Assessing and Promoting Quality in Kin and Nonkin Foster Care

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This article provides a comprehensive look at the elements that indicate quality of care in kinship and nonrelated foster homes, highlighting the philosophical reasons for providing quality care and the theoretical underpinnings of kinship care. The sparse literature on quality of care in foster homes is then augmented with indicators of quality in nonfoster homes, identifying a series of domains of quality. By articulating these domains we intend to frame an understanding of quality of care, to provide a guide for constructing a quality assessment tool for kinship and nonrelated foster homes, and to promote quality improvement in these vital areas.

Introduction

Children are placed in out-of-home care, often because they have been maltreated by their biological parent(s). The assumption guiding placement is that government-sponsored homes are safe. Tragically, a number of children are subsequently maltreated while they are in out-of-home care (New York City Administration for Children's Services 1999; Poertner, Bussey, and Fluke 1999; Courtney et al., in press) and, upon leaving the child welfare system, former foster youth experience a variety of adverse outcomes (Barth and Blackwell 1998; Courtney et al., in press). Although it can be argued that post–foster care outcomes are a result of the original maltreatment by biological parents, it is likely that children's

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lives are shaped by a combination of factors, including their experiences in care. Thus, barring the prevention of the original maltreatment, the quality of care that dependent children receive may be the most important aspect of the child welfare system.

Just as the fitness or quality of a biological family's home is determined by an investigation, substitute caregivers' homes should undergo similar scrutiny in order to insure the safety and well-being of children. Licensing standards, which vary widely by state, provide a baseline measure of safety for children in foster care. Yet licensing standards are strictly limited to home safety and supervision and do not speak to the other domains of quality that should be considered for dependent children. Further, until recently, state and federal laws were silent or ambivalent regarding licensing requirements for kin, leaving tens of thousands of children in state-sponsored, but nonregulated, care.

Although safety standards are important, they do not insure high-quality foster care. The full range of quality indicators is much larger and may vary between kin and nonkin placements. The purpose of this article is to understand some of the issues composing quality care and to suggest that child welfare workers obtain a working knowledge of these indicators, conduct on-going assessments of quality, and use these assessments to optimize care.

There is little information regarding quality-of-care indicators for children in foster care. We know even less about kinship caregivers since the overall literature on this placement type is in the early stages of development. At the least, family foster care is designed to provide children with a normalizing family experience (Wolins 1963). Since there is little specific evidence describing quality care within foster homes, this article will augment the sparse literature with indicators of quality care in non-foster homes in order to identify domains representing important components of quality family care. By articulating these domains, we can help frame an understanding of quality care that can serve as a rudimentary model for assessing kinship and nonrelated foster homes.

Philosophical Reasons for Providing Quality Care

While the role of child protective services ostensibly is to protect children from suffering harm at the hands of their parents, these services may be more accurately described as attempting to protect children from being further damaged once they have already been harmed (Lindsey 1994). In essence, the state assumes parental responsibility for children whose parents are deemed unfit to provide a safe and otherwise satisfactory level of care. Prior to state intervention, parents are entrusted with ensuring an adequate level of care for their children. If parents do not meet this minimal level of care, the state may remove the children and, through foster care, endeavor to provide a satisfactory

level of care. Defining the minimal sufficient level of care for both parents and the state, though, is problematic.

There are certain indisputable legal and moral requirements for biological parents when providing care for their children. First and foremost, children must not be abused or neglected. Physical abuse, sexual abuse, and neglect are grounds for state intervention. Arguably, physical abuse, sexual abuse, and severe neglect can be readily defined, and subjectivity in assessments is somewhat limited. General neglect, however, seems to be a highly subjective criterion for intervention (Rose and Meezan 1996; Zuravin 1999). Distinguishing among child neglect, bad parenting, and the effects of poverty is not easy, yet it is required when establishing criteria to justify state intervention.

The forgiveness of poor parenting behaviors or poverty-related deficits in the biological parent does not transfer to the foster care provider, however, since the state has assumed responsibility for the care of the child. The state acknowledges this higher standard by adopting licensing standards for formal foster homes; however, these standards mostly involve physical safety measures and do not certify that a true minimum standard of emotional and developmental care has been provided.

Children need a certain level of physical care, nurturing, and stimulation in order to develop into normally functioning adults. Children who have been maltreated may need additional support beyond that provided to children who have not been maltreated in order to attain this basic standard in adulthood. Since there are few empirical studies that quantify how much nurturing and stimulation are required or how to measure the quality of what is being provided, making determinations of what constitutes quality in foster care is difficult. In an early investigation of criteria used by social workers to evaluate the suitability of a home for foster care licensing, Martin Wolins (1963) proposed that a foster home should resemble a healthy family in its function and form. In addition to this family-like atmosphere and normal safety precautions, Wolins argued that foster homes should have an absorptive ability (permeable to entrances and exits of foster children), as well as a tolerance for continuing interactions with biological parents. Foster parents should have rational motives for becoming foster parents and be able to cooperate with child welfare agencies. Although Wolins's guidelines lend themselves to social worker subjectivity and bias, his inclusion of nonsafety criteria points to the fact that quality encompasses more than just child safety.

