

RESEARCH PROPOSAL: EXPLORING KINSHIP CARE

Research Proposal: Exploring Kinship Care
in the North Region of British Columbia

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Introduction

There are approximately 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) 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 has resulted in 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.

Rob Geen, one of the predominant writers and researchers on kinship care in the United States, contends that society is making a paradigm 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, 2003a). 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.

This thesis will focus on one primary research question and two sub-questions. The primary question will be, “What are the needs of kinship caregivers in the North Region of British Columbia?” 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.

Literature Review

In this literature review, I will define some of the terms used in this research proposal and will then offer a historical look at the use of kinship care around the world. I will offer a summary of the history of Aboriginal people in British Columbia and will then explore the literature for profiles of kinship caregivers and of children living in kinship care. Finally, I will discuss what the literature says about the needs of kinship caregivers.

Definitions

The following key terms are used throughout this proposal:

- a) *Kin*: One's relatives collectively; family; kindred; 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).
- b) *Kinship*: The state of being kin or related by blood (Morris, 1982).
- c) *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.
- d) *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).

- e) *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).
- f) *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).
- g) *Child*: A person between the ages of 0- and 19-years-old.
- h) *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], 2002).
- i) *Aboriginal Person*: a person who is registered under the *Indian Act*, who is of Aboriginal ancestry, or who considers her/himself to be Aboriginal.
- j) *Child(ren) in care*: Children who are in the custody, care, or guardianship of the provincial child welfare branch (MCFD, 2002).
- k) *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).
- l) *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.

- m) *Reflexivity*: The researcher is “conscious of the biases, values and experiences that he or she brings to the qualitative research study. Typically, the writer makes this explicit in the text” (Creswell, 2007).
- n) *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).

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 its 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). 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).

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).

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). 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). 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 (Scannapieco, Hegar, & McAlpine, 1990; CWLA, 1994; Hegar & Scannapieco, 1995).

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 notes that the decade of the 1990s "was a time of great turmoil for British Columbia's child welfare system (2007, p. 17). Two diverging opinions arose regarding the focus social work practice should take: a "child-centred" approach or a "least intrusive" approach (Cradock, 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 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 placements (a type of kinship care placement made under Section 8 of the *Child, Family and Community Service Act*) 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). Scannapocio (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 proposal.

History of 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).

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, 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.

As part of a larger plan to assimilate First Nations people into European Canadian culture, the British North America Act was enacted in 1867, giving 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, “four or five generations had returned from residential schools as poorly educated, angry, abused strangers who had no experience in parenting” (Fournier & Crey, 1997). In 1951, changes were made to the Indian Act which gave responsibility for Aboriginal health, welfare, and education to the provincial governments (Fournier & Crey) 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, 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). Walmsley 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, its 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). 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, Metis, 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). Aboriginal people are also much more likely to experience poverty, lack of education, dreary and overcrowded housing, incarceration, and substance abuse (Webb & Arnott).

As an Aboriginal social worker having worked with many Aboriginal people and communities in Northern British Columbia in the past 13 years, my perception is that the health of the families and communities is increasing every year. Webb and Arnott 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 (2001, 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 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.

Profile 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 (Brooks & Barth, as cited in National Abandoned Infants Resource Centre [NAIRC], 2005; Pecora, Le Prohn & Nasuti, 1999; Berrick, Barth, & Needell, 1994). 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.; Pecora et al.). They are most often a grandparent (48%) or an aunt/uncle (44%), and most likely a relative of the biological mother (73%) (Holtan et al., 2005). Kinship caregivers are also most likely to be women (Berrick et al.; Pecora et al.).

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 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 (2000). 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 carer. Musil, meanwhile, showed that grandparent caregivers tend to report relatively high anxiety (1998).

Kinship caregivers consistently receive fewer services from their local child welfare agency than foster caregivers, including respite care, counselling, 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).

Profile 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, Ronning, Handegard, & Sourander, 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 they are already family as well as that they don't want to interfere with the birth parents; however, they are also more likely than foster parents to commit to raising the children to adulthood (Berrick et al.). 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.).

