Does the child welfare system serve the neediest kinship care families?

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Abstract:

Little is known about how kinship care arrangements within the child welfare system compare to kinship placements outside the child welfare system. The purpose of this study is to better understand the characteristics that influence whether a child is placed in public or private kinship care. Using national level data, we employ bivariate analysis and logistic regression to evaluate how child, caregiver and state characteristics are related to the placement of children in public versus private kinship care. Our findings suggest that the child welfare system indeed serves the most vulnerable children. Children with disabilities, children with behavioral problems, and infants are all more likely in public kinship care compared to their counterparts. However, evidence on whether the most disadvantaged kinship caregivers are in public arrangements is mixed. On the one hand, kinship caregivers in public care are older, less educated, less likely employed, and more likely to have ever been on welfare. On the other hand, public kinship caregivers are less likely than private caregivers to live below the federal poverty line or experience food insecurities.

Keywords: child welfare system | kinship care | foster care

Article:

1. Introduction

In 2001, 2.54 million children lived in households with neither parent present. The large majority of these children—2.3 million—were cared for by relatives in "kinship care" arrangements.[1] Over 75 percent of kinship care arrangements are *private* placements that occur without the help or knowledge of child welfare officials.[2] This large group of children is understudied because it is difficult to identify in most data sets. Less common, though more studied, are *public kinship care* arrangements, which involve assistance from or contact with child welfare workers.

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[1] Kinship care is defined as the full-time care and protection of a child by a relative or an adult who has a close emotional bond to the child. Depending on state rules, the "kin" may be unrelated by blood to the child.

[2] Authors' tabulations from the National Survey of America's Families.

Although kin have long cared for related children privately when parents are unable to (Hegar & Scannapieco, 1995), the placement of children with relatives by the child welfare system is relatively new and has expanded considerably since the late 1980s (Boots & Geen, 1999, Harden et al., 1997). This increase has been driven, in part, by a rising demand for out-of-home care coupled with a dwindling supply of non-relative foster parents (Berrick, 1998). Because of or in conjunction with this increase, child welfare policies and practices have recently evolved to recognize relatives as an important source of out-of-home care.

Many researchers have studied the differences between public kinship care and non-relative care arrangements (Beeman et al., 2000, Berrick et al., 1994, Ehrle & Geen, 2002a, Gebel, 1996, Grogan-Kaylor, 2000, Iglehart, 1994, Le Prohn, 1994). An important conclusion from this work is that the benefits of kinship care must be balanced against the fact that kinship care families are typically more disadvantaged than non-relative caregivers.

In contrast to the sizeable body of work comparing public kinship care to non-relative care, little is known about how public and private kinship care arrangements compare. This is an important area of research for several reasons. First, differences between kinship care arrangements inside and outside the child welfare system may be just as great as those between kinship and non-relative placements. Second, families outside the child welfare system do not receive help from child welfare officials in securing resources to provide for the children in their care. Thus, it is critical to assess the extent to which the most at-risk children and families are involved with the child welfare system. Third, a comparison of public and private kinship care can help identify both child and family characteristics that influence the involvement of and decisions made by child welfare professionals.

The purpose of this study is to compare private and public kinship care arrangements using national level data. We employ bivariate analysis to compare the child, caregiver and state characteristics of families in both types of kinship care. Additionally, we conduct multivariate analysis using logistic regression to explore the determinants of public versus private kinship care.

2. Background

2.1. Previous literature

A number of researchers have examined the differences between public kinship care arrangements and non-relative foster care placements. These studies have shown that the benefits of kinship care (e.g., kinship care is less disruptive for children) must be balanced against the fact that kinship care families are typically more disadvantaged than non-relative caregivers (e.g., kinship caregivers are typically poorer, older, and less educated).[3] By comparison, little is known about how public kinship care arrangements compare to private kinship care arrangements outside the system. To the best of our knowledge, only three previous studies have compared public versus private kinship care arrangements.

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[3] See, for example, Barth et al., 1994, Berrick et al., 1994, Dubowitz et al., 1993, Ehrle & Geen, 2002a, Fein et al., 1983, Gebel, 1996, Gleeson & Craig, 1994, Le Prohn, 1994.

McLean and Thomas (1996) compare 60 private kinship care arrangements from a service program in Philadelphia to Berrick et al.'s (1994) study of public kinship care families in California and to Dubowitz, Feigelman, and Zuravin's (1993) study of public kinship care families in Baltimore. They find that private and public kinship care arrangements are similar in several dimensions, including caregiver age and marital status, the number of children cared for, and the reason for placement.

Harden et al. (1997) compare private and public kinship care arrangements using administrative foster care records and census data from California, Illinois, New York, and Missouri. Due to data limitations, age is the only individual-level characteristic available to compare children in both types of kinship care, and the authors find that younger children are more likely to be in public kinship care than older children.

Lastly, Goodman, Potts, Pasztor, and Scorzo (2004) use data on 581 grandmothers in the Los Angeles area to study grandmother caregivers. Approximately 36 percent of the grandmothers are in public care arrangements. The authors' findings support the idea that the child welfare system targets at-risk families. They find that grandmothers in public kinship care are less likely to be married, have more children in their care, are less likely to receive help from the birth parents in decision making, and are more likely to care for grandchildren with behavioral problems. Moreover, they find that grandmothers caring for their grandchildren through the child welfare system are more likely to have assumed care due to parental substance abuse and neglect.

