



National Resource Center for
Family-Centered Practice and Permanency Planning
at the Hunter College School of Social Work

INFORMATION PACKET:
***Health Care Issues for Children
in Kinship Care***

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The use of kin for placements of children removed from their parents' home is rapidly increasing (Urban Institute, 2000; Bissell and Allen, 2001; AAP, 2002), but legislation and policy have not kept up. Despite the fact that almost all states require foster care agencies to give preference to relatives for placement (Geen, 2002, Urban Institute, 2000), policies regarding financial assistance, health coverage and services for the caregivers do not reflect the particular needs of kinship foster families (Urban Institute, 2000). While all children in foster care are susceptible to a disproportionate number of health issues, children in kinship care experience unique hardships that require increased monitoring and assistance to ensure healthy development (Dubowitz, 1994; Bissell and Allen, 2001).

Children in placed in kinship care are likely to have suffered from abuse, neglect and pre- and post natal substance abuse. They are also more likely to live in poverty, less likely to have health insurance and less likely to receive assistance from foster care agencies than children in non-kin foster care (Bissell and Allen, 2001; Gibbs, Kasten, Bir, Duncan & Hoover, 2005). These compounding factors "suggest that they are a very vulnerable population." (Erlhe and Geen, 2002)

This information pack will address the remarkable lack of research, attention and funding regarding the health needs of children in kinship care. (Dubowitz, 1994; Carpenter & Clyman, 2004; Urban Institute, 2000) I have made the connection between the limited financial and social support provided to kinship foster families and the health-related issues that children face. This is primarily based on the well-established effects of poverty on children's health and development. A review of relevant statistics, federal and state policies and best practice tips will be provided as well. This information pack will be useful for service providers, policy analysts and kinship care providers.

Facts and Statistics

Health and Health Care for Children in Kinship Care

Dubowitz's (1994) seminal study found that, compared to children in the United States, children in kinship foster care:

- experienced inadequate primary care, less immunizations, and poor vision, hearing and dental care.
- had higher rates of anemia, asthma, poor growth and obesity

Dubowitz's (1992) cross sectional study of children in formal kinship care showed that 66% have more than one medical problem; the most frequent health problems were asthma, dental issues, obesity and skin abnormalities.

Despite increased rates of illness, dental problems and indicators of poor health, children in kinship care were less likely to receive medical care.

- 49 percent of children in informal or "private" kinship care arrangements received the health insurance coverage for which they were entitled under Medicaid. (Bissell & Allen, 2001)
- 36% of children living solely with grandparents lack health insurance (Hegar, 2005)

A U.S. General Accounting Office (1995) report found that children placed in kinship care received fewer health care services than children in non-kin foster care, despite having more health problems. Children in kinship care:

- Were estimated 3 times more likely to be at risk for future problems because of prenatal drug exposure which are associated with an increased risk for HIV and developmental delays
- Were nearly 3 times less likely to have received routine health care and all other health-related services.

- were monitored and assisted less frequently by caseworkers even though the home was more likely to be unlicensed

Only 11 percent of children placed in kinship care received specialized examinations, such as developmental evaluations, while 42 percent of those placed in non-kin foster care received specialized evaluations. (U.S. General Accounting Office, 1995)

Health of Children in Foster Care (Kin and Non-Kin)

The NY State Permanent Judicial Commission on Justice for Children, (1999) found that:

- Approximately 80% of foster children have at least one chronic medical condition, with nearly one-quarter of these children having three or more chronic problems.
- Half of all children in the Child Welfare System have developmental delays and mental health problems that warrant clinical intervention.
- 12% of foster children received no routine health care, 34% received no immunizations and 32% continued to have at least one unmet health need after placement.

