

## ***Children in Foster Homes: How Are They Faring?***

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**O***verview* Every year, public agencies place a substantial number of children in foster care after child welfare officials have determined that the parents of these children are either unable or unwilling to care for them. Most of these children are placed in foster homes, either with relatives (“kinship” care) or under the care of unrelated adults in family foster homes. Many of these children stay in foster care for brief periods (perhaps just a few weeks) before they are reunified with their families. Others remain in foster care for months or even years.<sup>1</sup> During 2001, the foster care system served 805,000 children across the nation.<sup>2</sup> Apart from the possibility of trauma of separation from their parents and adjustment to new caregivers or to multiple placements, most foster children have had to cope with additional hardships before they entered foster care. Among these hardships are abuse or neglect, poverty, and the experience of being raised by parents with a history of mental health disorders, substance abuse, incarceration, and childhood experiences of abuse or neglect.<sup>3</sup>

Despite the size and vulnerability of this population, and despite improvements in the quality of data about the health and well-being of America’s children in general over the past decade,<sup>4</sup> information on the status of the foster care child population is sparse. Previous research has often been based on small samples of children in specific geographic locations. In addition, most national surveys that include indicators of well-being do not identify whether children or adolescents are currently or have ever been in foster care.<sup>5</sup> Even for children who have been in foster care for years, most state data systems cannot provide aggregate measures of well-being. Given these limitations, it is difficult to know how foster children are faring as a population.

This Research Brief addresses this question for foster children who are living in foster family homes.<sup>6</sup> The brief presents findings from Child Trends’ analyses of new data from two nationally representative surveys, the National Survey of Child and Adolescent Well-Being and the National Survey of America’s Families (see box, page 2). We used data from the two surveys to take a detailed look at the well-being of foster children, as measured by selected indicators. It is important to note that this Research Brief does not attempt to untangle the reasons behind the observed levels of foster children’s well-being, nor does it speak to the outcomes these children will experience later in life. Rather, the purpose of this brief is to describe the well-being among the population of children living in foster homes.

An important finding in these analyses is the diversity of the foster care population. Results indicate that foster children in the United States have levels of well-being that are worse than other children in some areas that are critical to their development. For example, more than half of infants and toddlers can be described as being at high risk for a clinical level of neurological and cognitive development impairment, and nearly half of school-age children have a clinical level of behavioral and emotional problems. However, this level of risk is not apparent among all foster children. Further, many foster children have characteristics that can support their positive development, including health insurance coverage, positive relationships with foster parents or other adults, and religious involvement.

The brief supplements earlier efforts to learn more about how foster children are faring in areas that are critical to healthy development. Central to these efforts is the recognition that improving knowledge about foster children can help focus resources on areas of critical need. This knowledge, in turn, can inform efforts to coordinate prevention and treatment services across systems, including the health care, public health, and education systems, in order to better address the needs of vulnerable child populations.

## About the Research Sources for this Brief

Data on foster children in this *Research Brief* come from two sources: the National Survey of Child and Adolescent Well-Being (NSCAW) and the National Survey of America's Families (NSAF). These surveys contribute in different ways to our knowledge about how foster children are faring. For estimates and detailed information about the well-being of foster children and their caregivers, the NSCAW is the stronger survey. In contrast, the NSAF is the better choice for comparisons between children in foster care and other children in the general population.<sup>7</sup>

The NSCAW, a longitudinal survey, collected information about a large number of children under age 15 who have had contact with child welfare services, including 1,279 children living in foster care homes in 2000.<sup>8</sup> Therefore, while we cannot compare foster and non-foster children using the NSCAW, we can use the data to examine variations among foster children as a group. Another advantage of the NSCAW is that, in contrast to the self-identified foster families in the NSAF, the NSCAW identified children who have had contact with the child protective services system by administrative records. Additionally, the NSCAW collected information about many areas of child well-being through lengthy in-person interviews with caregivers and children, while the NSAF collected briefer information on child and family well-being from caregivers through telephone interviews.

