



Children Cared for by Relatives: What Services Do They Need?

Jennifer Ehrle and Rob Geen

Nearly two-thirds of children in kinship care live in low-income families.

In 1999 2.3 million children lived with relatives without a parent present, commonly referred to as kinship care.¹ Separation from a parent can be traumatic for a child (Bowlby 1980). Research suggests that living with a relative may minimize this trauma by providing the child with a sense of family support (Dubowitz et al. 1994). At the same time, many children in kinship care face risks to their healthy development, such as poverty, crowded households, and living with less educated or single caregivers;² yet kinship families often do not receive the services they need to overcome these challenges, even services for which they are eligible (Ehrle, Geen, and Clark 2001).

This brief looks at some of the specific service needs of children in kinship care. We find that many children in kinship care face personal health challenges and live in families experiencing significant financial hardships. Yet many of these children, despite being eligible, do not receive the services they need. Involvement with child welfare agencies might provide a link to services for the families caring for these children. Children living with kin as a result of child welfare involvement (public kinship care)³ appear to receive more services than children living with relatives without child welfare involvement (private kinship care).

Findings in this brief are based on data from the 1999 NSAF, a nationally representative survey of households with persons under age 65. The NSAF includes measures of the economic, health, and social characteristics of over 44,000 households. This analysis uses the sample of children under

age 18.⁴ The parent or caregiver most knowledgeable about each child's education and health care provided information on these children. Estimates are presented for the subsample of children living in kinship care, and estimates for children living in private and public kinship care are compared.

Among children in kinship care, the largest percentage is teens (44 percent), a third are school-age (35 percent), and 21 percent are 5 or younger. Forty-four percent are black non-Hispanic, 38 percent are white non-Hispanic, 15 percent are Hispanic, and 3 percent are of another ethnicity. About half (48 percent) are female. Nearly half of children in kinship care (46 percent) live with a caregiver who is over 50, and most (90 percent) live with a caregiver who is female. Most children in kinship care are cared for by a grandparent (57 percent), but a significant portion (22 percent) is cared for by aunts and uncles.⁵

Service Needs of Children in Kinship Care

Most children in kinship care live in families experiencing financial hardship. This is not surprising given that taking care of additional children can be quite expensive. Relative caregivers may be financially stable when caring for their own families, but their financial situation may become strained when children are added to their homes. Moreover, relative caregivers also tend to be older, and many are likely retired and live on fixed incomes (Hardin, Clark, and Maguire 1997). In this study nearly two-thirds (64 percent) of children in

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kinship care live in “low-income” families, those families with incomes below 200 percent of the federal poverty level (FPL) (see table 1). A third (31 percent) live in “poor” families, those families with incomes below 100 percent of FPL.

The housing, food, and child care needs of low-income kinship families are especially pressing, given their limited resources. Looking just at low-income kinship families, two in five children (39 percent) live in families experiencing either crowding or trouble paying housing costs. Affording more space can be difficult for low-income families, but this is often necessary when taking on the care of an additional child. Attaining more space may be a requirement for some families to meet foster care licensing mandates. Relatives living in senior housing that restricts children may have to relocate. Providing food can also be difficult when children are added to the household, especially if the family already has limited financial resources. Of children living in low-income kinship care families, nearly half (48 percent) experience food insecurity.⁶ Finding and paying for child care is another challenge often faced by relative caregivers, particularly for low-income single caregivers who work or two-caregiver families in which both caregivers work. Over a third (36 percent) of children in kinship care lived in such low-income working families.

Another difficulty for some children in kinship care is living with a caregiver facing health challenges. Roughly half (45 percent) of children in kinship care live with a caregiver who has a limiting condition or is in fair or poor health.⁷ This is not surprising since many caregivers are older. Caregivers may also face mental health challenges. The unexpected or sudden addition of children to their household can be a difficult adjustment for kinship caregivers. They may not have time to prepare for their new responsibilities and some may find it difficult to manage. Twenty-nine percent of children in kinship care live with caregivers facing mental health challenges.⁸ Similarly, 23 percent of children in kinship care live with a highly aggravated caregiver.⁹ These data do not indicate whether caregiver aggravation or compromised mental health preceded the addition of the new child or were partly caused by the added caregiving responsibilities.

However, other research has found grandparent caregiving itself to be directly linked to higher levels of depression (Minkler et al. 2000).

