POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

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Needs of Kinship Care Families and Pediatric Practice

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As many as 3% of children in the United States live in kinship care arrangements with caregivers who are relatives but not the biological parents of the child. A growing body of evidence suggests that children who cannot live with their biological parents fare better, overall, when living with extended family than with nonrelated foster parents. Acknowledging this, federal laws and public policies increasingly favor kinship care over nonrelative foster care when children are unable to live with their biological parents. Despite overall better outcomes, families providing kinship care experience many hardships, and the children experience many of the same adversities of children in traditional foster care. This policy statement reviews both the strengths and vulnerabilities of kinship families and suggests strategies for pediatricians to use to address the needs of individual patients and families. Strategies are also outlined for community, state, and federal advocacy on behalf of these children and their families.

INTRODUCTION

The number of children living with kin because of the absence of their parents is significant. In 2013, an estimated 2.5 million children in the United States, approximately 3% of the nation's children, lived in such kinship care arrangements.[1] Of the 427 910 children in foster care in 2015, 30%, or 127 821, are in the care of a relative[2] (Adoption and Foster Care Analysis and Reporting System AFCARS Report 23, accessed 2/18/17, available at: https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport23.pdf). A child typically enters the custody of a kin caregiver when the child's biological parents are absent (including a parent[s] who is incarcerated, is receiving extended inpatient medical care, or is deployed or geographically separated while serving in the military). Most often, the kin caregiver is a grandparent but may be another relative or adult with whom the child has a long-standing, significant relationship. Kinship care arrangements may be temporary until the parent is again

abstract

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Dr Kang-Yi conducted the literature review for the article and conceptualized and drafted the initial manuscript with Dr Rubin; Dr Springer and Ms Zlotnik reviewed the original draft as completed by Drs Rubin and Kang-Yi; they completed follow-up literature reviews, updated data and statistics, completed numerous draft updates and revisions, and addressed comments and concerns from American Academy of Pediatrics reviewers.

DOI: 10.1542/peds.2017-0099

To cite: Rubin D, Springer SH, Zlotnik S, et al. Needs of Kinship Care Families and Pediatric Practice. *Pediatrics*. 2017;139(4):e20170099

able to care for the child or may be long-term throughout the childhood years.

The growing number of children in kinship care arrangements requires pediatricians to be better informed about the unique needs of these children and their families. Nonetheless, it remains uncertain how often pediatricians inquire about the caregiving arrangements of children during regular visits to their practices. Given that the needs of children raised by kin versus biological parents may be different, clarifying caregiver and guardian relationships might prompt pediatricians to screen children uniquely on the basis of their needs and help connect these families to appropriate community resources intended to benefit them. Although the laws regarding the nature of kinship care arrangements and the public benefits available for families providing kinship care vary from state to state, they have similarities that can inform pediatricians' practice. This statement outlines the pathways to kinship care and summarizes existing literature on the unique needs and common challenges of families providing kinship care. The statement concludes with recommendations to assist pediatric practices in supporting children who live with kin as well as opportunities for advocacy on behalf of this group of children and families.

PATHWAYS TO KINSHIP CARE AND GUARDIANSHIPS ESTABLISHED FOR FAMILIES PROVIDING KINSHIP CARE

The vast majority of children living with kin are in voluntary arrangements made between the biological parents and the kin provider, without the involvement of a child welfare agency. Some families have completed legal documents granting both physical custody and legal decision-making capacity to the kin caregiver, but many have simply agreed to have children live in the physical care of a relative without completing any legal paperwork. This arrangement is in contrast to children who entered kinship care by placement through the child welfare system who are in the legal custody of the child welfare system, with decision-making rights that may be granted to the caregiver, retained by the biological parents, or require agency or court intervention, depending on what is being decided and variable state and local laws.

