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Children Cared for by Relatives: What Do We Know about Their Well-Being?

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Children in kinship care face significant barriers to well-being compared with children living with their parents.

Sometimes children are not able to live with their parents, possibly due to a parent's death, incarceration, abuse or neglect, poverty, mental illness, substance abuse, or unwillingness to raise a child. During these times relatives often step in to care for these children. In 1999, 2.3 million children, or 90 percent of children not living with parents, lived with a relative—or in kinship care—according to the National Survey of America's Families (NSAF).[1,2] Most often relatives make arrangements to care for the child privately within the family, but sometimes a child welfare agency will place children who have been abused or neglected with relatives rather than with unrelated foster parents (Ehrle and Geen forthcoming). This practice has become increasingly common among child welfare agencies (U.S. Department of Health and Human Services 2000).

A separation from a parent for an extended period of time can potentially be traumatic for a child, yet living with a relative may minimize the trauma by providing the child with a sense of family support (Bowlby 1980; Dubowitz et al. 1994). At the same time, previous research has shown that many children in relative care experience significant economic hardship (Ehrle, Geen, and Clark 2001). Yet it is uncertain whether the potentially damaging risks of poverty to children's development might be moderated by the benefits of living with a relative. In fact, very little is known about the well-being of children residing with relatives (Altshuler and Gleeson 1999).

This brief addresses this gap by examining the well-being of children living in kinship care using two types of comparisons. First, children living with kin are compared with children living with their parents. Findings indicate that children in kinship care face significant barriers to well-being compared with children living with their parents. Second, since many kinship families are poor, it is possible that some of these differences may be due to living in poverty (Ehrle et al. 2001; Lee and Goerge 1999). To address this concern, we compare children in low-income relative and parent care households (income falling below 200 percent of the federal poverty level). Given that children in low-income relative care have also experienced a separation from their parents, we expected that they would still fare worse than children residing in low-income parent care. However, findings suggest that children living with low-income relatives fare worse on some measures of well-being compared with children living with low-income parents, but on others they are doing just as well.

Findings are based on data from the 1997 and 1999 rounds of the NSAF, a nationally representative survey of households with persons under age 65.[3] The NSAF includes measures of the economic, health, and social characteristics of more

than 44,000 households in each of the survey years. This analysis uses information on the samples of children under age 18. The sample of children was obtained by randomly selecting up to two "focal" children, one under 6 years old and one between the ages of 6 and 17, from each household. This sample of children was then weighted to be representative of children in the nation. Information on these children was obtained from the most knowledgeable adult in the household, the parent or caregiver most knowledgeable about the child's education and health care.

Behavioral and Emotional Well-Being

Children in relative care may exhibit behavioral and emotional problems for many reasons. As previously stated, simply being separated from parents can be detrimental to a child's well-being (Bowlby 1973; Karen 1998). Additionally, some children may have experienced abuse or neglect by their parents that can further compromise healthy child development (Briere and Elliott 1994; English 1998). Alternatively, children with more behavior problems may be more likely to be abandoned by a parent. Based on a six-item scale to assess levels of behavioral and emotional problems among 6- to 17-year-olds, 13 percent of children in relative care exhibit high levels of behavioral and emotional problems (table 1).[4] This portion is higher than the 7 percent of children living with parents who experience these difficulties. Yet percentages of children who experience high levels of behavioral problems do not differ when comparing children in low-income relative and parent care.

Teenagers may exhibit behavioral problems in the school setting. Twenty-six percent of youth age 12 to 17 in relative care were suspended or expelled from school in the survey year. This portion is twice as high as the 13 percent of youth living with parents who were suspended or expelled from school in the survey year. In addition, a higher number of youth in relative care (22 percent) skipped school in the survey year compared with youth in parent care (16 percent). Youth in low-income relative care were more likely to be suspended or expelled than youth in low-income parent care, but the two groups of youth were equally likely to have skipped school.

