

CHILDREN AND FAMILY RESEARCH CENTER

**EVALUATING THE QUALITY OF
KINSHIP FOSTER CARE:
FINAL REPORT**

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DECEMBER 1999

A PROJECT OF THE CHILDREN BUREAU, AND THE ADMINISTRATION FOR CHILDREN,
YOUTH AND FAMILIES, OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

PREPARED BY

CHILDREN AND FAMILY RESEARCH CENTER

SCHOOL OF SOCIAL WORK

UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

1207 West Oregon Street

Urbana, Illinois 61801

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PART I: INTRODUCTION

The Children and Family Research Center of the School of Social Work, University of Illinois at Urbana-Champaign has conducted a project to create and test instruments to measure the quality of kinship foster homes. These instruments were designed for use by foster care providers to evaluate the quality of homes under their supervision. This study was conducted with the aid and support of the Survey Research Laboratory, University of Illinois at Chicago; the Research Triangle Institute; the American Bar Association's Center on Children and the Law and the Child Welfare League of America (CWLA).

The study had three phases: (1) item identification and instrument development; (2) field testing of the instruments with African-American, white, and Latino/a respondents; and (3) finalization of a set of recommended instruments for preliminary use in the field. The project team identified, operationalized, and tested core items to assess quality of care across various sites, situations, and cultures. To the extent possible in the course of this study, these items are designed to be sensitive to differences among children (e.g., age groups, handicaps, placement histories) and families (e.g., socioeconomic status, ethnicity).

The investigators developed a kinship foster care provider interview, child interview, worker self-administered instrument, and a case record review. These instruments measure quality of care in the kinship home, contextual factors impacting kinship family functioning, and selected indicators of child functioning.

Intended uses of these instruments include agency home studies and licensing activities, case monitoring, and training. This work will provide a foundation for future research on the quality of kinship family care.

1 BACKGROUND

The Children's Bureau recognized that, because of significant differences in some characteristics of kinship care and foster care, it was important to identify and develop more specialized criteria for foster home evaluation.

1.1 Integration of Kinship Care into the Formal Child Welfare System

Traditionally, care by relatives for children in need has been viewed as an alternative to the formal child welfare system. States often encouraged informal placements with relatives as a way to avoid foster care placement (Takas, 1992). Increasingly, however, kinship care has become a formal legal model as a type of foster care placement (Takas, 1992). In these cases, the state assumes custody of the child and is responsible for screening and monitoring placements, permanency planning, and providing services and financial support to the child and family. The child welfare system has been largely unprepared for this transition to kinship care as formal policy, and has lacked standards, case monitoring methods, and permanency planning methods tailored to kinship placements. The situation has been exacerbated by a rapid growth in many states of the number of children needing out-of-home care. In several states, kinship care has become the prevailing form of out-of-home care and is the fastest growing component of the foster care system (Barth, Courtney, Berrick, and Albert, 1994; Berrick and Barth, 1994; Gleeson and Craig, 1994; Wulczyn and Goerge, 1992).

1.2 The Need for Criteria to Assess the Quality of Kinship Care

Developing standards for quality in kinship care requires states and agencies to strike a delicate balance. On one hand, policies must be responsive to the extended family and sensitive to the differences between foster and kinship care. On the other hand, states must comply with the IV-E requirements to receive federal reimbursement, and must protect and plan for the futures of children in state custody. States must license or approve all foster homes, including kinship homes, but requirements not essential to child safety may be waived (Takas, 1994).

Many states apply the same regulations and policies to kinship placements as they do to foster placements (Gleeson and Craig, 1994; Everett, 1995). Although this approach may be good practice in terms of child protection, relative caregivers may face standards that are intrusive or unsuitable for kinship homes (Takas, 1992). For example, strict compliance with foster care standards about number of bedrooms or running water may exclude caring but economically disadvantaged relatives (Takas, 1994).

Other states have separate approval standards for relative homes, and may err on the side of underprotecting and undersupporting children in kinship foster homes. Screening procedures, monitoring, and evaluation of kinship foster families may be far less rigorous than for non-kinship foster families (Berrick, Barth and Needell, 1994; Iglehart, 1994). Many states do not conduct the same types of home studies and do not maintain the same requirements for kinship providers as they do for other foster placements (Gleeson and Craig, 1994). Kinship care families tend to

receive fewer services, more infrequent supervision, and less financial support than other foster families (Berrick, Barth, and Needell, 1994; Dubowitz, Feigelman, and Zuravin, 1993).

Some states (e.g., Illinois, New York) have responded to the kinship care situation by developing special approval and reimbursement procedures for kinship caregivers. For example, basic safety standards (such as criminal record checks and fire safety standards) are applied to relatives, while other standards (such as square footage and foster parent training requirements) are waived (Takas, 1992).

The lack of uniform standards for licensing/approval, spotty case supervision and monitoring, and lack of research knowledge about kinship care in general, makes the quality of kinship foster care extraordinarily hard to assess. Criteria are needed to help judge and monitor quality in a manner that assures the safety and well-being of children while maintaining sensitivity to the extended family.

1.3 Difficulties with Basing Kinship Care Quality Assessment Methods on Foster Care Quality Assessment Methods

Follow-up studies of children in kinship care are beginning to appear in the literature, providing some case outcome data (e.g., Barth, Courtney, Berrick, and Albert, 1994; Goerge, 1990; Testa, 1992; 1993; Thornton, 1991; Wulczyn and Goerge, 1992). Descriptive data of children in care are also available (e.g., Dubowitz et al., 1992; 1993; 1994; Dubowitz and Sawyer, 1994). However, research on quality in kinship care is minimal and our knowledge of how to assess quality of care in these homes is less than adequate (Dubowitz, 1994).

Unfortunately, the child welfare field requires a new set of quality assessment techniques for kinship foster care when those for non-kinship foster care are still in their infancy. Most work on standardization and validation of scales pertinent to child welfare typically have focused on the use of scales to evaluate interventions, but the instruments (e.g., Family Risk Scales [Magura, Moses, & Jones, 1987] and Child Well-Being Scales [Magura & Moses, 1986]) are not generally applicable to foster care. Evaluations of foster care quality tend to be conducted by practitioners using structured or semi-structured instruments devised specifically for the agency conducting the review. One notable example is the work of the Council on Accreditation (COA) that provides accreditation based on on-site reviews of an agency's child welfare practices. Although there are a few comprehensive standardized instruments designed to measure child well-being outcomes (e.g., Magura and Moses, 1986), most instrument development has taken place locally or through various accreditation agencies such as the COA.

Another problem with using general foster care instruments for kinship care is that these two types of placements differ significantly. These differences must be accounted for in the

measurement and assessment of quality in kinship care. For example, the context of care (i.e., the cultural, social and environmental factors that shape both the process and outcome of care) is more relevant in evaluating kinship care because it involves placing children within their and their parents' own social network (Gray and Nybell, 1990; Laird, 1979; Lewis and Fraser, 1987; Whittaker, 1983, 1986). Related issues include the ability of the kinship parent to protect the child from continued maltreatment, the relationship between the kin caregiver and the biological parent, and the kinship family's privacy expectations (CWLA, 1994; Takas, 1994; Gleeson and Craig, 1994).

Another major difference between kinship and foster care that evaluators must take into account is the perceived role of the kinship/foster caregiver. Le Prohn (1994), for example, found that kinship parents place more emphasis on maintaining contact with biological families and feel more responsible for helping with the child's emotional problems. A third, and possibly related difference, is that outcomes for children in kinship care differ from those of children in foster care. Reunification rates are slower for kin and adoption is less likely (Barth, Courtney, Berrick and Albert, 1994; Wulczyn and Goerge, 1992). Reasons for differences in outcomes have not been well-established by research. It could be that there are some unmeasured differences in children and families in kinship care that causes these outcomes, that the system treats these placements differently, or that biological families may be less inclined to regain custody of their children if the children are placed with kin (Barth, Courtney, Berrick, and Albert, 1994). Whatever the reasons, the differences in outcomes highlights a need for careful analysis of the differences between these types of placements.

A fourth difference between kinship and foster care is the role of the agency in supporting kinship placements and ensuring quality in these placements. A number of research studies have found that kinship homes receive fewer services and less monitoring than nonrelative foster care homes (Berrick et al., 1994; Meyer and Link, 1990). The reasons for this are also unclear. Possibly, relatives resent agency intrusion or caseworkers believe that these families do not require as much supervision. Alternatively, the child welfare system may be so overloaded that those children thought to be more "settled" receive fewer services (Meyer and Link, 1990). Again, whatever the reasons, diminished supervision and services provided to kinship homes may be a factor contributing to poorer quality of care, and correspondingly, belongs in an evaluation system.

Finally, kinship caregivers are different from foster caregivers. They tend to be older, lower income, single women of color, who had not planned on caring for children at this stage of their lives (Berrick, Barth and Needell, 1994; Minkler, Roe and Price, 1992; Thornton, 1987). Instruments to evaluate quality of care must be sensitive to these differences and must provide the agency with the qualitative information necessary to tailor services for the particular needs of this population.

1.4 Identifying Criteria to Assess the Quality of Kinship Placements

The CWLA (1994) developed standards for kinship foster family assessment that mirror those for non-kinship parents and include some timely considerations with respect to current family problems and special kinship considerations. They recommend evaluating 14 areas.

- (1) Relationship between child and relative
- (2) Ability and desire of relative to protect the child from the parent
- (3) Safety and nurturing environment of home
- (4) Willingness of family to accept child
- (5) Ability of parent to meet child's developmental needs
- (6) Relationship between birth parent and relative
- (7) Family dynamics in kinship home related to abuse or neglect of the child
- (8) Presence of substance abuse
- (9) Willingness to cooperate with the agency
- (10) Existing support systems
- (11) Number of children in the home and their status (e.g., hiv status, other medical conditions, drug use)
- (12) Health status of kinship caretakers
- (13) Age of kinship caretakers in light of child's long-term needs
- (14) The possibility that family members will pressure the child to recant any allegations of abuse.

The CWLA recommends that approval/licensing standards for kinship homes adhere to the same safety standards required of all foster homes, but also be flexible in standards unrelated to child protection (e.g., number of bedrooms). Standards should include a complete check for criminal records, child abuse history, and evaluation of home safety.

The CWLA recommendations provided a starting point for identifying criteria relevant to evaluating kinship care families and the context that mediates quality of care. We used key words from these and other recommended standards to guide our literature review of quality in kinship care.

2 STATE POLICIES ON KINSHIP CARE AND FOSTER CARE EVALUATION

In response to the large increase in formal kinship care, many state and county child welfare agencies have developed new, or adapted existing, guidelines and policies to address the distinctive characteristics of kinship care placements. Gleeson and Craig [1994] first documented states' kinship care policies based on an analysis of statutes, administrative rules and procedures, court decisions, and consent decrees submitted by 32 states. The American Bar Association Center on Children and the Law [the Center] conducted a survey to collect additional information on state practices with respect to kinship care in February 1996. We supplemented the survey data with personal interviews focusing on the assessment, monitoring, evaluation, and support of kinship homes.

2.1 Methodology

The Center contacted administrators in state child welfare agencies in all fifty states to request their participation in a brief survey about the policy and evaluation of kinship foster homes. In most cases, several telephone calls were required to reach the appropriate contact within the agency. After briefly describing the background of the research project and the survey, the Center requested permission to send a brief "mailed" survey by facsimile machine. (See Appendix A). All agencies agreed to participate in the survey. Initial distribution of the survey took place over a three-week period. The Center made follow-up calls one to two weeks after distribution to increase the response rate.

In addition to the survey, agencies were asked to forward copies of written policy, evaluation, and monitoring materials used in licensing and assessing kinship care homes. The research team also tracked the arrival of these materials, and made follow-up telephone calls to increase the response rate.

From March through May 1997, the research team collected more in-depth information from the original respondents through telephone interviews. When the original respondent no longer worked for the agency, his or her replacement was interviewed. Based on the mailed survey and the interview, a narrative description of each state's practices with respect to kinship care was developed and faxed to the respondent. The respondent was asked to verify the accuracy of the narrative and provide supplemental information where necessary. Each respondent was called a minimum of two times after faxing the narrative to verify receipt and to request feedback. The narratives were updated based on feedback received and distilled into a draft paper. All participants had an opportunity to review the draft prior to final revision.

Thirty-four states responded to original ABA survey. Of these states, thirty-three completed telephone interviews. Twenty-nine respondents verified receipt of the narrative description of practice in their state and confirmed its accuracy or provided additional feedback.

2.2 Results

This paper focuses exclusively on formal kinship care. Agency practices with respect to informal kinship placements that were not made through, or in conjunction with the state mandated child welfare agency were not included. For the purposes of this paper, homes providing formal kinship care were grouped into three categories: licensed kinship homes, approved kinship homes, and unlicensed kinship homes. Designations of categories were made by IV-E eligibility and local definitions. Licensed kinship homes were eligible for IV-E payments. Most states did not distinguish these homes from non-kinship foster homes. Approved kinship homes were also eligible for Title IV-E payments, but the states clearly distinguished these homes from non-relative foster homes. Unlicensed or unapproved kinship homes were not eligible for Title IV-E payments.

States were classified into three groups according to the types of homes providing formal kinship care (See Table 2.1). One group of states permits formal kinship care in licensed homes only. A second, larger, group of states places children in state custody in both licensed and unlicensed kinship homes. The third and smallest group of states permits formal kinship care in approved and licensed homes. State assessment, monitoring, evaluation, and support practices for kinship homes are presented by group.

Table 2.1 Types of Homes Providing Formal Kinship Care by State

Licensed Relatives Only	Unlicensed and Licensed Relatives		Approved and Licensed Relatives
Florida	Alabama	Mississippi	Arkansas
Hawaii	Arizona	Montana	Colorado
Iowa	Delaware	New Hampshire	Connecticut
Indiana	Idaho	Ohio	Massachusetts
Minnesota	Kansas	Oklahoma	New Mexico
North Dakota	Kentucky	South Dakota	New York
Virginia	Louisiana	Texas	Vermont
Wyoming	Michigan	Washington	
	Maryland	Wisconsin	

2.2.1 Placement With Licensed Kinship Homes Only

Administrators from several of the eight states using licensed kinship homes only indicated that they prefer to facilitate informal kinship arrangements in lieu of licensing relatives whenever possible. This generally involves encouraging voluntary placement with kin during a CPS investigation or transferring custody from the state to a relative after a child has been removed.

Assessment Procedures

When a child must be removed from his/her home, assessment procedures differ by state¹. Iowa reported that they do not place with relatives who are not fully licensed. Iowa placed children in emergency shelter care or non-relative foster care until kin can be identified and/or licensed. The remaining states in this group grant emergency or provisional licenses to facilitate placement with kin or other prospective foster parents in emergency situations. States most often required home health and safety assessments, criminal records checks, and CPS registry checks before granting an emergency/provisional license (see Table 2.2). At the time of the study,

¹ In non-removal cases, Indiana and Virginia initiate a licensing study when the case becomes known to CPS. The remaining states do not take children into State custody under these circumstances.

provisional licenses were valid for 30 days in Virginia² and Wyoming, 60 days in Hawaii, 90 days in Minnesota, and 6 months in Indiana, during which the applicant must complete the full licensing process. Florida and North Dakota did not report the time limit for provisional licenses. With the exception of Minnesota, emergency/provisional licenses are available to all applicants for licensure. Minnesota grants emergency licenses to relatives only.

Table 2.2 Assessment Methods Completed Before Granting an Emergency/Provisional License

State	Home Health and Safety Assessment	Home Study ³	Criminal Records Checks	CPS Registry Checks	Reference Checks	Other
Florida ⁴						
Hawaii	X		X			
Indiana	X		X	X		
Minnesota	X					
North Dakota						
Virginia	X			X		
Wyoming			X	X	X	

Standards and Waivers

Among states in this group, licensing standards, methods, and procedures are identical for kinship and non-kinship homes with the exception of emergency licensing procedures in Minnesota. States vary in their handling of households that cannot fully comply with licensing standards. Iowa, North Dakota, and Wyoming do not waive licensing standards. Florida, Indiana, Minnesota, and Virginia may waive licensing standards for any applicant for licensure. Hawaii may waive some licensing standards and pre-service training for any home seeking a special license, but not for homes seeking a general license⁵.

² Virginia DSS may extend this period to 45 days.

³ A home study includes assessment of issues such as the relative's commitment to the child, ability to meet the child's needs, ability to protect the child, and willingness to work with agency.

⁴ Florida CFS completes these activities before granting a provisional license to a relative with custody of a child. Requirements may differ for non-relatives.

⁵ Hawaii grants general licenses and special licenses. Homes with a special license are licensed for a particular child(ren). Any applicant, regardless of their relationship with the child, may receive a special license to care for a child, although DHS is attempting to limit this practice to applicants who have a pre-existing relationship with the child(ren).

Among states that grant waivers to licensing requirements, there are differences in the standards that may be waived. Florida, Hawaii, Indiana, and Virginia do not have a specific list of standards that can or cannot be waived. In these states, waiver decisions are made according to best social work judgment based on the circumstances of the individual case. In Minnesota, variances are available to the rule standards, but not statutory standards. Standards typically waived include requirements related to square footage; sleeping arrangements; and criminal records depending upon the severity of the offense, the length of time elapsed, and evidence of rehabilitation.

Casework Support and Monitoring

States that only place in licensed homes support and monitor all placements involving children in State custody through caseworker visits. The frequency of visits is the same for licensed kinship foster homes and licensed non-relative foster homes. Visitation schedules vary significantly by state. In Hawaii, Minnesota, and North Dakota, policy and rule do not specify a mandatory visitation schedule, and practice may vary by geographic region or administrative unit. Florida and Wyoming require monthly visitation, while Indiana and Virginia⁶ require quarterly visits. Iowa's visitation policies vary depending on the locus of case planning responsibility. Iowa policy requires a visit within 14 days and every 35 days thereafter if DHS has case planning responsibility. If a contracting agency has case planning responsibility, that agency establishes visitation policies for its social workers, and a DHS worker must visit the child every 60 days.

Evaluation

States that only permit formal kinship care in licensed homes require all homes to undergo a periodic evaluation or licensing renewal study. In no case do evaluation instruments, methods, procedures, or standards differ for kinship foster homes. The frequency of the licensing renewal study, as well as the methods and procedures used, varies by state. Most states require an annual reevaluation of foster homes. Exceptions include Minnesota which reevaluates foster homes after one year and biennially thereafter unless there is a problem in the home, and Hawaii and Virginia which reevaluate homes biennially.

With the exception of Iowa, states use a wide array of methods to evaluate foster homes. Iowa is unique in that it only conducts a home study. In addition to home studies, typical evaluation methods in other states include CPS records checks; interviews with the foster parents, child and other household members; criminal records checks; and case record reviews. Other evaluation methods include a medical report/TB test and caseworker reports in Hawaii; completion of the foster home survey report in Iowa; a caregiver self-declaration that the home is

⁶ Virginia has exceptions for special populations.

free of fire hazards and a caregiver health self-disclosure form in North Dakota, and a review of in-service training activities in Wyoming.

