Exploring Kinship Care: A Newly Recognized Age-Old Practice

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Abstract

This study explores the experiences of kinship caregivers in the North Region of British Columbia, paying particular attention to what those experiences tell us about their needs. It utilizes an exploratory case study design, using three sources of data: interviews with kinship caregivers, interviews with social workers, and file reviews. It looks at the types of children that are in kinship care and the types of families that provide kinship care. This study also explores the thoughts and experiences of the social workers who are facilitating kinship care placements. It closes with recommendations on changes in practice around kinship care as well as ideas around areas for future study.

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Acknowledgments

I'd like to begin by extending my gratitude to the 16 families who took time out of their busy lives to share their stories with me. I am humbled by your ability to give of yourselves. I'd also like to thank the social workers who took the time to meet with me and who make a difference in the lives of children and families every day. Thanks, too, to Robert Watts, who gave me the opportunity to research this valuable topic.

I want to extend my appreciation to my family – I couldn't have done this without each of you. Thanks to my husband, Mat, who supported me through the ups and downs of this journey and knew just what to say when I felt like it was too much. Thanks also to our children, Grace, Jenna, and Jake, for teaching me the intrinsic value and beauty of a child. My hope for each of you is that one day you get to fulfill your dream of writing your own "book". Remember that life is full of opportunities to learn and grow…and to give back. And thanks to my parents, Jackie, Lutz, Norm, and Diane, who filled in the gap when I couldn't be there for our kids. Thanks especially to my mom, Jackie, for first teaching me about the ties that bind us together.

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And thanks to God, our Creator – children are a gift from Him (Psalm 127:3). My hope is that we can honor this amazing gift by providing each of them with the care they deserve.

Chapter 1: Introduction

There are about nine thousand children in government care in British Columbia, approximately one thousand of those living in the North Region of British Columbia (O. Gill, personal communication, February 14, 2008). In the past decade, the Ministry of Children and Family Development (MCFD, the provincial child welfare authority) has for various social and political reasons increasingly shifted its focus to exploring ways for at-risk children to remain safe without entering the foster care system. This shift, which will be discussed in greater detail later in this chapter, has contributed to the rising use of out of care options by social workers, resulting in a growing number of children living in kinship care placements with friends or family members (F. Mossop, personal communication, February 12, 2008).

Rob Geen (2003a), one of the predominant writers and researchers on kinship care in the United States, contends that child welfare authorities are making a shift towards kinship care without the scientific research necessary to adequately support such a shift. While he supports kinship care, he claims that the practice guidance, support structure, and social worker base are lagging. Geen also claims that more in-depth research needs to be completed in order for us to implement kinship care programs effectively. This is the case in British Columbia, where the use of kinship care placements continues to increase, although virtually no research has been done on this subject in British Columbia, let alone in the unique geographical area of Northern British Columbia.

Research Purpose and Question

This thesis will focus on one primary research question and two sub-questions. The primary question will be, "What do the experiences of kinship caregivers in the North Region of British Columbia tell us about their needs?" It is important to note that the aim of this research is not only to look at the needs from a deficit perspective, but also to look at the needs which are being met, hopefully providing the readers with a picture of what is working and what could be improved. In order to provide a solid base from which to ask this question, two sub-questions will be explored: "What types of families are providing kinship care?" and "What types of children are being placed in kinship care?" If we are to continue using, and even increasing use of kinship care placements in Northern British Columbia, we have a responsibility to the children and families involved to increase our knowledge around kinship care.

Researcher Context

Motivation For Study

I was born and raised in Prince George, a city of about 80,000 people located in Northern British Columbia. I have spent fourteen years employed by the provincial government as a social worker in this city. I am a woman, I am French-Canadian Metis, and my passion as a mother and long-time adoption social worker is to contribute to the stability and healthy attachments of children. I strongly believe that we as a society have to come up with ways for children to stay more connected with family and to avoid moving from foster home to foster home.

For the past fourteen years, I've watched children come in and out of the British Columbia child welfare system. I've read child-in-care files that left me feeling raw, sad, angry, and impotent. I've seen young people turn 19 and, no longer covered under the foster care system, find themselves alone. As a mother, I've had children visit in my home who belonged to a foster family and a school and a community one day, and the next day, did not.

I provided short-term kinship care to a child and found this experience to be heartbreaking and rewarding. I bring all of these experiences to my journey as a researcher and acknowledge that they impact the lens through which I conduct this research.

I have watched kinship care being used increasingly within this region and my practice experience tells me that this increase is a good thing, but that it must occur with care. It seems like new ways of practice pass in and out of popularity, often, perhaps because they are used with little caution and then, when things don't go well, cease to be used at all. My hope is that the practice of placing children with kin will be used with care and, rather than passing out of popularity, will increase until all children who are unable to live with their birth parents will have the option of living with kin.

I have heard it said many times that Northern British Columbia (BC) presents a unique geographical (and therefore, living) situation for its residents. I believe it is important for research on kinship care to occur specifically in the North Region of BC and for that research to be made available to policy-makers so that they can create policy which fits the specific needs of this region's kinship caregivers. Perhaps most importantly, I believe it is important that those providing kinship care have an opportunity to put voice to their experiences and their met and unmet needs.

Finally, my experience as an adoption social worker has taught me that people who care for children who are unable to live with their birth parents require support. When that support is available, both families and children experience increased success. The goal of this research is to hear directly from kinship caregivers. As part of this goal, I will look at some of the experiences of kinship caregivers in other areas of the world and will compare these to kinship caregivers living in Northern BC.

Framework/Conceptual Lens

In describing the framework from which I conduct this research, I claim to operate from an Aboriginal perspective, recognizing the complexity of such a claim and the fact that it could hold different meanings for different communities and individuals. Aboriginal social worker Michael Hart (2003) writes "*tapwewin* (honesty) is required for true self reflection" (p. 300). In turn, *tapwewin* requires 'great care and careful consideration'" (Hart, 2003, p. 300). It is with these words that I begin my research on kinship care, recognizing that as an Aboriginal qualitative researcher, I need to hold myself to being honest with myself, my participants, and my audience.

For me, the word "Aboriginal" is loaded with a myriad of meanings and emotions. Growing up, I always knew I was of mixed French Canadian and First Nations heritage, but it wasn't until I reached adulthood and attached the word "Metis" to that reality that I really began to consider what it means for me to be an Aboriginal woman. Sometimes I feel like an imposter because I didn't grow up with any of the prejudices our society throws at that word and, even now, with my dark brown hair and fair skin, I am free to walk through this world with no more assumptions being made about me than the average 30-something woman.

Still, I find myself drawn inexplicably to Aboriginal belief systems, to the simple yet complex words of the elders, to the unabashed acknowledgment, even within the often staid world of academia, of the significance of spirituality. Perhaps I'm most drawn to the focus on the health of children because this, too, is the passion of my personal life, work, and education. Leroy Little Bear's (2000) words resonate for me: "Children are greatly valued and are considered gifts from the Creator. From the moment of birth, children are the objects of love and kindness from a large circle of relatives and friends" (p. 81). It's difficult for me not to consider the possibilities of a world where all of society embraced that belief. Ultimately, this research is about the health of children and about better understanding the needs of their caregivers so that they can go about the very important job of caregiving.

I am challenged by Linda Tuhiwai Smith's (1999) book on indigenous research and recall, at first reading it, rolling this question around in my head: am I a Métis researcher or am I a researcher who is Métis? To take that thought one step further: am I entitled to grapple with my role as an indigenous researcher? This issue is made more complicated by the fact that my research is not with Aboriginal participants per se; however, given the fact that Aboriginal children and families are so over-represented within the BC child welfare system, I believe it's fair to say that my research is, at least in part, Aboriginal research. Tuhiwai Smith writes about the complexities of insider-outsider research, noting that "there are multiple ways of both being an insider and an outsider in indigenous contexts. The critical issue with insider research is the constant need for reflexivity. At a general level insider researchers have to have ways of thinking critically about their processes, their relationships and the quality and richness of their data and analysis" (p. 137). Andrew Yellowjacket (personal communication, March 13, 2007) describes Aboriginal society as a series of concentric circles, with "child" being the center circle, encapsulated by "caretakers", then "storytellers", and finally "providers". This research on kinship care acknowledges the intrinsic significance of such a worldview, where children are the hub of a society and are protected and nurtured by the caretakers.

This research also takes into consideration the teachings of the medicine wheel, where the spiritual, emotional, physical, and mental must be kept in balance for whole health.

In facilitating this research, I aim to ask kinship caregivers about their experiences with an open mind, acknowledging my biases and assumptions, so that this research will hopefully give voice to their spiritual, emotional, physical, and mental needs and not just to my assumptions around those needs.

Definitions

The following key terms are used throughout this proposal:

a) *Aboriginal child:* A child who is registered under the *Indian Act* (Canada); who has a biological parent who is registered under the *Indian Act* (Canada); or who is under twelve years of age and has a biological parent who is of Aboriginal ancestry and considers her/himself to be aboriginal; or who is twelve years of age or over and considers her/himself to be aboriginal (Ministry of Children and Family Development [MCFD], 2003).

b) *Aboriginal Person*: A person who is registered under the *Indian Act,* who is of Aboriginal ancestry, or who considers her/himself to be Aboriginal.

c) *Care*: Physical care and control of a child (MCFD, 2003).

d) *Child*: A person between the ages of 0- and 19-years-old.

e) *Child(ren) in care*: Children who are in the custody, care, or guardianship of the provincial child welfare branch (MCFD, 1996).

f) *Continuing custody order*: An order under the CFCSA that places a child in continuing custody (MCFD, 2003).

g) *Custody*: Includes care and guardianship of a child (MCFD, 2003). A person who has custody is responsible for the day to day care and control of the child and decisions included with that.

h) *Fetal Alcohol Spectrum Disorder (FASD)*: A continuum of birth defects caused by maternal use of alcohol during pregnancy.

i) *Formal kinship care:* The parenting of children by kin as a result of determination by the court and the child welfare agency that a child must be separated from her/his parents "because of abuse, neglect, dependency, abandonment, or special medical circumstances" (CWLA, 1994, p. 3).

j) *Foster Care*: A foster home is "a substitute family setting that has met the criteria set out by a child welfare agency and is able to provide foster care services for a child in the care of that agency" (Fouhse, 2007, p. 10).

k) *Guardianship*: Includes all the rights, duties, and responsibilities of a parent (MCFD, 2003) including the ability to make both major and minor decisions about the child.

l) *Informal kinship care:* Kinship care which is arranged by parents or relatives where there are no concerns around safety and protection that have been brought to the attention of the child welfare system (CWLA, 1994).

m) *Kin:* One's relatives collectively; family; kindrid; kinsfolk (Morris, 1982). In this proposal, the meaning of the word "kin" is extended to include "any relative, by blood or marriage, or any person with close family ties to another (Takas as cited in Scannapieco & Hegar, 1999).

n) *Kinship:* The state of being kin or related by blood (Morris, 1982).

o) *Kinship Care*: "The full-time nurturing and protection of children who must be separated from their parents by relatives, members of their tribes or clans, godparents, stepparents, or other adults who have a kinship bond with the child"

(Child Welfare League of America [CWLA], 1994, p. 2). In this proposal, the term "kinship care" will include only formal kinship care arrangements.

p) *Kinship Caregivers*: Those adult caregivers involved in the "full-time nurturing and protection of children who must be separated from their parents by relatives, members of their tribes or clans, godparents, stepparents, or other adults who have a kinship bond with the child" (CWLA, 1994, p. 2).

q) *Neonatal Abstinence Syndrome (NAS):* A group of problems a baby experiences when withdrawing from drugs used by its mother during pregnancy.

r) *Out of Care Options*: Choices for permanency which include family preservation, kinship care, family reunification, foster-to-adopt, adoption, transfer of custody, and adult mentorship (MCFD, 2003).

s) *Restricted foster care:* A restricted foster home is a foster home where foster parents who are approved to care for a specific child with whom they have a previous relationship.

t) *Reflexivity:* The researcher is "conscious of the biases, values and experiences that he or she beings to the qualitative research study. Typically, the writer makes this explicit in the text" (Creswell, 2007, p. 243-244).

Locating the Study Within the British Columbia Context

According to the 2006 census, British Columbia has a population of 4,113,487 people and a land area of 924,815 km (Statistics Canada, 2006). Of that population, 196,070, or approximately 4.8%, self-identify as being Aboriginal. Interestingly, more than half of the population of BC resides in the 2,877 km that make up the Vancouver Census Metropolitan area (and includes Vancouver as well as cities such as New Westminster, Maple Ride, and

Langley). The other half of BC's population lives in the remaining 99% of the land area, resulting in a highly urbanized, densely populated southern area and a largely rural, more sparsely populated northern area.

As stated previously, this study was conducted in Northern BC. Because the participants have by definition had contact with the provincial child welfare authority, the MCFD region designated as the "North Region" has been used as the geographical boundary for this study. Generally speaking, this region covers everything North of the city of Quesnel, including the Queen Charlotte Islands. It includes a land area of 617,284 km (66.7% of the BC total) and has a population of 309,848 (7.2% of the BC total) (Health Authority, 2008). Out of the five regions in BC, this region has, by far, the largest percentage of population which self-identifies as Aboriginal (15.6%). It has the largest percentage of adult population receiving income assistance, the lowest life expectancy at birth, the highest unemployment rate, and the highest percentage of children in care (Health Authority, 2008). Although these statistics may seem dismal, as a life-long resident of BC, I can attest to the fact that this beautiful region is home to many people who, despite the geographical constraints of their communities, continue to thrive.

Legislative and Policy Context

Legislation

As stated previously, the child welfare authority in BC is the Ministry of Children and Family Development (MCFD). Within MCFD, formal kinship care arrangements are guided by the *Child, Family, and Community Service Act* (MCFD, 1996). This Act states under its "Guiding Principles" that the "safety and well-being of children are the paramount considerations" and goes on to say:

> children are entitled to be protected from abuse, neglect, harm or threat of harm; a family is the preferred environment for the care and upbringing of children and the responsibility for the protection of children rests primarily with the parents...kinship ties and a child's attachment to the extended family should be preserved if possible (p. 9).

It is interesting to note that, while the *Child, Family, and Community Service Act* was implemented in 1996, it wasn't until 2002 that MCFD amended the Act to include provisions for out of care options. This ability to enter into kinship care agreements with birth parents is found under Section 8, Section 35(2)(d), and Section 41.1(b). Which section is used in a particular situation depends on the child's current legal status (Appendix A).

Section 8 placements are often referred to as "Kith and Kin" placements and are used when a child must be removed from her/his birth parents and a relative or other significant person in the child's life is able to care for the child. Section 8 placements are agreements that occur between a parent and a caregiver and are done without the child coming into care. Although MCFD may provide funding, the government does not have either guardianship or care and custody. Due to MCFD's somewhat arm's length relationship with those involved in Section 8 Agreements, social workers have slightly different requirements than they would with a Section 35(2)(d) or 41.1(b) placement. For example, they do not have to actually see the child placed through Section 8 Agreement, but do for Section 35(2)(d) or 41.1(b). In addition, Section 8 Agreements occur with parental approval, whereas Section 35(2)(d) and 41.1(b) do not require parental approval. Section 8 Agreements also follow a different format than those made under Sections 35(2)(d) and 41.1(b).

Placements under Section 35(2)(d) and Section 41.1(b) are made following a removal when a child is placed in custody of a person other than a parent under MCFD supervision. Section 35(2)(d) is used during a presentation hearing to give interim custody and Section 41.1(b) is used during a protection hearing to give temporary custody. Many different stipulations can be included in the supervision orders which are attached to these agreements, depending on the particular situation of the family involved (Appendix B).

All three of these options have time-lines which restrict the amount of time that they can be used: the initial length of the agreement must not exceed 6 months and the total length of the agreement must not exceed 12 months for a child 5 years of age and younger, 18 months for a child older than 5 but younger than 12, and 24 months for a child over the age of 12 (CFCSA, 2002). Social workers can, however, apply to court for an extension and must demonstrate that the extension would be in the child's best interests.

Other out of care options exist as well, although they do not fall under the umbrella of "kinship care". Child in Home of Relative (CIHR) is a program run through the Ministry of Employment and Income Assistance and is intended for use when there are no child protection concerns and family members require funding in order to care for a child. Section 54.1 agreements (discussed earlier) can be made under the CFCSA with children who are continuing custody wards and result in a permanent transfer of custody to the caregiver. While these options will not be discussed in detail in this report, it is important to know that they exist within the continuum of out of care options.

In BC, it has long been possible to place children with their friends and family under the Family Relations Act (FRA); however, this Act does not allow the government to subsidize this transfer of custody (Cradock, 2007). Historically, when families required funding, they were designated "restricted foster parents" (due to the fact that they were only approved to care for a particular child or children) and given the regular foster care rate. Kinship care agreements were seen as falling somewhere in between these two: the government has more involvement (including the ability to provide funding) than it would under the Family Relations Act, but less involvement (and incidentally, less funding) than it would when families were designated as restricted foster parents. This situation provides its own dilemma: if the government is providing funding for private family placements does it have a responsibility to monitor and support those placements?

Legislation and Policy Regarding Funding

It is noteworthy that the CFCSA addresses the level of responsibility that the government has in supporting the out of care options in its Act, stating that a director "may…provide preventative and support services for families to promote the purposes of this Act" (Ministry of Children and Family Development, 1996, p. 60). Clearly, within this Act there is choice given as to whether or not the government will provide financial support. Also of interest is the fact that policy varies greatly regarding the amount of financial support allowed for each program. Kinship caregivers [Sections 8, 35(2)(d), and 41.1(b)] can apply for a monthly payment of $532.08 and CIHR caregivers are eligible for between $257.46 and $454.32, depending on the age of the child (Rate changes, 2008). Both regular foster caregivers and those who have custody under Section 54.1 are eligible for a payment of between $780.40 and $887.76, while specialized foster care homes can receive up to $4,826.82 for two children (R. Poirier, personal communication, November 24, 2008).

Also interesting is the fact that various provincial and federal policies affect this funding so that the actual dollar amounts that caregivers end up with at the end of the year are vastly different. For example, the kinship care payments are taxable income, whereas the foster care payments are not. Children in foster care also receive other benefits such as full medical and dental coverage. The kinship care program in the North Region BC requires social workers to explore options with caregivers rather than making medical and dental coverage automatic. If the kinship caregivers cannot provide their own medical coverage, two options are available. If either birth parent has a Family Service (FS) file, the child's medical can be covered through it; if not, the only remaining option is for social workers to reimburse for medical services on a case by case basis. Dental coverage is even more difficult to obtain as it can not be paid for off of a FS file. The BC government has a Healthy Kids Program which allows for coverage of up to $700 a year per child and caregivers are instructed to access this program.

Policy Regarding Collaborative Planning

Recently, changes have taken place within MCFD policy that are intended to increase the involvement of families in decision making for their children and one could argue that these will conceivably increase the use of kinship care options. For example, in June of 2008, the "Presumption in Favor of Collaborative Planning and Decision Making" guidelines were introduced to social workers in the North Region. These guidelines make it mandatory at certain points in the legal process for social workers to offer families the option of a Family Group Conference (FGC) or Mediation, or the option of following a cultural and/or traditional decision-making model (MCFD, 2008). These three options are described as "shared decision making models" where "families have a central role in case planning" (MCFD, 2008, p. 1). It stands to reason that, when families are involved in making placement decisions around their children, they will be more likely to advocate for them to live with family or friends than in a foster home, thereby increasing the use of kinship care options.

Policy Regarding the Approval Of Kinship Care Homes

MCFD social workers in the North Region are able to access a substantial amount of information regarding out of care options online (for example, refer to Appendix C). This information includes instructions on subjects such as how to assess kinship care homes, how to initiate payment, and how to complete a criminal record check. Requirements for a family assessment include a homevisit, a check through MCFD's electronic records (called a Prior Contact Check, or PCC), and two references, one of them from a relative (Appendix D). Social workers follow a format when completing the assessment and are able to add information as needed (Appendix E). Clearly, the legislation and policy around kinship care has evolved in the North Region of BC.

Thesis Outline

This thesis consists of five chapters. Chapter One provides the introduction, including information on the research question, the researcher context, and legislative/policy context. It also provides definitions of numerous words which are used in the following chapters.

Chapter Two provides the literature review. It offers information on the history of kinship care in various regions of the world and looks at kinship care within the context of Aboriginal peoples and history. It provides an overview of the characteristics of the caregivers and children involved in kinship care and then looks at the needs which arose out of the literature.

Chapter Three provides the research methodology. In it, I discuss my research approach and design and provide details on the participants, data collection, and data analysis. I also discuss the limitations of this study as well as the ethical considerations. I close with a look at the evaluative criteria used in this study.

In Chapter Four, I discuss my findings. This chapter focuses on the three data sources used in this thesis: interviews with the kinship caregivers, interviews with the social workers, and file reviews. In this chapter, I look at the characteristics of the kinship caregivers and children in my sample and then discuss the experiences of the kinship caregivers, with a particular focus on existing and needed supports. I then close with a brief look at the information social workers provided to me on the kinship care system.

Chapter Five contains my conclusions. In it, I compare my findings to those of the literature, discuss the children and kinship caregivers in my sample, and then offer my conclusions on existing and needed supports. This chapter concludes with a look at my suggestions for further areas of research.

Chapter 2: Literature Review

In this literature review, I will offer an historical look at the use of kinship care around the world. I will discuss some of the issues surrounding BC's Aboriginal population and will then provide a literature-based profile of kinship caregivers and of children living in kinship care. Finally, I will discuss what the literature tells us about the experiences of kinship caregivers around their met and unmet needs.

History Of Kinship Care

Kinship care is an age-old, world-wide practice. Early examples of children being raised by friends and family members can be found in the Bible and in early mythological tales (Hegar, 1999a). Kinship care has been and continues to be a central aspect of First Nations culture (Shoemaker as cited in Hegar & Scannapieco, 2000). Fournier and Crey (1997) note that, traditionally, there was no greater dishonour for an Aboriginal family than when it couldn't look after it's younger members; when this was the case, the surrounding community stepped forward to share in the raising of the child(ren). This responsibility of assuming the care of relatives' children was both implied and overtly stated in the oral traditions and teachings of most tribes (Johnson as cited in Geen, 2003a). In traditional Hawaiian practice, the grandparents had a greater claim over the children than the birth parents, who had to request permission to raise a child themselves (Hegar & Scannapieco, 2000). West Africa is also noted as a centre of kinship care, although there the term is not always associated with families being in crisis and West African children have historically been cared for by friends and family members for complex and diverse reasons (i.e. to learn a trade or to help in the home of a caregiver) (Castle as cited in Hegar & Scannapieco, 2000).

Attitudes regarding adults caring for children who were their kin, flowed from Europe to North America. In European history, children who could not be cared for by their parents were often sent to almshouses and workhouses, forced into apprenticeships, or made to emigrate (Hegar, 1999b). Relatives were also often expected to help out with child rearing. For example, the Elizabethan Poor Law of 1603 made it mandatory for grandparents to take responsibility for dependent children and this law was later extended into the American colonies (Hegar & Scannapieco, 2000), where the family and extended cultural community were relied upon when social problems arose. When orphanages were built, it was primarily due to wars and epidemics which had wiped out families and communities (Hegar, 1999b).

Many changes took place between the 1950s and present-day which increased the prevalence of kinship care placements in North America. One of these involved the emerging idea amongst theorists and researchers in the 1950s that there is an irreplaceable bond between a mother and her child and it is damaging to the child to break that bond (Bowlby as cited in Takas & Hegar, 1999). Then, in the 1960s, foster care began to transform as social changes took place such as it becoming more common for both parents to work outside of the home (Takas & Hegar, 1999). The result was that there were fewer foster homes available to children in care. During that same period of time, child protection guidelines were created which defined child abuse and neglect, reporting policies, and intervention strategies (Hutchinson as cited in Davidson, 1997). The guidelines, which began with the good intention of better protecting children, resulted in them coming into care at a greatly increased rate, many never returning home and instead living in multiple foster care placements (Davidson, 1997). In addition, a 1993 study by Bullock, Little, and Milham found that the majority of children and adolescents who are separated return to their parents or extended family members after leaving care (as cited in MCFD, 2003b). Just as society was gaining a new, deeper understanding of the importance of promoting family ties, there were an increasing number of children in the child welfare system and decreasing foster homes available. For example, in the United States there were 276,000 child in care in 1985 and 442,000 by the end of 1992. Meanwhile, the number of foster families decreased by 27% between 1985 and 1990 (CWLA, 1994). Several authors suggest that the increase in kinship care placements in North America resulted directly from this combination (CWLA, 1994; Scannapieco, Hegar, & McAlpine, 1990).