Although emergency health care can always be provided, nonemergency health care requires consent by an adult legally responsible for a child. Whether the child is in the custody of the child welfare system or in an informal kinship care arrangement, difficulties may occur when it is unclear who has consenting authority or when differences of opinion arise between a child's biological parents and caregivers. These consent issues may complicate even routine health care situations such as immunizations, developmental screenings, and dental care and can cause significant delays in more serious situations such as mental health referrals, diagnostic procedures, surgery, anesthesia, and chemotherapy.[3]

Kin caregivers have numerous legal options to expand their ability to provide medical consent for children's health care, including legal guardianship, durable power of attorney, standby/emergency guardianship, or specific Recognition to Provide Medical Consent for appropriate health care for their child.[4] These legal arrangements may be entered into voluntarily with biological parents' cooperation or by court order, and each affords specific legal authorities to kin caregivers. The options vary by state, and military families have procedures to follow for these concerns before a parent's deployment.*

Regardless of how they are formed, families providing kinship care can secure additional long-term guardianship rights through the courts or agreement with biological parents. Many caregiving kin often forego the option of adoption given the conflict such proceedings may introduce into the family. Adoption requires the termination of the biological parents' legal connection to the child, which many kin caregivers may be reluctant to explore.[5] For that reason, a popular alternative has been to obtain permanent legal guardianship of the minor child, which covers all guardianship and consent arrangements while retaining a legal recognition that the biological parent is still the child's parent.[6] Once permanent legal guardianship is established, no one can remove the child from the guardian's physical custody without the guardian's consent, and the guardian has the right to make all legal, medical, educational, and residency decisions for the child.[7]

FEDERAL LEGISLATION AND KINSHIP CARE

Since the 1950 Amendment to the Social Security Act (Pub L No. 81-734), which authorized eligible relatives and dependent children to receive payments under the former Aid to Dependent Children program (Title IV-A of the Act),[8] a series of federal and state laws have been enacted to support families providing kinship care. The Fostering Connections to Success and Increasing Adoption Act of 2008 (known as the Fostering Connections Act [Pub L No. 110-351])[9] provides increased support for families with both formal and informal kinship care arrangements.

*For more information about state laws and policies, contact the AAP Division of State Government Affairs at stgov@aap.org.

The Fostering Connections Act requires child welfare authorities to identify and notify grandparents or other relatives within 30 days of a child's out-of-home placement to explore the possibility of living with kin and to make reasonable efforts to keep siblings together. The legislation permits states to claim federal reimbursement for short-term training for relative guardians and to modify non–safety-related licensing criteria (such as the number of bedrooms or bathrooms required) for kin caregivers.[9,10] Additionally, the act mandates efforts to promote educational stability and allows states the option of funding permanent kinship guardianship placements with Title IV-E child welfare funds, thus enabling stable families providing kinship care to be removed from child welfare caseloads.[9,10] With these new mandates and options, states are increasingly providing preference to placement with kin.[2] Support to families providing kinship care was enhanced further after the passage of the 2014 Preventing Sex Trafficking and Strengthening Families Act (Pub L No. 113-183),[11] which extended resources to states for family finding and kinship navigators. This act also provides greater autonomy to foster parents, including licensed kin caregivers, to maintain the health, safety, and best interest of the child by requiring states to develop a "reasonable and prudent parent standard" to guide parental decision-making for participation in age-appropriate extracurricular and social activities.† The law was passed to promote healthy child development and provides legal clarification that kinship caregivers can allow children in their care to participate in developmentally appropriate activities outside of the home.

†For more information about state laws and policies, contact the AAP Division of State Government Affairs at stgov@aap.org.

WHAT ARE THE NEEDS OF FAMILIES PROVIDING KINSHIP CARE?

Understanding the unique needs of children raised in kinship care can permit better family-centered care in the pediatrician's office. Although the number of studies on kinship care has grown during the past decade, most study findings on the well-being and needs of these families have been limited to families providing kinship care within the child welfare system because they are easiest to locate and track. The data on the effects of kinship care for this subgroup of children within the child welfare system, although mixed, can help elucidate some of the risks for the broader population of children in kinship care, even if they are not entirely representative of the larger group. The following section summarizes the key findings from these studies.

Characteristics of Families Providing Kinship Care

Although there is great heterogeneity among families providing kinship care within the child welfare system, some notable trends exist. Compared with children placed in nonkin foster care, children in kinship care are more likely to be removed from the biological parent's home because of parental substance abuse and neglect than for other reasons.[12–15] Kinship care is more prevalent in the African American community,[16–20] which has the largest group of children in kinship care within the child welfare system.[21] Kin caregivers, compared with nonkin foster parents, tend to be significantly older, have less formal education, are more likely to care for large sibling groups, and are more likely to report chronic health conditions or disabilities because of their age.[21–24] The majority of families providing kinship care are single-parent households, in contrast to only one-quarter to one-third of such households providing nonkin foster care children.[21,23,25]