Children involved with the Child Welfare System are 3 times more likely to be in fair or poor health than children in the general population. (ACS report, 2005)

Kinship Foster Care

According to Rebeca Hegar (2005)

- 4% of U.S. children live in a household with neither parent; 8.2% of African-American children, 4.9% of Hispanic, 3.2% of Asian/Pacific Islander and 3.1% of White children live in family settings without either birth parent
- 44% of children who live with neither parent reside in the household of one or both sets of grandparents
- 46% of care-giving single grandparents live below the federal poverty line

- 49.5% of African-American children and 51.2% of Hispanic children who live with grandparents live in households with incomes less than the federal poverty level

Compared to children in non-kin foster care, children in kinship foster care are:

- generally younger
- more likely to be Black
- more likely to live in the South than in other regions
- more likely to be removed from their parents' homes due to abuse or neglect as opposed to other family problems such as parent-child conflict or behavioral problems
- more likely to come from homes in which birth parents had an alcohol or drug problem
- more likely to have young biological parents

There are significant differences between kin and non-kin caregivers. Kinship caregivers are:

- significantly poorer
- more likely to have less formal education
- more likely to be single
- more likely to care for large sibling groups
- older, with a striking difference in the number of caregivers over 60 years of age
- more likely to report being in poorer health themselves

Kinship caregivers of children who are not in state custody (private or informal care) usually depend on child-only TANF payments, which are much less than foster care payments. (Gibbs, et al, 2005; Leos-Urbel, Bess & Geen, 2002) For example, in South Carolina, the base rate for a care-giver of a child without special needs is \$330 per month; the TANF payment to a kinship caregiver is \$102 per month—70 percent less. Also, while foster

payments are the same for each additional child, TANF payments typically increase by smaller increments for subsequent children. (Gibbs, et al, 2005)

Bibliography

Bissell, Mary K. & Allen, MaryLee. (2001). Healthy Ties: Ensuring Health Coverage for Children Raised by Grandparents and Other Relatives. A look at Medicaid and CHIP Enrollment in the States. Washington, DC: Children's Defense Fund.

This survey analyzes the limited enrollment of children in kinship care in Medicaid and CHIP and then makes several recommendations about how to address barriers. They found significant barriers including restrictive state policies, such as requiring kin to obtain legal custody before applying to Medicaid. Other barriers identified were inconsistent policy implementation (kin receiving incorrect eligibility information), health access and consent issues (difficulties authorizing medical treatment on behalf of the children they are raising) and insufficient effort to include kin in outreach and information materials (see model program to address this below).

Carpenter, S., & Clyman, R. (2004). The long-term emotional and physical wellbeing of women who have lived in kinship care. Children and Youth Services Review. 26(7), 673-686.

This study found that kinship care was a significant predictor for suffering from anxiety and unhappiness but not with worsened health status. However the authors indicate the inclusion of children in informal kinship care and the exclusion of children who experienced non-kin foster care may have diluted the results to underestimate the health problems of children in formal kinship care.

Dubowitz, H., Feigleman, S., Harrington, D., Starr, R., Zuravin, S., & Sawyer, R. (1994) Children in Kinship Care: How Do They Fare? Children and Youth Services Review. 16(1/2), 85-106.

Dubowitz is by far the most cited writer in regard to health issues and health care for children in kinship foster care. This chapter presents the first comprehensive assessment of the physical and mental health status of children in kinship care. They also recommended improved communication between caregivers, caseworkers, health care providers, teachers and parents and addressed the need for “intermittent and systematic assessments” of all children in kinship care.

Ehrle, J., & Geen, R. (2002). Kin and non-kin foster care—Findings from a national survey. Children and Youth Services Review. 24, 25-35.

This chapter looks at differences between non-kin and kin care, including “voluntary” kinship care, private kinship care and kinship foster care. They discuss the differences in

the characteristics of the children, their environment, access and quality of financial and supportive services, etc.

Geen, R. (2004). The Evolution of Kinship Care Policy and Practice. The Future of Children, 14(1), 131-149. The Woodrow Wilson School of Public and International Affairs at Princeton University and The Brookings Institution.

Geen is very frequently cited author about kinship care and in this chapter he provides a run down on the relevant issues and controversies, the current trends in kinship care, policy and practice issues, etc. He covers a lot of material with current facts and statistics.

Gibbs, D., Kasten, J., Bir, A., Duncan, D., & Hoover, S. (Currently in press, online as of July 2005) Between two systems: Children in TANF child-only cares with relative caregivers. Children and Youth Services Review.

This article discusses the service needs and well being of children in TANF child-only cares with kinship caregivers. They conclude that children in kinship care have substantial difficulties and the TANF program lacks the necessary resources to meet their needs.