The increase in kinship care placements has followed similar trends in various areas of the world. In the United Kingdom, between 1996 and 2000 the number of children in care increased by 13% while the number of children in formal kinship care increased by 32% (Department of Health, as cited in Broad and Skinner, 2005). In the United States, the percentage of children placed in kinship care placements increased from 18% in 1986 to 31% in 1990 (Kusserow as cited in Geen, 2003a). In Australia it's the most common form of placement for Indigenous children and in some Australian states it's a more common form of placement for all children than foster care (Spence, 2004).

While British Columbia has been impacted by the historical shifts noted above, it also presents us with its own unique history around kinship care. Cradock (2007) notes that the decade of the 1990s "was a time of great turmoil for British Columbia's child welfare system (p. 17). As a result of the Gove report and a greater public focus on child welfare practice, the number of children in care in British Columbia rose significantly, from 7,278 in 1995/96 to 9,435 in 2001/02 (MCFD, 2003). Two diverging opinions arose regarding the focus social work practice should take: a "child-centered" approach or a "least intrusive" approach

(Cradock, 2007, p. 22). Kinship care was seen as a midpoint between these two: inherent in it was an acknowledgment that some parents are unable to care for their children as well as a recognition that family members should not be precluded from providing that care.

Previously, the emphasis in North America on early parental attachments and the acknowledgement that foster care drift was detrimental to a child's health was discussed. A change which resulted in British Columbia, in part due to these larger societal shifts, was a focus on permanency planning for children which began in the late 1990s and continues to this day. The provincial government began to promote the idea of "securing a safe, caring, legally recognized and continuous family outside government care" (MCFD, 2003, p. 3) and put laws into place which made more allowance for kinship care placements. While the Family Relations Act had for some time made it possible to transfer custody between friends and family members, it was the 1996 Child and Family Community Services Act that provided a way for the provincial government to financially subsidize those placements; interestingly, though, the parts of the act which allowed for service agreements with a child's kin were not implemented until 2002 (Walmsley, 2005). Prior to this act, family members were able to provide care by applying to become restricted foster parents and were eligible to receive the lowest foster care rate available (Cradock, 2007). The child, however, remained in care and continued to be the responsibility of the child welfare branch of the provincial government. Cradock (2007) argues that finances were an enormous incentive for the provincial government to promote the idea of kinship care placements: a foster home with children with exceptional special needs could receive up to $10,000 a month, a regular or restricted foster home could receive just over $700 and a kinship care home would receive $450. A new focus on out of care options emerged.

Across British Columbia, as elsewhere in North America, kinship care placements have been on the rise. For example, in August 2002 there were no Kith and Kin (Section 8) placements while by August 2007, there were twenty-seven (O. Gill, personal communication, September 19, 2007). These numbers have risen due to an intentional plan on the part of MCFD to increase the number of children in kinship care placements and decrease the number of children in foster care.

This somewhat brief history shows that, although kinship care has been known to many societies for centuries, it's relatively new within formal systems of child welfare (Connolly, 2003). Scannapecio (1999) contends that kinship care, as a formal placement plan, gained acceptance and usage so quickly that practice models have not been able to keep pace and meet the unique needs of the people providing kinship care. This idea will be discussed further in this thesis.

Aboriginal People in British Columbia

When one thinks about kinship care in British Columbia, it is difficult not to consider it in the context of First Nations history, especially given the fact that First Nations people have traditionally used a fluid system of kinship care within their communities. This topic gains additional importance when one considers that, of the approximately one thousand children in government care in British Columbia, over 750 of those are of Aboriginal ancestry (O.Gill, personal communication, February 14, 2008). Additionally, research has shown that Aboriginal children are more likely to become continuing care wards than non-Aboriginal children (MCFD, 2003), come into care at a younger age, stay longer, and are frequently placed outside their own culture (Rosenbluth as cited in MCFD, 2003).

At the time of European contact, approximately one-third of the First Nations people in Canada lived in British Columbia (Duff, 1997). It's important to note that these people did not make up a homogenous group, but consisted of numerous distinct cultures which were "large, proud and well-organized" (Duff, 1997, p. 61). Duff describes ten diverse groups which can further be broken down by language differences into twenty-six groups. Although the exact population of Aboriginal people at the time of contact is unknown, it's clear that those numbers rapidly declined after contact for a variety of reasons which won't be covered in this literature review.

The British North America Act was enacted in 1867; this act gave responsibility for the education of First Nations children to the Federal government. The result was the establishment of 80 residential schools across Canada by 1931 (Walmsley, 2005). Many Aboriginal children went to live in the residential schools, away from their kinship ties and, by the late 1940s, several generations of children had returned from residential schools as poorly educated, angry, abused adults who had no parenting experience (Fournier & Crey, 1997). In 1951, changes were made to the Indian Act which gave increased responsibility for Aboriginal health, welfare, and education to the provincial governments (Fournier & Crey, 1997) and by the following year, the province of B.C. had begun to provide services to Aboriginal people in "matters related to delinquent children, unmarried mothers, and adoption cases" (Stanbury as cited in Walmsley, 2005, p. 20). By the 1960s, residential schools began to be closed. It was during this transition period that the number of Aboriginal children in the child welfare system rapidly increased: there were 29 in 1955, 849 in 1960, and 1446 in 1964 (Walmsley, 2005). Walmsley (2005) suggests that this increase is primarily due to three changes: 1. The federal policy of integrating non-Aboriginal and

Aboriginal children into the same schools, which resulted in more children being moved home or close to home; 2. The extension of child welfare laws to reserves (discussed previously); and, 3. The liberalization of liquor laws after a century's worth of restrictions which resulted in more drinking and in less secretive drinking. It's also worth noting, from the previous section on the history of kinship care, that these changes occurred during roughly the same time as the changes in child protection guidelines which resulted in more children in general coming into care.

Over the next four decades, changes were gradually made within the British Columbia child welfare system which acknowledged the importance of kinship ties and, by extension, culture, to Aboriginal children. Some would argue that this process was very slow. For example, while one of the primary recommendations of the 1972 Berger Commission Report was that there should be "increased participation and representation of Aboriginal persons in human service decision making", this recommendation was not incorporated into the 1981 Family and Child Services Act (Walmsley, 2005, p. 23). The 1996 Child, Family, and Community Services Act brought about some additional reform regarding Aboriginal children and families, but, as mentioned previously, it's more progressive parts, such as the section of service agreements with a child's kin, were not implemented until 2002 (Walmsley, 2005).

Although British Columbia's Aboriginal population rapidly decreased after contact, it has been on the increase since the 1920s (Duff, 1997). The 1893 census gave the total Aboriginal population as 25, 618 (Duff, 1997). According to the 2006 Canadian census, that number is now 196, 070 (Statistics Canada, 2006). It's important to note when comparing these numbers that the 2006 census included all Aboriginal people (First Nations, Métis, Inuit), including people who self-identify as being Aboriginal, so cannot be directly compared to the 1893 number; however, clearly the Aboriginal population in British Columbia is on the rise. It's also interesting to note that the Aboriginal population is a young population, with 30% of Aboriginal people being between the ages of 0 and 14, while only 17% of non-Aboriginal people fall into that age group (BC Statistical Profile of Aboriginal Peoples, 2001).

British Columbia's Aboriginal population is not as healthy as its non-Aboriginal population. While the Aboriginal birth rate is twice as high as the non-Aboriginal birth rate, infant mortality rates are 11 per 1000 births, compared to 6 per 1000 for the rest of the population (Webb & Arnott, 2001). In 1990, First Nations people had an average life expectancy seven years lower than that of the non-First Nations population. They are more likely to have hearing, sight, and speech disabilities and twice as likely to have a long-term disability. In addition, AIDS/HIV is increasing at a greater rate among Aboriginal people than non-Aboriginal (Webb & Arnott, 2001). Aboriginal people are also much more likely to experience poverty, lack of education, dreary and overcrowded housing, incarceration, and substance abuse (Webb & Arnott, 2001).

As a person who has worked with many Aboriginal people and communities in Northern British Columbia in the past 14 years, my perception is that the health of the families and communities is increasing every year. Webb and Arnott (2001) note that "a source of strength for Aboriginal people is the continued connections between family and community", making the topic of kinship care and Aboriginal communities very timely (p. 12).

In the next section, I will discuss what the literature has to say about the types of families that are providing kinship care and the types of children that are in kinship care placements. I will then provide a summary of what the experiences of kinship caregivers tell us about their needs. It's important to note that most of the empirical literature on kinship care involves a comparison between formal kinship care and foster care. Also, although generalizations can be drawn from the studies, much of the research was done in specific geographical locations and therefore seems to most accurately capture the situation in the area from which the sample was drawn.

Characteristics of Kinship Caregivers

Compared to regular foster parents, kinship foster caregivers are older, more likely to be single, have a lower level of formal education, and are more likely to be in "fair/poor" health (Berrick, 1998). They also have a lower average level of income (Berrick, Barth, & Needell, 1994; Brooks & Barth, as cited in National Abandoned Infants Resource Centre [NAIRC], 2005; Pecora, Le Prohn, & Nasuti, 1999). The majority of kinship foster caregivers in the United States are people of color, while the majority of foster parents are Caucasian (Berrick et al., 1994; Pecora et al., 1999). They are most often a grandparent (48%) or an aunt/uncle (44%), and most likely a relative of the biological mother (73%) (Holtan, Handegard, Ronning, & Sourander, 2005). Kinship caregivers are also most likely to be women (Berrick et al.1994; Pecora et al., 1999).

Studies have shown that the mental health of kinship caregivers is not as good as that of the rest of the population. Fuller-Thomson and Minkler (2000) showed that grandparent kinship caregivers are at increased risk of depression and those raising children who they identify as having neurological, physical, emotional, or behavioural problems may be the least likely to seek support. Baker (2000) points out that grandparents are often in a state of crisis due to the fact that crisis usually precedes them taking over the parenting role, and are often experiencing stress over not knowing if their adult child will have more children or will become able to resume parenting their child/ren. He also points out that the familial component of some disorders may mean that the caregivers (in this case, grandparents) also struggle with them. For example, the schizophrenia/bipolar disorder/ADHD that contributed to a parent being unable to care for their child can potentially be found in the child and/or kinship caregiver. Musil (1998), meanwhile, showed that grandparent caregivers tend to report relatively high anxiety.

Kinship caregivers consistently receive fewer services from their local child welfare agency than foster caregivers, including respite care, counseling, and social worker visits (Berrick et al., 1994). Research suggests that social workers visit kinship care homes less often than foster homes for a variety of reasons including thinking the child is safe, feeling uncomfortable about intruding on family life and/or misinterpreting policy (Meyer & Link as cited in Berrick, Needell, & Barth, 1999).

According to Gaudin and Sutphen (as cited in Berrick, 1998), kinship caregivers provide a similar level of safety, support, and supervision to children as do foster parents; foster homes provide a somewhat higher standard of caregiving environment, but both kinship care homes and foster homes fall into an “average quality of care” range (p. 79).

As stated previously, some of the research on kinship caregivers is contradictory, perhaps due to the fact that these studies have been conducted in very diverse areas. For example, while the findings from the National Survey of Child and Adolescent Well-being suggested that kinship caregivers are significantly older than non-kin foster parents, contrary to some other studies, it did not find significant differences in marital status, employment, education, physical/mental health, or income (National Survey of Child and Adolescent Well-Being [NSCAW], 2003).

Characteristics of Children in Kinship Care

Gordon, McKinley, Curtis, and Satterfield (2003) found that the majority of the children in kinship care were brought into care due to substance abuse, incarceration, HIV/AIDS, and housing instability. Broad's (2002) research yielded similar results, indicating that the majority of the children were in kinship care due to child protection issues (often stemming from the substance abuse of the parent), the inability of a previous caregiver to cope, and the difficult behaviour of the child. Dolbin-McNab (2006), meanwhile, found comparable results, concluding that children are typically in kinship care due to parental substance abuse, abuse/neglect/incarceration, HIV/AIDS, mental illness, divorce, and death.

Children in kinship care have medical, emotional, and behavioural needs much higher than those of children in the general population; however, there is a great deal of debate regarding how their needs compare to those of children in foster care (Berrick, 1998). Berrick et al. (1994) found that children in kinship care have medical and dental needs that are similar to those of children in foster care and Dubowitz (as cited in Berrick et al.) found these children to have much higher rates of asthma, anemia, and vision and dental problems than American children in general. However, some studies have shown that the medical, emotional, and behavioural problems of children in kinship care are somewhat lower than that of children in foster care (Holton et al., 2005). In any case, they are at high risk for having difficulties such as bed-wetting, nervousness, bipolar disorder, and learning disabilities, and Attention Deficit (Hyperactivity) Disorder (NAIRC, 2005) and are often in high-arousal due to stress associated with estrangement from their birth parents (Johnson-Garner & Meyers, 2003).

Research has shown that children in kinship care experience fewer placements and breakdowns than had children in regular foster care (Holton et al., 2005; Berrick et al., 1994). For example, of the children who entered California's foster care system in 1988, 23% of those placed with kin moved on to live in another placement, while 58% of those living in foster homes experienced at least one more placement during a 3.5 year period (Berrick et al. as cited in CWLA, 1994). They are more likely to be younger children than older children, but research suggests that "kinship care is increasingly being used for all age groups" (Spence, 2004, p. 266). They also remain in care for longer periods of time than children placed in foster care and experience reunification rates which are slower than those children; similarly, they are less likely to be adopted, possibly because their caregivers already family as well as that they don't want to interfere with the birth parents; however, these caregivers are also more likely than foster parents to commit to raising the children to adulthood (Berrick et al., 1994). On the other hand, children in kinship care have more contact with their birth parents and therefore experience more consistency in relationships (Holtan et al., 2005).

Research suggests that children in kinship care placements are likely to be non-Caucasian. A study of 600 children in kinship and foster care showed that, of the children in kinship care, 46% were African-American, 32% were Caucasian, 14% were Latino, and 9% were from other ethnic groups (Berrick et al. as cited in CWLA, 1994). Another study out of the United States indicated that African American children are more than four times as likely to be in kinship care settings as Caucasian children (NAIRC, 2005). A 1989 study of

524 children in kinship care in Baltimore found that 90% were African-American and the rest were Caucasian (Dubowitz as cited in CWLA, 1994). Further, research has shown that, once children of black and mixed ethnicity enter the child welfare system, they remain in care for longer periods of time and have a tendency to have less stable placements than Caucasian children (Broad & Skinner, 2005).

In keeping with the research on kinship caregivers and finances, Ehrle and Geen found that 39% of children in kinship foster care live in households with income below the poverty level, compared with 13 % of children in non-kin foster care (as cited by Geen, 2003b). Interestingly, other studies have concluded that the vast majority of children feel "loved" by their kinship caregivers and say they are "happy" with the living arrangements (Wilson and Conroy as cited in Geen, 2003a).

What the Experiences of Kinship Caregivers Tell Us About Their Needs

A great deal of literature on kinship care explicitly looks at the needs of kinship caregivers and, consistently, researchers contend that kinship caregivers should receive increased services. Berrick et al. (1994) make a case for this increase very clearly, stating that "if we are to assume that kinship (caregivers), who themselves are older, in more fragile health, and less financially stable, will be able to care for these very difficult children with fewer financial and concrete supports than foster parents, then our expectations are unrealistic" (p. 59). The next section will take a look at some of these needs.

Need For Financial Support

Not surprisingly, the challenge to kinship caregivers that is most often noted in the literature is that of finances (Broad, 2002; Laws & Broad, 2000). As previously stated, the majority of studies on kinship caregivers have found that they are older, have less education, make less money, and live with poorer health than foster parents. Perhaps it goes without saying that the financial strain of adding another child to a family already struggling with these issues could be tremendous. Unlike foster parents, they usually have received little, or no, advanced notice and may not have had a chance to prepare for the placement by buying things such as a crib and a car seat (Geen, 2003a). Kinship caregivers are generally paid less money than licensed foster or group homes (Henderson & Cook, 2005). They are also often unaware of other sources of financial assistance such as housing assistance and scholarships (Washington State Institute for Public Policy, 2002). Some kinship caregivers who have been in receipt of benefits, while valuing the assistance, have expressed frustration with the difficulty involved in obtaining additional assistance for specific needs such as medical expenses (Spence, 2004). Interestingly, a study done by Testa and Slack (2002) found that placement stability is enhanced when kinship caregivers receive the full foster care subsidy.

Templeman (2003) points out that the concept of paying kinship caregivers the same amount as foster caregivers isn't quite as simple as it sounds. To begin with, foster caregivers are required to complete training and to have a home which follows certain requirements (i.e. in B.C., each child/sibling group in foster care must have a separate bedroom with a window or an alternate exit). There is some controversy over whether or not kinship caregivers should need to follow the same stringent guidelines, especially if they are to be paid the same rate as foster parents. Does it matter if you're sleeping on a couch if that couch is at grandma's house? There are also concerns that, if kinship caregivers are paid the foster care rate, this will provide an incentive to birth parents to have their children enter kinship care arrangements. In addition, some people worry that kinship caregivers who are provided with funding upon placement won't have an incentive to complete training

(Templeton, 2003). Finally, there are generally mixed feelings in society over whether or not family should be given pay in order to care for their own.

Need For Equal Treatment and Respect

A related topic has involved the perceived disparity between the treatment of foster parents and kinship foster caregivers, as often evidenced by their difference in pay: as mentioned, in many areas of the world, kinship caregivers receive substantially less pay than regular foster caregivers. When states were surveyed by the Office of the Inspector General regarding their kinship care practices, the policy in the majority of states was that relatives would not be excluded from any services which were available to foster homes; however, the study showed that, while kinship caregivers were not systematically excluded from the services, child welfare offices often had the authority to limit services to kinship caregivers and did so (Berrick et al., 1999). Although the ensuing disparity in pay may seem to be a purely financial issue, to many kinship caregivers it symbolizes a lack of recognition and respect for the services that they provide.

Kinship caregivers state that they would like to be treated with respect and appreciation for choosing to accept a responsibility that was not originally theirs (Mayfield, Pennucci, & Lyon, 2002). As stated previously, kinship caregivers consistently receive fewer services from their local child welfare agency than foster caregivers (Berrick et al., 1994), signalling more discrepancies between the treatment of non-kin and kin caregivers.

Interestingly, it's not just the rate of pay that impacts whether or not kinship caregivers feel respected. One study showed that grandmothers providing kinship care preferred receiving a foster payment over a welfare payment due to the stigma attached to receiving social assistance (Berrick et al., 1994). In British Columbia, this could perhaps be compared to kinship caregivers receiving a "Child In Home of Relative" payment (which is issued out of a social assistance office) versus a regular foster payment (which is issued out of a resource office, often by direct deposit into the caregiver's bank account).

Need for Respite

A topic that surfaces repeatedly in the literature is the need for kinship caregivers to receive respite. This need especially makes sense when we consider the profiles of the average kinship caregiver and child in kinship care. For example, many kinship caregivers are grandparents who have been gearing up for retirement and then have to assume 24-hour care of a child (Broad & Skinner, 2005). It also makes sense when one considers that the care of a child often occurs quite suddenly for kinship caregivers, with no time to plan for childcare beforehand; in addition, kinship caregivers report a difficult time locating childcare and many report having to quit their jobs because they cannot find affordable childcare (Geen, 2003b).

A study done on factors associated with positive well-being in grandparent kinship caregivers found that there was a positive correlation between respite care and well-being (Sands, Goldberg-Glen, & Thornton, 2005). It makes sense that if the caregiver experiences general well-being, that will impact positively on the care and well-being of the child.

Need For Education/Information

Across the United States, there are various requirements for the training of kinship caregivers. Some states require no training, others are developing training specific to kinship caregivers, and still others require kinship caregivers to complete the regular foster training (Templeton, 2003). The need for more training for kinship caregivers surfaces throughout the literature, taking on several different forms. For example, kinship caregivers often report a need for information on parenting. We've discussed the fact that kinship caregivers are often grandparents (parenting for the second time) and care of the child/ren is often thrust upon them in a time of family crisis. When this happens, they may have to learn parenting skills they haven't used in years and may need to learn updated information on current parenting practices (i.e. non-physical ways of child discipline), child development, and the particular special needs of their child/ren (Dolbin-MacNab, 2006).

Kinship caregivers often also don't have an adequate understanding of the legal system and their child's legal status. A focus group conducted out of Maryland showed that most caregivers didn't understand the legal status of the children in their care, for example the difference between having "custody" and "guardianship" of the child. Many others indicated that they hadn't been informed of the permanency options for the child/ren in their care (Gordon, et al., 2003).

In addition, because kinship caregivers have not typically worked in the foster care system, they often have a very limited understanding of the child welfare system: for example, what to expect of their social worker, what is expected of them, and what to expect of the court system (Geen & Malm, 2003). It has been suggested that if they received training in these areas, they would feel less frustration towards "the system" that they find themselves working within.

Need For Assistance in Obtaining Housing

Another need often mentioned by kinship caregivers is assistance with obtaining reasonably-priced, adequate housing. Given the profile of the average kinship caregiver and the fact that they are often taking in more than one child, it makes sense that they might need assistance in finding housing with more space at a price they can afford.

Although inadequate housing can also be an issue in a child's home or in a foster home, the difference is that there are rules for foster caregivers around living accommodations (Broad & Skinner, 2005). If these same rules were applied to kinship caregivers, they would preclude many kinship homes. Broad and Skinner make a case for government not increasing regulations, but providing additional funding to kinship caregivers for adequate housing when needed. They point out that, on average, it costs 100 pounds (approximately $190 Canadian) a week to keep a child in kinship care and 5000 pounds (approximately $9600 Canadian) a week to keep a child in a residential facility. Broad and Skinner contend that this extra money could be used to support families and government should not take the view that kinship care is "care on the cheap" (p. 66).

Need For Access to Counseling/Support Groups

Throughout the literature, the need for access to counseling and support groups comes up repeatedly. One example of this need involves the role confusion that grandparents feel when they begin to parent their grandchildren and struggle to reconcile their desire to be lenient grandparents with their perception that their grandchildren need firm parenting (Weber & Waldrop, as cited in Dolbin-MacNab, 2006). The loss of the traditional grandparenting role is something that must be grieved as well as the loss of the child having a traditional family (Landry-Meyer & Newman, 2004). Grandparents must also work through the social isolation they often experience due to their changing roles. One study quoted a grandmother as saying,

> We are in a totally different age group. If people (our age) are sharing anything, it's grandkids for a couple of days or something like that. We can't. . . We are kinda like in limbo or almost in a self-defined

> island, you know? Our friends are changing (Landry-Meyer & Newman, 2006).

Sands et al. (2005) found a correlation between grandparents' perception of stress and their actual well-being. They suggest that grandparents can be helped through supportive, strengths-based individual, or family counseling which can assist them in reframing their situation positively and by enhancing the "resilience that is within their families, such as a sense of cohesion, financial stability, a sense of mastery, and communication" (p. 78).

Much of the literature also discusses the use of support groups. In a study of predictors of grandparent carers' health status, Leder, Grinstead, and Torres (2007) found that grandparents reported considerable benefit from the emotional support they received from support groups and from their sense that someone else was in a similar situation as them. Meanwhile, Sands et al. (2005) reported a negative correlation between support groups and grandparent well-being. It's been suggested that in order for a support group to be effective, there must be a balance between having members vent and having them receive new information – a lack of balance in this area could increase the anxiety of the participants and impact the effectiveness of the support group.

Need For Health Care

Another theme within the literature is the need for access to quality health care. Given the profile of the kinship caregivers and the children in kinship care, along with the United States medical system, it makes sense that this need would surface. Many children become involved with the child welfare system due to neglect and are behind on routine medical and dental care (Scannapieco & Hegar, 2002). They require thorough medical and dental assessments as well as support in carrying through on recommendations. Broad and

Skinner (2005) point out that this need for health care can involve both the caregiver's health and the health of the child(ren). Also, it can involve both physical and mental health needs. Although children in kinship care have similar medical needs to children in foster care, additional medical funding is more available to children in foster care (Berrick et al., 1994).