Economic stress is highly prevalent among kin caregivers, who tend to be poorer than nonkin foster parents. Public benefits are limited but may be critical. Many kin caregivers depend on child-only benefits from the Temporary Assistance to Needy Families program to support household expenses. Only the small minority of kin caregivers licensed through foster care arrangements are eligible to receive additional subsidized guardianship.[21,26,27]

Despite the availability of such cash assistance for families providing kinship care, many eligible families do not receive benefits and are less likely to have appropriate health coverage than nonkin foster families within the child welfare system.[21,28] Among children in kinship care (both foster and informal) living with neither parent in 2012, 21% had no health insurance coverage, and 44% were living below the federal poverty level.[29] These proportions exceed the 9% of children living with biological parents who do not have health insurance and the 21% of such children living below the federal poverty level.[30] Newer health insurance options for families through state and federal marketplaces, as well as the expansion of Medicaid to adult caregivers under the Patient Protection and Affordable Care Act (Pub L No. 111-148 [2010]), may help to improve access to care for these families, but the implementation of these programs have been variable across the states,[31] and more recently, the future of these programs remains in doubt. Regardless, the data also suggest that there are barriers beyond simply the provision of insurance, likely related to the uncertain guardianship agreements and limited knowledge of health insurance access that kinship families face, that underscore the need for stronger navigation services to ensure that children in kinship care achieve the high rates of

insurance coverage and access that other children in their communities receive.

Kin caregivers often have significant physical and behavioral health needs of their own, which can be compounded by the increased stress of providing kinship care. Because caring for a kin child is often unexpected and unplanned, caregivers may have limited knowledge of, and therefore access to, services for the children in their care.[21,30] Caregivers also manage often-stressful relationships with the parent(s) of the children in their care, balancing their concern and parenting responsibilities for those family members as well as for the children now in their care. This stress is also felt by the children living in such arrangements. Indeed, because many kin caregivers are in declining health, some children in such arrangements deal not only with their own issues[32] but also with the stress of caring for their caregivers when they are ill.[33] The net result of these intergenerational pressures is that many children and caregivers in kinship care arrangements may require additional supports.

Well-Being of Children in Kinship Care

Although families providing kinship care face a number of challenges, there are also many benefits for children raised in such households. A principal measure of well-being for children in kinship care has been the stability of a child's home environment. In that context, children raised by kin within a foster care environment have been compared with children placed with non-kin caregivers. Such studies suggest that children in kinship care have less frequent placement moves compared with those placed with nonkin foster parents,[34–37] although they are reunified with their biological parents at slower rates compared with children in nonkin foster care.[38] Children in kinship care are also more likely to retain a relationship with their extended family and are more likely to have contact with siblings and biological parents over the long-term than those in nonkin foster care.[39]

Beyond the stability of the home environment, some studies suggest that children in kinship care may be at lower risk of behavioral health problems than children in nonkin foster care, although those data are not without limitations. A number of studies have reported that children in kinship care have fewer behavioral and emotional problems compared with children in nonkin foster care.[26,39,40] One study suggested that regardless of the stability of their placement history, children in kinship care may be as much as 50% less likely to exhibit behavioral problems several years after placement compared with children in nonkin foster care.[39] The same study also highlighted that the earlier children were placed into kinship care after a removal from a biological parent's home by child protective services, the better their behavioral outcomes.

Making Sense of the Conflicting Data on Well-Being

Although the data on stability and behavioral problems for children in kinship care compared with children in nonkin foster care are reassuring, it would be incorrect to conclude that children in kinship care are without significant needs themselves. For example, even in the study that demonstrated the protective effects of kinship care on behavioral problems regardless of placement stability, the rates of behavioral problems among children in kinship care greatly exceeded community rates of behavioral problems among other children living in poverty with biological parents.[39] Other studies reported similar concerns about the greater medical and behavioral health needs of children in kinship care despite the evidence of a more stable home environment.[36,39,40] For example, the prevalence of developmental delay for children in kinship care in a study that used a local sample was still higher than the prevalence among other children in the general population (17% vs 12%, respectively, for psychomotor development), although it was lower than the prevalence of delays among children in nonkin foster care (21%).[41] Another study reported higher rates of asthma, poor eating habits, poor sleeping patterns, physical disabilities, and hyperactivity among children in kinship care compared with the general population.[40] A more recent study based on the National Children's Health Survey 2007 replicated previous findings that children in kinship care had more medical and mental health needs than children living with biological parents.[42]

