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Kinship Care Providers: Designing an Array of Supportive Services

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ABSTRACT: Kinship care, the placement of children with their relatives, has become an integral part of the child welfare system in the United States. It is also becoming a more established way of meeting the needs of children in care in other western countries (Greeff, 1999). However, kinship care did not emerge as a child welfare issue until the late 1980s, and only recently has it become a part of the formalized system for out-of-home care (Hegar & Scannapieco, 1995). Since that time, many states have come to rely more heavily on placements with relatives to meet the needs of children removed from parental custody. For example, California has placed approximately 51% of the foster care population in kinship care, while Illinois has placed 55% (GAO, 1999).

Discussion about the reasons for the increases in kinship care has been widespread (Brooks & Barth, 1998; Gleeson, 1999; Harvey, 1999; Hegar & Scannapieco, 2000). Regardless of the impetus behind the increased use of kinship care, states must now incorporate kinship foster care into the traditional foster care system in order to qualify them for federal funding (O'Laughlin, 1998). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 amended federal law to require that states give priority to relatives when deciding with whom to place children who are in the foster care system (GAO, 1999).

The apparent paradigm shift from traditional foster parents to kinship care parents (Hegar, 1999) requires that agencies use both different approaches to assessment (Scannapieco & Hegar, 1996) and provide different types of intervention and services. Adapting placement services to the needs of kinship care providers is the focus of this article.

KEY WORDS: Kinship Care Providers; Placement Services.

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Kinship care, the placement of children with their relatives, has become an integral part of the child welfare system in the United States. It is also becoming a more established way of meeting the needs of children in care in other western countries (Greeff, 1999). As might be expected, the definition of who is a relative varies across jurisdictions, from those who are related by blood, marriage, or adoption, to any persons with close family (Takas, 1993). There are also historical and cultural traditions of relatives caring for their kin, especially in the African American community (Scannapieco & Jackson, 1996). The cultural roots of kinship care have been traced to West Africa, Polynesia, Oceania, and other parts of the world (Hegar, 1999).

However, kinship care did not emerge as a child welfare issue until the late 1980s, and only recently has it become a part of the formalized system for out-of-home care (Hegar & Scannapieco, 1995). Since that time, many states have come to rely more heavily on placements with relatives to meet the needs of children removed from parental custody. From 1990 to 1998, the number of children in foster care rose 38%, while the kinship care population rose 37% (USDHHS, 2000). In 1996, approximately 29% of all foster care children in the United States were in kinship care (USDHHS, 2000). In some states the proportion is much larger. For example, California has placed approximately 51% of the foster care population in kinship care, while Illinois has placed 55% (US GAO, 1999).

Discussion about the reasons for the increases in kinship care has been widespread (Brooks & Barth, 1998; Gleeson, 1999; Harvey, 1999; Hegar & Scannapieco, 2000). Regardless of the impetus behind the increased use of kinship care, states must now incorporate kinship foster care into the traditional foster care system in order to qualify them for federal funding (O'Laughlin, 1998). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 amended federal law to require that states give priority to relatives when deciding with whom to place children in the foster care system (GAO, 1999).

Further, the Adoption and Safe Families Act of 1997, which requires states to initiate termination of parental rights when a child has been in foster care for 15 of the last 22 months or in cases of serious criminal abuse, allows an exception when the "child is placed with a relative (at the option of the state)" (Percora et al., 2000, p. 350). In some cases, assisted guardianship is available to help relatives provide permanency for children when termination of parental rights and adoption may not best serve the child's interests. Of the ten states with policy waivers to use federal child welfare monies in experimental

ways in 1998, five (California, Delaware, Illinois, North Carolina, and Maryland) have developed guardianship programs to assist in making kinship placements more permanent (Percora et al., 2000, pp. 18–19). The apparent paradigm shift from traditional foster parents to kinship care parents (Hegar, 1999) requires that agencies both use different approaches to assessment (Scannapieco & Hegar, 1996) and provide different types of intervention and services. Adapting placement services to the needs of kinship care providers is the focus of this article. The following section draws from research concerning kinship care to provide a profile of kinship caregivers.