Need For Social Worker Support

Kinship caregivers cite a need for more social worker support. As stated previously, studies have shown that kinship caregivers receive less time with social workers than regular foster parents. Spence (2004) found that social workers often value kinship caregivers but question the agency's place in intervening in or supporting the family given the fact that kinship care is seen as a least intrusive measure. He also found that, due to caseload crisis, social workers often didn't have time for more than a brief contact or crisis work. On their part, kinship caregivers may be hesitant to ask for help because they fear that social workers will see them as being incapable of caring for the child(ren) or of being difficult (Geen, 2003b).

Some authors also cite a tendency for child welfare workers to remove children from an entire kin network assuming that parental failure must be a result of the network's failure (Gray & Nybell, 1990). Meyer and Link (as cited in Berrick, 1994) explored this issue and found that the majority of kinship care placements in their study provided a safer environment for children than continued living with the birth parents; they also found that in many cases the abusive or neglectful parent was the only dysfunctional family member.

Kinship caregivers particularly cite the need for support around birth parent contact and difficult child behaviors. This need is especially evident when one considers that studies have shown that birth parents have more frequent and unsupervised contact with their children in kinship than in non-kinship care (Berrick, 1994). Birth parents may assume that they have unlimited access to the child(ren) and kinship caregivers may find it difficult to regulate contact and to maintain their relationship with the child and the birth parent(s) (Broad & Skinner, 2005). Hirshorn, Van Meter, and Brown (2000) discuss the difficult relationship between birth parents and kinship caregivers, one which is often characterized by the birth parent having an on again/off again presence which plays upon the emotions of the children and upsets household rules and routines. Children often find it hard to leave their parents at the end of a visit and parents are often unreliable and miss visits or break promises that they make to the child(ren) (Broad & Skinner, 2005). Another stressor can be chronic conflict between the kinship caregivers (i.e. grandparents) and their adult children (Butler & Zakari, 2005). Some caregivers reported that they felt taken advantage of by the birth parents (who are in many cases their children), others expressed concern for the children's safety while visiting with the parents, and others reported mixed feelings over their desire for the children to be returned to the birth parents and their concern over the children's safety and well-being (Gordon et al., 2003). Generally, a need for social worker support in working through some of these difficulties is cited as a need.

Kinship caregivers also describe a need for social worker support around difficult child behaviors. Again, given the profile of both the kinship caregivers and the children in kinship care, and the fact that most kinship caregivers receive little training, it makes sense that they would need social worker support in this area.

Within the literature, there are also suggestions that the social workers who deliver services to kinship caregivers be specially trained in this area (Gillen, 2004; Laws & Broad, 2000) and have caseloads devoted to kinship carers. Specific caseloads would not only give social workers more time to devote to kinship caregivers, but would also allow them to become more knowledgeable about the specific issues around kinship care. For example, Szinovacz, Deviney, and Atkinson (1999) showed in a study on grandparents' mental health that "age, being married, education, and having dependent children in the household" reduced the negative impact of raising grandchildren while other studies have shown that "age and employment status and the number of grandchildren…contributed to distress" (Kelley, Whitley, Sipe, & Yorker, as cited in Sands et al., 2005). Knowing that being married and having dependent children in the household could reduce stress on the caregiver while the number of grandchildren could increase the stress could allow a specialized worker to more effectively assess families for placement and then provide them with needed supports. Broad and Skinner (2005) provide a good description of the use of "specialist kinship care teams" in the United Kingdom which are located within the adoption section of the local legal authority and manage all kinship care assessments and support (p. 58).

Need For Support Around Children's Education

Broad and Skinner (2005) point out that a high proportion of children in kinship care have had their education disrupted and have special education needs. It can be expensive to start at a new school and, during the year, the costs of things such as uniforms, school trips, and sports activities (Stevenson, Henderson, & Baugh, 2007) can be difficult for families to meet . In addition, the educational system can be overwhelming at times and families often need assistance in negotiating it and in helping to advocate for needed supports (Scannapieco & Hegar, 2002). Kinship caregivers, who are often elderly, also report the need for tutoring due to their inability to help their children with their homework (Geen, 2003b).

Need To Be Involved In the Planning

Research also indicates that kinship caregivers and extended family members need to be involved in the planning for children in kinship care if a strengths-based approach is to be effective (Scannapieco & Hegar, 2002). Geen and Malm (2003) point out that, although kinship caregivers often have more involvement in planning than foster parents, they also often have less input. They provide some possible reasons for this situation, including the possibility that kinship caregivers aren't invited to attend meetings, that they don't understand the process, that they feel that they won't be given a chance for real input, and/or that meetings are held during the day when they're unable to attend. In their discussions with social workers, Geen and Malm (2003) found that the input of kinship caregivers was valued by social workers and group facilitators and that ideas and decisions often surfaced during meetings that wouldn't have if family hadn't been given the opportunity to give their input.

Conclusion

In summary, the literature indicates that kinship caregivers receive fewer services than their non-kin counterparts, despite having overall greater services needs (Geen, 2003b). Some reasons for this disparity include the fact that workers offer fewer services to kinship caregivers, kinship caregivers request services less often, and kinship caregivers face barriers to accessing services. The topic of kinship care and needed services is very important. In their study on resilience in children in kinship care, Johnson-Garner and Meyers (2003) found that resilient children generally lived in homes with higher levels of support and, when kinship caregivers felt supported, they were able to be more effective with their families.

The main needs that surfaced were as follows:

- Adequate funding, equal to the foster payment, with the ability to apply for additional funding as needed
- Equal treatment and a feeling of being treated with respect and dignity
- Respite
- Assistance in obtaining and paying for adequate housing
- Education and training
- Access to counseling and support groups
- Assistance with health care
- Social worker support
- Support around their child(ren)'s education
- Involvement in the planning process

Chapter 3: Research Methodology

The purpose of this chapter is to outline the research design which has been used. The following topics will be discussed: researcher approach, research design, participants, data collection, ethical considerations, data analysis, limitations, and methodological integrity.

Research Approach

One thing I've learned over the years is that, if you truly want to understand how a certain caregiving arrangement is working, you need to speak directly with the people living within it on a daily basis. No politician, manager, team leader, or front-line social worker can truly attest to the triumphs and struggles of raising a child within a particular system. For that reason, I chose a qualitative design for this study: a primary task of qualitative research is to explain the ways that people come to understand, take action, and otherwise manage their day-to-day situations (Miles & Huberman, 1994). It also appeals to me that qualitative researchers conduct their studies in the 'field', where the participants live and work (Creswell, 2007). I've found that caregivers are most open when they're in their own familiar territory (i.e. at home) and that such a setting can also help to balance out power during an interview. Creswell (2007) offers a succinct, yet thorough definition of qualitative research, writing:

> Qualitative research begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning individuals or groups ascribe to a social or human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a

> natural setting sensitive to the people and places under study, and data analysis that is inductive and establishes patterns or themes. The final written report or presentation includes the voices of participants, reflexivity of the researcher, and a complex description and interpretation of the problem, and it extends the literature or signals calls for action (p. 37).

My goal was to include all of these elements in my thesis.

Research Design

Yin (1989) defines the research design as "*an action plan for getting from here to there*, where 'here' may be defined as the initial set of questions to be answered and 'there' is some set of conclusions...about those questions" (p. 28). Creswell (2007) provides us with further detail, noting that the research design refers "to the entire process of research from conceptualizing a problem to writing research questions, and on to data collection, analysis, interpretation, and report writing (p. 5). In this section, I will describe my research design.

I chose a case study design to explore my research question because I wanted to gain a deep, solid understanding of the experiences of a very specific group of families. Creswell (2007) notes that it is appropriate to choose a case study approach when the researcher has "clearly identifiable cases with boundaries and seeks to provide an in-depth understanding of the cases or a comparison of several cases" (p. 74). Yin further says that "case study allows an investigation to retain the holistic and meaningful characteristics of real-life events – such as individual life cycles, organizational and managerial processes, neighborhood change, international relations, and maturation of industries" (p. 14). My intention with this research was to do just that: describe the experiences of kinship caregivers in a holistic, meaningful way.

This research employed a collective case study method, drawing on the experiences of numerous kinship caregivers. Creswell (2007) discusses how case studies are defined by the size of the bounded case (defined below), such as "whether the case involves one individual, several individuals, a group, an entire program, or an activity" (p. 74). He defines a collective case study as one where one issue is selected, but the researcher chooses multiple case studies to illustrate it.

There are various types of case study research and I chose to use an exploratory case study design. While case studies are usually used to answer "how" and "why" questions, exploratory case studies can be used to answer "what" questions "when the goal is to develop pertinent hypothesis and propositions for further inquiry" (Yin, 1989, p. 17). Rather than posing a proposition, exploratory case studies state the purpose of the study as well as "the criteria by which an exploration will be judged successful" (Yin, 1989, p. 30). As stated previously, the purpose of this study was to gain a deeper understanding of the needs of kinship caregivers. The criteria by which it will be judged to be successful will be described later in this report, under the section titled "Methodological Integrity".

Myles and Huberman (1994) stress the importance of identifying boundaries early on in the research process. They describe this process as one where you "define the aspects of your case(s) that you can study within the limits of your time and means, that connect directly to the research question, and that probably will include samples of what you want to study" (p.27). Stake (2000) further describes how a case does not have to be an individual but can be whatever is within the "bounded system" of the study. In this situation, the case is a population of kinship caregivers which is made up of numerous individuals defined as follows: people over the age of 18 who are living in the North Region of BC, and, with MCFD involvement, are caring for children who are friends or family members, and who could not otherwise be cared for by their birth parents at this given time.

Participants

Sixteen participants took part in this study. They are made up of two groups: an initial sample of nine recruited in the Fall of 2007 when I completed a research practicum on kinship care with MCFD and a subsequent sample of seven recruited in the Fall of 2008. Because I was conducting my initial research as a practicum student on behalf of the Director of Integrated Practice, I was given approval to phone prospective participants directly. I used a criterion sampling method, phoning each caregiver who fit a certain criteria (i.e. living in Prince George, providing kinship care with involvement by MCFD). Each agreed to participate. During my interviews with the caregivers in the initial sample, I asked them if they would be willing to be contacted at a later date regarding me using their interview for my thesis. Each signed a consent giving me permission to contact them in the future. When contacted, nine out of the ten participants agreed to participate and signed an additional consent. One did not respond.

The subsequent sample of seven was also obtained using a criterion sampling method. An MCFD gatekeeper sent letters of invitation to all caregivers (approximately fifty) who fit a certain criteria (i.e. living in the North Region of BC, providing kinship care with involvement by MCFD) and those who responded to me indicating their willingness to participate were included in the sample. According to Patton (2002), the logic of criterion sampling is that it allows “all cases that meet some predetermined criterion of importance”

(p. 238) to be included: in this case, allowing for the inclusion of the voice of each kinship caregiver in the North Region of BC who wished to participate.

I struggled somewhat with sample size when choosing my research design. Case study designs generally use fewer than 5 cases, and often just 1; however, when presented with the opportunity to hear from 16 kinship caregivers, I chose to interview all of them. The North Region of BC is home to a very diverse population and my hope is that I was able to capture more of that diversity with a sample of 16 than I would have with a smaller sample.

Data Collection

Three sources of data were used in this research: interviews with participants, interviews with social workers, and reviews of MCFD files. One of the hallmarks of a case study approach is that multiple sources of evidence are used (Yin, 1989). This triangulation of data strengthens a study by using different research procedures to gather information from the same group of participants (Denzin as cited in Kirby, Greaves, & Reid, 2006). Patton (2002) contends that the point of triangulation is not to demonstrate that the different sources of data show exactly the same findings, but rather to "test for consistency" (p. 248). Different kinds of data can produce different results and those inconsistencies can offer deeper insight into the subject under study. For example, if I were to ask a kinship caregiver and her social worker what led to the child being placed in kinship care and received two very different responses, this information could lead to a deeper understanding of the experiences of kinship caregivers because I could ask why the descriptions were so different.

Interviews with participants

This study employed a semi-structured interview process. I asked participants specific questions, using an interview guide but probing for information as needed in order to fully understand their responses. As an adoption social worker, I am comfortable with this method as I have used it many times while completing homestudies on prospective adoptive parents.

The interview guide contained both open- and closed-ended questions and focused on eliciting from kinship caregivers a description of their experiences of providing kinship care, particularly around their needs and whether or not they are being met (Appendix F). The interview guide was constructed by completing a thematic analysis of 17 journal articles on kinship care from Great Britain the United States, Australia, Norway, and Canada. Sections in each article were given code names (i.e. "finances", "support groups") and those were then turned into questions (i.e. "Do you have any financial concerns for yourself/your family? If yes, please explain"; "Would you attend a support group for kinship caregivers if one existed? What might prevent you from joining/encourage you to join?"). Some questions were included because they were interesting, because it was felt that they were necessary to better understand each participant's situation, and/or because they were open-ended and therefore would result in more descriptive information than some of the closed-ended questions (i.e. "What is your relationship to the child/ren in your care? Please provide a description of how that child/ren came to live with you"). I focussed on obtaining a rich, "thick" description from the participants and kept in mind Donmoyer's (2000) assertion that "the bottom line for assessing the quality of a case study…is… the richness of the data presented" (p. 64).

Participants were given a choice regarding where the interview would take place. Choices included their home, an MCFD meeting room, or a more neutral place such as a restaurant or park. I attempted to have each interview occur in a setting which offered some privacy. For example, if a participant suggested a very small, quiet restaurant I pointed out that another setting might be more suitable due to the fact that other people might overhear us speaking; however, I left the final choice of meeting place with each participant. I interviewed each caregiver in person, recording the interviews and taking detailed notes. I kept a journal describing my thoughts before and after each interview and used this step to reflect and to debrief my thoughts and feelings.

I requested that the interview take place with the primary caregiver in the home but was open to other people attending as well. In many cases, both the primary and secondary caregivers took part in the interview. I found that having both caregivers present meant that an increased amount of information was shared with me.

From my experience as an adoption social worker, I anticipated that children might be present or close by during the interview process. This issue presented an ethical dilemma for me because I find that I am sometimes less comfortable discussing personal issues with children present than are the children's caregivers. For example, if a child was in the next room watching television and the topic of how that child came into kinship care arose, I would feel uncomfortable openly discussing issues such as the birth mother's addictions and street life unless I knew that the child was very aware of and comfortable discussing those issues and the caregiver was equipped to deal with questions and/or behaviours that could arise out of over-hearing such a discussion. I therefore requested that interviews take place when the children are not present (i.e. during school hours) or in a private area of the home where we could not be overheard. I was prepared to be honest with kinship caregivers if I felt worried that the child/ren will overhear the conversation. I found that in all instances I was comfortable with the arrangements made by the caregivers.

Each interview was transcribed verbatim. I transcribed all but one of them to allow myself maximum exposure to the words of the participants. I reviewed the one I did not transcribe, listening to the tape while reading the transcript to determine accuracy and facilitate my own analytical thinking.

Each participant was assigned a letter of the alphabet to identify them. The data from each participant (i.e. consent, transcript, interview notes, and cassette tape) was stored in a large envelope with the participant's identifying letter on it. One binder was kept which identified the link between each participant and her/his corresponding letter.

Interviews With Social Workers

During the process of interviewing each caregiver, I established the name of the social worker involved and then requested an interview with that social worker via email. I also interviewed the social worker in the North Region of BC who is employed as its "Out of Care Consultant". In total, I interviewed 11 social workers. Ten interviews took place in MCFD offices and one took place over the phone. Two social workers did not have time to meet with me. Eight of the social workers had one participant on their caseloads, one had two participants, and one had four. The interviews were unstructured and questions were based on information that arose during the participant interviews. I also asked each social worker to comment on her experiences with kinship care. I took detailed notes during these interviews.

File Reviews

Two types of files were reviewed for this study: Child in Care (CS) files, which are related to children who are in care, and Family Service (FS) files, which are related to families who receive services from MCFD. Not all of the children represented in this study had a CS file due to the fact that some kinship care options (Section 8 Agreements) do not involve a child coming into care; however, in several cases, a closed CS file (relating to previous time in care) was reviewed. During the file reviews, detailed notes were taken. Several topics were paid close attention: health of the child and parents (i.e. mental health issues, drug/alcohol exposure), placement history of the child, and general history of the child/family, including siblings.

It is important to note that MCFD opens a Resource (RE) File for kinship caregivers which is placed on the caseload of the child protection social worker involved with the child. RE files are typically linked to foster homes and are usually found on the caseloads of Resource Social Workers, who specialize in working with caregivers. The kinship caregivers' RE files were not reviewed for the purposes of this study as it was felt that adequate information could be obtained by reviewing the CS and FS files and interviewing the kinship caregivers and social workers.

Ethical Considerations

The research proposal for this study was submitted to and approved by the University of Northern British Columbia's Research Ethics Board (Appendix G) as well as by MCFD's Decision Support Branch (Appendix H). Each participant was provided with an information letter and a consent form that outlined the purpose of the study and discussed potential risks (Appendix I). Participants were assured that their participation was voluntary and that services received through MCFD would not be influenced by whether or not they chose to participate. They were told that, although I would try to maintain their confidentiality, it could not be guaranteed. The participants from my previous research practicum signed a consent stating that I could contact them in the future. Each of these participants, plus those obtained in my later sample, signed a letter of informed consent (Appendix J).

Role Of The Researcher

One of my most troubling ethical considerations was the fact that I was employed as an MCFD social worker while conducting research as a student. Undoubtedly, MCFD holds a great deal of power, particularly over families who have had child protection involvement. Although I considered withholding from participants the fact that I am also an MCFD employee, I felt it was more honest to describe both roles. My concern was that perceptions regarding my credibility and trustworthiness as a researcher could have been impacted if I was not forthright with participants and they later learned the truth.

The danger of being honest about my role as an MCFD employee was primarily that participants will feel an obligation to participate and that they would respond differently to me because of my dual role. There is also a small chance that I will come into contact with participants professionally in the future if they decide to adopt; however, my plan in such a case will be to request that a coworker provide them with services.

Confidentiality

Another ethical consideration is client confidentiality. I kept one identifying spreadsheet on my work computer with the name and contact information of each kinship caregiver. Each participant was assigned a letter which was used to identify them during all other data collection. This process ensured that, if someone did come into contact with my data, they would not be able to ascertain the identity of any participant. To further increase client confidentiality, I stored all other data at my MCFD office or in my home in a locked case. A copy of my thesis (which contains non-identifying information) was stored on my personal lap-top computer and USB key. One year after the completion of this research project, I will burn all of the data in a metal barrel in my yard.

Safety Of Participants

My goal was to make the interviews as comfortable as possible for the participants. For example, interviews were held in a place chosen by them. The interview questions were not expected to trigger any negative responses; however, if any participant had become upset during an interview, I would have stopped the interview and notified a support person as soon as possible. Kirby, Greaves, and Reid (2006) speak to the importance of minimizing harm while maximizing benefits. The ultimate goal of this research is that it will lead to more comprehensive services for kinship caregivers and children in kinship care, thereby maximizing the benefit to the participants, other kinship caregivers, and to society as a whole.

Data Analysis

I used a thematic analysis process to analyze my data. Boyatzis (1998) describes thematic analysis as "a way of seeing" (p. 1) that enables researchers to "use a wide variety of types of information in a systematic manner that increases their accuracy or sensitivity in understanding and interpreting observations about people, events, situations, and organizations" (p. 5).

Themes can be described as "a pattern found in the information that at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon" (Boyatzis, 1998, p. 4). Boyatzis points out that they can be theory driven, prior data driven, or raw data driven. In this report, I developed themes by looking both at the prior data arising from my literature review and at the raw data found in my interviews and file recordings.

First, as described previously, as part of my literature review, I compiled 17 reports and journal articles on the topic of kinship care. These articles came from the United Kingdom, Norway, Australia, the United States, and Canada. I carefully read through these articles, most of them two or three times, and highlighted sections related to the needs of kinship caregivers. I then identified significant phrases, noting those that arose multiple times as well as those that were particularly emphasized. A summary of these themes can be found at the end of Chapter 2. This method was used to provide me with some ideas around themes to look for in my interviews.

Secondly, I brought together the three types of data available for each kinship care placement (caregiver interview, social worker interview, and file review) so that each of the 16 families had one file made up of 3 data sources. I made photocopies of each family's file so I would be left with one original copy of each. Because I typed all but one transcript, I felt very familiar with the data and I continued to become more familiar as I read through the transcripts to find patterns and recurring ideas.

Next, I worked my way through each file, highlighting topics that had come up in the literature review, those that participants emphasized, and those that came up repeatedly. Creswell (2007) discusses the dilemma of whether or not qualitative researchers should count codes and notes that codes can be counted in order to give the researcher an indicator of participant interest in each code rather than to provide quantitative data. I counted codes in this way, giving weight to how much emphasis the participants had placed on them.

In the margin beside the typed or written data, I inserted a code word (i.e. medical) which I composed based on what I felt best described the information (Creswell, 2007). Once I had coded each file, I conducted a within-case analysis, looking at the themes that arose for each family as well as the discrepancies that arose. An example of a possible discrepancy would be a family saying they did not require a higher kinship care payment and saying that they required additional funding for activities. These themes were then recorded on a separate piece of paper, one for each file.

A cross-case analysis was then completed, again looking at both reoccurring themes and discrepancies. When conducting the cross-case analysis, I looked at both the code words that occurred within each case as well as the themes which arose from those code words. By doing this, I was able to see topics that were emphasized by the participants and/or that came up repeatedly as well as those that were perhaps not emphasized but that were found repeatedly across cases.

I then put the themes into clusters. I formulated the clusters according to my own conceptual framework which was based on my continuing thematic analysis and my recognition of the patterns in my data (Boyatzis, 1998). For example, I placed "expectations", "the caregivers' expectations" and "the child welfare system's expectations" together.

Next, I formed themes and sub-themes. Creswell (2007) describes these as being like families (the themes) with children (the sub-themes). For example, in the previous example, I put the sub-themes of the "the caregivers' expectations" and "the child welfare system's expectations" under the general theme of "expectations" because I felt that this combination would lead to a greater understanding of how these sometimes diverge.

Finally, I organized my themes and sub-themes into larger, general categories. These general categories arose out of my need to organize this report so that it would be as clear and comprehensive as possible. I attempted to use categories similar to those I had used in my literature review (i.e. existing supports and needed supports), but was also open to new categories as they arose (i.e. discussion with the social workers).

Table 1

Themes and Sub-themes Found In My Data

Categories	Themes	Sub-themes
Characteristics of kinship caregivers in this sample	Ethnicity	
	Health	
	Education	
	Occupation/wage	
Characteristics of the children in this sample	Ethnicity	
	Legal status	
	Reasons behind placement	
	Special needs	
	Placement history	
	Behaviors	
Experiences of the kinship caregivers	Motivation	
	Expectations	Caregiver expectations System expectations
	Parent health/involvement	Parental health Parental/family contact
	Parent/caregiver relationships	When the caregiver is the parent's parent Empathy Nurturance Issues arising from contact Boundaries Sense of threat
	Changing lives	Occupational changes Changes in life plans Social changes Changes for the other children
	Perceived improvements	

	Love and attachment	
Existing supports	Family Friends Community Support group MCFD/social workers	
Needed supports	Financial support Kids' activities Medical/dental Respite Information Training Equal treatment	
Feedback from the social workers		

Limitations

Sample

While this sample size is large for a case study design, it would be small compared to some of the samples used, for example, in quantitative research. Patton (2002) points out that "while one cannot generalize from single cases or very small samples, one can learn from them – and learn a great deal, often opening up new territory for further research" (p. 46). As with all qualitative research, it was not the goal of this study to generalize to all kinship caregivers or even to all kinship caregivers in the North Region of BC. Rather, my goal was to learn more about the experiences of kinship caregivers in my sample and to present this information in a format that would encourage its readers to think about kinship care in a deeper way.

In addition, although I attempted to obtain a sample that represented the diversity of the North Region of BC, only 3 of the 16 families I interviewed were from outside of Prince George and none of them were from remote areas. My findings might have been different if

I had interviewed families who were dealing with very limited access to resources (i.e. no doctor in the community, limited social worker access).

Methodological Integrity

Creswell (2007) discusses the fact that qualitative researchers strive for "'understanding', that deep structure of knowledge that comes from personally visiting with participants, spending time in the field, and probing to obtain detailed meaning" (p. 201). He points out that during or after our research, we ask ourselves whether or not we got it right, but, in reality, there are no "right" stories, just multiple stories that result in more questions rather than in endings. Still, it is important that we as qualitative researchers accurately reflect what our participants said and for that reason, it is important to demonstrate methodological integrity.

