Assessing Quality of Care in Kinship and Foster Family Care*

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This study includes a sample of 29 kin and 33 non-kin foster parents who participated in an in-home interview to assess quality of care. On a number of measures relating to the home environment, non-kin homes were rated *as more safe. Family relations between children and their caregivers were similar for kin and non-kin. Trends in the data point to the need for further research; changes in policy and practice that might strengthen the resources currently available to dependent children are also suggested.*

In recent years, kinship care has gained increasing attention from practitioners, policy makers, and researchers. Our attention has been captivated by the large numbers of children now being served in foster care by kin and the paucity of information available about this rapidly growing arrangement for care. A recent study found that among all states reporting the use of kin as foster care providers, over 31% of children were placed with relatives (Kusserow, 1992). In California, the growth in kinship placements has rapidly accelerated. Kinship care is now the predominant placement setting for children, recently surpassing foster family care. Statewide, kinship foster care accounted for approximately 46% of the caseload in 1994. In Santa Clara County, the site of this study, kinship foster care was utilized in 41% of the cases.

The development of kinship care as a foster care resource has been stimulated by legal, demographic, and value-based changes. First was the *Miller v. Youakim* Supreme Court (1979) case which determined that kin could not be excluded from the definition of foster parents and that under some conditions, kin might be eligible for federal IV-E foster care benefits. Second, the burgeoning foster care census and changing economic circumstances have left far fewer unrelated foster parents at home to care for children and have contributed to greater inclusion of kin as foster caregivers (Kaye & Cook, 1992; National Commission on Family Foster Care, 1991; National Foster Parent Association, 1991). Third, kinship care's development has been spurred on by a refocusing of values and priorities regarding the role of family—broadly defined—in the lives of children. Kinship foster care has developed at a time when calls for family preservation have grown increasingly urgent (National Commission on Children, 1993). Many child welfare experts believe that children will be better served if their care is provided by family members within the community of origin, rather than by strangers (Chipungu, 1991; Takas, 1992).

Review of the Literature

Research in the area of kinship care has not kept pace with its development as a placement alternative. Similarly, research on the characteristics of conventional foster care has been sparse (see Berrick, Barth, & Needell, 1994; Kaye & Cook, 1992; Lindholm & Touliatos, 1978). Until recently, few studies were available that focused on the characteristics of kin providers or on the kin children in care. Neither were studies available which addressed the services provided to kin through the child welfare system, or about the kin providers' views of their roles within this system. Researchers are now embracing this issue (see Berrick & Barth, 1994; Wilson & Chipungu, 1996).

Characteristics of foster parents and kinship caregivers. Thornton (1987) describes kin caregivers as older than foster family parents, and a group heavily represented by single women of color who are struggling themselves with limited incomes. One study found maternal foster grandmothers reporting high levels of poor health and depression (Kelley, 1992). These grandmothers also expressed concerns about their abilities to continue parenting young children into adolescence due to their own advancing age. Some studies also point to the challenge these providers face as they voluntarily take on a new set of roles with little preparation or planning (Kennedy & Keeney, 1987; LeProhn, 1994; Thornton, 1987). While foster family providers generally prepare for their new role as parents, kinship foster parents more often fall into older parenthood in response to a pressing family emergency. Berrick, Barth, and Needell (1994) have corroborated these findings in their study of kinship foster parents and foster family parents in California.

Characteristics of children in foster family care and kinship care. While the characteristics of foster parents and kin caregivers may be somewhat different, children placed in kinship foster homes share many similarities with their peers in foster family care. Dubowitz and associates (1994) found that children in kinship foster care had higher rates of asthma, anemia, vision and dental problems, and developmental delays than American children in the general population. Children in kinship care also exhibited greater behavioral problems. Similar studies which have examined the health problems of children in foster family care have, in general, found a population suffering from a wide variety of health and mental health problems (Fein, Mallucio, & Kluger, 1990; Halfon & Klee, 1991). Three of the only studies to compare kinship foster children to foster family children (Benedict, Zuravin, & Stallings, 1996; Berrick, Barth, & Needell, 1994; Iglehart, 1994) found comparable strengths and difficulties in these populations.

