A DESCRIPTIVE STUDY TO EXAMINE THE NEEDS OF KINSHIP CARE PROVIDERS

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A DESCRIPTIVE STUDY TO EXAMINE THE NEEDS OF KINSHIP CARE PROVIDERS

A Project

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Abstract

of

A DESCRIPTIVE STUDY TO EXAMINE THE NEEDS OF
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Xavier Maldonado
Wendy Rebentisch

This study examined the importance of support systems for kinship providers and identified gaps in the system of care for children in kinship care. The study used a non-random purposive sample of 45 professionals working with kinship care providers in Sacramento County. The study findings indicate the importance of increased financial support, training for kinship providers to understand the dynamics of caring for kin, increased access to services and social service professionals’ increased involvement through consistent home visits and supervision. The authors recommend interventions and preventive measures at each of the areas listed above. Both the researchers worked jointly to formulate the study problem, specify the research question, and shared the responsibilities of conducting literature review, developing the questionnaire for data collection, data analysis and writing the project report.

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___________________________
Date

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Wendy Rebentisch
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Chapter 1

THE PROBLEM

Placing children in what we now term as foster care and kinship care has been an ongoing phenomenon documented since the advent of human history. Informal kinship care has been a long-standing tradition in many cultures and continues today. Research suggests that the federal government was very slow in involving itself in the child placement matters, even after the establishment of the United States Children’s bureau of 1912 based on concerns for violating state rights (Hegar & Scannapieco, 1995). Although the involvement of government into the matters of child and social welfare had a lot of positive outcomes, providing adequate care to ensure the health, safety and welfare of children, continues to be an ongoing problem.

One area that continues to be neglected is Kinship Care. Kinship care did not emerge as a child welfare issue until the 1980’s, and only recently has it become a part of the formalized system of out-of home care (Scannapieco & Hegar, 2002). The research indicates that there are significant differences in supports provided to kinship care providers verses foster care providers. Individual and families who provide foster and kinship care serve the same functions in terms of providing care to the child, however child welfare agencies rarely provide the same resources to kinship families (Scannapieco & Hegar, 2002). Grandparents, who are usually called upon first to care for the child, are frequently elderly, are on fixed incomes, and often have medical issues that limit or disable them and create barriers in providing adequate care.
The research indicates that without increased levels of services in place, the greater the likelihood of a disruption in placements, in some cases causing the removal of the child from care. Additional contributing factors to disrupted environments include mental health issues, child abuse and maltreatment, and lack of access to resources. There is a substantial need for equality in services provided to kinship caregivers as a means of adequately maintaining a child in their care. This study will further examine the needs of kinship care providers, reinforce equality in support services between kinship and foster care, and finally demonstrate a need to reform current kinship care policies.

Background of the Problem

The orphan train (1854-1930) that relocated orphaned children from the city of New York to families in the Midwest was considered the beginnings of foster care (Cook, 1995). This program set the stage for a series of changes in the child welfare system and the development in programs aimed to accommodate and meet the needs of children removed from their families (Cook, 1995). Social welfare matters were primarily the domain of state and local governments (Downs, Moore, McFadden, Michaud, & Costin, 2004). Over time, as more and more children entered the child welfare system, the research shows that the federal government policies at the state and federal levels had to expand and evolve to accommodate and meet the needs of children entering the child welfare system (Cook, 1995). As such, the need to ensure the health, safety, and welfare of the children became paramount as problems in providing adequate care began to emerge.
With the increase in children being removed from their homes, the need for relative care was heavily relied upon based on the challenges in recruiting and retaining a sufficient number of quality foster homes to meet the needs of the children (Kolomar, 2000). However, the need for family members to care for their kin did not equate to equality in support services provided to ensure adequate care (Scannapieco & Hegar, 2002). The research strongly suggests that today kinship caregivers continue to receive less money and training, fewer resources, and less supervision and oversight of the child than foster parents (Scannapieco, 2002). There are also fewer supportive community based programs to reinforce stability, provide respite services, and offer much needed crisis-based support. Social services continue to recognize that children need to be with their families, yet have provided little to ensure stability, safety, and permanence of the population in their care.