The NSAF is a cross-sectional (or "snapshot") survey of more than 44,000 households in the United States.<sup>9</sup> The survey was designed to represent the entire civilian, non-institutionalized population under age 65, but it is sufficiently large that foster children can be examined, especially when multiple years of data are combined. Combining the 1997 and 1999 data yields a sample of 669 foster children, as well as nearly 60,000 children not in foster care, under age 15. The information on children is less detailed than that collected by the NSCAW. However, since the NSAF used identical methods to collect information on foster children and non-foster children, the data can be used to compare how these two groups of children are faring on identical measures of well-being and family environment.

## CHILD WELL-BEING

■ **Physical health.** Some research has shown that children in foster care are more likely to have health problems even when compared with other groups of disadvantaged children, such as other children receiving Medicaid, in families below the poverty threshold, or in families receiving Temporary Assistance for Needy Families (TANF).<sup>10</sup> Analyses of NSAF data show that the gap between the health of foster children and children not in foster care is greatest among young children: Foster children under age 6 are substantially more likely than other young children to be in fair or poor health, rather than in excellent, very good, or good health. And, according to the NSAF, foster children are almost four times more likely to have a disability than children who are not in foster care, regardless of their age.

More detailed data from the NSCAW amplify this portrait. Just under a quarter of foster children under age 15 (24 percent) have chronic health problems, including nearly

one-third of those under age 6 (30 percent). Almost one-third (30 percent) of foster children under age 15 have a disability. Data from the NSCAW indicate that 15 percent of foster children under age 6 are reported by their caregivers to be in fair or poor health.

With regard to use of an illicit substance, a minority of 11- to 14-year-olds report use in the last month. Nevertheless, any use at all is a concern. In the NSCAW, 1 percent report smoking cigarettes on 20 or more of the previous 30 days, 7 percent report having used illicit drugs of any kind<sup>11</sup> in the past 30 days, and 8 percent report drinking alcohol at least once in the previous 30 days.

■ **Health insurance and health care.** When foster children receive appropriate interventions, their health, developmental, and emotional status can improve.<sup>12</sup> While health insurance does not ensure that children have their health care needs met,<sup>13</sup> health insurance can be a route to receiving services. Since many foster children are categorically eligible for Medicaid, it is not

surprising that the vast majority of foster children under age 15 have health insurance. According to the NSCAW, 86 percent have public coverage and an additional 9 percent have private coverage. Moreover, foster children are no more likely than other children to lack insurance coverage, according to the NSAF.<sup>14</sup>

The vast majority of foster children have received appropriate vaccinations, according to their caregivers. The rate of childhood immunization is an indicator of the degree to which children are protected from an array of serious diseases and may also be an indicator that children have received other preventive health care services. Foster parents report in the NSCAW that 90 percent of foster children under age 5 are “up-to-date” with their immunizations. The majority of foster children also receive dental care. According to NSAF data, three out of four children ages 3 to 14 have visited a dentist in the previous year, regardless of their foster care status.

In another health-related area, evidence suggests that foster children are no more likely than other children to have an accident or illness requiring hospital care. The two groups are equally likely to have visited an emergency room in the previous 12 months and are equally likely to have stayed in the hospital overnight, according to the NSAF. A new question on accidents and injuries was added to the NSAF in 2002. According to these new data,<sup>15</sup> 14 percent of children not in foster care have had “any accidents or injuries that required medical attention” in the previous 12 months, according to their caregiver, which is the same percentage as for children in foster care. According to the NSCAW, an even smaller minority of foster children (3 percent) had “a serious injury, accident, or poisoning that required the care of a doctor or nurse” since the date of contact with a child welfare agency.<sup>16</sup>

■ **Development among infants, toddlers, and preschoolers.** One of the most troubling findings in the NSCAW data is caregivers’ responses to questions designed to assess infants’ and toddlers’ neurological and cognitive development.<sup>17</sup> According to this measure, 59 percent of foster children ages 2 months to 2 years can be described as

being at high risk for a clinical level of impairment. About one in ten children (9 percent) are at low risk.