Outcomes associated with kinship care. Some of the strongest research conducted to date comparing kinship foster care to foster family care has utilized statewide administrative data to examine children's entrances, exits, and service utilization while in care. Although children in kinship foster care reunify with their birth parents more slowly than children in non-kin care, the proportion of children ultimately reunified from kin and non-kin care is roughly similar for both groups after about four years (Berrick, Needell, Barth, & Jonson-Reid, in press; Needell, Webster, Barth, & Armijo, 1996). Because the rate of reunification is slower, and because children in kinship care experience

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fewer opportunities to exit the child welfare system, a number of recent studies have indicated that children placed with kin remain in care longer than children placed with non-kin (Benedict & White, 1991; Courtney, 1992; Courtney & Needell, 1997; Wulczyn & Goerge, 1992). Little is understood about this phenomenon given that children have greater access to birth parents during their stay with kin (LeProhn, 1993) and that visitation has largely been associated with more rapid reunification (Fanshel & Shinn, 1978; Meezan & Shireman, 1985). Some researchers have suggested that factors other than visitation may play a significant role in reunification rates for children in kinship care. Chief among these are the services kin families receive from the child welfare system. Kin receive less regular contact with workers and their access to training, day care, and respite care services is also limited (Berrick, Barth & Needell, 1994; Dubowitz, 1990; Kusserow, 1992; Meyer & Link, 1990). Another reason for slower reunification rates might include financial disincentives as the kin caregiver often receives a higher monthly rate (AFDC-FC) than does the child's birth parent (AFDC) (Berrick & Needell, in press; Testa, 1997).

While opportunities for exiting care are reduced for children placed in kinship homes, children may benefit from the increased stability of kinship placements. A recent study of very young children in the child welfare system in California indicated that among infants, almost one-third of children still in care after four years who had been placed in non-kin homes had experienced more than three placements, whereas approximately one-fifth of infants placed with kin had experienced comparable rates of placement instability (Berrick, Needell, Barth, & Jonson-Reid, in press).

Other outcomes which may be viewed positively include the reduced rate of recidivism for children placed with kin. Research suggests that kinship foster care may act as a buffer against subsequent re-entry. Even when age, ethnicity, health problems, number of placements, and length of time in care are taken into consideration (Courtney, 1995), children from kin care are less likely to experience subsequent re-entry to the foster care system.

The outcomes associated with kinship care are both positive and negative. While children placed with kin may have more stable placements and may be less likely to re-enter care, they are less likely to benefit from the long-term, permanent, legal status that adoption affords. One study indicates that the odds of adoption are halved for children placed in kinship homes compared to children with non-kin (Courtney & Needell, 1997). Studies indicate that many kinship foster parents are reluctant to consider adoption because they already regard themselves as "family" to the child (Berrick et al., 1994). Even when adoption subsidies are known to be available to kin, psychological and cultural characteristics of kin appear to hinder consideration of this permanent plan (Thornton, 1991).

Kin and non-kin care from the child welfare worker's perspective. Appreciating the phenomenon of kinship foster care from the public child welfare workers' perspective provides an added dimension to our knowledge. Focus groups with child welfare workers in California indicate that there is widespread support for the shifting focus toward the greater use of kin (Berrick, Needell, & Barth, in press); staff believe in the importance of strengthening children's ties to family and have confidence that kinship care provides this family continuity. But their enthusiasm for kinship care is dampened by significant concerns. County practices vary considerably in the amount and degree to which they require or encourage staff to assess kinship homes for basic safety and supervision. While some kinship homes offer appropriate protection for children, workers have some apprehension that other homes may not support the best interests of children (Berrick, Needell, & Barth, in press).

Were the trade-off between kinship care and foster family care greater, child welfare workers would probably be less conflicted. Yet the quality of foster family homes across counties was also described as greatly varied. Many workers voiced concerns that too many foster parents were simply "in it for the money." Others described highly devoted caregivers who viewed their foster children as an integral part of their families. Focus groups with public child welfare workers have heightened our concern about the quality of care in all out-of-home care arrangements; more research on these topics is therefore especially critical.

Purpose

To date, little has been done to assess the quality of care in kinship homes *in comparison* to foster family homes. Such a study is necessary as critics of the field have a rising voice (Nelson, 1990; Sheindlin, 1994). Some have suggested that children may not be adequately protected in kinship homes because of the caregiver's relationship to the abusive parent. Others note that kinship homes may be dysfunctional as evidenced by the abusive or neglectful parent or siblings raised in the same kinship network (Gray & Nybell, 1990). These concerns are also voiced by child welfare workers (Berrick et al., in press), although it is difficult to determine whether their apprehension is justified for kin providers as a whole, or whether only a small percentage of caregivers are indeed problematic. What remains are questions about whether various aspects of these two environments differ substantially in areas such as the demographic characteristics of the setting; the physical environment of the home; and the socio-emotional setting of the home. The following study was conducted in order to learn more about the quality of care across these domains in kin and non-kin settings in one California county. Following are the primary methods for developing the study and the findings from our research.