Kinship Care Providers

In order to design an array of services for kinship care providers, it is important to understand who they are and how they differ from the traditional foster parents whom agencies are often more accustomed to serving. As might be expected, women have been found to be the most frequent kinship caregivers (Benedict, Zuravin, & Stallings, 1996; Berrick, Barth, & Needell, 1994; Brooks & Barth, 1998; Dubowitz, Feigelman, & Zuravin, 1993; Gebel, 1996; LeProhn, 1994; Scannapieco, Hegar, & McAlpine, 1997; Thornton, 1991). The relatives who most frequently provide kinship care are maternal grandmothers (over 50% of the time), followed by aunts (up to 33% of the time) (Dubowitz, et al., 1994; LeProhn, 1994; Scannapieco, et al., 1996; Thornton, 1991).

Relative caregivers tend to be older than nonrelative caregivers (Berrick, et al., 1994; Dubowitz, et al., 1994; Gebel, 1996; LeProhn, 1994). The majority of caregivers completed high school (Berrick, et al., 1994; Dubowitz, 1994; Gebel, 1996; Scannapieco, et al., 1996), although nonrelative caregivers completed higher levels of education (Berrick, et al., 1994; Gebel, 1996; LeProhn, 1994; Scannapieco, et al., 1996). Relative caregivers are more likely to be single parents than are nonrelative caregivers (Berrick, et al., 1994; Dubowitz, 1994; LeProhn, 1994; Scannapieco, et al., 1996), although Gebel (1996) found no significant difference on this variable.

Up to 48% of kinship caregivers are employed outside of the home (Berrick, et al., 1994; Dubowitz, 1994; Gebel, 1996; LeProhn, 1994), but nonrelative caregivers have higher levels of income (Berrick, et al., 1994; Brooks & Barth, 1998; Gebel, 1996; LeProhn, 1994). Many relative caregivers (53% to 59%) own their own homes (Berrick, et al.,

1994; LeProhn, 1994), but in comparison, nonrelative caregivers are even more likely to do so (Berrick, et al., 1994; LeProhn, 1994).

The percentage of caregivers assessing their own health as poor ranges from 6% (Dubowitz, 1994) to 20% (Berrick, et al., 1994). Traditional foster parents rate themselves as having significantly better health than do kinship caregivers (Berrick, et al., 1994). Kinship caregivers differ from nonrelative caregivers on self-perception of their role, as well as in their attitudes towards the children they care for in their homes (Gebel, 1996; LeProhn, 1994). LeProhn (1994) found that relative caregivers scored higher (meaning they felt more responsible) on 4 out of 5 subscales on role perception. The four roles in which relatives expressed stronger feelings of responsibility were: facilitating child's relationship with birth family; assisting with social/emotional development; parenting; and partnering with the agency. There was no significant difference between relative caregivers and nonrelative caregivers on the spirituality role perception subscale score. After multiple regression analysis, relative status alone predicted how the caregiver might view his or her role on only two of the subscales: facilitating child's relationship with birth family, and parenting.

Gebel (1996) concluded that there was no difference in the willingness of relative and nonrelative caregivers in continuing to care for the children in their homes. This study did find that relative caregivers are more likely to have a favorable attitude toward physical discipline and a lower level of empathy towards children's needs than nonrelative caregivers (Gebel, 1996).

In light of these empirical findings about the characteristics of kinship caregivers, their needs for services should be assessed based on the unique circumstances of the family.

Assessment of Support and Intervention Needs

Kinship care providers and their families should be empowered to identify their support and intervention needs along with the social worker. One of the most promising models that allows families to truly collaborate with the child welfare agency is the family decision-making model. Family decision-making meetings are probably one of the most quickly proliferating practice concepts in the field of child welfare. There are two primary models of family group decision-making currently in use worldwide in child welfare. First, the New Zealand model, the family group conference (see Ernst, 1999), was

developed and implemented legislatively in New Zealand in 1989 and has since been adapted for use in communities in the United States and Canada. The second family decision-making model is the family unity model, which has been selectively used in Oregon since 1990 (American Human Association [AHA], 1996).