Kin as Foster Parents

As foster care placements have dramatically increased since the early 1980s, so has the number of children being cared for by their relatives (Goerge, Wulczyn, and Harden 1995). At the same time, fewer nonrelated foster homes are available (Chamberlain, Moreland, and Reid 1992), the public has come to view kin as an important resource for chil-

dren (Child Welfare League of America 1994), and states have introduced foster care payments to kinship caregivers (Courtney and Needell 1997). Because of reporting inconsistencies, the exact number of kinship foster placements in the United States is difficult to ascertain. However, in urban areas such as Los Angeles where child placement rates are highest, kinship care accounts for over 50 percent of all child placements (Needell et al. 2000). While licensing requirements and state expectations of nonrelated foster care providers serve to define and maintain a certain level of care in foster homes, requiring kin to follow licensing mandates is legally complicated. There is a strong legal tradition of noninterference in family matters in this country (Mason 1994), as well as a significant history of familial care, especially among African-American families (Stack 1978; Thornton 1991). Because of these considerations, requiring relatives to adhere to nonrelated foster care standards may be controversial.

Further, imposing licensing standards and supervision for kinship caregivers elicits concern about issues of race and class. Most children coming into the child welfare system are poor (Lindsey 1994), and their relatives largely hail from the same economic and social circumstances (Berrick, Barth, and Needell 1994). Licensing stipulates certain requirements (e.g., a limited number of children per bedroom, telephone service, and home safety) that may be difficult for families of lesser means to attain. In addition, the placement of a child is not a planned event. The need for a foster home is immediate, and the licensing process takes time. In some states, waiving licensing requirements for kin may be based on the belief that the strength of the familial relationship, both legal and emotional, transcends these concerns.

Philosophy of Kinship Care

The loss of a parent or parents, whether or not they provide a level of care that meets the state's minimum standard, is likely to cause significant trauma to a child. The child's loss may be exacerbated when he or she is placed in an unfamiliar living environment with unknown caregivers who have not yet gained the child's trust. Placing a child with kin may help offset some of this psychic trauma, providing the child with a familiar environment with known caregivers and maintaining the perceived warmth and safety of a family during the placement process. Additionally, studies have shown that resilient high-risk children usually have a close bond with an emotionally stable person, enabling these children to receive sufficient nurturing and to establish a sense of trust (Vaillant 1993; Werner 1995). According to Werner, "much of this nurturing came from substitute caregivers within the extended family, such as grandparents and older siblings" (p. 83).

Cultural continuity may also be enhanced by kinship placements. The high proportion of children of color entering the system, coupled with

large numbers of Caucasian foster parents, dictate that there will be a substantial number of ethnic dissimilarities between foster caregivers and dependent children unless family members are used. Another reason familial continuity may be maintained is that kin are much more likely to accept sibling groups of all sizes into their homes (Shlonsky, Webster, and Needell 2001). While empirical findings weighing the benefits of maintaining sibling groups in foster care are mixed (Staff and Fein 1992; Smith 1994; Hegar and Scannapieco 1998; Smith 1998), the benefit of positive sibling relationships has been well documented among nonfoster children (Hetherington 1988; Dunn et al. 1994).

Unfortunately, since they are not always obligated to meet licensing requirements, kin may not share nonrelated caregivers' professional training in parenting skills and protective services requirements, nor may they meet health and safety standards (such as those related to fire alarms, evacuation plans, and safe storage of poisons and firearms). Additionally, some might argue that relatives might be part of the family dysfunction that necessitated the removal of the child. As most kinship caregivers are grandparents (Berrick et al. 1994), many children are placed with the very people who raised the abusive parent. However, this view assumes that the caregiver is largely responsible for the biological parent's behavior despite the presence of other detrimental environmental factors or inherent personality traits.

If factors associated with poverty are linked to poor developmental outcome (Haveman and Wolfe 1995; Korenman, Miller, and Sjaastad 1995; Brooks-Gunn, Duncan, and Maritato 1997; Smith, Brooks-Gunn, and Klebanov 1997) and kinship caregivers are more likely than nonrelated foster parents to be poor (Gebel 1996), then outcomes for children placed with kin might be adversely affected. This may also hold true for some nonrelated foster parents, many of whom are facing the same difficult economic circumstances (U.S. Department of Health and Human Services n.d.). However, studies analyzing the detrimental effects of parental poverty on children have only been conducted with nondependent children, thereby limiting generalizations to other types of caregivers.

These considerations may lead to speculation as to whether kinship or conventional foster care is preferred. However, the rise in the substitute care population (Tatara 1994; U.S. Department of Health and Human Services n.d.) and the scarcity of nonrelated foster homes (Chamberlain et al. 1992) make both types of care indispensable. This, coupled with philosophical considerations, serves as the backdrop for policy considerations in this area.

A Definition of Quality Out-of-Home Care

Since there are few substantive studies assessing quality of care in foster homes, it is difficult to create a single definition of quality. Quality of care

may be a fluid measure, varying by placement type, by amount of time spent in care, and by a child's unique attributes. For example, a home may meet health and safety requirements, yet the caregiver may be unable or unwilling to support permanency. Similarly, a child may develop behavioral problems due to placement issues (such as conflict with a caregiver), thereby decreasing the quality of the home for that child.

