used the sum score of the two items to calculate perceived well-being, and the variable was used as a continuous variable.

**Placement Disruption**

Researchers operationalized the dependent variable, placement disruption, as entry into non-relative foster care over a one-year period after the first interviews. This outcome variable was initially created using the foster care entry records from the state child welfare administrative data. Researchers then used the one-year follow-up survey data to further authenticate the outcome. The variable was coded as dichotomous, with 1 indicating “entering non-relative foster care” and 0 indicating “staying with the same kinship caregiver.”

To avoid any bias, children who did not have records in both the child welfare administrative data and the one-year follow-up survey were excluded from the final analysis. Seven children, who were either re-unified with their biological parents or who moved to other relatives or friends, were also excluded from the analysis.

**Data Analysis**

The data for this study included 321 children within 222 families, indicating two or more children for 36% of the families. Some children
shared the same information on the caregiver and the household and their answers were correlated with each other. The dependent variable, placement disruption, was binomial. Both the independence of variables and normality have been violated in this study given the nature of the sample. To compensate for the clustered structure of the data, generalized estimating equations (GEE) were used (Liang & Zeger, 1986). GEE was developed to accommodate data with correlated observations within subjects (Horton & Lipsitz, 1999). GEE is a recommended method when the data is clustered, such as with panel data and family studies (Ziegler & Grömping, 1998). This study used Stata (2015) statistical packages 14 for its analyses.

Results

Sample Characteristics

Table 1 presents the characteristics of the sample as a whole group. Our study sample included a few young caregivers who were siblings and relatives rather than grandparents. Most of the caregivers were between their early 40s and early 60s, although the sample had a number of quite older and very young caregivers as well. Many caregivers were not financially well-off. About two-thirds of the caregivers reported an income less than $50,000 while living in counties where the average median household income was close to or above $50,000. On average, caregiver-perceived combined physical and mental health was good, but it had a wide range, from 3 being somewhat poor to 10 being excellent.

Children’s age also varied widely, ranging from under one to 20 with a mean age of 7.8. The sample included both male and female children. More than one-fourth of the children began living with the current kin caregivers when they were infants. In those cases, many caregivers reported that the children were placed with them right after birth.

Since the study recruited kinship caregivers through social service and community agencies, the sample included many families where children were living with kinship caregivers for extended periods of time. The duration of stay with the current informal kinship families
The study targeted both private and voluntary kinship caregivers. As a result, our sample included a large number of children who have been extensively involved in the child welfare system. Almost two-thirds had at least one CPS record prior to moving in with the current kin caregiver. In addition, one out of four children in the sample had

Table 1. Sample Description ($n = 321$)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequencies</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement Outcome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-relative Foster Care</td>
<td>32</td>
<td>10%</td>
</tr>
<tr>
<td>Staying with Kin</td>
<td>289</td>
<td>90%</td>
</tr>
<tr>
<td>Child Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>162</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>159</td>
<td>50%</td>
</tr>
<tr>
<td>Household Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under $20,000</td>
<td>99 (65)b</td>
<td>32% (30%)</td>
</tr>
<tr>
<td>$20,000-50,000</td>
<td>107 (75)</td>
<td>34% (35%)</td>
</tr>
<tr>
<td>Over $50,000</td>
<td>105 (75)</td>
<td>34% (35%)</td>
</tr>
<tr>
<td>Prior CPS Involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>204</td>
<td>64%</td>
</tr>
<tr>
<td>No</td>
<td>117</td>
<td>36%</td>
</tr>
<tr>
<td>Prior Foster Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81</td>
<td>25%</td>
</tr>
<tr>
<td>No</td>
<td>240</td>
<td>75%</td>
</tr>
<tr>
<td>Infant at Move-in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under age of 1</td>
<td>87</td>
<td>27%</td>
</tr>
<tr>
<td>Age of 1 or over</td>
<td>231</td>
<td>73%</td>
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</table>

<table>
<thead>
<tr>
<th>Variables</th>
<th>$N$</th>
<th>Mean</th>
<th>Std. Dev</th>
<th>Min</th>
<th>Max</th>
</tr>
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<tbody>
<tr>
<td>Child Age</td>
<td>317</td>
<td>7.8</td>
<td>4.8</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Caregiver Age$^b$</td>
<td>303</td>
<td>52.2</td>
<td>11.1</td>
<td>20</td>
<td>86</td>
</tr>
<tr>
<td>(221)</td>
<td></td>
<td>(52.4)</td>
<td>(11.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Months Stayed with Kin</td>
<td>321</td>
<td>41.4</td>
<td>49.2</td>
<td>0</td>
<td>230</td>
</tr>
<tr>
<td>Caregiver Perceived Well-being$^c$</td>
<td>303</td>
<td>7.1</td>
<td>1.8</td>
<td>3</td>
<td>10</td>
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<tr>
<td>(221)</td>
<td></td>
<td>(7.1)</td>
<td>(1.7)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$^a$ N is based on children in the analysis sample
$^b$ Numbers in parentheses were calculated based on family units.
$^c$ Based on questions on health and emotional health. A higher number indicates better well-being

had a wide distribution, ranging from 0 months, which indicates the child had just moved in with the kinship caregivers at the time of study recruitment, to 230 months, which indicates the child was living with the kinship caregiver for almost 20 years.
foster care experiences prior to moving in with their current kinship caregiver. Over the one-year period, one-tenth of children in the sample entered into public foster care with non-relatives.

