

Kinship Care in Northern British Columbia

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An exploratory case study design using three sources of data—interviews with kinship caregivers, interviews with social workers, and file reviews—was used to identify the needs of kinship caregivers in northern British Columbia. The research found that kinship caregivers identified many needs that must be addressed if kinship caregiving is to be a viable and sustainable option for children in need of care.

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British Columbia (BC) is the third most populous province in Canada, with 4,402,931 people (BC Statistics, 2008). This population includes 900,000 children and youth aged 0 to 18; approximately 9,000 of those are in the care of the provincial Ministry of Children and Family Development (MCFD; 2003). During the past decade, MCFD has increasingly shifted its focus to explore ways for at-risk children to remain safe without entering the foster care system. One approach has been to increase the amount of kinship care.

Kinship Care

The Child Welfare League of America (CWLA; 1994) defines kinship care as “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” (p. 2). Kinship care is not a new concept, but beginning in the 1950s, significant social and legislative changes encouraged an increase in kinship care placements in North America. There was an increased understanding of the importance of maintaining children’s family ties. At the same time, foster care began to transform due to an increase in the number of families in which both parents worked outside of the home, resulting in fewer available foster homes (Takas & Hegar, 1999). Child protection guidelines that defined child abuse, neglect, reporting policies, and intervention strategies were created.

Kinship Care in British Columbia

Although BC was similarly affected, it has its own unique history around kinship care. Cradock (2007) notes that during the 1990s, there was considerable turmoil in BC’s child welfare system. The

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death of a young child led to a major review of child welfare services and practice. Subsequently, Gove (1995) emphasized the need for intervention, and the number of children in care in BC rose significantly from 7,278 in 1995–1996 to 9,435 in 2001–2002 (MCFD, 2003). While the Family Relations Act had for some time made it possible to transfer custody between friends and family members, the 1996 Child and Family Community Services Act provided a way for the provincial government to financially subsidize those placements, though the parts of the act which allowed for agreements with a child's kin were not implemented until 2002 (Walmsley, 2005). Cradock (2007) argues that finances were an enormous incentive for the provincial government: a foster home with children with exceptional special needs could receive up to CDN\$10,000 a month, a regular or restricted foster home could receive just over CDN\$700, and a kinship care home could receive CDN\$450. A new focus on out-of-care options emerged. In these situations there was MCFD involvement but the children did not come into care.

Kinship Caregivers

In comparison to regular foster parents, kinship foster caregivers are older, have a lower level of formal education, and are more likely to be single and in fair to poor health (Berrick, 1998). They also have a lower average level of income (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., 1994; Pecora, Prohn, & Nasuti, 1999). Kinship foster caregivers are most often a grandparent (48%) or an aunt/uncle (44%) and are 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).

Fuller-Thomson and Minkler (2000) found that grandparent kinship caregivers are at increased risk of depression and those raising children who have neurological, physical, emotional, or

behavioral problems may be the least likely to seek support. Baker (2000) notes that the familial component of some disorders may mean that the caregivers (in this case, grandparents) also struggle with the disorder.

Kinship caregivers consistently receive fewer services from child welfare agencies 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: believing that the child is safe, feeling uncomfortable about intruding on family life, or misinterpreting policy (Meyer & Link, 1990, as cited in Berrick, Needell, & Barth, 1999).

The Needs of Kinship Caregivers

Kinship caregivers report some clearly defined needs. Not surprisingly, the need most often noted in the literature is financial (Broad, 2002). They usually receive little or no advanced notice and may not have a chance to prepare by buying things such as a crib or a car seat (Geen, 2003). Kinship caregivers are generally paid less money than licensed foster or group homes (Henderson & Cook, 2005). They are also often unaware of 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).

Kinship caregivers also report a need for respite. Many are grandparents who have been gearing up for retirement and then have to assume 24-hour care of a child (Broad & Skinner, 2005). The need to care for a child often occurs suddenly, with no time to plan for child care beforehand; in addition, kinship caregivers report a difficult time locating and paying for childcare and often have to quit their jobs (Geen, 2003).

Kinship caregivers reported additional needs: respectful treatment for choosing to accept a responsibility that was not originally

theirs (Mayfield, Pennucci, & Lyon, 2002), education around child behaviors and matters such as permanency planning (Dolbin-MacNab, 2006; Templeton, 2003), counseling, and support groups (Dolbin-MacNab, 2006).