While quality-of-care issues have not been sufficiently addressed for children in foster homes, quality assurance is a part of funding requirements for group and residential placement. Susan B. Price, Fred Chaffe, and Gerry Mozenter (1989) describe residential treatment quality assurance indicators, such as gross child safety, security and supervision adequacy, service planning appropriateness, client's engagement in services, and discharge appropriateness. However, applying these indicators to family foster care may be problematic. Family foster care does not currently share group care's ability, or responsibility, to function as a treatment modality (Lindsey 1994). Therefore, a different set of quality-of-care standards appears necessary.

The factors constituting quality in foster homes vary and depend on the child's individual needs. The combination of concrete measures (such as freedom from further abuse and neglect; physical care; cooperation with child welfare agencies; and meeting medical, dental, educational, and developmental needs) with less tangible indicators (such as a warm, safe, loving home) describes quality in a foster home. Meeting these baseline standards of care is important given the seriousness and complexity of problems faced by foster children.

Domains of Quality

A review of the literature was conducted using the Research Triangle Institute's *Encyclopedia of Kinship Care* as an initial guide.[1] After culling relevant materials, the information was sorted into broad fields resulting in a series of domains of quality that form a rudimentary guide for understanding and assessing the care children receive in kin and nonkin homes. The domains are made up of child safety (including child maltreatment, physical safety of the home, neighborhood, and medical and dental care), educational support, mental health and behavioral support, developmental support, the furtherance of attachment, caregiver characteristics, and foster children's quality of life. Literature on both kin and nonkin caregivers will be examined.

Child Safety

Child maltreatment.—One of the most obvious and incontrovertible baseline standards for quality care is the intolerance of further abuse in out-of-home care. In a case-control study comparing foster parents (both related and nonrelated) who had a confirmed maltreatment report with

a group of caregivers who did not maltreat over the course of a 5-year period ($N = 66$ cases, 240 randomly sampled controls), Susan Zuravin, Mary Benedict, and Mark Somerfield (1993) found that nonrelated foster parents were twice as likely as kin to have a confirmed case of child abuse filed against them, about half of these involving child sexual abuse. However, the kinship caregivers in this sample were licensed, making generalization to the majority of kinship caregivers uncertain. There also is a possibility of maltreatment reporting bias, since children may be less likely to report maltreatment if they are placed with kin and since the level of child protective services supervision of kinship foster homes is frequently lower than that of nonrelated foster homes (Meyer and Link 1990; National Commission on Family Foster Care 1991; Child Welfare League of America 1994; Gebel 1996). Another possibility is that caseworkers employ a more lenient standard with kin, thereby tacitly allowing reportable transgressions such as limited corporal punishment or undesirable environmental conditions due to low income. Further, children in nonrelated foster homes may have more behavior problems than children in kinship homes (Benedict, Zuravin, and Stallings 1996), and this may provoke more abuse reports for reasons ranging from adolescents making false allegations against foster parents to increases in the use of unsanctioned disciplinary practices. While the characteristics of maltreating caregivers remain elusive, Howard Dubowitz et al. (1993) found that their sample of relative and nonrelative caregivers in Baltimore were more likely than the general population to be accused of abusing a child in their care, though most reports in this study were unsubstantiated and the vast majority of foster parents are not reported for maltreatment. More sobering is an examination of former foster youths' perspectives on care. One-third of former foster youth in Wisconsin reported one or more forms of maltreatment at the hands of their caregiver(s) while in care (Courtney et al., in press). The most widely reported form of abuse was neglect, and approximately 13 percent reported physical assault by their caregiver.

Another province of concern is the potential for unsupervised access to a child by an abusive parent. In a disturbing finding of a study of 39 caregivers of drug exposed infants (11 of whom were kin), Carol Rodning, Leila Beckwith, and Judy Howard (1991) found that over half of the children placed with kin in their sample were being surreptitiously cared for by their biological mothers. This finding has not been duplicated in other studies, and the selection criteria and sample size of the study prohibit generalization. Nevertheless, some kinship caregivers might be more inclined to allow unauthorized, unmonitored birthparent contact than would nonrelated foster parents, possibly exposing children to increased risk of harm.

Although all child-welfare agencies require criminal background checks for kinship and nonrelated caregivers, it is less clear whether

background checks are regularly performed on all adults living in or frequenting the home. While criminal activity cannot be unequivocally linked to potential child maltreatment, parental histories of domestic violence and drug offenses are troubling for many children who live at home (Rivera and Widom 1990; Richters and Martinez 1993), and this concern may carry over to out-of-home placements if parental contacts are not properly supervised. The violent or criminal histories of other kin who live with or frequently visit the caregiver's home also merit attention. This concern, however, is equally applicable to nonkin caregivers and their relatives or visitors.

Physical safety of the home.—Basic home safety precautions represent another baseline quality-of-care standard, especially when the child being placed is young. Young children are active and easily injured, a combination that puts child safety concerns at the heart of any placement decision. The accessibility of articles or structures in the home that can injure or kill (such as small, easily swallowed objects, toxic solutions, firearms, pools, combustibles, and exposed wiring) and the presence of functional and correctly placed fire alarms are easily measured indicators of safety. Yet the literature on physical safety of the placement setting is noticeably lacking, largely because foster homes must legally possess these basic criteria for licensing. Bernard Meyer and Maryjane Link (1990) found that a substantial majority of kin provide a safer home environment than the biological parent, though a comparison was not made with nonrelated foster parents. In a survey of child protective services workers in California ($N = 512$), however, Berrick, Needell, and Barth (1999) found that caseworkers believed that a majority (71 percent) of kinship homes met the standards of average foster homes.