A danger of the data on increased stability in home environments for children in kinship care has been to misconstrue these children as not having the same level of need as other children in foster care. As a result, their access to services has been tenuous at best. For example, despite similar health care needs as children in foster care, children in kinship care have been found to lack adequate access to primary care, immunization, vision, hearing, and dental care services.[21,24] The US General Accounting Office reported in 1995 that children in kinship care were less likely to have received routine health care and other health-related services compared with children in nonkin foster care.[43] Children in kinship care are also reported to be about half as likely as children in nonkin foster care to have an outpatient mental health evaluation.[44] Teenagers in kinship care may be more likely than their peers in nonkin foster care to have

TABLE 1 Resources

Resource Link	What It Addresses
http://www.childwelfare.gov/outofhome/kinship/support/navigator.cfm#statelocal	This resource from the Child Welfare Information Gateway provides information on kinship navigator programs.
http://www.childwelfare.gov/outofhome/kinship/support	This resource from the Child Welfare Information Gateway provides government data and resources on kinship care
http://www.grandfamilies.org	This site provides multiple resources for grandparents raising grandchildren.
www.casaforchildren.org	CASA (Court-Appointed Special Advocates for Children) provides legal advocacy for children in the child welfare system.
www.aap.org/fostercare	The AAP Healthy Foster Care America Web site features health information for children in all types of foster care.
https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Fostering-Health.aspx	Online version of the AAP manual *Fostering Health: Health Care for Children and Adolescents in Foster Care.*
http://www.acf.hhs.gov/programs/cb/research-data-technology/reporting-systems/afcars	The Adoption and Foster Care Reporting System (AFCARS) is a data-collecting system within the Children's Bureau of the Administration for Children & Families, in the federal Department of Health and Human Services. Data from across the United States on numerous child welfare issues are updated annually.
http://www.nrcpfc.org/fostering_connections/	Fostering Connections is a 2008 federal law designed to improve outcomes for children in foster care by promoting permanency, improving health care, stabilizing educational supports, and extending more services to American Indian/Alaska Native children.
http://www.childrensdefense.org/child-research-data-publications/data/making-it-work.html	This report from a collaborative of child welfare agencies examines promising practices in kinship care under the Fostering Connections kinship care provisions.
http://www.nrcpfc.org/fostering_connections/download/Kinship_Care_&_Fostering_Connections_Act_KimHertz.pdf	This information packet from the National Resource Center for Permanency and Family Connections (NRCPFC) focuses on kinship care as it relates to the Fostering Connections Act. It provides a summary, facts, and statistics on factors that account for the increase in kinship placements as well as the benefits of kinship placements, an overview of policy and legislation and links to related resources and examples, select best practices and model programs, and descriptions and links to online resources.
https://www.childwelfare.gov/outofhome/kinship	The Child Welfare Information Gateway of the US Department of Health and Human Services' Administration for Children & Families has a wealth of information available on all aspects of child welfare practice. The section on kinship care contains numerous resources and links to information, programs, and resources related to kinship care.

problems with substance abuse or to become pregnant.[45] Although the Fostering Connections Act has provided funding and incentives for kinship navigator programs to help caregivers find resources for the children in their care, these programs are not universally available, and many kin caregivers struggle to meet the needs of the children in their care. Successful kinship navigator programs have been identified (see Table 1).

Coupled with data demonstrating that kin caregivers are themselves at a high risk of having health or financial concerns[21,30,34,46,47] and that they often fail to receive benefits to support the children under their care,[21,48] a picture emerges of children missing out on supports, despite their great risk of poor long-term outcomes. As such, it is not surprising that some data suggest that children in kinship care may be particularly at risk for poorer longer-term outcomes, particularly when compared with children living with biological parents. Compared with the nonkin foster care population, children in kinship care are found to have lower academic achievement, including more problems doing homework and below-average scores in reading, math, cognitive functioning, problem solving, reasoning, and listening comprehension.[49] Kin caregivers may need help navigating the developmental and educational support systems for the children in their care.