**Differences in Child and Kinship Family Characteristics by Placement Outcome**

Table 2 presents differences in characteristics by two groups. The first group is the placement stability group (children who stayed with the same kin caregivers at the one-year follow-up) and the second is the placement disruption group (children who entered non-relative foster care between the first survey and the one-year follow-up survey).

**Table 2. Differences in Child and Kinship Family Characteristics by Placement Outcome (n = 321)**

<table>
<thead>
<tr>
<th></th>
<th>Staying with Kin</th>
<th>Non-Relative Foster Care</th>
<th>X²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td><strong>Child Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>148 (91.36%)</td>
<td>14 (8.64%)</td>
<td>.642</td>
</tr>
<tr>
<td>Female</td>
<td>141 (88.68%)</td>
<td>18 (11.32%)</td>
<td></td>
</tr>
<tr>
<td><strong>Household Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under $20,000</td>
<td>84 (84.85%)</td>
<td>15 (15.15%)</td>
<td>5.492†</td>
</tr>
<tr>
<td>$20,000-$49,999</td>
<td>98 (91.59%)</td>
<td>9 (8.41%)</td>
<td></td>
</tr>
<tr>
<td>Over $50,000</td>
<td>99 (94.29%)</td>
<td>6 (5.71%)</td>
<td></td>
</tr>
<tr>
<td><strong>Prior CPS Involvement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>178 (87.25%)</td>
<td>26 (12.75%)</td>
<td>4.807*</td>
</tr>
<tr>
<td>No</td>
<td>111 (94.87%)</td>
<td>6 (5.13%)</td>
<td></td>
</tr>
<tr>
<td><strong>Prior Foster Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>71 (87.65%)</td>
<td>10 (12.35%)</td>
<td>.682</td>
</tr>
<tr>
<td>No</td>
<td>218 (90.83%)</td>
<td>22 (9.17%)</td>
<td></td>
</tr>
<tr>
<td><strong>Infant at Move-in</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 1 or under</td>
<td>211 (91.34%)</td>
<td>20 (8.66%)</td>
<td>.641</td>
</tr>
<tr>
<td>Over Age 1</td>
<td>78 (89.66%)</td>
<td>9 (13.34%)</td>
<td></td>
</tr>
<tr>
<td><strong>Mean (SD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Age</td>
<td>7.82 (.27)</td>
<td>7.82 (4.78)</td>
<td>7.82 (1.02)</td>
</tr>
<tr>
<td>Caregiver Age</td>
<td>52.18 (.62)</td>
<td>52.38 (.60)</td>
<td>50.38 (3.10)</td>
</tr>
<tr>
<td>Months Stayed with Kin</td>
<td>41.28 (2.75)</td>
<td>43.53 (2.92)</td>
<td>21.06 (7.04)</td>
</tr>
<tr>
<td>Caregiver Perceived Well-being</td>
<td>7.08 (.10)</td>
<td>7.07 (.10)</td>
<td>7.19 (.33)</td>
</tr>
</tbody>
</table>

† p < .10, * p < .05
Children with any prior CPS report(s) before moving in with their current kinship caregiver were more likely to experience placement disruption than children without prior reports. Interestingly, there was no significant difference in children's prior foster care experiences between the placement stability group and the placement disruption group.

While household income was only marginally statistically significant by group, researchers observed a pattern of increased instability related to low household incomes. About 15% of children living in households below the federal poverty guideline entered non-relative foster care over the one-year period, but only about 6% of those living in, at, or above median household incomes did so.

The time spent in the current kinship care setting at the time of the first survey was another significant group difference. On average, children who experienced placement disruptions over the one-year period had much shorter durations with their kin than children who had continually stayed with their kin. In other words, the longer children had been with the current kin caregiver at the time of the first survey, the less likely they were to experience placement disruption over the one-year period.

**Predicting Entry into Non-Relative Foster Care**

The GEE models examined the relationships between the explanatory variables and entry into non-relative foster care over the one-year period. As discussed earlier, the sample included only children that had both child welfare administrative records and survey interviews, so cases resulting in reunification with biological parents or moving in with different relatives were not included. Thus, the final model, as presented in Table 3, included 300 children who either stayed with the same kinship caregiver or had entered non-relative foster care at the one-year follow-up.

A child's age significantly predicted placement disruption. Consistent with other research, older children were more likely to enter foster care after a stay in the informal kinship care setting. Intriguingly, being an infant at the time of placement with kin increased the risk for placement disruption. Infants were five times more likely to enter foster care than
children over one year old. Researchers calculated the predicted probability of children entering foster care by whether the child was an infant or not at the move-in. As indicated in Figure 1, almost 16% of infants entered non-relative foster care after a stay with kin.

In addition, the amount of time spent with the kin caregiver at the time of the first survey was positively associated with stability. The children who spent a longer period of time with the caregiver at the time of the first survey had a lower probability of entering foster care at the one-year follow-up than the children who did not.

Caregiver age was negatively associated with placement disruption. Children with older kinship caregivers were less likely to enter foster care at the one-year follow-up than those with younger kinship caregivers. Our sample of caregivers included a range of ages from 20 to 80. This statistically significant relationship suggests that older age is a positive factor for placement stability.
Discussion

The current study brings much needed attention to the child welfare experience and placement stability of children in informal kinship care. The vast majority of children in out-of-home care settings are not in the formal foster care system but reside with grandparents or with other kin by arrangements made either voluntarily through child welfare services or privately with birth families. This population is hard to identify and track, as many of them slip through the official records or are lost between systems. Not surprisingly, over the years, they have eluded child welfare researchers.