2.2. State and federal policies

2.2.1. Federal income assistance and child welfare policies on kinship care

Federal income assistance policy has provided financial support to kinship caregivers since 1950, when an amendment to the Social Security Act qualified relative caretakers for assistance under Aid to Families with Dependent Children (AFDC).[4] Relative caregivers could obtain AFDC based on the income and assets of their own family (including the child) or the child could be considered separately from the caregiver's family and receive a child-only grant.[5]

Federal child welfare policy, on the other hand, has been unclear about what kind of support to provide kin caregivers. In the late 1970s and early 1980s, two pieces of federal legislation demonstrated a preference for the use of relatives in out-of-home care placements. First, the Indian Child Welfare Act of 1978 stated that a Native American child should be placed "within reasonable proximity to his or her home…" and advised states to place the child with "a member of the Indian child's extended family…" whenever possible. Second, the Adoption Assistance and Child Welfare Act of 1980 required states to find the "least restrictive, most family-like setting available located in close proximity to the parent's home, consistent with the best interests and special needs of the child."

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[4] Kinship caregivers similarly qualify for TANF benefits.
[5] However, the federal definition of a relative was narrowly defined.

Nonetheless, federal guidelines did not specify how states should financially support kinship caregivers. In 1979's *Miller v. Youakim*, the Supreme Court determined that kinship caregivers are entitled to the same foster care maintenance payments as non-kin foster parents, provided they care for Title IV-E eligible children and meet foster home licensing requirements. However, the Court did not guide states in how to support relatives caring for non Title IV-E eligible children or relatives who do not meet foster home licensing requirements.

A number of more recent federal policies have reinforced the right of relatives to serve as foster parents and to receive public support for doing so. In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) addressed the issue of kinship care by requiring states to "consider giving preference to an adult relative over a non-related caregiver". Relative caregivers were further recognized by 1997's Adoption and Safe Families Act (ASFA), which states that a "fit and willing" relative can provide a planned permanent living arrangement for children in out-of-home care. A final ruling on the ASFA in January of 2000 entitles states to federal reimbursement for kinship foster care expenses if kin meet the same licensing requirements as non-relatives.

2.2.2. State policies on supporting kinship caregivers

Because federal policy has not clearly specified how states should treat all kinship caregivers, state policies differ widely. Even the definition of "kin" for child welfare purposes varies across states. Some states only include persons related by blood, marriage or adoption, while others also consider unrelated persons with a close emotional bond to the child such as neighbors, family friends and godparents.[6]

In addition, the standards states use to license kin caregivers as foster parents differ. In some states, kin can only be licensed by the same standards applied to non-relatives.[7] In others, kin can be licensed by a modified or waived standard in which one or more of the non-relative licensing standards that do not affect safety (such as training or physical space requirements) are waived for kin. Some states also or alternatively offer kin caregivers a separate, usually less stringent, licensing process designed specifically for kin caregivers.

State policies also vary in how kinship care families are supported. All children in kinship care are eligible to receive federal income assistance such as a TANF child-only grant. In comparison, the receipt of foster care maintenance payments is reserved for children in public kinship care and depends upon the licensing process used for the kin caregivers.[8]

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[6] In 2001, for example, 22 states defined kin to be more inclusive than blood relatives. These 22 states are Arizona, Colorado, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Hampshire, New Mexico, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Texas, Utah, and West Virginia (Jantz et al., 2002).

[7] In 2001, these states included California, Colorado, the District of Columbia, Hawaii, Iowa, Minnesota, Missouri, North Dakota, Oregon, Pennsylvania, Utah, Vermont, Virginia, West Virginia, and Wyoming (Jantz et al., 2002).

[8] If kin caregivers are fully licensed, they are eligible for foster care maintenance payments. These payments are typically greater than TANF child-only grants and do not decline as the number of children increases. In some states, kin caregivers can receive foster care payments if they meet less stringent standards, but most states with less rigorous standards for kin provide them with a smaller payment, usually a TANF child-only grant.

3. Methods

3.1. Data description

We use data from the 1997, 1999, and 2002 waves of the National Survey of America's Families (NSAF). The NSAF is a nationally representative survey of over 44,000 households from 13 focal states and a sample from the remainder of the country.[9] The NSAF is well suited for this study for three reasons. First, it allows us to identify public versus private kinship care arrangements and it contains a variety of measures of child and caregiver well being. Second, whereas the majority of existing studies on kinship care have used small, unrepresentative samples, our sample is nationally representative. This allows us to generalize our results to the population of children in kinship care while allowing for important, unobservable state differences in kinship care policy and practice. Third, we have data across 3 years, which allows us to capture unobservable year specific effects which are common across states.

To construct our sample analysis, we select all children identified as being in kinship care. Kinship care arrangements are classified as either public or private according to whether the arrangement involved social services. Observations are merged across the 3 years to create a repeated cross-section file. The resulting analysis sample contains 2979 children in kinship care, of which 24 percent are in public kinship care and 76 percent in private kinship care.[10] The data set includes probability weights, and these weights are used in all of the analysis.

3.2. Measures

The dependent variable for our analysis is a categorical variable equal to one if the child is in a public kinship arrangement and zero if the child is in a private kinship care arrangement. We explore how this dependent variable is associated with 5 groups of independent variables: child characteristics, caregiver demographic characteristics, caregiver economic characteristics, caregiver "coping" characteristics, and state-level characteristics.

Child characteristics include gender, race/ethnicity, age, and whether the child has a physical, mental or health disability that limits his or her activities. We also include a measure of whether the child has a behavioral problem, such as lying, cheating, performing poorly in school, or acting high-strung. Behavioral problems are only recorded for children ages 6 and older.