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).

Needs of Kinship Caregivers

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. 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 (1994, 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 carseat (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 carers 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 give 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 carer 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 carers, 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's 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 \$ Canadian) a week to keep a child in kinship care and 5000 pounds (approximately \$ 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 counselling 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" (2005, 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 birth 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 Child's/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 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 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 (2003).

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 carers felt supported, they were able to be more effective with their families.

In the literature I reviewed, the main service 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

Research Design

I've worked as a social worker for the past thirteen years, often supporting adults who are caring for at-risk children (primarily as adoptive parents or foster parents). 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 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) as 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 being 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).

I plan to include all of these elements in my thesis.

Regarding methodology, I plan to use a case study approach. Creswell (2007) describes case study research as research which involves “the study of an issue explored through one or more cases” (p. 73). He further expands on this idea by describing a multiple case study, where again one issue is selected, but multiple case studies are used to demonstrate the issue. I plan to interview 10 – 20 kinship caregivers/families, which will represent 10 – 20 case studies on the issue of kinship care. I plan to interview these families using a semi-structured interview process, transcribe the interviews, and use thematic analysis to find the themes which occur in the interviews.

As stated previously, I plan to use a sample of between 10 and 20 kinship care families. I will use a criterion sampling strategy and will “review and study all cases that meet some predetermined criterion of importance” (Patton, 2002, p. 238). In this case, the criterion will be that all participants involved will live in the North Region of British Columbia and will be caring for a child or children through a formal kinship care arrangement with the knowledge of the Ministry of Children and Family Development. I plan to interview the primary caregiver in the home and, if other family members join the interview, I will be open to that as well. I plan to focus less on having a large sample and more on obtaining a rich, “thick” description from the

participants. According to Patton, qualitative methods facilitate the study of issues in “depth and detail” (2002, p. 14) and I feel that a small sample size allows for that.

Miles and Huberman (1994) stress the importance of defining boundaries early on in the research process. They define this process as one where you “define 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). The boundaries of this research on kinship care will include people over the age of 18, living in the North Region of British Columbia and, with MCFD involvement, 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.

Limitations

One of the obvious limitations of this study is that it will involve a sample of approximately 10 to 20 kinship caregivers and the findings will not be generalizable to all kinship care families. The study will look primarily at families living in or near Prince George, a city of approximately 80,000 people, which means that the voices of families living in more rural conditions will not be conveyed.

It is difficult to ignore the fact that the participants might feel differently in sharing information with me, as an MCFD social worker, than they would with someone more neutral. I will acknowledge both roles to my participants, but will emphasize that I will be working with them in my role as a researcher. There is a small chance that the kinship care providers I interview will at some time have involvement with the adoption office in which I work (i.e. if they apply to adopt a child in their care). There are numerous social workers on my team and I

will ensure that I do not work with anyone who is both a research participant and an adoption client.

I also come with certain biases as a researcher, both due to who I am as an individual and due to my life experiences. I was born and raised in Prince George and have spent my entire career as a social worker in this city. I am a woman, I am Metis, and my passion as a mother and a long-time adoption social worker is permanency for 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. I bring all of these facets of me as an individual to my role as a researcher.

Ethical Considerations

As alluded to above, this topic is very personal to me. For the past thirteen 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 "age out" of the system 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 then the next day, did not. I provided short-term kinship care to a young child and found this experience to be rewarding, heartbreaking, frustrating, and, ultimately, uplifting. I bring all of these experiences to my journey as a researcher and it would be naïve to think that they won't impact my research in some way.

As a form of self-care, I write poetry about my work and say prayers for the children and families that I have a hard time letting go of. I will continue to do this.

Expectations

It's exciting to be working during a time when the importance of kinship connections are being re-realized. It's also 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 initially completed some of this research for a practicum and already it has been read by several people who have an impact on policy as well as those that work within those policies. My hope is that the findings from this research will continue to be used to make a positive change for the people providing kinship care and, ultimately, the children living within kinship care arrangements.