According to the U.S. Census Bureau (2000), more than six million children in the US live in households headed by relatives other than their parents who provide full-time care, nurturing and protection. Research suggests that this population is growing (Child Welfare League of America (CWLA), 2003; National Data Analysis System (NDAS), 2003). To serve the large number of children entering the system by virtue of being removed from the home of their biological parents by state child protective services, child welfare agencies place children in out-of-home placements. One such placement to assist in managing the number of children entering the system is through kinship care, or the informal or formal caring for a child by a relative (Downs, Moore, McFadden, Michaud, & Costin, 2004). This type of family-based placement with
relatives has become “an integral part of the child welfare system in the United States” (Scannapieco & Hegar, 2002). Formal kinship care is now the fastest growing placement option for children in state custody (Gibbs & Muller, 2000). With the large number of children entering the system, child welfare is struggling to recruit a sufficient number of foster parents, and has come to rely heavily on placements with relatives to fill the gap.

This change in dynamics has produced a number of studies looking at the risks and benefits of kinship care, as well as the quality of care provided by family members. Some of the benefits noted by proponents of kinship care suggest that kinship has the potential to be a valuable and culturally sensitive resource for children, community, and families by offering continued growth and development within the context of the child’s culture (Gibbs & Muller, 2002). In some instances, children in foster care may not be placed in communities or with families that are of the same cultural background making it difficult to form appropriate relationships and secure attachments. Placement with family is said to reinforce children’s sense of identity and self esteem, which flows from knowing their family histories and culture.

As relative care suggests, children placed with relatives are better able to maintain social and familial connections with limited interruption from the court system (Kroll, 2007). Children who are given the opportunity to stay in the same neighborhoods and school environments are said to fair better and transitions more easily than if they were completely removed, as in most foster family placements. In this environment, children have a better chance of maintaining contact and communication with other close family, friends, and potentially parent(s). Stability in a secure placement may also result in fewer
placement changes. Finally, research indicates that removing a child from his or her home can be significantly traumatizing. Children placed with relatives is said to “lessen the trauma to children when they are separated from their parent or parents” (DiNitto, 2007, p. 422). Staying with grandma or auntie is more familiar than staying with a stranger, which may be troubling to the child.

However, just as there are benefits to kinship care, researchers also identify potential hazards and concerns related to this type of care. As indicated there are also a number of risk factors debated throughout the research. Those who are critical of kinship care have raised concerns about the quality of care by kinship providers and the outcomes for children in relative care (Gibbs & Muller, 2000). One of the risks reported in the research involve the potential for re-abuse by the parent (DiNitto, 2007). Kinship care was once believed to increase the risk of recurring maltreatment due to ease of access by the abusive parent (DiNitto, 2007; Gibbs & Muller, 2000). However, according to DiNitto (2007), “the research has shown that children cared for by relatives are no more likely to be re-abused or incur repeated maltreatment than children placed with non-relatives” (p. 422-423).

Another risk factor addressed in the research is re-exposure to drug abusing parents. When there is a substance abuse history, research suggests that children in relative care may be re-exposed to the environment in which they were removed (Kroll, 2007). This not only increases the chances for long-term emotional and behavioral challenges, but also creates additional issues with attachment (Kroll, 2007). As we will
address, in many cases of relative care the caregivers are not trained to manage
significant behavioral or mental health problems (Hegar & Scannapieco, 1995).

Finally, the issue of aging grandparents as caregivers has also created controversy
as it relates to the ability to provide adequate care for their kin. More often than not,
grandparents are determined to be the most suitable placement, and are often the first to
step up and assume the caretaker role (Chang & Liles, 2007). Relatives of children are
assumed to be already attached to them, and therefore have a sense of love or familial
obligation that provides a different motivation for providing care. However, researchers
have also determined that children placed with grandparents present significant risks due
to the age, health/medical issues, energy levels, unrealistic expectations, and finances of
the grandparent (DiNitto, 2007).

With the rise in children entering the child welfare system, there has been an
increase in interest in Kinship Care policy. As we can see, there is a significant need to
reform current policies and practices to accommodate the needs of caregivers and kin.
The researchers will show that there is a considerable difference in the number of
services and support available to kinship caregivers verses foster caregivers, primarily as
it relates to financial support, training, access to resources, and oversight and supervision.
These differences in services and supports combined with the inequalities of existing
child welfare policies and practices, leaves kinship foster parents at a significant
disadvantage when compared to non-kin foster parents (Gibbs & Muller, 2000). Children
in kinship care require a very distinctive level of care and monitoring to maintain safety,
avoid placement disruptions, and minimize re-traumatizing the child.
The intention of this research is to fill the gaps in existing kinship care policy, and reinforce positive changes in the current level of support provided to kinship caregivers. Child welfare has increasingly been at the forefront of debate, and many question whether it does more harm than good (DiNitto, 2007). The need to place children back with their families must be the focus of child welfare and social services, as it is becoming an increasing need with the increase in children entering the system. Many changes are needed in order for these transitions to be successful.