Economic Hardship of Kinship Families

Consistent with other studies on this population, many of the children and caregivers studied faced economic hardships. Almost two-thirds of children were placed with kinship caregivers whose family incomes were below the U.S. median income. While the current study did not use a population-based sample, its findings on household
income are similar to those of a national survey of children with non-
parental caregivers (Radel et al., 2016). The survey, based on a rep-
resentative sample, found that only one-third of children living with
a caregiver who was not their parent were living in households with
incomes greater than 200% of the federal poverty level (Radel et al.,
2016). While household income was not statistically significant in
predicting placement disruption in a multivariate model, bi-variate
results suggest further analysis of the association with income is war-
ranted. As indicated in Figure 1, children living in households at or
below the poverty threshold faced an increased risk of placement dis-
ruption. Not surprisingly, the poverty group (under $20,000) had the
highest risk. Taking into consideration other factors, children in the
lower income group (between $20,000 and $50,000) had a compar-
able risk of entering foster care to the income group that was above the
median ($50,000).

**Prior Involvement in the Child Welfare System**

One aim of this study was to examine the extent of children’s prior
involvement in the child welfare system given the opportunity allowed
by the inclusion of state child welfare administrative records. The
study’s findings not only provide further evidence for the maltreat-
ment history of children in informal kinship care (Gleeson et al., 2009;
Walsh, 2013), but also suggest that a significant number of children
exited from formal foster care to informal kinship care. While we do
not know what precipitated this transition, our data indicate that none
of the caregivers in the study became a licensed foster caregiver, which
would allow them to receive a foster care subsidy.

**Risk Factors for Placement Disruption**

While the scope of this study is limited to informal kinship care, its findings
may provide some insights on children’s risk for entering formal foster care
following a kinship placement. Consistent with the literature (Webster
et al., 2000; Oosterman et al., 2007; Rosenthal & Villegas, 2011), older youth have a higher chance of placement disruption. Infants at the time of move-in also have an increased risk of placement disruptions. The researchers speculate that these seemingly paradoxical findings may be related to the circumstances surrounding initial placement decisions, and thus may explain why children stay in informal kinship care or enter formal foster care.

The study recruited both kinship caregivers who had cared for children for a period of time as well as those who only recently assumed the custody of children, especially infants. Caring for an infant presents many challenges for a kinship caregiver, particularly those without assistance and support from the child welfare system. Prior research indicates a positive relationship between caregiver’s readiness and capacity to parent (Denby et al, 2015). Given additional challenges of caring for infants, the researchers speculate that caregivers may reassess their readiness to parent during the early period of placement.

It seems that after the period of adjustment, placement stability followed. Research findings support this observation. Many children in the study stayed with their kin for a long period of time, and a shorter stay was associated with increased entry to foster care. The study findings suggest that kinship caregivers commit to provide out-of-home care to children in the long term.

This study included caregivers who were grandparents, but also other relatives and kin who tended to be younger than grandparents. The range of caregiver age in the sample provided an opportunity to detect its effects on placement stability. A previous study by the authors (Lee, Choi, & Clarkson-Hendrix, 2016) found that family needs were negatively related to the caregiver’s age. Older caregivers reported fewer family needs, which included employment, housing, and leisure time. Additionally, a study of older sibling caregivers raising their brothers and sisters found that these younger caregivers had a high level of service needs (Denby & Ayala, 2013).
Limitations

The current study has several limitations. First, participants were recruited from community and social service agencies in five counties and thus findings should not be generalized. It should also be noted that the counties administer their own child welfare systems under state supervision. Second, the sample might be skewed toward those who were more economically disadvantaged and more likely to be involved in child welfare services. Third, the measure of caregiver well-being used in the study is limited. Using two questions for the measure was not ideal. Finally, the survey data contained inherent recall bias. For example, kinship caregivers were asked for the exact month and year of the move-in. While a majority of the caregivers provided the date, a few reported the timing using words such as “since birth” or “two years ago.” This fact was substantiated with all other supporting documents (e.g., child’s birth date and interview date) and recoded accordingly, though not all information could be verified.

Practice and Policy Implications

Despite these limitations, the study’s findings have a number of practice and policy implications. First, child welfare practices relying on voluntary kinship placements should include supports and assistance that are consistent with the level of support for children in formal foster care. This is important given that the high needs of informal kin caregivers are associated with elevated parenting stress (Lee, Choi, & Clarkson-Henderson, 2016; Yankura, 2013). Caregiver depression has been associated unfavorably with outcomes for children (Garcia et al., 2015; Anderson & Fallesen, 2015).

Currently, out-of-home care options are divided into public foster care, public kinship care, and informal kinship care (both voluntary and private). As documented in this study, maltreated children move in and out of the public child welfare system but become invisible to the public system when they enter informal kinship care. Child
welfare workers need to inform caregivers of the option to become licensed kin foster caregivers instead of asking them to take children “voluntarily.” They also need to judiciously work with kin caregivers to utilize resources such as KinGap for those children who were in licensed kinship care and TANF Child Only (NPC) grants for others. Existing policies are just good intentions if they are not equitably implemented. Ensuring the safety and stability of children requires providing adequate support and assistance to informal kin caregivers so that family bonds can be strengthened while promoting stability.

Scholars need to reexamine the current status of research on informal kinship care and build more complex research agendas to advance our knowledge on how best to support positive kinship placements. This may include collecting more extensive data, ideally population-based, that examines the paths of children into both voluntary and private kinship care. In addition, collective understanding must move beyond artificial divisions, such as private versus voluntary kinship care, in order to more firmly place informal kinship care within the continuum of the child well-being framework.