Caregiver demographic characteristics include age, education, marital status, and gender. We also control for the relationship of the caregiver to the child. Caregiver economic characteristics include measures of whether the caregiver works outside the home, whether she has ever received AFDC/TANF benefits, and family income compared to the federal poverty line. Lastly, we include a number of variables to capture the caregiver's level of "coping". We capture caregiver health by including a measure of whether the caregiver reports being in fair or poor health. We capture housing insecurity by considering whether the caregiver was unable to pay her rent, mortgage or utility bills in the last 12 months. We also include two measures of food

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[9] The focal states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.
[10] We discarded 351 observations out of an original sample of 3330 due to missing values for key variables.

insecurity: whether the caregiver or other adults in the family skipped meals or reduced portions in the last 12 months because there was not enough money for food and whether in the last 12 months the family often ran out of food due to lack of money. Finally, we include a measure of whether the caregiver feels that she has to give up more of her life to meet the child's needs than she expected.

We supplement the NSAF with data from a number of other sources. First, to proxy for the fact that we do not observe whether abuse was a reason for entry (and to help control for differences in reporting over time) we use data from the National Child Abuse and Neglect Data System to control for the number of child abuse cases per 1000 children. Second, to capture state-specific economic characteristics, we supplement the NSAF data with per capita income (obtained from the Bureau of Economic Analysis and the Census Bureau) and the ratio of the average foster care maintenance payment to the average TANF child-only grant. Both payment amounts are obtained from various years of the Green Book (U.S. House of Representatives). Lastly, to capture state-specific kinship care policies, we supplement the NSAF data with data obtained from surveys conducted in 1997, 1999 and 2001 by the Urban Institute (Jantz et al., 2002, Leos-Urbel et al., 1999, Leos-Urbel et al., 2002). These surveys collected a variety of information on states' kinship care policies, and we use this information to capture whether kin caregivers can be licensed as foster parents under a waived, modified, or separate standard.

3.3. Analysis

First, we employ bivariate analysis (*F*-tests) to compare child, caregiver and state characteristics across public and private kinship care groups. We then conduct multivariate analysis (logistic regression) to explore the determinants of public versus private kinship care. In this analysis, we control for state fixed effects to capture time-invariant, unobservable state-specific factors that influence whether a kinship care arrangement is public or private. These may include unchanging state kinship care policies, child welfare workers' attitudes, or community involvement. We also control for year fixed effects to represent national trends in variables, such as the reporting of child maltreatment and federal child welfare policy, which may be correlated with trends in public versus private kinship care. Results are presented in the next section.

4. Results

4.1. Bivariate analysis

We test the statistical difference between the characteristics of children and caregivers in public and private kinship care arrangements using *F*-tests. Table 1 presents results for the child characteristics and reveals several important similarities and differences between children in public and private kinship care. First, the proportion of females in private kinship care is not significantly different from the proportion in public kinship care. Second, the overall distribution of ethnicities and races between the two groups differs at the 5 percent significance level. In particular, compared to children in private kinship care, a larger percentage of children in public kinship care is African-American and a smaller percentage is white. Third, children in public kinship care are twice as likely as children in private kinship care to have a physical, mental or health disability that limits activities. Fourth, children in public kinship care are almost three

times as likely as children in private kinship care to have a behavioral problem. Lastly, children in public kinship care are almost 1 year younger than children in private care on average, and there are statistically significant differences in the distribution of children across age categories.

Table 1. Characteristics of children in kinship care

Characteristic	Private	Public	*F*-test result
Gender female	0.479	0.485	$F = 0.02, p = 0.877$
Ethnicity			
White	0.360	0.263	**$F = 8.29, p = 0.004$**
Hispanic	0.157	0.143	$F = 0.38, p = 0.540$
African-American	0.449	0.545	**$F = 5.81, p = 0.016$**
Other	0.034	0.050	$F = 0.62, p = 0.433$
All categories jointly			**$F = 3.15, p = 0.024$**
Disability	0.127	0.258	**$F = 14.17, p = 0.000$**
Behavioral problems	0.071	0.204	**$F = 15.79, p = 0.000$**
Age groups			
Infant	0.078	0.073	$F = 0.06, p = 0.803$
Preschool	0.153	0.183	$F = 1.22, p = 0.270$
Preteen	0.404	0.478	$F = 3.40, p = 0.065$
Teenager	0.366	0.267	**$F = 7.75, p = 0.005$**
All categories jointly			**$F = 2.83, p = 0.037$**
Age in years	10.020	9.238	**$F = 4.82, p = 0.028$**

Bold entries denote significance at the 5% level.

Table 2 presents *F*-test results for the characteristics of caregivers in public and private kinship care arrangements. We find no significant differences in caregiver demographic characteristics between public and private kinship caregivers. The economic characteristics show that public kinship caregivers are more likely to have received AFDC. At the same time, private kinship caregivers are more likely to live in poverty. Specifically, 35.0 percent of families in private kinship care report incomes below 100 percent of poverty compared to only 27.3 percent of families in public kinship care. Finally, Table 2 shows that public and private kinship caregivers have similar coping characteristics. The exception to this is that public caregivers are more likely than private caregivers to report feeling like they have to give up more of their lives than expected to meet the child's needs.

Table 2. Characteristics of caregivers in kinship care

Characteristic	Private	Public	*F*-test result
Demographic characteristics			
Age in years	49.289	51.060	$F = 3.26, p = 0.071$
Highest education level			
Less than high school	0.271	0.328	$F = 2.32, p = 0.128$
High school	0.328	0.292	$F = 0.95, p = 0.329$
Some college or beyond	0.401	0.380	$F = 0.29, p = 0.592$
All categories jointly			$F = 1.21, p = 0.298$
Relationship to child			
Grandparent	0.661	0.636	$F = 0.40, p = 0.528$
Aunt/Uncle	0.227	0.229	$F = 0.00, p = 0.968$
Other relative	0.041	0.029	$F = 0.68, p = 0.409$