Neighborhood.—As many kinship caregivers and a fair number of nonrelated foster parents have low or limited income (Fein, Maluccio, and Kluger 1990; Berrick et al. 1994; Denby and Rindfleisch 1996; Simmel et al. 1997; U.S. Department of Health and Human Services n.d.), an argument can be made that many foster homes are located in neighborhoods that may not be optimal for raising vulnerable children. Generally, economically depressed neighborhoods have increased crime rates, poor housing, poor schools, decreased social mobility, and widespread unemployment (Danziger and Gottschalk 1995; Korbin and Coulton 1996). Robert Haveman and Barbara Wolfe (1995) analyzed longitudinal data following children from early childhood to young adulthood and found that children who grew up in neighborhoods with "bad characteristics" were less likely to graduate from high school and more likely to make use of income assistance programs. While foster care homes are not required nor necessarily designed to provide optimal care to children, adequate support should be provided to children in kin and nonkin settings, regardless of neighborhood circumstances.

Neighborhood conditions should probably be taken into account

when making decisions influencing children in care (Cicchetti and Lynch 1993; Richters and Martinez 1993). For example, if a neighborhood has "bad characteristics," the caregiver must take steps to enhance safety and take advantage of community resources. If the neighborhood has "good characteristics" and the child comes from a neighborhood with "bad characteristics," the caregiver must attempt to curb the negative effects of that transition. Poverty and neighborhood limitations are not always prescriptions for poor outcomes, but caregivers must recognize the potential effects of these circumstances.

Medical and dental care.—Timely and appropriate medical and dental care is both a necessary and quantifiable indicator of the quality of care a foster child receives. In general, foster children have many health problems. In possibly the most widely cited and well-constructed study in this area, Dubowitz et al. (1992) provided nearly 80 percent of children who were residing with kin under the supervision of the Baltimore City Department of Social Services ($N = 407$) with pediatric and mental health assessments, examined their medical records, and administered questionnaires to their caregivers. The authors found that children in kinship care have significant problems, such as impaired visual acuity and hearing, poor growth, obesity, dental carries (tooth decay), and asthma, and that these problems were frequently not addressed. However, when the authors compared their findings with the findings of other studies with samples of nonrelated foster children, the two groups appeared fairly similar (see, e.g., Simms 1989). Further, the authors contend that children in kinship care have similar rates of problems experienced by poor, nonfoster children in several areas (such as dental problems, visual acuity, and obesity), though children in kin care were more likely to have hearing problems and asthma. A major weakness of the child welfare system for children placed with either kin or nonkin caregivers is that social workers and other caregivers do not regularly detect these problems when children enter care (Simms 1989; Dubowitz et al. 1994).

Educational Support

The relationship between educational attainment and economic success (Danziger and Gottschalk 1995) makes it necessary for caregivers to support the educational needs of the children in their care. Children must attend school regularly and receive support and encouragement in their educational endeavors. This is especially true for foster children, who may never have had this type of support and who are especially vulnerable to underachievement (Cook 1994).

Children in foster care appear to have more educational difficulties than children in the general population (Berrick et al. 1994; Dubowitz et al. 1994; Benedict et al. 1996), which makes quality care that much more important. Mary Fox and Kathleen Arcuri (1980) analyzed a

sample of Pennsylvania children in nonrelated foster care who received psychological testing ($N = 163$) and found that the general level of cognitive and academic functioning of children in foster care resembled the largely poor functioning of low-income and minority children. This finding is understandable given the demographics of the foster care population and the usual history of maltreatment before entering foster care (Heath, Colton, and Aldgate 1994).

Children in kinship care evidently have problems similar to those of children in nonrelated foster care. Richard Sawyer and Howard Dubowitz (1994) collected information from teachers of school-age children in kinship care in Baltimore ($N = 282$) and found that children in relative care scored significantly lower on core subjects than did nonfoster children, more often repeated a grade, and frequently used special education. But in a study of adolescent children in foster care in Los Angeles ($N = 990$), Alfreda Iglehart (1994) found no significant educational differences between adolescents in kin and nonkin homes.

The ability to promote a child's education may be influenced by a caregiver's educational and economic attainment. Parental education has been correlated with children's high school completion, years of school attendance, teenage out-of-wedlock birth, and future economic inactivity (Haveman and Wolfe 1995), and the presence of persistent poverty while growing up has been linked to decreased educational achievement (Pagani, Boulerice, and Tremblay 1997). Data on the effect of nonparental caregivers' level of education and economic circumstances are limited; however, nonrelated foster parents tend to be more educated than kinship caregivers (Berrick et al. 1994), which possibly allows them to be more adept at meeting children's educational needs. Jill Berrick et al. (1998) contend that an environment where education is not stressed or where the caregiver has limited educational experience may decrease children's educational achievement. Yet, despite the apparent differences of educational attainment between kin and nonkin caregivers, Mary Benedict et al. (1996) found no differences in educational outcome between children in kinship and nonkinship homes in their interviews of 214 former foster youth. Jennifer Solomon and Jonathan Marx (1995) found that children reared solely by grandparents fared better in overall school adjustment than did children in biological single-parent homes; however, interpretation of this study is limited because both abused and nonabused children were combined in the analysis.