Table 2.3 Evaluation Methods by State for Licensed Foster Homes

State	Case Record Review	Criminal Records Check	CPS Records Check	Health and Safety Assessment	Foster Parent Interview	Child Interview	Household Member Interview	Other Methods
Florida	X	X	X	X	X	X	X	
Hawaii		X	X	X	X			X
Iowa				X				X
Indiana	X	X	X	X	X	X	X	
Minnesota	X	X	X	X	X	X	X	
North Dakota			X	X				X
Virginia	X	X	X	X	X	X	X	
Wyoming			X	X				X

Financial Resources

In these states, resources available to kinship foster homes are the same as the resources available to non-relative foster homes. Licensed homes are eligible for IV-E or state/local foster care board payments. Indiana reports that some licensed kinship homes accept AFDC, but this is unusual. Child support, SSI, SSA, or VA benefits may be used to support a child in a licensed home if the child is eligible. In addition to these basic funding sources, every state except Florida makes additional resources available to relatives. Clothing assistance is the most common resource offered to foster parents. Flex funds are also commonly made available. This category includes Special Service Costs funds in Hawaii; an annual allotment for miscellaneous expenses and occasional payments for incidental medical costs in North Dakota; and state pool funds for services, educational fees and expenses, special education, medical services, transportation, and day care in Virginia. Exceptional care funds include difficulty of care payments in North Dakota and specialized and/or therapeutic foster care rates in Wyoming.

Table 2.4 Resources Provided to Licensed Foster Homes by State

State	Clothing Allowances ⁷	Flex Funds	Exceptional Care Funds	Day Care	Respite Care	Other
Hawaii	X	X				
Indiana	X					
Minnesota	X					
North Dakota	X	X	X			
Virginia	X	X				
Wyoming	X		X			

2.2.2 Placement with Licensed and Unlicensed Relative Homes

Most states participating in the study permit formal kinship care in licensed and unlicensed homes (see Table 2.1)⁹. These states have different perspectives on the desirability of licensing relatives. Alabama, for example, prefers to license all kinship homes, and places in unlicensed kinship homes only under the direction of a court order. In contrast, Louisiana prefers to place with unlicensed relatives.

Unlicensed Relatives

Assessment Procedures. With the exception of Washington and Wisconsin¹⁰, all states are required to assess unlicensed relative homes prior to placement when a child is removed from his or her home. Most states complete a full assessment of unlicensed kin prior to placement. These states include Alabama, Arizona, Delaware, Idaho, Kansas, Louisiana, Michigan, and Ohio¹¹. In contrast, Kentucky, Maryland, Mississippi, Montana, Oklahoma, South Dakota, Texas, Washington, and Wisconsin may conduct additional assessment of unlicensed kinship homes following placement. In these states, statute and policy do not require the local agency to complete a full assessment before placement. However, in many cases, the activities listed below may be completed prior to placement. In non-removal cases, most states report that the home is assessed when the case becomes known to CPS. Texas reported that they do not take children into State custody in these cases.

⁷ Clothing allowances may include initial, ongoing, and/or special/exceptional allowances.

⁸ Virginia reimburses day care expenses from state pool funds.

⁹ Practice in Idaho varies by region. Some regions do not place children in State custody in unlicensed homes.

¹⁰ The Kinship Care assessment in Wisconsin is used to determine eligibility for Kinship Care payment, not to determine whether to place or to continue placement.

¹¹ In Ohio, some rural counties may not complete full assessments prior to placement in all cases.

The most commonly used assessment methods include a home health and safety assessment, a home study, criminal records checks, and CPS registry checks. With the exception of Washington and Wisconsin, all states require a home visit for the purposes of conducting a home health and safety assessment and/or a home study prior to placement.

Table 2.5 Assessment Methods for Unlicensed Kinship Homes by State

State	Home Health and Safety Assessment	Home Study	Criminal Records Checks	CPS Registry Checks	Reference Checks	Other
Alabama	X	X	X	X		
Arizona	X		X	X	X	
Delaware						
Idaho	X	X	X	X		
Kansas	X	X				
Kentucky ¹²	X	X	Y	Y		
Louisiana	X	X	X	X	X	
Maryland ¹³	Y	X	Y	X		
Michigan	X		X	X		
Mississippi	X	Y	Y	X	Y	
Montana		X	Y	Y		X
New Hampshire	X	X	Y	Y		X
Ohio	X	X	X	X		
Oklahoma ¹⁴	X	X	X	X	X ¹⁵	
South Dakota	X	X	X	X	X	
Texas	X	X	Y	X	X	X ¹⁶
Washington	Y	Y	Y	Y		
Wisconsin		Y	Y			

X=Completion required before placement; Y=Completion not required before placement.

¹² In Kentucky, the Family Services Worker must initiate criminal records and registry checks with two working days of placement and complete the narrative of the home evaluation within 30 days if these were not completed before placement.

¹³ Maryland regulations and policy do not specify when the home study or CPS registry checks must take place.

¹⁴ Oklahoma also completes a more in-depth home study using the Kinship Placement Assessment Guide following emergency placement with kin.

¹⁵ In Oklahoma, if the prospective kinship caregiver is a blood relative, DHS collects the name and address of each reference prior to placement. If the prospective kinship caregiver is affective kin, DHS contacts each reference prior to placement.

¹⁶ In Texas, the formal risk assessment is required when the Agency cannot complete a full written assessment prior to the full adversary hearing.

Standards. Standards for unlicensed homes are less strict than standards for licensed homes in all states except Ohio. Typically, licensing requirements that do not pertain to child safety, e.g., square footage or space requirements, are not applied to unlicensed relatives. In some states, if the agency has concerns about a relative who would normally not become licensed, e.g., if state/local criminal records checks raise issues, the agency may ask that the relative become licensed. In Ohio, homes in the newly established (1996) Kinship Program and applicants for licensure are assessed using the same standards, methods, and procedures. Ohio counties have the discretion to grant a waiver to any standard that does not affect child health or safety for homes in the Kinship Program. Oklahoma's standards and assessment process are very similar for unlicensed relatives and licensed relatives.

Licensed Relatives

Licensing Procedures and Standards. Alabama, Idaho, Kentucky, Louisiana, Maryland, and Washington may grant provisional or emergency licenses to facilitate placement in emergency situations. Provisional licenses are granted to both relative and non-relative applicants in these states. The length of the provisional license varies from 90 days in Louisiana¹⁷, Mississippi, and Washington to 120 days in Maryland to 6 months Alabama. Idaho and Kentucky do not place time limits on provisional licenses. The remaining states, including Arizona, Delaware, Kansas, Michigan, Montana, New Hampshire, Ohio, Oklahoma, South Dakota, Texas, and Wisconsin, do not grant emergency or provisional licenses. In these states, kinship homes can be licensed prior to placement or provide care as an unlicensed kinship provider until a licensing study is completed.

In most states that place with licensed and unlicensed kin, licensed kinship homes must meet the same minimum standards as non-relative foster homes, and licensing procedures and methods are also the same for all applicants. Montana and Oklahoma are the only exceptions to the general rule. These states have different standards for kin and non-kin applicants for licensure. In Montana, the kinship rules are modeled after rules for non-relative foster homes, but particular rules may differ. In addition, the kinship licensing rules include a set of standards that address issues unique to kinship placements. In Oklahoma, licensing standards are identical for kin and non-kin with two exceptions: a) relatives must have access to an automobile, while non-relative must have an automobile; and b) relatives must have access to a telephone, while non-relatives must have a phone in the home. Delaware is currently developing a separate set of licensing standards for kinship homes.

¹⁷ Louisiana may grant additional 90 day extensions to the provisional license if required.

States have differing policies regarding waivers and variances to licensing standards and requirements. Montana, Oklahoma¹⁸, and South Dakota report that they do not waive or make exceptions to minimum licensing standards for any home. Kansas¹⁹ and Kentucky make exceptions for relatives only. The remaining states make exceptions for kin and non-kin applicants for licensure²⁰.

Among states that waive or make exceptions, some do not have a specific list of standards which can be waived. Arizona, Delaware, Michigan, Mississippi, New Hampshire, Ohio, and Texas can waive any standard as long as the waiver does not pose a risk to child health, safety, or well-being. Washington²¹ and Wisconsin may waive any standard except a specific set of provisions. Alabama, Idaho, Kentucky, Louisiana, and Maryland have a specific list of standards that may be waived. These include exceptions for certain criminal offenses depending on the nature of the offense, time elapsed since the offense, and evidence of rehabilitation (AL, ID, LA, MD); pre-service training (KS, KY), caregiver age (KY); length of marriage (KY); capacity requirements (LA, TX); (confirmed, indicated, or substantiated) child abuse or neglect with approval of local director (MD); and sleeping arrangements (MD).

Casework Support and Monitoring. States that place in licensed and unlicensed relative homes have several approaches to monitoring kinship placements. The majority of states, monitor all homes with the same frequency and intensity regardless of licensure status. These states include Alabama, Idaho, Kansas, Maryland, Montana, New Hampshire, Oklahoma, South Dakota, Washington, and Wisconsin²². Within this group, the frequency of mandatory contacts varies. Alabama, Idaho, New Hampshire, Oklahoma, and South Dakota require monthly visits. In Maryland, a caseworker must visit the child within 5 working days of case assignment and 2 months thereafter except in Baltimore city where monthly visits are required for 6 months with visits every 2 months thereafter. Washington requires quarterly visits, while Kansas, Montana, and Wisconsin²³ do not impose casework contact standards on either non-relative foster care or kinship care.

¹⁸ In Oklahoma, if a home does not meet a licensing standard that does not pose imminent risk to child health and safety, DHS may grant licensure pending the caregiver's fulfillment of a Written Plan of Compliance. The Written Plan of Compliance requires the caregiver to meet the certification standards within a specific time period.

¹⁹ The Central Office may exempt approved relatives from the pre-service training requirement, but they do not refer to this as a waiver.

²⁰ Alabama and Idaho reported that they do not waive or make exceptions to minimum licensing standards for any applicant. However, these states do permit exceptions for certain criminal offenses. Arizona has an 'alternative method of compliance with rule in licensing requirements' in lieu of a waiver system.

²¹ Washington may only grant waivers to non-statutory requirements, and DCFS may waive some safety standards for a specific time period to allow the applicant time to comply with the standard.

²² In Wisconsin, kinship homes that do not receive a Kinship Care payment are not monitored.

²³ Wisconsin policy does impose casework contact standards for treatment foster care.

Other states monitor licensed and unlicensed homes differently. In Louisiana, Ohio, and Michigan, requirements for caseworker contacts are different for licensed foster homes and unlicensed kinship homes. Louisiana monitors all homes through monthly visits, but all visits with unlicensed homes occur in the home, while only quarterly in-home visits are required for licensed homes. Ohio and Michigan respectively require visits twice monthly and monthly with children in licensed foster care, but do not specify visitation frequency with children in unlicensed kinship care. In Arizona, Delaware, Kentucky, and Texas, the child's caseworker visits all homes monthly. In addition, a licensing/foster care worker monitors licensed homes quarterly in Arizona, Delaware²⁴, and Texas and periodically in Kentucky.

Mississippi is a unique case. MDHS monitors relative homes, regardless of licensure status, differently than non-relative home. MDHS workers must visit all children monthly for the first year. After the first year, children living with relatives, licensed and unlicensed, must be visited quarterly. Monthly visits are required for children living in non-relative foster care after one year unless DHS has signed a long term foster care agreement with the foster parents. In that case, caseworkers must visit the foster home quarterly.

Evaluation. States in this group have different evaluation policies for licensed and unlicensed homes. Only Wisconsin requires a formal evaluation of kinship homes beyond ongoing caseworker monitoring²⁵. In Wisconsin, Kinship Care living arrangements must be reviewed no less frequently than every 12 months to determine whether the eligibility requirements continue to be met, while foster home licenses may be issued for a period of up to 2 years. The remaining states evaluate all licensed homes using the same standards, methods, and procedures. The frequency with which states evaluate homes varies from biannually in Idaho to every three years in Washington. Maryland, Mississippi, New Hampshire, and Ohio require an evaluation every 2 years, and the remaining states evaluate foster homes annually²⁶.

Evaluation methods vary by state. All states evaluate homes through health and safety assessments and foster parent interviews. With the exception of Ohio, all states also require criminal records and/or CPS records checks. Other evaluation methods include reviews of in-service training activities, reference checks, and medical reports.

²⁴ In Delaware, the foster care worker must visit every two months for the first year and quarterly thereafter.

Policy does permit semiannual visits if the foster care worker's caseload exceeds 20 cases.

²⁵ Maryland requires that the child's worker to conduct a visit in the home once every 6 months 'of sufficient duration and privacy to allow the child, and any other appropriate individual, to express concerns regarding the placement.' The respondent characterized these visits as a reassessment to ensure that the home continues to meet basic child safety standards.

²⁶ Alabama, Louisiana, and Michigan evaluate foster homes after the first six months and annually thereafter.

Table 2.6 Evaluation Methods by State

State	Case Record Review	Criminal Records Check	CPS Records Check	Health and Safety Assessment	Foster Parent Interviews	Child Interviews	Household Member Interviews	Other Methods
Alabama	X	X	X	X	X	X	X	X
Arizona	X	X	X	X	X	X	X	
Delaware			X	X	X			X
Idaho		X	X	X	X	X	X	X
Kansas		X	X	X	X	X	X	
Kentucky	X	X	X	X	X	X	X	X ²⁷
Louisiana		X ²⁸		X	X		X ²⁹	
Maryland		X ³⁰		X	X		X	X
Michigan		X	X	X	X	X		
Mississippi	X	X	X	X	X	X	X	
Montana			X	X	X		X	X
New Hampshire		X	X	X	X			X
Ohio				X	X	X	X	
Oklahoma	X	X	X	X	X	X	X	X
South Dakota	X		X	X	X	X	X	
Texas		X	X	X	X			X
Washington	X	X	X	X	X	X	X	
Wisconsin ³¹		X		X	X			X

Funding. States in this group handle the funding of licensed and unlicensed homes differently. Unlicensed homes are typically referred to AFDC, and child support, SSI, SSA, or VA benefits may be used to support a child in an unlicensed home if the child is eligible. Within this group, Michigan and Wisconsin are unique cases. In Michigan, unlicensed homes caring for a child in State custody have the option of receiving a Family Independence Program grant or state foster care board payments. Unlicensed homes caring for a child in the custody of a county agency or ward of the court are eligible for AFDC or county foster care board payments. Counties may be partially reimbursed from state funds for payments made to unlicensed relatives caring for a ward of the court or a child in County custody, but most counties opt not to pay these

²⁷ Kentucky did not say that they have other methods, but they do have an in-service training requirement for all homes.

²⁸ Louisiana requires criminal records clearances of all new household members over aged 18 or older.

²⁹ Louisiana requires interview with all new household members over age 5.

³⁰ Maryland requires criminal records checks for new members of the household.

³¹ Evaluation methods pertain to licensed homes only. Reviews of unlicensed Kinship Care arrangements are limited to an assessment to determine whether the placement is in the child's best interests.

unlicensed relatives. In Wisconsin, unlicensed homes eligible for a Kinship Care payment receive \$215/month regardless of the child's needs and ineligible homes receive no funding.

In some states unlicensed kin may be eligible for additional support (see Table 2.7). Special care funds include difficulty of care payments in Michigan. Other resources include kinship care funds from a specific line item in the State budget in Ohio³² and a Home-Based Services Fund to assist relatives in crisis in Washington³³.

All licensed homes are eligible for the same funding and resources. Licensed homes are eligible for IV-E or state/local foster care board payments, and child support, SSI, SSA, or VA benefits may be used to support a child in an unlicensed home if the child is eligible. Licensed homes are typically eligible for other support as well (see Table 2.7). Flex funds include personal/auxiliary payments Arizona; supplemental reimbursement funds for various expenses related the child's needs and/or case plan in Kansas; funds for hair care in Kentucky; allowable expenses in LA, and reimbursement for incidental expenses in South Dakota. Exceptional Care Funds include difficulty of care payments in Michigan; difficulty of care payments based on the child's needs if the child does not meet the Title XIX therapeutic level of care in Oklahoma; supplemental payments for medically needy children and therapeutic payments for children requiring therapeutic care in Texas; higher board rates for children with special needs and funds from an Exceptional Costs Plan in Washington, and supplemental and exceptional payments for special needs children in Wisconsin. Other resources include foster parent liability insurance and transportation reimbursement in New Hampshire.

In addition to the disparity between foster care board payments and AFDC, most states offer substantially less support to unlicensed kinship homes than to licensed homes. Exceptions include Arizona, Louisiana, Mississippi, Montana, Oklahoma, and South Dakota. The first four states in that group offer the same level of general support to licensed and unlicensed homes. Only Oklahoma and South Dakota offer more general support to unlicensed homes. In Oklahoma, unlicensed kinship homes may receive day care funding if they meet federal eligibility requirements, but certified homes not eligible for day care funds. South Dakota may provide resources for clothing and incidental expenses to unlicensed relatives who are not eligible for AFDC, but clothing and incidentals are included in foster care board payments for licensed homes.

³² In Ohio, unlicensed homes are eligible for a financial stipend of \$100 per month for 6 months or services equivalent in value to \$100 per month for 12 months.

³³ This fund is typically used to provide family preservation services to prevent placement, and Washington DCFS prefers not to use the funds for relative placements.

Table 2.7 Resources Available to Licensed and Unlicensed Homes by State

State	Clothing Allowances	Flex Funds	Exceptional Care Funds	Day Care	Respite Care	Other
Alabama	X,Y	X				
Arizona	X,Y	X,Y		X,Y		
Delaware	X,Y	X ³⁴				
Idaho	X	X,Y				
Kansas	X	X				
Kentucky ³⁵	X	X				
Louisiana	X,Y	X,Y		X,Y		
Maryland	X	X,Y ³⁶				
Michigan	X,Y ³⁷		X,Y ³⁸			
Mississippi	X,Y					
Montana	X,Y	X,Y				
New Hampshire	X	X		X,Y	Y	X
Ohio	X		X,Y ³⁹			
Oklahoma	X		X	Y		
South Dakota	Y	Y				
Texas	X		X			
Washington	X		X,Y			
Wisconsin	X		X			

X=licensed homes, Y=unlicensed homes, Z=approved homes

2.3 Placement with Approved and Licensed Relative Homes

Arkansas, Colorado, Connecticut, Massachusetts, New Mexico, New York, and Vermont place children in State custody with relatives who have been approved and with relatives who have been licensed. Colorado does not apply these rules uniformly across the state. In general, counties have either approved relatives or licensed relatives depending on local philosophy. Each

³⁴ Delaware offers flex funds where reunification is the goal or the family needs a bed for the child.

³⁵ As a rule, Kentucky does not provide unlicensed homes with a clothing allowance or flex funds, but exceptions are made on a case by case basis.

³⁶ In Maryland, flex funds for licensed foster parents come from a different, larger budget than flex funds for relatives in the Kinship Care Program.

³⁷ In Michigan, children in State custody living in an unlicensed kinship home are categorically eligible for a semi-annual clothing allowance. The eligibility of children in County custody living in an unlicensed kinship homes is determined at the county level.

³⁸ In Michigan, children in State custody living in an unlicensed kinship home may receive difficulty of care payments on an exception basis. The eligibility of children in County custody living in an unlicensed kinship homes is determined at the county level.

³⁹ In Ohio, some counties may provide additional funds to licensed homes, but there are no state flex funds.

county has the choice of holding relatives to approval or licensing standards. NM approves relatives as part of a special demonstration project, and approval may not be an option statewide.