Finally, children in kinship care may face their own personal challenges. They have been separated from their parents and may have been abused or neglected. One in five (20 percent) either has a limiting condition or is in fair or poor health. Eleven percent of 6- to 17-year-old children in kinship care exhibit high levels of behavioral or emotional problems.¹⁰

Gaps in Service Receipt

All kin, regardless of their income, who are caring for a relative child are eligible to receive Temporary Assistance for Needy Families (TANF) child-only payments to help pay for the child’s care.¹¹ Payment amounts differ from state to state; in 2000 they ranged from \$68 to \$514 per month for one child, with an average of \$238 per month.¹² These amounts are prorated at a declining rate for each additional child and do not vary depending on the age of the child. Kin caring for a child involved in the child welfare system can receive foster care payments if the child is taken into state custody and the kin caregivers meet foster care licensing requirements.¹³ In 1999 basic foster care payments ranged in average from \$250 to \$657 per month depending on the age of the child, with an overall national average of \$403 per month.¹⁴ Foster payments are not prorated for additional children. Moreover, foster parents typically receive supplemental payments for clothing, school expenses, or for the care of special needs children.

Few children in kinship care live in families that receive foster care or child-only payments. About a quarter (27 percent) of all children in kinship care and 36 percent of low-income children in kinship care live in families that receive either a child-only or a foster care payment. In comparison, 69 percent of TANF-eligible persons received benefits in 1997 (DHHS 2000b).

Many kin also fail to receive other services that may assist with hardship, such as food stamps and government assistance with housing and child care. Of those children in low-income families with housing difficulties, either crowding or trouble

TABLE 1. Service Needs and Receipt for Children in Kinship Care (in percent)

	All children in kinship care (N = 1,160)	Children in private kinship care (N = 911)	Children in public kinship care (N = 249)
Financial hardship			
Receiving foster care or child-only payments	27	18*	65*
Poor ^a	31	31	32
Low income ^a	64	61*	76*
Receiving foster care or child-only payments	36	25*	73*
Housing difficulties (for low-income families)			
Receiving housing assistance	15	16	9
Having difficulty paying housing bills or crowding	39	39	40
Receiving housing assistance	12	NA	NA
Food shortages (for low-income families)			
Receiving food stamps	42	37*	59*
Experiencing food insecurity ^b	48	48	48
Receiving food stamps	53	47*	74*
Child care (for low-income families with a child 12 or under)			
Working, with probable child care needs ^c	36	NA	NA
Receiving child care assistance from a government agency or other organization	17	NA	NA
Caregiver's health			
Currently insured ^d	82	81	87
In fair or poor health or has a limiting condition	45	43	52
Currently insured ^d	87	86	91
Has symptoms suggesting poor mental health	29	30	21
Receiving mental health services ^d	20	NA	NA
Knows of at least one "help place" in the community	82	82	85
Highly aggravated ^e	23	20	35
Knows of at least one "help place" in the community	84	80	94
Attended religious services in survey year	87	86	90
Child's health			
Currently receiving Medicaid	42	35*	75*
Currently insured	81	78*	91*
In fair or poor health or has a limiting condition	20	17*	33*
Currently insured	81	75*	94*
Has high levels of behavioral or emotional problems	11	8	24
Receiving mental health services	61	NA	NA

Source: Urban Institute calculations from the 1999 National Survey of America's Families.

Note: The sample sizes in the column heads do not apply to estimates based on subgroups.

NA = Estimates are not available because of small sample sizes.

a. "Low-income" is income below 200 percent of the federal poverty level; "poor" is income below 100 percent of the federal poverty level.

b. For a definition of "food insecurity," see endnote 6 in the text.

c. Includes families where a single caregiver works or both caregivers in a two-caregiver family work.

d. This question was asked randomly of either the caregiver or the caregiver's spouse/partner, but not both. If the caregiver's spouse/partner answered this question, the value is missing for this child, resulting in slightly lower sample sizes (all children in kinship care = 848, children in private kinship care = 654, children in public kinship care = 194).

e. For a definition of "highly aggravated," see endnote 9 in the text.

* Based on t-tests, estimates for children in private and public kinship care are statistically different at the 0.05 level.