Characteristic	Private	Public	*F*-test result
Unrelated kinship caregiver	0.071	0.106	$F = 2.90, p = 0.089$
All categories jointly			$F = 1.17, p = 0.318$
Married	0.511	0.439	$F = 3.20, p = 0.074$
Female	0.888	0.879	$F = 0.12, p = 0.724$
Economic characteristics			
Employed	0.519	0.456	$F = 2.40, p = 0.122$
Has ever received AFDC	0.307	0.508	**$F = 25.09, p = 0.000$**
Income < 100% of poverty	0.350	0.273	**$F = 4.72, p = 0.030$**
Coping characteristics			
Fair or poor health	0.330	0.360	$F = 0.61, p = 0.435$
Housing insecurity	0.229	0.248	$F = 0.27, p = 0.606$
Skips or cuts meals	0.161	0.150	$F = 0.16, p = 0.690$
Runs out of food often	0.078	0.084	$F = 0.05, p = 0.827$
Gives up more than expected	0.270	0.350	**$F = 4.04, p = 0.045$**

Bold entries denote significance at the 5% level.

Table 3 presents results for state characteristics. State per capita income and whether the state offers kin caregivers a flexible licensing option do not differentiate public and private arrangements. On the other hand, families in public kinship care are more likely to live in states with a higher average number of child abuse cases per 1000 children than families in private kinship care arrangements. Surprisingly, we find that families in public kinship care are more likely than families in private kinship care to live in states that have a lower ratio of foster care maintenance payments to TANF child-only grants.

Table 3. Characteristics of states in which kinship care families reside

Characteristic	Private	Public	*F*-test result
Child abuse cases per 1000 children	6.976	7.758	**$F = 4.05, p = 0.044$**
Per capita income (1000s)	24.166	24.425	$F = 0.86, p = 0.354$
Benefit ratio	2.576	2.143	**$F = 17.12, p = 0.000$**
Flexible licensing for kin	0.827	0.827	$F = 0.00, p = 0.994$

Bold entries denote significance at the 5% level.

4.2. Multivariate analysis

The bivariate analysis suggests that a number of caregiver, child, and state characteristics are related to the likelihood that a child is in public versus private kinship care. However, this analysis only considers one variable at a time. In this section we use standard multivariate techniques to identify how each of the child, caregiver and state characteristics introduced above is related to the placement of children in public versus private kinship care while simultaneously controlling for all other characteristics.

Table 4 presents results from two logistic models in which the dependent variable is equal to one if the child is in a public kinship care arrangement and equal to zero if she is in a private kinship care arrangement. The first model controls for the explanatory variables as presented in the bivariate analysis above. The second model builds on the first by i) interacting child's age with the behavioral problems indicator, ii) interacting caregiver's relationship to the child with both marital status and gender, iii) expanding caregiver's age to six categories, and iv) expanding

family income to six categories. These expansions allow for nonlinearities in the effects of these variables. We include both models to highlight the effects of allowing for non-linear relationships in key explanatory variables, and we present both models side-by-side to facilitate easy comparison between them. Finally, each model controls for both state and year fixed effects.[11]

Table 4. Logistic regression: Predictors of public and private kinship care

[Empty Cell]	Model 1		Model 2	
	Marginal effect	**OR**	**Marginal effect**	**OR**
Child characteristics				
Gender female	− 0.001 (0.024)	0.994	− 0.002 (0.024)	0.988
Hispanic	0.038 (0.037)	1.321	0.045 (0.030)	1.383
African-American	0.065** (0.030)	1.567**	0.058* (0.030)	1.504*
Other race/ethnicity	0.076 (0.093)	1.667	0.044 (0.076)	1.373
Disability	0.092** (0.041)	1.734**	0.082** (0.039)	1.647**
Behavioral problems	0.217** (0.060)	3.117**	–	–
Preschool	− 0.032 (0.065)	0.851	− 0.032 (0.067)	0.843
Preteen	− 0.081 (0.058)	0.643	–	–
Preteen – no behavioral problems	–	–	− 0.081 (0.061)	0.622
Preteen – with behavioral problems	–	–	0.203* (0.104)	2.439*
Teen	− 0.165** (0.058)	0.344**	–	–
Teen – no behavioral problems	–	–	− 0.162** (0.060)	0.316**
Teen – with behavioral problems	–	–	− 0.042 (0.079)	0.795
Caregiver demographic characteristics				
Age in years	0.006** (0.001)	1.038**	–	–
Age 30–40	–	–	0.082** (0.041)	2.284*
Age 40–50	–	–	0.066* (0.035)	2.004
Age 50–60	–	–	0.109** (0.038)	2.747**
Age 60–70	–	–	0.246** (0.054)	5.767**
Age greater than 70	–	–	0.351** (0.107)	9.049**
Less than high school	0.093** (0.034)	1.811**	0.067** (0.033)	1.539**
High school	0.025 (0.028)	1.200	0.002 (0.028)	1.015
Female	− 0.100** (0.049)	0.558**	–	–
Married	− 0.039 (0.027)	0.772	–	–
Grandparent	− 0.312** (0.070)	0.191**	–	–
Single grandmother	–	–	− 0.306** (0.075)	0.211**
Married grandparent	–	–	− 0.339** (0.071)	0.158**
Aunt/Uncle	− 0.160 (0.074)	0.497**	–	–
Single aunt	–	–	− 0.245** (0.079)	0.320**
Married aunt/uncle	–	–	− 0.119 (0.085)	0.606
Other relative	− 0.178 (0.117)	0.455	–	–
Single female other relative	–	–	0.037 (0.171)	1.158
Married other relative	–	–	− 0.361** (0.094)	0.125**

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[11] We also conducted a stepwise analysis in which we used hierarchical procedures to build the models in Table 4 so that caregiver economic and coping characteristics as well as state characteristics could be viewed separately from child and caregiver demographic characteristics. However, the results from this analysis did not reveal substantial differences in terms of marginal effects, odds ratios, significance, or overall explanatory power. Thus, we only report results from the full version of these models.