School and Activity Experiences

Children who are highly engaged in school tend to have higher levels of achievement (Kuh and Wadsworth 1991). Based on a scale to measure school engagement included in the NSAF, nearly a third (29 percent) of children living with relatives exhibit low levels of school engagement

TABLE 1. Behavioral and Emotional Problems of Children Living with Relatives (percent)

	All Incomes		Income < 200% FPL	
	Children in relative care (N = 2,257)	Children in parent care (N = 67,865)	Children in relative care (N = 1,464)	Children in parent care (N = 28,567)
High levels of behavioral/ emotional problems (age 6–17)	13**	7	14	11
Suspended/expelled (age 12–17)	26**	13	31*	21
Skipped school (age 12–17)	22*	16	21	21

Source: Urban Institute calculations from the 1997 and 1999 National Survey of America's Families.
Note: Reported sample sizes are for all children age 0 through 17. Sample sizes vary depending on age of children selected for each analysis. Sample sizes for age subgroups = age 6–17, 1,672 in relative care, 43,418 in parent care, 1,078 in low-income relative care, 17,189 in low-income parent care; age 12–17, 947 in relative care, 21,398 in parent care, 584 in low-income relative care, 7,641 in low-income parent care. All children were selected unless noted otherwise.
FPL = federal poverty level.
Based on t-tests, statistically significant differences between the parent and relative care groups are denoted as * = $p < .05$ and ** = $p < .01$.

(table 2).[5] This portion is higher than the 20 percent of children living in parent care who exhibit low engagement in school. Children in low-income relative care are also more likely than children in low-income parent care to have low levels of engagement in school.

Involvement in activities such as sports, lessons, and clubs can help children move successfully across developmental stages by enhancing their social skills and enabling personal accomplishment (Ehrle and Moore 1999). A larger proportion of children living with relatives (26 percent) are not involved in any activities compared with children living with their parents (17 percent). However, children in low-income relative and parent families had similar levels of activity involvement.

Interactions with Adults

When a child is separated from a parent, a stable and nurturing relationship with another adult who can provide consistent care can mediate the trauma of the separation (Grigsby 1994; Henry 1999). Yet when a caregiver suffers from poor mental health or is under substantial stress, it may be difficult to develop such a relationship. Based on a five-item scale to assess caregiver mental health, about a quarter (26 percent) of children in relative care live with a caregiver reporting symptoms of poor mental health (table 3).[6] This percentage is higher than the percentage of children living with parents reporting these symptoms (16 percent). Similarly, according to a four-item scale assessing caregiver aggravation, more than twice as many children in relative care reside with a caregiver with high levels of aggravation (21 percent) compared with children living with parents (9 percent). Both of these differences in caregiver aggravation and mental health remain when comparing children in low-income relative and parent care.

Interactions young children have with adults can provide important stimulation for healthy cognitive and emotional development (Kotulak 1996). More than a fifth of young children (age 0 to 5) living with relatives experience low levels of cognitive stimulation based on two indicators. Twenty-two percent of children in relative care are read to two or fewer times a week and 23 percent are taken on outings two or three times a month or less. These percentages are similar for young children living with their parents, suggesting that relatives are as likely to engage young children in stimulating activities as are parents with their own biological children. Additionally, similar percentages of children in low-income relative and parent care receive low levels of cognitive stimulation.

Physical Health

Previous research shows that children who have been separated from a parent may have compromised physical health (Halfon, Mendonca, and Berkowitz 1995). Alternatively, children with health conditions may be more difficult to care for, and

Nearly a third of children living with relatives show little interest in school.

TABLE 2. School and Activity Experiences of Children Living with Relatives (percent)

	All Incomes		Income < 200% FPL	
	Children in relative care (N = 2,257)	Children in parent care (N = 67,865)	Children in relative care (N = 1,464)	Children in parent care (N = 28,567)
Low engagement in school (age 6–17)	29**	20	31*	24
No activity involvement (age 6–17)	26**	17	28	29

Source: Urban Institute calculations from the 1997 and 1999 National Survey of America's Families.
Note: Reported sample sizes are for all children age 0 through 17. Sample sizes vary depending on age of children selected for each analysis. Sample sizes for age subgroups = age 6–17, 1,672 in relative care, 43,418 in parent care, 1,078 in low-income relative care, 17,189 in low-income parent care. All children were selected unless noted otherwise.
FPL = federal poverty level.
Based on t-tests, statistically significant differences between the parent and relative care groups are denoted as * = $p < .05$ and ** = $p < .01$.