For this study, I chose to use Lincoln's (1995) seven criteria for judging the quality of qualitative research: positionality, community as arbiter of quality, voice, critical subjectivity, reciprocity, sacredness, and sharing requisites of privilege.

Positionality

Lincoln (1995) states that research that demonstrates honesty or authenticity is open about its own standpoint and about the position of the researcher, rather than being detached and claiming author objectivity. From an epistemological standpoint, positionality acknowledges that all writing is partial and incomplete and does not represent whole or complete truth (Lincoln, 1995).

It has been my goal in this text to present my standpoint honestly and openly so that my readers can ascertain the subjective standpoint from which I conducted the research. Further, I have not tried to arrive at a place of complete truth around kinship care because I acknowledge that such a place does not exist; rather, my goal has been to honor my participants' stories, staying as true to their accounts as possible while documenting my subjective stance in my journal. In doing so, I will hopefully cause my readers to think about kinship care on a deeper level.

Community as Arbiter of Quality

This criterion acknowledges that research takes place in, and is addressed to, a community (Lincoln, 1995). The goal of the research is to meet the needs of the community rather than to simply produce more academic knowledge.

After I was asked to research this topic for my practicum, I quickly realized that the topic had been given to me because MCFD management genuinely wanted to know more about kinship care in the North Region in order to make changes to policy. Although I had considered other thesis topics, I decided to research this topic further because I felt that this would allow me to give back to my community rather than writing on something simply for academic interest. I have written this thesis as a prerequisite for my graduate degree but my ultimate hope is that it will positively affect the kinship caregivers in this Region. The MCFD manager who initially requested that I research this topic has requested an invitation to my defense and I plan to invite him. I will give this manager a copy of the published text in the hope that the voices of my participants will be heard by those who are in a position to make changes for them. I have also requested that, if possible, I be involved in MCFD discussions around changes to kinship care in the North Region so that I can bring the voices of the kinship caregivers in my sample to the table.

Voice

Lincoln (1995) discusses voice as being concerned with "who speaks for those who do not have access to the corridors of knowledge or the venues of the academic disciplines?" (p. 284). Thus, inclusion of voices that would not typically be heard is viewed as criteria for judging the quality of research.

I feel that this research includes the voices of a group of people who are not normally given a chance to share their views. Without exception, the participants were keen to tell me their stories and I believe that is because they welcomed the opportunity to talk about a topic that was having such a profound effect on their lives.

Critical Subjectivity

Critical subjectivity, or reflexivity, emphasizes the importance of self-awareness, political and cultural awareness, and ownership of your own perspective (Patton, 2002). Researchers who are engaged in reflexivity continually reflect on how their own biases, values, and experiences impact their research and then make these explicit to their readers (Creswell, 2007).

I have already discussed some of the assumptions that I brought to this research, some based on my life experiences and some on my own practice wisdom: I believe that children require stability and that they generally do best when living with family or friends; I believe that caregivers are able to provide their best care when they are supported; I believe that society has a responsibility to hear what the caregivers are saying, to be aware of their experiences and needs for support, and to fulfill those needs when at all possible.

As an adoption social worker, I spend a considerable amount of time with families post-placement, discussing what is and is not working for them. My experiences with these families impacted my ability to be completely neutral regarding the responses I expected from kinship care families; however, I was aware of this bias from the beginning of the research project and I believe that this awareness helped me to be open to responses that were different than what I expected. In fact, I have found in my job as a social worker that I must constantly work on being aware of my own biases, values, and experiences. I have found this process to require ongoing work because not only do I change as an individual, but I also come across new situations frequently. To some degree, I am now in the habit of being mindful of my biases, values, and experiences. While working on this research, I also kept a journal to document some of my thoughts and feelings and I occasionally went back to read my words to help me be aware of how my own subjectivity was impacting my work.

Reciprocity

Lincoln (1995) says reciprocity is essential to qualitative research because of its person-centered nature. She speaks of the importance of everyone involved in the research having "a deep sense of trust, caring, and mutuality" (p. 284). Because I only knew my participants for a short period of time and wanted them to feel comfortable opening up to me, it was important for me to bring as much warmth and genuineness to our meeting as possible.

While I did not compensate my participants for their time, when asked, nearly every one of them requested a copy of the completed research. I will be sending them a copy with my thanks and my hope is that they can learn and feel a sense of community from each other's experiences.

Sacredness

Lincoln (1995) speaks of sacred research as research that makes "space for the lifeways of others and create(s) relationships that are based not on unequal power, but on mutual respect, granting of dignity, and deep appreciation of the human condition" (p. 284). Creswell (2007) notes that a researcher who operates from this standpoint "respects the collaborative and egalitarian aspects of research" (p. 213).

I believe that people innately sense how we view them and I therefore make an effort to reflect on my biases regarding the people I am working with. I do not believe that people would open up to me as a researcher if they sensed that I was coming from a judgmental or self-elevated standpoint. I truly believe that the care of children is a sacred topic. They are some of the most vulnerable members of our society and the children who come to the attention of the child welfare system are even more vulnerable than the average child. I also believe in the dignity of the other members of the kinship care triad: the caregivers and the parents. Over the years, I have learned that the vast majority of people genuinely want what is best for the children in their lives. Sometimes mental health and addiction issues get in the way of families making good choices, but that in no way negates their basic dignity. Finally, I genuinely respect the caregivers in my sample for the sacrifices they make in order to provide care to the children in their lives. I believe that the people in my sample sensed these beliefs in me because they were willing to share a great deal about themselves in the short while they knew me.

Sharing the Perquisites of Privilege

Sharing the perquisites of privilege involves acknowledging that "research is written for ourselves...and it earns us the dignity, respect, prestige, and economic power in our own worlds that those about whom we write frequently do not have" (Lincoln, 1995, p. 285). We can share this privilege in part by acknowledging the debt that we as researchers owe to the people whose lives are portrayed in our research. I told all of my participants that this research would be used towards me receiving a graduate degree in social work. I also thanked each of them for their willingness to participate and share so much with me. Several of the participants told me that they appreciated the opportunity to share their experiences with me and I had the sense from all of them that they hoped that their participation would result in positive changes to the kinship care system. I will continue to acknowledge the debt I owe my participants at each presentation and in all my written work.

Although I believe that each of these criteria are important, it is most important to me as a researcher to know in my own mind that this text accurately represents what my participants told me. I had the honor to sit and hear their stories. I transcribed most of their interviews. I read and re-read their words countless times as I coded the transcripts. I feel like I was genuinely able to immerse myself in the data and, because of that, I can know in my own heart that this is what they told me.

Chapter 4: Discussion of Findings

It's exciting to be working during a time when the importance of kinship connections are being re-realized. I was very honored by the fact that 16 kinship care families trusted me with their stories and my hope is that this report will reflect their experiences as accurately as possible. In this section, I will discuss my findings. I will loosely follow the format found in my literature review. First I will discuss some of the characteristics of the families and children in my sample and then I will discuss some of the themes that arose during my interviews and file reviews. This information will serve to create an increased understanding of kinship care in the North Region of BC and will serve as a springboard in the proceeding discussion on both the existing and needed supports. I will close with a brief review of the social workers' feedback on the kinship care system.

Characteristics of the Kinship Caregivers in this Sample

The caregivers in this sample had varied kinship ties to the children for whom they were caring:

- Grandparents (7 families)
- Great-grandparents (1 family)
- Mother's second cousin (2 families)
- Mother of the youth's friend (2 families)
- Acquaintance of the mother's from church (1 family)
- Mother's former foster parents (1 family)
- Friend of child's grandmother (1 family)
- Ex-wife of children's uncle (1 family)

These findings were interesting to me because the kinship ties were not always what I would describe as being "close". While I was working on this study, I was often asked by friends and family to explain my topic and was often met with the response, "Well, shouldn't family take care of family?", the insinuation being that caregivers should not require government support in order to care for their kin. I believe that this response stems in part from an assumption that kinship caregivers are often very closely related to the children for whom they are caring (i.e. a grandparent or an aunt); however, in this sample, while some of the ties were close, others were not.

The kinship caregivers in my sample were demographically quite diverse and varied greatly in age, the youngest being 37 and the oldest being 68. Two of the primary caregivers were in their 30s, six were in their 40s, six were in their 50s and one was 60. All of the primary caregivers were women. Five of the primary caregivers were single, ten had partners who lived and co-parented with them, and one had both a partner and an ex-partner who lived and co-parented with her. Including partners, the sample of 16 kinship care families represents 28 individual caregivers.

Ethnicity

The caregivers also represented diverse ethnic backgrounds. Fourteen described their ethnicity as Canadian, three as French-Canadian, and two as Polish. One caregiver was Chinese, one was Samoan, and one was Spanish. Six were Aboriginal (four were Carrier and two were Cree). In five of the homes, the primary caregiver was Aboriginal.

Health

Many of the caregivers reported difficulties with their health, but these problems were not always related to their status as a kinship caregiver. Some of the caregivers had pre-existing physical and mental health conditions including lupus, bi-polar disease, depression, rheumatoid arthritis, diabetes, osteoporosis of the spine, fibromyalgia, and chronic back pain, which impacted their care of the children to various degrees. One caregiver, whose husband was dealing with chronic back pain, arthritis, and depression, described how her husband's negative mind-set was worsened by the fact that he could no longer play with the children. For her, on the other hand, the children had become a motivation to get healthier. She was struggling with her own health problems, including fibromyalgia and rheumatoid arthritis and described her goal to improve her health:

> *I want to get healthy. I want to go out and play with the kids and make snow angels and in between the arthritis and fibromyalgia I can't always know…what I am going to be able. But I'm taking positive steps right now.*

Other caregivers reported a decrease in health resulting directly from their role as a kinship caregiver. Nine of the caregivers reported that they had increased anxiety and depression. One caregiver spoke of her stress in dealing with the frequent phone calls from the child's mother, who was struggling with delusions due to schizophrenia at the time and was staying in a mental health facility:

> *I had a lot of trouble with anxiety when it first happened. And I went to the doctor and he said, "What's happening?" and I don't want to…you know, it's just at the point where I can't look after (the child) anymore, so I'm on a very small dose of anti-depressant and I think I will just stay there until things are over.*

It is important to keep in mind both the pre-existing and post-placement health issues of the kinship caregivers in my sample because they would no doubt permeate every aspect of the caregivers' lives, including the supports they would require in order to provide appropriate care.

Education

The caregivers in my sample had various levels of education. Half had a completed post-secondary degree or some post-secondary education and the other half had high school graduation or less. It was not within the scope of this study to compare that number to the average education level found in the North Region population, nor to a similar sample of foster parents; however, I believe it is fair to conclude that, on the whole, the caregivers in my sample cannot be characterized as having a low level of education, and at least half of them could be characterized as being well educated.

It is important, however, not to assume a direct correlation between education levels and income. Some of the self-employed caregivers in my sample who had minimal formal education reported a higher level of income than those who had completed post-secondary training and were unemployed, on disability, or had taken a leave from work in order to provide kinship care.

Occupation/Wage

The families in my sample indicated that money came into their home through a variety of sources. Seven of the caregivers were self-employed and worked out of their homes. Their businesses provided services such as dog grooming and daycare. Twelve of the caregivers worked outside of their homes at various jobs such as lab technician, roofer, and housekeeper. Three were on disability. Two were at-home moms and had left their jobs in order to provide kinship care. One was a student. One was unemployed. One was receiving financial assistance from the provincial government. One was receiving a pension.

Fourteen of the 16 families in my sample agreed to share information regarding their yearly wage with me. I asked families to include all of their revenue in this figure, so this number includes wages plus other sources of funding such as the Child Tax Credit and the kinship care payment. Within my questionnaire, I asked this question using a Likert Scale, giving participants the option to choose from a wage of "$0-10,000", "$10,000-20,000", "$20,000-30,000", "$30,000-40,000" and "Over $50,000". In retrospect, I wish I would have constructed a scale that went to $100,000 so that I could have a slightly more accurate figure. At any rate, their wages ranged from less than $ 10,000 a year to over $50,000. Five of the families indicated that they made more than $50,000 a year and nine made under $50,000. I met with many of the kinship caregivers in their homes and when I consider the types of homes they lived in and our discussions around finances, I would say that, as a whole, they represent a middle- to lower-middle class level of income.

Characteristics Of The Children In this Sample

Like the caregivers, the children in my sample were generally quite diverse. There were twenty-three children in total, 11 girls and 12 boys. They ranged in age from 10-months to 14-years-old and their average age was about 5 ½.

Ethnicity

Nine were Caucasian, 12 were of First Nations heritage, and two were of mixed First Nations/Caucasian heritage. This number coincides with the fact that the First Nations population is over-represented within BC's child welfare system.

Legal Status

Nine of the children were in kinship care under a Section 8 Agreement, 12 were under a section 41(1)(b) Agreement, and two were under a 35.2(d) Agreement. Given the previous discussion on legislation around kinship care, this tells us that MCFD had a slightly more "hands-off" relationship with the nine children under Section 8 Agreements, compared to the other 14, affecting areas such as the social workers' responsibility to see the children in the kinship care home.

Reasons Behind Placement

The children in my sample had varied backgrounds, although 19 of the 23 shared the fact that they were in kinship care due to issues arising from their birth parents' ongoing alcohol and drug addictions. Three were in kinship care due to their birth parents' mental health issues and 1 was in kinship care due to both alcohol/drug and mental health issues. It is important to note while reading this section and the sections that follow that this information is based on file recordings and interviews with caregivers and social workers and likely does not represent the true complexity of each child's situation.

Special Needs

Most of the children in my sample had not received comprehensive assessments, so information related to diagnoses is no doubt incomplete; however, the data did show several striking similarities. For example, the children in 14 of the 16 kinship care homes came from families which had experienced domestic violence. Fifteen of the 23 children were noted to have witnessed domestic violence and this violence was often severe. For instance, one child's file noted that her father "pulled (her mother's) hair, slammed her up against a wall, and struck her". Four of the children's mothers were assaulted while pregnant with them and in one case the violence was severe enough for the child's father to break the mother's collarbone.

Although only 5 of the children had been formally assessed for Fetal Alcohol Spectrum Disorder (FASD) (and had received FASD diagnoses) and none of the children had a diagnoses of Neonatal Abstinence Syndrome (NAS), 15 of the children were noted as being alcohol and/or drug exposed. My experience in working with a similar population of children who typically have had formal assessments is that these diagnoses would likely be much higher if these children were assessed, especially given the fact that 21 had mothers with ongoing alcohol and/or drug addictions.

This lack of formal assessments/diagnoses indicates that the parents and caregivers of these children could be unaware of issues stemming from drug and alcohol exposure (i.e. decreased ability to learn from consequences) which could impact their expectations of the children and, ultimately, their parenting. In addition, it would mean that the children would be unable to access certain services through the school system, thereby potentially increasing their need for support from other sources.

Similarly, although only one of the children had a mental health diagnoses (schizophrenia), 17 of the children had a genetic risk of developing mental health issues. These issues included schizophrenia, bi-polar disorder, anxiety, depression, personality disorder, and obsessive compulsive disorder. Nine of the children had a genetic risk of mental health issues stemming from both their maternal and paternal families, while eight children had a genetic risk from either their paternal or maternal sides. This information could have a substantial impact on the caregivers who were caring for teens and/or those who planned to provide care in the children's teen and young adult years, when most mental illnesses surface.

The children had experienced a range of abuse. The data indicated that 15 had been neglected, 12 had been physically abused, and six had been emotionally abused. When looking at the rest of the data on the children, it becomes apparent that these numbers are likely much higher. For example, one could postulate that all of the children had been emotionally abused due to the various experiences they have been subjected to. In addition, the chaos experienced by the children due to their parents' unhealthy lives placed all of them at much higher risk for abuse than the rest of the population.

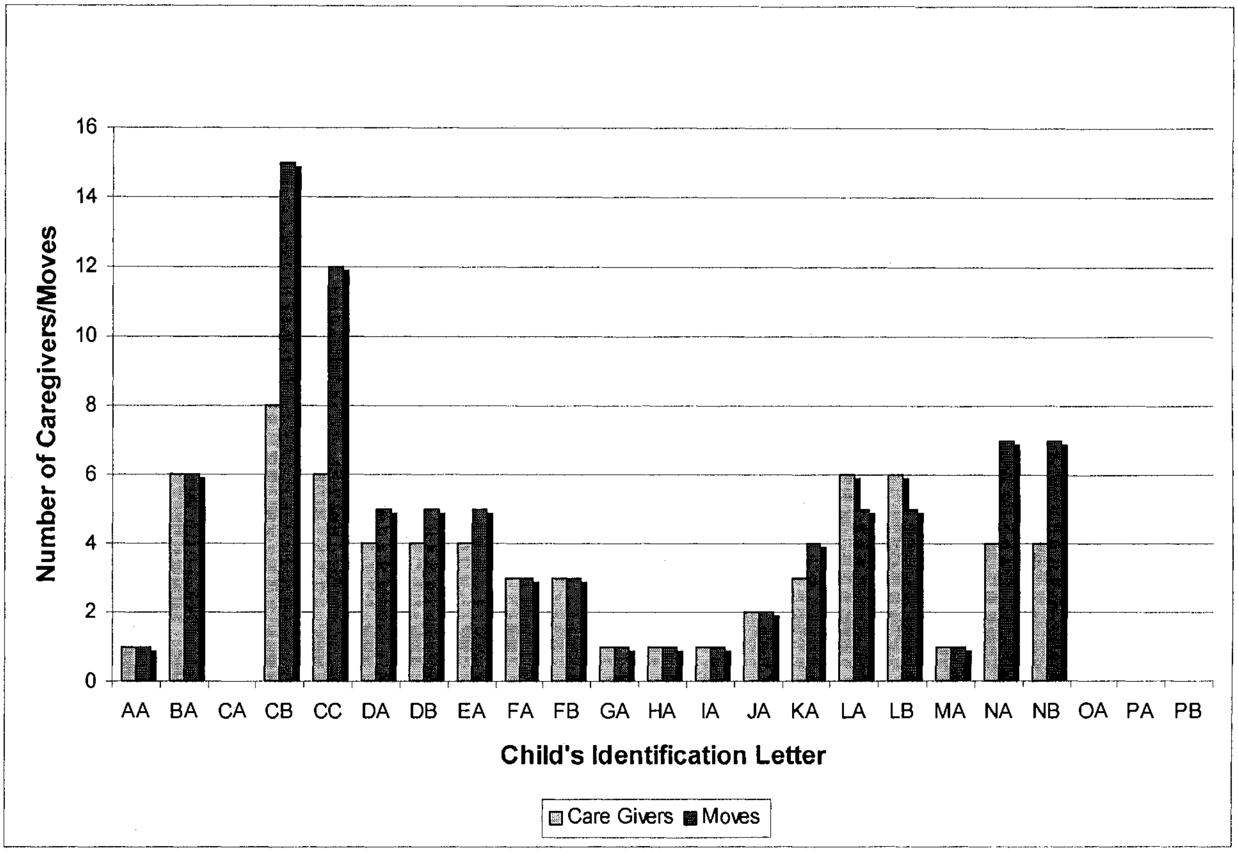
Placement History

The children in my sample had also experienced various numbers of placements and moves. When looking at these numbers, it is important to note that sometimes a child had experienced more moves than placements due to some placements being used more than once. Also, placements with parents were counted in these numbers as some of the children moved back and forth from parents to other caregivers and each of these moves would represent a disruption to the child; however, if the child lived with her/his parents after birth, I did not count this as a placement as this would be a normal move for any child. In addition, these numbers do not include informal placements that were made without MCFD involvement. It is important to note that several of the children's files indicted that they had been placed with various, often inappropriate, caregivers over the years, and therefore the number of caregivers/moves experienced by each child could be much higher than that reported in this study.

The number of caregivers ranged from one to eight and the number of moves ranged from one to 15. Table 1 speaks to the fact that many of these children had experienced numerous disruptions in life, which would no doubt impact them in areas such as behaviors and emotional health.

Table 2

Number of Caregivers and Moves Experienced by Children in Sample

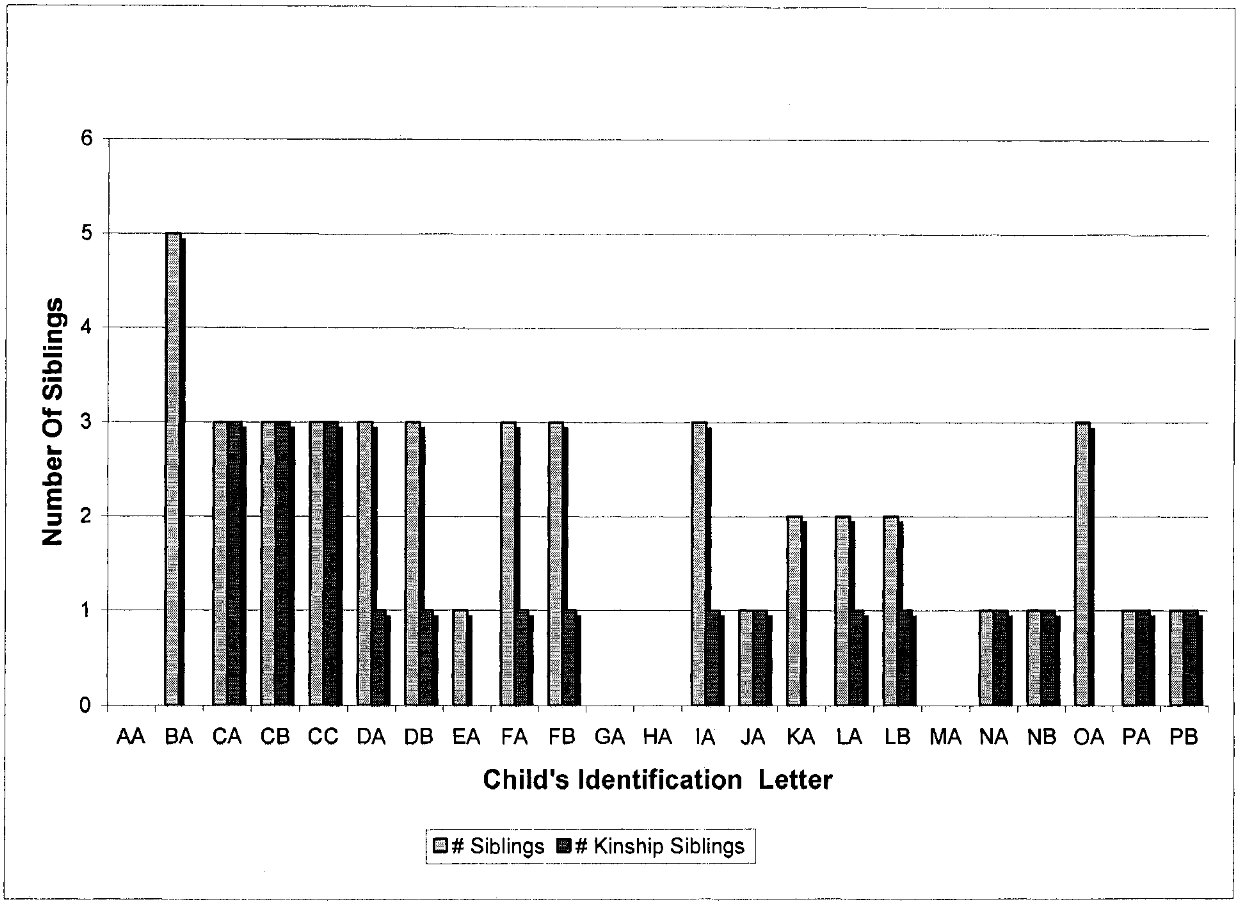


Sibling status

Nineteen of the 23 children in my sample had one or more siblings, some of whom they were living with and others who were living in foster care, with relatives, with parents, or independently (See Table 2). Again, it is important not to underestimate the impact these separations could potentially have on the children's behaviors and on their emotional health.