At present there are policies that assist in helping families meet the basic needs of the child. However, there needs to be expansion on what exists already in terms of providing financial support, training, and oversight to kinship caregivers. At present, the Title IV-E and Title IV-B, of the Social Security Act are the primary sources of funding for Child Welfare Policy. Many would say that they have failed the families due to strict requirements and loose standards. The kin care providers are generally on their own to ensure the health, safety, and welfare of the child in their care, and deemed capable due to the pre-existing relationship with the child. The assumption is that relatives take in children at their own risk, at no fault of the government or its policies.

This research will demonstrate that there are significant gaps and areas of inequality in the system of care for children in kinship care. As the kinship population continues to grow, something must be done to reinforce stability in the homes of these caregivers. It is well know that kinship caregivers often receive less services and support than foster caregivers, however little is being done to address this issue. Foster caregivers are given routine supervision and oversight, consistent and reliable financial support, and
regular required trainings to ensure the safety and well-being of the child placed in
his/her care. Kinship providers are often left to navigate the system by themselves with
limited support from social services, and must manage any and all behavioral and
emotional challenges presented in the home. The hope is that this study will contribute to
the current research available by continuing to address the needs of kinship caregivers,
and identify strategies to make positive changes within the system of care.

Statement of the Problem

Kinship providers are not afforded the opportunity to adequately care for their kin
due to the inequality in supports available. These inequalities often result in placement
disruptions and challenges in providing quality care to their family members. The
primary issues impacting kinship include the following: too many children and not
enough homes/family available, too few funds allocated to the kinship caregivers that do
step up, limited oversight and support geared toward training and mental health services,
over-worked social workers with large caseloads, few state mandated requirements (more
oversight), children in kinship do not qualify for the same resources that foster kids have
access to including crisis centers, respite care, mentorship programs, scholarships, etc.
There are many children that end up back in the system due to caregivers being
overwhelmed due to lack of county and community support, lack of financial resources to
maintain the child in the home, and limited training for children with mental health
issues. When a child is placed in long-term placement with a kin caregiver, the
supervision and oversight is limited and inconsistent. Caregivers often take a back seat to
foster children who have ongoing support from foster care agencies on a weekly or
monthly basis. The discrepancies are so clear and so unequal, that the chances for success and long-terms stability are great impacted.

The change in policy would make the system’s standards more uniform. It would require that the kinship providers meet the same standards of licensure and training as their foster provider counterparts. The caregiver would have similar oversight and supervision by social services, at minimum for the first year, and would receive the same monthly funding allotments that foster children receive. This would ensure that the caregivers have been given ample support and opportunity to gain what they need in order to provide a safe and stable living environment for the child. Equalizing supports and services could also potentially see a reduction in disruptions and placement changes, and increases in guardianship or adoption if the child could secure a placement with family who was confident, capable, and well supported. These changes would likely reduce the number of stressors involved, when family members are given the chance to take in the relative kin, and who would otherwise not have the financial support or motivation to do so.

**Purpose of the Study**

The purpose of this study is to examine the needs of kinship care providers from the perspective of child welfare professionals. In obtaining a variety of perspectives, the researchers will be better able to understand the challenges and needs in maintaining a child in the placement of the relative caregiver. Specific questions will be asked to determine the level of importance of the support and services to clarify significance and
need based on the professional’s understanding. We focus on the professional as they are on the primary distributor of supportive services.

The survey questionnaire was designed by the researchers in an effort to gain knowledge on the direct connection between lack of support for kinship care providers and their ability to adequately care for the child. The idea set forth by the researchers was to gain a snapshot of where strengths and weaknesses are located in the system of kinship care in order to further kinship care practices. It is hoped with the results of this survey will direct county agencies to combine their resources and expertise in the most effective ways to ensure that kinship care providers are receiving the appropriate level of resources in order to be adequately prepared in caring for children.