2.3.1 Approved Relatives

Assessment Procedures

Assessment procedures for approved kin vary. Every state except New York requires homes to undergo a home health and safety assessment, a home study, criminal records checks, and CPS records checks. New York does not require criminal records checks. Most states also require reference checks and/or other assessment methods. All states conduct some level of assessment prior to placement when a child must be removed from his/her home, but no state requires kin to complete the approval process prior to placement⁴⁰. With the exception of Massachusetts all states require a home health and safety assessment and a home study prior to placement. The time allowed to complete the full approval process ranges from 20 days in Massachusetts to 60 days in Arkansas and New York. Connecticut allows 45 days, and the remaining states did not report a timeframe. In non-removal cases, all assessment occurs when the case becomes known to CPS, except in New York which does not accept non-removal cases.

Table 2.8 Assessment Methods for Approved Homes by State

State	Home Health and Safety Assessment	Home Study	Criminal Records Checks	CPS Registry Checks	Reference Checks	Other
Arkansas	X	X	Y	X	X	X, Y
Colorado ⁴¹	X ⁴²	X	Y ⁴³	X		X
Connecticut	X	X	Y	X		Y
Massachusetts	Y	Y	X	Y	Y	
New Mexico	X	X	X	X		
New York	X	X		X	Y	X
Vermont	X	X	Y	X	Y	X

X=Completion required before placement; Y=Completion not required before placement.

⁴⁰ New Mexico did not report what assessment procedures may be completed after placement.

⁴¹ Colorado policy requires a complete assessment, with the exception of completed CBI and/or FBI checks, prior to placement, but actual practice varies by county.

⁴² Colorado DHS may work with families to correct deficiencies in physical standards following placement.

⁴³ Results of the CBI check do not need to be received prior to making a placement if all other areas of assessment indicate that placement should be made. [Child Welfare Services 7.504.21 Kinship Care D.4.g.]

Standards

Approval standards generally address the same domains as licensing standards, but are more flexible. The differences are intended to account for the socio-economic circumstances of may kinship caregivers. Typically approved homes are not required to meet the same square footage requirements (AS, CT, NY), maximum capacity standards (AS), pre-service training requirements (AS, MA, NY, VT), minimum age requirements for caregivers (AS), physical safety requirements (CO, MA, VT), sleeping arrangements (CO, NY), number of personal references (NY, VT), or completion of medical reports prior to placement (NY) as licensed homes. In addition, criminal history information may be treated more flexibly (AS). In Colorado, the kinship assessment criteria address a number of kinship-related issues not covered in the licensing standards. Connecticut and New York may waive approval standards that do not affect the child's health, safety, or well-being.

New Mexico is a unique case. In that state, relative homes are approved using reunification criteria. Approved relative homes participate in reunification training instead of traditional pre-service training. Relatives are approved when a short-term intervention or placement is required. Approved relatives work with CYFD to facilitate reunification by serving as a role models for the birth parent(s) and helping the birth parent(s) comply with the case plan. Initially, CYFD approves relative homes for 6 months. The Department may renew the approval for an additional six months. After one year, approved relative homes must become licensed if the placement continues.

2.3.2 Licensed Relatives

Licensing Procedures and Standards

Connecticut, New Mexico, New York, and Vermont grant emergency/provisional licenses to facilitate placement in emergency situations. New Mexico only grants provisional licenses to relatives. A full licensing study must be completed within 30 days in Vermont, 45 days in Connecticut, and 60 days in New York. Arkansas does not grant emergency or provisional licenses, and Colorado and Massachusetts did not provide any information on this aspect of their licensing policies.

In these states, licensed kinship homes must meet the same minimum standards as non-relative foster homes. With the exception of New Mexico, licensing procedures and methods are the same for all applicants. New Mexico grants provisional licenses only to relatives, and foster care regulations permit relative foster parent applicants to participate in individualized pre-service training focused on the specific needs of the child(ren) to be placed in lieu of the standard group pre-service training.

These states have different policies regarding waivers or variances to licensing standards. Arkansas and Massachusetts do not grant waivers to licensing standards. The remaining states do make exceptions. Colorado, Connecticut, New York, and Vermont will grant waivers to all applicants, while New Mexico only makes exceptions for relatives. Connecticut only grants waivers until the home comes into compliance.

Among states that waive or make exceptions to licensing standards, most states do not have a specific list of standards that can be waived. Colorado, Connecticut, New Mexico, and New York can waive any standard that does not pose a risk to child health, safety, or well-being. Exceptions often involve space or sleeping arrangement requirements. In contrast to these states, Vermont only grants full or partial exceptions to the pre-service training requirement depending on the applicant's experience and circumstances.

Casework Support and Monitoring

States that license and approve relative homes have two approaches to monitoring kinship placements. Colorado, Connecticut, Massachusetts, New Mexico, New York, and Vermont monitor all homes with the same frequency regardless of licensure or approval status. Among these states, there is some difference in the frequency of mandatory caseworker contacts. Colorado, Connecticut, and Vermont⁴⁴ require monthly caseworker visits. New York⁴⁵ requires two visits with the child in the first month and quarterly visits thereafter, as well as two visits with the caregiver in the first month and quarterly visits thereafter. In addition, New York also requires monthly case planner contacts with caregiver. Massachusetts requires monthly visits by the child's worker and bimonthly by family resource social worker. Similarly, New Mexico requires monthly caseworker visits and biannual placement worker visits.

Arkansas is the only state in that monitors licensed and approved homes differently. Arkansas requires monthly contacts with children in licensed homes and quarterly visits with children in approved homes that are considered stable⁴⁶.

⁴⁴ Vermont DSS has also developed foster home support and supervision contracts with private agencies throughout the state. These contracts require a minimum of 1 contact by phone per week and 2 in home contacts per month with all homes caring for a child in state custody. Eight of Vermont's 12 districts have developed proposals to implement this initiative. Implementation in some districts began on April 1, 1997.

⁴⁵ NY requires quarterly contact if the child has entered care because of maltreatment or the parent's service need. Monthly ongoing contacts are required if placement occurred because of the child's service need.

⁴⁶ If problems occur in an approved home, or the child needs more intensive services, visits must occur monthly.

Evaluation

States that place with licensed and approved relatives have three approaches to evaluating kinship homes following the initial assessment. In Colorado, homes are not subject to a formal reevaluation unless the caregiver moves. [Colorado has a system of permanent licensure. In order to decertify a home, the county agency must initiate a revocation process.] Connecticut, Massachusetts, and New York evaluate all homes using the same methods and procedures regardless of licensure status. The sole difference is the set of standards applied when those are different for licensed and approved homes. Massachusetts and New York require annual evaluations, while Connecticut requires biennial evaluations. Arkansas⁴⁷, New Mexico⁴⁸, and Vermont evaluate licensed homes annually, but these states do not require a formal evaluation of approved homes beyond ongoing caseworker visits.

The content of the evaluation or licensing renewal study varies by state. Typical evaluation methods include a review of health and safety standards and interviews with the caregivers. Unique evaluation methods include annual communicable disease and TB skin tests in Arkansas; personal, employment, school and medical reference checks in Massachusetts; documentation of in-service training⁴⁹, a new medical report every 3 years, and a new foster parent agreement in New Mexico; and a written evaluation of the care provided in the home and a written physician's statement about the family's health every two years in New York.

Table 2.9 Assessment Methods for Licensed and/or Approved Homes by State

State	Case Record Review	Criminal Records Check	CPS Records Check	Health and Safety Assessment	Caregiver Interviews	Child Interviews	Household Member Interviews	Other Method
Arkansas	X			X	X	X	X	X
Connecticut			X	X	X		X	
Massachusetts	X	X	X	X	X	X	X	X
New Mexico					X			X
New York				X	X		X	X
Vermont	X		X					

⁴⁷ In Arkansas, approved homes are subject to annual TB skin tests.

⁴⁸ In New Mexico, approved homes must become licensed if placement continues more than one year.

⁴⁹ New Mexico may exempt relative from in-service training. Exceptions are made on a case by case basis for relatives only.

Funding

All states that place children with licensed and approved relatives offer the same resources to all homes. All homes are eligible for IV-E or state/local foster care board payments⁵⁰. In addition, child support, SSI, SSA, or VA benefits may be used to support a child in an unlicensed home if the child is eligible. Kin are also eligible for additional support (see Table 2.10). Flex funds include State General funds to provide for needs not covered by board payments of Medicaid in Arkansas; supplemental funds through the Parents and Children Together (PACT) program for services required by special needs children in Massachusetts; state child welfare monies to cover services for special needs children that are not covered by Medicaid in New Mexico; and funds to reimburse expenses related to the child's care in Vermont. Special Care Funds include degree of difficulty payments in Vermont.

Table 2.10 Resources for Licensed and Approved Homes by State

State	Clothing Allowances	Flex Funds	Special Care Funds	Day Care	Respite Care	Other
Arkansas	X,Z	X,Z				
Colorado	X,Z	X,Z		X,Z		
Connecticut	X,Z					
Massachusetts	X,Z	X,Z				
New Mexico	X,Z	X,Z				
New York	X,Z					
Vermont	X,Z	X,Z	X,Z			

X=licensed homes, Y=unlicensed homes, Z=approved homes

2.4 Conclusion

While state policies and laws are always changing, this survey, conducted in 1997, gives a thorough overview of the major issues confronting states with respect to evaluating and supporting kinship foster homes. In addition, it describes the many diverse and creative approaches to working with kinship caregiving families. One major finding in the law and policy study and throughout the project has been that less official or child welfare agency contact with the kinship caregiving family is not necessarily better - for the caregiver or the child.

⁵⁰ In Vermont, approved kinship providers are eligible for foster care board payments at the provisional rate, while licensed foster parents are eligible for higher foster care board rates based on training and experience.

In this study, the treatment and handling of kinship homes depends less on the state than on the category of home. With few exceptions, unlicensed kinship homes are assessed less rigorously, evaluated less thoroughly, and funded at lower levels than other homes providing out-of-home care to children in state custody. Unlicensed kinship homes also receive less casework support and monitoring in several states. In contrast, licensed and approved kinship homes are usually handled like non-relative foster homes, although states often allow these homes more flexibility in meeting licensing standards. Approved kinship homes are generally subject to slightly different standards than non-kinship foster homes, and licensed kinship homes may be more likely to receive waivers or exemptions to licensing standards.

Additional research is required to understand the effects of state policies on the well-being of children for whom kinship care is an option. There are three important issues that deserve immediate attention. First, it is important to understand the impact of state policies on the willingness and ability of kin to care for a child. If kinship care does, in fact, improve outcomes for children, states should formulate policies that encourage and support kinship placements. Developing policies that facilitate kinship care requires an understanding of the ways in which current policies and practices impact a caregiver's a) decision to accept a child for placement; b) ability to meet assessment criteria; and c) provide quality care.

On the other hand, states need to strike a balance between policies that facilitate kinship care and child protection. For this reason, it is critical to understand the impact of assessment, monitoring, and evaluation practices on the safety of children in kinship care. For philosophical and practical reasons many states have lower assessment standards for kin, particularly unlicensed kin. These same homes often receive less casework support and monitoring, and they are generally not formally evaluated after the initial assessment. Although some practitioners express concerns about these practices, little is known about the impact, if any, of kinship-specific assessment, monitoring, and evaluation on child safety.

Finally, there is little information on how kinship care affects other outcomes for children. A number of studies have addressed case outcomes for children in kinship care compared to children in regular foster care. However, there are few studies that examine the impact of kinship care on the child's functioning while in care or subsequently. One example, Benedict et al. (1996), found no difference in the adult functioning of subjects who had been in kinship care compared to subjects who had been in regular foster care. Future research should address child functioning in the placement and adult functioning while controlling for the impact of state policies. It may be that in many cases, state policies directly or indirectly influence outcomes for children by affecting the quality of care provided in the kinship home.

PART II: INDICATORS OF QUALITY

Indicators of quality of care in kinship foster homes were identified by collecting data from a variety of sources, identifying the major trends and themes, defining the major constructs that comprise quality, and then operationalizing the constructs to produce measurable indicators. The sources of data included the following.

- State survey of evaluative methods, reported above
- Focus groups with kinship foster caregivers, children, and caseworkers
- Review of existing national standards of professional and accrediting organizations
- Review of existing instruments that measure quality of care
- Review of the literature on quality in foster care, the nature of kinship foster care, measuring outcomes for children in foster care and identification of intervening variables that impact on outcomes for children.

The following sections provide the findings of the focus groups and standards, measurement, and literature reviews.

3 FOCUS GROUPS

3.1 Purpose of Study

The focus group study had two primary purposes. The general goal was to determine what constitutes high quality kinship care from the perspective of the main stakeholders: caregivers, children, and social workers involved. The information provided helped to characterize special issues of concern in selecting and evaluating kinship families. In addition, the investigators sought the participants' views on outcomes and the impact of intervening factors on quality. In particular, they hoped to gain a greater understanding of whether and how quality care in a kinship placement differs from quality care in a traditional foster care placement. The second purpose of the focus groups was to collect information that would assist in developing tools for evaluating and monitoring kinship families. The experiences and perspectives of the focus group participants

were used to inform the development of instruments to measure quality of kinship care. These findings summarize the indicators of quality identified in multi-ethnic focus groups conducted in rural and urban areas in two states.

3.2 Methods

3.2.1 Study Design

Twenty-four focus groups were planned with major kinship care stakeholders: kinship caregivers, children living with relatives, and caseworkers of children in kinship placements⁵¹. In order to capture a diversity of experience and opinion, purposive samples of stakeholders stratified by state, region, and culture/ethnicity were included. The investigators also believed that perspectives and experience might vary as a result of several other factors. Urban - rural differences are often important. In addition, experience may be different in states with specific policies for addressing kinship placements and those without such policies. Illinois has a state-administered child welfare system that has developed policies and procedures specific to kinship placements. In contrast, child welfare services in North Carolina are state-regulated and county-administered. At the state-level, North Carolina had not developed policies and procedures specific to kinship care at the time of the study, and local practice with respect to kinship placements varied significantly. Table 3.1 summarizes the study design.

In order to compare the responses of focus group participants across groups, the participants completed a short survey. These mini-surveys for participating youths and caregivers collected demographic information and information on select characteristics of the placement. The mini-survey for participating social workers collected demographic information, as well as information on relevant education and work experience. Prospective participants were not required to complete the survey as a prerequisite of participation.

3.2.2 Recruitment

The researchers worked with the Illinois Department of Children and Family Services (IDCFS), the North Carolina Department of Social Services (NCDSS), and the North Carolina Commission on Indian Affairs (NCCIA) to identify focus group sites. The primary selection criteria included willingness to participate in the project and the presence an adequate number of prospective participants to assemble the desired groups. IDCFS identified suitable sites and

⁵¹The study design did not include focus groups with biological parents. Although they have a significant stake in kinship care, the resources required to organize focus groups with this population were beyond the scope of this project.

prospective focus group participants in each site. NCDSS identified prospective sites based on their knowledge of county caseloads. Departments of Social Services in each county identified prospective focus group participants. NCCIA helped to secure permission to conduct the focus groups from the Cherokee Tribal Council.

Each cooperating agency was asked to identify all potential participants meeting the eligibility criteria discussed below.

- **Caregivers** Eligible caregivers included members of the targeted race/ethnicity who had cared for a child in DSS custody in the previous 2 years. We hoped to organize groups of caregivers from 6 to 10 households. We intended to give preference to women caregivers unless a sufficient number of men to form a group could be identified in one site.
- **Children** Eligible children included children over 10 years who were living with a relative at the time of recruitment. In addition, the project's advisory panel suggested participants should be the same gender. We hoped to organize groups of children from 6 to 10 households.
- **Social Workers** The sites selected caseworkers who had experience working with kinship placements.

Trained moderators conducted each focus group using topic guides developed for each set of participants. Moderators with experience conducting focus groups and/or knowledge of child welfare issues and experience working with groups were recruited. Moderators received training on the project's research objectives, procedures for conducting the groups, and the topic guides prior to conducting groups. Each group was led by a moderator from the same racial or ethnic background as the participants.

The focus group protocols were designed to elicit the values, perspectives, and experiences of caregivers, children, and social workers with respect to kinship care. In particular, we wanted to learn how kinship care differs from traditional foster care and the care of biological children by their parents, what issues are important to consider when selecting and evaluating kinship caregivers, and what special services are needed by kinship families. We also hoped to develop an understanding of how perceptions of kinship care differ by region and racial/ethnic group.

Moderators recorded each focus group on audio tape. In addition, moderators in Illinois took notes on the proceedings, and a note-taker documented the focus groups in North Carolina. With two exceptions, the audio tapes were transcribed prior to analysis. The exceptions included one group that was not taped and one tape that was incomprehensible.

3.3 Groups Conducted

Twelve focus groups, including pilot groups, were conducted in five North Carolina counties and an urban site in Illinois. This analysis includes information collected in the pilot focus groups. The focus group topic guides did not require significant revision following the pilots; therefore the pilot information is included in these analyses. The following table summarizes the types of groups conducted.

Table 3.1 Focus Groups Conducted

Population	Urban	Rural
North Carolina		
African American Caregivers	Site A	Site B
White Caregivers	Site C	Site D
African American and White Caregivers	Site E	
White Children	Site C	
Caseworkers	Site C Site E	Site D
Illinois		
African American Caregivers	Site F	
White Children	Site F	
Caseworkers	Site F	

It was difficult to organize focus groups in many locations. Limited pools of potential participants were a major obstacle in many sites. Although sites were selected based in part on the number of children in kinship care, kinship caseloads in some sites were not large enough to successfully recruit groups of 6 to 12 participants. This had the most dramatic impact on the children's groups. Most children in kinship care were less than 10 years old. Because of the age and gender criteria, potential group sizes ranged from 0-4 in North Carolina counties and the rural Illinois site. The original rural Illinois site is an extreme example of the problems associated with small pools of eligible subjects. In addition, the IDCFS originally identified a single site for focus groups with rural African American and white caregivers and children. However, the private agencies providing services to relative care placements indicated that there were no white families on their caseloads. Because of time and money constraints, groups that could be scheduled by the end of the project's first year were not included in the study.

A lack of agency resources to identify and help recruit potential participants was also an obstacle. The successful organization of each focus group required significant assistance from local agency personnel. Cooperating agencies performed several essential tasks, including identifying clients who met the focus group selection criteria; obtaining the clients' consent to be contacted; providing the names, addresses, and telephone numbers of consenting clients; and in

some cases, following up with clients to encourage participation. The project staff could not organize focus groups in any site without this support. Unfortunately, several cooperating agencies lacked the staff resources to provide the required support in a timely manner. This resulted in the cancellation of some focus groups.

The groups had the following characteristics. Thirty-three caregivers representing 25 households participated in 6 focus groups. Because the urban Illinois participants did not generally complete the surveys, this summary only includes information on participants from North Carolina. The nineteen female and six male participants ranged in age from 25 to 65 years old. On average, participants from two urban North Carolina sites were older than participants from the remaining sites. Of the five groups, two groups included only African American participants, two included only white participants, and one group included both African American and white participants. Participants included twelve grandmothers, six aunts, five grandfathers, one great grandmother, and one uncle. Four caregivers from three households were licensed foster parents receiving foster care payments. The unlicensed relatives all receive AFDC funding for the children in care. The children in their care had lived with the participants from 2 months to 8 years, and the number of relative children in the household ranged from 1 to 6 children. Most of these children entered care as a result of parental maltreatment related to substance abuse.