For those children who are at risk of poor developmental outcomes, Head Start may provide an opportunity for educational enrichment and cognitive stimulation. High-quality center care - whether Head Start, nursery school, or an early childhood development program - also has the potential to expand the educational and social horizons of young children. Data from the NSCAW indicate that 6 percent of foster children under age 6 are in Head Start, and nearly one-third (29 percent) attend some type of child-care center. According to the NSAF, foster children are slightly more likely than other children to be in Head Start, and they are equally likely to be in any type of child-care center.

■ **Education and school engagement among school-age children.** The NSCAW interviewed foster children ages 6 to 14 directly about their level of engagement in school, and their answers suggest that about three out of four children are engaged, while one in four are not.<sup>18</sup> About three-quarters report that they often or almost always “get along with [their] teachers” (74 percent), “listen carefully or pay attention in school” (76 percent), and “get [their] homework done” (74 percent). However, foster children are somewhat less likely to report doing well in other areas of school life. For example, a smaller proportion of foster children report that they often or almost always “get along with other students” (64 percent), and just over half (58 percent) report that they often or almost always “enjoy being in school.”

Previous research suggests that foster children tend to be less engaged in school<sup>19</sup> and to have lower school achievement and educational attainment than do other children.<sup>20</sup> In the NSAF, caregivers’ responses to four questions about 6- to 14-year-old children’s engagement in school indicate that foster children are about twice as likely as other children to be poorly engaged in school (39 percent versus 18 percent).

■ **Behavioral and emotional problems.** Scores on a standardized measure of behavioral and emotional problems included

in the NSCAW<sup>21</sup> indicate that nearly half of foster children have a clinical level of problems: 47 percent of children ages 6 to 11, and 40 percent of children ages 12 to 14. Mental health or behavioral problems can be an important concern for foster children, leading to poorer psychological adjustment while in care and difficulties that contribute to changes in foster care placements.<sup>22</sup> Previous research has also shown that children in foster care are more likely than other children to have behavioral and emotional problems.<sup>23</sup> Indeed, NSAF analyses reflect this pattern: a scale of behavioral and emotional problems shows that foster children ages 6 to 14 are about four times as likely to have a high level of problems, compared with other children.<sup>24</sup>

Despite the incidence of behavioral and emotional problems among school-age foster children, three out of four report that they *never* “get sent to the office, or have to stay after school, because [they] misbehaved [at school].” Further, serious delinquent behaviors are relatively rare among foster children during early adolescence. For example, in the past six months, among children ages 11 to 14, 1 percent report being involved in a robbery (that is, using a weapon or force to steal something), 3 percent report being involved in a minor theft (including stealing something worth less than \$50), and 2 percent report having been involved in illegal activities such as prostitution or selling drugs. However, adolescents report that other problems are more common. About one in ten 11- to 14-year-old foster children report running away from home, skipping school, or lying about their age (12 percent), and a similar proportion report being involved in a public disorder (such as hitchhiking illegally, begging from strangers, or being rowdy in a public place).

- **Relationships with foster parents and other adults.** One of the most important assets for a child is to have an enduring, positive relationship with an adult who cares about that child.<sup>25</sup> This adult need not always be a parent or caregiver, but may be a relative or other adult. According to several measures, the majority of foster children do have a positive relationship with such an adult. For example, in the NSCAW, 11- to

14-year-olds rated how well a series of statements described the relationship with their primary caregivers.<sup>26</sup> For three statements on the structure provided by their caregiver, 90 percent gave positive responses,<sup>27</sup> and 94 percent gave positive responses to three statements about their emotional security with their caregiver.<sup>28</sup> On four statements about the involvement of their caregiver,<sup>29</sup> 97 percent answered positively. Finally, for two statements about the support caregivers provided for adolescents’ autonomy,<sup>30</sup> 90 percent answered positively. It is also noteworthy that half or more of foster children gave the most positive responses possible<sup>31</sup> to all of the statements.

In another series of questions, the majority of 11- to 14-year-old foster children reported that they felt close to their caregiver and that their caregiver cares about them. Specifically, 76 percent said that they feel “quite a bit” or “very close” to their caregiver, and 89 percent said that they think their caregiver cares about them “quite a bit” or “very much.”