Table 3

Siblings Of Children in Kinship Care Sample



Behaviors

Given the history of the children in my sample, it is not surprising that a theme that surfaced during my conversations with the kinship caregivers was the children's behaviors. Some of these behaviors could possibly be age-appropriate (i.e. a two-year-old hitting her caregiver, a four-year-old refusing to eat anything but candy) while others were less typical. For example, three of the children were reported to be involved in sexually acting out with other children. One child had a history of aggression, self-mutilation, anger, cruelty to animals, and sexually acting out. Another child, who suffered from schizophrenia, experienced hallucinations. His caregiver expressed her confusion over the behaviors arising from his mental health issues, saying:

> *He takes pills in the morning and at night time, so I need to know more about that cause he says he sees things, but I don't know – he doesn't tell me those things...why isn't he telling me that he's seeing these things? And, um, shouldn't the doctor, his own doctor be involved in it and to find out about his physical – how he is, if it is really happening? The social worker, I don't know if it's up to her to try to look into it. I don't know.*

Even when the child's behaviors were somewhat within an age-appropriate range, the caregivers still expressed their frustration with dealing with them. One caregiver of a teenager said she thought MCFD should make training mandatory for kinship caregivers, adding, "*It's hard dealing with what the parents have taught the kids – the world owes me. That's the toughest thing to break*". Another caregiver expressed how the child's behaviors had ultimately resulted in a break-down of the placement:

> *You can't trust what she says. I mean, she can look you in the eye and lie to you about something you know perfectly well she did...I'm looking, "Do I really want to go through the teenage years with somebody that, you know, hasn't conquered those things?" Because, I mean, I can put up with a lot, but I expect people to tell me the truth.*

It is important to look at the children's behaviors because many of these would be encountered by the caregivers on a day-to-day basis, thereby impacting their care and their need for supports.

Experiences of the Kinship Caregivers

In this section, I am going to look at the themes that arose out of my conversations with the kinship caregivers in my sample. This information is important because it provides a base from which to better understand their particular needs.

Motivation

As discussed previously, the caregivers in this sample had various relationships with the children in their care and those relationships no doubt impacted their motivation in agreeing to provide care. Although the families were sometimes motivated by their strong existing connection with the child (i.e. the caregiver was a grandparent), when the relationship was more distant, the caregivers said that they had agreed to provide care because they wanted to do the right thing and prevent the child from entering the foster care system. Eleven families mentioned this desire. One caregiver who was a friend of the grandmother of the child in her home said:

> *When it came down to her going to ...foster care or her find someone to take her, she tried relatives first and none of them would take her and I said, "I can't see her going into foster care" because I knew her since she was born. So I said I would take her if she couldn't find anybody.*

This quote demonstrates that this caregiver was not agreeing to provide care because she had a particular need to care for this child, but rather because there was no one else available and she felt that it was not right for a child that she knew to enter the foster care system.

With other caregivers, I had the sense that they had agreed to provide care out of a sense of familial obligation. This was especially apparent with two of the Aboriginal homes, where the primary caregiver, who was Aboriginal, was caring for the child/ren of her second cousin. It is a common Aboriginal custom to ask family members to care for children when the parents cannot and it is considered inappropriate for families to decline this request. One of those caregivers said:

> *She wanted them to be with me. Well, she didn't want them to (be removed from her), but she asked, she phoned and she asked if I could have the kids instead of putting them in one home to another. She wanted them with family, so she chose me to take care of them.*

Although these caregivers did not indicate that they were only caring for the children out of family obligation, this element no doubt contributed to their decision.

I feel it is important to look at motivation because it tells us a great deal about what the caregiver's intentions were when they first agreed to provide kinship care. Some of the caregivers intended to provide a loving, secure home for as long as needed. Others intended to provide a service to society or to help out a child in need. I believe that these differences in motivation directly impacted not only the caregivers' expectations around support, but ultimately their willingness to make sacrifices in order to provide care. For example, a grandparent kinship caregiver might be willing to go into financial debt, while a neighbor might not. In addition, a caregiver who feels she is providing a service to society might place a higher expectation on society to support her in providing that help.

Expectations

Along with discussing what motivated them, the kinship caregivers also talked about their expectations of the kinship care arrangement. In addition, they discussed the expectations that were placed upon them.

Caregiver expectations.

Many of the caregivers expressed the fact that they were initially told the child/ren would only be in their home for a short period of time. One caregiver, a 36-year-old single mother of two who had agreed to care for her ex-husband's toddler nephews and quit her job to do so, described how she was initially approached to care for the boys for only a few months:

> *My ex-husband called me if I could do it and I said yes…and just take care of them until January and then you can move on with your life and keep going. So it's like I stopped my life a little bit to do this…the social worker told me that she believes they're not going back to (the mother)…it just scares me because so far I'm the only one who can take care of them….and I feel bad because it's kind of sad to bring them into foster care.*

She later went on to describe how she had only had one weekend of respite during the two months she had cared for the boys and therefore was not able to enjoy the activities that she had previous to this placement, which increased her feeling that she was putting her life on hold.

Another family, which had been caring for an acquaintance's daughter for 15 months while the woman went in and out of treatment, described how they came to realize that the child would be in their home long-term:

> *We began thinking – this is not a short-term proposition. This is going to be a long-term proposition. So (the child) needs long-term care and we're not prepared to do that kind of long-term care. It was only suppose to be for three months in the very beginning, so we felt like we had done our three months and then some.*

This family eventually asked for the girl to be moved and a family placement was found for her.

A similar experience was echoed in the words of a single mother of two, who said:

> *...When I originally took (the child) in, it was only suppose to be for a few weeks while mom was in treatment and... that didn't happen. So, you know, first it was okay but then, you know, you've got to start buying clothes and there's dental and eye care and, you know, there's other things that children need, that they have to have.*

This placement lasted for nine months before the caregiver asked to have the child moved because she needed respite to attend an important function and was not given it.

Although some of the families only wanted to care for the children short-term, others hoped that the initial plan for a short-term placement would work into something more long-term if the parents could not provide care. One participant, a single mom with health issues who was caring for a toddler, described how her expectations had changed, saying:

> *Yeah, the not knowing is what is the killer to me because three months into this (the social worker) came to me and asked me (to adopt)...at first I told them I would not adopt... because I didn't know if my health would hold up...But once ...I found out I could do it, and they came to me and said, "If it came down to (mom) losing baby, would you adopt?" And I said, "Absolutely"... but now that we're going through this court thing, I asked them if that still holds. You know, if I'm going to be allowed to adopt if it comes down to it, and she wouldn't give me an answer. She left me in the air. Very stressful.*

It is important to look at the caregiver's expectations when they first agreed to provide kinship care because it was most often during that time that they were asked about their needs. A caregiver who thinks the child will be in her home for three months might assess her need for supports differently if she knows she will be providing care for a year.

System expectations.

Many of the caregivers I spoke to also said that they felt that there were undue expectations placed on them by the child welfare system. These expectations often centered around parent-child contact, specifically around providing supervision and transportation to and from visits. Some caregivers were also responsible for providing transportation to Project Parent North, a parenting course which parents are often mandated to complete as they work towards having their child returned to them. Of the 16 families involved in this study, three did not specifically discuss expectations around visitation. Seven described visits which took place in their homes and were supervised by them, two described visits which took place outside of their homes and were supervised by them, four discussed phone calls between the parents and child and one discussed exchanging emails. In my experience, this contact is certainly more than what would generally be expected of a foster parent.

One kinship caregiver, who lived about an hour away from the community where the child's parents lived, described how she would make the trip twice a week, staying in town for the day while the child went to Project Parent North with her parents and then had a home visit. This woman had taken a year's leave from a well-paying position in order to provide care to the child:

> *They expect a lot from us and that sort of bothers us a little bit…I drive to (the city) twice a week so (the child) can go to Project Parent North with her mom…so it makes for a long day and I'm doing that twice a week and now they're wanting even more access, so she's going to have overnights.*

When I asked if she could negotiate a less onerous schedule with the child's social worker around the upcoming weekend visits, she said:

> *She's very comfortable in our home and in our environment. You know, we're sort of given the impression that if we don't do this, they might put her in foster care for those few days.*

Clearly, this woman felt that any attempt to try to change the expectations of the child welfare system could result in serious repercussions for the child and therefore she felt obligated to continue with the schedule even though it was placing pressure on her.

When looking at the needs of kinship caregivers, it is important to note that the expectations which are placed on them (i.e. in areas such as facilitation of family visits) are often higher than those placed on foster parents. These increased expectations would undoubtedly have the potential of increasing their need for support.

Parental Health/Involvement

Another theme that arose was that of the parents' health and how it impacted their involvement in their children's lives. The kinship caregivers often discussed the fact that the parents' mental health and/or alcohol and drug addictions made contact difficult and/or often resulted in them having sporadic involvement with their children.

Parental health.

My sample represented 16 mothers and 14 fathers. In two cases, the father was not mentioned during the interviews or file reviews, either because he was unknown or uninvolved. These thirty parents had struggled with a variety of historical, addiction, and mental health issues.

Table 4

Parental Issues Founds in Parents Whose Children Were in Kinship Care

Birth Parent Identification Letter	ISSUE																
	Bi-polar	Schizophrenia	Depression	Anxiety	Personality disorder	Possible/diagnosed FASD	Sexual abuse	Physical abuse	Alcohol/drug addiction	Learning disability	Low IQ	Sexual offender	Seizure disorder	Suicide attempts	Brain injury	Aspbergers	Obsessive compulsive disorde
A1	X						X		X								
A2									X								
B1					X				X	X							
C1			X	X					X								
C2	X		X	X					X								
D1						X			X								
D2									X								
E1									X								
F1			X						X								
F2									X			X					
G1				X		X					X						
G2																	
H1	X				X								X				
H2						X											
I1						X			X		X						
I2						X			X								
J1		X				X			X		X						
J2		X							X					X	X		
K1	X		X				X	X	X								
K2	X								X								
L1									X								
L2									X								
M1		X														X	X
M2	X	X					X	X									
N1			X			X			X								
N2									X								
O1			X						X								
O2									X								
P1									X								
P2									X								

This table shows that none of the birth parents in my sample were healthy and most were struggling with a variety of issues. Because the kinship caregivers were all connected in some way to the parents, they were well aware of this lack of health and often worried about how it would affect the child(ren) in the long-term. One caregiver discussed this concern:

> *I'm so worried. And then I think, "You've got to let me keep him. Please. Do something". You know. And again, it's not that I'm such a perfect person. It's just that they're, they both have such...deficits. They can't even help themselves. How are they going to train or teach a small child who is so, so vulnerable and receptive?*

Not surprisingly, the parents' involvement with their children was often complicated by this lack of health and therefore difficult for the caregivers to navigate. This topic will be discussed in the next section.

Parental/family contact.

The parents in my sample had various levels of involvement with their children, ranging from periodic emails to one case where the child lived in the same house as both the kinship caregivers and her parents, who provided all of her basic care. The contact took various forms including visits (in the kinship care home or another location), phone calls, and email.

Several of the caregivers reported that the contact was sporadic and seemed to happen in spurts or to occur frequently right after placement and then slowly diminish. One caregiver described the visits which occurred between the youth she was caring for and his father:

> *So when we first got (the youth), he was coming to visit every Tuesday and then…these visits kind of petered off and didn't really see much of him in August. He phoned a few times. Haven't seen much of him in September. He's phoned a couple of times. He came yesterday to pick him up, first time in quite awhile. And then he says they're having this meeting on Wednesday and I'm, like, "I'd kind of like to know what's going on".*

Other caregivers described how the parents' instability and mental health and/or alcohol and drug issues made it difficult to set up visits and often resulted in the parents not showing up for visits or being inappropriate during contact. One couple, which was raising their grandkids, described some of the chaos associated with the parental contact. The primary caregiver said:

> *Mom has tried as much as possible to be the life of the boys, but she's so emotional that sometimes she traumatizes the boys because she's crying on the phone and she misses them, stuff like that, so…we're making sure they're not over-traumatized again. So what we're doing right now is letters with the internet and sending photos of the boys and keeping it like that for now so we can filter.*

The secondary caregiver agreed, saying:

> *Because we at some point, we had to listen to their conversation all the time on the phone and then we got a block put on them and…the dad would try to figure out some information through us or through the kids or the mom and on and on, both sides, right? It's just a crazy thing.*

Another caregiver described the disappointment that the child felt when his father did not show up for scheduled visits:

> *And then sometimes (dad), he didn't come here and I gave him hell one day 'cause I said, "You keep telling me that you're coming and I tell (the child) and then you don't show up and (he) cries". And then he owned up to me, he'd been on a three day drunk.*

Earlier, some of the expectations placed on kinship caregivers around parental contact were discussed. When one considers that these parents were struggling with a variety of issues, the potential difficulty of navigating this contact becomes apparent.

Interestingly, although all of the children had some contact with their parents, the majority of the parents did not contribute in any way to their children's needs. When they did contribute, it was very minimal or it involved things that their children did not actually need. For example, one parent had bought diapers for the child twice while another had bought his son a video game system. Out of the 16 kinship care families I spoke to, only three reported that the parents had ever contributed to the child's care, either by giving them money or buying things. Two of the families reported that the extended family had contributed, either by buying things (i.e. a carseat, a cellular phone) or by providing assistance (i.e. respite). I believe that this finding is contrary to most people's expectations when they think of kinship care. Generally, one pictures a situation where there is minimal government involvement and the extended family is for the most part taking care of the child's needs; however, in my sample, the caregivers were meeting almost all of the children's needs with limited familial help.

Parent/Caregiver Relationships

Along with the discussion around parental contact and involvement, caregivers often discussed the complexity inherent in the relationships that they had with the children's parents. Some of these relationships seemed more positive than others, but all of them were complicated by the fact that the caregivers were caring for the children because an MCFD social worker had told the parents that they could not. Even in the case of Section 8 Agreements [which are made between the parent(s) and caregiver(s)], clearly the plans had been made because the parents knew they had no choice but to give up care of their children. In the proceeding section, I will discuss some of the themes that arose around parent/caregiver relationships.

When the caregiver is the parent's parent.

As discussed previously, seven of the 16 families were grandparents to the child in kinship care. In five of these cases, the relationships were somewhat complicated by the fact that one of the caregivers was a step-parent to the child's parent and did not necessarily have the same connection with the child's parent as her/his partner. Still, even in the homes where only one grandparent was biologically related to the child, I had the sense that both were very committed to the child and were willing to make the sacrifices necessary in order to provide care.

All but one of the grandparent caregivers described the tumultuous nature of their relationship with their adult child. These caregivers were torn between their love of their adult child, their disappointment and frustration, and their desire to keep their grandchild safe. One caregiver, who was looking after the toddler son of her adult daughter who was struggling with mental illness, said:

> *... it would be easier if she was addicted to crack. At least there wasn't a child involved. You know, I could shut her out of my life, but with (the child) involved, I*

> *have to keep some kind of good relationship with her. Like, I love her to pieces no matter how annoying she is. She's mine and she's my first.*

Another caregiver similarly voiced her frustration with her daughter, who was also struggling with mental illness, saying:

> *I was just so upset over (child's mom) and the situation and her behavior was more and more bizarre and she called the cops on me and , oh God, I didn't think I'd be able to cope with it.*

One caregiver, who was raising his daughter's three young sons while she continued to struggle with alcohol and drug addiction, described one incident, saying:

> *Things came up like kidnapping. We're going to kidnap the kids and bugger off which, like I say, I'm one of the parents of my daughter. That's my daughter. Holy God, I say, this can't go on, and stuff like that. And then when they have a visit with you and then dad would be hiding in the closet until people would go away or whatever. And stuff like that – all kinds of stupid things.*

It is easy to assume that the caregiving relationship would be simplified when there was a pre-existing bond between the caregiver and the parent; however, my findings indicate that this bond further complicated the situation by, for example, triggering the caregivers' own feelings of frustration and shame around their adult child's behavior.

Empathy.

Many of the caregivers expressed empathy towards the parents. For example, one caregiver described how the children's mother would sometimes come to their house after she had been using drugs for a period of time and would crawl into the caregiver's bed, pull the covers over herself, and fall to sleep. Another caregiver provided me with insight on why her daughter would stop taking the medications which were prescribed for her schizophrenia:

> *So she gets tired of being fat and lazy. She hates being fat and lazy. She wants to get up and do things. So she goes off her meds, she gets skinny, she goes insane, she goes back in the hospital, they put her on a different type of meds, blah, blah, blah, slowly she puts the weight back on and loses her motivation, gets upset with herself and goes off her meds, so it's just a cycle.*

This caregiver clearly understood that, for her daughter, regaining custody of her child was not as simple as choosing to take her medications consistently, because this choice came at a substantial cost.

Given the difficult relationship between the caregivers and the parents, it is not surprising that for several of the families, the expression of empathy was tinged with an equal amount of frustration. One caregiver, who was caring for a child whose mother was diagnosed with mental illness, described how she struggled to deal with the mother:

> *And the problem was the mother harassing me on the phone, constantly. From the psych ward, from wherever, giving me orders from the psych ward. Aghhhhh. And I felt badly for her because I do, you know, I do have empathy. You know, it's not her fault that she's mentally ill...she's so obnoxious to deal with.*

These quotes demonstrate the complexity of the relationship between the caregivers and the parents in my sample, even when the caregivers were able to view the parents' situation with empathy. It seemed that the closer the familial relationship between the caregiver and the parent, the more complex their interactions.

Nurturance.

In spite of the fact that the caregiver/parent relationships were often complicated, several of the caregivers in my sample had made a genuine effort to promote the parent/child bond. Having worked within the MCFD system for many years, I found that this nurturance was more than what one would see in the average foster home.

Several caregivers described the close contact they had with the parents while providing kinship care. For example, one family had the child's birth family over for Christmas and Thanksgiving dinners. Another family told me about how they had let the mother stay in their home when she was on leave from her treatment centre. Others described how they supported the mother prior to the child coming into the kinship care system so that she could try to retain care, and several families described how they would pick the parents up for visits and take them and the child to places like the park or the swimming pool. One caregiver, who was struggling financially, described the three-times-weekly visits she facilitated between the toddler in her home and the child's father, saying:

> *And if we're on a daddy visit and it's near lunchtime, I will buy the lunch and she can sit with her daddy or her mom and eat. I've always instilled in them that's important. That's just as important as playing with them. The sharing food with them, because that's a time you can bond, you can talk, and she does. She sits there and talks to them and eats and they eat with her and it's bonding somehow.*

Clearly, this caregiver, who hoped to adopt the girl in the future if her parents could not raise her, was striving to promote the parent/child bond.

Another caregiver of a teenage boy described how she felt that his contact with his siblings was important although he did not enjoy visits with his younger sisters. This caregiver was willing to open up her home to the teen's father and younger siblings so that she could nurture the family bond:

> *So I offered for dad to bring the girls here. You know, bring them over and lets have some visits and I can help him work with that because, you know, when you're 14-year-old and you haven't had small children around, it's a little annoying sometimes. Especially if they're climbing all over you, you know?*

Generally, I found that the caregivers in my sample were trying to nurture the parent/child bond while at the same time trying to establish a sense of family and belonging within their own homes. Achieving this balance was no doubt a difficult feat, especially when we consider that they often did not know how long the child(ren) would be in their homes as well as the fact that, for most of them, the very act of providing care was causing them to develop a strong attachment to the child(ren).

Issues arising from contact.

The goal of any MCFD kinship care plan is to return the child to her/his parents. In light of this fact, all of the children in my sample had contact with at least one parent and the kinship care families, by extension, were in a position where they had to deal with the issues that arose from that contact.

One issue that arose for some families was the fact that the child's immediate family was not always consistent with their visits and this inconsistency impacted the child negatively. One caregiver of a teen described how her brothers and mom would phone whenever they wanted and then would say they were going to visit:

> *When I took in (teen) I was not prepared for dealing with her mother and her brothers or her father. I didn't know how to deal with, "My brother's coming to visit*

> *me". Brother doesn't show up or phone, you know? Or mom telling her she can do something, but obviously she can't and, you know, how do you deal with that sort of situation?*

Other caregivers echoed the difficulty that could arise when the parents would send messages to the children which did not coincide with those of the caregivers. One caregiver described the difficult situation this created for the three boys she was caring for:

> *They're very conflicted when the mom shows up and has her visit with us because she doesn't like the way I raise the boys, let's say. She'll create a conflict by telling the boys differently or she'll challenge me all the time. So it was creating conflict, having the parents coming to our home.*

At the end of every interview, I asked families if there was anything we had not discussed which they felt was important or if there was any message they would like to send to people around kinship care. One caregiver's response was:

> *Be prepared that the parent will invade your home... be prepared for the fact that the birth parent will invade and try to insist on their own way on it, on how things are done. But don't give in unless you're in agreement with it.*

This need to set boundaries was another theme that arose and will be discussed in the following section.

Boundaries.

Several caregivers mentioned that, once the child(ren) had been in their home for a period of time and they had experienced what it was like to work with the parents, they realized the need to set boundaries. These boundaries ranged from things like not letting the parent visit if she/he had been using alcohol and/or drugs to making them accountable for their financial decisions. For example, one caregiver described how an agreement had been made between her, the parent, and the social worker that the parent would continue to receive the Child Tax Credit (CTC), but would give it to the caregiver for as long as the child was with her. Later, the caregiver learned that this situation was illegal as well as that the parent had not been giving her the full amount she received. When the parent asked her to write a letter to Revenue Canada saying that she had received the full amount, she refused:

> *"No, I'm not going to lie to them...Guess what? You're paying it back." Because I struggled during that time to keep food and diapers and this baby – baby food is so expensive. I even went to the point of making all her food.*

Another caregiver discussed how important it was to set boundaries but also described times when she had not been consistent. For example, she described how she had told the child's mom (her daughter) that if she moved away from home, she would not be allowed to return. Several months later, when her daughter broke up with her boyfriend, the caregiver relented and let her move back in – an arrangement that lasted twenty-four hours before the daughter returned to her partner. Later in our conversation, the caregiver summed up where she was at in her relationship with her daughter:

> *And actually, it's not bad anymore now that I've kind of made amends and realized that I can't do anything else for (mom). That was my only stress – just her. You know, go to bed thinking about her, wake up thinking, "What's next?" But now I'm pretty much, like I said, guilt free. I've tried and at some point you just have to shut if off and say, "There's nothing else I can do". Well, and stay sane.*

As mentioned previously, many of the caregivers indicated that their relationship with the parents was complicated. When you consider the fact that many of the caregivers were facilitating visits with parents who were struggling with mental illness and/or addictions issues, it is easy to imagine some of the complexities that would arise. Some parents indicated that their ability to set boundaries was complicated by the fact that they felt threatened by the parent, a subject which will be discussed in the next section.

Sense of threat.

Previously, I discussed some of the complications inherent in the parent/caregiver relationship. A final complication which arose involved some of the caregivers worrying that, if they made the parents angry, they might restrict contact with the child in the future. This concern resulted in the caregivers hesitating to set boundaries. One caregiver described how she felt obligated to maintain a positive relationship with the child's father out of fear that he would limit her contact with the child in the future:

> *(The child's) dad, I can't stand him. He doesn't know that. I never show it and I would never stop him from coming. I encourage him constantly, but I really - I really dislike him...I think that's the most stressful is having to, if you despise someone, putting on a happy face. But you do. You have to. For me, I have to for one reason only, that's because if it ever happens that he went back to him, then being the grandparent, he could make it quite difficult for me to do the same.*

Two other grandmother caregivers echoed a similar sentiment, discussing how their worry that the child's father would limit their contact prevented them from being completely honest with him and with others involved in the child's life (i.e. MCFD social workers). This worry undoubtedly left these caregivers caught between the child and the parents and at times impacted their ability to truly advocate for what they felt was right for the child. When we consider that the caregivers were also trying to meet the expectations of MCFD, which imparts to families its own power and sense of threat, it is clear that these families were truly involved in a balancing act of often-diverging needs.

Changing Lives

Another theme that surfaced repeatedly during my interviews with the kinship caregivers in my sample was the fact that many of them had so drastically changed their lives in order to provide kinship care. One could argue that, given the fact that each caregiver assumed care of a child, all of their lives changed to some degree; however, for nine families in particular, the changes were extensive.

Occupational changes.

Six of the 16 families reported that they had made changes at work in order to provide kinship care. Six of the families had cut back or eliminated the hours worked by the primary caregiver and in three families this change resulted in the secondary caregiver having to work longer hours in order to continue providing an adequate income for the family. This change resulted in the secondary caregiver spending less time at home, increasing the amount of energy the primary caregiver had to devote to providing care. In the remaining three families, either the caregiver was single or the secondary caregiver was not able to work extra hours. One family, which had bought a modest but larger house to accommodate the child they were caring for (and who were incidentally raising the child's sibling through the CIHR program), described how the primary caregiver had taken a leave from her job as a taxi driver in order to provide care, resulting in her husband having to work longer hours. When I asked how many hours the secondary caregiver was working, his wife replied:

> *I haven't seen him today. He goes to work at about, well, let me see, he works...between forty and sixty hours a week, depending on how busy he is...he'd be*

> *working less hours right now than he is. Like, he's working more than sixty hours a week right now because we changed houses and it's a very expensive thing to move.*

These occupational changes were felt in a particularly acute way when the families were near or at retirement age.