Methods

Instrumentation

This study was designed to assess "quality" in kin and non-kin homes. Quality, however, is a term about which few hold similar views. In order to capture the characteristics of quality that child welfare workers use in their decisions about placements for children, we convened a group of child welfare managers from the sponsoring county to discuss the issue. An open meeting was held and all interested child welfare staff were invited to attend.

A draft instrument designed to assess quality was developed based on these meetings and upon a review of the literature, including standards for care offered by a large child welfare organization (Child Welfare League of America, 1994). These guidelines provided a baseline for assessing quality. We also reviewed current licensing procedures for California. Next, we collected existing assessment instruments and guidelines for certifying kinship homes that are utilized in some California counties.

Having developed a draft instrument, three subsequent meetings were held with child welfare staff. The instrument was then pilot tested with four families (two kin and two non-kin) to ensure that the language of the instrument was appropriate and easily understood by caregivers. Based upon the pilot test, the instrument was revised again, with several questions deleted (to reduce administration time), and others re-worded for clarity. The questionnaire was designed for oral administration by a trained graduate student researcher.

Based upon the extensive involvement of county child welfare staff, we believe that the instrument rates highly in face validity, however, the few standardized assessments included in the completed instrument makes the reliability and criterion-related validity of the instrument uncertain to determine. The completed instrument was designed to measure a variety of domains of care including demographic characteristics of the child and caregiver; physical environment of the home; and the socio-emotional climate of the home.

Demographic characteristics of the child and caregiver. The instrument included five questions about the child's age, ethnicity, length of time in the caregiver's home, and their emotional adjustment to placement (e.g., "How did <child> adjust to living in your home when s/he first arrived?"). In addition, we included three questions regarding the caregiver's characteristics including their age, ethnicity, and access to support services. The Duke Health Inventory (Parkerson, Broadhead, & Tse, 1990) was used as a standardized self-assessment instrument for measuring adult health. The Duke Health Profile is a 17-item standardized self-report instrument that contains six health measures including indicators of physical, mental, social, general, perceived health, and self-esteem. Four measures of individual dysfunction are also included: anxiety, depression, pain, and disability. Reliability is reported as adequate with Cronbach's alpha scores of .55 to .78.

Physical Environment of the Home. Nine questions were asked to assess the presence or absence of hazards in the home and the caregiver's preparedness for an emergency. Additionally, 12 items were modified from the "Home Observation for Measurement of the Environment" (HOME) (Caldwell & Bradley, 1984) and the "Revised Index of Physical Environment" (Coulton, 1990), in order to assess the physical surroundings of the home and neighborhood. After completion of the interview, interviewers responded to items on a scale of 0 (not at all) to 10 (very much/many). Examples include: "Presence of obvious physical hazards to exterior of home, yard, courtyard, walkway, etc.," and "How pleasant and aesthetically pleasing is the respondent's neighborhood?"

Socio-Emotional Climate of the Home. The dimension of socio-emotional climate included questions which measure the adequacy of supervision for children; the health, educational, and extracurricular support provided to children; family relations between the caregiver and child; and the child's access to his/her parent. Regarding *supervision*, four questions were asked of caregivers to assess babysitting arrangements, after-school, and evening supervision. Regarding *health care*, four questions were also included to review practices in coordinating children's routine health and dental care (e.g., "Who makes medical and dental appointments for child: caregiver, social worker, other;" "Since child has been living with you, when was the last time s/he was seen by his/her general doctor, eye doctor, or dentist?;" "Does your child see a counselor or therapist?") Regarding *education*, we also examined the extent to which caregivers were involved in activities associated with their child's school with four questions (e.g., "Do you have some of child's school work or report cards at home? Do you have school photos, mementos, or other memorabilia of child's?). And seven questions were included about the kinds of *extracurricular activities* in which the child might be involved (e.g., "Does child participate in any extra or community activities such as swimming lessons, sports teams, music or art lessons, boys/girls clubs?;" "About how many hours a day does child watch television or videos?").

The instrument included questions for caregivers regarding their *family relations* including items about their attitudes toward the child in their care, their long-term commitment to the child, and their perceptions of the birth parent. The Index of Family Relations (IFR) was selected as a standardized assessment of family relationships between caregivers and children. The scale was designed for therapists or researchers to measure the quality of personal and social functioning. The 25-item scale was a self-report measure with high reliability (.90), and good content validity (Hudson, 1982; Hudson & Acklin, 1980). We asked respondents to think of their "whole" family, including the child in their care, as a family member when answering questions in this scale.