Additional evidence from the NSCAW suggests that the vast majority of 11- to 14-year-olds have a foster parent, relative, or other adult on whom they can rely for help. Nearly all – 97 percent – reported that there is “an adult [they] can turn to for help if [they] have a serious problem, 96 percent said that they could “go to a parent or someone who is like a parent with a serious problem,” and 82 percent said that they could “go to another relative (not a parent) with a serious problem.”

These reports contrast with the negative media reports of foster parents. Indeed, given that many foster children have been living with their present caregiver for only a brief time, and given the trauma that most have experienced, these are unexpectedly positive responses. We compared the responses of foster children living with kin to those of children living with non-related caregivers and found that they did not differ significantly.<sup>32</sup> It may be that foster parents are particularly nurturing and caring individuals or that vulnerable children attach quickly to a caring adult. Alternatively, some children may be motivated to provide

the “right” answers to such questions, which could bias their responses. Clearly, more in-depth research is warranted.

- **Religiosity.** A growing body of research suggests that religious involvement may help promote positive outcomes among children in the general population.<sup>33</sup> This area may also represent a strength for many foster children: More than half of foster children ages 11 to 14 attend religious services weekly or more often (59 percent), and 69 percent report that religion or spirituality is “very important” to them.

## IMPLICATIONS FOR POLICY AND PRACTICE

The findings reported in this *Research Brief* suggest that the diversity and complexity of the foster care population require serious attention and further analysis. The evidence on indicators of children’s well-being reported here suggests that foster children are more likely to have problems than are non-foster children in an array of areas including behavioral and emotional problems, poor school engagement, and health. Yet, many foster children also have strengths that can promote their resilience. For example, most foster children report having a positive, caring relationship with a foster parent or other adult, religion plays a role in the lives of most, and nearly all foster children have health insurance coverage.

It bears mentioning that it would be unfair to “blame” foster care per se for the higher level of problems seen among many foster children. Rather, foster children’s poorer well-being may be due to the multiple hardships these children have faced before entering foster care, as noted earlier. In addition, the turbulence associated with entering foster care may pose further risks for children.<sup>34</sup> These preexisting conditions present a dilemma for the child welfare system, which is now expected to promote children’s well-being, in addition to ensuring children’s safety and achieving permanent placements for children.<sup>35</sup> The dilemma is magnified in cases in which children are placed in foster care for a short time. Then only a narrow window of opportunity exists during which to affect children’s outcomes.

Nevertheless, children’s experience with foster care may *improve* child outcomes.<sup>36</sup> This could

be the case if a foster care placement enables a child to have greater access to needed services or to have the chance to live in a more nurturing, less tumultuous household. Thus, it is important to track the progress of individual children over time while they are in foster care, to monitor whether their outcomes are improving.

One-size-fits-all solutions are unlikely to improve the well-being of children in foster care. Instead, multi-faceted approaches are receiving more attention in the research literature. For example, although the following strategies have not yet been evaluated rigorously, research and experience suggest they may increase the capacity of foster parents to support foster children’s development:

- Almost one-third (29 percent) of children in foster homes are living below the poverty threshold.<sup>37</sup> Their well-being might be improved by increasing economic resources for foster families through higher reimbursement rates for caring for foster children and by assuring access to affordable and adequate housing.<sup>38</sup> Alternatively, more foster parents from households with incomes that are well above the poverty line could be recruited.<sup>39</sup>
- Improved standards of health care can be obtained by providing health insurance for foster parents and all children in their households (including their own biological children),<sup>40</sup> by ensuring continuity of health insurance coverage for foster children as they move into and out of foster care,<sup>41</sup> and by providing initial health and developmental assessments upon entry to foster care, as well as routine comprehensive health evaluations following placement.<sup>42</sup> Other service integration efforts that seek to improve child well-being include ensuring that the special needs of foster children are considered in designing managed care systems,<sup>43</sup> improving the coordination of health care across providers,<sup>44</sup> ensuring that children have a regular health care provider,<sup>45</sup> and taking advantage of the “window of opportunity” provided when children enter foster care to treat children who have critical or chronic health care needs, even if those children are quickly reunified with their parents.<sup>46</sup>
- Supportive environments and systems of care can help reduce the stress of caring

for difficult or troubled children. Possible interventions for foster parents and kinship caregivers include additional training, access to liability insurance, child care, and respite care.<sup>47</sup>