Changes in life plans.

Four of the families discussed how they had modified their life plans in order to provide kinship care. With two of the families, these changes involved their retirement plans and with one it involved their plans for independence. One caregiver, who had three birth children living in her home, described how she had looked forward to her kids getting older so she could enjoy more activities with her husband:

> *I'm definitely mourning my being that close to being out and about again. My husband is, for sure. Like, we're avid bikers and this summer we didn't get out once... We've done a lot and we've planned a couple of big trips, so I guess that's the biggest disappointment...and it's not that –I wouldn't give (the child) up to have it back, but in the same sense to be able to get up on a Sunday morning ...and take off for four hours on your mountain bike and not have to worry... When you look at it in the long run and think, "God, do I want to do this forever again?", knowing that you're away from it. But in the same sense, when you look at him, there's no way you'd do anything but. So it's that damned if you do and damned if you don't kind of feeling.*

Another caregiver, whose husband was close to retirement age but had chosen to work longer hours so she could stay home with the child, echoed a similar sentiment, saying

> *Of course our plans change. We were going to Mexico, we were going to Europe, we were going to do this and that and the other thing. I was going to drive a Mazda Miata…now I've got a Ford Focus station wagon…our income went way down and just a complete reversal.*

She, too, echoed her willingness to provide care even though that meant a sacrifice on the part of her and her husband:

> *I need for them to grow up a little bit and be more independent so I can get my life back. I just started getting my life back with (other child in the home under CIHR) and then it all fell to pieces again. But I'm glad it fell to pieces. I'm glad I can provide this protection and a regular life for (the child).*

Lifestyle changes.

Three of the caregivers discussed how they had changed their lifestyles and/or schedules in order to provide kinship care. For example, one caregiver discussed how she and her son had always taken a vacation every year, but now that they had another child in the home, they were no longer able to afford this trip. Another caregiver described how her husband use to do something with their first child (who was in their home under the CIHR program) on Sundays to give her a break, but when the second child joined their home through kinship care, he felt unable to take both children, so she no longer received a break. This change was felt particularly acutely by this woman who used this time to attend a local church, a ritual which she says was very uplifting for her.

Social changes.

Two of the primary caregivers described the social changes they had made after welcoming a young child into their home through kinship care. One 58-year-old caregiver who was providing care to her 2-year-old granddaughter described how she had cultivated new friendships with other women who were mothers of young children. She said with a laugh, "*My daughter bugs me that all my friends are in their thirties*". Another woman, a 59-year-old widow who was caring for her young grandson, described her response when her friends would invite her out for drinks:

> *I think, and my friends all know, if they want to invite me out, he has to come. That's just the way it is. And the ones that are my true friends understand totally because I said, "I wouldn't even have a good time if I knew I had pawned him off somewhere". And what do we do that he can't be there?*

Changes for other children.

Two of the caregivers, who had already been providing long-term care to the children's older siblings, described the changes that had taken place when the second child had joined their home. One caregiver described her frustration over the aggression that the younger child was displaying towards the older child:

> *Like, I caught her, I caught her like there at the top of the stairs, I caught her just about pushing (the other child) again and I had to scream at her, "You stop that right now. Don't you dare do that!"*

With the second caregiver, it was the older child who was aggressive and who responded negatively to the addition of his younger sister. She explained with laughter:

> *And (the older child) is kind of a different person, but (he) is use to being the ruler of the house and to have this little girl come in with a different personality than him – she's friendly and she's very inquisitive and she's destroyed his life.*

Clearly, the dynamics of going from raising a single child to a sibling group would have an impact on any family, especially when both those children had issues relating to early childhood trauma. This change would undoubtedly impact the entire home, particularly the primary kinship caregiver.

It is important not to under-estimate the potential strain of all of these changes on the kinship caregivers. Often, the role of kinship caregiver had fallen on the families quite quickly, giving them little time to prepare. While they were learning to navigate the new role of caregiver and to work with the parents and social workers, they were also needing to make changes around occupation, life plans, and social activities while potentially dealing with new behaviors from their other children as they adjusted. I think it is fair to say that this situation would pose a challenge for most of us.

Perceived Improvements

Another theme that arose was the caregivers' perceptions that the children had improved while in their care. This belief seemed to contribute to their conviction that the care the children had been receiving from their parents was sub-standard and to a desire on many of their parts to have the children remain with them:

> *At first, everything with them was negative. It was negative, negative, negative. They said everything negative for the first time when I had these kids. But now, when I listen to them talk, they're starting to see positive things and say positive things.*
>
> * * *
>
> *But this is a young girl who came to us with no boundaries. She never wore underwear, she didn't wear socks, so we basically had to teach (her) the basics...she's doing wonderful now.*
>
> * * *

He picked up as soon as he started eating vegetables and fruits and healthy eating... (youth) is getting B+'s and B's and C+'s and I'm so good with that. He goes, "It feels so good to pass" and I go, "Yeah".

* * *

We don't drink or do drugs or any of that kind of crap, so she's in a safe place and so she has continuity, she has stability, she has a routine... I think she feels safe and the difference between her living with her mother and her living with me is just, like, night and day. She's happier. She doesn't have tantrums at the daycare anymore.

* * *

She's almost 4-years-old, but she was more like an 18-month-old when she came here. I mean, she'd never seen a toothbrush before... it was awful. She was... wearing 24-month clothing. She had potty training problems still. She couldn't talk. She didn't eat anything but candy. And she was use to getting her own way... we've got her on a good diet now. Like, she's growing. Like, that shirt that she's wearing is a size 4.

* * *

Her large motor skills... were 25% when we got her and now they're up in the 90's.

* * *

Within a couple of months, she just boomed. She gained weight. Her hair started to grow in.

* * *

When you see them changing and doing well and them blooming and their self-esteem is better and their self-confidence, you think, "Oh my God, that didn't happen alone".

* * *

> *The daycare, they can attest to the difference it's been since he's been with me.*

In the next section, I will discuss the themes of love and attachment which arose, often hand-in-hand with the caregivers' discussions of how the children had improved in their homes.

Love and Attachment

Several of the caregivers openly discussed the love that they felt for the children in their homes. The relationships typically preceded the kinship care placement (i.e. in the case of grandparents providing care). One grandmother said:

> *I do, I do love him. There isn't anything I wouldn't do for him. Nothing…And I think he knows it, too. Whatever I'm doing, he comes up to me all of a sudden and he kisses my hair, he hugs my leg and he says, "I love you Grandma" and I say, "I love you, too".*

Another grandmother said:

> *Kinship care is about love. Total devotion to benefit the boys, a lot of unselfish giving…my love is doubled with the boys and kindness, too…It's a beautiful journey. It's all worth it. This is one of my best accomplishments in life. The love is there.*

Other caregivers, who were providing kinship care to their former foster daughter's children, described their feelings, saying:

> *I don't know if I can tell you how much (husband) and I love those two kids. That we would do anything for them.*

Another caregiver, who was caring for her ex-husband's nephews, described how she felt that she had different feelings for the boys than a non-family caregiver would have:

> *Yeah, well, because it's part of the family. It's an attachment there. An attachment because they are my, my kids' (cousins). So, I don't know, I feel like there's more...there's a little extra love there.*

Along with the discussion of their feelings for the children, the caregivers often discussed the worry they felt about the children returning to their parents. Interestingly, all of the families in my sample who expressed this worry as being pervasive were grandparent caregivers.

One grandmother discussed the possibility that her grandson would return to his father's care:

> *I would look after that little boy forever. It's a labor of love as far as I'm concerned. But my terror and my fear is the legal system we have. I don't know if they're going to put him back there or God only know what else will happen to him...I just want him to be happy, you know, and safe. You know, getting proper meals and nobody yelling at him. And allowing him to be his own person and make his own mistakes...I'm prepared that if that happens, I have to let go. I mean, if I have to, I have to.*

Another grandmother caregiver expressed similar feelings:

> *We would like to raise her. It's the best for everybody and after having her for so long, we're attached to her. It's going to be extremely difficult for us if we don't (continue to provide care), but it's for her own good and for their good, but they don't see that...The big picture is what happen to (the child). We want her to be safe and to have the best care. She's an important little person.*

When you combine the perceptions of the caregivers that the children were improving in their homes along with their growing love and attachment, it makes sense that they would worry about the children leaving and would want to ensure that they remained in their homes.

In this section, I have looked at the topics which arose during my discussions with the kinship caregivers in my sample. My goal during these discussions was to come to a deeper understanding of what it was like for these caregivers to provide kinship care. In the next sections, I will look at existing and needed supports.

Existing Supports

The themes of existing and needed supports were woven throughout my conversations with the kinship caregivers and will be written about separately, as they were the ultimate focus of this study. I will begin by discussing existing supports and then will discuss needed supports.

Family

Previously, I discussed the fact that the caregivers in my sample had received minimal support from the children's immediate families. On the other hand, 12 of the 16 kinship care families I spoke to indicated that their own family was a source of support to them, a fact that takes on additional meaning when one considers that many of these family members were not related biologically to the children. This support took many forms: providing babysitting/respite, listening to the caregiver "vent", buying the child necessities such as clothing and food as well extras such as toys and gifts, and giving professional advice (i.e. one couple's daughter was trained in Early Childhood Education, while another was a pharmacist). Four of the primary caregivers said that they went to their husbands when they needed someone to talk to. One indicated that she avoided talking to her husband about issues arising out of the kinship care arrangement (i.e. court) because it upset him too much.

Friends

Ten of the 16 primary caregivers indicated that friends were a source of support to them. Each of these families stressed how important these friendships were in helping them to feel supported. The contact with friends took place over the phone, in person, and via email. The friends ranged from previous and current co-workers to neighbors to people that the caregiver had met in the community. They provided support such as babysitting/respite, purchasing things for the child, and listening to the caregiver vent. One caregiver described how her previous coworkers were a source of support, saying:

> *I go down to the taxi stand sometimes. They buy the kids…there's a candy machine there and they give the kids each a loon and they go, "Oh, (child), you're getting so big!". "Oh, you look so cute today" and stuff like that. And I go, "Rant, rant, rant".*

This caregiver later discussed how she also used the internet for support:

> *I've got a few people that I write to on email. So, they're not actually physically…I've never even met one of these people. Which makes it really cool cause I can rant and rave and she can't tell anybody.*

Several of the caregivers brought up the fact that it was sometimes difficult to vent to friends because, due to confidentiality, they did not feel that they could tell their friends everything about the child's situation; however, overall, friends provided a solid source of support to the majority of kinship caregivers in my sample.

Faith

In the interviews, I asked caregivers both about their religious and spiritual belief systems. Nine of the 16 families identified that religious or spiritual beliefs were part of their life and were an important source of support to them. The sources of faith identified were: Christianity (four families), Catholicism (two families), Aboriginal spirituality (two families) Jehovah Witness (one family), and a 12-step group (one family). There is some overlap because one of the families identified with both Catholicism and Aboriginal spirituality. It is important to note that several of the families who identified organized religion as a source of support also spoke of how they practiced spirituality on their own. For example, one caregiver who use to attend church spoke of how she could not attend since the child had moved to her home, so she prayed on her own:

> *Oh, I pray. I have my communication with God. It's always outside. Trees. I don't worship trees or anything, but I talk to trees. Yeah, praying for me has to be outside.*

Many of the families that identified this faith as a support emphasized its importance in their role as a kinship caregiver. For example, caregivers said:

> *It's a daily thing when we need it, not just a Sunday thing...It's a source of support to me in everything in my world.*

* * *

> *I pray before I go to bed in bed – thank God for the kids and my mom living...it soothes my mind.*

* * *

> *It's just…when you're…you get sort of narrow. We've got a very narrow focus here. And it's just good to get out into the community and see other people and be part of something, even if I'm only on the fringes.*

One caregiver who faithfully attended a 12-step group, said the following when asked if it was a support to her in providing kinship care:

> *Yes, absolutely…I guess I have support from other members with more experience and it's a different way of life. It's not just about not drinking, it's about living your life according to the spiritual principles.*

Community

Community was also noted as a source of support by several families and it seemed that this was the most creative source of support utilized by families. Community support took many different forms: the local health unit, infant development program, parent's drug and alcohol treatment centre, foster parents, Salvation Army, teacher's assistant, and assessment centre staff. In some instances, the support was in the form of a readily available public program (i.e. mother/tot drop-in through the health unit, Salvation Army food hampers). In other instances, it seemed that the parents and community had been creative in establishing the support. For example, in one case, the kinship caregivers turned to the mother's drug and alcohol treatment centre for support and advice and said that the staff at the centre were readily available to offer that support even though it did not fall within their mandate. The teacher's assistant who helped one family was not the child's teaching assistant, but simply one who worked at the school that their child attended. It was interesting to see the creativity involved in such arrangements and I could not help but wonder if similar relationships would be found in larger urban centers with a greater number of formal supports.

Support Group

Although there is a support group in Prince George for grandparents who are raising their grandchildren, only one of the caregivers I spoke to had attended that group. This finding would appear to indicate that, although this is an existing support, it is not well-used. Ten of the 16 primary caregivers said they would attend a support group and 6 said they would not. Interestingly, the caregivers envisioned the group differently. One said that she thought it should be a family night, where families could come together and participate in inexpensive activities, rather than just a forum for people to talk; another said she would attend if she could have a place to vent. Three caregivers mentioned that they would go if the children were invited to attend. One caregiver mentioned that it would be better if no social workers attended so that people would be able to speak freely.

The one caregiver who did attend the local grandparent support group cited it as a good source of support. She said:

> *It's very interesting going to the first meeting and realizing all of us are in the same boat but we got into that boat by different means. It's just weird how it all happens. And it was also strange the different types of funding that are there for different custodial arrangements.*

This caregiver showed me a booklet that had been mailed to her by the group coordinators and commented that the booklet was not particularly helpful. This caregiver was trying to obtain dental funding for the child in her home, whose teeth were severely decayed:

> *So, resource booklet – they're suppose to give me resources to find funding for dental. No, they tell me how to brush my kid's teeth properly. Hello! We're grandparents. We've been through this. We know that stuff. Tell me where to get the money to get the kid's teeth fixed.*

Clearly, the caregiver was looking for practical advice about meeting her child's needs and not about day-to-day parenting.

Although 10 of the 16 primary caregivers said they would attend a support group, my sense from the rest of our conversations was that, while they liked the idea of a support group, the logistics of fitting one in their lives would be difficult. Also, it seemed like families envisioned a support group as meeting different, often conflicting needs. One caregiver said she would attend if she could "vent" about issues, another said she would not attend if such a format were used. My perception was that only a small percentage of caregivers would actually attend and this belief is supported by the fact that several of the grandparent caregivers knew about the grandparent support group but chose not to attend, even though they said a kinship care support group would be of interest to them. On the other hand, the positive potential impact of a support group for caregivers who choose to attend should not be under-estimated and I certainly had the sense that many of the caregivers I spoke to would benefit from hearing others' stories.

MCFD/Social Worker

I have placed this section on existing supports last because the caregivers described MCFD and their social workers as being both a source of support and as being unsupportive. As discussed previously, most of the families were receiving tangible supports from MCFD, including things such as a kinship care payment and reimbursement for medical/dental expenses. Some of the families were receiving a daycare subsidy, while a few others had extra expenses such as music lessons and school tuition covered.

Overall, the caregivers spoke very positively about their social workers, even while acknowledging that the social workers were often too busy to meet their needs. Some of the comments from caregivers are as follows:

> *Before, I was always playing phone tag with the social worker and we're having problems with daycare and we're having problems with funding and all kinds of problems and now we have (social worker) and all of a sudden we're her number one priority and it's awesome.*

* * *

> *The social worker that we have with (the child) is pretty fabulous... She knows that I'm doing fine, so she always says, "I know – I'm neglecting you" and I go, "If I needed something, I know where to get a hold of you".*

* * *

> *And she (the social worker) knows a lot. She supports me well. I can't say enough how awesome she is.*

* * *

> *We really appreciated her. She was a good person to talk to and to work with...She was always there for us...she was very knowledgeable and she was never gruff or upset or grouchy or anything like that.*

* * *

> *Actually, I wanted to phone one day just to thank her because I felt that she was behind the expediting of – because I sent her a letter saying, "I need your help" and it was right after that that everything fell into place. And I thought, "Bless you". And I thought, well, I would phone but then she's always so busy and I would say to the gal, "I just wanted to say thank-you".*

* * *

> *...the social worker herself, really listens to me regarding what is good for the boys and their state of mind to make a decision if the parents should be in touch or not. Like, they're really trusting me now, which, that took awhile – you have to build the trust... (our social worker) is a sweetheart.*

Other caregivers described their social workers as being less supportive, particularly around being unavailable and not providing supports such as daycare and respite. Some of the comments from caregivers included:

> *I guess one of the things I found frustrating once in awhile is that it's so hard to get a hold of anybody at the Ministry. And, of course, we realize of course that, you know, they have their work and they have extremely busy schedules, but sometimes you need or you wanted information or whatever and it's just very difficult to get a hold of somebody.*

* * *

> *She's got so many things that she's dealing with. I know that. I'm not the only person. But it would be nice to know where I stood. I think that's what's keeping me awake at night. I was up at four o'clock in the morning and that's the first thing on my mind.*

* * *

I don't know, I just feel like there's not enough – like, I was offered to have respite, I was offered that they would help me to find daycare, I was offered that someone would come with speech therapy, um, I was offered a Native social worker coming to my house and – nothing happened...I just feel like if you are not calling and reminding, that they forget...I just don't like to be in people's faces all the time. I just feel like they should, it should be more like it's right there for you when you do these kind of things.

* * *

She (the social worker) doesn't know enough about legal issues like joint custody. She said she'd look into it and get back to us – that was the end of August.

* * *

It's been so difficult to get a hold of - like, they keep switching social workers on us and we'd have to go through the whole sad and sordid story again to bring her up to speed. And they do it, I'm sure, to prevent them from getting emotionally attached. So they give you a new one all the time so these people don't get a change to know you and know what the issues are and what special needs are because they want them to be uncaring.

As a social worker, I found these quotes to be particularly interesting because even the families that expressed criticism towards their social worker(s) consistently commented on how they understood that their social worker was very busy with other caseload issues. It seemed that families were frustrated by the lack of support while at the same time not placing blame on the social workers, but rather on a system (MCFD) that requires too much of them.

Needed Supports

The kinship caregivers that I spoke to very readily discussed the supports that they needed. Surprisingly, although my literature review included very few Canadian sources, the needs of the kinship caregivers in my sample quite closely matched those in the literature review.

Financial Support

One of the topics that arose frequently was that of financial support. All but one of the primary caregivers in my sample was receiving a kinship care payment from MCFD and the one who was not said that the child's mother (who also lived in the home) was receiving Income Assistance for her. Several of the families had initially cared for the children without the kinship care payment, when it seemed that the placement would be short-term. Some of these had received vouchers for groceries, while others had received no funds at all. One family said that they had received a kinship care payment for five of the 15 months they had provided care. Another single mom of two teens described how it initially was not an issue for her to only receive grocery vouchers:

> *Well, you know, when I originally took (the youth) in, it was only suppose to be for a few weeks while mom was in treatment and, you know, that didn't happen. So, you know, first it was okay, but then, you know, you've got to start buying clothes and there's dental and eye care.*

This caregiver said that she finally spoke to a friend who worked for a local family support services agency and was encouraged to advocate for herself to get the kinship care payment, which she successfully did.

Several of the caregivers discussed the fact that the parents did not help out financially as originally planned. The family who did not receive pay for the first ten months described how the initial kinship care agreement specified that the child's mother was suppose to give them $200 a month, but she only did this sporadically. The primary caregiver described how she had to call the mother on payday and offer to take her to the bank as a way of prompting her to contribute to her daughter's care. She also noted that this strategy seldom worked.

Before beginning this research, I thought that all of the caregivers would cite a need for increased financial support, but not all of them did. In fact, nine of the 16 families said that they would provide kinship care even without the kinship care payment. I quickly realized, however, that, for almost all of these families, raising the child(ren) without financial support would mean a huge sacrifice and in some cases was not practical, causing me to wonder if these families were too optimistic in thinking that they could provide kinship care without support. For example, when asked if she could care for her grandson without the kinship care payment, one widowed 59-year-old grandmother living in a modest home on a modest income responded:

> *Absolutely. I don't care what we'd do. We'd find a way. Yes we would. Yes we would. It's nice that it's there…But, um, no, the house is paid off except for what's owed against the line of credit. But if I had to, I'd sell the house in a heartbeat if it means I could get to keep him.*

Caregivers like this woman were willing to make whatever sacrifices were needed in order to keep the child in their home safe; however, we have to wonder about the long-term ramifications on this caregiver and the child in her home if such sacrifices were made.

Even some of the families that said they would not struggle unduly if they had to provide kinship care without funding discussed their frustration over the funding situation. In one family, the primary caregiver had taken leave from a lucrative job in order to stay home with the child. They were paying $300 a month for a special formula as well as paying for gas to travel approximately 400 km a week for parental visits. They were anticipating that they would have to spend money out of their Retirement Savings Plan to pay for a lawyer to fight to retain custody of the child and were anticipating that the total lawyer bill would be between $20,000 and $40,000.

Interestingly, although the amount of the kinship care payment was consistent, the families in my sample were receiving varying degrees of extra funding. For example, one family had a fence built in their back yard as part of their initial kinship care agreement. One family was receiving tuition for private school while another said she was paying for it out of her own pocket. Some families had difficulty getting the child's medical and dental needs reimbursed, while another child was receiving ongoing funding for piano lessons. It seemed that the amount of funding depended primarily on two factors: the belief that each family's social worker and her team leader had around kinship care and the status of the family. For example, the family that received payment for a fence were long-term foster parents for MCFD. The child that received piano lessons had a social worker who was a well-respected, skilled advocate.

Kids' Activities

I was surprised by the fact that seven of the 16 families I interviewed said that they would like help to pay for extra-curricular activities for the children in their homes. All seven of these families discussed the fact that the child(ren) in their homes had already been through a lot in life and were struggling with issues relating to their history. They felt that these children could benefit from extra-curricular activities but also felt that they could not always afford to pay for them. One single mother of two who provided kinship care to a teen girl who had a history of engaging in alcohol and drug use said:

> *(Extra-curricular activities) certainly would not be covered by (the kinship care payment…it would have given her some kind of goal, something to look forward to…a reason maybe not to do the things she wants to do.*

One grandmother commented that her 4-year-old grandson had not experienced a lot in life due to his neglectful early years:

> *And I would like to take him for swimming lessons – I'd like to be able to do some extra things for him that he never had a chance to do before.*

Another caregiver mirrored this belief, describing how her two nephews had not experienced a lot of activities:

> *…the kids, they need more. The events they're happening around Prince George, some of these kids, they've never seen things…so we took them to the Monster Mash, monster truck event, that one was, like twenty-three dollars a kid and we paid it ourselves and they had fun. They talked about it for two weeks.*

Interestingly, as mentioned previously, in some cases, MCFD was paying for activities for the children. For example, MCFD was paying for half of the cost of swimming lessons for one sibling group. In another case, one child's social worker had successfully advocated for her piano lessons to be covered. In other cases, however, the children were not receiving funding for extra-curricular activities and this was clearly an area where several of the kinship caregivers wished for increased support.

Medical/Dental

Initially, the topic of medical and dental coverage was very confusing for me because it seemed that some children were completely covered while others had no coverage. In addition, some of the children with no coverage had their medical and dental costs reimbursed by MCFD, while others did not. When I interviewed the social workers involved, I found that they were also confused and, in a few instances, the social worker asked me if I could clarify the situation for her. I eventually came to realize that MCFD is not mandated to ensure that children under kinship care have medical and dental coverage. If one of the parents has a Family Services (FS) file open, the child can receive coverage under that file. If, however, there is no open file, the social worker has no means to cover these costs other than to request reimbursement from her team leader. Some team leaders are more willing to provide this reimbursement than others, depending on their philosophy around kinship care. For example, on one file, I found an email from a social worker to her team leader requesting reimbursement of $206.00 for a child's dental work. The child had been severely neglected and the family had temporarily down-sized to one income in order to provide kinship care. The team leader expressed her reluctance to pay, saying that she felt it was:

> *...not necessarily above/beyond day to day costs for the care of a child, or something that would be unexpected... If the parents are unable to pay and it is clear why the caregiver is financially burdened to pay, then we can pay.*

Clearly, the philosophy of this team leader was that kinship caregivers should be able to cover all of the day-to-day costs of the children in their home with the kinship care payment. In other instances, the team leaders reimbursed similar amounts without question.