[Empty Cell]	Model 1		Model 2	
	Marginal effect	**OR**	**Marginal effect**	**OR**
Single male relative	–	–	− 0.220* (0.123)	0.369
Caregiver economic characteristics				
Employed	− 0.087** (0.030)	0.560**	− 0.073** (0.029)	0.609**
Has ever received AFDC	0.178** (0.036)	2.957**	0.167** (0.035)	2.814**
Poverty (income < 100% poverty)	− 0.146** (0.027)	0.335**	–	–
Income 50–100% of poverty	–	–	− 0.015 (0.029)	0.848
Income 100–150% of poverty	–	–	0.159** (0.042)	2.971**
Income 150–200% of poverty	–	–	0.169** (0.049)	3.128**
Income 200–300% of poverty	–	–	0.141** (0.050)	2.709**
Income > 300% of poverty	–	–	0.060 (0.042)	1.655
Caregiver coping characteristics				
Fair or poor health	− 0.014 (0.027)	0.907	− 0.009 (0.027)	0.939
Housing insecurity	− 0.004 (0.029)	0.973	− 0.020 (0.028)	0.867
Skips or cuts meals	− 0.053* (0.032)	0.683	− 0.057* (0.031)	0.653*
Runs out of food often	0.012 (0.051)	1.084	0.020 (0.049)	1.144
Gives up more than expected	0.000 (0.028)	1.002	− 0.002 (0.027)	0.988
State characteristics				
Abuse cases/1000 children	0.012 (0.007)	1.082	0.013* (0.007)	1.093*
Per capita income (1000s)	0.021 (0.035)	1.152	0.013 (0.033)	1.091
Benefit ratio	0.064 (0.049)	1.532	0.070 (0.044)	1.610
Flexible licensing for kin	0.024 (0.046)	1.179	0.024 (0.045)	1.183
Full model χ^2	237.70		270.55	
Sample size	2979		2979	

Standard errors are in parenthesis.
Both models control for state and year fixed effects.
* Statistically significant at 10%.
** Statistically significant at 5%.

Table 4 reports both marginal effects and odds ratios.[12] We report marginal effects in addition to odds ratios because we have a particular interest in understanding how individual, family, and state characteristics affect the probability that a kinship care arrangement is in the public system. For a continuous independent variable (such as the benefit ratio), the marginal effect is the change in the probability of being in public kinship care associated with a small change in an independent variable. For an indicator variable (such as whether the child has a disability), the marginal effect is the difference in the probability when the variable under consideration equals one minus the probability when the variable equals zero. For instance, the probability of being in public kinship care is 9.2 percentage points higher for a disabled child compared to one without a disability. Unlike a regression coefficient in an OLS model, the value of the marginal effect depends on the values of the other variables in the model. We follow standard procedures and report marginal effects holding all other variables at their means. For reference, the probability of public kinship care when all variables are at the (weighted) sample means is 0.183.

The odds ratios provide an alternative way of indicating how strongly each independent variable is associated with being in public kinship care. Odds ratios less than one indicate that a one unit change in the independent variable is associated with a decrease in the odds of being in public

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[12] Long (1997) provides a discussion of marginal effects and odds ratios in logistic models.

care (or an increase in the odds of being in private care), and odds ratios greater than one indicate that a one unit change in the independent variable is associated with an increase in the odds of being in public kinship care (or a decrease in the odds of being in private care). For example, children are 1.567 times more likely to be in public kinship care if they are African-American than if they are white. We report odds ratios in addition to marginal effects to facilitate comparison to other estimates. However, in what follows we discuss only the marginal effects.

The results from Model 1 are presented in the first two columns of Table 4. Consistent with the bivariate results, the multivariate results indicate that the probability of being in public kinship care is higher for African-American children, children with disabilities, and infants as compared to their counterparts. Behavioral problems are associated with a 21.7 percentage point increase in the probability of being in public versus private kinship care. Model 2 (the second set of columns) considers a more flexible specification of behavioral problems and shows that the magnitude of the effect of behavioral problems depends on the child's age group.[13] Preteens with behavioral problems have a probability of being in public kinship care that is 20.3 percentage points higher than infants while preteens without behavioral problems have a probability that is 8.1 percentage points lower.[14] While all teenagers are less likely than infants to be in public care, the probability of being in public kinship care is 4.2 percentage points lower for teenagers with behavioral problems and 16.2 percentage points lower for teenagers without behavioral problems.

Unlike the bivariate results, the results from both logit models reveal statistically significant differences between the demographic characteristics of caregivers in public and private kinship care. First, we find that the probability of being in public kinship care increases with caregivers' age. Whereas this relationship is assumed to be linear in Model 1, Model 2 allows for different effects at different ages by including six caregiver age groups. This expansion reveals that the positive association between caregivers' age and public care is not linear and is particularly important for caregivers age 50 and older.

Second, findings from both logit models indicate that caregivers with less than a high school education are more likely than caregivers with at least some college to be in public arrangements. Having less than a high school education is associated with a 9.3 percentage point increase in the probability of being in public care in Model 1 and a 6.7 percentage point increase in Model 2.

Lastly, the logit model results show caregiver's gender and relationship to the child to be significant predictors of public versus private kinship care. Model 1 indicates that the probability of being in a public arrangement is 10.0 percentage points lower for female caregivers than male caregivers and 31.2 percentage points lower for grandparents compared to unrelated kinship caregivers. Model 2 interacts the caregiver's relationship to the child, gender, and marital status

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[13] Infant and preschool are not interacted with the behavioral problem indicator because behavioral problems were not recorded in the data for children under the age of 6.