The number of caseworkers participating in each focus group varied from 2 in rural North Carolina to 12 in urban Illinois. In the latter case, all caseworkers serving kinship placements in the county participated. With the exception of the urban Illinois group, most, but not all, participants in each group were women. Participants ranged in age from 21 to 60 years old. All groups included both African American and white participants, and the urban Illinois group included four Latino/a participants. Participants' experience with kinship placements ranged from 0 to 26 years. On average, participants from one urban North Carolina site had considerably more experience than participants from the other sites. Reported caseloads ranged from 0 to 37 cases. One urban North Carolina site reported smaller average kinship caseloads than the other sites. All participants had at least a college degree.

Seven white children, representing 3 households, participated in two focus groups. The participants in one group consisted of a single sibling group. Participants ranged in age from 11 to 18, and they were living with their grandparents and their uncle and/or aunt. They had been living with these relatives from 1 to 4 years.

3.4 Findings

3.4.1 Selecting and Evaluating Foster Homes

Selection refers to the process of assessing a caregiver's capacity to provide adequate care before a child enters placement. Evaluation refers to the process of assessing the care provided after a child is placed. This section begins with an overview of the major screening and evaluation criteria mentioned by the participants. A discussion of issues of particular importance when screening and evaluating kinship homes follows.

Although selection and evaluation are conceptually distinct activities, they are discussed together because of the degree of topic overlap in the discussions. It is not clear that participants made, or felt any need to make, a conceptual distinction between the factors important in selecting and evaluating homes, and in many instances, participants addressed same issues when discussing selection and evaluation. When asked what they would look for if they had to select a relative to care for their child and how they could tell if the neighbors were providing quality care to their grandchild, participants often cited the same characteristics or behaviors in response to each question. In addition, many participants would select homes by examining the care being provided to children currently living in the home.

Selection and Evaluation Criteria

Tables 3.2 and 3.3 respectively summarize the main selection and evaluation criteria mentioned by participants. The participants largely focused on the provision of basic care. The components of basic care include child protection, physical care, emotional care, and support for normal growth and development. Although we discuss each aspect of basic care separately, the areas are not mutually exclusive. For example, the provision of stable daily routines and regular meals both contribute to a child's emotional well-being. In addition, some factors like the caregiver's age and health affect multiple aspects of child care. The participants' emphasis on the potential caregiver's child-rearing history and practices underscores the need to view child care holistically.

Table 2: SELECTION CRITERIA	Sites	CASEWORKERS				CAREGIVERS					YOUTHS		
		NC			IL	NC					IL	NC	IL
		D	E	C	F	B	D	A	C	E	F	C	F
Willingness to work toward reunification		X	X		X								
Caregiver's motivation		X			X			X					
Commitment to care for the child as long as necessary		X	X	X	X								
Caregiver's capacity to protect the child from the biological parents		X	X										X
Caregiver believes maltreatment allegations against the parent(s)			X	X	X								
Caregiver's family history				X	X								
Protective services checks		X	X	X	X		X						
Criminal records and police checks		X	X	X	X								
Child knows and has an existing relationship with the caregiver		X	X	X	X							X	
Child knows and has an existing relationship with the caregiver's children				X									X
Caregiver's age relative to the child's needs		X						X	X		X		X
Caregiver's health relative to the child's needs		X	X	X	X	X		X	X	X	X	X	
Caregiver capacity to provide love						X	X		X	X	X		
Caregiver has patience							X		X		X		
Caregiver likes children							X				X		
Caregiver is respectful to children							X	X					
Caregiver does not have a temper							X				X		
Caregiver has a job			X					X		X	X		X
Caregiver's child rearing history		X	X	X	X	X		X		X			
Caregiver's capacity to provide stability and security							X			X			
Child is allowed to bring possessions										X			X
Caregiver's capacity to provide structure and rules						X		X	X				
Caregiver's capacity to provide moral/spiritual guidance						X	X	X	X	X	X		
Caregiver's capacity to provide the child with direct supervision or day care		X						X					
Caregiver's willingness to follow agency rules re: discipline		X			X								
Caregiver's capacity to provide adequate diet		X				X		X					
Caregiver's capacity to provide adequate housing		X	X					X					
Caregiver's neighborhood					X							X	X
Caregivers' capacity to provide basic safety			X		X								
Caregiver's access to transportation		X									X		
Caregiver's financial capacity to care for the child		X	X		X		X		X	X	X		
Caregiver's general family relationships		X	X		X	X					X		
Fighting or domestic violence		X					X					X	
Substance abuse		X	X			X	X	X	X	X			
Availability of community and extended family support		X		X	X			X					

Issues of child protection were prominent in the discussions about the selection and evaluation of kinship homes. Participants addressed three topics related to child protection: basic safety, protection from potentially dangerous activities in the caregiver's home, and protection from continued maltreatment by the biological parent(s). Basic safety involves protection from hazards in the physical environment in and around the home. Although not a major topic of discussion, several participants believed that kinship homes should ensure the child's basic safety, and it may be considered one component of adequate housing. Participants were more concerned with protecting the child from the consequences of negative behaviors by members of the caregiver's household. Such behaviors included criminal activity, child maltreatment, domestic violence, and substance abuse. With respect to general child protection, caseworkers placed a strong emphasis on background screening, including criminal history and protective service's records checks. Participants of all types discussed the need to ensure that the child is not exposed to domestic violence, substance abuse, or the final child protection factor, continued maltreatment by the biological parent. Because of the caregiver's relationship with the child's biological parent, many participants believed that children in kinship care are at greater risk of continued maltreatment. For this reason, participants emphasized that the caregivers must establish and enforce appropriate boundaries with the biological parent.

The second aspect of basic care is the provision of physical necessities. At the selection stage, the participants focused on the caregiver's capacity to provide stable physical care. This was often expressed as a preference for employed, financially stable caregivers. Evaluation criteria focused directly on the provision of food, clothing, shelter, physical and mental health care, and hygiene. There were no remarkable differences between the types of participants regarding this aspect of care.

The third aspect of basic care is basic emotional care. Emotional care has a number of dimensions, including placement stability, the caregiver's emotional capacities and characteristics, caregiver - child interactions, and the caregiver's ability to respect the parent - child relationship. Both caregivers and caseworkers raised the issue of placement stability in terms of the caregiver's commitment to the child. Caseworkers generally described commitment as a willingness to care for the child as long as necessary, while caregivers more often provided emotional testimonies of the sacrifices required. Caregivers also focused more on the caregiver's emotional capacities and characteristics. They characterized a desirable caregiver as a person with a balanced temperament who can provide children with love and respect. All participants agreed that loving interactions between the child and caregiver provided evidence of quality care. Participants also focused on one particular aspect of caregiver - child interactions; the caregiver's representation of the biological parent to the child. There was widespread agreement that the caregiver should refrain from denigrating the child's parent(s) in order to protect the child's emotional health.

The final aspect of basic care is the provision of the requisites of normal child growth and development. These requisites include the provision of daily structure and rules for child behavior;

chores and responsibilities for the child; supervision; moral and spiritual guidance; discipline; educational opportunities; and recreation. There was general agreement among the participants on these aspects of care.

Most of the screening and evaluation criteria discussed do not apply uniquely to kinship care; all out-of-home placements should provide all aspects of basic care. However, the participants did raise a number of issues that pertain more specifically to kinship care. These issues include the placement process itself, screening and licensing standards, protection of the child from continued maltreatment by the biological parent, discipline, and the caregiver's age and health. Each issue is discussed below.

Placement Into Kinship Homes

Unlike non-relative foster parents, most kinship caregivers in the participating states are not licensed before a child is placed. As a result, caseworkers may have little information about the caregiver at the time of placement, particularly in emergency situations. As one worker explained:

'Say you have a child in crisis, a placement crisis that needs immediate placement. You need time to evaluate the families [for] unknown factors. You've got a child that's at risk. You need time to evaluate the family. Whereas you've got foster parents that have been evaluated and licensed.' [Site C - Worker]

The same worker resolves this dilemma by *'[using] a foster placement immediately to protect the child because the agency is responsible for that child's safety. Then proceed with evaluating the relatives.'* [Site C - Worker]

In other emergency situations, children are placed directly with kin. Under these circumstances, caseworkers have little time to conduct a full pre-placement assessment of the kinship home. Workers generally report that some screening occurs prior to placement. However, subsequent assessments may reveal significant issues in the kinship household that may have precluded placement with that relative under other circumstances.

I do think there are times when there is a time crunch, like I talked about before, a certain emergency removal of kids when you've just got to move them. That places workers in a situation where they might make some preliminary checks and things and it looks okay. Then we find out later that it's not going to be something because of other dynamics. I just feel like those are more like emergency situations where the workers have very little to make a full assessment. [Site C - Worker]

I think one of the problems with relatives involves how relatives are approached...We work in follow-up, and a lot of times when we get a case, the relative will have already been chosen...At that point, the child's been placed there and that relative has all the appeal rights...a foster parent does...Even if that relative may not be appropriate by all of the ways we have talked about today, we're...stuck. [Site F - Worker]

Many caregivers had children placed in their home in the manner described above. In addition, some report not being given a choice - the worker delivered the child and left with no opportunity for argument.

All of a sudden this DCFS worker calls me and tells me I've got to take these four kids. This lady is just like, and this is exactly the way she did it, she just called me down there. Ms. X, you have to take these children. I don't have any place for them to go. They've been in my office all day. I've got to go to a meeting and you've got to take these children home with you. I'm sitting there in shock. I've got a husband at home where am I, and this is a nine month, nine day old baby. Where am I going to take these children lady She says you're going to put them in your car and you're going to take them home. She ushered me out. She kept typing this paper up. She ushered me out of her office and put these kids in my car. I'm sitting there, like Lord, what happened? What am I going to do? [Site F - Caregiver]

I didn't even know he was coming to live with us, and I got a call at 10:00 will you come pick him up because we were the only stabilized family that could keep him. [Site B - Caregiver]

In addition to raising child safety issues, unplanned placements can create problems for members of the caregiver's household and the child being placed. To minimize strain on all parties, some participants suggested that social services should prepare families by conducting preplacement meetings between the families involved. They felt that such meetings would benefit both the children entering care and the kinship families, as well as the biological parents. These meetings would provide an opportunity to discuss the child's needs and each party's expectations of the placement.

The [agency] people should have a meeting with the entire family which the child is going to...It'd be like prenatal care I guess, but for the family. That's the best way to describe it. You know to have them understand how the children and parents feel. [Site F - Youths]

I think you have to make the relative more a part of the [selection] process. If they become more actively involved with the whole thing, as opposed to just sitting there and telling them what it is they will do. Give them some choices. The way I see it right now, we give them no choices up to and including who will service their case. [Site F - Worker]

If there's enough time [a meeting] would be nice so everybody knows what's going happen and who's going where. [Site B - Caregiver]

Although participants recognized the need for more careful preplacement planning and screening, the exigencies of the placement situation make desired changes difficult to implement. Children often require emergency placement, and licensed foster homes are scarce. In many cases,

relatives are the easiest or only placement resource available in these situations regardless of their desires or suitability.

All too often the relative caretaker is essentially the easiest and quickest way out, at least for initial placement. [Site F - Worker]

Or the only available resource sometimes. You can't find a lot of foster homes for 15 year olds or a year old. [Site F - Worker]

Screening/Licensing Standards: Caseworkers in North Carolina often discussed screening kinship caregivers with reference to the licensing standards applied to foster parents in general. In participating counties, kinship homes are not subject to the same standards as non-relative foster homes unless the relative wishes to become licensed. One county reports that fire inspections, health inspections, and proof of caregiver immunizations are not required of kinship homes. [Site D - Worker] Another county reported that relative homes are not required to have a fire extinguisher, a smoke detector, a fire inspection, a health inspection, or a water inspection if the home uses well water. [Site E - Worker] In another county, caregivers are not required to have physicals and home size regulations do not apply. [Site C - Worker]

Caseworkers generally believed that agencies should not hold kinship homes to the same standards as non-relative foster homes. Standards that should not apply include square footage requirements, exit signs over doors, training requirements, number of children per room. [Site C - Worker] Workers in another county agreed that square footage requirements should not apply to relatives. [Site E - Worker] Workers also indicated that a prior felony conviction or protective services substantiation should not automatically disqualify relatives from serving as caregivers. When background records checks uncover child protection issues, caseworkers believed that the agency should consider a number of factors when determining the appropriateness of placement with the relative. These factors include the severity of the incident, how long ago the incident occurred, steps taken to change behavior, and behavior after the incident.

They could have a felony charge years and years ago that might not stop us from putting a child in the home now, whereas if they were becoming foster parents, a felony stops their licensure. [Site E - Worker]

We have certain crimes that will automatically call for a denial of license to that home. It doesn't really matter how long ago this took place. I think that should be given consideration. I mean, was it 30 or 40 years ago that this took place? [Site F - Worker]

I think sometimes we need to look at what type of situation it was. For example, a person who abused sexually a minor, and after that we don't know what happened in terms of this person... we don't know too much about it, and it was 25 years ago. We don't know if he is still abusing kin or still sexually abusing others. So, we

need to be careful in that direction. How long was it, and what type of crime was it, and the circumstances. [Site F - Worker]

We have to look at when did this occur. Under what conditions did this occur? Where is this family member at now? Was this five years ago? What have they been doing since that time? Has there been a record since that time? So, if they said I've been in treatment, we can verify that. There's not been any, you can even check police calls to the house. If police have not been going to this house for these things they have been going to before, we can see there's a change. It's a probably change. It would cause us to say it's a safe place for the kids. [Site C - Worker]

Although caseworkers generally believed that the agency should not hold kin to the same standards as licensed foster parents, the participants recognized a need to apply minimum standards to kinship caregivers. However, there was uncertainty about where to draw the appropriate lines. Social workers were often unsure how to weigh the relative importance of kinship vs. other factors when screening homes. One worker suggested a practical standard for screening kinship homes. According to this worker, kinship homes should be held to protective services standards for removal; if the conditions in the household would not warrant removal of a child, then the home is acceptable for placement of a relative child.

I think certainly, if it's a difference between being able to place a child with relatives and not being able to place a child with relatives, yes, then it's important that we make exceptions or waivers certainly. But at the same time, relatives need to be held up to a certain level of standards because too often kids are placed in homes because they are relatives, and it doesn't mean the home is in their best interest or even appropriate. [Site F - Worker]

3.4.2 Protection of the Child from Continued Abuse by the Birth Parent:

The relationship between the child's parent and caregiver raises issues of basic child protection when children have been placed because of maltreatment by a parent. As the section on familial visitation makes clear, participants believe that kinship care increases contact between the child and parent, and they view parental visitation as a beneficial aspect of kinship care. Because of the potential for increased contact, some workers believe that it is more difficult to ensure a child's protection in a relative care setting. One participant summarized the issue in a single word, 'Access.' [Site F - Worker] Birth parents generally know where the relative lives, and relatives may be more inclined than non-relative foster parents to permit unsupervised visitation. Caseworkers believe that increased access equates to increased risk of continued maltreatment by the birth parent.

The child lots of times feels emotionally better...but they have more access to the perpetrator. [Site C - Worker]

Sometimes, as well, there's not enough separation between the family members and the parents. These relatives make it seem as though these children were never taken away. They give full access to the parents to the kids. [Site F - Worker]

It may be more difficult to caregivers than foster parents to establish boundaries with the biological parent because the parent knows where the child is living. [Site D - Worker]

Because of the potential for abuse as a result of inappropriate parent-child contact, caseworkers felt that it is important to explore a caregiver's commitment and ability to control parental visitation. Caregivers should comply with the visitation rules outlined in the case plan. In some cases, the natural parents behavior may be so extreme or volatile that the caregiver cannot enforce the case plan. Under these circumstances, placement with a relative may not be appropriate regardless of other factors.

You also have to look at the commitment of that relative. Is that relative going to allow that child to go back to the home without our knowledge? [Site E - Worker]

It's good that the relative and parent can get along so that the parent can come there and spend time with the children. But that relative needs to be able to control his or her environment to say this is enough, you need to leave. You can't come back until such and such day, until you can show some appropriate behavior. I think it varies, but when you have someone that is real close, and close to the point where they don't know how to set boundaries with that parent, then you have some problems. [Site C - Worker]

If you have a really crazy, violent parent, I don't think you can risk relative placements. I mean, it takes an extreme relative to be able to handle that. That is the positive side to foster care. Sometimes you have to put children where some of these extreme people do not know where they are at. [Site C - Worker]

Workers felt that inappropriate contact between the parent and child is particularly likely when the caregiver does not believe the accusations against the parent. For this reason, these workers believed that the agency should assess whether the caregiver believes the allegations before placing the child.

[Relative placements] can be a problem if the relative doesn't believe that the abuse happened or that the neglect was that bad. They may expose the child. [Site E - Worker]

Another issue that is more important is finding out where this relative is with whatever this birth parent has or hasn't done that has caused this child to need a place to live. How this relative views what's occurred is going to tell you whether they're going to comply with regulations that we had to compile, including court order regarding visitation and things like that. It's real important to know how they feel towards that parent's actions. [Site C - Worker]

Some caregivers acknowledged the need to monitor and regulate parental visits and discussed the need to set rules and boundaries for parental visitation. These caregivers were most concerned with ensuring that parents did not visit when under the influence of drugs or alcohol. When caregivers did not feel comfortable supervising visitation, they may request agency supervision.

And we have an understanding with her even though her parental rights has been limited and she cannot come to my house unless she get permission even though she's my daughter. She found out the hard way that I will put her in jail. She cannot come there drinking, she cannot come there smoking, she will not come there high on drugs. When she have herself cleaned out, she can come visit. And those are the only grounds that she can come. [Site E - Caregiver]

She went to prison this time, and she's back out again which is what makes it hard on us because the mother is back in town. And she still doesn't have it together and she keeps wanting to see the child. That's the one thing that I asked DSS. Would they please monitor visitation and just set stipulations. [Site E - Caregiver].

Although parents acknowledged the need to control parental visitation, many caregivers found the task difficult. Two factors accounted for this difficulty. In some cases, the caregiver's emotional attachment to and relationship with the birth parent make it difficult to enforce rules. In other cases the birth parent's behavior may be so extreme or unpredictable that the caregiver cannot control visitation.

Because they are a relative, you have that, and it makes it a little more difficult to administer, whether it's your decision or the court's decision, or social service's decision. [Site C - Caregiver]

In our case, we have the additional fear of the mother herself. It's not just the child's fear and insecurity, it's...I mean this girl, man, she can whip any of us. I mean she's just; she's a monster. [Site E - Caregiver]

3.4.3 Discipline

Because previous research indicated that kinship caregivers are more likely than non-relative foster parents to hold favorable views of physical punishment [Gebel 1996], we asked caregivers about their disciplinary techniques. Caregivers indicated that they use a wide array of disciplinary techniques to make their children mind. Frequently cited disciplinary techniques included time out, positive reinforcement, loss of privileges and allowance, and object lessons. Participants expressed mixed views on the use of physical punishment to discipline children. Caseworkers and some caregivers indicated that spanking is not acceptable.