Kinship caregivers receive less time with social workers than regular foster parents and cite a need for increased social worker support. 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 social workers did not have time for more than brief contact or crisis work. Also, 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 children (Geen, 2003).

In summary, the literature indicates that kinship caregivers receive fewer services than their nonkin counterparts do despite having overall greater service needs (Geen, 2003). Some reasons for this disparity include the fact that social workers offer fewer services to kinship caregivers, kinship caregivers request services less often, and kinship caregivers may face barriers to accessing services.

Research Methodology

Given the rapid expansion of kinship care in BC and other jurisdictions, it is important to develop a clear sense of the needs of kinship caregivers and to establish whether those needs differ across jurisdictions. In northern BC, a high population of Aboriginal children in care, the rapid expansion of kinship care, and the lack of research into the needs of kinship caregivers prompted this research, which asks this: What are the needs and experiences of kinship caregivers in northern BC?

The research took the form of a case study that included a group of 16 individual kinship caregivers over the age of 18 living in northern BC and caring for children who are friends or family members with MCFD involvement. The 16 participants were recruited with the consent of MCFD through a criterion sampling

method. The kinship caregivers' social workers were also identified and a total of 11 social workers agreed to be interviewed. Data was also gathered from reviews of the children's and the birthparents' files. The collected notes and transcriptions were analyzed using a thematic analysis. Notes were made in the margins of each data source and themes or issues were coded. Once each file was coded, a within-case analysis was conducted by looking at the themes and discrepancies that arose. These themes were then recorded on a separate piece of paper.

A cross-case analysis was then completed, looking at both recurring ideas as well as discrepancies. The code words that occurred within each case, as well as the themes that arose from those code words, were studied. By doing this it was easier to see topics that were emphasized by the participants or topics that came up frequently, as well as those that were not emphasized but that were found repeatedly across cases. The themes were organized into clusters and grouped within a conceptual framework based on the continuing thematic analysis and recognition of the patterns in the data. Following this, themes and subthemes were developed. Finally, the themes and subthemes were organized into larger, general categories.

Findings

Characteristics of Caregivers and Children

The caregivers and children represented a diverse sample. Grandparents comprised the largest number of caregivers (seven) and there was also one great-grandparent. They varied in age, with the youngest being 37 and the oldest being 68. All of the primary caregivers were women. Of the primary caregivers, 5 were single, 10 had partners who lived and coparented with them, and 1 had both a partner and an ex-partner who lived and coparented with her. Ethnicity also varied but 6 cited aboriginal ancestry. Overall, the caregivers were not a healthy group, and a number of them had preexisting health problems including bipolar disorder, depression,

arthritis, and chronic back pain. Education levels varied, but 8 caregivers had some postsecondary education; 11 reported a family income of under \$50,000 per year. The caregivers in the sample were looking after 23 children. A total of 19 of the 23 children were in care because their birthparents had serious problems with alcohol and drugs. Also, 15 of the 23 children had witnessed domestic violence, usually abuse of their birthmother. Of the children, 5 had a diagnosis of fetal alcohol spectrum disorder, and 12 had experienced physical abuse. Many of the children had been moved from foster home to foster home, with one child experiencing 15 moves.

Motivation of Caregivers

Although the families were sometimes motivated by a 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. This desire was mentioned by 11 families. 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 finding 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 look after this child, but rather because she felt a sense of duty.

Caregiver Expectations

Many of the caregivers said that they were erroneously told the children would be in their home only for a short period. 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.

System Expectations

Caregivers also said that they felt that there were undue expectations placed on them by the child welfare system. These expectations frequently centered on parent-child contact, specifically around providing supervision and transportation to and from visits. 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 a parent education and skill development program with her parents and then had a home visit. This woman had taken a year's leave from a well-paying position to provide care to the child.

The birthparents' instability and mental health 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 grandparent caregiver described some of the chaos associated with the parental contact: "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."

Caregiver/Parent Relationships

All but one of the grandparent caregivers in this sample 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."

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

Nurturance

Despite the fact that the caregiver/parent relationships were often complicated, several of the caregivers made a genuine effort to promote the parent/child bond. For example, one family had the child's mother over for Christmas and Thanksgiving dinners. One low-income caregiver described the thrice-weekly visits she facilitated between the toddler 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 ... because that's a time you can bond, you can talk, and she does."