[14] In comparison, Model 1 predicts a much smaller increase in the probability of public care for preteens with behavioral problems (13.6 = 21.7–8.1 percentage points) and essentially an identical reduction for preteens without behavior problems (8.1 percentage points).

and reveals similar results for grandparents, but differing results for marital status depending on whether the caregiver is an aunt or other relative.[15]

The results for the caregiver economic characteristics indicate that employed caregivers are less likely than unemployed caregivers to be in public kinship care and that having received AFDC/TANF increases the probability of being in public care by approximately 17 percentage points. Model 1 shows that the probability of being in public care is 14.6 percentage points lower for poor caregivers compared to caregivers with family incomes above the federal poverty line. Model 2 allows for more flexibility in this relationship by considering 6 different categories of family income: income below 50 percent of poverty; income between 50 and 100 percent, 100 and 150 percent, 150 and 200 percent, and 200 and 300 percent of poverty; and income above 300 percent of poverty. The results reveal that the probability of being in public care is greatest for families with incomes between 100 and 200 percent of poverty.

The results for the caregiver coping characteristics show that skipping or cutting meals is associated with a 5 percentage point reduction in the probability of being in public care. Consistent with the bivariate findings, the results from Model 2 show that the probability of being in public versus private kinship care is increasing in the number of child abuse cases per 1000 children.

Finally, we note that the interaction terms and expanded categories of Model 2 appear to improve the overall explanatory power of the model. The χ^2 statistic for overall fit is higher in Model 2 than in Model 1.

5. Discussion

We use national level data to compare the characteristics of kinship care families in public and private arrangements and find important similarities and differences between groups. We also use logistic regression models to explore the determinants of public versus private kinship care and identify various child, family and state characteristics that are associated with the involvement of child welfare professionals. Without knowing the determinants of the public versus private kinship care decision, policy makers cannot design policies to improve the delivery of services to all children in kinship care. This is especially important for these children, who are faced with the stress of separation from their families and are frequently placed with economically disadvantaged families.

We provide evidence that the most vulnerable children in kinship care arrangements are being served by the child welfare system. Children with disabilities, children with behavioral problems (particularly preteens), and infants are more likely than their counterparts to be in public versus private kinship care. Fig. 1 illustrates this point for age and behavioral problems by depicting the probabilities of being in public kinship care for infants, preschoolers, preteens with and without behavioral problems, and teenagers with and without behavioral problems. It demonstrates clearly that the probability of being in public care decreases with age for children without

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[15] We chose this categorization because single grandmothers and aunts are frequently the caregivers, and we wanted to focus special attention on single female relatives by type of relationship. We grouped the single male relatives together because they are relatively few.

behavioral problems. It also shows that behavioral problems are associated with an increased likelihood of being in public care and the different effect behavioral problems have for preteens and teenagers—the difference in height for the two preteen bars is much greater than the difference in height for the two teenager bars.
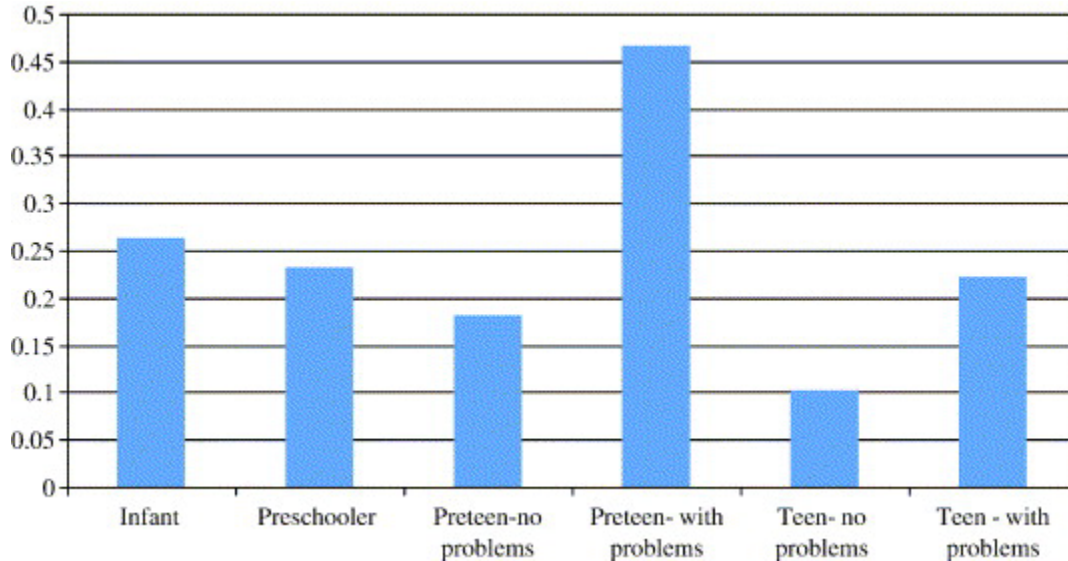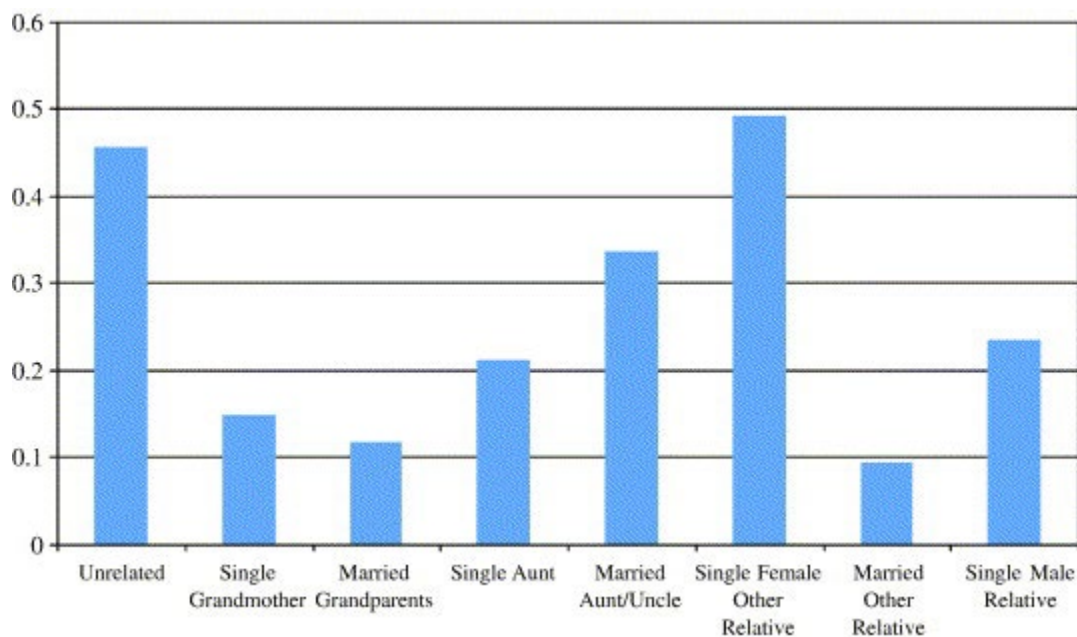