Kin involved with child welfare agencies enjoy greater access to financial assistance, food stamps, and Medicaid.

paying bills, only 12 percent receive housing assistance.¹⁵ Families who are income-eligible can receive food stamps to supplement their food supply. For kinship families, the relative child will be included in their food stamps grant. Of those children in low-income kinship care families with food insecurity, about half (53 percent) receive food stamps. Child care assistance may be very important to a low-income relative who works full time but has just taken on the care of a new child. Of children with low-income kinship caregivers who work, only 17 percent receive child care help from the government or an organization.¹⁶

Some kin caregivers with significant health challenges do not get the services they need. Of children in kinship care living with a caregiver with physical health challenges, while the majority (87 percent) are insured, 13 percent live with a caregiver who is uninsured. Of those children living with a caregiver in poor mental health, only 20 percent live with a caregiver who received mental health services in the survey year. It does seem, however, that kinship families are fairly integrated into the community, a potential source of support. Eighty-two percent of children in kinship care live with a provider who knows of at least one source of help in the community, and 87 percent of children in kinship care live with a relative who attended religious services at least a few times during the survey year. Of the children living with a highly aggravated caregiver, 84 percent live with a caregiver who knows of at least one “help place” in the community.

Many of the children who have physical and mental health challenges themselves do not receive services, despite being eligible. For example, all children in kinship care are eligible to receive Medicaid, either through the foster care system or if a child-only grant is being made in their name, but only 42 percent of children in kinship care do. In comparison, 66 percent of all children eligible to receive TANF and Medicaid benefits receive Medicaid.¹⁷ In addition, of the children in kinship care who are in fair or poor health or who have a limiting condition, while the majority (81 percent) are insured, 19 percent have no health insurance. Of children in kinship care with high levels of behavioral or emotional problems, 61 percent receive mental health services.

Child Welfare Involvement and Links to Services

For many kinship families, being involved with the child welfare system may make them more likely to receive services that could alleviate some hardships. For example, 65 percent of children in public kinship care (involved with the child welfare system) live in families that receive either a foster care or TANF child-only payment. In comparison, significantly fewer children (18 percent) in private kinship care (not involved with child welfare) live with kin who receive either payment.¹⁸ This difference was even more pronounced for low-income children in kinship care, those most in need of financial assistance. Of those low-income children in public kinship care, 73 percent are receiving government assistance; only 25 percent of those in private kinship care do (see figure 1).

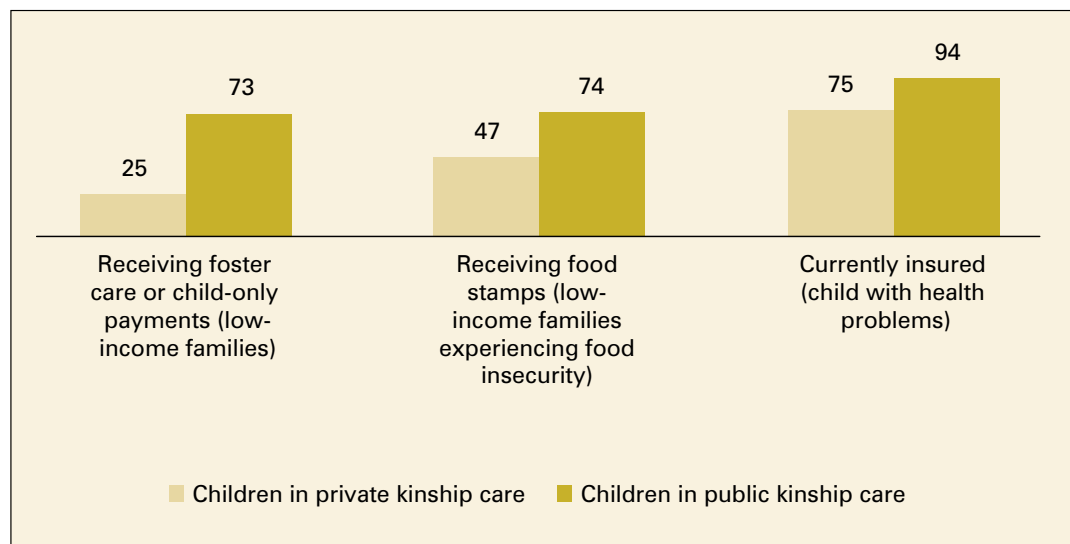
Low-income children in public kinship care are also more likely to live in families receiving food stamps than low-income children in private kinship care (59 and 37 percent, respectively). And of those experiencing food insecurity, nearly three-quarters of children in public kinship care receive food stamps compared with about half of children in private kinship care (74 and 47 percent, respectively). There is no significant difference in receipt of housing assistance between children in public and private kinship care, and housing problems are experienced at similar levels by children in both groups.