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**APPLICANTS ARE REMINDED THAT RESEARCH WITH HUMAN SUBJECTS
SHOULD NOT BE UNDERTAKEN
PRIOR TO APPROVAL BY THE RESEARCH ETHICS BOARD.**

APPROVAL FORM

Please check [X] one of the following options before completing the rest of the application.

- [] This is the protocol statement of a routine undergraduate class project that is usually employed in your class. Please submit 8 copies to the Office of Research for full review by the Research Ethics Board (REB).
- [X] This is a research project and a full Research Ethics Board review is requested. Please submit 8 copies to the Office of Research.

1. Researchers Name	Susan Burke		
2. Address	XXXXXXXXXXXXXXXXXXXX		
3. Phone No.	XXXXXXXXXX	Email	XXXXXXXXXXXX

4. Supervisor’s Name & Signature (if Researcher is a student)

Name & Position (Print)	Glen Schmidt, Associate Professor – Social Work Program
Signature	

5. Program

Masters of Social Work

6. Title of Project

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

7. Type of Project

- Class Project (Class projects are normally reviewed by professors after a protocol has been reviewed by the Research Ethics Board).
- Thesis
- Faculty Research

8. Source of Funding (if any)

None.

9. Is this project a replication of an earlier project or protocol that received ethics approval?

- Yes** (Attach copy of the Certificate or letter and submit to the REB. Please clarify (on a separate sheet) if there are any changes being made to the previously approved proposal or if the proposals are identical).
- No** (Go to Question 10)

10. Purpose of Research

This research is part of a thesis pertaining to kinship care. It is intended to gather information from families who are caring for a child or children in a kinship care arrangement or who have done so in the past. In asking questions pertaining to their lived experiences, the researcher will gather evidence concerning:

- the challenged of caring for a child through kinship care
- the rewards of caring for a child through kinship care
- what could be done differently
- what is being done well
- what changes participants feel should take place in order to improve the current system of kinship care
- what services kinship caregivers feel they would benefit from

11. Project Dates:

Expected Start Date	April 2008
Expected Completion Date	February 2009

12. Does this project require any physically invasive procedures (e.g. blood tests), potentially harmful physical regimes (e.g. special dieting) or potentially harmful psychological or social experiments (e.g. illusory perception tests)?

Yes

No

13. Summary of Methods: In the text box below give us a brief summary. Sufficient information must be given to assess the degree of risk to participants.

It is my intention to use the qualitative paradigm to conduct the research. I will use the words and experiences of participants who are caring for or have cared for children in kinship care arrangements.

It is my intention to ask the participants 35 questions through a semi-structured interview process. **Please refer to Appendix A for a list of these questions.** These questions will be a beginning point only and there will be the opportunity for further discussion.

Once all of the interviews have been conducted, a thematic analysis will be completed as a means to find the commonalities in the data.

14. Please append a complete copy of the research project proposal, including any interview protocols or questionnaires.

Attachments:

- Research Project Proposal **(Please see Appendix F)**
- Interview Protocols
- Questionnaires **(Please see Appendix A)**

15. How will participants be recruited? In the text box below give us a brief summary.

I completed a research practicum with the Ministry of Children and Family Development in November of 2007. This research involved assessing the needs of kinship caregivers in the North Region of BC. At that time, the names of the families providing kinship care were provided to me by MCFD and I contacted a sample of these families via phone to inquire as to whether or not they would be willing to participate. I quickly became very interested in this topic and requested of MCFD that I be given approval to use it for my thesis topic. I also asked the participants, at the end of each interview, if they would be willing to be contacted at a later date regarding me using their information for my thesis. All families agreed. **(Please see Appendixes B and C, which are the consent forms I used for that process).**

I am in the process of requesting approval from MCFD to use the information I gathered in my initial research project as well as to interview ten additional families to add to the robustness of my research. I plan to obtain these names from MCFD and contact them in the exact way I did in my earlier research project. I will also contact the families from that project to inquire as to whether or not they would be willing to have their information used for this thesis project.

16. Will participants be competent to give consent?

Yes (Go to Question 17)

No (e.g. Children and cognitively impaired people.) How will the issue of consent be addressed? In the text box below give us a brief summary.