It is within the family decision-making meeting that assessment of the kinship care provider's needs should be reviewed.

The key elements to both models, as applied in the United States, are:

- Family meetings are called if a child welfare agency performs an initial assessment and determines a child is in need of care and protection.
- Families who currently or could potentially play a role in the child's life attend the meeting. This may include the child's parent(s), extended family members, close friends, godparents, and others whom the family defines as family.
- The child welfare worker, teachers, psychologists, and other professionals who are working with the family also typically attend the meeting. In the New Zealand model, they do not participate in the family's decision-making process, whereas they can in the Oregon model.
- Parents can limit participation by other family members.
- The meeting setting is amicable and provides an opportunity for all members to feel comfortable to express their thoughts and feelings.
- The New Zealand model adaptation varies from place to place, but its underlying major principle is family decision-making and centers on what is in the best interests of the child. In both models, the family brainstorms options for the care and protection of the child.
- Children are given an opportunity to give input about where and with whom they want to be.
- Child welfare workers mediate the decision-making process by helping the family develop a plan for the child (AHA, 1996; Wilcox, et al., 1991; Berrick, Needell, & Barth, 1995).

Family meetings, whatever the configuration, have been found to reduce out-of-home placement and increase placement of children in their same ethnic, racial, and/or religious group (AHA, 1996). This practice concept is culturally sensitive and is proving to be quite effec-

tive in addressing the kinship care provider, child and family well being.

Differential Assessments

Within the context of the family decision-making meeting, social workers need to be aware of two possible placement situations, i.e., short-term and long-term. Research on kinship placements reveals that they are typically quite stable and tend to last for extended periods (Berrick, et al., 1994; Dubowitz, 1990; Gabel, 1992; Iglehart, 1994; Task Force, 1990; Scannapieco, Hegar, & McAlpine, 1997; Thornton, 1991; Wulczyn & Goerge, 1992). Some models of kinship care require less rigorous training and offer less supervision of kinship homes than is true for traditional homes (Scannapieco & Hegar, 1995). Research also reveals a low level of services to kinship homes in some jurisdictions (Brooks & Barth, 1998; Berrick, et al., 1994; Iglehart, 1994). Scannapieco and Hegar (1996) argue that the stability and length of kinship placements, as well as the diminished supervision often offered them, suggest that two kinds of screening of support service needs are required—initial approval of the home and screening at the time of permanency planning.

The assessment of support and intervention requirements of kinship care providers, therefore, demands attention to two sets of factors: those associated with the first use of any home for child placement (including parenting and family aspects, emergency care, and physical environment), and those associated with a permanent placement for particular children (including school, medical, financial, and social support). Across all of these factors, kinship placement raises issues that are substantially different from traditional foster care, suggesting that each criterion for assessment must be adapted for use with kinship homes.

Support and Intervention Needs

Kinship caregivers are one of the most important resources of the child welfare system in caring for children. Individuals and families who provide foster and kinship care are essentially contributing the same services to child welfare agencies, but child welfare agencies rarely provide the same resources to kinship families. On average, kinship care homes receive less money and fewer services, and moni-

toring of the homes is less frequent (Brooks & Barth, 1998; Scannapieco, 1999). Child welfare programs need to provide services that are more equitable across both types of out-of-home care. Child welfare workers often think that kinship care families have fewer needs; however, this belief is not supported by the research. The needs of kinship providers may be different, but the needs of the children in care are similar.

In designing an array of support services for kinship care providers and their families, four categories of needs should be considered: financial, services, social support, and educational.

Financial. Kinship families may receive funding from a range of sources. Depending on whether they are licensed or certified as foster families, they may or may not be eligible to receive foster care monies, particularly federal Title IV-E funds. If a family is not licensed, but the child is eligible for federal welfare assistance, they may receive limited assistance under The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWOR). However, states have considerable latitude in how to implement Temporary Assistance to Needy Families (TANF) under this Act, so relatives raising children are not eligible for the same financial help in all states (see Hegar and Scannapieco, 2000).