Finally, system involvement may help kinship care families access health services. Seventy-five percent of children in public kinship care receive Medicaid compared with only 35 percent of children in private kinship care. Similarly, higher percentages of children in public kinship care are insured compared with children in private kinship care (91 and 78 percent, respectively, of all children, and 94 and 75 percent, respectively, of children with health problems).

Summary and Discussion

Children in kinship care face many challenges, both personally and in the environments in which they live. Despite their increased need, children in kinship care families often do not receive services,

FIGURE 1. Service Receipt for Children in Public and Private Kinship Care (percent)



including many for which they are eligible. Agencies that work with kinship caregivers may want to develop strategies to improve their access to available services, to expand existing services, and to develop new programs to address the needs of this group.

Kinship care families' relatively low level of receipt of TANF, Medicaid, and subsidized child care raises questions about barriers they face in accessing these supports. Many kin report that they are not aware that they are eligible for benefits, do not want a handout, want to avoid involvement with public agencies, or have applied for benefits and have been denied (DHHS 2001). Because kinship care families are a relatively small group, they are often overlooked by program administrators and policymakers. Outreach materials that discuss services available to "parents" may be ignored by kinship caregivers.

Even if kinship caregivers are aware of the services for which they are eligible, the stigma they feel from accepting public assistance may keep them away. Agencies may want to consider service delivery approaches that reduce this stigma. For example, welfare agencies could train designated staff in the unique circumstances of these families or allow them to apply for benefits by phone or mail. Additionally, kinship caregivers may feel less stigma if an agency other than welfare, such as an aging office or the school system, delivers the services.

Some kinship caregivers who apply for public assistance are mistakenly denied benefits. Studies have found that eligibility workers may not be aware of the services that kinship care families can receive (Chalfie 1994; Hornby, Zeller, and Karraker 1995). In other cases the denial of benefits to kin is consistent with program regulations, which may have the intended or unintended consequences of excluding children living in kinship care. For example, some states require relative caregivers to obtain court-ordered legal custody or guardianship to maintain Medicaid or State Children's Health Insurance Program coverage for the children they are raising, and a few require caregivers to prove their blood relationship through official documentation (Bissell and Allen 2001). TANF agencies may also deny benefits to kin who are not related by blood to the children in their care.

Even if kinship care families received all of the income supports for which they are eligible, they would still have significant unmet needs for services such as housing, mental health care, and child care. Several public agencies may be in a position to expand such services to kin. TANF agencies have begun to examine how they can use the flexibility of the TANF block grant to better serve kinship care families (DHHS 2001). Recent authorization of the federal Older Americans Act provides state aging offices with funds to support older caregivers raising related children.

Housing agencies have begun to recognize the need for housing specifically designed for older kinship caregivers, and legislation has been introduced in Congress to remove eligibility barriers from kin receiving Section 8 subsidies and to train housing eligibility workers on the rules pertaining to kin.

For abused or neglected children, child welfare agencies are primarily responsible for ensuring that needed services are delivered. Kin involved with child welfare agencies enjoy greater access to services, including financial assistance, food stamps, and Medicaid, compared with kin caring for children privately. Experts have suggested that the services available to kin through the child welfare system provide an unintended incentive for private kinship care families to seek out child welfare services (Johnson 1994). The fact that private kin families appear to have similar needs as public ones also raises equity concerns. As policymakers continue to develop strategies to meet the needs of the kinship care population, they must consider the needs of both public and private kin, determine when child welfare agencies should be involved, and determine when kin can be served effectively by other public agencies.