Leos-Urbel, J., & Geen, R. (2000) The evolution of federal and state policies for assessing and supporting kinship caregivers. Children and Youth Services Review, 24, 37-52.

This is an informative article that addresses the ongoing debate about the merits of kinship care and the challenges in creating appropriate policy. They discuss waiving licensing requirements—often a reflection of middle-class values, such as square footage or number of bedroom and the payment provided to kinship caregivers (foster care payments vs. TANF child-only payment.)

Urban Institute. (June, 200) Report to the Congress on Kinship Foster Care: Executive Summary. Retrieved online on October, 24th, 2005 from <http://aspe.hhs.gov/hsp/kinr2c00/>

This report describes how federal child welfare policy has systematically disregarded the role of kinship caregivers. It reports that 29 percent of all foster children were in kinship care in 1998 and described the three main factors for the recent growth of kinship care—decreasing non-kin foster parents relative to the increasing number of children needing placement; a more positive attitude toward the use of kin as foster parents from child welfare agencies; and recent federal and state policy recognizing the rights of relatives to act as foster parents and their financial compensation (usually through TANF child-only grants).

U.S. General Accounting Office. (1995) Foster care health needs of many young children are unknown and unmet. GAO/HEHS-95-114. Washington, DC: U.S. General Accounting Office.

This report covers the current state of health care services provided to children in foster care, and found that young children in kinship care received fewer health-related services of all kinds than children placed with non-kin foster parents. They also received less monitoring and assistance from caseworkers.

Other sources used:

Administration of Children's Services. (2005). National Survey of Children and Adolescent Well-being—CPS Sample Component Wave 1 Data Analysis Report.

American Academy of Pediatrics, Early Childhood, Adoption and Dependent Care. (2002) Health Care of Young Children in Foster Care, Policy Statement. Retrieved October 24th, 2005 on <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;109/3/536>.

Hegar, R., & Scannapieco, M. (2005). Kinship care. In G. Mallon and P. Hess (Eds.) Child Welfare for the Twenty-first Century: A Handbook of Practices, Policies and Programs (pp. 488-503). New York: Columbia University Press.

Institute for Research on Woman and Families, California Foster Children's Health Project. (1998). Code Blue: Health Services for children in foster care. Sacramento: Center for California Studies, California State University.

McCarthy, J., & Woolverton, M. (2005). Healthcare needs of children and youth in foster care. In G. Mallon and P. Hess (Eds.) Child Welfare for the Twenty-first Century: A Handbook of Practices, Policies and Programs (pp. 129-147). New York: Columbia University Press.

A Review of Policies and Legislation

Federal Laws:

Indian Child Welfare Act of 1978: stated that Native American foster children should be placed with their extended family and near their home if possible. (Leos-Urbel, Bess & Geen, 2002)

Adoption Assistance and Child Welfare Act of 1980: required states to place children in the “least restrictive most family-like setting available,” implying a preference for relative placements. As of 1992, 29 states required foster care agencies to give preference to relatives of

foster children and 44 states commonly placed foster children in kinship care. (U.S. General Accounting Office, 1995)

Personal Responsibility and Work Opportunity Act of 1996: required states to give preference to kin when determining placement as long as the relative meets the “State child protection standards.” (Urbel et al, 2002)

Adoption and Safe Families Act of 1997 (P.L. 105-89): made several modifications of previous foster care policy to acknowledge the unique position of kinship placements. It indicated that a “fit and willing relative” could provide “planned permanent living arrangement.” AFSA also allowed states to seek federal reimbursement for kinship foster care expenses only if kin meet the same foster care licensing standards as non-kin, on a case-by-case basis.

The Kinship Caregiver Support Act (introduced to the Senate in May, 2005; pending enactment)

- Establishes a **Kinship Navigator Program**, which will help agencies serve kinship care families more effectively by funding grants to help link relative caregivers, both inside and outside of the child welfare system, to a wide range of services and supports necessary for their children and themselves.
- Establishes a **Kinship Guardianship Assistance Program**, which allows states to use federal funds for subsidizing guardianship payments to relative caregivers who commit to permanently caring for children outside the formal child welfare system, once reunification and adoption are ruled out. Currently 35 states have subsidized guardianship programs.
- Requires state child welfare agencies to provide **notice of the removal of a child** to all grandparents and other adult relatives of the child within sixty days. This provision is

likely to connect children with able and willing relatives and allows kin to get involved in the child's care early on.