For those who can receive foster care payments, board rates also vary from state to state. Kinship families receiving foster care payments are allocated a designated amount per day per child. Families may receive more money per child if the child has special needs (e.g., HIV). Kinship families that are not eligible for foster care payments may receive welfare benefits for the child. Additionally, if the kinship caregiver is caring for a sibling or cousin in the same family, the caregiver may receive an incremental increase (not the full amount s/he would receive in foster care) in his or her welfare payment, based upon the standard welfare increases.

- *Clothing.* Kinship caregivers need assistance in providing clothes for children, which cannot be covered totally with the per diem that the families receive. Special occasions, such as proms or sporting activities, may require extra clothing. It is important that the child welfare worker assist the family in locating additional clothing resources.
- *Transportation.* As in any family, children require transportation to and from sporting activities, school events, doctors, etc.

This sometimes requires the child welfare worker to assist in locating transportation or assisting in the transport of children. Unlike other children, kinship children may have additional transportation needs that may put strain on the family. Many children are in therapy, or need to have visits with parents and siblings. To reduce stress on the kinship families, child welfare workers should assist families in identifying transportation resources.

Services. Kinship families require comparable—but in some circumstances different—services as traditional foster families. Compared to foster families, kinship families are poorer, older, more likely to have a single parent, and less educated. In assessing needs of kinship families, the child welfare worker has to examine the triad: the caregiver, parent, and child. Children placed in kinship families often require the same services, because the reasons for entering into care are comparable. The worker must examine the case management, legal, mental health, medical, and dental services that are needed by the child in kinship care.

- *Case Management.* The child welfare worker, after establishing a collaborative intervention plan with the family, will have to manage and oversee the progress in meeting the objectives and goals of the permanency treatment plan. Kinship families may demand that the child welfare worker more actively act as an advocate and broker of services than does the foster family. At the same time, kinship families may perceive any intervention as intrusive, because they see the child placed in their homes as their "kin" and may feel they know what is best for the child. It is a balancing act that the child welfare worker needs to negotiate with the family, but with the child's needs clearly a priority.
- *Legal.* The court system is another arena that the child welfare worker should help the kinship family negotiate. Often families and children are required to be present in court, which requires a lot of time. It is helpful for the child welfare worker to inform the kinship family about the court process and what to expect (e.g., delays). Additionally, kin caregivers frequently request assistance with legal matters that range from obtaining guardianship to adoption of the children they have in care.
- *Mental Health.* Kinship children come into care for similar rea-

sons and need mental health services at parallel rates. Based on a thorough assessment, the child welfare worker identifies what mental health resources are most appropriate for the child, and assists the foster or kinship family in obtaining the service. Additionally, in the case of kinship families, the caregiver may need mental health services as well. Often the caregiver may be struggling with the reality of his or her child's drug exposure or status of being HIV+.

- *Medical.* Many children enter care due to neglect and, as a result, are often behind on routine medical care. Foremost, the child needs to be evaluated to ascertain his or her current medical status. Families then will need support in following through on medical recommendations. In numerous circumstances the child enters care with special medical needs (i.e., HIV+ or other sexually transmitted diseases; lice; physical or sexual abuse injuries), which require immediate attention. The ultimate responsibility of the child welfare worker is to ensure that the child has received all required medical treatment.
- *Dental.* Not only the parent, but also the caregiver, often overlooks dental care. Children require routine dental check-ups. Since children in kinship care are covered under Medicaid, families may need assistance in identifying a dentist who accepts this type of insurance. A doctor who accepts Medicaid is often different than the family's current dental care provider, and may involve a further travel distance. Both medical and dental care may place extra stress on families because of the extra time and distance. The child welfare worker needs to keep this in mind when negotiating with families to provide this care.