Even some of the families who were reimbursed expressed some frustration with the system, however, saying that it was not an easy task to get reimbursed for either medical or dental needs. They had to first get a quote regarding the cost, then go to the social worker to request approval, then pay for the service, then go back to the social worker with the receipts and wait for reimbursement. Especially for low-income families, this system proved onerous at best.

It is also important to note that BC has a "Healthy Kids Program" which provides up to $700 a year for dental coverage for children who qualify (i.e. low- to middle-income families); however, as several of my families pointed out, when a child's teeth have been severely neglected, $700 often does not cover the amount needed to fix them. One caregiver had been told by her dentist that it would cost $1800 to fix the child's teeth. In addition, there is no such program to cover the medical costs of children and some of the children in my sample were on a myriad of expensive medications due to their special needs.

Respite

In the North Region, difficulty in finding respite providers is an issue for birth, adoptive, and foster parents of special needs children. Five of the 16 primary caregivers in my sample conveyed a need for help in paying for respite as well as in finding someone who could provide this service. For the families who felt respite was an issue, it was a serious issue.

For example, one 37-year-old woman who was caring for her two young nephews expressed the fact that she might ask for them to be moved because she had only received one short break in the two months she had been caring for them. My sense was that this woman genuinely cared for her nephews, but was exhausted by caring for the boys and her two birth children without a break. Another woman, who was caring for her daughter's teen friend, said she had eventually asked for the girl to be moved, partially due to the lack of respite:

> *...I couldn't send her to her mom's, her brothers weren't reliable, her dad was in (another community). You know, there really was no support as far as a respite situation...and that's actually part of the reason why she's not here.*

It is important to reflect that many of the people providing kinship care in this sample were grandparents and/or were at a stage in their lives where they would naturally be enjoying some freedom and they were now providing care to children with a variety of special needs.

Information

Eleven of the 16 families I spoke to demonstrated a need for additional information regarding the child(ren) in their care, particularly around the plan for the child. For the families who lived with this need, it had a significant impact on their lives:

> *I would like a bit of forewarning (before the child returns to his father) – like, I would like to get that in place before he just comes in and gets him. And I just don't know how this works. I have no idea what the parameters - like what the time frame is.*

* * *

> *...it looks like they're moving towards giving (the child) back to the mom. They're giving her a lot more access, unsupervised access, and we're very nervous about that...but we don't know what's going on. It's the uncertainty...our whole future is wrapped around what happens with (the child).*

* * *

Yeah, the not knowing is what is the killer to me.

* * *

Well, there's always this uncertainly and having to plan our lives around court dates.

* * *

...(The father) says that they're having this meeting on Wednesday and I'm, like, "I'd kind of like to know what's going on"...the last papers (the social worker) gave me were for continuing custody, so I'm kind of assuming that that's what this meeting is about tomorrow.

In each of these instances, the caregivers cited worry over the potential loss of the child; however, it is important to note that the outcome of these decisions would significantly impact the lives of the caregivers in other ways as well. For example, some of the caregivers were putting off retirement, taking leave from work, investing thousands of dollars in lawyers, and dipping into their retirement funds while they waited to hear more information about the child(ren) in their home.

Some caregivers also expressed a general lack of information about the legalities associated with kinship care:

Like, the kith and kin is good. I didn't understand it when I first, like when they first put (the child) in my care. I didn't know what I had, or what, what - I just agreed that he could be here for any amount of time.

* * *

At first I didn't quite understand what she meant by mediation – I got to be there and I didn't even understand what that meant and I didn't know how it was important I

> *was there the first month…but the second month I said, "Okay, I'll be there", and then right away they put the kids with me when I was there.*

* * *

> *It's stressful. It's very stressful. Because it's all a guess. Like, even with the court date – we knew we were going to court – when they had the last one, they set a date…none of us – me, (mom), or (dad) knew what it was for…we didn't know we were going to trial until we got there.*

One grandmother, who was thrilled to be caring for her grandson, said that she was not asked to care for him, but was told that she would:

> *I think it was that constable that phoned me at work one day and she said, "You've got supervisory guardianship" and that was the end of it. And I'm, like, "A-be-a-be-dee-a. What do I do now?"*

A final theme of needed information arose when some of the caregivers explained their situations to me in such a way that I could tell that they needed more information. For example, when I asked one caregiver who her social worker was, she told me that she did not have one, but gave me the name of the child's social worker. This caregiver did not understand that she, the child, and the birth parents shared the same social worker and I feel that this both reflected her somewhat strained relationship with the social worker as well as her ability to feel more connected to the social worker.

Another area where I noted lack of information was regarding the Child Tax Credit (CTC). According to BC law, the CTC is to be paid to the people with whom the child is living. On the kinship care agreements, it notes that caregivers should apply for this benefit; however, only 8 of the 16 primary caregivers said that they were receiving the CTC. Five were not receiving it. Two were unsure whether or not they were receiving it. Some families felt they would not be eligible because of their wage and at least one social worker concurred with this belief. However, the bigger point is that, if the caregivers do not apply for the CTC, the birth parents continue to receive it, which makes them guilty of fraud. In at least one situation, the child's mother, who was living off of Income Assistance, was having to pay back a substantial amount of money due to this lack of information around the CTC program.

Training

I specifically asked the kinship caregivers whether or not they had been offered any training prior to providing kinship care, whether or not they feel they would have benefited from training, and what types of training they could have used. One of the 16 primary caregivers said she had been offered training and 10 said they would have benefited from training. Caregivers most often cited the need for training around parenting and also talked about training around grief/loss, anger management, caring for a child with special needs, and working with a child's parents.

Equal Treatment

I asked all of the kinship caregivers in my sample to describe to me their perceptions of the differences between kinship and foster care. Some of the families provided a lot of feedback (i.e. caregivers who were or had been foster parents), while others were less sure of how the foster care system works.

All of the caregivers in my sample spoke positively about kinship care in general. As mentioned previously, many of the caregivers had agreed to open their home so that they could keep the child out of care or, more specifically, out of a group or foster home and all of them felt positively about their ability to do that. Some of the comments were:

> *It's less structured, it's more family, more natural, more normal. I feel like it's more…there's a little extra love there. I mean, I don't know anything about foster care, but I don't think the kids have the most stable of lives.*

* * *

> *I think the feelings would be different because you, like, I've taken care of my little cousins and we know they're our cousins so we show high respect for those little kids.*

* * *

> *…a lot of foster parents won't take teens, right? There's a lot of work. I tell you what, my workload has doubled since he moved here.*

Three of the 16 families said that they thought kinship care and foster care were the same. One caregiver cited as an example the fact that, although she was the child's grandmother, as a kinship caregiver, she had no decision-making power in the child's life. Another caregiver reasoned that kinship care and foster care are the same because they provide the same service to the child. The third family reasoned that it was easier for the child if they told others they were her foster parents because it prevented lengthy explanations.

Several of the families argued that they should receive the same pay as foster parents because they provided a similar, or better, service:

> *Well, I think it should be the same, personally. Just because we're related to the child, I don't think there should be a penalty against us because we provide – I think we provide better care, I would think, because we're related.*

In addition, several of the families noted that they had more contact with the child's family than a foster parent would. This contact was seen as being both positive and negative:

> *I'm related to them and I think they get to meet – they get to meet other parts of their family – cousins and uncles.*

* * *

> *We accommodated a lot because we were family, right? Which you won't see foster parents having parents coming to their home…because we're family, we opened our doors a lot more to accommodate them more and put our needs aside for them.*

* * *

> *There's more pressure because it's family. The parents want to see the children when they want to and we have to supervise.*

* * *

> *So in that respect there's a lot more stresses via, say, in the visitation part. and I have to be in attendance when either of them are to see him…when (dad) comes over, he tries to question me about (mom) and what she's doing…which I don't think he would do if it was a foster person.*

Similarly, the caregivers' feelings regarding the amount of support that they received versus foster parents varied. For example, one caregiver said MCFD supported her more than they would have supported a foster parent in making decisions regarding things such as parental visits. Other caregivers, however, pointed out that foster parents receive additional supports such as medical/dental and funding for kids' activities, as well as increased pay to meet the children's needs.

The kinship caregivers also varied in their feelings around the expectations that were placed on them versus those that were placed on foster parents. One caregiver, who was also a long-term foster parent, said that she felt the expectations were lower. She cited the fact that, as a foster parent, she has to provide written monthly reports to MCFD, whereas, as a kinship caregiver, she does not. Another caregiver said that she knew a foster parent who had to have fire alarms and fire extinguishers in her home, whereas that had not been required of her when she was asked to provide kinship care. Other families argued that there were more expectations on them as kinship caregivers. One caregiver described how she was expected to transport the child to and from parental visits and supervise those visits, whereas as a foster parent, she would not be expected to do that.

Although there were various levels of understanding amongst the caregivers in my sample regarding the differences between kinship and foster care, they all clearly felt that the care they were providing was equal to or better than a child would receive in foster care. The caregivers who did understand that foster parents received more funding and services than kinship caregivers consistently expressed surprise and confusion over what they viewed as an inequity. This belief enforced their desire to be treated as well as foster parents, whether it be via funding or other supports.

Discussions with the Social Workers

I initially interviewed the social workers of the caregivers in my sample in order to get a richer, more detailed picture of each child's history and of each family's existing and needed supports; however, I quickly found that the social workers I spoke to also wanted to talk to me about the systemic issues surrounding kinship care in the North Region of BC. These discussions shed a great deal of light on the experiences of the caregivers and, for that reason, I have chosen to include them in this discussion.

The social workers consistently acknowledged that they liked the idea of placing children with their friends and family members rather than in a foster home; however, they also discussed how much more work it is to initiate and then maintain a kinship care placement versus a foster care placement. Several social workers mentioned the fact that, with a kinship care placement, they are responsible for three files: the child's file, the parent's file, and the caregiver's file, whereas with a foster care placement, the caregiver's file would be monitored by a social worker from a different office who specializes in supporting caregivers. Having three files not only increased their work load, but also posed a conflict of interest as they tried to support both the child, the parent(s), and the caregivers in their often-conflicting needs. The social workers also discussed their perception that the kinship caregivers, who were often new to caregiving and had limited training, required a great deal of ongoing support which they did not always have time to provide. As one social worker said, "*It's a supportive role, but we're crisis driven*". Two of the social workers that I spoke to discussed the need for outreach workers who could go into the home and provide basic support to the caregivers and/or the child, thereby alleviating some of the pressure on the social worker.

Most of the social workers discussed the fact that the system which is in place to help them implement a kinship care placement does not work well. The computer system was particularly frustrating for the social workers and they discussed the fact that, although each placement is different, the computer system does not allow any flexibility or creativity. Social workers are usually not trained to use it and do not use it often enough to become proficient at it. If they input data incorrectly, the computer does not warn them of this and they do not find out until the family's pay is late. Once they fix the computer error, families have to wait approximately six more weeks for their pay.

Several of the social workers brought up the fact that there is an "Out of Care Consultant" position in place in Prince George and that person's job is to help them to navigate the kinship care system. Social workers were not always having this person assist them and therefore were still continuing to do a great deal of the work themselves. One reason they gave for not seeking assistance was that this person was busy and they did not want to give her too many requests. Another reason was that she sometimes worked as an acting supervisor on child protection teams and therefore they felt that they could not approach her regarding kinship care issues. Some of the social workers did not know that there was an out of care consultant available to assist them. The social workers who had received assistance from the Out of Care Consultant said that it was very helpful to them in initiating the kinship care placement; however, they were still left with the ongoing support work around the placement.

Another topic that arose was that of the need to advocate for families in order to have them receive services. More experienced social workers pointed out that they were more likely to be strong advocates than newer workers because they would continue to advocate even after being told "no". They pointed out that attitudes within MCFD change with time and whether or not a support is paid for could depend on who is in management as well as what is the overarching belief system of MCFD at the time. For example, the social worker who had advocated for one family to receive money for a fence as part of the kinship care plan said that she happened to ask for it at a time when MCFD was encouraging creative thinking around family placements.

Social workers also discussed the complexities inherent in their relationships with the kinship caregivers. For example, they pointed out that they are bound by confidentiality laws and therefore cannot always share all the details of the case with the caregivers, leaving them feeling like they are not being informed. Previously, I discussed the time-lines around kinship care and the fact that many caregivers worry about the child being returned to her/his parents. Social workers shed some light on this situation by saying that they often do not decide whether or not to return the child to the parents until the agreement is close to its end so that they can give the parents the time necessary to make changes. They also often look to the parents to provide different standards of care than those expected by the kinship caregivers. Social workers cited the fact that the kinship caregiver often wants the best life possible for the child, whereas it is MCFD's mandate to look strictly at safety. This difference in focus can cause a strain between the social worker and the caregiver when the caregiver begins to feel that the child's best interests are not being considered.

Social workers discussed the fact that, due to the way that the system is set up, families often only receive services if they are able to advocate for themselves – a prime example of *"the squeaky wheel gets the grease"*. They suggested that the system, should, on the other hand, support families proactively by asking them, *"What tools do you need?"* rather than waiting for them to ask. Families often do not ask, one social worker noted, until they are at or near the point of breakdown.

Overall, the message I received from social workers was that they felt positive about offering children the option of living with their kin; however, they felt constrained by their own lack of support in implementing kinship care. Further, they acknowledged the fact that this lack of support for them resulted in a decreased ability on their part to support families.

Summary

In this chapter, I have discussed the findings of my research. I included a profile of both the caregivers and the children in my sample, described the themes which arose around the experiences of the kinship caregivers, outlined the existing and needed supports, and closed with a summary of the feedback I received from the social workers involved in this study. In the following chapter, I will discuss the conclusions I came to as a result of this research and will close with some ideas for further research.

Chapter 5: Conclusions

Conclusions about My Findings

The goal of this research was to look at what the experiences of kinship caregivers in the North Region of BC tell us about their met and unmet needs. My research indicated that the kinship caregivers in my sample were able to have some of their needs met through family, friends, their communities, support groups and, in some cases, MCFD and their social workers. They expressed ongoing needs in the areas of financial support, kids' activities, medical/dental, respite, information, training, and equal treatment. In this chapter, I will take a closer look at what those themes imply. I will discuss implications for policy and practice. Then, I will offer some suggestions for further research.

Themes and Caregiver Characteristics

The themes that arose suggest certain characteristics on the part of the kinship caregivers. I think the fact that each of them had opened up their homes to a child in need indicates that they are concerned with and responsive to others' needs. This characteristic is also evidenced by the fact that, during the interviews, the kinship caregivers were very focused on improving the children's lives. For example, they asked for dental coverage to fix the children's neglected teeth. They asked for funding for activities to help build the children's self-esteem and physical health and to give them back some of the positive experiences that they had missed out on in life. When the kinship caregivers mentioned a need for additional money, it was not said in the context of them making money, but so that they could provide for the basic needs of the children. Even themes that were more directly related to their needs (i.e. respite and training) were discussed in the context of them needing to be supported so that they could continue to provide care and provide it in such a way that they were truly meeting the children's needs.

Another characteristic that surfaced was resourcefulness. Although the kinship caregivers cited numerous needs, there were also many ways in which they were ensuring on their own that their needs were met. For example, they often turned to family and friends for support. They read books and searched the Internet for information. They advocated for and accessed services through community agencies.

A third characteristic that surfaced was resilience. I particularly noted this characteristic amongst the grandparent caregivers, who had experienced the anguish of watching their child struggle with drug and alcohol/mental health issues and then had risen to the task of raising their grandchildren. Even though the caregiving arrangement complicated their lives and their relationships with their adult children in many ways, they continued to provide care and were able to speak with candor and humor about their experiences.

Comparing My Findings to the Literature Review

The themes from my research also suggest a strong correlation with the themes from my literature review. As discussed previously, the literature came from such diverse areas as the United Kingdom, Norway, Australia, and the United States; it is interesting that caregivers in Northern BC would be describing similar experiences. The two issues from the literature that did not surface were housing and counseling; not one of the kinship caregivers that I spoke to voiced concerns in either of these areas.

It is possible that counseling and housing are not issues for the majority of the population in the North Region of BC. I believe that counseling is fairly accessible in both Prince George and the surrounding communities. For example, in Prince George family counseling is available through Intersect, a government-funded counseling agency, and no fee is charged for this service. Many of the families that I spoke to were accessing counseling through Intersect. Similarly, I believe that housing is not a major issue for lower-middle-income to middle-income families in Prince George and surrounding areas, such as those that I interviewed for this study. It would have been interesting to interview some families who lived in boom towns in BC, where housing is generally more difficult to acquire, to see if housing would arise as an issue.

One issue that the caregivers stressed repeatedly which did not come up in my literature review was that of kids' activities. As a mother of three school-age children, I would hypothesize that this difference could have arisen because my sample captured a more current place in time than the majority of articles and books from my literature review: there is currently a substantial amount of pressure on caregivers to have their children in activities and the benefits of nurturing a child's interests and keeping them busy so that they stay "out of trouble" is quite commonly accepted. These activities pose an additional expense for families and, it stands to reason, this expense would be particularly noticed by families that unexpectedly found themselves providing care to a child.

Existing Supports

It is important to look at the existing supports because they have the potential of telling us what is working for kinship caregivers in this Region. Not only is it important to recognize the work that has been put into creating those supports, but it is also important to ensure that they remain in place. Clearly, with the implementation of a kinship care payment and a framework by which social workers can place children in kinship care, MCFD has attempted to support these plans. In addition, formal supports can be found in the North

Region through agencies such as Intersect and the Health Unit. My research has suggested that, although the needs of each family vary, formal supports are necessary for the majority of families.

I admired how creative the kinship caregivers in my sample were in creating their own informal supports. Many of the caregivers were being supported by friends, family, and community members. The caregivers researched topics on the internet, read books from the library, and asked questions of professionals in the community. They were supported through their spiritual beliefs and by fellow believers. They often convinced professionals to provide assistance even when these professionals were not mandated to provide help. I believe that this creativity points not only to the resilience found in these caregivers, but also to the willingness of the larger community to step in and provide help.

Needed Supports

Having worked with caregivers in this Region for the past fourteen years, many of the themes around needed supports did not surprise me. For example, I anticipated that the kinship caregivers would mention a need for additional respite because I have seen this theme surface repeatedly with both adoptive and foster parents. In addition, I have witnessed how overworked some of my fellow social workers are and was not surprised that many of the kinship caregivers said they needed more contact with their social worker.

As mentioned previously, though, some of the discussions around needed supports did surprise me. For example, it was not until I began to work through my coding that I noticed how many of the caregivers mentioned that they would benefit from help to pay for activities for the child(ren) in their homes. Similarly, I thought that every caregiver I spoke to would cite a need for increased financial support and was surprised when this was not the case. However, once I really paid attention to the entire message from each caregiver, I realized that, for a variety of reasons, it was not as simple as saying that some could provide care without financial support.

Implications for Policy and Practice

The data obtained from my interviews and file reviews suggests that continuing with the status quo around kinship care is not enough. Previously, I discussed the fact that BC's child protection legislation holds up the safety and well being of children as its paramount considerations. I believe that this safety and well-being is directly impacted by the amount of support that is offered to each child's caregivers. The kinship caregivers in my sample were stretched by their role as a kinship caregiver, not only in providing day-to-day care for the children, but also in fulfilling duties such as working with the social worker and the child's parents and dealing with her/his own life changes. As in all caregiver/child relationships, the health and well-being of each caregiver directly impacted the level of care and therefore the safety and well-being of the children in the home.

Although some families said they were happy with the amount of pay they received and one family said that they did not actually need the pay, all of the families that I spoke to said that they needed additional supports. Some of these supports, such as respite and funding for kids' activities, cost the caregivers money, and therefore I would argue that all of the caregivers did require additional funding, whether in the form of increased pay or direct services. The other needed supports (i.e. training and social worker time) would not have cost the caregivers any money, but would cost the provincial government money in order to implement. Overall, then, I think it is fair to conclude that MCFD needs to invest more money in the kinship care program, in the form of increased pay or in direct services such as respite, training, and social worker support.

Earlier, I outlined some of the feedback provided to me by the social workers involved in this study. As an adoption social worker, I believe I can provide an added perspective because an integral part of my job for the past 11 years has involved supporting caregivers in this Region. Like the kinship caregivers in my sample, the adoptive parents that I work with are very different from one another: they have different levels of support from family and friends, different financial means, and different levels of experience and skill. All families who adopt through MCFD are eligible to apply to the Post Adoption Assistance Program, which can provide support services and monthly maintenance payments until the child turns 19. Families are assessed individually both regarding their needs and regarding their eligibility (i.e. they are income tested). Although this process is somewhat labor-intensive, I believe it works very well in supporting adoptive families to care for their children and I feel that a similar program would work well with kinship caregivers.

Additionally, I feel it is important to point out that MCFD supports these parents long after the adoption finalization, when the parent/child relationship is legally considered to be the same as if the child was born to the adoptive parents. Therefore, the argument that government should not subsidize (or should minimally subsidize) families in caring for their own members does not hold up. I would argue that if the government recognizes that adoptive parents in our province need a comprehensive support program in order to maintain successful, long-term adoptions, the same consideration should be given to kinship caregivers.

Many of the caregivers in my sample brought up the fact that they were receiving less pay than foster parents but were generally required to provide more services (for example, foster parents are not generally required to provide transportation and supervision for parental visits and the children in their care are given complete medical and dental coverage). I feel that this disparity points to an awkward situation on the part of the provincial government. There is a recognition on the part of government that families should be involved in the decision-making for their children and that children should be placed with kin whenever possible. There is a recognition that many of these children would be in foster care if not placed with kin, which would cost the government money. There is also recognition that kinship caregivers are not always able to provide the same standard of care as foster parents and controversy over whether or not this should be expected of them. In addition, there is an attempt on the part of MCFD to retain somewhat of an arm's-length relationship with kinship care placements (particularly with Section 8 Agreements), while at the same time staying involved enough to ensure that the children placed in kinship care are safe. These aspects of kinship care place the provincial government in a bit of a quandary: if you are supporting kinship caregivers in the same way that you would support foster parents, should you not have the same requirements of both and are you not placing an equal seal of approval on both?

I would argue that this question is flawed because kinship caregivers and foster parents are fundamentally not the same. They provide a different service under different circumstances and have a different relationship with the children in their care. What is similar, I would argue, is the population of children to whom they are providing care. Therefore, the question should be, "How much does it cost to raise a child and what kinds of supports do individual caregivers require in order to provide an appropriate level of care?" It does not make sense that it would cost a kinship caregiver less money to raise a child than a foster parent, nor that a kinship caregiver would require fewer services than a foster caregiver. Although their needs may be somewhat different, it is unlikely that one group would consistently have fewer needs than another.

One of the social workers that I spoke to suggested that kinship caregivers be proactively asked what supports they would need in order to provide kinship care and then be provided with those supports. I think this is an excellent suggestion and would take it one step further: this question should be asked of them not only when they first begin to provide kinship care, but periodically throughout the kinship care arrangement as they become more aware of their needs and as their needs change.

I would also suggest that the responsibility of supporting kinship caregivers does not rest solely on MCFD, but also on the larger community. As mentioned previously, the caregivers in my sample were being supported by people who they knew personally and professionally. I believe that each of us has a responsibility in both our personal and professional lives to support kinship care families where possible, recognizing that these families are providing a service not only to a child and her/his parents, but really to all of us as a larger community.

Earlier, I discussed some of the history leading up to the formal use of kinship care by MCFD. This history shows that the provincial government has moved towards being more inclusive of families and making plans for children to remain with family or friends whenever possible. However, I would mirror the sentiment voiced by Rob Geen (2003a) earlier in this study: this shift has been made without the practice guidance, support structure, and social work base needed to support it. I have spent my entire life living in the North Region of BC and have worked here as a social worker for over fourteen years; my experience tells me that if families are not adequately supported in providing care to children, there could be dire consequences for the children in their homes. We as a society have a duty to support the families that are caring for our most vulnerable members.