The secondary purpose of this study is to identify additional needs, not otherwise focused on this study. This additional component may result in recommendations not previously considered as necessary or significant. Additionally, providing the survey to professionals may increase awareness of the current level of problems, and reinforce the need for advocacy of the study population. It is hoped that this understanding will demonstrate the need for not only change, but also reinforce the need for equality in financial support, training, access to resources, and oversight and supervision for kinship care providers. The increase in support for kinship caregivers would greatly benefit the child who would otherwise get lost in the system. If the emphasis is indeed reunifying the child with family, this advocacy for change should support the goal. Family members who would otherwise not be able to afford taking in another child, would potentially step up to the plate if there was more financial support, training, services and oversight in
place. We could also potentially see a reduction in placement changes, and increases in guardianship or adoption if the child could secure a placement with family who was confident, capable, and well supported. These changes would likely reduce the number of stressors involved, when family members are given the chance to take in the relative kin, and who would otherwise not have the financial support or motivation to do so.

**Theoretical Framework**

When looking at Kinship Care it is helpful to view it in the context of theory and application. This section will look specifically the systems perspective and attachment theory. Payne (2005) notes that “systems theory focuses on individuals as part of and incorporating other systems” (p. 142). System interact with each other in a variety of ways, and exploring these ways helps to understand how individuals interact with other people in families and communities and in the wider social environments (Payne, 2005). As a social worker, systems theory is extremely important in working with families in order to understand what influences help or hinder family functioning. Within Kinship care, systems theory addresses the complex nature of the family and its connection with larger supportive systems.

Kinship care is the result of a disrupted system. Once a child has been removed from the home, he or she is dumped into the larger systems at work including court systems, county systems such as child protective services, and out-of-home or family-based placements. Examples of out-of-home placements include: family foster care, treatment foster care, kinship care, institutional care, and group home care (Downs, Moore, McFadden, Michaud, & Costin, 2004). When a child has been removed, they may
be placed by county or state agencies such as child protective services (CPS), which seek to place the child in the least restrictive setting possible. Most often agencies try and locate family relatives as a means of keeping the child within the family if deemed to be in the best interest of the child (Downs et al., 2004).

Family systems disrupt for a variety of reasons, which ultimately impacts the child on all levels, may that be behaviorally, emotionally, psychologically, or physically. Children are generally brought to the attention of social service agencies because of complaints related to abuse (emotional, physical, or sexual) and neglect by parents or other caretakers (CWIG on Kinship Caregivers and the Child Welfare System, 2005; Downs, et al, 2004). When children are removed from the home, it can be emotionally traumatic and confusing. Children are frequently placed with relatives to reduce the level of trauma they may have experienced had they been placed with strangers (DiNitto, 2007). In most instances, children are able to adapt to the new environment with ease when they are given the opportunity to remain with family. Many of these children often require the support of mental health agencies to address the trauma and other psychological and behavioral issues that may result from the experience (Downs, Moore, McFadden, Michaud, & Costin, 2004).

Kinship Care assists in this process in reinforcing the need for strong family systems. The researchers propose that increasing supports, services, training and access to resources will ultimately reduce family stressors and reinforce stability and permanency for the child. The child stands a better chance at experiencing a smoother transition into
placement and reducing the incidence of placement disruption when risk and stress factors are minimized.

Another framework to consider when discussing kinship care is attachment theory. “Attachment theory provides the foundation for understanding the importance of relationships in attaining healthy development outcomes” (Downs, Moore, McFadden, Michaud, & Costin, 2004, p. 94). Attachment theory is based on the idea that early experiences of attachment to secure and responsive adults, usually parents, are an important foundation for later social competence and interactions (Payne, 2005, p. 81). As infants, children instinctively have a need to develop secure attachments, however, if the interaction and responsiveness is not reciprocated the attachment does not form appropriately.

The kind of care-taking behaviors that the adult brings to the relationship is also fundamental to the quality of the attachment that develops (Downs, Moore, McFadden, Michaud, & Costin, 2004, p. 94). Children that receive the same level of responsiveness, love and affection, as they do from the parent figure, the stronger the psychological bond created. Children rely strongly on the parental figure through this process, which ultimately influences the child’s the formation of identity, or self, and social and personal relationships with others. According to Payne (2005), warmth, mutuality, support and security are also qualities of relationships that tend to produce coherent, well-organized later selves).

The environment is also critical to this process. If a child is born into or exposed to unhealthy relationships, the child’s ability to form a strong and healthy bond with
others may be severely hindered. Attachment may be challenged even further when a child is removed from the care of his or her biological parent. The formation of attachment built from early experiences is critical in the child’s ability to transition effectively to the home of a caregiver, adjust, and communicate his or needs effectively within the new environment. Research suggests that this transition is smoother and less traumatic when the child is placed with a relative and not with strangers.