Finally, caregivers were asked six questions about the child's *proximity and visitation* with birth parents including the amount and degree to which parents visit with the child and any barriers birth parents face in gaining access to visitation with their child.

Sample

A random sample of 123 kinship and 97 non-kin homes was drawn by county staff from their foster care database. The sample was restricted to those homes that included a child age 5-12 in care as of December, 1995. All kin and non-kin providers from this sample were sent a letter describing the scope and purpose of the study. Providers were offered a $20.00 stipend for their participation. A follow-up letter was distributed two weeks later.

Fourteen kin (11%) and 11 non-kin (11%) providers responded to the request for participation. Due to the low response rate, a second sample of non-duplicated providers, including 159 kin and 131 non-kin was also drawn from the database. These providers were also contacted for their participation. Forty-six kin (29%) and 44 non-kin (34%) responded affirmatively. We believe that the response to the initial request was especially low as it was received by potential respondents during the winter holidays—an especially hectic season.

Ultimately, 28 kin and 33 non-kin were interviewed for this study. Although small, we believe that the size of the final sample is sufficient to provide an initial indication of some of the differences that can be found in kin and non-kin homes. Because of the low response rate, however, we also believe that some bias is also present in this sample. It is likely that those providers who are most confident about the quality of the care they provide, or who have the most positive relationships with the county agency responded affirmatively. Those providers who would prefer more privacy, or who would like to be less closely scrutinized, may have been less likely to participate.

Administration

This study involved an in-person interview with kin and non-kin providers in their homes, at times that were convenient

Table 1
Significant Differences between Kin and Non-Kin: Demographic Characteristics

	Kin	Non-Kin	Sig.
Respondent believes child has emotional difficulties associated with his/her past.	63.0%	90.6%	$p < .01$
Child sees a counselor or therapist.	44.4%	78.1%	$p < .01$

for the care providers. Interviewers were trained graduate student researchers studying for an M.S.W. degree at U.C. Berkeley and all had extensive prior experience working with the foster care system. All interviewers were ethnically matched to the provider and, where the provider's first language was Spanish, interviews were conducted entirely in Spanish ($n = 4$).

Analysis

Bivariate analyses were conducted to examine the relationship between kin and non-kin status and various indicators of "quality" as described previously. Thirty-eight separate tests were conducted on the dependent variable, increasing the likelihood of a Type I error. To account for this potential problem, a Bonferroni adjustment was made by dividing the conventional significance level of .05 by 38. This resulted in a reduced significance level of .0013 that was required in order to determine differences between kin and non-kin settings. Findings approaching significance at the .01 level are also presented in the tables.

Findings

Demographic Characteristics

Characteristics of the Child in Care. The average age of children in both groups was about eight and one-half years. Both groups of children had been living with their caregivers for approximately 18 months. Thirty-two percent of children were Latino/Hispanic, 23.7% Caucasian, and 18.6% African American (the remainder included children of other ethnic groups and mixed-race children). More girls (61.7%) than boys (38.3%) were the subject of study.