Given the placement stability associated with informal kinship care, this type of care should be viewed as a permanency option that should be supported with financial assistance and not just as a cost-saving measure for the child welfare system. Informal kinship placement of children with an extensive child welfare history merits further examination as a child welfare service and deserves recognition, financial assistance, and support services.

References


Private and voluntary kinship caregivers face challenges raising their kin children. Through focus groups and interviews with Kinship Navigators (KNs) and caregivers, this case study examined: the (1) evaluation activities shaping the definition of the Kinship Navigator Program (KNP); (2) essential components of the program; and (3) perceptions of KNs and caregivers regarding facilitators, barriers and efficacy of the program. Essential components included program advertising, needs assessment, resource and referral, support groups, in-home services and advisory council. KNs and caregivers were in substantial agreement regarding facilitators and barriers, perceived the KNP as useful for caregivers and their kin children, and strongly supported the continuation of the program.

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Westat

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Private and voluntary kinship caregivers face challenges in raising their kin children. These challenges may be even greater than those experienced by public kinship caregivers. Research has identified common problems faced by both private and voluntary kinship caregivers who are caring for children who are not in public kinship care. These include: insufficient knowledge of and access to needed services and resources, inadequate social supports, financial strain, and poor health (Cuddeback, 2004). Grandparents who are informally caring for grandchildren may face even greater challenges; these caregivers tend to be older, have less access to resources and supports, and have lower incomes than non-kinship foster parents (Hayslip & Kaminski, 2005; Minkler, & Fuller-Thomson, 2005, Sakai, Lin, & Flores, 2011).

Although many states offer poor and low-income, private, and voluntary kinship families child-only grants through the Temporary Assistance to Needy Families (TANF) program, the grant payment amount is much less than the typical foster care maintenance payment (Annie E. Casey Foundation, 2012). In addition to limited financial assistance, private and voluntary kinship caregivers often lack access to information and services available in the community (Bullock, 2004; Hayslip & Kaminski, 2005; Letiecq, Bailey & Porterfield, 2008; Strozier & Krisman, 2007). Services available to public kinship caregivers have also been criticized for failing to help kin caregivers sufficiently access needed information, resources, and supports; yet the services available to public kinship caregivers far surpass those available to private and voluntary kinship caregivers (Letiecq et al., 2008). Despite the lower levels of services and financial assistance available to private and voluntary kinship caregivers, these caregivers report a desire to support their kin child without the child’s being taken into public custody (Annie E. Casey Foundation, 2012; Gleeson et al., 2009). Still, the tremendous need for services and other supports among private and voluntary kinship caregivers, especially low-income grandparent caregivers, may place these families at special risk for placement disruption and potentially child maltreatment.
Literature about programs to support private and voluntary kinship caregivers is just beginning to emerge. Wallace and Lee (2013) describe collaboration between legal services, kinship navigator services, and public social services to support private and voluntary kinship caregivers. Studies of other programs found that caregivers reported improved access to legal services, better mental health for their children, progress toward legal custody, better relationships with birth parents, feeling supported, and valuing the program (Beltran, 2011; Denby, 2011; Lin, 2014; Nelson-Dusek & Gerrard, 2012; TriWest Group, 2005; Wichinskya, Thomasa, DeJohna, & Turneya, 2013).

The Family Connections Discretionary Grant Program

The Fostering Connections to Success and Increasing Adoption Act (FCA) represented a major effort to address the unique challenges experienced by private and voluntary kinship caregivers and thereby support the safety, permanence, and well-being of children and youth in their care and prevent their removal into foster care (Fostering Connections to Success and Increasing Adoption Act [FCA], 2008). As part of the FCA, the Family Connections Discretionary Grant Program (FCDGP) was created to target kinship caregivers regardless of their status as informal or formal caregivers. Specifically, grants were awarded to public and private entities through a competitive application process in order to “assist kinship caregivers in learning about, finding and using programs and services to meet the needs of the children they are raising and their own needs, and to promote effective partnerships among public and private agencies to ensure kinship caregiver families are served” (Catalog of Federal Domestic Assistance, 2013). After two rounds of Family Connections funding in 2009 and 2012, 20 states have established Kinship Navigator Programs for private and voluntary caregivers, including the Mid-Atlantic state referred to in this article.
The Kinship Navigator Program in a Mid-Atlantic State

With support from the discretionary grant component of the FCA, this Mid-Atlantic state’s Kinship Navigator Program (KNP) demonstration project targeted private and voluntary kinship caregivers, including grandparents, siblings, other relatives, and fictive kin. This target population was chosen because of their need and the limited number of benefits available to them. These benefits included: TANF child-only benefits, known as Temporary Cash Assistance (TCA) in this state, in the amount of $288 a month for one child, $503 a month for two children, and an additional approximately $120 a month per additional child; and medical assistance for the child and caregiver. If the kinship caregiver qualified for supplemental nutrition benefits the child-only TCA income could affect the amount received for food.

The demonstration project was designed to provide information and support to private and voluntary kinship caregivers to help the caregivers maintain their kin children safely in their home while at the same time facilitating legal permanence. At the centerpiece of the program was the staff position of Kinship Navigator (KN) in each jurisdiction. There were seven county departments of social services (DSS) who created the KN position: five KNs were DSS employees and two were employed by private social services agencies under contract to DSS. The KN position was free-standing—i.e., not part of another service unit—and was formulated to provide information and referral, linkage to services, and support groups for target families. Kinship caregivers could call a dedicated KN call line to request help. The KN assessed the level of need with a screening tool in some cases, or through conversation, and either met the need over the phone, or referred the kinship caregiver to an in-home services worker if unable to meet the need over the phone. Phone assistance included referral to legal or medical resources in the community. In a limited number of cases the KN provided in-person services, such as a home visit or accompanying the kinship caregiver to court to file for legal custody. The KNs created and disseminated information packets and maintained a statewide resource and referral...
database. The KNs advocated for the kinship caregivers by meeting with school and TANF personnel to educate them on the special needs of this population. They also organized and ran advisory boards whose mission was advocacy for this population. These KNs (service providers) and the kinship caregivers who received services from them (service recipients) participated in the evaluation of key service components, facilitators and barriers. The grant also supported the evaluation of the KNP.