As discussed previously in benefits of kinship care, the idea of connectedness and secure attachments was addressed. Proponents of kinship care argue that kinship care: facilitates secure attachment and reinforces the connections of the child to siblings, family, and cultures; reduces trauma children may experience when they are placed with strangers; reinforces the child’s sense of identity and self esteem; encourages families to consider and rely on their own family members as resources; and strengthens the ability of families to provide children the support they need (Gibbs and Muller, 2000). All of the benefits noted here center around the child’s well-being and preservation of connectedness or attachment with the family system.

The need to form secure attachments continues throughout life (Downs, Moore, McFadden, Michaud, & Costin, 2004). Kinship Care assists in this process by reinforcing family connections and relationships through the act of placing children with their relatives. However, many placements disrupt due to lack of supervision and oversight, resources and services, which contributes to the child’s lack of security and safety. This can be minimized if the stressors are reduced with the support of policy changes. Attachment theory best reinforces the benefits of kinship care, and need for greater
attention to the needs of kinship providers in providing a safety, healthy, and supportive family foundations.

**Definition of Terms**

*Child Welfare.* Child welfare encompasses programs and policies oriented toward the protection, care, and healthy development of children. Within a national, state, and local policy and funding framework, child welfare services are provided to vulnerable children and their families by public and nonprofit agencies with the goals of ameliorating conditions that put children and families at risk; strengthening and supporting families so they can successfully care for their children; protecting children from future abuse and neglect; addressing the emotional, behavioral, or health problems of children; and when necessary, providing permanent families for children through adoption or guardianship children (NASW Standards for Social Work Practice In Child Welfare, 2005).

*Disrupted Placement or Placement Disruption.* For the purposes of this study a “disrupted placement” or “placement disruption” means any condition, reason, or situation where a relative kin or child must be voluntarily or involuntarily removed from the home of the primary caregiver.

*Fictive Kin.* For the purposes of this study, a “fictive kin” refers to a non-related close family acquaintance (Downs, Moore, McFadden, Michaud, & Costin, 2004, p. 20-21).

*Foster Care.* For the purposes of this study, foster care refers to the temporary placement of a child or children with a non-related adult(s) who has been trained,
assessed, and licensed or certified to provide shelter and care (California Department of Health and Human Services on Foster Care, 2007).

*Foster Parent, Foster Care Provider, Foster Caregiver.* For the purposes of this study, foster parent, foster care provider, and foster caregiver may be used interchangeably, and shall be assumed to have the same meaning. A foster parent is an individual who provides a supportive and stable family for children who cannot live with their birth parents until family problems are resolved. In most cases, foster parents work with social services staff to reunite the child with birth parents. Foster parents often provide care to many different children (CDSS on Foster Care, 2007).

*Guardianship.* Guardianship refers to the physical and legal placement with someone other than the biological parent, because parents are by law the natural guardians of their children (Downs, Moore, McFadden, Michaud, & Costin, 2004, p. 198).

*Kinship Care.* Kinship care refers to the placement of children with their relatives, which occurs when the biological parents of the child are unable to maintain a minimally sufficient child-rearing environment in the home, or who are unwilling to care for their children (Downs, Moore, McFadden, Michaud, & Costin, 2004, p. 20). Kin Caregiver, Kinship Care Provider. For the purposes of this study, the terms “kin caregiver” and “kinship care provider” may be used interchangeably, and shall be assumed to have the same meaning. The kin caregiver refers to the family member who cares for the child.

*Kinship Foster Parents.* For the purposes of this study, kinship “foster” parents, according to the Child Welfare information Gateway, are the relatives who are caring for
the child that was placed in their care, and who have been involved in the formal training and licensure process for the caregivers. They also receive monthly payments to help defray the costs of caring for the child, and support services (Child Welfare Information Gateway, Updated 2010).

Oversight. For the purposes of this study, the term “oversight” refers to the level of interaction of the social worker or child welfare agencies in providing case management, resources (agency or community based), and other specific needs of the kin caregivers (e.g. clothing vouchers).

Supervision. For the purposes of this study, the term “supervision” refers to the level of direct and indirect contact and attention given to the kin caregiver at any given time while the child is in his or her care.