Table 2
Differences between Kin and Non-Kin: Physical Environment of the Home

	Kin	Non-Kin	Sig.
Characteristics of the Home			
Do you own or rent your home (% indicating "own").	46.4%	78.8%	$p < .01$
How many bedrooms in the home?	2.97	3.50	ns
	$SD = 1.02$	$SD = 0.94$	
Does child have his/her own bedroom or does he/she share? (share responses)	78.6%	45.5%	$p < .01$
Have you ever been threatened or attacked with a gun, knife or other weapon, either by family or a lover or friend in your home? (% yes)	14.3%	6.3%	ns
Have you ever been threatened or attacked by anyone without a weapon but with the intent to injure you either by family or a lover or a friend in your home? (% yes)	28.6%	3.1%	$p < .01$
Have you ever been concerned about drug or alcohol use among other adults who live in your home or who stay here occasionally? (% yes)	32.1%	6.1%	$p < .01$
Interviewer observation: Rate the general structural conditions of the respondent's home on a scale from 0-10 (0 = very poor condition, 10 = well kept up).	8.62	9.70	$p < .01$
Interviewer observation: Presence of obvious physical hazards to exterior of home, yard, courtyard, walkway (% yes).	14.8%	0.0%	ns
Interviewer observation: Rate the internal condition of the respondent's home on a scale from 0-10 (0 = very poor condition, 10 = well kept up).	8.6%	9.7%	ns
Physical Safety			
Do you have a first aid kit? (% yes)	71.4%	97.0%	$p < .01$
Do you know CPR? (% yes)	57.1%	93.9%	$p < .001$
Do you have an earthquake kit? (% yes)	21.4%	60.6%	$p < .001$
Do you have a fire extinguisher? (% yes)	53.6%	97.0%	$p < .001$
Do you own any guns? (% yes)	3.6%	33.3%	$p < .01$
Neighborhood Conditions			
Interviewer observation: How pleasant and aesthetically pleasing is the respondent's neighborhood (0 = unpleasant, 10 = pleasant).	7.89	9.61	$p < .01$
Interviewer observation: How well kept are the exteriors of the structures in the immediate vicinity of the respondent's home (0 = very poorly kept, 10 = very well kept).	8.18	9.48	$p < .01$
Does child feel safe going to school by his/herself?	57.7%	73.1%	ns
Does child ever go to the library, by her/himself?	18.5%	17.9%	ns
Doyou feel that (the park) is a safe place for child to play?	88.9%	78.8%	ns
Are there any special activities or services available in your neighborhood that child takes advantage of? (% yes)	44.4%	40.6%	ns
As a place to raise children, would you say your neighborhood is excellent or very good? (% yes)	57.1%	66.7%	ns
Do you feel that violence connected to drug use or drug dealing is a problem in your family or neighborhood? (% yes)	35.7%	3.0%	$p < .001$

Table 3
Differences between Kin and Non-Kin: Socio-Emotional Climate

Characteristics	Kin	Non-Kin	Sig.
Supervision			
Do you work outside your home?	57.1%	66.7%	ns
Who, if anyone, is with child when you are unable to be there? (% indicates formal or informal arrangements)	100%	100%	ns
When child is by her/himself, does s/he know to call or where to go in case of emergency? (% yes)	96.3%	78.6%	ns
Health, Education, and Extracurricular Support			
Since child has been living with you, when was the last time s/he was seen by his/her general doctor, eye doctor, or dentist?	96.6%	96.8%	ns
Do you have some child's school work or report cards at home?	92.9%	93.5%	ns
Do you have school photos, mementos, or other memorabilia of child's?	100%	87.9%	ns
Does child participate in any extra or community activities such as swimming lessons, sports teams, music or art lessons, boys/girls clubs?	60.7%	73.3%	ns
How many hours per day does child watch t.v.?	1.97	1.27	$p < .01$
	$SD = 1.20$	$SD = 0.74$	
Family Relations			
Index of Family Relations score	14.32	19.79	ns
	$SD = 2.4$	$SD = 2.5$	
What is the primary method you use to discipline children?			
Proportion of "time-out" responses	46.4%	75.0%	ns
Proportion of "spanking" responses	32.1%	15.6%	ns
Relationship, Proximity and Visitation with Birth Parents			
Birth mother's relationship to child indicated as "very warm or warm."	75.0%	31.3%	$p < .001$
Percent indicating relationship with birth mother as "non-existent."	3.6%	34.4%	$p < .001$
How often does the child's birth mother see him/her? (% indicating weekly to 2x weekly)	29.6%	27.3%	ns

Children in non-kin homes may have been somewhat more emotionally unsettled, on average, by their past experiences ($X^2 = 6.52$, $df = 1$, $p < .01$—see Table 1 for a review of all significant and near-significant findings) and were more likely to be receiving counseling or therapeutic services ($X^2 = 7.10$, $df = 1$, $p < .01$).

Characteristics of the Caregiver. The mean age of kin caregivers was 48.9 years ($SD = 12.0$); the mean age of non-kin caregivers was not statistically different at 46.4 years ($SD = 9.3$). Non-kin caregivers were more likely to be Caucasian. The majority of kin caregivers (53.6%) were grandmothers to the subject child.

Using the Duke Health Inventory, we assessed caregivers' health. No significant differences were found between kin and non-kin. Both kin and non-kin scored in the "healthy" range compared to normative scores on all sub-scales, although both groups had somewhat elevated levels of pain and somewhat more problems with their physical health, in general.

Physical Environment of the Home

Characteristics of the home. Non-kin were more likely to own their home than to rent ($X^2 = 6.87$, $df = 1$, $p = .008$). Most homes were relatively large in size, including three bedrooms (see Table 2). Non-kin homes were, on average, somewhat larger than kin homes ($t = -2.07$, $df = 57.29$, $p < .05$). As a result, kin children experienced somewhat greater crowding in kin homes; more children in kinship homes had to share their bedroom compared to non-kin children ($X^2 = 6.96$, $df = 1$, $p < .01$).