Relatives in many cases have been de facto caretakers of the child long before we ended up entering the scene. They have their ways of doing something...If granny says I always give him a swat or something or other like that, it's real hard to get the message through granny's thick skull that no, it is not all right for you to give him a swat. [Site F - Worker]

I do not believe in hitting or spanking; it teaches them to hit. She was hurt enough. [Site D - Caregiver]

However, some caregivers felt that spanking should be an acceptable means of disciplining children, and several admitted spanking the children in their care. Although they were generally aware of agency prohibitions against the use of physical punishment, many caregivers believed that spanking is the only effective means of making children behave. Participants who spank their children generally resorted to physical punishment as a last resort. They were careful to distinguish between spanking and abuse.

I told Social Services, if I felt like one needed a spanking, they were going to get it. Sometimes I have to. I spank them. They get in there and mind. [Site A - Caregiver]

I look at it this way, if you try everything else, you know time out, everything but bribery. Then it's time for a spanking...but you don't abuse them. [Site B - Caregiver]

3.4.4 Caregiver's Age and Health

Research shows that kinship caregivers tend to be older and experience more health problems than non-relative foster parents. For this reason, we asked participants what role age and health should play in selecting a relative to care for a child. Participants generally believed that age *per se* should not be a factor in selecting a relative to care for a child. In contrast, participants believed that the caregiver's health is a significant issue. They felt that the caregiver's physical and mental health should allow him/her to provide care that meets the child's particular needs. Also, caring for the child should not pose a threat to the caregiver's health.

I think attitude is more important than age. [Site C - Caregiver]

A lot of them, they have health problems. You have to just determine if that health problem is going to be a detrimental problem in providing for the care of the child. [Site C - Worker]

Depending upon the age of the child. Because health would be real important. Because, I mean you wouldn't want to give a person that has heart trouble or something a new born or a two year old. Somebody that they have to run around and catch up with. Then, it depends upon the age of the child. [Site A - Caregiver]

Several groups discussed health factors that should potentially disqualify relatives from providing care. One group of caregivers indicated that HIV infection, a ‘nervous’ personality, a bad heart, a mental condition, or a chronic condition that would be worsened by child care may be grounds for not selecting a caregiver [Site A - Caregiver]. Caseworkers in one group cited limited mobility, a contagious disease, a heart condition, or terminal illness as health conditions that might disqualify a potential caregiver [Site F - Worker]. These workers same stressed that the impact of any health condition depends on the child’s capacity for self-care. They alluded b to one case in which a blind couple was licensed as foster parents for an older, largely self-sufficient child.

3.4.5 Outcomes in Kinship Care

Table 3.4 outlines the major outcome measures mentioned by the focus group participants. Caregivers tended to focus on the child’s school performance, behavior, and happiness. Caseworkers were more concerned with permanency, although permanency issues pervaded the caregiver focus groups as well. The impact of the kinship placement on the caregivers family also emerged as a significant issue in measuring kinship outcomes. Although few participants mentioned changes in kinship family dynamics as an outcome per se, many discussed the adverse effects of the placement on their family. The remainder of this section addresses the issues of permanency, reunification with the biological parents, and kinship family dynamics.

Table 4: OUTCOME MEASURES	CASEWORKERS				CAREGIVERS					YOUTHS		
	NC			IL	NC					IL	NC	IL
	D	E	C	F	B	D	A	C	E	F	C	F
Measures	Sites											
Child does well in school				X		X		X	X			
Child's behavior (general)					X			X	X	X		
Child is polite and respectful							X		X			
Child is happy		X		X			X		X	X		X
Child dresses appropriately							X		X			
Child receives 'permanency'	X	X	X	X								
Child has contact with biological parents		X										X
Placement negatively impacts the caregiver's family relationships			X		X	X		X	X	X		X

Table 5: INTERVENING FACTORS	CASEWORKERS				CAREGIVERS					YOUTHS		
	NC			IL	NC					IL	NC	IL
	D	E	C	F	B	D	A	C	E	F	C	F
Criterion	Sites											
Level of financial assistance to caregivers	X	X	X				X	X	X			
Assistance with child(ren)'s clothing		X	X		X		X		X			
Assistance with medical care					X	X	X					
Assistance with Christmas presents			X			X						
Timing of assistance			X		X		X		X			X
Preplacement planning and preparation of the kinship family				X	X							X
Agency caseloads			X				X					
Supervision of kinship placements	X	X	X				X			X		
Caregiver input in case planning and decision-making			X	X				X		X		
Caseworker communication and support		X		X	X		X	X		X		X
Caseworker provision of information re: services, policies, and case status		X	X	X			X		X			X
Training for caregivers		X	X						X			
Provision of day care	X		X				X		X			
Provision of counseling for children in care					X				X			
Provision of support groups for caregivers		X	X						X			

Permanency

Caseworkers in all groups identified permanency as a desirable outcome in kinship care. This is not surprising given that social workers operate in legal and policy environments that define permanency as success. Consistent with accepted interpretations of permanency, social workers often described successful outcomes as reunification or adoption with reunification as the preferred outcome. As one worker put it, ‘Of course our first goal is to return to the parent, and if that does not work out, as a second alternative, we would like placement with an appropriate relative...Plan B.’ [Site E - Worker]

From the perspective of many participants, a definition of permanency that limits acceptable outcomes to reunification and adoption will doom many kinship placements to ‘failure.’ In general, participants were not sanguine about the prospects for parental reunification from kinship homes (see below). Adoption also appears unlikely in many cases. Although a number of caregivers expressed an interest in adopting their relative, others were openly hostile to the idea. Caregivers who opposed adoption generally did so because they saw no need to adopt a relative. For these caregivers and others, permanence is not primarily a legal issue.

Other caseworkers defined permanence in terms that reference the caregiver’s long-term commitment to the child. This is in keeping with an emphasis on commitment and stability expressed throughout the focus groups.

I look for a sense of permanency, a sense of long term responsibility and commitment to the kids future and those things. Just that they’re thinking about where he’s going to go to school. What he’s going to do next summer. They’re looking ahead together as a family until, including that child in there, and thinking about the kids being adults. [Site C - Worker]

The children are pretty much stabilized in the home in regards to their emotional stability and their relationships with the other kids in the home. That has reached a point where the relative can adequately make decisions about what is right for this child, the way she would her own. She’s gotten to know the child and you don’t have to step in to do anything. [Site C - Worker]

Workers who embrace a broader definition of permanency expressed frustration with policies that constrain caseworkers to push for reunification or relative adoption.

What we are getting in court now is either you come up with a permanent home or you put this kid up for adoption. So even if we think we have a successful placement in a [kinship] foster home, that cannot be maintained. The court is giving us time constraints. [Site F - Worker]

These caseworkers were more willing to accept other long-term kinship arrangements as successful. For example, a successful kinship placement could be one in which ‘the child has seen the foster parent as a surrogate parent whether or not the natural parent is in the picture at all. A

situation, where on the one hand, there is not real hope of return home, and on the other hand, adoption doesn't seem to be an option either. Provided the child is 'safe, stable, happy, [and] doing as well in school as possible,' caseworkers may view that as successful case outcome although 'it is not something that necessarily fits in with the supposedly vowed [sic] departmental goals of either return home or adoption within as quick a period of time as possible.' [Site F - Worker]

Other workers believe that the transfer of legal custody to the relative caregiver can indicate a successful kinship placement. 'Sometimes I know if it's successful because the relatives tell me they're ready. They are ready to let go of our support and the structure and the protection and all of the things, the involvement. They sort of become, they start feeling successful, I've done a good job, I'm doing a good job, I can keep on doing this. Everything is in place. It's sort of like they begin to say, I'm ready. When we go back into court, I'm hoping to get custody this time.' [Site C - Worker] Some caregivers also expressed support for legal custody without agency involvement. 'If this were the situation where you have custodial or legal documents, I'm not so sure I would want DSS involved. Not unless I really needed a caseworker.' [Site C - Caregiver]

Reunification

Participants had a variety of perspectives on the impact of kinship care on the prospects for a child's reunification with the natural parents. Some participants believed that kinship placements can facilitate reunification. If the parent and caregiver have a positive relationship, increased visitation and the caregiver's support may help the parent reunify with his or her child.

When you have a positive relationship, they can be more reinforcing to the parents in their goal; working toward their goal. If [the parents] are doing well, [the caregivers] are more supportive. [Site F - Caregiver]

If all of them, the foster parent, the natural parents, whatever, are all working hard toward a goal of reunification, I think it is something that can probably make it easier. [Site F - Worker]

I think there are sometimes when I think [a close relationship] is good because if the parents can come and visit the child, then they can reconnect with this child in order for them to get the child back. [Site E - Worker]

Other caseworkers believe that kinship care makes reunification with the child's natural parent more difficult. According to one worker, 'relative placements [are] almost a forecasting down that the parents will not get the children back.' [Site C - Worker] Ironically, these workers conclude that the increased parent-child contact often seen in kinship care can work against reunification. Parents may feel more comfortable knowing that a relative rather than a non-relative foster parent is caring for the child. This psychological comfort when combined with

frequent contact between the child and parent may undermine the parent's incentive to work toward reunification.

If it's a good placement and the relative cares, if the visits are there freely and the parents can come and go as they want, sometimes that parent may lose some of his or her incentive to complete the service plan. [Site F - Worker]

[A close relationship] can undermine the children leaving that placement and going back home. I mean, if the parent gets all the goodies of having children, they can go play with their kids, grandma fixes supper so they can go eat with their kids, they seem them whenever they want. They have no motivation to go and do the work that needs to be done to parent the children. [Site C - Worker]

Frequent contact between the caregiver and the parent may also undermine reunification. Kinship caregivers often have more knowledge about the birth parent's activities than non-relative foster parents. Relative caregivers are likely to know what efforts the parent has made to change the circumstances that necessitated placement. This knowledge may hinder reunification if the caregiver believes that the parent is not taking adequate steps to comply with the case plan. Under these circumstances, caregivers may resist reunification even when the parent has satisfied the conditions for reunification set by the agency.

Caregivers often hear with their hearts and not their ears. They don't always internalize that placement is short term. [Site D - Worker]

In a lot of cases with kinship placements, it seems that there very well might be kind of a conflict between grandma, uncle, aunt, cousin, whoever it might happen to be who is taking care of the child and who certainly has the child's best interests at heart. But at the same time, may also be looking at it from the point of view of I can certainly do a better job as a parent of this child than mom who is off drinking too much, or doing too much drugs, or that sort of thing. It is an attitude that may be oppositional toward an avowed attitude of return home, particularly if the parent is showing some, but not necessarily 100% success of going through the various objectives we have placed for them. [Site F - Worker]

3.4.6 Negative Impact on Caregiver

Negative changes in the kinship caregiver's family relationships are often one outcome of relative placements. No participant specifically cited changes in kinship family relationships as an outcome measure. However, so many participants raised the issue in various contexts that it seems appropriate to include it as an outcome. Relative placements may affect any or all of the caregivers existing family relationships. In addition to the obvious impact that placement may have on the caregiver's relationship with the child and the child's parent, participants also mentioned negative

changes in their relationships with spouses, children, grandchildren, and the child's other grandparents.

One difference with taking care of a relative's child and with taking care of your own is that your own kids think you give more attention to the other one than you [give to them], and then they gonna get mad and fuss and fight. [Site B - Caregiver]

Because we had two more grandchildren with another daughter who didn't think it was fair that Courtney was able to live with us for a while. So see, it's a lot of friction. [Site C - Caregiver]

I think dealing with the other grandparents, it's difficult. In that we did what we though was best and they did not think that was the thing to do. It caused, we didn't know them that well, but it caused stress between us. [Site C - Caregiver]

3.4.7 Intervening Factors (Agency Role)

This section focuses on the relationship between kinship caregivers and the placing agency. Agency activities can play a considerable role in determining the quality of care received by children in kinship care. Some caregivers may not be capable of providing quality care despite their best efforts without outside assistance. With agency support and services, these same homes may provide high quality care. This section examines the relationship between social service agencies and kinship caregivers from their own perspectives.

Table 3.5 summarizes the principal services and support that participants felt should be provided or arranged by the placing agency. Financial assistance and services dominate the list. Participants also discussed the need for more support and monitoring. This section discusses these issues in greater detail beginning with the participants' general perspectives regarding the relationship between kinship providers and the placing agency. It continues by exploring issues surrounding the licensing of relatives, funding and service needs, and agency monitoring and support.

General Relationship

Discussions of the relationship between kinship caregivers and the placing agency inevitably used the relationship between non-relative foster parents and the placing agency as the point of comparison. There is a perception among many participants that social service agencies treat kinship caregivers differently than non-relative foster parents. This perception is a source of resentment for caregivers and frustration for caseworkers.

Because you are taking care of family members, you are denied a lot of different things that foster care...families get. [Site A - Caregiver]

Relative placement has always been the preferred form of foster care. The problem is... they don't have the same support from our placement agencies that license. [Site C - Worker]

In addition to the imbalance in treatment, participants from one North Carolina site referred to a basic power imbalance in the relationship between kinship caregivers and the system as a whole. Caregivers expressed frustration that social workers and judges have more control over case-planning and decision-making than they do. Caseworkers also discussed the relative powerlessness of relative caregivers in the system. This fundamental imbalance struck participants as unfair and caused resentment.

You can not refuse DSS, as I have ever heard of. Maybe you could, but most people probably aren't in that position. [Site C - Caregiver]

Kinship caregivers] are providing primary care and know that kid better than anybody, and yet have zero power in terms of decision making input into court action, custody action, agency plans. It's an incredible imbalance of power for those relative caretakers. They have less power I think than foster parents do. [Site C - Worker]

Both caregivers and caseworkers felt that agencies should correct power imbalances by involving caregivers more fully in the case planning process.

To work as a team. [Caseworkers] talk about being a team, but they don't practice it. [Site F - Caregiver]

Make that relative caregiver feel like she/he is part of the process. Talk with them instead of to them. Give them some choice in the decision making process if something major is happening. [Site F - Worker]

I think they need some legal rights. I think when we have court hearings that these kinship caretakers need to have some representation and a vehicle for communication, at least communication with the court about their observations and awareness of that child's life to share with that court. Right now they can not get any input into that system. [Site C - Worker]

Licensing Policies: Comments about unfair treatment generally related to the licensing status of the caregiver. Because North Carolina and Illinois have different licensing policies, this section addresses the issues raised in each state separately.

North Carolina does not have a statewide policy with respect to licensing relatives; policy and practice varies by county. The comments of participants indicated that participating counties do not routinely license kinship caregivers. Many caregivers did not know that they could become licensed, indicating that local agencies do not regularly inform kin of this option. Although most counties will attempt to license relatives at their request, local agencies typically discourage the practice.

Caseworkers in North Carolina had mixed opinions about the desirability of licensing relatives. The debate typically focused on the difference in funds available to licensed and non-licensed caregivers. Some caseworkers believed that kin should not receive additional funds because families are obligated to take care of their own. One caseworker asked, *My thought was, how money hungry are they if they can't take care of their own grandkids?* [Site E - Worker] Generally however, caseworkers felt that families needed and should be entitled to the assistance provided to non-kin foster families. Caseworkers recognize that licensure brings concrete benefits to caregivers. Non-licensed kin must rely on AFDC benefits which pay considerably less per child than foster care subsidies.

Caregivers are given the short end of the stick financially. Foster parents are given room and board for a child, but they must be financially self-sufficient. Kinship caregivers may not be financially self-sufficient. They can provide care, but it may be a hardship for caregivers. Foster parents receive the foster care subsidy, Medicaid and day care, while kinship caregivers may get AFDC and Medicaid. [Site D - Worker]

Finances are an issue. I don't see it as parents wanting to take children for the sake of, I mean relatives, wanting to take children for the sake of getting money. It's not a lot of money. But, this can help out a great deal in, even down to the emotional aspect, because a lot of emotions come into play when you have a whole lot of bills and a whole lot of responsibilities and very little resources. [Site C - Worker]

Despite the recognition that kin may need the additional benefits that licensure brings, caseworkers did express practical reservations about licensing all relatives. In one county, caseworkers worried that licensing relatives would strain the agency's resources. Other caseworkers believed that licensing relatives negatively impact the agency's capacity to relinquish custody of children to their caregiver.

If we start licensing every grandparent in the county, we're going to work ourselves to death. [Site E - Worker]

As an agency we try not to [license relatives] very much because we continue to have custody of those children until they turn eighteen. They belong to a foster care case and plan. We try to focus on giving relatives custody of children for one year if parent's do not get their act together so that we're out of it. [Site C - Worker]

Illinois DCFS promulgated policies intended to facilitate the licensing of relatives in contrast to the North Carolina sites. Gleeson [1996] synopsis DCFS's policies regarding the licensing of kin. Following the 1979 *Miller v. Youakim* decision by the U.S. Supreme Court, Illinois began providing foster care payments to relatives caring for children in state custody regardless of the child's eligibility for Federal reimbursement or the caregiver's licensing status. In 1986 under pressure from Federal regulators, DCFS created licensing standards specific to relative homes to increase the number licensed kin. DCFS revised these standards several times to facilitate the licensing of relative homes. Despite these changes, approval rates remained between 40% and 60% through April 1992. DCFS relaxed licensing policies further as a result of the 1992 *Reid v. Suter* consent decree. Under the decree, DCFS agreed to grant waivers of the relative licensing standards and to strengthen the appeals process for relatives denied a license. Burgeoning caseloads and fiscal constraints led DCFS to reevaluate its kinship policies, culminating in the 1995 Home-of-Relative Reform Plan. The plan eliminated separate licensing standards for kinship homes among other reforms.

Caregivers in Illinois raised a number of issues related to licensing. As in North Carolina, financial issues were the principal topic of conversation. Caregivers expressed resentment at being stuck with children with no support, and they believe that DCFS thinks they should take care of the children just because they are relatives. According to one caregiver, 'Failure to license a home is a form of state-sanctioned neglect because children are not getting needed financial support.' The caregivers recognized that licensing serves to protect children. However, some caregivers expressed resentment over having to be licensed after raising children. Many caregivers report difficulties obtaining licenses, especially due to criminal histories. They also report that good private agencies will advocate for caregivers and help them obtain a license, while DCFS will not.

Caseworkers in Illinois expressed reservations about licensing non-removal cases.

Many years ago when we first started licensing relatives, we saw too many women just walking away from their children and leaving them with grandma so that grandma, in the State of Illinois, would take custody, and then the parent would move in with grandma. I'd go in the front door, and I'd see mom sneaking out the back. That's a problem. [Site F - Worker]

I've had relatives split the child with the parent...The kid is not really living there, but we can't prove it unless we stake out the house 24 hours a day. [Site F - Worker]

3.4.8 Funding and Services

North Carolina: Agency funding and services to kinship placements were major issues addressed by participants. When asked about the major difference between kinship care and regular foster care, one group of caseworkers cited money and fewer resources as the main

difference. [Site C - Worker] In participating counties, kinship caregivers do not receive foster care payments unless they are licensed as foster parents. The services provided by each county agency vary considerably. Caregivers in one county believed they received all of services they required. However, many caregivers felt that they needed additional support for the child in care. When discussing services that are available to regular foster parents, but not kinship parents, caseworkers in one county mentioned car seats, baby beds, clothing, physicals for children coming into care, and respite care. [Site E - Worker] In another county, DSS provides allowances for clothing and shoes, Christmas presents, and counseling for children in regular foster care, but not children in kinship care.