TABLE 3. Interactions with Adults (percent)

	All Incomes		Income < 200% FPL	
	Children in relative care (N = 2,257)	Children in parent care (N = 67,865)	Children in relative care (N = 1,464)	Children in parent care (N = 28,567)
Caregiver reports symptoms of poor mental health	26**	16	33**	25
Caregiver reports high levels of aggravation	21**	9	24**	13
Caregiver reads to child two or fewer times a week (age 0–5)	22	21	25	27
Caregiver takes child on outings 2–3 times a month or less (age 0–5)	23	17	26	22

Source: Urban Institute calculations from the 1997 and 1999 National Survey of America's Families.
Note: Reported sample sizes are for all children age 0–17. Sample sizes vary depending on age of children selected for each analysis. Sample sizes for age subgroups = age 0–5, 585 in relative care, 24,447 in parent care, 386 in low-income relative care, 11,378 in low-income parent care. All children were selected unless noted otherwise.
FPL = federal poverty level.
Based on t-tests, statistically significant differences between the parent and relative care groups are denoted as * = $p < .05$ and ** = $p < .01$.

therefore may be more likely to be separated from their parents. We find that 14 percent of children living with relatives have a limiting condition and 7 percent are in fair or poor physical health (table 4).[7] These percentages are nearly twice that of children living with their parents (8 percent and 4 percent, respectively). Children in low-income relative care are as likely to be in fair or poor health as children in low-income parent care, but more likely to have a limiting condition.

Discussion

This brief provides a national overview of the well-being of children living in relative homes. We find that children living with relatives fare worse than children living with their parents on most measures of behavioral, emotional, and physical well-being. This is not necessarily surprising given that these children have experienced a separation from their biological parents and some may have been abused or neglected. However, many children living with relatives live in poverty, which also may contribute to their poor well-being (Ehrle et al. 2001). Looking just at low-income children, we find that children in relative care fare worse than children living with their parents on some measures, but on others they fare just as well.

TABLE 4. Health of Children Living with Relatives (percent)

	All Incomes		Income < 200% FPL	
	Children in relative care (N = 2,257)	Children in parent care (N = 67,865)	Children in relative care (N = 1,464)	Children in parent care (N = 28,567)
Limiting condition	14**	8	17**	11
Poor/fair health	7**	4	9	8

Source: Urban Institute calculations from the 1997 and 1999 National Survey of America's Families.
Note: Reported sample sizes are for all children age 0–17. Sample sizes vary depending on age of children selected for each analysis. All children were selected unless noted otherwise.
FPL = federal poverty level.
Based on t-tests, statistically significant differences between the parent and relative care groups are denoted as * = $p < .05$ and ** = $p < .01$.

One measure where low-income relative children fare worse than children in low-income parent care is on school engagement. These children may have difficulty engaging in school because they have had to change schools or they may be adjusting to their new living situation and feel distracted. Children in relative care are also more likely to be suspended or expelled from school. These children may act out in school because they are having difficulty adjusting to living with a relative caregiver or are angry about being separated from their parents. In addition, children in low-income relative care are more likely to have a limiting condition, which includes any physical, learning, or mental health condition. Past research has shown such conditions are more prevalent among children in the foster care system, and among those who have been abused or neglected, compared with other low-income children (Bilaver et al. 1999).

On several measures, however, children in low-income relative care and parent care fare similarly well. They have comparable levels of behavioral and emotional problems and activity involvement, and are equally likely to skip school. They also fare similarly in terms of physical health status. We speculate from these findings that, for some children, living with a relative may help them overcome challenges from their past. By providing a familiar environment and helping the child maintain connections to his or her biological family, the relative may help reduce some of the trauma of being separated from a parent. Research shows that, compared with living with a nonrelative, residing with a relative helps the child maintain stronger family and community bonds, provides more frequent contact with birth parents and siblings, and reduces the number of times the child changes homes (Davis et al. 1996; Gleeson, O'Donnell, and Bonecutter 1997; Inglehart 1994; Zwas 1993).

Yet while it appears relative caregivers may help children overcome some challenges, findings also suggest that they may have a difficult time providing this care. Children in relative care are more likely to live with caregivers who have symptoms of poor mental health or who experience high levels of aggravation, regardless of poverty. Providing care to an additional child can be difficult, particularly when the child has emotional, behavioral or health problems. In fact, past research on grandparents raising grandchildren found the caregiving experience itself is directly linked to higher levels of caregiver depression, even when taking into account precaregiving rates of depression and other demographic factors often related to depression (Minkler et al. 2000). Yet, at the same time, research on grandparent caregiving also suggests that the experience can be rewarding and meaningful and therefore may be beneficial to psychological well-being (Giarrusso, Silverstein, and Feng 2000).