Nevertheless, it may be that kinship caregivers are able to mitigate the effects of their generally lower educational attainment by providing more stable out-of-home experiences (Berrick et al. 1994), and decreased family mobility has been associated with better academic performance among maltreated children (Eckenrode et al. 1995). These enduring homes may also assist children by allowing them to maintain friendships and other potentially important community affiliations.

Neighborhood mapping of child placements conducted by the University of California, Berkeley, demonstrates that the residences of kinship caregivers tend to cluster around children's communities of origin (Needell 2000). This proximity affords children the benefits of family, community, and continuity, but it may also relegate children to poorer, more disadvantaged school systems. In a study conducted by Penny Johnson, Carol Yoken, and Ron Voss (1995), 48 percent of foster children in the sample ($N = 59$) indicated that their schools improved when they were placed in care, but slightly more than half also indicated that it was difficult to change schools and get acquainted with new friends and teachers.

In any case, if caregivers' educational achievement is predictive of the educational achievement of the children in their care, or if some children are returned to disadvantaged school settings, caregivers may require more educational assistance. This aid may take many forms, not the least of which is identifying educational needs and actively pursuing resources (such as special education services and tutoring).

Mental Health and Behavioral Support

It is reasonable to expect increased behavior problems among abused and neglected children across placement settings. This has been confirmed in several studies (Simms 1989; Berrick et al. 1994; Dubowitz et al. 1994; Bilaver et al. 1999), but comparisons between kin and nonkin placements are sparse. Two studies comparing children in relative and nonrelative care (Berrick et al. 1994; Benedict et al. 1996) found fewer behavioral problems among children in kinship care. These studies, however, do not address the differences that may exist between the children on entry to the two types of care. Also, the studies compare only caregivers' perceptions of behavior. Kin may interpret behavior more positively, while nonrelated foster parents may be inclined to label behavior as pathological (Berrick et al. 1994; Gebel 1996).

Assessing the quality of care is made difficult in this area because many foster children are prenatally exposed to drugs and alcohol, which possibly creates educational, developmental, and behavioral difficulties (Silver 1999). In the only study comparing behavior problems among drug-exposed and non–drug-exposed children in kin and nonkin care, Devon Brooks and Richard Barth (1998) find that non–drug-exposed children in kinship care are much less likely to have behavior problems than are either drug-exposed children in kinship care or exposed and unexposed children in nonrelated foster care. Although drug-exposed children in kinship care are most likely to have behavior problems, this likelihood is not statistically different from that of exposed children in the nonrelated caregiver group, leading to the conclusion that both drug-exposed groups have a similar likelihood of having behavior problems and may require special types of support.

There may be variables other than type of placement that influence behavior in foster children. In a case control study comparing foster and nonfoster youth with similar demographic characteristics ($N = 65$ cases), Thomas Hulsey and Roger White (1989) find that differences in biological family structure and stability (such as marital stability, marital status, legal history, and the child's rank in the sibling birth order) are the most important predictors of behavioral problems over time rather than the effects of placement. However, the study is limited by self-report on behavioral measures, bias in control group selection, and the exclusive focus on children ages 4–8 who were in their first placement. Despite these limitations, these findings seem to have relevance, since family structure and stability have been found to have significant effects on behavior in studies of nonfoster children (McLanahan 1997).

In addition to being placed with family members, biological family structure and stability may also be important for children in kinship placements. Sandra Altshuler's (1998) study of caseworkers of 77 randomly selected children in relative care finds that caseworker ratings of child well-being (a composite of mental health and school functioning) were higher if children's birth mothers were unmarried and were not experiencing housing problems. However, marital status and the presence of maternal housing problems may be proxies for other maternal or maltreatment characteristics. While family structure and biological parent characteristics are not quality measures, awareness of their potential consequences and subsequent efforts to countervail any negative effects may reflect upon the quality of a home. If quality care is to be provided, caregivers must have an understanding of a child's mental health needs and must have the ability to deal with behavioral difficulties.

Developmental Factors

Quality care also includes providing children with the stimulation required for them to reach normal developmental milestones. Adequate levels of cognitive stimulation vary by the age of the child, but the most critical time period for brain cell formation and the capacity to form trusting human relationships occurs in the first 3 years of life (Smith et al. 1997; Silver 1999). Recent studies show that poverty has a great impact on cognitive development and is a strong indicator of developmental outcome, especially in early childhood (Haveman and Wolfe 1995; Duncan and Brooks-Gunn 1997).

The influence of a biological parent's income level on child outcome may also be generalized to out-of-home caregivers. In one of the few studies to address this issue, Edith Fein et al. (1983) conducted follow-up investigations of 187 children who had been in various foster care settings for at least 30 days. They discovered that high caregiver incomes

were associated with better child outcomes (i.e., family adjustment, emotional and developmental functioning, behavior, and school functioning) in all placement categories. Interpreting a similar finding with older children, James Gaudin and Richard Sutphen (1993) claim that "as children get older the lower income extended family care providers, who are also more often single parents, find it more difficult to meet the children's increasingly greater needs for experiences that contribute to their intellectual and social development" (p. 144).