Social Support. Social support interventions provide for many of the needs kinship families present. The child welfare worker is charged with helping families assess challenges in their social network and to make the appropriate connections in their communities to address them.

- *Formal social support.* The child welfare worker may be one of the most important formal social supports the foster or kinship family has to rely on. The child welfare worker provides fundamental support to families.

  Kinship families may be very involved in their community

support systems (i.e., family support services, churches, schools, businesses, community centers), but if they are not, or if a child presents a need not met by a current support system, the child welfare worker can encourage families to become connected with formal support systems. Social support can reduce stress and provide concrete and emotional needs and information to families.

Another form of formal social support that the child welfare worker may aid in providing is respite care. Respite care may be the deciding factor for families when considering taking a special needs child. It provides a needed break from what is often a very stressful situation.

- *Informal social support.* Informal social supports provide emotional as well as tangible support to kinship families. It is important for the child welfare worker to encourage families to build informal social support systems such as family, friends, and co-workers. Particularly in kinship families, informal social supports are significant. Considering that the majority of children in kinship care are from families of color, and that culturally these families rely on extended family for support, the child welfare worker should support and acknowledge this as a valuable resource in kinship homes. A seventy-year-old grandmother may need assistance in caring for her grandchildren, and may need to depend on an aunt or an uncle to provide some of the care.

Educational. Educational planning for children is a key need in kinship families. Many children in care are developmentally delayed and require special education. The system is overwhelming at times, and one that families often want aid with negotiating. The child welfare worker may need to act as an advocate for the child to get the needed resources to meet the child's educational needs. Another education issue is ongoing training for kinship care providers.

- *Individual Educational Plans (IEP).* This is a formal process of assessment of the child's educational needs. The child welfare worker and the foster or kinship caregiver may be required to be at the meeting. The foster or kinship family may need assistance in understanding the IEP process and what they can demand from the educational institution.
- *Special Services.* Some children will need to be placed in a spe-

cial classroom or need speech or hearing classes. Kinship families may demand assistance in understanding and accessing these services, which can be facilitated by the child welfare worker.

Behavioral problems of the child may be another area that requires special services and causes additional stress on the kinship families. It will be important for the child welfare worker to facilitate a program that will help reduce the child's problematic behavior (i.e., a behavior modification program).

- *Training.* Although in many states training is mandated for kinship caregivers, the child welfare worker may want to identify areas of training needs for the families and try to find resources that meet that need. Videos and books can often serve as part of mandated training. The child welfare worker may have access to videos that aid the family when faced with a particular situation. It would be very appropriate and supportive if the child welfare worker would aid in obtaining training resources, thus contributing to the overall well being and functioning of the family.

Discussion and Conclusions

Kinship care has proliferated over the past 15 years, and child welfare professionals must respond to the impact this has had on kinship care providers. The field relies on kinship care providers as a placement resource for a record number of children who have been abused or neglected, and therefore should respect providers and what they can bring to the discussion. Kinship caregivers deserve and require both financial and emotional support, which is crucial to the well being of children in care and their families. A multidimensional assessment must be utilized to address the array of support and intervention needs a provider may require. Participation on the part of the kinship care provider is necessary for a strengths-based and family approach to be effective. As in the traditional foster parent system, the provider needs to be seen as a partner in the helping process.

Kinship care providers have become a major resource for caring for children in our society. In order to assure the well being of children in their care, practice and policy must address the support and intervention needs they bring to the situation. Both legislative and public debate on the Personal Responsibility and Work Opportunity Act of 1996

(PR&WOA, P.L. 104-193) failed to consider that about 10% of children who received AFDC did so in the homes of caregiving relatives (Hegar & Scannapieco, 2000). As in the family decision-making model, the kinship care providers must be included in the development of policies and practices as they relate to kinship care. Policy on the state and federal levels will be informed by participation of kinship care providers and will reduce the errors as represented in the PR&WOA, P.L. 104-193. In order to assure quality placements that honor family, safety, and well being for families and children, kinship care providers must be valued and cared for by society.

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