Fig. 1. Probabilities of kinship care: child age and behavioral problems.

Studies have linked child abuse and neglect to subsequent delinquent and problematic behavior (e.g., Widom, 1989). Thus, the association we find between behavioral problems and public care may reflect an increased incidence of abuse among these children. Indeed, Goodman et al. (2004) find that grandmothers in public kinship care are one and a half times as likely as grandmothers in private kinship care to be caring for children due to parental neglect. Alternatively, such differences may reflect that public kinship caregivers are better able to identify and diagnose children's needs or that private kinship caregivers are more apt to view children favorably (Berrick et al., 1994).

We also find evidence that the most vulnerable caregivers are involved with the child welfare system, at least in terms of demographic characteristics. For example, older caregivers, particularly those over 60, are much more likely to be in public kinship care than are younger caregivers. To show the magnitude of the differences, Fig. 2 graphs the predicted probabilities of being in public care (all else equal) for caregivers in each of the six caregiver age groups considered in Model 2. The figure shows that, compared to caregivers under age 30, the probability of being in public care is two and a half times larger for caregivers in their 50s, four times larger for caregivers in their 60s, and five and a half times larger for caregivers in their 70s and older. These results are important because older caregivers may face challenges that younger caregivers do not. For instance, older caregivers may have more health problems, may live on fixed incomes, or may lack the energy needed to care for and supervise children (Ehrle & Geen, 2002a). Additionally, older caregivers may be less prepared or more hesitant to assume parenting responsibilities at this point in their lives (Geen, 2004).
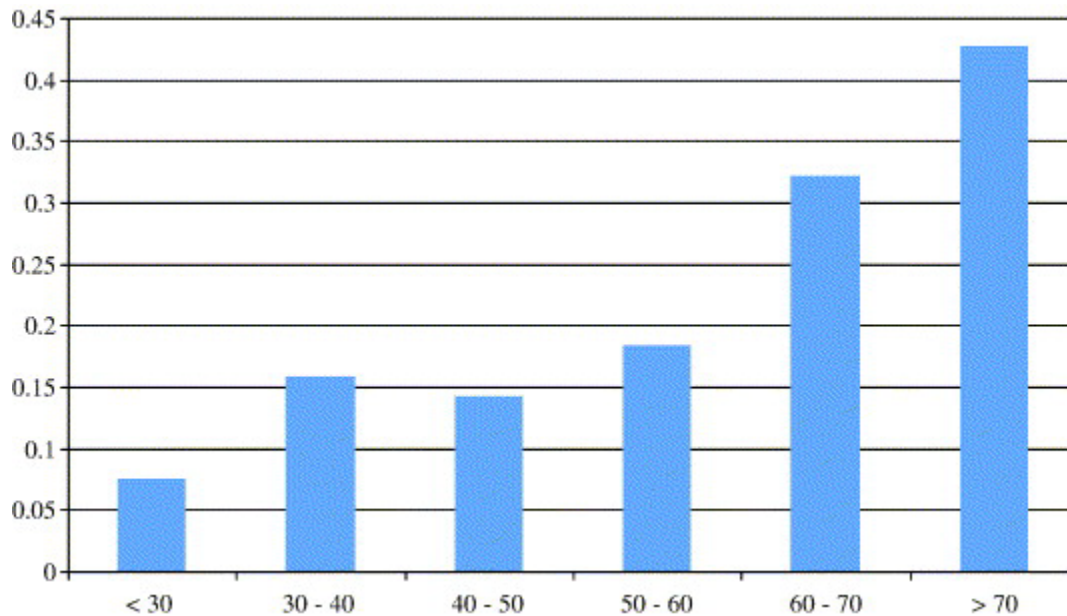
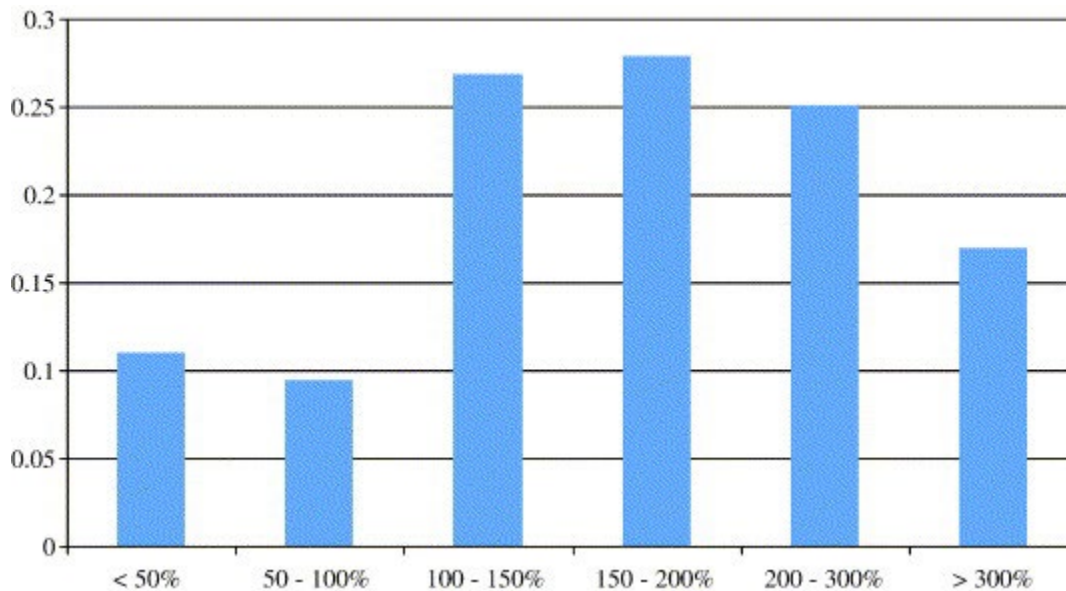**Fig. 2.** Probabilities of public kinship care: caregiver age group.