The current study seeks to answer the following questions: (1) How did the evaluation activities contribute to the formalization of the KNP model?; (2) What were the essential components of the KNP model?; (3) What were the perceptions of service providers and recipients regarding the facilitators and barriers to program implementation?; and (4) What was the perceived impact of the KNP on kinship caregivers and their children?

**Methods**

**Procedures**

The study used a two-pronged, multi-source evaluation approach, gathering data at both the recipient and provider levels. Specifically, semi-structured interviews and focus groups were conducted with KNP staff, and focus groups were held with kinship caregivers participating in the Kinship Navigator program. All evaluation activities were grounded in an implementation science perspective, based on the theory that implementation is driven by specific factors that can either facilitate or inhibit successful formalization of a program (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). All procedures were approved by the Institutional Review Board at the Mid-Atlantic state’s main university.

**Kinship Navigator Program Staff Interviews**

To explore the perceptions of KNs regarding the essential components, and the usefulness of the program for private and voluntary kinship
caregivers, two rounds of semi-structured interviews and focus groups were conducted with the seven KNs. In the first round two KNs were interviewed and five participated in a focus group, and in the second round three KNs were interviewed and four participated in a focus group.

Six of the seven KNs responded to a survey distributed through Qualtrics Research Suite, a web-based survey platform. Of these, three were permanent staff and three were contractual staff. Two were full-time KNs and four were part-time KNs. Five had worked as a KN for one year and one had worked for two years. Three of the respondents were African American and three were White. Four were between 31-40 years of age, five were female, and four had an MSW.

The focus group/interview guide included 18 questions which examined six broad areas: (1) caseload and the referral process; (2) assessment of need of the caregivers; (3) service provision; (4) training and supervision; (5) perceptions of the essential components of the program; and (6) perceptions of the usefulness and impact of the program. The same focus group/interview guide was used during both rounds of focus groups, and interviews which were conducted midway through and at the end of the project.

**Kinship Caregiver Focus Groups**

To explore the caregivers’ perceptions of KNP services and its usefulness for them and their kin children, two separate focus groups were conducted with 22 caregivers who were new recipients of KNP services within the preceding two years. The first focus group \( n = 10 \) was held in a predominately rural county, and the second focus group \( n = 12 \) was held in a predominately suburban county. Private and voluntary kinship caregivers were recruited by the KN and/or through mailed letters from the research staff. Immediately prior to the focus group, research staff explained the purpose and procedures for the study and obtained informed consent from caregivers who expressed continued interest in participating in the focus group.
The majority of the 22 participants were female \((n = 19)\) and most ranged in age from 51 to 70 years old \((n = 17)\). The participants were predominately white \((n = 16)\), followed by African American \((n = 6)\). Nearly all caregivers were grandparents \((n = 16)\). Eighteen had legal guardianship or custody of their kin children as a result of judicial proceedings initiated by the caregiver not child protective services. Four kinship caregivers were acting in loco parentis without any formal legal status. Seventeen lived with one or two kin children in the last 12 months. About one-half of the kinship caregivers \((n = 10)\) had incomes of $34,999 or less.

The focus group guide for the kinship caregiver groups included 16 questions that examined three broad areas: (1) characteristics of the services received and relationship with the KN; (2) perceived aspects of the programs that were helpful or not helpful; and (3) perceived impact of the KNP support group and other services for the caregiver and their kin children. Caregivers received an incentive ($10) for their participation in the focus group. All focus groups were recorded and transcribed.

**Data Analysis**

Qualitative analyses of the semi-structured interview and focus group data were conducted using the NVivo 10 software (QSR International Pty Ltd., 2012). To develop the coding scheme for each, we created a set of codes to capture the content of each of the questions of the interview and focus group guides. Additional codes emerged during the initial process of open coding involving two coders for both the semi-structured interviews and focus groups. For each, the coding scheme was modified accordingly and the final coding scheme was used to code the study transcripts. The two coders coded each transcript, met to compare every instance of coded text, and worked to achieve consensus on all instances of coding discrepancies by discussing the merits of the codes selected.
Results

Data analysis of the KN focus groups and interviews yielded themes related to the program model/structure, essential program components, facilitators and barriers to the implementation of the program, and perceived impact on families served. Analysis of the data from caregiver focus groups yielded themes regarding facilitators and barriers and perceived impact on their kin families. The themes are organized below, by topic, to offer both KN and caregiver voices on the topic where available.