Permanency. For the purposes of this study, permanency refers to a guiding principle of child welfare practice intended to limit placement into, and the time spent in, out-of-home care. It includes an array of social work and legal efforts directed toward securing safe, nurturing, life-long families for children (NASW Standards for Social Work Practice in Child Welfare, 2005)

Relative and Relative Care. The term “relative," in the context of kinship care, means an adult who is related to the child by blood, adoption, or affinity within the fifth degree of kinship, including stepparents, stepsiblings, and all relatives whose status is proceeded by the words "great," "great-great," or "grand," or the spouse of any of these persons, even if the marriage was terminated by death or dissolution ... only the following relatives shall be given preferential consideration for the placement of the child: an adult
who is a grandparent, aunt, uncle, or sibling (California Department of Health & Human Services, 2007; California Department of Health & Human Services, 2003).

Assumptions

Although there are a number of factors impacting relative care, the researchers are not focusing on all needs relevant to this topic. One such area is the misappropriation of assistance by means of caring for a child for monetary gains. Some states may provide cash assistance or some level of aid to families to assist in providing basic needs for the child who has come into their care, however there have been reported instances in which these funds did not go toward the care of the child. One such example of this is that of an alcohol or substance abusing caregiver. When a caregiver is abusing drugs and alcohol, in this instance it is not unreasonable to consider that assistance may be used to support a caregiver’s habit.

The researchers shall also consider the potential that there are multiple risk factors that may require additional support services to address placement disruption, crisis situations, and poverty. All of which may be accessed by the supervising social worker assigned to the family. These areas will not be fully addressed, but will be considered throughout the research as areas in need of attention.

Another area that the researchers will presume to be included in needs is that of social needs that are intrinsic to social functioning and wellness. The researchers also recognize that social needs such as adequate support, respite needs, education and parent training, may be met through other means. For example, it can be presumed in some instances that the caregiver can independently pursue their own supportive means by
seeking the support of family members, signing up for training, and accessing some level of respite care if necessary to maintain a child in care. Finally, the researchers presume that not all kinship caregivers are in need for supports and services to adequately provide for the child in their care. In many instances, there are caregivers have the financial means to provide food, clothing, and shelter, and other needs without the support of community or county agencies. There are also caregivers that have access to resources that other may not enjoy.

_Justification_

There is a significant need for change within the Child Welfare system, and this study seeks to advocate for those children who deserve to be placed within his or her family. There are thousands of children every year that enter the system due to unfortunate circumstances, and research suggests that the numbers continue to escalate. With the recent economic climate and financial tightening of budget dollars, more and more families are slipping under the poverty line. Many succumb to personal and work-related stress, and desperation in trying to keep their families intact. Unfortunately, many children end up succumbing to circumstances out of their control and are forced out of their homes into the arms of strangers. Changes within the kinship care system must be made in order to reduce this trend. It is the responsibility of the child welfare system to ensure the health, safety and welfare of all the children in out-of-home care, reinforce family systems, minimize neglect and abuse, and reduce financial barriers to providing care to the child.
Poverty in many instances prohibits family members from considering a family member who has been removed from their biological parents’ home. The lack of financial support available often dictates the feasibility of placement with relative caregivers. As mentioned previously, grandparents are frequently called to take custody of the child removed from the care of his or her parents. According to the U.S. Census Bureau (2000), on average, 19% of grandparent caregivers have incomes below the poverty level in the United States. Many grandparent caregivers live on fixed incomes, are older, less educated, and less likely to be employed (Swan & Sylvester, 2006). Grandparents are more likely to receive welfare benefits in order to adequately provide basic necessities. It is well known that many caregivers also will not move to permanency planning involving guardianship or adoption, based on the fact that the limited assistance they receive will be lost. Providing equality in financial support would greatly reduce this barrier in providing care. These changes would likely reduce the number of stressors involved when family members are given the chance to take in the relative kin, and who would otherwise not have the financial support or motivation to do so.

As the news and media report, children continue to be abuse, violated, and neglect in out-of-home care. Proponents argue that maintaining continuity with past ongoing relationships with extended family,” not only reduces the level of protection from continued abuse by birth parents, but also increases the risk of intrafamilial transmission of violence and abuse (Gibbs & Muller, 2000). Gibbs and Muller (2000) suggest that the reintegration of the child back into a potentially chaotic, unstable, and dangerous environment may actually do more harm than good when the well-being of the child is at
stake. When a child is removed from his or her home for abuse and neglect, the primary goal of social services should be that they do not re-experience the same abuse and neglect in alternative placements. From the perspective of the researchers, increasing supervision and oversight in caregiver’s homes has the potential to not only reduce the incidence of child maltreatment and placement disruption, but also may increase the opportunity for crisis intervention when necessary to avoid risk.