For foster children, developmental problems may be more pronounced owing to the combined presence of poverty and maltreatment, making high-quality substitute care even more urgent. Studies in this area have found that foster children have a propensity for growth retardation (Wyatt, Simms, and Horwitz 1997) and have a greater risk of psychopathology due to maltreatment (Cicchetti 1989).

Lower-income caregivers may be at a disadvantage as they attempt to reverse the effects of early or repeated exposure to violence and neglect, since they may not have sufficient means to provide age-appropriate toys, books, and funded activities. In a small study of Connecticut foster homes (N = 28), Mark Simms and Sarah Horwitz (1996) conducted in-home interviews and found that the more impoverished households "were in relatively poor physical condition, with limited areas for young children to play outside safely" (p. 171) and that a considerable proportion of the foster parents in their sample "were significantly understimulating and inadequate to support normal cognitive development, much less the repair of prior neglect" (p. 174).

Poverty's association with decreased levels of education and literacy may also translate to decreased levels of language stimulation for children in the care of impoverished caregivers. Using a sample of nonrelated foster children ages 3–6 years (N = 38, 61 percent response rate), Maureen Smith (1994) discovered that higher-quality childrearing practices by foster parents, which included greater language stimulation, were associated with fewer emotional and behavioral problems. In an analysis that included kin, Gaudin and Sutphen (1993), however, found few differences in levels of affection, attention, and verbal response between related and nonrelated caregivers. Thus kin and nonkin may provide similar levels of stimulation, but there is important variation among caregivers on this measure.

Further study in this area is necessary given the increased risk of developmental delay faced by foster children. Mark Simms (1989) found that about half of his sample of 113 children visiting a medical clinic in Connecticut experienced a developmental delay, yet about 60 percent of children with delays were not receiving treatment for this condition. Thus, placement decisions should incorporate both a recognition of the developmental problems children face prior to placement and a consid-

eration of the level of cognitive stimulation children are likely to require from a specific foster care provider.

The Furtherance of Positive Reciprocal Attachment

Most theoretical constructs of attachment describe the relationship between birth parents and their children; foster parents are established as primary caregivers, thereby playing a similar role in the lives of children (Berrick et al. 1998). In one of the most important and compelling texts establishing the legal and moral need for permanency planning, Joseph Goldstein, Anna Freud, and Albert Solnit (1973) propose that children should be provided with an "opportunity for being wanted and for maintaining on a continuous basis a relationship with at least one adult who is or will become his psychological parent" (p. 22). Although the concept of imprinting or bonding among humans is debatable, more recent research shows that the presence of a stable, nurturing caregiver to whom a child can become attached (Erickson, Sroufe, and Egeland 1985; Sroufe 1988; Rutter and Rutter 1993) and who will attach to the child (George and Solomon 1996) is an essential component of cognitive and affective development. This area is of critical concern since children's ability to develop a positive, nurturing relationship with a caregiver can be affected by abuse or neglect. In a case control study comparing the effects of child maltreatment on security of infant-adult attachment ($N = 32$ maltreating parents, 32 nonmaltreating controls), Michael Lamb et al. (1985) found that maltreatment of infants by their mothers was associated with the infant's insecure attachment to both the mother and the subsequent caregiver. The authors further speculate that these insecure relationships cause future developmental problems with significant long-term consequences.

Because they are related to the child, kin have been perceived as able to cultivate attachment and to reciprocate that attachment in a manner that more closely resembles the relationship of a biological parent (Scannapieco and Hegar 1996). There is some support for this notion, since kinship caregivers usually have a preexisting relationship with the foster child, and kin have been found to provide more stable, long-term placements than do nonrelated foster care providers (Berrick et al. 1994; Courtney and Needell 1997).

The importance of the stability of kinship homes should not be taken lightly. Although Rodning et al. (1991) find no significant differences in security of attachment between infants who experienced changes in caregivers (instead finding that prenatal exposure to drugs is correlated with level of attachment), many studies have linked multiple placements of foster children with poor outcomes (Fanshel and Shinn 1978; Fein et al. 1983; Pardeck 1984). However, none of these studies were able to

determine whether poor behavior resulted from multiple placements or whether multiple placements resulted from poor behavior on the part of the foster child. Nonetheless, lack of placement stability is theoretically related to attachment deficits in foster children (Goldstein et al. 1973) and continues to play a key role in the provision of out-of-home care.

Reciprocal attachment may also be affected by the nature of the temporary foster parent relationship. Foster parents may be hesitant to develop mutual attachment to a foster child, since the child may not live with them permanently (Dando and Minty 1987) and, until recently, foster care policy and practice promoted disengagement between caregivers and children as evidenced by the reluctance to support foster parent adoptions. The quality of the caregiving environment is undoubtedly influenced by the nature of the relationship between the caregiver and the child. Indeed, child welfare workers interviewed by Berrick et al. (1998) described relative caregivers as "emotionally committed to children at a level that often exceeded foster family care" (p. 187). Nicole LeProhn (1994) found that kinship caregivers often feel they should play a major role in the lives of the children they care for. This level of commitment might help mitigate some of the potentially traumatic effects of placement and may facilitate the development of positive and secure attachment among maltreated children. Nevertheless, caseworkers may find themselves weighing the degree of mutual attachment between the child and the related caregiver and the preservation of family ties against the increased average socioeconomic status and perceived higher quality parenting that may be given by trained foster parents.