- Allows states to establish **separate licensing standards for relative foster parents** that recognize that certain licensing standards for non-relative foster parents, such as square feet of household, may not be appropriate for kin. This would make some kinship caregivers eligible for higher-payment and allow states to receive federal support for more children living with relatives. (*The Kinship Caregiver Support Act, 2005*)

New York State Laws: (some other states have similar legislation regarding kinship care)

Medical Consent to Immunizations and Emergency Medical Care (N.Y. Public Health law 2504): enables relatives, and non-relatives acting in a parental relationship, to consent to immunizations. In addition, medical, dental, health and hospital services may be rendered to the child without the consent of the parent or guardian when the child is in need of emergency medical attention and an attempt to secure consent from the parent would result in a delay of treatment that would increase the risk to the child's life or death. (AARP, 2005)

Grandparents Rights Act (NY Dom. Rel. Law 72, Chapter 657): If a child has resided for two or more years in a grandparent's home, judges must decide legal custody based on the best interests of the child. The law also provides that social service departments must notify all grandparents of their options when child protective services removes a child from his or her parents' home. These grandparents and any other known relatives must be told that: (1) they may qualify as foster parents; (2) they may become legal custodians or guardianship independent of the foster care system; and (3) their failure to intervene may ultimately result in adoption by an unrelated foster family. (AARP, 2005)

Best Practice Tips and Model Programs

Targeted Outreach Brochure for Kinship Care Families

In a national survey by The Children’s Defense Fund, Bissell and Allen identified barriers to access to adequate health care for children in kinship care, including the lack of informational brochures geared toward kinship care families. Applications and other materials often do not provide adequate instructions or attention to kinship caregivers, who are almost never mentioned specifically. However, Ohio has created a brochure about Healthy Start, the state’s health insurance program, specifically designed for grandparents raising their grandchildren. The brochure is widely distributed at senior health fairs and other outreach presentations aimed at kinship care families. The brochure explicitly covers several important points: it specifies that the caregiver’s income (unlike parent’s income) is not counted in determining a child’s financial eligibility and that legal guardianship is not required for a caregiver to apply. It provides a toll-free number that provides assistance to caregivers about filling out the applications and information about what health services are covered. (Bissell and Allen, 2001)

Bissell and Allen (2001) also identified ten important considerations for ensuring that Medicaid and CHIP Applications are “Kinship Care-Friendly”:

- Who can apply for the children—Any parent, relative or other adult caregiver.
- Legal custody and guardianship—They should not be requirements for eligibility
- Income and asset information—only the child’s income information should be required.
- Immigration status—Only the child’s immigration status should be relevant.
- Absent parent information—Only if for the purpose of pursuing medical child support.
- Personal information—personal information about the caregiver should not be required.

- Caregiver’s medical status and health coverage—Only if caregiver is also requesting coverage
- Who to contact—if caregiver has questions about filling out application.
- Mail-in application—should be able to submit without face-to-face interview.
- Accompanying documentation—lists what should be submitted with the application.

Kinship Caregiver Model Programs

Programs such as California’s Kinship Support Service Program, New York City’s Grandparent Caregiver Law Center and American Association for Retired Persons’ Grandparent Information Center have been created to provide a variety of services to assist kinship caregivers in raising children. They offer parenting help, support services, financial and legal assistance and referrals. (ACF, 2005)

Kentucky educates kinship care families about the availability of the state’s health insurance plan through a partnership between the Office on Aging’s Kentucky KinCare Project and the Governor’s Cabinet for Children and Families. They sponsor support groups for grandparents raising their grandchildren in local schools across the state. (For more information, call 502-564-6930) Wyoming has also created a “Spanning the Generations” program information kinship caregivers that they may apply for health coverage for the children they are raising. The brochure will be distributed at family services centers and senior centers. (For more information, call 307-777-7574) (Bissell and Allen, 2001)

Best practices in Health Care Services

- The American Academy of Pediatrics (Policy Statement, 2002) identified four crucial components of health care services for all children in foster care (therefore, children in formal kinship foster care should be included): initial health screening, comprehensive

medical and dental assessment, developmental and mental health evaluation, and ongoing primary care and monitoring of health status.