- Bureaucratic delays can be reduced by improved service coordination through the formation of community partnerships that can integrate resources and also offer informal approaches to meet the needs of children in foster care and the families that care for them.<sup>48</sup>

## CONCLUSION

Improving outcomes for foster children requires greater consensus about the areas of well-being and harm that require attention by service providers, as well as targeted interventions that include the development of measurable outcomes and evaluation studies to assess the effects of service delivery and placement policies and practices. Additional work is also needed to monitor foster children's well-being over time. Two key steps that can be implemented with minimal cost deserve attention because they would provide routine data about the status of children in foster care, based on large national samples: (1) the addition of measures of child well-being to state and federal child welfare administrative data systems, and (2) the inclusion of foster children – from residential, group, and therapeutic settings as well as family foster care – in nationally representative surveys of children and youth.

By looking at how *all* foster children are faring, and comparing their status with trends in the well-being of *all* of America's children, policy makers and service providers can more accurately assess areas of need and strengths and focus resources more effectively to improve the health and development of one of the nation's most vulnerable populations of children.

This document includes data from the National Survey on Child and Adolescent Well-Being, which was developed under contract with the Administration on Children, Youth, and Families, U.S. Department of Health and Human Services (ACYF/DHHS). The data have been provided by the National Data Archive on Child Abuse and Neglect. The information and opinions expressed herein reflect solely the position of the author(s).

Nothing herein should be construed to indicate the support or endorsement of its content by ACYF/DHHS.

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## Endnotes

<sup>1</sup> For an examination of children who "age out" of foster care, for example, see Wertheimer, R. (2002, December). Youth who age out of foster care: Troubled lives, troubling prospects (Research Brief). Washington, DC: Child Trends; available at: <http://www.childtrends.org/PDF/FosterCareRB.pdf>.

<sup>2</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. (2003). The AFCARS report (No. 8). Available at: <http://www.acf.dhhs.gov/programs/cb/publications/afcars/report8.pdf>.

<sup>3</sup> Leathers, Sonya J. (2002). Foster children's behavioral disturbance and detachment from caregivers and community institutions. *Children & Youth Services Review*, 24(4), 239-268; Marx, L., Benoit, M., & Kamradt, B. (2003). Foster children in the child welfare system. In A.J. Pumariega, & N.C. Winters (Eds.), *The handbook of child and adolescent systems of care: The new community psychiatry* (pp. 332-350). San Francisco, CA: Jossey-Bass; Orme, J.G., & Buehler, C. (2001). Foster family characteristics and behavioral and emotional problems of foster children: A narrative review. *Family Relations*, 50(1), 3-15; Rosenfeld, A.A., Pilowsky, D.J., Fine, P., Thorpe, M., Fein, E., Simms, M.D., Halfon, N., Irwin, M., Alfara, J., Saletsky, R., & Nickman, S. (1997). Foster care: An update. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36(4), 448-457.

<sup>4</sup> For example, the federal government began publishing the annual reports *Trends in the Well-being of America's Children and Youth* in 1996 and *America's Children: Key National Indicators of Well-Being* in 1997. For an even wider representation of data now available on the well-being of children in the United States, see the Child Trends Data Bank at <http://www.childtrendsdatabank.org/>. U.S. Department of Health and Human Services. (1996). *Trends in the Well-*

*Being of America's Children and Youth*. Washington, DC: U.S. Government Printing Office; Federal Interagency Forum on Child and Family Statistics. (1997). *America's Children: Key National Indicators of Well-Being*. Washington, DC: Author.

<sup>5</sup> One important exception is the National Survey of America's Families.

<sup>6</sup> The population of children under consideration in this *Research Brief* refers only to those children who are in foster homes and does not refer to children living in residential or group care, who are frequently the most troubled children within the foster care population.

