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Effects of kinship care on behavioral problems by child age: A propensity score analysis

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ABSTRACT

When a child must be removed from the family home, placement with a relative is often sought because kinship care is the least restrictive and most family-like out-of-home placement. Although kinship care has become a preferred option in most U.S. child welfare systems, this preference is often based on "soft evidence" rather than rigorous evaluation of the risks and benefits of kinship care. Therefore, an evaluation of the impact of kinship care on child behavioral problems is needed to guide child welfare practice and policy. In addition, given that children of different ages and in different developmental stages are likely to have varying placement experiences, the evaluation of kinship care should explore the effect of kinship care on child behavioral problems across age groups. To fill these knowledge gaps, we compare the behavioral problems of 584 children in kinship care with those of 470 children in non-kinship care. Moreover, we examine the impact of kinship care on behavioral problems in 2 age groups: younger children (0 to 5 years) and older children (6 to 17.5 years). The analysis uses data from Waves 1 and 2 of the National Survey of Child and Adolescent Wellbeing, and applies propensity score methods to account for selection bias. Results show that older children in kinship care had significant lower levels of externalizing, internalizing, and total behavior problems. However, for younger children, the effects of kinship care on child behavioral problems did not reach statistical significance. The implications for practice, research and policy are discussed.

1. Introduction

Kinship care refers to "the full-time nurturing and protection of children who must be separated from their parents, by relatives, members of their tribes or clans, godparents, stepparents, or other adults who have a kinship bond with a child" (Child Welfare League of America, 1994, p. 2). Kinship care has emerged as a preferred placement choice for foster children for several reasons. First, the increased number of children entering foster care has exceeded the number of traditional foster homes. A second factor driving the use of kinship care is the federal directive to place children in the "least restrictive placement" possible (mandated by the Adoption Assistance and Child Welfare Act of 1980; Allen, DeVooght, & Geen, 2008; Gibbs & Müller, 2000). With enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (1996), kinship care was given priority as a preferred placement option among child welfare professionals (Harris & Skyles, 2012). The Adoption and Safe Families Act (1997) sought to accelerate *child permanency* (i.e., placement with a permanent, lifetime family after exiting foster care) and established kinship care as a viable permanency option (Geen, 2003). In addition, the enactment of the Fostering Connections to Success and Increasing Adoption Act of 2008 helps to maintain children's family and cultural connections and to support kinship care by providing a mechanism for reimbursement/payments.

Thus, the child welfare system often turns to kinship care as the preferred least-restrictive, most family-like placement when a child must be removed from his or her family. The percentage of foster children placed in kinship care has increased dramatically over the past three decades (Strozier, Elrod, Beiler, Smith, & Carter, 2004; U.S. Department of Health and Human Services, 2012; Wulczyn & Goerge, 1992). The proportion of children in state custody placed in kinship care increased from 18% in 1986 to 31% in 1990 (Kusserow, 1992), and stabilized in the 1990s at around 24% of the foster care population (Beeman, Kim, & Bulleridick, 2000). By 2010, 2.7 million children were living in kinship care, which was a 70% increase in the past 20 years (Annie & Foundation, 2012). Children in foster care placements are tracked through the Adoption and Foster Care Analysis Reporting System and the Child Welfare League of America. Data from 2007 and 2010 show that approximately 26% of the nearly half million children in out-of-home care were placed with kin (Hong, Algood, Chiu, & Lee, 2011).

Children in kinship care have unique characteristics as compared with children in non-kinship care placements. For example, children in kinship care are typically older when they enter the child welfare system than children in non-kinship care (Beeman et al., 2000). In one study conducted in England, Farmer (2010) found that older child age was linked to kinship placement disruptions in situations where child behavior is severe and caregivers are not highly committed. In addition, African

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American children are 3 times more likely than White children to be placed in kinship care (Ortega, Grogan-Kaylor, Ruffolo, Clarke, & Karb, 2010). The disproportionate number of African American children in kinship care may stem from the long tradition of kinship care in the African American community that began as an adaptation to slavery, ongoing discrimination, and lack of economic opportunities (Fuller-Thomson & Minkler, 2000; Smith & Devore, 2004). Further, a majority of children placed in kinship care have been removed from the family home because of parental substance abuse, whereas placement in non-kinship foster care is more often the result of maltreatment and neglect (Beeman et al., 2000). Several studies have found that children with better mental health (i.e., fewer emotional or behavioral problems) are more likely to be placed in kinship care (Beeman et al., 2000; Iglehart, 1994; Landsverk, Davis, Ganger, Newton, & Johnson, 1996; Stein et al., 2014). However, Morse (2005) proposed that, in regard to physical health, children in kinship care have more health issues (greater number or greater severity) and also receive fewer health care services than children in non-kinship care. Last, some evidence has suggested that children for whom placement with a relative was possible (i.e., kinship care) generally came from households with better family functioning than children placed in non-kin foster care (Dubowitz, Zuravin, Starr, Feigelman, & Harrington, 1993). However, given that these children were removed from the family home due to some form of maltreatment, the extent of family dysfunction may be a less important factor.