**Contribution of Evaluation Activities to the Formalization of the Program Model**

Initially, the Mid-Atlantic state had a loosely defined model of the KNP without clear guidelines of how it should be implemented at each site. As mentioned above, the model included information and referral, linkage to services, support groups and a statewide resource and referral database. The evaluation allowed a look at how the model was implemented in practice. This included details of the KN position and how it fit with the local employment structure, what kind of training was provided, what supervision and support was available to the KNs, and how the needs of the families were assessed. The evaluation team used a formative evaluation approach whereby our interview and focus group guides were structured to include questions about implementation drivers in order to develop a model of what the KNs were actually doing, what was working, and what was perceived as most helpful from the perspective of both the KN and kinship caregivers. Implementation drivers are factors that either support or impede the implementation of an innovation and include competency, organization, and leadership supports. These factors work together and a deficit in one area can be compensated for in another area (Fixsen et al., 2005). The two rounds of interviews and focus groups allowed us to look at changes and development of the model over time. Through
Table 1. Kinship Navigator Program Model Description

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Population</td>
<td>Relatives or fictive kin caring for related children either privately or voluntarily but with no CPS involvement. Many were low income, were isolated and needed help navigating the system in order to access needed resources.</td>
</tr>
<tr>
<td>Selection/ Training</td>
<td>Four KN were permanent staff and three were contractual staff; two were full time and four were part-time staff. All were trained in the Family Connections Model and received technical assistance from a senior consultant. Most received monthly supervision and some attended regional conferences and educated themselves about KN programs in other places.</td>
</tr>
<tr>
<td>Initiation and Advertising</td>
<td>Advertising was done through flyers, meetings with internal and external staff, and advertisements in local press. Constant reminders to referral sources were needed. Referrals came from Family Involvement Meetings, Temporary Assistance to Needy Families and CPS channels, Department on Aging, Board of Education, and churches.</td>
</tr>
<tr>
<td>Needs Assessment</td>
<td>This was usually done over the phone, using a checklist developed for the program as well as through informal discussion. Most KN were able to tailor services to the level of need, including offering in-home services where needed.</td>
</tr>
<tr>
<td>Service Organization</td>
<td>Five out of seven counties provided all KN services in house including the KN themselves; two of the agencies had contracted the KN service out to a private agency, but provided the in-home services in-house.</td>
</tr>
<tr>
<td>Resource and Referral Services</td>
<td>This was the cornerstone of the program and a dedicated phone line was established to provide this service, which was considered essential to the success of the model. Cases were kept open and no limit was placed on how many times a person could call.</td>
</tr>
<tr>
<td>Support Groups</td>
<td>Facilitated by KN, and considered a central aspect of the KNP. Children were included in activities, or participated in concurrently run child only programs. Guest speakers on topics of interest to private and voluntary kinship caregivers, such as experts in legal, medical and educational fields were invited and opportunities for mutual support were included.</td>
</tr>
<tr>
<td>In-home services</td>
<td>Provided by in home service workers other than the KN. This was done on a limited basis. KN referred cases as needed, but a vital option for placement stability.</td>
</tr>
<tr>
<td>Advisory Council</td>
<td>These were convened by the KN. They consisted of community partners and caregivers and were responsible for developing a resource guide and flyers, advertising the program through events and work of mouth and advocating for the needs of informal caregivers, including working on sustainability plans for the KN service.</td>
</tr>
</tbody>
</table>
semi-annual reports and monthly feedback to program administrative staff, the authors provided information that was used by the KNs to strengthen their practice and learn from each other about what was working, such as sharing resource guides and materials to assist caregivers in providing care for their children (e.g., a form to enroll their children in school). The program model is a coherent articulation of those components and reflects refinements informed by the pilot implementation.

**Essential Components of the KNP Model**

These themes emerged from analysis of both the two rounds of KN focus groups/interviews and the kinship caregiver focus groups. Table 1 presents the nine essential components of the KNP, which includes: (1) the target population; (2) selection/training of the KN; (3) program initiation and advertising; (4) needs assessment done by the KN; (5) how the KN service was organized; (6) resource and referral services provided by the KN; (7) kinship caregiver support groups run by the KN; (8) in-home services provided to the kinship caregivers; and (9) advisory councils established by the KN.

Figure 1 depicts the three main components of the KNP model, consisting of (1) the KNP service delivery to the target population; (2) the service coordination provided by the KNs; and (3) the KN professional development activities, including the support they receive in providing KN services and capacity to form relationships with kinship caregivers. Together, these components were hypothesized to lead to better quality of and access to services for the private and voluntary kinship caregivers.

Advertising the program regularly and consistently was considered an essential component of the program; KNs noted a need for ongoing advertising through flyers and other notices distributed widely in the community, as well as regular meetings with service providers (both within the agency and with external partners) to educate them.
about the program. KNs also reported that Advisory Councils set up by the KNs, comprised of community partners and kinship caregivers, were very valuable. These councils assisted with developing a resource guide, advertising the program, and developing ideas to advocate for the needs of private and voluntary caregivers. The KNs ran support groups, which they noted were central to the program and provided an opportunity for caregivers and their related children to form relationships with others in the same situation. Information and referral services were a cornerstone of the program and having a dedicated phone line for this service was seen as essential. The option of referring families for more intensive in home services was also considered essential to maintaining placement stability.
Perceptions of Kinship Navigators and Kinship Caregivers Regarding Efficacy of the KN Program

Perceptions of the Kinship Navigators

Data analysis of the KN focus groups and interviews yielded the following themes related to the perceptions of KN of the efficacy of the KNP: (1) facilitators and barriers to the implementation of the program, including the appropriateness of the target population, the KN being outside the usual child welfare structure, the lack of tangible resources, and child welfare system constraints; and, (2) perceived impact on families served.