<sup>7</sup> All differences in percentages based on Child Trends analyses that are noted within this *Research Brief* are statistically significant at the  $p < .10$  level. Additionally, all data are weighted to represent population estimates.

<sup>8</sup> The NSCAW sampling frame included all children who were subjects of child abuse or neglect investigations (or assessments) conducted by child protective services from October 1999 through December 2000, with the exception of those living in four states whose policies prevented their participation in the survey. Child Trends' analyses are based on data from the initial wave of the survey and are limited to children in out-of-home care. The majority – about 90 percent – of children who were subjects of child abuse or neglect investigations remained at home with their families

<sup>9</sup> The NSAF has been conducted in 1997, 1999, and 2002 as part of *Assessing the New Federalism*, a joint project of the Urban Institute and Child Trends.

<sup>10</sup> For example, see Bilaver, L.A., Jaudes, P.K., Koepke, D., & Goerge, R.M. (1999). Note on research: The health of children in foster care. *Social Service Review*, 73(3), 401-417; Marx, Benoit, & Kamradt. (2003); Rosenbach, M., Lewis, K., & Quinn, B. (2000). *Health conditions, utilization, and expenditures of children in foster care*. Washington, DC: U.S. Department of Health and Human Services, Offices of the Assistant Secretary for Planning and Evaluation. Available at: <http://aspe.hhs.gov/hsp/fostercare-health00/>; U.S. General Accounting Office. (1995). *Foster care: Health needs of many young children are unknown and unmet*. (No. GAO/HEHS-95-114). Washington, DC: U.S. Government Printing Office.

<sup>11</sup> The NSCAW asked about adolescents' use of marijuana, hashish, inhalants, hard drugs such as cocaine, crack, or heroin, and prescription drugs without a prescription.

<sup>12</sup> Rosenfeld, et al. (1997).

<sup>13</sup> U.S. General Accounting Office. (1995); Marx, Benoit, & Kamradt. (2003); Rosenbach, Lewis, & Quinn. (2000); Rosenfeld et al. (1997).

<sup>14</sup> Additionally, Kortenkamp and Ehrle (2002) found that foster and non-foster children under age 18 were equally likely not to have had health insurance at some point during the prior year (about 16 to 17 percent). Kortenkamp, K., & Ehrle, J. (2002). The well-being of children involved with the child welfare system: A national overview (Assessing the New Federalism Brief, No. B-43). Washington, DC: The Urban Institute.

<sup>15</sup> The sample size of foster children under age 15 in the 2002 NSAF is 290.

<sup>16</sup> The difference between the foster care estimates from the NSAF and NSCAW could be due to different wordings of the questions and to differences in the reference periods of the questions in the two surveys. According to the NSCAW, about half of foster children (52 percent) have lived with their current caregiver for 4 months or less.

<sup>17</sup> The Bayley Infant Neurodevelopmental Screener Record Form.

<sup>18</sup> No general summary measure of school engagement has been developed for the NSCAW.

<sup>19</sup> Kortenkamp and Ehrle. (2002).

<sup>20</sup> Blome, W.W. (1997). What happens to foster kids: Educational experiences of a random sample of foster care youth and a matched group of non-foster care youth. *Child and Adolescent Social Work Journal*, 14(1), 41-53.

<sup>21</sup> The NSCAW used the Child Behavior Checklist to assess behavioral and emotional problems. Data presented here are based on children's total problems score.

<sup>22</sup> Barber, J.G., Delfabbro, P.H., & Cooper, L.L. (2001). The predictors of unsuccessful transition to foster care. *Journal of Child Psychology & Psychiatry & Allied Disciplines*, 42(6), 785-790.

<sup>23</sup> Brand, A.E., & Brinich, P.M. (1999). Behavior problems and mental health contacts in adopted, foster, and nonadopted children. *Journal of Child Psychology and Psychiatry*, 40(8), 1221-1229; Hulsey, T.C., & White, R. (1989). Family characteristics and measures of behavior in foster and non-foster children. *American Journal of Orthopsychiatry*, 59(4), 502-509; Kortenkamp and Ehrle (2002); Leathers, S.J. (2002); Marx, Benoit, & Kamradt. (2003); Orme & Buehler. (2001); Rosenfeld et al. (1997).