When asked what services the agency should provide to kinship caregivers, most participants focused on funding. They generally believed that AFDC funds were inadequate to raise a child.

I can't understand why...when they place a [relative] child in your home...they, right away, use your income. I can't understand that. To me, that's not right. My income may be enough to provide for my family, but this is something, this is in addition. I mean, you can't go by you know, I'm just barely making it myself. [Site A - Caregiver]

There is an assumption because they are with strangers that we have an additional financial responsibility for the children that somehow we don't have if we plunk them in on the relatives. Like somehow we're not responsible. Why, I don't get it. [Site C - Worker]

In addition to funding needs, participants discussed concrete service needs that should be funded by the agency. Many participants indicated that kinship caregivers without insurance need help paying the child's medical expenses [Site D - Caregiver; Site B - Caregiver]. African-American caregivers often discussed the need for funds for clothing [Site E - Caregiver; Site A - Caregiver; Site B - Caregiver]. Other common service needs include day care [Site D - Caseworker; Site A - Caregiver; Site E - Caregiver], support groups for children [Site F - Youths], support groups for caregivers [Site E - Caseworker; Site E - Caregiver], tutoring services [Site F - Worker], counseling for caregivers [Site F - Caseworker; Site E - Caregiver], counseling for children [Site E - Caregiver; Site B - Caregiver], and training for caregivers [Site E - Caregiver].

Illinois: Chicago caseworkers stated that they provide the same level of service to kin as non-kin regardless of licensure. [Site F - Worker] Some caregivers raised the issue of inadequate funding when a caregiver was not licensed, but they had few complaints about the services provided. When they did mention problems with services, participants often discussed the private agencies contracted to provide services to kinship placements. Caregivers believed that the level of services provided depended upon the agency serving the placement. Caseworkers also felt that private agencies did not consistently provide services to kin.

My granddaughter that was with me, she was pregnant when they brought her back. I had a hideaway bed for her to sleep on. I asked [Agency A] if they could get her a bed by the time she had her baby. They said no. We think we give you enough money to buy that...When [Agency B] came about a week later and took over their case, the case worker said, what do you need. I said, well I asked for another hideaway bed, but they told me they wouldn't get me one. She said just tell me what you need. [Site F - Caregiver]

There doesn't seem to be uniformity...[caregivers] are now with [a private] agency and they are being told they can't get any, or it takes six months instead of where we were doing things in less time, or they have to wait now for counseling services because of this change. There just seems to be a lot of problems between the private agencies and services and DCFS. [Site F - Worker]

3.4.9 Caseworker Support

Participants in many groups raised the issue of caseworker support for kinship placements. Participants specifically cited two types of caseworker support. The first involved the provision of information about funding, services, and the child welfare system in general. The second involves assistance with child-rearing issues. In both cases, participants discussed the need to provide support on a timely basis.

Participants indicated even when services and resources are available to kin, caregivers may not be aware of their existence. In one focus group, many caregivers lacked basic knowledge about what services were available, how to access those services, and the status of their child's case. Other caregivers indicated that there were long delays in finding out about funds and services available to them. Some caregivers were afraid to request services because they were afraid that they would lose the children. Because of these experiences, a number of respondents indicated that agencies should inform caregivers about funding, services, and case planning issues.

What's available. I think that's pretty much the biggest thing that everybody feels. Because, you know, if there's services available to you, a lot of times you are not aware of them until after the fact. You will find out after the fact that these services are available to you. [Site A - Caregiver]

Foster parents are trained and have contact with the agency, but the kinship caregiver doesn't get enough. Kinship cases often don't know what DSS does or what services are available. [Site D - Worker]

Participants also discussed the need for caseworkers to support caregivers dealing with the children in care. Generational differences and the special needs of children in care raise issues that many caregivers are ill prepared to address.

When you tell them you're having trouble with a kid, they're supposed to come by and see about it.
[Site F - Caregiver]

I think another role for social workers in some cases is letting the relatives know that this is life. Because sometimes they will call you about issues that, you know, it's just a typical teenager, and they think that, you know, DSS can jump in and just turn this child around, and you know you can't. [Site E - Worker]

Caseworker Monitoring of Placement: Many caseworkers and caregivers believed that kinship cases received less monitoring than non-kin placements. One worker acknowledged that the low level of agency monitoring in kinship cases may have implications for child safety.

Foster parents are trained and have contact with the agency, but the [kinship] caregiver doesn't get enough...The more stable the kinship placement, the less contact. Caregivers may feel like the child is dumped on them with no follow-up DSS contact. This is true. [Site D - Worker]

Ain't nobody called me. [DCFS] don't know that mine is living or dead. They don't know. [Site F - Caregiver]

3.5 Conclusion

The most common outcomes identified by caseworkers, caregivers and youths as indicative of quality of care are 1) whether the placement has a negative impact on the caregiver's family relationships and 2) whether the child is "happy." Caseworker groups concurred with one another that permanency was an important outcome, while caregiver groups thought that school achievement and the child's behavior were good indicators of child well-being.

Evaluation criteria (in addition to outcomes described above) that were identified by caseworkers and caregivers from most groups in both states follow.

- Setting boundaries with the birth parent
- Caregiver does not denigrate the birth parent
- Child has adequate clothing
- Child receives adequate food

- Child's health and social service needs met
- Caregiver's interactions with child (8 of 9 groups).

The youths uniformly identified emotional support from the caregiver and caregiver provides rules and structure. On all other items identified by the groups there was less independent identification by other groups.

These groups underscored the identification of the most salient points in evaluating quality of care and provided special insights for each group's perspectives.

In addition, despite the similarities of indicators of quality to regular foster care, existing tools for measuring quality of care may not be adequate for use with kinship homes in several ways.

When screening and evaluating homes, caseworkers must pay particular attention to the caregiver's ability to protect the child from continued maltreatment by the biological parent. Prior to placement, caseworkers may want to ascertain whether the caregiver believes the allegations against the parent. An important factor is the caregiver's willingness to establish and enforce rules for parental visitation. In addition, workers should assess the parent's potential for violence. Kinship placements may not be appropriate when a potentially violent parent directs anger toward the caregiver or is generally out of control. Evaluation issues should focus on the caregiver's compliance with the guidelines for parental visitation outlined in the case plan and methods to control the parents' behavior.

Caseworkers should also assess the caregiver's attitude toward physical punishment during the screening stage. Caregivers who believe that they need to use spanking as a method of behavior control should receive support from the agency to prevent the use of physical punishment. Support may come in the form of foster parent training or intensified supervision and monitoring. Immediate assistance with the child's behavioral issues and the suggestion of alternative means of disciplining the child may help to limit the use of physical punishment by the caregiver.

In general, kinship caregivers need a great deal of support from the social service agencies. The participants indicate that the funding and services provided to kinship placements are often inadequate. As part of a larger evaluation of the quality of agency performance in kinship foster care, the nature and degree of agency support of the kinship foster parents is a critical. At a minimum, evaluation tools must account for the funds, services, and level of monitoring provided to kinship caregivers. Workers should also consider the initial circumstances of the placement when conducting early assessments. Caregivers, and members of the caregiver's household may

require more time than non-relative foster parents to adjust to an unexpected placement. This lengthy adjustment period may impact the child as well.

4 LITERATURE AND DOCUMENT REVIEW

4.1 Methodology

This literature search included a review of professional and accrediting organization standards, existing instruments for measuring quality of care or home environment, and the literature available on the relevant topics of interest. The fugitive literature was searched through contacts with state and government agencies, clearinghouses, resource centers and word of mouth. The published literature was searched using the methods described below.

Our initial literature search on kinship care uncovered very little information specifically focusing on quality of care. Although there are a growing number of studies on kinship care, few address quality issues specifically. We thus broadened our search to include: (1) the general kinship care literature; and (2) topics applicable to measuring quality of care and outcomes in the broader child welfare field. This approach allowed us to build upon existing knowledge in the child welfare literature about quality of care while accounting for factors specific to kinship care.

We originally searched the PsycInfo and Sociofile Abstracts on a comprehensive set of key words, and collected and reviewed over 300 sources. In addition, throughout the life of the study we updated the literature review with recent publications. We primarily chose our descriptors from those sources dealing with the following topic areas.

- The nature and quality of care for children in biological, foster, kinship foster, and group home settings
- Descriptive studies of children in kinship care
- Correlational studies assessing the associations between various variables and “successful” foster placements
- Longitudinal studies of children in foster care
- Qualitative studies of the well-being of grandparents caring for their grandchildren
- The role of child welfare agencies in promoting and enhancing quality of care
- Policy discussions about kinship care and foster care
- Similarities and differences between foster and kinship foster care, including cultural, ethnic, social, and contextual issues relating to quality of care

- Agencies' standards for quality of care
- Child well-being concepts
- Risk assessment for child maltreatment
- The Indian Child Welfare Act
- Instruments for measuring child well-being, family functioning, and client satisfaction
- Outcome evaluation in child welfare services

The most recent update included a search of PsycInfo from January 1996–August 1999 for literature on keywords such as kinship care, foster care, grandparents/grandchildren, quality of care/foster care, Indian Child Welfare Act and foster care/instrument.

The findings of the document and literature review are presented in a companion document, Evaluating the Quality of Kinship Foster Care: Literature Review. The information was organized into tables outlining the descriptors or indicators of quality by major topic area. The conceptualization and organization of the literature, standards and measures is described below. The findings of the literature review are summarized in Section 4.3.

4.2 Conceptual Framework

Our literature review indicated that four categories of measurement were necessary to comprehensively assess the quality of kinship homes: (1) measures to screen/select/approve kinship/foster parents; (2) measures to evaluate the quality of the out-of-home care; (3) outcome measures to assess how the placement affects the child, biological family, and kinship/foster family; and (4) measures to account for intervening factors that may affect outcomes, but that are not directly related to quality of care. Many items appear in the document more than once because they apply to several different topic areas.

The Selection tables in the literature review contain items to help the agency appraise the kinship/foster family's ability to provide a high quality placement for the child. This category includes factors such as characteristics of the kinship/foster parents and family, their ability to meet the child's physical and emotional needs, their capacity to function in the role of foster parents, and their ability to protect the child from further maltreatment. The items in this category consider characteristics of the prospective parents and family as well as their compatibility and relationship with the child and biological family. The items in the Selection tables are relevant to assessing the family prior to placement, and are appropriate for use in screening or approving prospective placements.

The Evaluation tables consist of items to guide assessment of care provided by the kinship/foster family after the child has been placed. Evaluation items are relevant to case monitoring. The items in these tables are similar to, and in some cases are identical to, the descriptors in the Selection tables. The major difference between the two sets of tables is that the selection items predict a family's ability to care for the child prior to placement, while the evaluation items are based on empirical evidence of the family's ability to meet the child's needs. Evaluation descriptors are also appropriate for assessing changes in the family's ability to care for the child, such as changes in income or health.

The Outcome items assess the impact of the placement on the problems and functioning of the child, kinship/foster family, and biological family. Magura and Moses (1986) identified "client satisfaction," "case status," and "client status" as the three main types of outcome variables in child welfare service evaluations. We based our tables on this framework, but divided the "client status" category into child, kinship family, and biological family functioning. In addition, we included a table that outlined overall scales and quality of care measures.

Caution should be used in attributing any single outcome to quality of care. "Client satisfaction" variables indicate the degree to which the placement has fulfilled a child's or family's subjective needs, expectations, or wishes (Magura and Moses, 1986). Satisfaction may reflect a variety of factors, such as quality of care, compatibility of the child and foster parents, and level of agency services. Case status variables reflect a mixture of child outcomes and service system indicators, and may or may not indicate "quality care." Similarly, client status variables may partially reflect the child and family's placement experience, but likely capture other contextual variables as well.

Recognizing that many historical and contextual factors in addition to placement quality affect placement outcomes, we also constructed Intervening Factors tables. We defined "intervening factors" as variables unrelated to quality of care that may affect placement outcome. This category includes such items as the child's characteristics (e.g., mental and physical health), agency characteristics (e.g., reunification policies, services provided) and child's placement and biological family history (e.g., number of previous placements, biological family functioning).

4.3 Findings of the Literature Review

The Child Welfare League of America (CWLA, 1994) developed specific standards for the assessment of kinship foster homes (see Section 1.4, above). This review started with the CWLA recommendations for identifying criteria relevant to evaluating quality in kinship care as a framework for organizing findings. Other relevant material and literature was then sought to identify additional indicators and to develop operational definitions and instruments for measuring quality of care.

4.3.1 Kinship Care Literature Relevant to Evaluating Quality of Care in Kinship Homes

The theoretical and empirical literature reviewed for this study highlights many of the items laid out by the CWLA, often providing empirical support for the importance of the items emphasized as important for the evaluation of quality in kinship care. The development of a theoretical and empirical literature on the use of kinship caregivers in the formal child welfare system is a recent phenomenon. References to studies of formal kinship care are rare prior to 1990, however, kinship foster care is currently a major focus in child welfare. Two prominent journals, *Children and Youth Services Review* and *Child Welfare* each devoted special issues to the topic of kinship care, in 1994 and 1996, respectively. The first national conference on kinship care was held in 1997 (Pasztor & Barbell, 1997).

Much of the work on kinship care is descriptive, documenting the rise in numbers of children in kinship foster care and the policy climate in which this has occurred, describing the characteristics of both children and caregivers in the kinship foster care system, and comparing outcomes for children in kinship foster care with outcomes for children in unrelated foster care. This information, however, provides important background information highlighting what is important to measure to evaluate quality in kinship care.

4.3.2 Caregiver Characteristics

Comparisons of kinship caregivers with non-relative foster care providers reveal significant differences in the two populations. Compared to non-relative foster parents, kinship caregivers are more likely to be older African American women (Gebel, 1996; Berrick et al., 1994; LeProhn, 1994; Thornton, 1991). Kinship families are more likely to be headed by a single caregiver (Berrick et al., 1994; LeProhn, 1994) with less education and lower incomes (Gebel, 1996; Berrick et al., 1994; LeProhn, 1994) than non-kinship foster parents. Reports of the comparative employment status of kin and non-kin vary. Gebel (1996) reported that relative caregivers are less likely to be employed outside the home, while Berrick et al. (1994) found that kinship caregivers are more likely to be employed outside the home. They also found that kinship caregivers were more likely to report that they are not in good health.

In addition to demographic differences, kinship caregivers also have different attitudes about child-rearing, the children in their care, and their role as caregivers. Gebel (1996) reported that kinship caregivers have more favorable attitudes toward physical punishment than non-relative foster parents. Kinship caregivers were less likely than non-relative caregivers to describe the child as 'difficult to handle' (Gebel, 1996), and they have higher expectations for the child (Berrick et al., 1994). LeProhn (1994) found that kinship caregivers feel more responsible for tasks related to basic parenting than non-kin foster parents, and they were more likely than non-relative foster parents to define tasks related to maintaining the child-birth parent relationship as part of

their role. Kinship caregivers are also less likely to believe that the child had been in grave danger prior to placement and more likely to think the child had been in no danger (Berrick et al., 1994).

4.3.3 Child Characteristics

Although less is known about children in kinship care, research indicates they do not differ dramatically from children living with non-kin foster parents. They tend to be younger (Iglehart 1994), but they share many of the same physical and emotional characteristics and needs. Several studies indicate that children in kinship care have slightly fewer problems than children in non-relative foster care. Iglehart (1994) found that children in kinship care had similar educational and behavioral functioning, but higher mental health functioning, than children in non-relative care. Berrick et al. (1994) found that children in kinship care between the ages of four and fifteen have fewer reported behavioral and educational problems. Benedict et al. (1996) report that children placed with kin had fewer developmental and behavioral problems reported in their social service records and fewer developmental, behavioral, mental health, and school-related behavioral problems while in care than children in non-relative foster care. At the same time, they found little difference in the adult functioning of children placed with kin and those placed with non-kin. However, in spite of the apparent positive comparisons of kinship foster children with non-kin counterparts, when compared to normative samples, children in kinship care have significantly more problems than children not in care (Berrick et al., 1994). Dubowitz et al. (1994) report that children in kinship care have significant health care needs and more behavioral problems than normative samples.

4.3.4 Agency Services

Research indicates that social service agencies provide less funding and fewer services to kinship placements than non-kin placements. Despite few reported differences in the children in care, kinship caregivers receive less money than non-relative foster parents (Berrick et al., 1994). Kinship caregivers have less contact with agency social workers than their non-relative counterparts (Gebel, 1996; Berrick et al., 1994; Iglehart, 1994), and caseworkers do not know adolescents in kinship homes as well as those in non-relative care (Iglehart, 1994). Kinship caregivers are less likely to receive training (Gebel, 1996; Berrick et al., 1994), and they are less likely to receive respite care, day care, and support groups (Berrick et al., 1994). In addition, more foster children than kin children are receiving mental health services (Berrick et al., 1994).

4.3.5 Outcomes

Researchers have found that kinship care may affect a number of case outcomes. Kinship care placements tend to be more stable than other placements. The literature indicates that children living with relatives experience fewer placements (Benedict et al., 1996; Iglehart, 1994), and have more contact with their biological parents than their counterparts in non-relative foster care (Berrick et al. 1994). The research regarding length of stay in foster care is mixed. Early

research indicated that children living with relatives receiving a foster care payment tend to remain in care longer than children in other forms of out-of-home care (Wulczyn and Goerge, 1992; Benedict and White 1991). In contrast, Benedict et al. (1996) and Iglehart (1994) found no difference between the overall length of stay for children placed with kin and those placed with non-kin.

Placement with kin may negatively impact a child's chances for adoption or reunification. Thornton (1991) found that relative caregivers are hesitant to adopt the children in their care and fewer children in kinship care had a permanency goal of adoption. However, other research indicates no difference in the willingness of kin to adopt (Gebel, 1996; Testa et al., 1996; Testa, 1993). Several studies have found that a lower percentage of children in kinship care are adopted than children in non-relative foster care (Barth et al., 1994; Dubowitz et al., 1994; Iglehart et al., 1994). Thornton (1991) found that children in kinship care were less likely to have a permanency goal of reunification, and several studies indicate that children in kinship care are less likely to return home than children in non-relative foster family care (Courtney, 1994; Testa, 1993; Goerge, 1990).

This research indicates a need to develop evaluation tools that take into account the distinct set needs and characteristics of kin caregivers and the children with them. Although tools exist for selecting and evaluating foster homes, these must be modified to address kinship placements.

4.3.6 Elements Essential to Measuring Quality in Kinship Foster Care

Publications reviewed for this project can be broken down into four major types. They are conceptual formulations, often focused on evaluating quality in foster care or on needed research in kinship care; empirical studies using either non-kinship foster care or kinship care samples; materials describing federal and state policies related to kinship foster care; and those describing instrument development. The literature can also be categorized as pertaining to selection of foster homes, evaluation of care provided, outcome measures, and identification of intervening variables that impact on outcomes for the child and families. Further analyses and development for this project focused on the child's experience in his or her kinship foster care home.