Fig. 3. Probabilities of kinship care: caregiver relationship to child.

In contrast to the higher probabilities of public care for older caregivers, the results for the caregiver's relationship to the child indicate that grandparents are relatively unlikely to have contact with child welfare services. Fig. 3 depicts the probability of public kinship care for the eight categories of relationship to the child included in Model 2 (single grandmother, married grandparents, single aunt, married aunt/uncle, single female other relative, married other relatives, single male relative, and unrelated). As the figure demonstrates, single female other relatives have the highest probability of being in public kinship care followed closely by unrelated caregivers. In comparison, married other relatives and grandparents have the lowest probabilities. Grandparents may be particularly reluctant to allege or substantiate allegations of

abuse or neglect to child welfare officials for fear of losing custody of their grandchildren and/or risking the parental rights of their own children. They may also be more unwilling than other relatives to seek child welfare services, preferring instead to care for their grandchildren privately.

To this point, the evidence presented suggests that public kinship caregivers are more vulnerable than private caregivers across a number of demographic categories. In terms of economic characteristics, however, the results are more mixed. On the one hand (and consistent with the results for the demographic characteristics), unemployed caregivers and caregivers who have received welfare are more likely to be in public arrangements than are employed caregivers or caregivers who have not received welfare. The higher probability of public care for welfare recipients may have a number of causes. Families with experience on AFDC/TANF may have more knowledge about government services or be less reluctant to ask for help. In addition, the children in these families may have already come to the attention of social services while on welfare. Alternatively, it may reflect that under Title IV-E of the Social Security Act, the federal government reimburses state and local governments for foster care expenses incurred for children whose natural families were either receiving AFDC payments or were eligible for AFDC at the time of the child's removal. The cost of foster care for children who do not qualify for Title IV-E payments is primarily the responsibility of state and local governments. Thus, states have an incentive to ensure that every child who is eligible for federal assistance receives it.

Fig. 4. Probabilities of public kinship care: income as % of poverty.

On the other hand, our results also show that families experiencing food insecurities and poor families are less likely to be in public arrangements than more economically secure families. Fig. 4 graphs the probabilities of being in public kinship care for each of the 6 income categories considered in Model 2 and illustrates the non-linear relationship between income and the probability of public care. The probability of being in public care is greatest for families with incomes between 150 and 200 percent of poverty and declines in family income thereafter.

Families with incomes less than 100 percent of poverty are considerably less likely to be in public kinship care than families with incomes above the poverty line.

This is an important result because involvement with the child welfare system is associated with the receipt of services which can help mitigate these economic hardships. Child welfare services such as payment for health care not covered by insurance, clothing vouchers, school supplies, and child care are only available to children in public kinship care. Moreover, Ehrle and Geen (2002b) show that children in private kinship care are less likely to live in families that receive food stamps, foster care maintenance payments or TANF child-only grants. Children in private arrangements are also less likely to be covered under Medicaid compared to children in public arrangements (Ehrle & Geen, 2002b).

Overall, our results point to a need to reach poor families who are not currently involved with the child welfare system. Difficulties arise because private kinship families are unknown to child welfare workers by the very definition of private care. Moreover, these families may not want to be reached if they believe that their circumstances (e.g., poverty) may result in the removal of the children from their care. These families may also be reluctant to take-up any government services (e.g., Medicaid) for fear of being "turned over to" child welfare services.

Policies that clearly define the preferences given to kin and clarify the standards kin caregivers must meet may help convince kin caregivers that they can receive support and services without fear of losing the children. For families who are simply unaware of the services available to them, better publicized policies may also increase take-up of services even if child welfare workers do not become directly involved with the family. Unfortunately, our data do not allow us to explore the reasons why caregivers have not had contact with child welfare services or why caregivers have not taken up benefits for which they are eligible.

Finally, it is important to note that our study is limited by a lack of information on a child's family of origin, reason for placement, and out-of-home care history. This information is certainly important in examining the determinants of whether children are placed in public versus private kinship care. For instance, children who are victims of abuse or neglect are more likely to be in kinship care arrangements inside the child welfare system (Goodman et al., 2004). The addition of this information to a national data set such as the one used in this study would greatly improve our understanding of the factors which influence the placement of families in public versus private kinship care and is left for future research.

Acknowledgements

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