<sup>24</sup> The NSAF asked caregivers six age-appropriate questions about children's behavior, such as how often their child "doesn't get along with other kids," "feels worthless or inferior," or "lies or cheats."

<sup>25</sup> Bronfenbrenner, U. (1994). Who cares for the children? in *Resources for Early Childhood: A Handbook* (H. Nuba, M. Searson, and D. L. Sheiman, eds.). New York: Garland.

<sup>26</sup> The Research Assessment Package for Schools – Self-report Instrument for Middle-School Students.

<sup>27</sup> Statements about structure included not knowing "what [their] caregiver wants from [them]" and whether the caregiver "is fair with [them]" and "doesn't think [the children] can do very much." Positive responses were those indicating that the statement was "sort of true" or "very true" (or "not at all true" or "not very true") as appropriate.

<sup>28</sup> For emotional security, foster children reported how true it was that they felt "good," "mad," and "unhappy" when with their caregivers.

<sup>29</sup> For caregiver involvement, foster children reported whether the caregiver "enjoys spending time with [them]," "does a lot to help [them]," "doesn't seem to have enough time for [them]," and "doesn't seem to know how [they] feel about things."

<sup>30</sup> For autonomy support, foster children reported whether the caregiver "trusts [them]" or "doesn't let [the children] make any of [their] own decisions."

<sup>31</sup> The most positive responses possible were "not at all true" or "very true," as appropriate.

<sup>32</sup> Child Trends' analyses also show that, compared with foster children in non-relative care under age 15, those in kinship care fare similarly on all the areas of well-being examined in this *Research Brief*, with only a couple exceptions: In two important health-related areas, children in kinship care look *better* as a group than children in non-relative foster care. Specifically, children in kinship care are *less likely* to have a limiting physical, mental, or health condition, particularly among those under age six; and to have been a patient overnight in a hospital or to have visited an emergency room. However, readers should note that these comparisons are descriptive; we did not account for other likely important differences between children in kinship care and those in non-relative foster care in our analyses.

<sup>33</sup> For a review, see Bridges, L.J., & Moore, K.A. (2002, September). Religious involvement and children's well-being: What research tells us (and what it doesn't). (Research Brief). Washington, DC: Child Trends. Available at: <http://www.childtrends.org/PDF/ReligiosityRB.pdf>.

<sup>34</sup> Blome. (1997); Brand & Brinich. (1999); Leathers. (2002); Marx, Benoit, & Kamradt. (2003).

<sup>35</sup> Refer to Adoption and Safe Families Act (ASFA) of

1997 (P.L. 105-89); full text link available at: <http://www.acf.dhhs.gov/programs/cb/laws/index.htm>

<sup>36</sup> Rosenfeld, et al. (1997).

<sup>37</sup> Barth, R.P., Wildfire, J., Green, R., & NSCAW Research Group. (2003). Child welfare and poverty: Using the National Survey of Child and Adolescent Well-being to explore the complexity of child welfare services involvement among poor and non-poor families. Presentation at the Joint Center for Poverty Research Conference on Child Welfare Services Research and Its Policy Implications. Washington, D.C., March 20, 2003.

<sup>38</sup> Barth. (2001).

<sup>39</sup> Orme & Buehler. (2001).

<sup>40</sup> Barth. (2001).

<sup>41</sup> Rosenbach et al. (2000).

<sup>42</sup> American Academy of Pediatrics. (2002). Health care of young children in foster care. *Pediatrics* 109(3), 536-541; Leslie et al.

(2002); Shonkoff, J., & Phillips, D. (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

<sup>43</sup> Rosenbach et al. (2000).

<sup>44</sup> Rosenbach et al. (2000); Marx et al. (2003); American Academy of Pediatrics. (2002).

<sup>45</sup> Marx et al. (2003).

<sup>46</sup> Chernoff et al. (1994).

<sup>47</sup> *Ibid.*

<sup>48</sup> For example, the Center for Community Partnerships in Welfare. See: <http://www.cssp.org/center/index.html> for more information.

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