The need for change is reflected in the fact that placements continue to be disrupted due to a variety of reasons including inadequate supervision and oversight, difficulty accessing resources and services, and finally lack of financial support. The research will demonstrate that children continue suffer due to the lack of attention to needs of kinship caregivers who are committed to keeping their families in tact.

Limitations

The researchers recognize that there are several limitations to this study. As the research will suggest, kinship care is not a uniform phenomenon. Aspects of services and supports vary from state to state, causing great disparities in policies and practices. For example, in just under two-thirds of the states, kin are permitted to care for children in state custody without meeting all of the same licensing standards that non-kin foster parents must meet (Allen, DeVooght, & Geen, 2008). Although developing a uniform proposal across states would be the optimal goal, the focus of the study is directed at changing California’s policies on kinship care. The research also does not take into consideration individual family circumstances, and recognizes that all family situations require variable needs. The findings cannot be attributed to the family’s parenting skills,
family resources, or economic situation. Nor can the findings be attributed to the caregiver’s willingness to care for the child.

The focus of this study is simply aimed at making recommendations to improve the quality of care for kinship care providers. The researchers are conducting the study in an effort to gain knowledge on the direct connection between lack of support for kinship care providers and their ability to adequately care for the child. It is hoped that the outcomes of the surveys will assist in directing county agencies to combine their resources and expertise in the most effective ways to ensure that kinship care providers are receiving the appropriate level of resources in order to be adequately prepared in caring for children.

Additionally, the formation of the study excludes the perspective of the kinship care providers and includes a small sample size, which may have implications to the validity of the study. The findings can therefore not be generalized to the kinship care population as a whole. The researchers have also identified that the study does not take into consideration the current economic or political climate.
Chapter 2
LITERATURE REVIEW

Introduction

More than six million children in the United States live in households headed by relatives other than their parents who provide full-time care, nurturing, and protection (U.S. Census Bureau, 2000). The research suggests that there has been an increase in the number of children reunified with their families, however there is little being done to support permanency in the homes of kin caregivers providing this level of care (Reed, & Karpilow, 2002). Kinship foster care providers are required to financially support the child as if they were their own with very little financial support from the state or federal government. Family members that decide to open their hearts and homes to their relatives are offered little in terms of training to not only keep the child safe, but to ensure that their mental, emotional, and physical needs are met. Additional mental health support may be needed to assist the child in adjusting to difficult life circumstances. In fact, many children come with emotional and/or physical needs that caregivers may not be equipped to handle on their own.

The current policy on kinship care in California does not provide enough support to the families who want to care for their relatives. This chapter will provide an understanding of the needs of kinship foster parents and grandparents. We will give a historical perspective on kinship care, identify significant federal and state policies impacting kinship care, define kinship care verses non-kin foster care, and evaluate the current policy as it applies to kinship care providers in California. The researchers will
make the evaluation based on policy and system issues, kinship care provider issues, and quality of care issues. The four primary areas that researchers will focus the research on will include financial support, training, access to resources, and oversight and supervision.

**Historical Perspective**

“The voluntary fostering of children in the homes of relatives or friends is a tradition found in the regions as diverse as medieval Europe and twentieth century Africa” (Hegar, & Scannapieco, 1995, p. 203). In the United States, research indicates that significant historical changes in policy occurred as a result of “placing-out or orphan train strategy” that occurred between 1854 and 1930 (Cook, 1995, p. 181). It is said that the orphan train relocated approximately 150,000 orphaned or impoverished children and youth from the city of New York to families in the Midwest. This event was considered the “forerunner of modern foster care” (Cook, 1995).

According to Hegar and Scannapieco (1995), “until the time of the industrial revolution and the corresponding growth of social institutions in the Europe and the United States, there were few alternatives for children whose parents died or became unable to care for them” (p. 204). Under English Poor Law, grandparents became responsible for their grandchildren in cases of dependency … England developed wardship as a legal mechanism that placed other dependent children, usually heirs to property, in the care of relatives and other adults” (Hegar and Scannapieco, 1995, p. 204). During the 18th and 19th century, orphanages were developed to house abandoned and
neglected children, in response to epidemics and wars that decimated whole communities and kinship networks” (Hegar & Scannapieco, 1995, p. 204).