Facilitators and Barriers

Appropriateness of the target population. According to the KN’s reports, the defined target population of caregivers caring for their relative (or fictive kin) child without the involvement of Child Protective Services (CPS) was the appropriate target population recipient of the program. All the KNs reported serving caregivers with a range of relationships to their relative children, with grandparents being the most common service recipient. The KNs reported that many of these caregivers had high financial needs, lack of transportation, and an initial distrust of the public child welfare agency. They all agreed that the characteristics of the caregivers contributed to them being in need of support and help to cope with loneliness and anger, as well as assistance with navigating “the system” to obtain needed resources. They were also often not eligible for other services. For these reasons the KNs overwhelmingly agreed this was the appropriate population to target for their services.

The KN outside the usual child welfare structure. A perceived strength of the program was that the KN was a point person with their own dedicated phone line who could be accessed directly and would respond to kinship caregivers directly, without having to go through
the usual child welfare referral process. According to some KNs, this helped build trust with the community and presented a more positive face of DSS than is usually perceived both by people who have and have not had direct contact with DSS:

I think it definitely brings a new perspective for families that have been [previously] involved with child welfare to know that we’re definitely—the department is looking at ways to support families, not just to break them up.

This was a voluntary program, unlike many of the usual child welfare programs, and some KNs reported this contributed to the uptake acceptance of the program. One KN reported: “I’m not the bad guy when I come in. I’m the one that’s trying to resolve this and give you some options.”

Some of the KNs were able to hold their meetings and support groups in the community—such as at a library—and could include children in the meetings. They reported this built collaborative relationships with community partners, which strengthened the program. Most of the KNs reported that partnerships with community service providers, such as the courts and legal aid clinics, proved useful for the caregivers, and made it easier for them to access these services.

**Lack of tangible resources.** The biggest barrier for the KNs was their experience of not being able to offer more financial assistance to the caregivers. They all believed that foster care subsidy policies embodied an inherent injustice, and that denying a similar type of subsidy to private and voluntary caregivers caused them to suffer financially. One KN described it this way: “(I)f we’re asking family members to take on responsibility of these children, something should be done in that area of the cash assistance, financially. There needs to be better assistance.”

Some of the KNs thought some of the in-home caseworkers were unwilling to take the time to fully explain to private and voluntary caregivers all the financial ramifications of taking on the care of their relative child in the cases where voluntary placement with diversion
from state custody was sought. Most of the KNs expressed concern that this lack of knowledge and ensuing financial burden could negatively impact the stability of these placements, despite their best efforts to provide support to these families.

**Child welfare system constraints.** Most of the KNs identified several constraints in providing services through the child welfare service system. Some KNs also reported that many caregivers erroneously assumed that all DSS services were linked and that they could do “one-stop shopping” for all the services for which they were qualified. Some KNs expressed some limitations on the extent to which they could refer families for in-home services.

KNs who were contracted out to a private agency thought that this structure for KNP service provision was a less intimidating setting for the caregivers, but felt hampered in not having access to DSS files and information in order to verify that there was no current CPS involvement.

**Perceived Impact on Families**

All the KNs perceived that the KNP had a positive impact on the children and families served by allowing the caregiver to feel more empowered to establish custody and thus ensure the stability of the placement. Most of the KNs reported that having the option of non-CPS in-home services was beneficial to the caregivers. One KN reported: “So those (in-home) services were being offered to some of them, the more needy ones or the ones that said, ‘Hey, I can’t do this without you guys staying involved.’” All of the KNs believed that the caregivers benefited from having the opportunity to talk to someone who could help them feel supported and cared for, and make sure they knew what resources were available to them. As one KN put it, “Sometimes they just need that help to get over that little edge and then they’re fine again. And they’re like, ‘Okay, I’m good. Back up now. We’ve got this until the next crack in the road.’”
**Perspectives of Private and Voluntary Kinship Caregivers**

Data analysis of the kinship caregiver focus groups yielded themes related to: (1) facilitators and barriers to the implementation of the program including the responsiveness and helpfulness of the KN, and unmet financial needs; and (2) kinship caregivers’ perceptions of the KNP services and the impact of the services on caregivers and their children.

**Facilitators and Barriers**

**Responsiveness and helpfulness of the Kinship Navigators.** Overwhelmingly, the caregivers described their KN as responsive and respectful. Interactions with the KN were viewed as positive and helped to fuel the caregiver’s motivation to access information, resources, and referrals. One caregiver explained, “[the Kinship Navigator] is helpful with information and [is] never condescending in anyway. She’s always happy to see you. Remembers your kids’ names.” Caregivers also reported that the KN provided them with helpful information and services that extended beyond the support group. One caregiver described the usefulness of the resource book developed by the KN: “You share a lot of community resource information too. The book that she made up really gives you a lot of information for other help, outside of department of social services.”

**Unmet financial needs.** Private and voluntary kinship caregivers discussed their need for additional financial assistance as a major challenge raising their kin children. Many participants indicated that despite experiencing financial strain, they were ineligible for existing forms of financial support for private and voluntary kinship caregivers. One caregiver said, “And I’m not eligible for anything else because of my income. I can’t touch nothing because of my income.” When asked what services they needed that were not provided by the KNP, caregivers expressed that the program should do more to help them obtain needed financial resources to provide food and other necessities for the children.
Positive Impact of the KNP Support Group

The helpfulness of the KNP for caregivers and their kin children was described at length by the majority of participants. Participants indicated that a particularly helpful aspect of the KNP support group was the information provided by the KN, invited speakers, and other caregivers. Caregivers reported that the support group has helped them by featuring guest speakers to address specific topics. Lawyer guest speakers were mentioned as providing valuable information to the caregivers who often desired information and advice on establishing legal custody or guardianship. One caregiver said, “[T]hat’s a big, a big thing for us, when we have to get legal for these children. And they had a lawyer come in and he spoke about the family law…”

Caregivers described the support group as an important way to meet and form relationships with other private and voluntary kinship caregivers. Caregivers provided supportive listening and advice to one another as well as shared needed resources to better care for their kin children. The support group as a forum for mutual support, both emotional and instrumental (i.e., sharing of goods) is illustrated by this quote: “Somebody needed a toddler bed, I had a toddler bed—here, you can use it.”