Suggestions for Further Research

It seemed like the more I learned about kinship care while completing this study, the more questions I had. I believe that an important area for further study would be to look at the outcomes for children who have spent time in kinship care compared to those who have grown up in foster care. Although it seems logical that children would have better long-term outcomes in kinship care, it would be interesting to see if research supports that thinking.

Several of the participants in this study noted that parents are not as motivated to make positive changes when their children are in kinship care as they are when their children are in foster care because they feel that their children are being well cared for; it would be interesting to take a closer look at this claim by comparing the outcomes of parents whose children are in foster care versus those who have children in kinship care. As part of this study, researchers could look at whether children had an increased or decreased chance of returning home based on whether they are in kinship or foster care.

I also feel it would worthwhile to look at the standard of care found in kinship care homes. As a social worker who spends a considerable amount of time assessing families, I would like to know whether or not the standards of kinship care homes are comparable to those of foster homes. Since the kinship care program was introduced in the North Region of BC, the standards for home assessments have increased considerably and it would be interesting to see whether or not these changes have increased the standards in these homes as well as whether or not they have impacted the ability for families to be approved to provide kinship care.

It would be interesting, too, to compare the experiences of urban kinship caregivers to their rural counterparts. I attempted to recruit a sample for this study which included both rural and urban caregivers; however, as mentioned previously, the majority of my participants lived in Prince George, which is the largest city in the North Region. Even the caregivers in my sample who lived in rural areas had easy access to amenities such as medical clinics and paved roads, unlike some of the citizens of the North Region who live in truly remote areas. I think it would be worthwhile to compare some truly urban areas (i.e. Vancouver) with some truly rural areas (i.e. Haida Gwai) in BC.

In addition, although this research included the voices of the kinship caregivers and their social workers, I believe it would be interesting if further research included the voices of the parents as well as the children themselves. I believe that such research would shed further light on what is and is not working with kinship care by including the people who have the most at stake in these arrangements.

Conclusion

It is exciting to be living in an area of British Columbia where I, as a researcher, can have an actual role in some of the changes that are occurring. I was very grateful throughout this experience for the kinship caregivers who shared their stories with me. I was also touched by their willingness to make sacrifices in order to help a child in need. My hope is that this research will shed some light on their experiences and will positively impact the policies that affect them and the children in their care.

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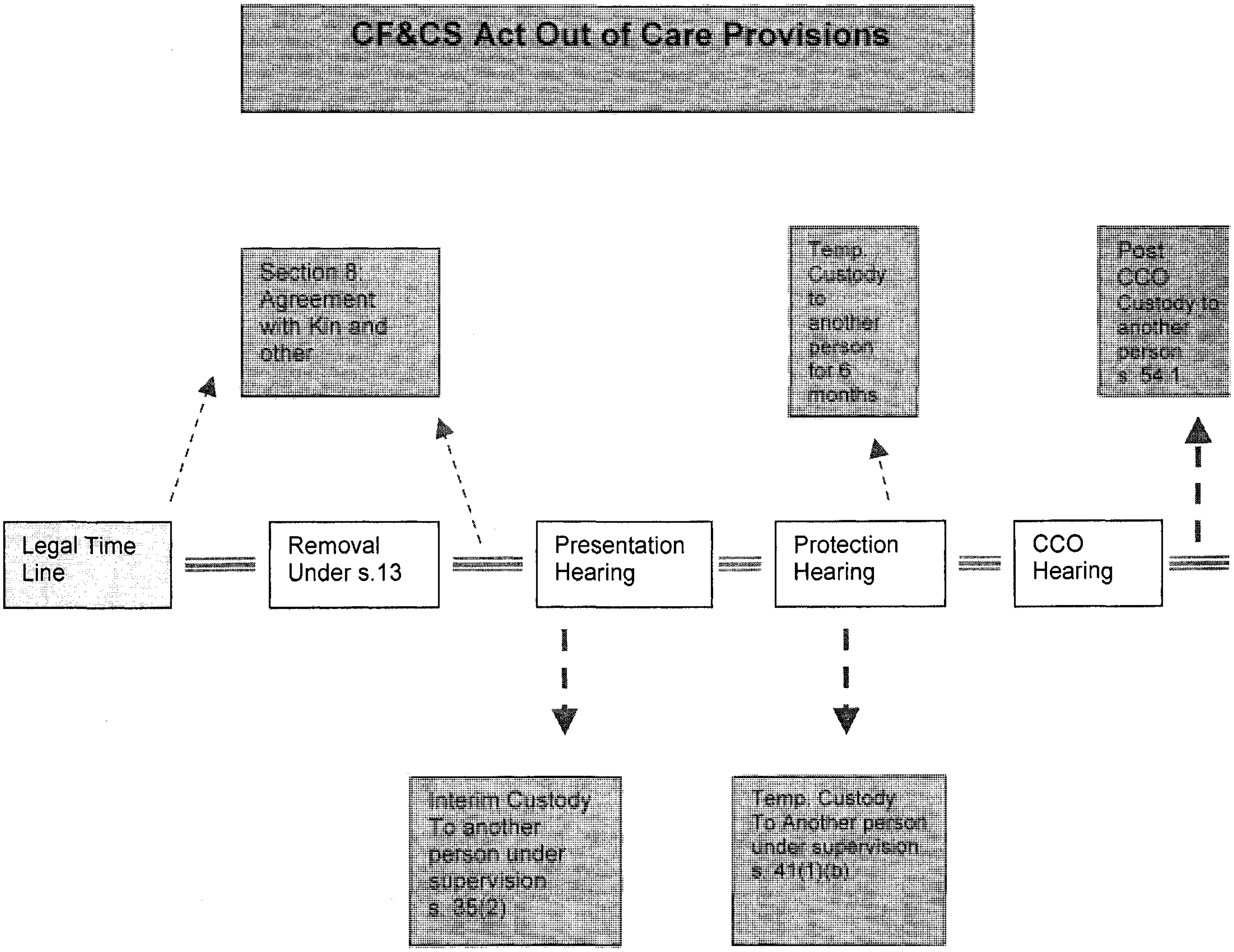
Appendix A: CFCSA Out of Care Provisions



Appendix B: Possible Terms and Conditions of a Supervision Order

The following are examples of terms and conditions that have been attached to supervision orders made in BC and other jurisdictions, which are not specifically included in, s. 42(1).

Change of address

parent(s) to inform the director of any change of address
parent(s) not to change address without permission of the director

Residence

parent(s) to arrange suitable accommodation in a reasonable time
parent(s) to remain at a particular residence
parent(s) and child to reside with a designated person
parent(s) to ensure the designated person's residence is adequately equipped for a child
the designated person must still be willing and able to provide their residence
parent(s) not to reside with a particular person or persons
parent(s) not to reside with any third persons without prior permission of the director

Required visits

parent(s) to allow community health nurse to visit
parent(s) to ensure no third person(s) are present during scheduled visits of the director or other designated professionals

Health

parent(s) to ensure child is given periodic medical check-ups
doctor to send medical reports to mother and the director
parent(s) to provide consent forms to allow the director full access to medical, psychiatric, or school records
parent(s) to ensure the recommendation of the child's physician regarding medication, treatment, follow up are adhered to

Education

parent(s) to ensure they are kept continually informed about child's education
parent(s) to attend parent/teacher meetings regularly
parent(s) to ensure child is enrolled in and attending school on a regular basis
parent(s) to ensure child has transportation to and from school
parent(s) to show child's report cards to the director

Children

parent(s) must not leave child alone overnight
if parent(s) does leave, must ensure child is in care of an adult
before parent(s) leaves child in care of another adult, must have permission of the director
parent(s) must have permission of the director before leaving child overnight with another adult
parent(s) not to take child with them for overnight visit
child to remain in home and not be taken on excursions to public places
child not to be left alone with particular person(s)
child not to be left in charge of younger siblings
child to attend day care
child to attend required assessment, treatment, counselling program

Parents

parent(s) must abstain from the use, possession, and consumption of alcohol
parent(s) must abstain from use, possession, and consumption of non-medically prescribed drugs or narcotics
parent(s) must abstain from smoking in the confines of apartment
parent(s) to ensure they have no contact with particular person(s)
parent(s) to have no contact with each other except for access arrangements

parent(s) to agree to assessment, treatment, counselling, parent education programs, homemaker services

Access

parent(s) granted specific access times with child
parent(s) to ensure particular persons are present during visits
parent(s) to ensure particular persons are not present during visits

Appendix C: Checklist of Activities for MCFD Social Workers

Checklist of Activities for Sec 8, 35(2)(d) or 41(1)(b)

(detailed instructions for each step are attached)

T/L consult to use as part of the Risk reduction Service Plan	
Involve the parent and child ins electing the proposed caregiver	
Assessment of Caregiver includes: a) PCC – review of any records of the proposed caregiver's previous involvement with a person delegated under the CFCSA	
b) Criminal record Checks are completed on the potential care providers and on any person over 18 years of age who lives in the home or may have significant or unsupervised access to the child.	
c) Obtain two written references, including one who is a relative, to confirm suitability of the potential care providers. If the child needs to be placed with the caregiver immediately, references may be obtained verbally, with follow up written references.	
d) Home visit - see home environment of potential care providers to assess the Caregiver's readiness, capacity and commitment. The home's adequacy can be assessed by the band Social Worker, the Public Health Nurse or a Delegated Social worker.	
Discuss the living arrangements with the child/youth (if Applicable)	
IF you are seeking an order granting custody to someone other than the parent (35(2)(d) or 41(1)(b) and the assessment is positive, the next step is to complete the appropriate court forms: • Form 1 – Presentation Form • Form 2 – report to Court Agreement with a person other than the Parent who has interim or Temporary Custody of a Child , with all parties signing, specifying: The care provider's obligations in meeting day to day care responsibilities for the child or youth; the terms of the agreement; the time period in which the agreement is in effect; the notice required to end the agreement; if required, the financial support to the care provider under the agreement; and any parental contribution to the child's care.	
Advise the care provider to apply for Child Tax Benefit. Even if they believe they are not eligible, they need to apply.	
MSP coverage for child or youth Sources of medical coverage include: Caregiver (add child to health plan as a dependant) Healthy Kids Program (through MEIA 1-800-748-1144) MCFD – from the parent's FS file	

Link to register for Fair Pharmacare (coverage for prescriptions for low income families): https://pharmacare.moh.hnet.bc.ca/	
Arrange payment to caregiver. • Open RE file and Add RAP contract on MIS • Register Legal Status on FS file • Update Location and Placement for child, on FS file	
Extending or ending the Agreement? To extend an agreement, ensure that the duration of the agreement is consistent with the time period of the interim or temp custody order. An agreement ends when any one of the following apply: • The interim or Temp order expires • The parent resumes care of the child • The child no longer resides with the caregiver • The required written notice is given by either the Director, the care provider, or other action is taken under the CFCSA or other legislation relating to the care of custody of the child.	

Appendix D: Sample Request for a Reference Letter

MINISTRY OF CHILDREN
AND FAMILY DEVELOPMENT

TO: ______________________________ **DATE:** ________________
NAME OF REFERENCE **(YYYY MM DD)**

____
MAILING ADDRESS

____
CITY/TOWN/PROVINCE

Re: Reference letter for:

____
NAME OF PROSPECTIVE CARE PROVIDER

The above named person(s) have given your name to the Ministry of Children and Family Development as a personal reference. They are willing to assume temporary responsibility for the care, parenting and nurturing of _____ (#) child(ren), whose ages are: ________________.

The information you provide is part of the assessment of their capacity to provide for the emotional and physical care of the child(ren).

Please complete the reference questions on the enclosed outline about the prospective care provider(s)' ability to care for the child(ren). Attach a separate sheet of paper if you wish to provide additional information.

If it becomes necessary to discuss the contents of your reference with the prospective care provider(s), every effort will be made to preserve your anonymity. However, because of the personal information contained in the reference, the prospective care provider(s) may be able to determine your identity indirectly. If you have any questions, please call me to discuss them.

Yours truly,	Please mail your reference form to:
______________________	______________________
Signature of child's worker	Office mailing address
______________________	______________________
Name of child's worker	City/Town
______________________	______________________
Area code and telephone number	Postal Code

MINISTRY OF CHILDREN
AND FAMILY DEVELOPMENT

Re: Reference letter for:

____

NAME OF PROSPECTIVE NON-MINISTRY HOME CAREGIVER

1. How long have you known the caregiver(s)? What is your relationship to the caregiver(s) and what kind of activities do you share?

2. Please describe the personality, interests, and strengths of the caregiver(s).

3. Please describe the caregiver(s)' experience with children. Describe how the caregiver(s) relate to their own children and/or the children of others.

4. If there are children in the family, how do you think they will respond to a child or children temporarily joining the family?

5. Please describe how stress and difficult situations are handled by the caregiver(s). Are problems handled alone or with support from friends, family professionals or others?

6. Please describe any problems the caregiver(s) have that might affect the well being of a child or children in the home.

7. If you have children would you leave them with the caregivers for any extended period of time.

SIGNATURE OF REFERENCE

PRINT NAME

DATE (YYYY MM DD)

Appendix E: Format for Home Assessments

Assessment of Out of Care Provider

File Name: ______________________ File ID: ____________________

Date ______________________________

Social Worker/Office/Caseload:

Team Leader/Office Caseload:

Assessment report Completed by:

Parents Names:

Subject Children/DOB:

Potential Caregiver: **Relationship to Child:**

Purpose of Referral: (this section includes a summary of current circumstances and the reason for referring to the Out of Care Options Worker, including tasks that will need to be completed)

Prior Contact Check: (includes a review of previous intakes and family service file information as it pertains to the potential caregiver)

Summary/Assessment of Previous Contact: (include a summary of historical issues, including how family circumstances have changed and how historical issues have been addressed, etc)

Reference Checks: (include the names off references (minimum two), contact information, relationship to care provider and summary of information provided on the Reference Outline)

Criminal Record Checks: (This section includes the names of potential caregivers and any other person over 18 yrs of age, residing in the home and/or will have any responsibility for providing care to the child(ren), as well as information disclosed by the parties in regards to any historical involvement with RCMP or the Criminal Justice System, in addition to the outcome of the Criminal Record Search).

<u>Voluntary Disclosure</u>:

<u>Results of Criminal Record Search</u>:

Assessing the Care Provider' Readiness, Capacity and Commitment: (Social worker notes of contacts with family/child and service providers should be attached. This section would included summaries of important contacts/events.)

Care Provider and Residents:
(List everyone who lives in the home and DOB; primary care provider; anyone who will have a role in providing care to the child)

Readiness:
(this section provides information about the caregiver's relationship to the child(ren); understanding of child's specific needs; safety plan in the event of an emergency; forms or discipline)

Capacity:
(this section includes information regarding the physical surroundings of the home; including storage of hazardous materials, firearms, etc; and any barriers to meeting the needs of the child(ren); and family strengths)

Commitment:
(This section includes information about the caregiver's willingness to work with MCFD, with the natural family as well as the commitment to a specified period in which care to the child would be provided)

Additional Information/Comments:
(any additional information that is not included in other sections of the assessment)

Needs Assessment:
(this includes any needs identified by the Caregiver, Social Worker and Worker completing assessment. Should include physical needs as well as services/supports required by the caregiver and child, to support the placement being successful.

Management Approval, is required:
(attach written approval or denial, if applicable)

Appendix F: Questionnaire

Semi-Structured Interview Guideline Questions (To be completed with the female adult caregiver in the kinship care home. Questions regarding male caregiver to be asked if applicable)

1. What is your first and last name?
   What is the first and last name of the male caregiver?

2. What is your date of birth?
   What is the date of birth of the male caregiver?

3. Are you:
   a. Married
   b. Widowed
   c. Separated
   d. Divorced
   e. Single, never married

4. What is the name of community in which you reside?

5. What do you consider to be your ethnicity?
   What is the ethnicity of the male caregiver?

6. How many children live in your home? Under what status is each child in the home? (i.e. kith and kin, birth child, foster child, etc)? What are their ages and ethnicities?

7. For how many months have your been providing kinship care?

8. What is your relationship to the child/ren in your care? Please provide a description of how that child/ren came to live with you.

9. Have you previously provided care to children other than your own birth children? If yes, please specify in what capacity.

10. Have you ever thought about how your role compares to the role of a foster parent? What are some of the similarities and differences?

11. Please provide a detailed description of the special needs of the children in your home under kinship care. Have these special needs been formally diagnosed?

12. Please describe a typical day in your family.

13. What is your level of formal education?
    a. less than high school graduation

   b. high school graduation
   c. some college/university/trade school
   d. college/university/trade school graduate or more

   What is the male caregiver's formal level of education?
   e. less than high school graduation
   f. high school graduation
   g. some college/university/trade school
   h. college/university/trade school graduate or more

14. Are you employed outside of the home? If yes, what is your occupation? How many hours per week do you work?
    Is the male caregiver employed outside of the home? If yes, what is his occupation? How many hours per week does he work?

15. Is your yearly net wage, excluding kinship care payments (for both caregivers, if applicable) between:
    a. $0 – 10, 000
    b. $10, 000 – 20, 000
    c. $20, 000 – 30, 000
    d. 30, 000 – 40, 000
    e. 40, 000 – 50, 000
    f. Over 50, 000

16. What are your alternate sources of funding?
    a. disability pension
    b. employment insurance
    c. income assistance
    d. Canada Pension Plan
    e. Other, please specify

17. Do you have financial concerns for yourself/your family? If yes, please explain.

18. Do you own your own home, rent, or receive a subsidy?

19. How many times have you moved in the past 3 years?

20. Do you believe that you use some of your own money to care for the children in your home under kinship care?

21. How would you rate your physical health?
    a. Excellent
    b. Good
    c. Fair
    d. Poor

How would you rate the physical health of the male caregiver in the home?
   a. Excellent
   b. Good
   c. Fair
   d. Poor

22. How would you rate your mental health? (i.e. depression, anxiety)
   a. Excellent
   b. Good
   c. Fair
   d. Poor

   How would you rate the mental health of the male caregiver in the home?
   e. Excellent
   f. Good
   g. Fair
   h. Poor

23. Do you follow a specific religious belief system? If yes, please specify. How often do you take part in religious ceremonies (i.e. attend church)? Do you consider this attendance to be a source of support?

24. Do you practice spirituality in other ways? If yes, please specify. Do you consider this participation to be a source of support?

25. What kind of training did you receive in order to provide kinship care? Did you receive training in:

   a. Caring for a child with special needs
   b. Parenting/Disciplining a child
   c. Working with a child's birth parents?
   d. Caring for a child of a different race/culture?
   e. Caring for a sexually abused child?
   f. Helping a child work through grief/loss issues?
   g. Teaching a child skills for living on his/her own?
   h. Contacting MCFD after hours if an emergency arises?
   i. Other, please specify

26. Do you feel that you could benefit from more training? If yes, what type?

27. Is there anyone to help you take care of your children in kinship care by providing things such as respite?

28. Is there anyone to help you take care of your children in kinship care by buying things for them or helping you to buy the things you need?

29. Please list the supports that you receive in caring for your children in kinship care.
30. What do you have right now in the way of resources/supports that you could not do without?
31. What do you need most that you aren't getting?
32. Who listens to your problems/concerns?
33. Would you attend a support group for kinship carers if one existed? What might prevent you from joining/encourage you to join?
34. How often do you have contact with a social worker in relation to your child/ren in kinship care? Do you feel that this contact is enough? Do you feel that your social worker knows enough about the kinship care to support you adequately?
35. When you think of your role as a kinship caregiver, is there anything you would like people to know?

Appendix G: UNBC Research Ethics Board Approval

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

RESEARCH ETHICS BOARD

MEMORANDUM

To: Susan Burke
CC: Glen Schmidt

From: Greg Halseth, Acting Chair
Research Ethics Board

Date: July 17, 2008

Re: **E2008.0520.095**
What do the experiences of kinship caregivers in the North Region of BC tell us about their needs?

Thank you for submitting the above-noted research proposal to the Research Ethics Board. Your proposal has now been approved.

We are pleased to issue approval for the above named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or consent form must be approved by the Research Ethics Board.

Good luck with your research.

Sincerely,

Greg Halseth

Appendix H: MCFD Research Approval

Hello Susan Burke

re: Exploring Kinship Care in the North Region of British Columbia
ref: 175563

This note is to inform you that Mark Sieben, Chief Operating Officer, and Acting Ministry Executive responsible for Research has approved this research proposal.

Please be reminded of the agreed upon terms and conditions with regard to privacy and confidentiality, disclosure, security, records management and any other relevant terms outlined in the research agreement. Should you need any further information or clarification please contact Anne Thomson at the Research Application Approval Process [mailto:MCF.ResearchApplication@gov.bc.ca].

We look forward to receiving a copy of the final report upon completion.

Anne Thomson *for*
MCF Research Application
Decision Support Branch
Ministry of Children and Family Development
Address: 4th Fl., 777 Courtney St.
Phone: (250) 387-7617
Fax: (250) 387-7618

Appendix I: Information Sheet

What are the needs of kinship caregivers in the North Region of British Columbia?

Information Sheet

Dear Participant:

Thank-you for your interest in this research project and for your potential willingness to answer questions pertaining to your family.

Your name has been provided by the Ministry of Children and Family Development (MCFD) as a current or past provider of Kinship Care in North-Central BC. This research is being conducted in order to better understand the needs of Kinship Caregivers in this region. Another goal of this research is to provide a picture of the types of families that are providing Kinship Care and the types of children being cared for in Kinship Care arrangements.

Your participation in this study should take between 1 and 2 ½ hours. It will involve an interview which can take place in your home or another area designated by you. Your participation is entirely voluntary, so if you need to withdraw at any time, you may do so without prejudice. There is no known risk to you associated with this research. The benefit is that, as a person who has lived the real experience of providing Kinship Care, you will be able to give your input, hopefully resulting in more of the needs of Kinship Caregivers being met in the future. There is no remuneration for your participation.

Once your interview is completed, the results will be grouped with the other interview results and analyzed. Your responses will be kept confidential and best efforts will be used to ensure your identity is not revealed. The information you provide will be reflected in the final thesis; however, anonymity will be maintained. The data will be stored in a locked suitcase at the researcher's home and only she will have access to your responses. Once the research is complete, all data, including identifying information, will be destroyed via a wood-burning fireplace.

In case of any questions about the interview, please contact the researcher, Susan Burke, at 250-561-4600 or burke@unbc.ca. The final report will be available after completion of the research (in approximately February of 2009). If at that time you would like a copy, please do not hesitate to contact Susan at the phone number or email above. If you have any complaints about this research, please direct them to the UNBC Office of Research at 250-960-5820 or reb@unbc.ca.

As part of this process, a copy of your consent form must be given to you. Whether or not you choose to participate in this interview, I would like to thank you for your time spent in reading over the above information.

With warm regards,

Susan Burke

Appendix J: *Informed Consent*

What are the Needs of kinship caregivers in the North Region of BC?:

Informed Consent

I understand that Susan Burke, who is a graduate student in the Masters of Social Work Program at the University of Northern British Columbia, is conducting a research project on kinship care.

I understand that the purpose of this research project is to gain insight and information regarding the experiences of kinship caregivers.

I understand that I was chosen because I am or was a kinship caregiver. I will be interviewed by the researcher, Susan Burke, based on 35 questions about my experiences as a kinship caregivers.

1. This consent is given on the understanding that Susan Burke will use her best efforts to guarantee that my identity is protected and my confidentiality maintained.

2. I give my consent freely and understand that I may end the interview at any point and withdraw from the research process at any time. This decision will not impact the services I receive through the Ministry of Children and Family Development.

3. I understand and agree that the information I have given to Susan Burke in our interview will be treated in the following manner:

   a. The interview will be tape recorded and hand-written notes will be taken during our discussion.
   b. This data will be securely stored by Susan Burke, only in a secure, locked metal cabinet in her private residence or in a secure, locked room at her place of work.
   c. The data will be used only by Susan Burke and only for her thesis project
   d. The data will either be returned to me or burned in a metal fire pit at the end of the thesis project.

4. I hereby waive any claim again Susan Burke, Dr. Glen Schmidt, the University of Northern British Columbia, its employees, administration, and Board of Governors with respect to the use of said information, provided it is used in accordance with this agreement.

5. I understand that if I have any comments or concerns, I can contact the UNBC Office of Research at 250-960-5820 or reb@unbc.ca.

PARTICIPANT: ______________ SIGNED ____________________ DATE _______

RESEARCHER: ______________ SIGNED ____________________ DATE _______