Characteristics of Quality Caregivers

The level of quality care provided may be influenced by certain personal and demographic characteristics of the caregiver. In interviews with social workers who rated foster parents, Isabel Dando and Brian Minty (1987) found caseworkers agreed on three criteria for high quality foster parenting: (1) understanding and accepting social service agency workers and procedures, (2) basic child care (warmth, interaction, discipline and control, good home environment), and (3) special capacity to handle the child's difficulties and to work with the child's natural parents. The authors then compared these quality criteria with a group of foster parents, finding higher-quality foster parents to have motivations such as "strong personal needs" (p. 397), which were defined as the inability to conceive a biological child or needs associated with having been abused as a child. Although kin were not included in this study, their position as family members implies strong motivations of a different nature.

Other studies conducted in this area proffer varied and sometimes

conflicting results, possibly leading to the conclusion that a quality caregiver cannot be defined by demographic characteristics alone—that each caregiver, like each child, is unique and possesses strengths and weaknesses that positively or negatively influence quality care. For instance, Dando and Minty (1987) found that foster mothers under age 40 are more likely than older women to be ranked by caseworkers as excellent. Jonathan Kraus (1971) concludes otherwise, suggesting that foster mothers over the age of 46 have more successful placements than younger women, and Alma Jordan and Margaret Roadway (1984) find that effective foster parents are more often between the ages of 35 and 44. A number of studies assessing the psychological functioning of relative caregivers find that older grandparent caregivers tend to experience greater levels of impairment when a child is placed with them (Minkler, Roe, and Price 1992; Kelley 1993; Shore and Hayslip 1994), and this impairment may be most pronounced for grandparents without adequate family resources or social support, or with physical health problems (Yorker et al. 1998; Kelley et al. 2000). Although a clear understanding of the influence of caregiver age on child well-being has not been clearly established, its effect on both the child and the caregiver must be carefully evaluated. For example, a young foster parent may not have enough experience or time to devote to an active or problematic child, or an older caregiver may have medical problems that could influence her or his ability to care for a very young child.

The structure of the home may also be related to quality care. Fein et al. (1983) find that foster children do less well in single-parent homes with no other adults present than in two-parent homes or in families with other adults in the home. Also, the authors find that foster children in homes with a larger number of children have better outcomes, though this finding is questionable, as Haveman and Wolfe (1995) contend that nonfoster children from large families do not fare as well as those from small families. These findings notwithstanding, the physical structure of the family may not be as important as the social structure, which includes good communication, satisfaction with relationships among family members, and the flexibility to adapt to each child's unique attributes (Jordon and Rodway 1984; Walsh and Walsh 1990).

Many times, placements are considered only on an emergent basis. However, there is a strong likelihood that the placement will not be temporary, especially if the caregiver is a relative (Wulczyn and Goerge 1992; Needell et al. 1997). Given the importance of placement stability, quality care must be provided for the duration of the placement. This may entail a more careful consideration of placements or the addition of extra agency or family support to bolster the effects of age, illness, or other potential impediments to permanent, quality care. A recent review of several foster care evaluation studies finds that enhanced support ser-

vices are related to higher-quality caregiving environments and may be linked to more positive child outcomes (Soliday 1998). Thus, caregiver supports are an essential component of quality care.

Quality of Life

Any discussion of the quality of care should look at foster children's perceptions of their quality of life. Qualitative interviews of foster children are a powerful tool for understanding the personal impact of placement, though such interviews are necessarily limited to older, more verbal children and, too, implementation of well-designed studies are hindered by an array of methodological and bureaucratic barriers (Berrick, Frasch, and Fox 2000). Two studies (Gil and Bogart 1982; Johnson et al. 1995) indicate that the loss of control experienced by a child who enters care has a negative effect. In interviews of Cook County foster children ages 11–14 years ($N = 59$), Johnson et al. (1995) find that, "actions taken in the interest of protection were often confusing, frightening, and dehumanizing" for the children involved (p. 973). For a youth who is already experiencing the debilitating effects of maltreatment, the loss of personal control and the choice of home environment may represent yet another stressor. This perception appears to be supported by the suggestions made by foster children to improve their placement experience. Frequently, children wanted more information regarding the circumstances of their placement and more control over their service plans (Gil and Bogart 1982; Colton 1989; Johnson et al. 1995). However, more control or decision-making power may be less important for children placed with kin (Altshuler 1998).

Most children surveyed in these qualitative studies identify parental and familial contact as very important (Gil and Bogart 1982; Johnson et al. 1995), which corresponds to the findings of some outcome studies (Fanshel and Shinn 1978; Milner 1984; Hess 1987). Since kinship care has been linked to increased parental contact (Oyserman and Benbenishty 1992; Berrick et al. 1994; LeProhn 1994), relative care is more likely to meet this quality of life indicator for children.

A child's level of satisfaction may also increase her or his commitment to the placement (Colton 1989). This may be particularly important for older children with behavior problems, who tend to be predisposed to placement instability. Kinship homes appear to be more likely to promote satisfaction and engender a commitment to the placement, possibly contributing to increased placement stability (Wulczyn and Goerge 1992; Courtney and Needell 1997).