Endnotes

1. This figure is a significant increase from the 1.8 million children living in kinship care in 1997 according to the 1997 National Survey of America's Families (NSAF). However, it is difficult to discern whether the increase is real or due to possible estimation error. Both the NSAF and data from the Current Population Survey (CPS) from the U.S. Census Bureau show a similar increase between 1997 and 1999, suggesting the increase may be real. However, CPS estimates since 1994 have fluctuated. These fluctuations may result from the fact that estimates are based on small samples with room for more estimation error, rather than from real changes in the population. Thus, caution should be exercised when suggesting an increase in relative care based on only a two-year time interval.
2. These environments, although high in risk, may be considerably better than the environments from which the children came.
3. Child welfare agencies often place children with relatives when they must be removed from their parents' care to minimize the trauma they experience from this separation and because of shortages in available non-kin foster homes (DHHS 2000a). In some cases these children are taken into state custody and placed with relatives (kinship foster care), and in other cases the child is placed with relatives but not taken into state custody (voluntary kinship care). "Public kinship care" includes children in kinship foster care and voluntary kinship care.
4. This sample of children was obtained by randomly selecting up to two "focal" children, one under age 6 and one between the ages of 6 and 17, from each household. This sample was then weighted to be representative of children in the nation.
5. Except for race and ethnicity, children in public and private kinship care arrangements generally do not differ in their demographic characteristics. Children in private kinship care are more likely to be white non-Hispanic and less likely to be black non-Hispanic than children in public kinship care.
6. To measure food insecurity, caregivers were asked whether they or their families worried that food would run out before they got money to buy more, the food they bought did run out, or one or more adults ate less or skipped meals because there was not enough money for food. Families that had experienced one or more of these problems in the past 12 months were included in the percentage of families reporting "food insecurity."
7. A limiting condition is defined as a physical, mental, or other health condition that limits the kind or amount of work the caregiver can do.
8. To assess mental health, the caregiver was asked how often in the past month she or he had been very nervous, felt calm and peaceful, felt downhearted and blue, been happy, and felt so down in the dumps that nothing could cheer him or her up. Response options were all of the time, most of the time, some of the time, or none of the time. The answers were calibrated to a 100-point scale, and a score of 67 or less indicated poor mental health according to the developers of the scale (Ehrle and Moore 1999).
9. A four-item scale was used to assess parent aggravation. The items included the caregiver's estimate of how often in the past month she or he felt a child was much harder to care for than most, the child did things that really bothered the caregiver a lot, the caregiver was giving up more of his or her life to meet the child's needs than expected, and the caregiver felt angry with the child. Response options were all of the time, most of the time, some of the time, or none of the time. Respondents' answers were summed to create a scale score ranging from 4 to 16. A score of 11 or less indicated high aggravation. To fall into this category the caregiver had to answer most or some of the time to at least two of the four scale items (Ehrle and Moore 1999).
10. The NSAF included two six-item scales to assess behavioral and emotional problems in children, one for 6- to 11-year-olds and one for 12- to 17-year-olds. Caregivers were asked whether the child doesn't get along with other kids, can't concentrate or pay attention for long, and has been unhappy, sad, or depressed. Caregivers for 6- to 11-year-olds were also asked whether the child feels worthless or inferior; has been nervous, high-strung, or tense; or acts too young for his or her age. Caregivers for 12- to 17-year-olds were asked whether the child has trouble sleeping, lies or cheats, or does poorly on schoolwork.

Response options were often true, sometimes true, or not true at all. A score of 12 or more on this scale indicates high levels of problems (Ehrle and Moore 1999).

11. In Wisconsin, the child must be at risk of harm if living with biological parents in order for the relative caregiver to be eligible for a TANF child-only payment.
12. These data are based on a telephone survey of states conducted by the Congressional Research Service and from Urban Institute tabulations.
13. In California and Oregon, kin must be caring for a child who came from an impoverished family to receive a foster care payment.
14. These data are based on the State Child Welfare Agency Survey conducted by the Child Welfare League of America and from Urban Institute tabulations.
15. Assistance includes the government paying for part of their rent, help from a government program to pay housing bills, or welfare vouchers for rent.
16. Some of these families may, however, have received assistance through the tax code. The NSAF did not ask about such assistance.
17. This estimate is based on analyses done by Lisa Dubay and Jenny Haley at the Urban Institute using 1999 NSAF data.
18. Technically, private kinship care families are only eligible to receive TANF child-only payments, which may contribute to their lower percentage of payment receipt. However, public kinship care families often do not receive foster care payments because of difficulties becoming a licensed foster home, making them only eligible for TANF child-only payments (Leos-Urbel, Bess, and Geen 2000).

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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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