What This Means to Pediatricians

By identifying families providing kinship care in their practices, pediatricians can play a pivotal role in better meeting the health needs of children in kinship care. The pediatrician's role is especially important because most families providing kinship care are not connected to child welfare or other formal services. At a minimum, the greater health needs of children in kinship care suggest that the guidance from the American Academy of Pediatrics (AAP) for health care of children in foster care in *Fostering Health: Health Care for Children and Adolescents in Foster Care*[3] should be considered for children in kinship care, including more frequent follow-up visits within the context of a medical home. These visits should more intensively evaluate the child's developmental, educational, and emotional status and provide greater guidance to caregivers around their own challenges to raising children (eg, access to entitled benefits) and the prospective planning for guardianship, should a caregiver's

health decline. These visits can be appropriately coded as follow-up care for the identified medical, mental health, behavioral, or developmental risks and needs of the individual child.[48,50,51]

Although collaboration among child welfare, education, health, and mental health care professionals has increased the capacity to meet the needs of children in kinship care who are in the public child welfare system, these gains have not always been realized for families providing kinship care outside the child welfare system.[52] Because pediatricians are, like teachers, well situated to identify children in kinship care, they can play an important role by providing comprehensive, coordinated care that recognizes the unique stresses and needs of families providing kinship care.[53]

RECOMMENDATIONS FOR PEDIATRIC PRACTICE

1. The child's medical home can identify guardianship arrangements during routine office updates of demographic, contact, and consent information to allow for comprehensive care coordination. Consent guidance is outlined in the AAP clinical report "Consent by Proxy for Nonurgent Pediatric Care."[54]
2. Pediatric practices can learn more about community resources available to families providing kinship care, including community legal services and navigator programs. Table 1 contains links to assist in finding resources in local communities.
3. Because laws for guardianship and consent vary from state to state, pediatric practices should learn about local statutes that govern guardianship and consent for children in kinship care. Public health insurance plans play a key role in the access to health screening, treatment, and monitoring, and thus pediatricians should be aware of state laws and policies on public health insurance for children in kinship care. Children in the foster care system qualify for coverage through Medicaid programs in most states. Children not under child welfare supervision may qualify as dependents if their caregiver has private insurance or may qualify for Medicaid or Children's Health Insurance Program coverage.‡ State and federal health care marketplaces can be used to access these options.[32]
4. Considering that children in kinship care have similar developmental, physical, and mental health needs as children in nonkin foster care, pediatricians should adopt pediatric health care guidance developed by the AAP for children in foster care as a standard of care for children in kinship care (see Table 1).
5. Pediatricians should offer standardized developmental and behavioral health screening for children in kinship care and should refer children with developmental or behavioral health needs for early intervention or behavioral health treatment as needed, in keeping with AAP guidance outlined in detail in *Fostering Health*.[3]
6. Families providing kinship care who are not in the child welfare system are likely to have no one to help them navigate community resources. Pediatricians should provide families providing kinship care with guidance on how to access community resources that can provide information and referral for health insurance, legal support, and other social services. The Web sites listed in Table 1 provide good starting points for these supports.

‡For more information about state laws and policies, contact the AAP Division of State Government Affairs at stgov@aap.org.

PUBLIC POLICY AND HEALTH CARE SYSTEM ADVOCACY OPPORTUNITIES

1. The AAP supports pediatrician, AAP chapter, and federal efforts to work with policy makers to identify and eliminate barriers to the use of kinship care arrangements so that children are able to be placed with kin, when appropriate.
2. The AAP supports pediatrician, AAP chapter, and federal efforts to work with policy makers to support strong systems of kinship care through increased and robust funding to support kinship caregivers in both providing care and accessing needed health and social services.
3. Residency curricula should require education and training on guardianship arrangements, consent issues, and unique health needs of children living in kinship care.
4. The AAP supports pediatrician and AAP chapter efforts to partner with adult primary care and geriatric physician organizations to develop stronger supports for families providing kinship care. Such work might include topics such as better advance planning around guardianship and health care arrangements for children should their caregiver's health decline and education for older caregivers on current safety standards for sleep, vehicular travel, and injury prevention.
5. To effectively provide support services to families providing kinship care, integration between health and mental health care systems, schools, and social service agencies is important. As a part of the pediatric medical home, pediatric practices can collaborate with other service providers in their communities to improve the accessibility and effectiveness of health, mental health, and social services

provided to families with kinship care arrangements.

6. Pediatricians can provide community leadership toward establishing and strengthening local kinship navigator programs that would help families providing kinship care navigate multiple child-serving community systems. More information on these can be found in Table 1.

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ABBREVIATION

AAP: American Academy of Pediatrics

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

FINANCIAL DISCLOSURE: The authors have indicated they do not have a financial relationship relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

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