Most caregivers who participated in the support group took advantage of the free child-care during the support group. A number of caregivers indicated that the support group helped their children make friends and interact with other children living with kinship caregivers and facing similar problems (e.g., unhappiness due to being separated from their biological parents). One parent explained, “They’re loving it, they’ve made friends…”

The caregivers described a range of ways in which participation in the support group has changed their outlook on their situation. More specifically, caregivers discussed how talking with other caregivers who faced similar challenges as private and voluntary kinship caregivers enabled them to know that they were not alone in their situation. One caregiver stated, “I had no idea that there was such an epidemic of people out there like me. I have learned so much that everybody is in the same boat.”
Discussion

This study is one of the first to examine kinship navigator services for private and voluntary kinship caregivers from the perspective of both KNs and kinship caregivers. We identified the essential components of the KNP and examined facilitators and barriers of the KNP services and the perceived impacts on kin caregivers and their kin children.

Initially, the state had a loosely defined model of the KNP without formal guidelines of how this should be implemented at each site. KNs provided details regarding their strategies and implementation drivers, including how their position fit into the DSS or a private agency structure, how they initiated and implemented the program, and resources available to support the program. A combination of information from both service recipients (kinship caregivers) and providers (KNs) gave valuable insight and a more nuanced picture of what was both useful and essential for the model to succeed. The kinship caregivers and providers were in general agreement about what these essential components were, and these components provided a guide for how to formalize and organize the program so that it could be implemented in an existing child welfare system.

Our study findings indicate that KNs and kinship caregivers were in substantial agreement regarding the facilitators, barriers and impacts of the program. The KN felt that having the KN as a dedicated point person, outside of the usual child welfare structure, helped build trust with the community. This was echoed by the kinship caregivers, who reported high regard for the KNs. This is in contrast to the usual relationship between the child welfare service recipients and providers reported by the KNs.

Both providers and recipients agreed that the KN-run support groups were central to the model and were helpful to the caregivers and for the children. Support groups can be vehicles for providing information and resources, as well as non-instrumental help, such as...
mutual support and reduction in a sense of isolation. Both the KNs and the kinship caregivers from the two focus group sites perceived that the support groups provided these benefits. This was consistent with the results of a survey of kinship caregivers conducted across the seven study sites and reported on in another paper (Woodruff, Murray, & Rushovich, 2014).

An important barrier mentioned by the kinship caregivers and corroborated by the KNs was a lack of financial resources available to kinship caregivers. The kinship caregivers reported that this detracted from their ability to provide adequate care for their children, and the KNs worried that this could lead to placement instability for the children. Woodruff, Murray, and Rushovich (2014) reported the survey component of the broader evaluation of this KN program, had similar findings, where caregivers reported wanting more financial support in their role as caregivers. The TANF child welfare only grant was viewed as inadequate to cover the costs of caring for a child. One difference was that the KNs reported wanting to be able to provide more intensive services to the caregivers than their job description allowed, however most of the kinship caregivers in this study appeared satisfied with the level of contact they had with the KN.

Despite these drawbacks, the KNs and the kinship caregivers perceived that the KNP had a positive impact on the kinship caregivers and their kin children. The program reduced their sense of isolation and gave them access to needed resources and referrals that made it easier to care for their kin children, such as referrals to a lawyer specializing in custody issues, or a KN created from with information needed to enroll their child in school. These findings fit well with available research on kinship caregiver programs, which revealed improved social support and other positive benefits for caregivers (e.g., Kelly, Yorker, Whitely, & Sipe, 2001; Littlewood & Strozier, 2009; Strozier, McGrew, Krisman & Smith, 2005; Sharpe, DePanfilis, Streider, & Gregory, 2009).
Limitations

The findings must be considered in light of the formative nature of the evaluation. Kinship caregiver focus group participants represented a small fraction of the caregivers served by the KNP in the two counties where the focus groups were held. Thus, we cannot generalize study findings to represent all caregivers who were served in those counties and other counties. We did not reach kinship caregivers who had not made contact with the KN. These people may have had different perceptions of the program, but we did not have a way to find and contact them. We only interviewed KNs, so their responses cannot be considered representative of child welfare workers in general. It is possible that other workers both in the public and private child welfare field may have had a different perception of the KNP and how useful the program was for kinship caregivers. Findings should be interpreted with caution given the limited generalizability of the study findings.

Implications and Conclusion

Comprehensive models such as this Mid-Atlantic state’s KNP are crucial to address the needs of private and voluntary kin caregivers and their kin children. Insufficient knowledge of, and access to, needed services and resources are identified needs for private and voluntary kin caregivers (Cuddeback, 2004). Our results consistently highlighted the importance of the KN in facilitating the acquisition of needed services for kin caregivers. This was corroborated by both the KN providers and recipients. Both reported that through service delivery and program coordination, private and voluntary kin caregivers felt supported and no longer isolated. The findings from this study, with insights from both providers and recipients, give a rich, nuanced view of what a successful KN model can encompass. Funding for more rigorous summative evaluations of KNP model is critical, and if demonstrated to be effective, broad-scale roll-out of the models will be warranted to ensure continued success for these vulnerable families.
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