- In addition, AAP indicated that changes in foster homes usually lead to changes in physicians and incomplete health information. Several states have developed a **Medical Passport** to increase the continuity of care. It provides a brief listing of the child's medical problems, allergies, chronic medications and immunization data as well as basic social service and family history. This form is designed to facilitate the transfer of essential information among physical and mental health professionals and (kinship and non-kin) foster parents. (AAP, 2002)

Checklist for the Healthy Development of Foster Children

1. Has the child received a comprehensive health assessment since entering foster care?
2. Are the child's immunizations complete and up-to-date for his or her age?
3. Has the child received hearing and vision screening?
4. Has the child received screening for lead exposure?
5. Has the child received regular dental services?
6. Has the child received screening for communicable diseases?
7. Has the child received a developmental screening by a provider with experience in child development?
8. Has the child received a mental health screening?
9. Is the child enrolled in an early childhood program?
10. Has the adolescent child received information about healthy development? (NY State Permanent Judicial Commission on Justice for Children, 1999)

Websites and Resources

News You Can Use: Kinship Caregiver Programs (Administration for Children and Families, Children's Bureau Express)- http://cbexpress.acf.hhs.gov/nonissart.cfm?issue_id=2002-04&disp_art=436 This is an excellent source of information with links to specific kinship caregiver programs and kinship care fact sheets with information the different types of kinship care, what to expect from the child welfare system, what services kinship caregivers are entitled to, etc.

Child Welfare League of America <http://www.cwla.org>

The Children's Defense Fund is another great resource for anyone involved with, affected by or interested in kinship foster care. They have several reports, guides and resource kits for and about kinship caregivers

The Kinship Caregiver Support Act (S. 985) Offers Help the Children Raised by Relatives- http://www.childrensdefense.org/childwelfare/legislative/kcsa_2005_one_pager.pdf describes the act in user-friendly language

Kinship Caregiver Support Act -Questions and Answers

http://www.childrensdefense.org/childwelfare/legislative/kinship_caregiver_support_act.pdf

Healthy Ties: The Grandparent's and Other Relative Caregiver's Guide to Health

Insurance for Children -http://www.childrensdefense.org/pdf/healthyties_cg.pdf covers multiple important questions regarding Medicaid and CHIP including eligibility, applications, program details, where to find help, etc.

The Grandparent's and Other Relative Caregiver's Guide to Raising Children with Disabilities (PDF)-

http://www.childrensdefense.org/childwelfare/kinshipcare/grandparents_guides/raising_children.pdf

provides information about policies protecting children with disabilities' rights, how to get services and evaluations, how to get help paying for healthcare, the intersection between policies regarding foster care and adoption and individuals with disabilities, etc.

State Fact Sheets for Grandparents and Other Relatives Raising Children

<http://www.aarp.org/research/family/grandparenting/aresearch-import-488.html>

A collaborative effort by AARP, the Children's Defense Fund, Casey Family Programs' National Center for Resource Family Support, The Brookdale Foundation, the Child Welfare League of America, and Generations United that provides national and state data about children in kinship care, lists programs that can help, lists facts about children in foster care and describes public benefits like financial assistance, food stamps, and health insurance.

Ensuring the Healthy Development for Foster Children: A Guide for Judges, Advocates, and Child Welfare Professionals (PDF) New York State Permanent Judicial Commission on Justice for Children. (1999).

<http://www.zerotothree.org/policy/policybriefs/ensuringhealthydev.pdf>

This guide discusses the need to address health and development at every step in the child welfare process and that judges, advocates and child welfare professionals are all accountable for this task. They created a useful checklist to ensuring appropriate assessment and treatment for every child in foster or kinship care.

Meeting the Health Care Needs of Children in The Foster Care System -

http://gucchd.georgetown.edu/programs/meeting_health_needs/index.html

Summary of State and Community Efforts Key Findings, and Strategies for Implementation.