Much of the evaluation literature focused on studies of traditional foster care or instruments developed for non-kinship foster care. It is supplemented by studies of kinship populations which often document the need for unique areas of evaluation for kinship homes, or, in some cases, highlight the need for revisions or extensions of existing instruments. For example, empirical studies provided support for the idea that it is particularly important to evaluate the physical health of kinship caregivers in order to evaluate the quality of care provided to children, by finding that kinship caregivers are older and in poorer health than non-kinship foster parents.

After considering both the literature specifically focused on assessing quality, based primarily in studies of non-kinship foster care, and the kinship care literature, 10 areas were identified that clinicians and researchers have identified as areas requiring attention in the evaluation of quality of care in kinship homes. These areas include: the kinship caregiver's cooperation and contact with the placing agency, the kinship caregiver's commitment to the child, child maltreatment by the kinship caregiver or caregiving family, the kinship family's relationship with the biological family and child, whether the child's developmental, emotional, and social needs are being met, whether the child's physical needs are being met, the kinship caregiver's physical and emotional capacity to care for the child, the kinship caregiver's economic functioning, the kinship caregiver's family functioning, and the kinship caregiver's social functioning.

There is a wide disparity among these ten topic areas in the degree to which measures for evaluation have been developed or tested. Because, in some respects, evaluation of kinship homes and non-kinship foster homes does not differ, some measures which have already been developed for non-kinship foster care can be applied to kinship homes. In both cases, for example, placement workers must ensure that the home addresses basic child care issues, including physical care, emotional care, child protection, and the requisites of normal growth and development. In these areas, some evaluation tools already exist designed for use with non-relative foster homes.

However, previously existing tools were not adequate for use with kinship homes in several areas. For example, the kinship caregiver's willingness and ability to protect the child from continued maltreatment by the biological parents is an issue that has not been evaluated in non-kinship foster care, since biological parents do not generally have access to non-kinship foster parents' homes. As a result, measurement in those areas where evaluation of quality in kinship homes overlaps with evaluation in non-kinship foster homes is much better developed than in areas in which kinship foster care poses new challenges for evaluation. In addition, measurement in some of the areas of overlap required renewed attention due to unique aspects of kinship care. For example, while the non-kinship foster parent's involvement with a placing agency has been evaluated, the evaluation of the kinship foster parent involvement with the agency poses unique challenges since a kinship caregiver may have been caring for a child for some time prior to the agency involvement, and may perceive agency involvement as intrusive.

Two standardized instruments cover many of the topic areas considered important for foster care evaluation. Each of these instruments was developed for child welfare, although not specifically for foster care. The two instruments include the Child Well-Being Scales (Magura & Moses, 1986) and the Family Risk Scales (Magura, Moses, & Jones, 1987). Both of these instruments, while containing important items relevant to kinship foster care, have important differences in the population for which they were designed and the purpose for which they were designed, which limit their utility for the evaluation of kinship foster care. The Child Well-Being Scales (Magura & Moses, 1986), although containing at least one relevant item for six of the ten major topic areas identified by our review of the literature, were not designed for evaluation, nor were they designed for foster care. The scales were designed for outcome evaluation in child

welfare services, with validity and reliability testing conducted on samples of birth parents. The Family Risk Scales (Magura, Moses, & Jones, 1987), which also contain items addressing many (seven) of the ten major topic areas, were designed to measure a child's risk of entering foster care, so are also tested on a sample of birth parents, and were not originally intended to be used to evaluate foster care.

None of the remaining measures covered in the tables approximate this kind of comprehensive instrument development covering a wide spectrum of topic areas relevant to evaluation. The remaining measures address specific domains, such as family functioning or parenting skills. Many of these measures were designed for non-kinship foster care, although some were designed for individuals outside the child welfare system, and were later used in child welfare studies. The following section reviews these remaining measures, as well as the two comprehensive measures discussed above, in the context of the ten topic areas important for evaluation in kinship foster care. This review begins with areas in which measurement is relatively well developed, and then proceeds to areas where very little has been done.

In general, the areas in which more standardized measurement has occurred include the caregiver's physical and emotional capacity to care for the child, the caregiver's family functioning, the caregiver's social functioning, whether or not the child's developmental, emotional, social, and physical needs are being met, and some aspects of child maltreatment by the caregiver. Areas where little work has been done regarding developing standardized measures tend to be areas that are more often emphasized in the kinship literature, but did not appear to be a major focus in evaluating non-kinship foster care. These include the kinship caregiver's cooperation and contact with the placing agency, the kinship caregiver's commitment to the child, the kinship family's relationship with the biological family and the child, the kinship family's economic functioning, and some aspects of child maltreatment by the kinship caregiver.

The evaluation of whether a child's developmental, emotional, and social needs are being met appears to be one of the best developed of the ten topic areas in the measurement of quality in foster care. Many of the measures used were developed with general population samples and later applied to foster parents, although a few were developed specifically for non-kinship foster parents. In many areas, these measures can also apply to kinship care, possibly with some revisions. In addition to multiple items which are included in the two comprehensive child welfare measures mentioned above, measures addressing this issue that are described in the tables include measures of parenting skills (Foster Parent Evaluation Scales (FPES), Doelling & Johnson, 1989; Family Assessment Checklist (FAC), Cabral & Strang, 1983; Parent Attitude Scale, Easterbrook & Goldberg, 1984); emotional and cognitive development (Childhood Level of Living (CLL), Polansky et al., 1978; the HOME Inventory, Caldwell & Bradley, 1984); attachment (Strange Situation, Ainsworth et al., 1978); and intellectual development (FPAP, Fanshel & Shinn, 1978). Some of these measures have strengths which are worth noting. All have been used with a foster care population, and many have been standardized with low SES populations. While some

still rely on a caseworker's subjective report, some have improved on this methodology by specifying observable criteria, greatly increasing reliability. These measures allow assessment from various perspectives, as some are based on observation while others are based on interviews with caregivers, or caseworker report.

The Strange Situation and the HOME Inventory have been used in comparisons between non-kinship foster parents and kin caregivers (Gaudin & Sutphen, 1993). Gaudin & Sutphen (1993) found differences in the caregiving environment between children living in non-kinship foster care and children living with kin caregivers. Other than these findings, little empirical work documents differences or similarities between kinship and non-kinship foster parents in the area of meeting a child's developmental, emotional and social needs.

The evaluation of whether a child's physical needs are being met is less frequently addressed in the foster care literature than evaluation related to developmental, emotional, and social needs, although all three of the comprehensive child welfare instruments address the issue in considerable depth. In addition, both the CLL scale and the FPES contain items relevant to evaluation in this area. In the areas of children's physical needs, health and housing needs are the most frequently addressed areas.

One study points to the importance of evaluating health needs in the kinship care population. In a well-designed study which evaluated health care provision, Dubowitz et al. (1992) found that children in kinship care had many medical and dental problems which had not been addressed. The study used a large sample, and collected data regarding health status from multiple sources including medical records, questionnaires to biological parents, caregivers, caseworkers, and current health providers, as well as clinical assessments. Although Dubowitz et al. did not have a comparison group of children in non-kinship foster care, so comparisons could not be made between the two groups, his findings do emphasize the need to evaluate the provision of health care to children in kinship care.

The literature regarding the kinship caregiver's physical and emotional capacity to care for the child is unique among the ten topic areas; a significant amount of empirical work has been done with kinship caregiver samples. These studies have generally appeared in the gerontological literature using samples of custodial grandparents. These studies have generally found that grandparent caregivers have significant emotional and physical problems (Minkler & Roe, 1992; Shore & Hayslip, 1994; Kelly, 1993). Studies in the formal child welfare system have also shown that kinship caregivers are in fragile health relative to non-kinship foster parents (Barth et al., 1994), pointing again to the particular relevance of evaluating physical and emotional capacity in kinship caregivers. While the studies evaluating emotional status have generally used well developed standardized measures of well-being (e.g. Life Satisfaction Scale, Neugarten, Havighurst & Tobin, 1961) or general symptomatology (HSCL-90-R; Derogatis, 1983), the measures used to evaluate physical health status have not generally been very well developed. For example, in studies included in the tables, foster parent physical health is variously measured by the yes or no

subjective response of the caseworker to a question regarding whether the foster parent has medical problems, by the kinship caregiver's self-rated health status as excellent, good, fair, or poor, or by one item each on the Child Well-Being Scales and the Family Risk Scales. Both the CWLA and others have emphasized the need to evaluate health status in this population of caregivers who are older and poorer than non-kinship foster parents.

Family functioning is another one of the most well developed areas in evaluation in foster care. Many of these measures were developed for the general population and later applied to foster care, while others were developed specifically for evaluation in foster care. Examples of standardized instruments in this area include the McMaster Family Assessment Device (FAD; Epstein, Baldwin & Bishop, 1981), the Family Functioning Scale (FFS; Geismar, 1980), the Family Environment Scale (FES; Moos & Moos, 1994), the Family Assessment Checklist (FAC, Cabral & Strang, 1983), and the Foster Placement Evaluation Scale (FPES; Doelling & Johnson, 1990). There is even one study, although it has a small sample size (N=60 – 30 non-kinship foster parents and 30 kinship foster parents), where a standardized measure of family functioning (FACES III; Olson, Bell & Portner, 1982) is applied to kinship foster care. In addition, several qualitative studies of grandparent caregivers have investigated the impact of caring for their grandchildren on the family functioning of caregiving families.

Although the CWLA (1994) has suggested that the evaluation of caregiver substance abuse, a specific area of family functioning, is particularly relevant to kinship care, it has not been well developed in the foster care evaluation literature, although two of the three comprehensive scales addressed above each contain items addressing this issue.

Evaluation of the caregiver's social functioning is quite well developed in the traditional foster care literature. Conceptual work has suggested significant differences between the social networks of both Latino/a (Delgado, 1978 & Humm-Delgado, 1982) and African American (Stack, 1974) families, pointing to the possibility of significant deficits in traditional evaluation methods for kinship caregivers, many of whom are minority families. Empirical studies using non-kinship foster care samples have evaluated social functioning using a variety of standardized measures including the Heimler Scale of Social Functioning (HSSF; Heimler, 1967) and the Social Network Assessment (Patterson, Llamas, & Hurd, 1979). One study used the Social Support Network (Berkman & Syme, 1979 in Minkler et al., 1994) in a study of kinship caregivers. The conceptual work regarding social networks in Latino/a and African American families has focused on the existence of natural support systems that workers must recognize and consider in evaluation of a kinship family. This work suggests the necessity of extending current evaluation tools to cover these important variables.

Evaluation of child maltreatment is addressed quite comprehensively in the Child Well-Being Scales which cover a wide range of types of maltreatment from food deprivation to sexual abuse. Studies using kinship care samples have addressed the issue of child maltreatment using

measures of reports of maltreatment and confirmed cases of maltreatment (Dubowitz et al., 1993; Zuravin et al., 1993). While these studies have suggested that maltreatment rates are lower in kinship populations than in non-kinship care, basing findings on reported cases introduces the obvious potential bias of different reporting rates in non-kinship and kinship homes. Some authors have also suggested that these findings could reflect the lower levels of monitoring provided to kinship homes. Without adequate measures to evaluate rates of maltreatment, this question will not be resolved.

An additional issue related to child maltreatment that requires evaluation in kinship care, that is not relevant for non-kinship foster care, and for which measurement has not been developed, is the issue of protection of children from their abusing biological parents, who likely have significantly greater access to children in kinship homes than they would in non-kinship homes. Conceptual work suggests the need to evaluate the child's need for protection from the parent, the relative caregiver's ability to protect the child from the parent, and the relative's willingness to limit the child's access to the parent without prior approval. Prior to this study, this conceptual work has not been translated into measures that can evaluate the caregiver's ability to protect the child from the biological parent.

The evaluation of the kinship caregiver's cooperation and contact with the placing agency appears to be an area where measurement has been significantly under-developed. Very few studies, in either kinship or non-kinship foster care (for an exception, see Stone & Stone, 1983), have evaluated foster parents' cooperation or involvement with the agency. This does not seem surprising, as it is an area where problems are more likely to arise in kinship care than in non-kinship foster care. Non-kinship foster parents expect to be involved with agency staff, and may be less likely to see agency involvement as intrusive into their private family lives. The empirical literature is not clear on the subject of kinship caregivers' opinions about involvement with placing agencies. While empirical findings suggest that non-kinship foster parents requested and received more information about agency policies and services than kinship foster parents (Chipungu & Everett, 1994), it is unclear whether kinship foster parents prefer it that way, or whether agency or other variables contribute to the lower level of services received by kinship foster parents.

This issue is particularly important for the evaluation of quality in kinship homes, where services may be particularly needed in a population of kinship caregivers that is older, less well off financially, and that has more health and mental health problems than non-kinship foster parents (Berrick et al., 1994; Dubowitz et al., 1994; Ingram, 1996; Kelly, 1992; Thornton, 1991).

The evaluation of the kinship caregiver's commitment to the child is another extremely under-developed topic area; few studies have evaluated this aspect of kinship care. Existing studies indicate that kinship caregivers are more likely than non-kinship caregivers to expect to keep a child until emancipation (Berrick et al., 1994; Thornton, 1991). A significant controversy regarding kinship caregivers' commitment to children concerns permanency planning efforts for children in kinship foster care. Reasons why rates of both adoption and reunification are lower

for kinship foster care than for general foster care are unclear. It may be that reunification services are neglected by agencies or are perceived as unnecessary by parents and kinship foster parents, and there may be legal and personal barriers to adoption by relatives (Scannapieco & Hegar, 1999). Given the financial constraints faced by states, however, policy debates continue regarding how long the state will subsidize placement with relatives.

A survey of child welfare experts (Dubowitz, 1994) suggested that evaluation of the kinship family's relationship with the child and the child's biological family was particularly relevant for kinship care. They suggested that a strained relationship between the kinship caregiver and the biological parent could adversely affect the child, that boundary definitions could be difficult, particularly in cases where supervised visitation was required. While the conceptual work is clear on this subject, empirical investigation in the area is sparse. Existing measures, developed for traditional foster parents, do not appear adequate to address the unique challenges posed to kin caring for their relative children.

The area of the kinship caregiver's economic functioning is one that has been rarely considered in evaluations of traditional foster care, but its importance for kinship foster care has been repeatedly noted (Burnette, in press). Its importance for evaluation in kinship care has been demonstrated by comparative studies indicating that kinship foster parents tend to be poorer than non-kinship foster parents (Berrick et al., 1994), and by studies that have associated caregiver income with non-kinship foster care outcomes (Fein et al., 1983; Jordan & Roday, 1984; Kraus, 1971). In addition, grandparent studies have documented the financial strain reported by grandparents due to taking in their grandchildren (Minkler & Roe, 1993). Measurement in this area is very under-developed, reflecting the lack of attention paid to this topic area in past studies. Generally, economic functioning has been evaluated by the simple measure of caregiver's self-reported income (Fein et al, Jordan & Rodway), which does not take into account other variables that may impact how much income a particular family may need to meet a child's needs; these studies found that a caregiver's income was positively correlated with outcome measures. Kraus, however, used a more complex measure of economic functioning, and found no correlation between economic functioning and outcome, indicating the need for more careful measurement in this area. The Family Risk Scales (Magura, Moses, & Jones, 1987) also contain a measure of economic functioning on a four-point, well-anchored scale.

4.4 Conclusion

The creation of kinship foster care evaluation instruments has been a sizeable undertaking. There have been many decisions about what to incorporate and what to exclude as the focus of the study and the instruments have been trimmed to a manageable size. The literature summarized here represents a thorough review of the current kinship research and a representation of the major work on foster care program evaluation. Since the undertaking of this study, the literature on outcomes has mushroomed and the U.S. Department of Health and

Human Services, Administration for Children, Youth and Families has developed uniform outcome measures for foster care that focus on reunification and permanency planning.

The major issues addressed in this literature and in the instruments derived therefrom have focused on the experience of the child, family, caregiver and caseworker with respect to the child's experience in the kinship caregiver's home. In addition, any system of foster care evaluation should also include the outcomes for the child, biological family, caregiving family, and the activities of the agency providing foster care services. Recent work done by New York City Administration for Children's Services has taken this holistic approach and provides one example of a multi-faceted approach to the goal of ensuring quality of care.

The Literature Review tables not only formed the foundation for our work, they are provided in a companion volume as a reference for use in locating relevant information for all facets of evaluation and for beginning to look at programs in an evaluative fashion.

PART III: INSTRUMENT CONSTRUCTION

The items selected for these instruments and the instruments themselves were tested in a number of ways. The literature review and constructs selected for measuring quality of care were reviewed at three points in time by the project's Advisory Board who are all experts in this field. In addition, selected authorities with special knowledge in kinship care and experts in survey research reviewed the instruments.

The instruments were then reviewed again by the University of Illinois Survey Research Laboratory (SRL), pre-tested in the field, modified, and all but the child interview were submitted to a full field test by SRL. SRL used standard interviewing techniques to complete instruments for 37 caregivers, 52 case record reviews and 33 caseworkers. The child interview instrument remains largely untested. The full field test of the child interview was deferred to a later study due to the limited success rate for obtaining the public agency guardian's permission to contact the children. In addition, due to the voluntary nature of the study and the difficulty of recruiting children to talk during after-school hours, the pre-test was limited to two participants. As these instruments are tested by the agencies themselves during actual evaluations, response rate and opportunities for analysis will improve.

After the field test, the instruments were modified again to reflect field test findings. The instrument scoring instructions and guidelines for interpretation are also derived from the results of these tests and reviews.

5 ITEM CONSTRUCTION

An effort was made to write items to cover every dimension that had been identified through the literature review as relevant to the quality of care. Existing measures in relevant areas were consulted. In some areas, such as the physical adequacy of the home, there were numerous existing measures or other lists of indicators that could be consulted and adapted. In other areas, such as the caregiver's relationship with the birth parents, few previous measures were available, and operationalization of the constructs was a more time-consuming process. This was due in part to the fact that those areas tended to be inherently harder to operationalize.

The process of item construction took into account the potential range of the various respondents' backgrounds--in particular, the race/ethnicity, age, education, and living situation of the caregivers and children in care. Not only the form of the question, and the appropriate set of answer options, but also the topics covered, and the detail with which they were covered, were influenced by these considerations. The caregiver's commitment to care for the child is a dimension that is not covered in the child instrument, for example, both because it might be too sensitive for the child, and also because the child would not necessarily have an accurate picture of the caregiver's commitment. The topic of the caregiver's contact and cooperation with the agency plays a more prominent role in the caseworker measure than in the others, because this is a topic

of great importance to caseworkers, and they are in a good position to report on it. Items written for the case record review measure are of a more purely objective nature than items in the other instruments, as the reviewers will generally be relying only on material written or supplied by other persons, and not on their own personal knowledge of the case.

Another consideration that was important in constructing the instruments was the order of topics presented. A national expert in survey research advised us that it was important that the measures, particularly the interviews of the child and caregiver, begin with topics that are of great natural interest to the respondents, but that are not threatening (S. Sudman, personal communication, 9/18/97). The expert also suggested that the questions in an early version of the instruments tended to be uniformly negative, and that additional questions, inquiring about positive events, should be added. Some questions about positive occurrences, such as whether the caregiver praises the child when he or she has been particularly helpful, were added as a result of this suggestion.