In addition to the basic composition of homes, we were also interested in the general tenor of homes where children resided. When asked, "Have you ever been threatened or attacked with a gun, knife or other weapon, either by family or a lover or friend in your home?" most respondents, kin and non-kin, indicated that they had not. When asked the same question relating to violence in the home not involving a weapon, however, kin were more likely to indicate that they had been previously threatened or attacked ($X^2 = 7.58$, $df = 1$, $p < .01$). When asked "Have you ever been concerned about drug or alcohol use among other adults who live in your home or who stay here occasionally?" About 32% of kinship foster parents answered affirmatively, in comparison to 6% of non-kin providers ($X^2 = 6.97$, $df = 1$, $p < .01$).

On a scale of 0-10, subjective judgements were made by interviewers regarding the general up-keep of the home. In general, scores for both kin and non-kin were rather high. Non-kin received somewhat higher (i.e., better) marks in the area of "general structural conditions," where 0 indicated "very poor condition, major structural damage, large holes in walls or floors, etc." and 10 indicated "well kept up and in good repair." Non-kin had a score of 9.70 and kin scored 8.62 ($t = -3.07$, $df = 29.05$, $p < .01$). Where specific exterior hazards were evident, these were found in or around kinship homes (11%) and included electrical fixtures in need of repair, sharp objects within reach of children, and roof or walls needing repair. Non-kin also had somewhat higher scores on measures of the general interior up-keep of the home, although differences were not significant.

Physical safety. We asked respondents a series of questions regarding general safety precautions the caregivers adhered to in their homes. Some differences were found between kin and non-kin regarding safety procedures. For example, non-kin were more likely to indicate that they owned a first aid kit, owned an earthquake kit, knew CPR, and owned a fire extinguisher. Non-kin were more likely to indicate that they owned one or more guns (although all indicated that guns were kept in locked storage either inside or outside of the home).

Neighborhood Conditions. Interviewers were asked to rate the respondent's neighborhood on a 10-point scale from "unpleasant—no trees or green space, debris and garbage obvious" (0) to "pleasant—lots of grass, neat, no debris" (10). While both kin and non-kin homes were rated relatively highly, non-kin homes were given a higher rating at 9.61, compared to kin (7.89) ($t = -3.44$, $df = 29.66$, $p < .01$). Interviewers were also asked to rate the "exteriors of the structures in the immediate vicinity of the respondent's home" from 0 (very poorly kept, dilapidated, major repairs needed) to 10 (very well kept and in good repair). Structures in the immediate vicinity of non-kin homes were rated 9.48 and structures surrounding the kin homes were rated 8.18 ($t = -2.84$, $df = 29.96$, $p < .01$).

Kin and non-kin were comparably likely to indicate that they felt their neighborhood was safe enough for their child to go to school, to go to and play at the park, and to go to and spend time at the library alone. They were also similarly likely to respond (about 40%) that their children took advantage of special activities and services in their neighborhoods. In response to the question, "As a place to raise children, would you say your neighborhood is excellent, very good, good, not too good, or awful," 57.1% of kin and 66.7% of non-kin described their neighborhood as either "excellent" or "very good." In response to the question, "Do you feel that violence connected to drug use or drug dealing is a problem in your family or neighborhood?" kin were more likely to answer affirmatively ($X^2 = 10.95$, $df = 1$, $p < .001$).

Socio-Emotional Climate

Supervision. Kin and non-kin were similarly likely to work outside the home and they were comparably likely to have arranged child care when they were out of the home. According to these caregivers, children in kinship care were somewhat more likely to know where to go or who to call in case of an emergency ($X^2 = 3.89$, $df = 1$, $p < .05$; see Table 3).

Health, Educational, and Extracurricular Support. We found no differences between groups in any areas concerning the caregiver's support for the child's routine health needs, their participation and support for the child's educational development, or in the kinds of extracurricular activities in which the child might be involved. Children living in kinship homes reportedly watched more television daily than children living in non-kin homes. Caregivers indicated that children in kin homes watched an average of two hours (1.96) of television per day, in contrast to children in non-kin homes, who reportedly watched 1.26 hours of television per day ($t = 2.74$, $df = 46.24$, $p < .01$). Virtually all caregivers indicated that they monitor, control, or limit the programs their children watch.