17. Will participants be compensated?

Yes How?

No (Go to Question 18)
In the text box below give us a brief summary.

18. Will consent be obtained from each participant either in writing or recorded?

Yes Please attach a copy of the Consent Form or the questions/statements to be recorded. Each participant must receive one copy of the signed consent form at the time of signing. **(Please refer to Appendixes D and E).**

No Please attach information which will be provided to participants and/or participant communities.

Note: Checklist of items to be addressed in your Information Sheet or Consent Form is provided at the end of this Approval Form.

19. Does the project involve any deception?

Yes Justify the use of deception and indicate how disclosure finally will be addressed.

No (Go to Question 20)

20. What is your plan for feedback to participants? How do you propose to distribute results to participants?

I will inform participants through the Information Sheet (**Appendix D**) that they can contact me via phone or email to request a copy of the final report. I will also offer to meet with families to discuss the findings of the final report.

21. Will the research participants be from an institutional population; e.g. company, agency, schools, colleges, universities, hospitals, prisons, etc.

Yes (Go to Question 22)

No (Go to Question 23)

22. If the answer to Question 21 is yes, attach a letter of consent for access from the institution: e.g. company, agency, schools, colleges, universities, hospitals, prisons etc.

Letter(s) of Consent attached

23. Will the research participants be participating as representatives of, or on behalf of, an Aboriginal group?

Yes Attach letter of consent from appropriate authority, e.g. Band Council, etc.

No Go to Question 24)

24. Does this project require any other ethical approval, e.g. Hospital, First Nations Band, Health Board, etc.? If so, please ensure that all guidelines are followed.

Yes Please specify the agency and attach letter of consent/ethical approval from the appropriate authority.

Ministry of Children and Family Development – Approval is being requested contingent on UNBC Research Ethics Board approval being granted.

Letter(s) of Consent attached

No

Appendix A: 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 you 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 B: Research Practicum Informed Consent 1 (Given before interview)

Informed Consent

You are invited to participate in a research study on kinship care in the North Region of British Columbia. This study will be conducted by Susan Burke, Ministry for Children and Family Development employee, at MCFD Regional office. This study is interested in the people who are providing kinship care in Northern BC: Who are they, what are the needs of the children they care for, and what are their service needs?

Your participation in this project will include an in-person interview. The interview can take place in your home or, if you prefer, at another location chosen by you. The interview will be about 1 to 1 ½ hours in length.

Your participation in this project is voluntary, and you have the right to withdraw from the study, without penalty, at any point. At any time during the interview, you can ask to have the tape recorder turned off, not answer a question, or refuse to participate further.

Confidentiality and anonymity are guaranteed. No one will have access to the interview information except the researcher and an MCFD research analyst, and no one will be able to see your identity in the final research report. The tapes, interview notes, and transcripts will be securely stored in the researcher’s office at MCFD Regional Office.

If you have any questions, please feel free to contact Susan Burke at the MCFD Regional office by phoning XXXXXX or by writing #462-1011-4th Avenue, Prince George, BC, V2L 3H9.

I understand the purpose of the research and what my participation will entail. I am willing to participate and give my permission to Susan Burke to use the information in a final research report for MCFD.

Signature of Participant

Date signed

Signature of Susan Burke

Date Signed

Appendix C: Research Practicum Informed Consent 2 (Given after interview)

I have agreed to take part in a research project being conducted by Susan Burke, Ministry of Children and Family Development employee.

I am willing to be contacted at a later date regarding signing consents for Susan Burke to use the information from my interview in a thesis project for the University of Northern British Columbia.