Given these findings, there are three areas in which systems might be further developed to provide support for families caring for relative children. First, many children in relative care have difficulty engaging in school. Schools could provide counseling or tutoring for these children, as well as links to after-school programs. Additionally, they can provide relative families with referrals to Medicaid, which may provide increased access to health care and other services. For example, all children that have Medicaid coverage are eligible for the Early and Periodic Screening, Diagnosis, and Treatment Program (Bissell and Allen 2001), making the diagnosis of a physical, learning, or mental health disorder at an early stage more likely. The identification of these problems may be instrumental in assisting children in improving school performance over the long term. Second, area offices for the aging may be able to provide needed respite care, transportation, or parenting training to older relative caregivers. An occasional break from caregiving responsibilities may reduce levels of aggravation. Finally, local community organizations might expand offerings of support groups, counseling, and a range of other services to relative caregivers. Sharing experiences with other caregivers may validate a caregiver's feelings and provide important mental health benefits.

Relative homes represent an important resource for providing care to children whose parents cannot. This study shows

Children living with low-income relatives fare worse than children living with their low-income parents on some measures, but on others they fare equally well.

that children residing in relative homes generally have poorer well-being compared with children in parent homes, and children in low-income relative homes fare worse on some measures of well-being compared with their low-income counterparts. Moreover, many of the caregivers themselves experience personal difficulties that could make providing care challenging. These findings increase our understanding of the needs of children in kinship care and their caregivers and can therefore help us to improve service delivery to maximize the benefits of relative care.

Endnotes

1. This represents a significant increase since 1997, as 1.8 million children were recorded as living in kinship care at that time. This increase is driven primarily by the growth in the number of children living with relatives outside the child welfare system, also referred to as private kinship care. These arrangements consisted of 1.8 million children in 1999, compared with 1.3 million children in 1997. The population of children involved with child welfare services, also known as public kinship care, remained steady between 1997 and 1999, ranging between 400,000 and 500,000. It is important to note that these are not necessarily foster children; these include children "involved" in the child welfare system that are not in state custody.
2. The NSAF sample does not include children living in institutional care.
3. The 1997 and 1999 rounds of the NSAF were combined to increase the sample size of children available for statistical analysis. Prior to combining the NSAF rounds, both were compared to identify any differences on measures of well-being. Very few significant differences between the rounds were observed.
4. Caregivers were asked how often during the past month the child didn't get along with other kids, couldn't concentrate or pay attention for long, and was unhappy, sad, or depressed. Then respondents were asked three age-specific questions. Respondents with 6- to 11-year-olds were asked how often during the past month the child felt worthless or inferior, was nervous, high-strung, or tense, and acted too young for his or her age. Respondents with 12- to 17-year-olds were asked how often during the past month the child had trouble sleeping, lied or cheated, and did poorly at schoolwork (Ehrle and Moore 1999).
5. To measure level of school engagement, caregivers were asked to respond to each of the following statements: How much of the time the child (a) cares about doing well in school, (b) only works on schoolwork when forced to, (c) does just enough schoolwork to get by, and (d) always does homework (Ehrle and Moore 1999). Activity involvement was measured using a group of three questions assessing the child's participation in clubs/organizations including (1) after-school/weekend involvement in groups such as scouts, a religious group, or Girls or Boys Club, (2) after-school/weekend involvement in a youth group, student government, drama, band, chorus, or religious/community group, or (3) any other organized activities during the past year (Ehrle and Moore 1999). These measures were for children age 6 to 17 only.
6. Caregiver mental health was measured using a five-item scale. Respondents were asked how much of the time during the past 30 days they had been a very nervous person, felt calm and peaceful, felt downhearted and blue, been a happy person, and felt so down in the dumps that nothing could cheer them up (Ehrle and Moore 1999). Parental aggravation was assessed using a four-item scale. Respondents were asked how often in the past 30 days the child did things that really bothered them a lot, felt they were giving up more of their lives to meet the child's needs than expected, felt angry with the child, and felt the child was harder to care for than most (Ehrle and Moore 1999).
7. A limiting condition was defined as any physical, learning, or mental health condition that limits the child's participation in the usual kinds of activities done by most children his/her age and/or limits his/her ability to do regular school work (Ehrle and Moore 1999).

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This series presents findings from the 1997 and 1999 rounds of the National Survey of America's Families (NSAF). Information on more than 100,000 people was gathered in each round from more than 42,000 households with and without telephones that are representative of the nation as a whole and of 13 selected states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin). As in all surveys, the data are subject to sampling variability and other sources of error. Additional information on the NSAF can be obtained at **http://newfederalism.urban.org**.

The NSAF is part of ***Assessing the New Federalism,*** a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

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