Family Relations. Utilizing the Index of Family Relations, we attempted to characterize family relationships. Lower scores indicate more positive family relations. Scores higher than 30 indicate a degree of disharmony that is "clinically significant" (Hudson, 1992). Scores on this item in our sample ranged from 0 to 67. The mean score for kin was 14.32 ($SD = 2.4$, $n = 28$) and the mean score for non-kin was 19.79 ($SD = 2.5$, $n = 31$). These differences were not statistically significant. Their ratings indicated a high degree of fondness among family members.

We asked caregivers how they discipline children. Few differences were found between kin and non-kin. In general, kin and non-kin use the same types of disciplinary measures.

Proximity and Visitation with Birth Family. Respondents were asked to describe the birth mother's relationship to the child from "very warm and positive" to "hostile." About half of all birth mothers' relationships (51.7%) were described as "very warm or warm," although children living in kin homes were more likely to have warm relationships with mothers than children in non-kin homes. Children in non-kin homes were more likely to not have any relationship with their birth parent at all ($X^2 = 14.03$, $df = 1$, $p < .01$).

Discussion

Quality of care has been little studied in foster care services. The study reported here offers an initial examination of this issue, yet the study's limitations may compromise firm conclusions we might draw from the findings. The sample included in this study was small and self-selected—given the available data, we cannot determine how the caregivers who consented to participate differ from those who did not. Similarly, the data were largely obtained through participants' self-reports (although some information was secured through the researchers' observations) and may include unmeasured biases. Standardized scales were used where possible, however the nature of the study subject precluded the use of a standardized instrument for the collection of all data. The data provided in this study were also derived from a single county in California; further research that includes a larger sample of families (kin and non-kin) from a wider community will be necessary to address this topic conclusively. Although the sample was ethnically diverse, Caucasians were more heavily represented among the non-kin sample and more families of color were included in the kin sample. This suggests that differences between kin and non-kin providers may be related as much to differences in ethnicity and other factors as to their relationship to the child.

In spite of these limitations, this study offers otherwise missing information about the quality of care in kin and non-kin homes. Summing up the findings, we see certain similarities and differences in the children, the caregivers, and the characteristics of homes and neighborhoods in kin and non-kin settings. It appears that kin caregivers in this sample believed the children in their homes were less emotionally traumatized by their past experiences than children in non-kin homes. These findings mirror those of Berrick, Barth, & Needell (1994) who found that kin caregivers rated the behavioral and emotional problems of children in their care as less problematic than the problems described by non-kin caregivers about the children in their care. Both studies, however, relied upon caregiver rating of the children in their care. Until outside observers can validate these findings it will remain unclear whether the differences between kin and non-kin children are actual or perceived. That is, kin caregivers may minimize the difficulties children experience during and after placement, or the abuse and subsequent placement experience may be less traumatic for children in kin care.

Kin and non-kin caregivers were relatively young. The age of kin caregivers is especially notable as the majority of these caregivers were grandmothers to the children in their care. This sample did not include especially elderly men or women. As a result, the overall health status of these caregivers was very good. Some researchers have expressed concern about placing children with relative caregivers who are so elderly or who have such compromised health conditions that they will be unable to see

their child into adulthood (R. Barth, personal communication, May 24, 1996). This sample of caregivers did not shed light on this topic; further research with a larger and more representative sample is needed to track the life-time experiences of children placed with kin.

Corroborating other evidence which has indicated that kinship caregivers are, on average, a poorer group of families than non-kin caregivers (Mayor's Commission for the Foster Care of Children, 1993; Thornton, 1987), and findings that kinship caregivers are more likely to include families of color (LeProhn, 1994; Testa, 1997), this study identified a number of factors that point to the challenges many ethnic minorities may face—particularly those living in poverty. Kinship homes and neighborhoods were more often rated as somewhat more compromised than non-kin homes and neighborhoods. Problems with drugs or alcohol, when evident, were more likely to occur around kinship homes. The same was true for incidents of violence or threatened violence. Although homes were generally well kept, when hazards were evident, these were only found in kinship homes.

Non-kin were better prepared than kin to handle emergency situations as measured by the presence of specific health-related safety devices and procedures. It should be noted, however, that the questions asked were specific to standard items generally considered for foster parent licensure. Other equipment and materials might be available in kin homes that could be used in emergency situations. For example, although fewer kin caregivers possessed a first aid kit, some may have owned other items and routinely kept them in their medicine chest (e.g., Band-Aids, gauze, tape, anti-bacterial lotion, etc.)