Given the unique characteristics of children in kinship care, some researchers have questioned whether kinship care or non-kinship care leads to better outcomes for child safety and well-being. In addition, researchers have raised questions regarding whether kinship caregivers have the level of resources to adequately provide for the complex, and often costly, care of children who have been abused or maltreated (Cuddeback, 2004). These concerns are not without merit. In the United States, kinship caregivers are primarily grandmothers and aunts, and they are more likely to be older, less educated, and socioeconomically disadvantaged as compared with non-kin caregivers (Berrick, Barth, & Needell, 1994; Ehrle & Geen, 2002; Gaudin & Sutphen, 1993; Gebel, 1996; Le Prohn, 1994; Stein et al., 2014). Studies have also shown that kinship caregivers receive less formal training in foster parenting and fewer support services from the child welfare system than non-kin caregivers (Berrick et al., 1994; Sakai, Lin, & Flores, 2011; Scannapieco, Hegar, & McAlpine, 1997). However, one study found that placement outcomes were better when kin received financial support in addition to foster parent training (Farmer, 2010). Kinship caregivers are more likely to be depressed than non-kinship caregivers (Garcia et al., 2015), and often have limited social networks and resources (Harden, Clymanb, Kriebelc, & Lyons, 2004; Strijker, Zandberg, & van der Meulen, 2003), which may constrain their ability to provide good care. Indeed, many grandmothers report concerns about their abilities to parent young grandchildren (Burton, 1992).

Despite many disadvantages faced by relative caregivers, some research suggests that children in kinship care are just as safe as children in non-kinship care placements (Koh & Testa, 2011; Testa, Bruhn, & Helton, 2010; Winokur, Crawford, Longobardi, & Valentine, 2008), and children tend to experience fewer placement disruptions in kinship care than in non-kinship care placements (e.g. Koh, 2010; Strozier & Krisman, 2007; Testa, 2001, 2002; Winokur et al., 2008; Zinn, DeCoursey, Goerge, & Courtney, 2006). In terms of child well-being outcomes, previous studies suggest that children in kinship care may exhibit fewer behavioral problems than those in non-kinship care, but the evidence to date is still inconclusive. For example, some studies have found few or no differences regarding children's behavioral, cognitive, educational, or developmental outcomes based on placement type (e.g., Barth, Guo, Green, & McCrae, 2007; Berrick et al., 1994; Dubowitz et al., 1994). However, other studies have shown that, as compared with children in non-kinship care, children in kinship care have lower rates of behavioral problems (Berrick et al., 1994; Iglehart, 1994; Keller et al., 2001; Landsverk et al., 1996; Rosenthal & Curiel, 2006; Shore, Sim, LeProhn, & Keller, 2002; Tarren-Sweeney & Hazell, 2006; Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Andries, 2012; Winokur, Holtan, & Valentine, 2009). As a case in point, Rubin et al. (2008) found that kinship care had beneficial long-term effects on children's behavioral problems, and showed that, as compared with children in non-kinship care, children in kinship care had fewer behavioral problems 3 years post-placement.

Moreover, Rubin and colleagues found that these children's behavioral problems were largely attributed to their experiences with their birth parents rather than conflicts with their kinship caregivers. These researchers also showed that placement in kinship care leads to greater reductions in behavioral problems than did placement in non-kinship care. A notable finding contrary to Rubin et al. was Keller and colleagues' (2001) study that found that children in kinship care had more behavioral and health problems than children in non-kinship foster care; however, the behavioral and health problems of children in kinship care stemmed from prenatal drug exposure.

One possible explanation for the positive outcomes associated with kinship care in some studies is that placing a child with a relative might reduce the traumatic effects children experience from being separated from their birth parents (del Valle, Lázaro-Visa, López, & Bravo, 2011; Folman, 1998). Another potential explanation is that kin caregivers may have a lower perception or higher tolerance of behavior problems than do their non-kin counterparts (Timmer, Sedlar, & Urquiza, 2004). For instance, the inclusive fitness theory (Hamilton, 1964) holds that the genetic similarity of relatives makes kin caregivers more likely to remain committed to child permanency and well-being than a non-kin caregiver, and the drive to preserve the genetic line sustains the kin caregiver's commitment even when the child has difficult behavioral challenges (Testa, Snyder, Wu, Rolock, & Liao, 2014).

Several previous studies have compared kinship and non-kinship foster care, but the effect of kinship care on child well-being is still largely unknown or mixed (Font, 2014; Taussig & Clyman, 2011). Moreover, few studies have examined the effects of kinship care across different age groups. According to Piaget's child developmental theory, children experience different stages of cognitive development as they age and show different characteristics in these stages (Hetherington & Parke, 2003). Thus, the impact of kinship care on child well-being may vary across developmental stages.

In addition, few studies have used advanced statistical methods to control for selection bias when making comparisons between children in kinship care and those in non-kinship care (Font, 2014; Koh, 2010; Koh & Testa, 2008, 2011; Liao & White, 2014), and thus accounted for differential selection into different placement types (Font, 2014). Selection bias is a distortion in outcomes between the treatment and comparison groups that stems from systematic variation between groups that is not due to the treatment of interest (i.e., groups are not balanced on extraneous characteristics that potentially affect outcomes). Selection bias is frequently introduced through errors in sampling, participant enrollment, assignment and treatment, or attrition. According to Maddala (1983), many factors can contribute to sampled groups being unbalanced on either observed or unobserved characteristics, including participants' self-selection into a study or selection of participants by an administrator. In the current study, without the ability to control for baseline functioning, it would be difficult to determine whether differences in outcomes between children in kinship and non-kinship care were due to the effects of kinship care or pre-existing systematic differences between groups. Therefore, to control for possible selection bias, this study used propensity score analysis.

To address the research gaps noted in the child welfare literature, this study aimed to explore whether children placed in kinship foster care show fewer behavioral problems than children in non-kinship care, and to assess whether the effects of kinship care on outcomes