Signature of Participant

Date signed

Signature of Susan Burke

Date Signed

Appendix D: 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 XXXXXXXXXXXX or XXXXXXXXXX. 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 E: 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 location in her private residence.
 - 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 _____

RESEARCH APPLICATION FORM B
(For research involving non-person identifiable information)

Ministry of Children and Family Development*

Contents

Proposal and Agreement:	Part A – Identification of Researcher Part B – Description of Research Project Part C – Information and/or Records, and Resources Part D – Agreement on Terms and Conditions of Access Part E – Approval
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PART A - Identification of Researcher

Researcher:

Susan Burke
 Adoption Social Worker
 Prince George XXXXXXXXXX
Institution Affiliation/Department
OR Public Body/Program
 University of Northern British
 Columbia
 3333 University Way
 Prince George, BC V2N 4Z9
 Phone: 250-960-5555
 Email: www.unbc.ca

Academic Advisor: Dr. Glen
 Schmidt – 250-960-6519

PART B - Description of Research Project

- A properly completed Application Form.
- Written confirmation of approval in principle by a designated regional Community Service Manager and/or Regional Executive Director.
- Approval was sent on March 4/08 via email, as agreed, by Robert Watts, Director of Child Welfare, North Region.

* For purposes of this document, the Ministry of Children and Family Development is referred to as the/a “public body”.

- Ethics review/approval if research is affiliated with a post-secondary institution.
- Please see attached document. The UNBC ethics board is being asked to approve this project, contingent on the MCFD Decision Support Branch approving the project.

- Consent form to be signed by research participant or his/her parent or legal guardian if the research involves direct contact with a person served by the ministry. The consent form must include a) a statement that s/he voluntarily agrees to participate; b). a statement that the organization will continue to provide services whether this participation occurs; c) a description of the nature of the research and what will be required of the participants; and d) a clear description of possible risks or discomfort.
- This research will involve direct contact with people served by MCFD. Participants will be asked to sign a consent form which includes the above-listed statements.

- Other requirements from the ministry (e.g. staff time, data volume, advisory or consultation needs.)
- This research will be completed on the researcher's personal time. As part of the research, several child protection social workers will be asked to consent to an interview. Information will be sought from the North Region Research Analyst. Consultation will be sought from Robert Watts, Director of Child Welfare and possibly by other MCFD employees as the need arises.

- The intended recipients/audience for the final research.
- The thesis which will result from this research will be published and copies will be available to the public through the UNBC library, so the intended audience could include anyone with an interest in kinship care. My audience will also include my thesis committee.

- Statement that a copy of the final research report will be provided to the Ministry.
- A final copy of my thesis will be provided to Robert Watts, Director of Child Welfare, and to the Decision Support Branch upon completion.

- Research Topic: In the Fall of 2007, I completed a research project on kinship care through the MCFD North Region as part of my Masters of Social Work program requirements. I came up with one primary research question and two sub-questions. My primary question was, "What are the needs of kinship caregivers in the North Region of BC?" and my sub-questions were, "What types of people are providing kinship care?" and "What types of children are in kinship care?"

I began by completing a literature review, looking at what the literature has to say about the 3 questions noted above. I also looked at the history of kinship care.

I worked primarily with Robert Watts, Director of Child Welfare, and Owen Gill, Research Analyst. I was provided with a list of kinship caregivers in the North Region and used MIS to refine this list to active kinship caregivers in the Prince George area. I was left with a sample size of 10. I was careful not to include any families in my sample that I have previously worked with, nor families who I will likely work with in the future.

I constructed two spreadsheets, one with the names of the caregivers and one with the names of the children. I then assigned each caregiver and each child a code (i.e. "A", "A1") and this information was put into another set of spreadsheets so that the names could be removed. The spreadsheet with the names is kept on my MCFD work compute. All of the work that I did from that point identified each family/child by a code letter/number only.

I contacted the kinship caregivers in my sample and requested an interview. All of the caregivers agreed to meet with me. I had them sign two consent forms at that time, a standard form as well as another form indicating their consent for me to contact them at a later date regarding using the information for my thesis. All of the kinship caregivers signed both forms without hesitation.

I used a semi-formal interview process, meeting with the kinship caregivers at a place chosen by them. I gave each a copy of the questionnaire I had constructed and we proceeded with a discussion for 1 - 2 ½ hours.

I later conducted a thematic analysis using this information and came up with themes in the stated needs of the kinship caregivers.