Kin and non-kin were equally likely to work outside of the home and to have arranged child care, but children in kin homes were more likely to know who to call or go to in an emergency. This finding again highlights the close bonds of family that are evident in kinship foster homes. When placed with kin, children are not only cared for by the primary kinship foster parent, but may be surrounded by a group of caring individuals who can be relied upon in various situations.

Even though kin providers came to their role with less planning and preparation than non-kin providers who must become licensed and trained before taking children into their care, kinship caregivers experienced the child's inclusion into their family equally positively. Kin caregivers were somewhat less likely to give "time-outs" when disciplining the child in their care. Other than this minor difference, disciplinary practices between kin and non-kin were relatively similar.

Using a standardized measure of family relations, there were no differences between kin and non-kin caregivers' views about their relationship with the child. In both samples, family relationships were described in very positive terms.

One of the significant strengths of kinship foster care, found elsewhere (Berrick et al., 1994; LeProhn, 1994) and confirmed here, is the role kinship care plays in promoting and maintaining close relationships between foster children and their birth parents. Approximately three-quarters of the children in kinship foster homes had "warm and positive" relationships with their birth mothers compared to about one-third of children in non-kin homes. Children in non-kin settings were also more likely to have no relationship at all with their birth parent. Not surprisingly, kinship caregivers had a closer relationship to the birth parent than non-kin caregivers. This does not necessarily mean that kinship foster care promotes close relationships between caregivers and birth parents, but that those mothers who did not have a close relationship with their mother or other relatives were probably less likely to have their child placed in kinship foster care.

Implications for Policy and Practice

A growing body of evidence points to the need for changes in policy and practice that might strengthen the kin and non-kin resources currently available to dependent children. This exploratory study adds to the field and suggests specific issues that social service agencies may wish to consider to support children's caregivers.

Many child welfare workers currently make placement decisions without written guidelines, training, or screening tools for assessing kinship homes. While this approach may result in suitable placements for many children, individual discretion may become a faulty mechanism for assessing all kin caregivers. Because kinship foster care is developing so rapidly across the country, it may be advisable to take a proactive approach to kinship care policy. General guidelines concerning the caregiver, the home, and the neighborhood should be developed in order to provide more uniform standards for child welfare workers in their selection of kin.

As described in this study, some kin caregivers do not have basic tools in their homes that might be needed in emergency situations. Social services agencies should therefore consider developing small discretionary funding sources for social workers to draw upon in instances where kinship caregivers are ready and able to care for children but they do not have the financial resources to purchase emergency aids such as fire extinguishers, smoke detectors, fireplace screens, first aid kits and earthquake kits. Social service agencies may need to work with their local service clubs in order to locate additional funds for larger purchases that will increase the safety of kin and non-kin homes (e.g., fences around swimming pools, etc.).

Social service agencies have shown a traditional reluctance to engage kinship foster parents in foster parent training sessions. While unique training programs may be required for kinship caregivers, these adults should *at least* be required to know or learn how to administer CPR should a child in their care need emergency assistance. About half of the kinship foster parents in this study indicated a willingness to receive additional training from their social services agency. Basic health and safety training should be required for all caregivers of dependent children.

Training for kin *and* non-kin should include information about appropriate disciplinary techniques for dependent children. About 32% and 16% of kin and non-kin caregivers respectively utilized "spanking" as a disciplinary measure with the children in their care. Significant efforts should be made to encourage alternative disciplinary strategies when working with abused and neglected children. Strengthening the parenting practices of kin and non-kin can be enhanced through training, ongoing support, and monitoring by the social services agency.

Children in kin care are more likely to know who to call in case of an emergency than children in non-kin care. Social workers should remind non-kin foster parents of the importance of acquainting the children in their care with their neighbors and relatives so that children know of other "safe houses" in case of emergency.

As increasing numbers of children are placed in kinship foster care settings, child welfare agencies are finding unique strengths and special challenges associated with these placements. In many respects, data from this study indicate many similarities between kin and non-kin foster care arrangements, however, some of the initial differences reported here point to the need for further research to understand the nature and extent of these variations in order to better determine how to strengthen placement settings for all children.

Kinship care is a developing phenomenon, falling somewhere between family preservation and foster care. As a form of government-sponsored care for dependent children social service agencies must not lose sight of the basic requirements of safety and protection that must be guaranteed to these children. Distinctive efforts to enhance and support kinship foster care through initial and on-going assessments will strengthen the care these children are already receiving from their grandmothers, aunts, and other caring relatives.

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