An important aspect of item construction concerned the choice of answer options. We were mindful of the importance of the ultimate scoring system for the instruments, but also of the importance of the appropriateness of the answer options for the question being asked. Since yes/no questions are easier to answer and interpret than questions that require discrimination on a 5-point range, the questions in the child instrument are all of the yes/no variety. The questions in the case record review measure are also all of the yes/no variety, although a few have open-ended follow-ups, because the record either does or does not reflect that a particular event happened. In order not to confuse other respondents, and to simplify the scoring of the instruments, an effort was made to keep the answer options uniform within topic in the caregiver and caseworker measures. For example, all of the questions in the caregiver measure that concern the caregiver's relationship with the child are Likert-type questions, because that is a topic with many gradations, but the questions that concern the adequacy of the caregiver's home are all yes/no questions, because those topics are easily dichotomized.

One other aspect of the answer options that merited careful attention was the provision of a Not Applicable option. For purposes of maximizing the validity of answers provided, the response of Not Applicable needed to be provided whenever it was conceivably appropriate, no matter how infrequently. However, for a few questions, thought to be applicable to everyone, regardless of age or geographic area or living situation, the Not Applicable option was not provided. For example, the question in the caregiver measure about violence in the caregiver's neighborhood is applicable to everyone and does not contain the Not Applicable option. A respondent could still choose to answer "don't know," however, since that option is provided for every question scored.

After the instruments had already gone through several iterations, they were sent to members of the advisory panel and other interested experts, with a request for feedback. Feedback was provided on numerous aspects of the measures, including the answer options provided for particular questions, and the overall length of the measures. The burden placed on respondents was a major issue for several of the reviewers. The feedback provided was carefully considered, and changes were made in the instruments to incorporate some of the suggestions.

Table 5.1 lists the major constructs addressed in the instruments that formed the basis for the subscales. In addition, it describes the component parts of each construct which were then developed into items. These constructs were derived from the literature and document review. They form the framework for the review of the literature pertaining to evaluation of the home when the child is in care. The instruments themselves and coding of items by subscale are provided in a companion document, Evaluating the Quality of Kinship Foster Care: Evaluation Package.

Table 5.1 Construct, Concept, And Item Map

Construct	Indicators
Kinship Caregiver's Cooperation and Contact with Placing Agency	Caregiver Attitudes about and Cooperation with Placing Agency
	Caregiver Involvement in Agency Case Planning and/or Services
Caregiver's Commitment to Foster Child and Acceptance of Role	Commitment to Child
	Acceptance of Foster/Kinship Role
Caregiver's Capacity to Meet Child's Developmental, Emotional, and Social Needs	Caregiver's General Parenting Knowledge and Skills
	Caregiver Emotional Engagement and Provision of Affection/Emotional Stimulation
	Provision of Developmental/Intellectual Stimulation
	Caregiver Encouragement and Support in Educational Activities
	Provision of Daily Structured Routines
	Provision of Leisure and Recreational Opportunities
Kinship Family's Economic Functioning	Caregiver Family Income
	Extent of Economic Deprivation
	Caregiver Money Management Skills Economic Capacity to Meet Child's Needs
Kinship Family Functioning	General Family Functioning
	Caregiver Marital Status/Quality of Caregiver Marital Relationship
	Family Substance Abuse

Construct	Indicators
Kinship Family Relationship with Biological Family and Child	Kinship Family Relationship to Biological Family/Child
Caregiver Capacity to Meet Child's Physical Needs	Child's Physical Needs are Met (General)
	Adequacy of Child's Clothing
	Adequacy of Child's Diet/Nutrition
	Child's Health, Mental Health and Social Service Needs are Met
	Adequacy of Caregiver's Housing
	Adequacy of Household Sanitation
	Adequacy of Children's Hygiene
Child Maltreatment	Adequacy of Provision of Safety and Protection to Children
	Protection of Child from Continued Maltreatment by Biological Parents
Caregiver's Social Functioning	Evidence of Child Maltreatment by Kinship/Foster Caregiver
	Overall Caregiver Social Functioning
	Caregiver's Social Network/Informal Social Support
Caregiver's Physical and Emotional Capacity to Care for Child	Caregiver's Use of Formal Social Services When Needed
	Caregiver's Health Status
	Caregiver's Emotional Functioning
These additional items pertain directly to the satisfaction of the caregiver/child with the living arrangement, and to caregiver/child outcomes.	
Child/Kinship Caregiver Satisfaction	Child/Kinship Caregiver Satisfaction
Outcomes for Kinship Caregiver/Caregiving Family	Outcomes for Kinship Caregiver/Caregiving Family
Physical/Emotional Outcomes for Child	Physical/Emotional Outcomes for Child

The subscales that address the capacity of the caregiver to meet the child's physical and emotional needs contain, for the most part, items that are concerned with whether these needs are actually met. In addition to the items focusing specifically on evaluation of the home and the child's experience there, the instruments contain a few items pertaining to client satisfaction and outcomes for the child and caregiving family. The instruments consist of a caregiver interview, child interview, caseworker self-administered questionnaire, and a case record review.

6 INSTRUMENT TESTING

6.1 Sample

The database used for this study was derived from a sample pulled from the DCFS administrative database on December 31, 1998. The sample was comprised of DCFS clients that were currently placed in relative care. The database identified the clients and the agencies where they received services. Three agencies were recruited from Chicago. These agencies provided services to clients within Chicago as well as clients from other areas of Cook County. The fourth agency was recruited to represent a semi-rural area outside of Chicago. The identified agencies needed to grant permission to contact the clients from the database. Three of the agencies allowed an unrestricted random sample. The fourth agency directed that the participants be drawn from clients of caseworkers who had at least a few months of experience, and whose cases did not include problematic situations.

The final sample included 114 caregiver names. Of these caregivers, reasons for not obtaining consent to participate included: the caregiver was no longer a foster parent, the caregiver did not wish to participate in the study, the researchers were not able to contact the caregiver, the caregiver agreed to participate, but failed to meet with the researchers, the caregiver participated in another study and was unavailable for this study, or the case was closed. Fifty-two caregivers could be contacted.

The characteristics of the caregivers known to the researchers from the database were analyzed to determine whether there were any differences between the 37 who finally participated and the group of 15 caregivers who declined to participate. Chi-square analyses were run with these two groups by crossing them with child sex, child race, the caregiver's license status, and the caregiver's area of residence. The analysis of a client's willingness to participate failed to yield any results that were statistically significant.

The data was analyzed further to determine if the group of 52 caregivers who were contacted about participating in the study differed from the group of 48 caregivers who we were unable to contact about participating in the study. Chi-square analyses were run with these two groups by crossing them with child sex, child race, the caregiver's license status, and the caregiver's area of residence. There were no differences between contacted or not, and sex, race, and license status. The analysis of "contacted or not" and "regional separation" showed that 44% of the clients that were contacted lived in Aurora, 36.2% lived in Chicago, and 19.2% lived in Cook/non-Chicago. For those that weren't contacted 81.3% lived in Chicago, 10.4% lived in

Cook/non-Chicago, and 8.3% lived in Aurora. The chi-square supported that these results were significant with a .000 significance.

6.2 Testing

The University of Illinois Survey Research Laboratory (SRL) conducted the test of the four instruments that are designed to evaluate the effectiveness of children in substitute kinship care placements.

6.2.1 Pretesting

SRL received four draft instruments, which were evaluated by the SRL Questionnaire Review Committee. The instruments were pre-tested with a small number of cases drawn from child welfare cases at private child welfare agencies contracting with IDCFCS. For the pretest, 3 children's interviews were completed, and 5 relative caregiver instruments were completed. 5 records were also reviewed. The SRL project coordinator and one experienced interviewer conducted all of the pretest interviews and record reviews. Based on feedback from the pretest, the caregiver instrument and the record review instrument were modified for the main study.

SRL interviewed 3 children for the child's instrument. A decision was made by CFRC to discontinue work on the child's instrument due to difficulty in obtaining consent from the guardian. SRL cautions that this instrument will require additional field testing before any conclusions can be drawn about its usefulness.

6.2.2 Caregiver Interviews

SRL conducted training of 7 experienced SRL interviewers. During this training, the interviewers were briefed on the specifics of the study, and engaged in mock interviewing.

Because CFRC had received signed consents for each participant in the study, all addresses were up to date. For cases where an initial telephone contact was not possible (to schedule an interview) interviewers made unannounced visits to the home. The main problem reported by interviewers was the inability to make contact with the caregivers in order to schedule interviews. SRL received 39 caregiver names for the main questionnaire, and of those, they interviewed 37. Of those, 15 caregivers were re-contacted and asked their impressions of the interviewers and interview. No caregivers contacted reported having a negative interaction with the interviewer.

6.2.3 Record Reviews

For the record reviews, SRL received a list of 75 cases that were located at four private agency locations, three in the city of Chicago, and one in suburban Aurora. Of those cases, SRL was notified by agency staff that 5 cases were either closed due to child's adoption or return home, or the child had been moved out of relative care. Due to the lack of time available, the SRL project coordinator conducted the record reviews.

SRL staff reviewed 52 records. The remaining record reviews were unable to be completed due to study time constraints.

6.2.4 Mail Questionnaire

SRL also administered a questionnaire by mail to caseworkers that referred to a child in their care who was placed in a kinship foster home. A total of 75 caseworker questionnaires were mailed out. Again, SRL was notified during the course of completing the record reviews that approximately 5 of those cases had been closed, or changed placement status. Of the remaining cases, 35 were returned. Follow-ups of non-responders were conducted by telephone. These calls did not prove to be particularly fruitful, as many of the caseworkers were difficult to contact by telephone.

7 FINDINGS OF FIELD TEST

The data analyzed and discussed here include responses to items that had little or no variability. Such items were included in our analyses so that mean scores obtained from our field test would begin to provide a basis for evaluating scores obtained in the future with these instruments. However, agencies using these instruments to assess individual caregivers on quality of care may wish not to score items that show little or no variability for their caregivers, as that would make distinctions among caregivers' scores clearer.

7.1 Item and Subscale Variation

In the caregiver measure, approximately half of the items that concerned the physical adequacy of the home had less than 5% variability - that is, 95% or more of the respondents answered the same way. For example, 36 of 37 caregivers said their stove worked, and all 37 said their toilet worked. (However, 8 of the 35 caregivers who answered the question concerning whether drugs were being sold on the streets near their house responded affirmatively.) Similarly, there are a number of items in the scale concerning whether the child's physical needs were met that were all answered with the socially desirable answer: all caregivers reported that the child

usually had clean clothes to wear and that the caregiver kept enough food in the house so that the child did not go hungry.

Questions in the caseworker measure with low variability tended to occur in items having to do with the caregivers' need for and use of social services. For example, one question concerns whether or not the caregiver has any emotional problems that interfere or could interfere with the care of the child. Only one caseworker responded affirmatively, although four others responded that they did not know. Another caseworker scale on which there were a number of items with low variability concerns the caregiver's protection of the child from continued maltreatment by the birth parents. (These items were not applicable if the child had not had contact with either parent in the last year, which reduced the number of answers in which variability was possible.) For example, 26 caseworkers said that the caregiver ensured that the parents followed the agency's rules for treatment of the child during visits, while only one caseworker said the caregiver did not. And all 33 caseworkers said that the caregiver understood the reason the child was removed from the parents.

Looking at scale variability, the scales varied considerably, both within and across measures. There was one scale on which both the caseworker and the caregiver agreed almost uniformly. All believed that the caregiver's physical and emotional capacity to care for the child was very high. It may be that the items targeted more serious difficulties or that the responses were an artifact of social desirability.

On three scales the scores of the caregiver and the caseworker differed notably. On the caregiver's commitment to the foster parenting role and the child, the caregivers were uniformly high in their self assessment. The workers scored the families on their caseloads (not necessarily the same families) as committed, but to a lesser degree. The caseworker's assessment of the caregiver's family functioning was very different than the caregivers'. These differences, as with others, may also be an artifact of the selection process in participation. The more cooperative caregivers and more positively committed may have agreed to participate. The caseworkers, on the other hand, were referencing a wider range of kinship foster parents, not limited to those who agreed to be interviewed. The final major difference was found in the scores on the caregivers' relationship with the child's parents. The caregivers were uniformly less positive about this. One hypothesis might be that the caseworkers are not totally aware of the difficulties that the kinship caregivers encounter on a day to day basis. This hypothesis was supported to some degree in the focus groups with the caregivers.

Interestingly, the caregiver's cooperation with the placing agency were relatively high, as far as the caseworker was concerned. The low scores on family functioning, caregiver social functioning and relatively low score on child maltreatment by both types of respondents are of great interest and bear further investigation.

Some subscales in the case record review had little or no variability. However, five of the subscales on the case record review, as scored for this sample, had only 1 or 2 items, so the lack of variability is understandable. Table 7.1 provides the quartile breakdown for each subscale by the caseworker and caregiver instruments. The case record review was not included in the table due to lack of variance in the subscale scores - uniformly high.

	Quartiles*	Caseworker N=33**	Caregiver N=37**
1. Cooperation with Agency	25%	.79	.67
	50%	.88	.67
	75%	.95	1.00
2. Caregiver's Physical and Emotional Capacity to Care for the Child	25%	.95	1.00
	50%	1.00	1.00
	75%	1.00	1.00
3. Caregiver Commitment to Child and Foster Parenting Role	25%	.61	.80
	50%	.70	1.00
	75%	.75	1.00
4. Child's Developmental, Emotional, and Social Needs are Met	25%	.65	.84
	50%	.75	.87
	75%	.83	.93
5. Caregiver's Economic Functioning	25%	.80	.73
	50%	1.00	.83
	75%	1.00	.83
6. Caregiver's Family Functioning	25%	.43	1.00
	50%	.50	1.00
	75%	.56	1.00
7. Child Maltreatment by the Parents or Caregiver	25%	.75	.73
	50%	.75	.82
	75%	.78	.90
8. Child's Physical Needs are Met	25%	.61	.93
	50%	.67	.97
	75%	.70	1.00
8. Caregiver's Relationship with the Child's Parents and the Child	25%	1.00	.45
	50%	1.00	.57
	75%	1.00	.76
10. Caregiver's Social Functioning	25%	.57	.74
	50%	.75	.86
	75%	.80	.92

*Quartiles indicate the percentage of respondents whose subscale scores were equal to or less than the score indicated. For example, 25% of caseworkers scored the caregiver's social functioning at .57 or lower. In addition, the top 25% of the scores were .80 or better. Half of the scores given by the caseworkers regarding the caregiver's social functioning were between .57 and .80.

** The N's vary to some degree by subscale depending on the degree to which scale items were not applicable.

Caregiver interview subscales had more items and more variability than case record review subscales. Only one subscale on the caregiver interview had fewer than 5 items: the subscale concerning the caregiver's cooperation and contact with the agency had 3 items. The scales on the caregiver measure had ranges in mean score varying from .14, for the family functioning scale, to 1.0, for the caregiver's capacity to care for the child scale.

The lowest quartile in the caregiver subscales was the kinship family's relationship with the biological family subscale; with a cut-off score for the lowest quartile of .45. The subscale with the next lowest cut-off score for the lowest quartile was the scale concerning the caregiver's cooperation and contact with the agency, which had a cut-off score of .67 for the lowest quartile. In two subscales (caregiver's physical and emotional capacity to care for child, and family functioning), the cut-off for the lowest quartile was the highest score possible on the subscale.

Excluding the scale concerning the caregiver's relationship with the biological family, on which the mean score was .59, the lowest mean score was .75, for the caregiver's contact and cooperation with the agency. Three of the scales had mean scores of .95 or above (family functioning, child's physical needs met, and caregiver's physical and emotional capacity to care for child).

Turning to the caseworker measure, its ten subscales had ranges varying from .23, for the maltreatment subscale, to 1.0 for the economic functioning subscale. In general, the scales showed greater variability in the caseworker data than in the caregiver data.

Although scores tended to be moderately high on the caseworker scales, there were no scales with a mean of .95 or above, in contrast to the 3 such scales in the caregiver data. The two caseworker subscales with mean scores in the lower .90's concerned the caregiver's capacity to care for the child and the relationship of the kinship family with the biological family. Moreover, there were 6 subscales in the caseworker data with means of .75 or lower, whereas there were only 2 subscales with scores in that range in the caregiver data.

Thus, the only subscale with a mean score which was among the highest three on both of the two measures was the subscale concerning the caregiver's capacity to care for the child.

One major reason for the relatively high scores on the measures is that the children's circumstances in placement may be generally desirable. In addition, there are psychometric issues to be addressed in future testing. For example, the samples on which the 3 instruments were tested were voluntary. Families or caseworkers who felt that the placement was not working well may have declined to participate. Thus, the sample may have consisted primarily of more competent caregivers and caseworkers. In the future, when these measures are used to evaluate

quality of care outside of the research setting, a wider range of competence and cooperation may be expected, along with greater variability in scores.

7.2 Item-Subscale and Inter-Subscale Correlations

Item - scale correlations within each instrument were run to determine the degree to which each item was related to the mean score of all of the other items in the subscale. In addition, correlations were run between each item and every other subscale. Due to the variability in response sets for different respondents, coefficient alpha was not deemed to be an appropriate measure. For example, some questions did not apply to the care of infants; therefore, the subscale for respondents with infants would be comprised of somewhat different items than those with adolescents in their care. Scales in which there was no variability were omitted from this analysis.

Some scales had a high degree of item-scale relationship. For example, in responses to the caseworkers' questionnaire, items in the subscale regarding the caregiver's cooperation with the agency, were generally highly correlated with the subscale. Fourteen items correlated with the subscale at .57 or above, with more than half of these at .7 and above. These items tended to deal with obtaining needed or required services for the child, such as glasses, dental care, giving information to the caseworker, attending case reviews, following the caseworker's recommendations and participating in the service plan. The items that showed virtually no relationship pertained to going to court and meeting with the caseworker. One item, significantly negatively correlated at .05, was ensuring that the child's parents follow agency rules. The correlation was -.47.

The subscale for cooperation with the agency was positively correlated with three other subscales at .05 or less: meeting the child's developmental needs, meeting the child's physical needs, and absence of child maltreatment. Table 7.2 shows that for the most part the scales are not highly inter-correlated, suggesting the need for a multi-dimensional approach. In addition, the potential for developing measures with sound psychometric properties is supported.

The inter-scale correlations are provided below:

	Agency cooperation	Commitment to the child	Developmental needs met	Economic functioning	Family functioning	Child maltreatment	Physical needs met	Social functioning
Commitment to the child	-.13	1.00						
Developmental needs met	.55**	.03	1.00					
Economic functioning	.23	.04	.13	1.00				
Family functioning	.05	.20	-.01	.33	1.00			
Child maltreatment	.41*	.31	.07	.11	.37*	1.00		
Physical needs met	.51**	-.13	.43*	-.12	.14	.18	1.00	
Social functioning	.36	-.22	.28	.51**	-.01	-.14	.08	1.00

* Significant at .05; **Significant at .01

These analyses present a preliminary look at the psychometric properties of these instruments. The next steps for instrument development include further examination of the nature of the subscales, appropriate application of scoring, developing norms on larger and more diverse populations and determining the extent to which these items and subscales capture the desired information when used by wider audiences. Information on future analyses will be available from the Principal Investigator and Project Director identified in the front matter of this report.

Additional work in this area has been done by other Children's Bureau projects and should be available soon from the National Clearinghouse on Child Abuse and Neglect.

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