Sense of Threat

Some of the caregivers worried 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 [the child] went back to him [the father], then ... he could make it quite difficult for me.

Occupational Changes

Of the 16 families, 6 reported that they had made changes at work to provide kinship care. Six of the families cut back or eliminated the hours worked by the primary caregiver and in three families this change resulted in the secondary caregiver working longer hours to provide an adequate income. One family, which bought a modest but larger house to accommodate the child they were caring for (and who were raising the child's sibling through another program), described how the primary caregiver had taken a leave from her job to provide care, resulting in her husband having to work longer hours. These occupational changes were felt in a particularly acute way when the families were near or at retirement age.

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 substandard. One caregiver said,

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.... We've got her on a good diet now. Like, she's growing. Like, that shirt that she's wearing is a size four.

Supports

Caregivers drew support from a number of different sources including family, friends, community, faith groups, support groups, and social workers. Of the 16 primary caregivers, 10 indicated that friends were a source of support. Nine cited faith as a source of

support, including Christian churches as well as traditional Aboriginal spirituality. Regarding support groups, one caregiver 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.

Overall, the caregivers spoke very positively about their social workers, even while acknowledging that the social workers were often too busy to provide adequate support. Comments such as this one captured the essence of the caregiver opinions about the social workers: "Before, I was always playing phone tag with the social worker and we're having problems with daycare and ... all kinds of problems and now we have [social worker's name] and all of a sudden we're her number one priority and it's awesome."

Needed Supports

Caregivers cited the need for numerous supports including increased funding, assistance in paying for extracurricular activities, respite, and additional information. One of the topics that frequently arose was the need for financial support. All but one of the primary caregivers in the sample was receiving a kinship care payment from MCFD and the one who was not said that the child's mother (who 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 received vouchers for groceries, while others received no funds at all. One family said that they received a kinship care payment for 5 of the 15 months they provided care. One single mom of two teens described how it initially was not an issue for her to receive only grocery vouchers: "Well, you know, when I originally took [the youth] in, it was only supposed 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."

Of the 16 families, 9 said that they would provide kinship care even without the kinship care payment. However, for almost all of these families, raising the children without financial support would mean a huge sacrifice and in some cases was not practical. 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 small home on a modest income responded: "Absolutely. I don't care what we'd do. We'd find a way. 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 to keep the child in their home safe.

Of the 16 caregivers, 7 said that they would like help to pay for extracurricular activities. All 7 of these people discussed the fact that the children had already been through a lot in life and could benefit from extracurricular activities, but that they could not always afford to pay.

Of the 16 primary caregivers in this sample, 5 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. One 37-year-old woman caring for her two young nephews said that she might ask for them to be moved because she received only one short break in the two months she had been caring for them. Another woman, who was caring for her daughter's teen friend, said she had eventually asked for the girl to be moved, partly 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."

Of the 16 caregivers, 11 demonstrated a need for additional information regarding the children in their care, particularly around the plan for the child. Some caregivers also expressed a general

lack of information about the legalities involved 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.”

Social Workers

The social workers consistently acknowledged that they liked the idea of placing children with friends and family members rather than in a foster home; however, they also said 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, parent’s, and caregiver’s—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 workload, but also posed a conflict of interest as they tried to support the children, the parents, and the caregivers to meet needs that might conflict. 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 discussed the need for outreach workers who could go into the home and provide basic support to the caregivers or the child.

Another topic that arose was the need to advocate for families to receive services. Experienced social workers pointed out that they were more likely to be stronger advocates than new workers because they would continue to advocate even after being told “no.”

Social workers also discussed the complexities inherent in their relationships with the kinship caregivers. 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. They also look to the

parents to provide different standards of care than those expected by the kinship caregivers, looking strictly at safety while the kinship caregivers want the best life possible for the child. 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.

Implications and Summary

Kinship caregivers and their social workers believe that continuing with the status quo around kinship care is not enough. The kinship caregivers in this northern BC sample were stretched by their role, in not only providing day-to-day care for the children, but also fulfilling duties such as working with the social worker and the child's parents, while dealing with their 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 caregivers said that they needed additional supports. Some of these supports, such as respite and funding for children's activities, cost the caregivers money, and therefore the caregivers 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 to implement. Overall, 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.

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