The disruption of home life can, many times, include the disruption of friendships, schools, and contact with relatives. Johnson et al. (1995) find over half of their subjects report residing in different neighborhoods and attending different schools as a result of placements. Place-

ment with kin is less likely to disrupt these community associations (Berrick et al. 1994), which may increase children's satisfaction with placement. However, one study of placement satisfaction that includes kin (Wilson and Conroy 1996) finds similar levels of satisfaction among children placed with relatives and children placed in traditional foster care. This single finding notwithstanding, if placing children with kin results in greater satisfaction for children, then high-quality kinship care is preferable to other types of care. However, high satisfaction is an inadequate substitute for low quality in areas such as supervision, developmental stimulation, or safety.

Conclusion

While the experience of care varies widely, some data suggest that care may be substandard in a very high proportion of cases (Courtney et al., in press). Focus group interviews conducted with older youth in or exiting care suggest that quality care could be better promoted if social workers made routine, unannounced visits to foster homes (Fox, Frasch, and Berrick 2000). This point is poignantly made by one such foster youth who commented, "My foster mama had lasagna on the table and flowers in the house when the social worker came. We never got to have lasagna" (p. 150). Despite a clear legal and philosophical preference for kinship placements, assumptions about the quality or benefits of kin care should be cautiously guarded against. Mounting evidence suggests that foster children—whether graduating from kin or nonkin care—suffer disproportionately from poor outcomes (Cook 1994; Courtney et al., in press). Many of these outcomes are surely driven by the maltreatment experience, but if foster care is a viable intervention, we must also believe that higher-quality foster homes will produce better outcomes.

Defining quality of care and implementing the resulting standards in practice can be difficult. Child safety, support for education, development, and special needs, as well as the presence of a close, stable caregiver, are essential to quality care. Although each child is different and requires special attention, these differences can be accommodated within the framework of the basic tenets of quality highlighted in the preceding sections. These tenets, however, may not be exhaustive. A quality home must have the flexibility to incorporate individual children's needs into its care plan. To this end, child welfare agencies must use quality indicators and combine them with regional and individual considerations to help support caregivers. Yet simply creating a list of quality indicators is insufficient if resources are not applied to help caregivers create quality environments. Families should be helped to meet quality standards rather than just have these standards imposed on them. The strengths and weaknesses of each placement should be weighed and individualized plans developed to maximize quality.

Quality care programs may need to be implemented differently for kin and nonkin caregivers, as they tend to have varied strengths and weaknesses. Kin, while usually having an established relationship with the child, may also have certain familial and socioeconomic circumstances that may impede their ability to provide high quality out-of-home care. Nonrelated foster parents, while trained to provide safe care, do not usually have the benefit of a preexisting relationship with the child. Especially with older children, this may translate into reciprocal attachment difficulties and, later, with permanency problems. While not insurmountable, these issues need to be actively addressed in order to glean the full benefit of kinship care and nonrelated foster care placements.

With the introduction of the Adoption and Safe Families Act (ASFA), states will now be compelled to develop licensing standards for kin in order to draw down federal IV-E funds. This clarification of previous policy offers states an opportunity to closely examine quality standards for kin and nonkin foster homes and to develop meaningful guidelines for social workers in the field. Rather than a newly imposed burden on states and localities, the ASFA regulations can be seen as an appropriate step toward ensuring quality for children in out-of-home care. States can approach implementation of the new law by using a variety of strategies. Some state policy makers may choose to coordinate kin and nonkin licensing qualifications by loosening standards for nonkin. The benefit, of course, will be to simplify the process for social workers in the field, to largely accept the care currently provided by kin, and to widen the net of future eligible nonkin caregivers. While bureaucratically efficient, such an approach largely ignores the philosophical and moral considerations that should guide child welfare practice, and it potentially relegates many children to inadequate, or at least inequitable care. Instead, ASFA offers the potential for a reexamination of the meaning of quality for all children in out-of-home care, and it can be used as the springboard for creating new, standardized assessment criteria—appropriate to kin and nonkin—that can be uniformly implemented for all children.

The domains included here can be seen as a guidepost for the development of such standards, but specific assessment criteria that operationalize these domains may be state- or county-specific. As a starting point, education for future social workers should include curriculum materials focused on assessing and promoting quality care for children so that the next generation of children may be better supported.

Reform of the child welfare system may include better efforts to prevent abuse and forestall placement, shorten children's stay in care, and improve family functioning, but all of these efforts will do little for the children currently being raised by the state. Efforts to improve their experience and future development merit equal attention by researchers, practitioners, administrators, and policy makers. For years, nonrelated

foster parents and kin have striven through adversity to provide the best care possible. Many have devoted their lives to raising some of the most injured and disadvantaged children in our society. Child welfare agencies have the responsibility to support these caregivers and to assist them in mending, not simply maintaining, the children in their care.

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1. In 1996, the Research Triangle Institute (RTI) created an *Encyclopedia of Kinship Care* to be used as a foundation for RTI's development of an instrument to assess quality of care in kinship homes. RTI used the Child Welfare League of America's (1994) standards for kinship care assessment, which includes key factors to consider in assessing quality of care, to develop a summary of pertinent kinship literature (Child Welfare League of America 1994). This work was used as an initial guide and supplement for the literature review conducted in this study. The Children and Family Research Center (1999) of the University of Illinois at Urbana-Champaign completed the RTI project and produced a guide and instrument for evaluating the quality of care received by children in kinship homes.