Kinship Care

Moira Szilagyi, MD, PhD

From the Department of Pediatrics, University of Rochester, Rochester, NY
The author declares that she has no conflict of interest.
Address correspondence to Moira Szilagyi, MD, PhD, Department of Pediatrics, University of Rochester, 601 Elmwood Ave, Box 777, Rochester, NY 14642 (e-mail: Moira_Szilagyi@urmc.rochester.edu).
Received for publication September 11, 2014; accepted September 12, 2014.

ACADEMIC PEDIATRICS 2014;14:543–544

ABOUT 4.2% (3.1 million) of children in the United States, according to census data,[1] reside with relatives or close family connections and with neither parent, an arrangement termed *kinship care* (KC). Health professionals frequently encounter children in KC and may better serve these children if they are aware of both the benefits and complexities of kinship arrangements.

There at least 3 types of KC: 1) private—the most common type, arranged by the family without child welfare involvement; 2) informal—which occurs after child welfare investigation, without certification of the kin as foster parents, and with or without child welfare custody of the child (about 400,000 children annually); and 3) formal (or foster) care—in which the child is in state or local child welfare custody with a certified relative as foster parent.[2,3] In this issue, Stein et al[4] look at a national sample of children placed in informal KC as a result of child protective investigation and compare them with children in formal KC and in nonrelative foster care (Table).

Data tell us approximately how many children live in KC but not the reasons for these arrangements or how many children have ongoing contact with or reunite with their parent or parents. We have virtually no information about children in private KC. Child maltreatment and a parent with mental health and/or substance abuse problems are the major reasons for KC placement by child welfare. Less commonly, children live in KC because parents are deceased, incarcerated or in long-term institutional placement, or they relinquish adolescents because of their behavior, mental health problems, or sexual orientation. A growing number of unaccompanied refugee minors are being placed with kinship caregivers in the United States. Thus, the KC population is diverse.

The population of children in KC increased significantly in the last decade.[2,3] The Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351) requires child welfare agencies to notify and explain all placement possibilities to all adult relatives within 30 days of a child's removal. This legislation was enacted in response to studies indicating relatives were often unaware children had been removed from their parents. It remains unclear whether relatives receive full disclosure of their options, which include becoming a licensed foster care provider for related children. There is wide variation among states regarding who is considered eligible to be kinship caregivers and how child welfare defines KC, licenses family members as foster parents or approves them as kinship providers, and supports and oversees KC. In general, the criteria for licensure of kinship homes (formal KC) are less stringent than for nonrelative foster care and child welfare oversight, and support of a kinship placement after CPS investigation varies widely in practice.[5] There is concern that the increased pressures to keep foster care numbers (and therefore costs) low is driving the diversion of children into informal KC. However, many agencies prefer KC, recognizing that families are often better positioned to be the primary decision makers on behalf of related children than child welfare. Ultimately, it is child welfare's duty to achieve some balance among child safety, family autonomy, and government responsibility, and the debate about level of oversight needed to ensure that children are safe continues.[5]

Stein et al corroborate earlier reports that kinship caregivers have tremendous needs. They have fewer financial and other resources available to them to help children, and they are older, less educated, in poorer health, and less likely to have health insurance. The authors suggest increasing subsidies and supports for kinship caregivers. Other advocates suggest licensing and oversight of all kinship caregivers.[5] However, there are concerns that foster care can be overly prescriptive in ways that might prevent an otherwise capable and caring relative from providing a home for a child.

The information from the national sample analyzed by Stein et al also confirms earlier findings from small population studies that children in formal and informal KC have poor overall health and a high prevalence of chronic health conditions.[4] They also found that children in informal KC had less access to educational resources. Other data indicate that these children have experienced multiple childhood adversities and carry with them a burden of childhood trauma and toxic stress that is similar to their peers in foster care.[5–7]

Overall, the advantages of KC are believed by many to outweigh the disadvantages. There is mounting evidence that maintaining children within their family of origin

Table. Terms Used for Foster and Kinship Care

Term	Meaning	Child in Custody of State	Reference
Foster care, nonrelative foster care	Nonrelative certified foster parent caring for a child in child welfare custody	Yes (n = 184,379)	2
Kinship foster care, formal kinship care	Certified foster parent who is related to and caring for child in child welfare custody	Yes (n = 108,841)	2
Informal kinship care	Caregiver who is not a certified foster parent caring for a related child removed by child welfare	Yes or no (n ~ 400,000)	3
Private kinship care	Caregiver caring for a related child without child welfare involvement	No (n > 2 million)	1

and their culture has advantages for a child as long as the child-rearing environment is physically and emotionally safe. Placements with kinship caregivers are more stable over time, and there is less disruption of sibling groups compared with placements in nonrelative foster care.[6] Other proposed advantages of kinship placement (formal or informal) over nonrelative foster care are the decreased stigma of living with relatives versus foster parents and the higher likelihood of maintaining a sense of belonging in their family of origin and existing relationships within their community and culture.[5] Kinship caregivers do report lower rates of mental health and behavioral problems than nonrelative foster parents,[4–7] and the authors suggest that this may be related to the emotional protection afforded by having a preexisting relationship with their kin caregiver and their greater placement stability compared with children in nonrelative foster care.

Advocates have also outlined some disadvantages of KC. There are concerns that the boundaries, roles, and responsibilities of kinship caregivers and parents are not clearly delineated. Some kinship caregivers report feeling pressured into caring for relative children to prevent foster care placement. Parent and kinship caregiver strengths and needs may not be adequately assessed and addressed. Limited oversight by child welfare may place children at risk. Lack of enforcement may infringe on a parent's right to visitation.[5]

KC may be accompanied by emotional conflict for all involved parties.[5,6] Kinship caregivers may experience anger, fear, guilt, and/or relief when the child is placed with them. Children may resent or blame the kinship caregiver for their removal from the parent, feel confused or betrayed by the parent or kinship caregiver, or maintain a fierce loyalty toward the parent. Parents may experience emotions including grief, anger, jealousy, guilt, relief, and/or gratitude. In one study, parents reported more positive feelings about foster parents than kinship caregivers.[7]

There is limited information about the outcomes for children in kinship versus foster care. Some data suggest that child behavioral health has more to do with prior and ongoing trauma experiences and the number of previous out-of-home placements than with placement type.[5] Outcomes may also be affected if there is preferential placement of children with more volatile histories into nonrelative foster care.

Permanence and a sense of belonging in a family are fundamental to helping children heal from family disruption and early childhood adversities.[5] For some advocates, permanency means that KC requires ongoing oversight, reunification services for parents, and a concrete plan for the child that includes either guardianship or adoption. However, many kinship caregivers who are willing to provide a home for related children may struggle with legalizing that relationship because of their preexisting and complex relationship with the child's parent. The unclear legal status of children in KC has implications for accessing health insurance and educational and health services for children.

Recommendations for improving KC include: 1) individualized assessment of child, family, and kinship caregiver needs and identification of needed services and supports for each; 2) creation of a permanency plan for children in KC that maintains ties to their parent when safe to do so; 3) in the absence of guardianship or adoption, granting the kinship caregiver some authority (custody?) to make key decisions for the child (regarding health care, school enrollment, Early Intervention or Head Start, referral; and 4) provision of needed support and financial resources to kinship caregivers, parents, and children.

Further research is needed to determine what affects placement decisions, the effect of assessments on placement choices, what factors are considered in assessing safety issues, and the outcomes for children in terms of safety, permanency, health, mental health, and education compared with children in foster care, formal KC, and remaining at home.

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