I read through the CS files of the children who were in the kinship care placements as well as the FS files of the parents of those children. I took notes regarding the reasons for the children becoming involved in the child welfare system and being placed in kinship care, as well as any noted special needs. I also took note of any physical/mental health issues faced by the birth parents. I requested a meeting with

the social worker attached to each family/child and met with them to discuss their understanding of the child's special needs, birth parents special needs, and reasons for the children being in kinship care. I then looked through this information for themes.

All of the information noted above was compiled into a report for my practicum supervisor, Robert Watts.

At this time, I am requesting permission to use the information obtained through my research practicum for my thesis. I am also requesting approval to facilitate this process with 5 - 10 additional kinship care placements. This process would include interviewing the families, reviewing the CS/FS files, and speaking to the involved social workers.

I feel that this is exciting research. The use of kinship care placements by MCFD has been on the increase in the past 10 years, yet virtually no research has been conducted on kinship care in BC, let alone in the unique geographical area of Northern BC. I hope that this research will increase the knowledge that we have around kinship care. I hope that it helps the families who are providing kinship care and, ultimately, that it will help the children who live in kinship care placements.

PART C – Information and/or Records and Resources

Please list **all** information, records or resources to which access is requested. Access will be given **only** to information, records or resources listed below. Any changes or additions to this list after submission should be made in writing to DSB, and will require approval.

This section defines the parameters of access. To facilitate the research project, access is required to: (for example, child protection social workers)

Information

- Information from the MCFD Intranet (i.e. Vision Statement).
- Information from Mars program (statistical program) regarding kinship care and foster care.
- Access to the MIS system to retrieve contact information regarding kinship caregivers.
- Information obtained from interviews with kinship caregivers and with the social workers who are working with them and with the children in their homes.

Records

- CS files of children in kinship care. FS files of parents whose children are in kinship care.

Resources

- Robert Watts, Director of Child Welfare, North Region - 565-4367

- Owen Gill, Research Analyst, North Region - 565-4376
- Elaine Lamb, Guardianship Team Leader, North Region - 565-6215
- Frank Mossop, Practice Analyst, North Region - 565-4367

PART D - Agreement on Terms and Conditions of Access

1. If this proposal is approved and I am granted access to the information, records and/or resources listed in Part C, I understand that

X as an employee of a public body, performing research for the public body, I will abide by, my Oath of Employment and Code of Conduct regarding confidentiality, disclosure, security and records management.

as a private citizen, performing research for my own interest, I must not collect, disclose or use the information/resources/facility to which I have been granted access except as outlined and for the purposes set out in this Agreement. Unauthorized access to, or modification of, or use of, the information, resources or facility, except as provided in this Agreement, is a fundamental breach of the Agreement. Penalty for such a breach would include immediate termination of access and referral to appropriate institution or public body for investigation and possible legal action.

2. I agree to appropriately reference the source of the all data as being the British Columbia Ministry of Children and Family Development, or Authority(ies) (as appropriate).
3. I, the Researcher, will provide the signing head of the public body or delegate (as indicated on the signature page of this agreement) with copies of the final written findings of the research project, prior to these being published or distributed.
4. The public body will be deemed to have approved release of any proposed publication or distribution unless the Researcher is notified to the contrary within 45 days of the DSB's receipt of the materials. When submitting the materials, reference should be made to a citation for a publication. In the case of a separate publication, not as an article in a journal, one copy of the final publication shall be provided to APMB.
5. I, the Researcher, agree to destroy all data at the conclusion of the research project.
6. I understand that I am responsible for ensuring complete compliance with these terms and conditions, and in the event that I become aware of a breach of any of the conditions of this agreement, I will immediately notify APMB by phone.
7. Further, I accept that the expiry date for access to the information, records and/or resources in Part C is the date as listed below.

Signed at _____, this _____ day of _____, 20_____.

Signature of Researcher

Signature of Witness

Name and Position of Witness

This application to be electronically submitted by Researcher to: anne.thomson@gov.bc.ca, Decision Support Branch. 'Approval in principle' from the designated ministry manager must accompany the application.