Research also contributes a strong influence of relative care to the era of slavery. During this time, the African concept of extended family was responsible for the survival of the family (Downs, Moore, McFadden, Michaud, & Costin, 2004; Danzy & Jackson, 1997). The African proverb, “It takes a village to raise a child,” reinforced the idea that the community acted together to take responsibility for the community and its members (Danzy & Jackson, 1997, p. 33). During the 18th and 19th century, African American children were excluded from placement in the orphanages as well as the orphan train, “possibly because of concern that the agency would be accused of practicing slavery or due to their small numbers in New York and the prejudices of both sending and receiving communities” (Cook, 1995, p. 184). Danzy and Jackson (1997) suggest that when a child is in crisis, “the children were informally adopted by the slave community … Thus, the practice of defining kinship beyond blood ties and vesting non-kin with kin status helped sustain a sense of family despite slave conditions” (p.32). Today African American children continue to represent the largest percentage of children involved in the formal kinship care system (Danzy & Jackson, 1997).

**Kinship Care - Evolution of State and Federal Policy**

As more and more children entered the child welfare system, policies at state and federal levels began to expand and evolve to address child welfare system issues. It was said that after the end of slavery, African American children continued to be “excluded and under-serviced” by the “formal institutions for dependent children” (Hegar &
Scannapieco, 1995, p. 204-205). Around the 1920’s and 30’s, this disparity was attacked by Chicago social workers that advocated for and established public child welfare agencies to addressed these issues.

“The federal government was slow to involve itself in child placement matters, even after the establishment of the U.S. Children’s Bureau in 1912” (Hegar & Scannapieco, 1995, p. 206). According to Downs, Moore, McFadden, Michaud, & Costin (2004), the federal government was reluctant to become involved based on concerns of violating state rights, “as social welfare was primarily the domain of state and local government … Traditionally, the right and the responsibility for raising children had been held by parents; the government’s role was confined to local matters and protection” (Downs, Moore, McFadden, Michaud, & Costin, 2004, p. 14).

The Children’s Bureau was established by President William Howard Taft on April 9, 1912 to address arising child welfare issues (Congressional Digest, 1923). The purpose of the Bureau was to investigate and report upon all matter pertaining to the welfare of children and child life among all classes of our people and especially to investigate questions of infant mortality, the birth rate, orphanages, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment and legislation affecting children in the several States and Territories (Congressional Digest, 1923). The purpose of the bureau was not directed toward “the delivery of much needed services to the families,” but rather “oriented toward wide dissemination of information” (Downs, Moore, McFadden, Michaud, & Costin, 2004, p. 14). Since this time, there have
been a number of state and federal child welfare policies that have evolved to directly
directly address child welfare issues and needs:

*Social Security Act of 1935.* The Great Depression of the 1920’s and 30’s open
the eyes of lawmakers toward the plight of the needy and less fortunate. “It made clear
that government intervention was essential to help many persons and families cope with
various overwhelming problems” (Downs, Moore, McFadden, Michaud, & Costin, 2004,
p. 14). One such effort to address this issue was the Social Security Act of 1935. The
Social Security Act of 1935 first offered states matching money for child welfare
services, but it was not until 1961 that federal funds were available to pay foster care
costs for AFDC-eligible children who came into state custody (DiNitto, 2007; Hegar &
Scannapieco, 1995).

*Aid to Families with Dependent Children (AFDC).* “Aid to Families with
Dependent Children was established by the Social Security Act of 1935 as a grant
program to enable states to provide cash welfare payments for needy children who had
been deprived of parental support or care because their father or mother was absent from
the home, incapacitated, deceased, or unemployed … “States were required to provide
aid to all persons who were in classes eligible under federal law and whose income and
resources were within state-set limits” (U.S. Department of Health and Human Services,
AFDC and TANF, 2009).

*TANF (Temporary Aid to Needy Families).* In 1996, TANF replaced the AFDC
program. TANF is one form of cash assistance available to kinship care providers when
they don’t qualify for other types of aid. TANF was established in 1996 by the federal
welfare legislation to provide public assistance and other services to low-income families. This program replaced the Aid to Families with Dependent Children program … TANF allows states to provide assistance to needy families so that children may be cared for in their own homes or in the homes of their relatives (U.S. Department of Health and Human Services, Office of Family Assistance on TANF, 2009).

*The Indian Child Welfare Act of 1978 (ICWA).* “ICWA was signed into law in 1978. Congress intended for ICWA to serve the best interests of American Indian children and to promote the stability and security of tribes by providing a means of keeping Indian children in homes, which will reflect the unique values of Indian culture. Moreover, according to the U.S. House Report, ICWA seeks to protect the rights of the Indian community and the tribe in retaining its children by establishing a Federal policy that enabled an Indian child to remain in the Indian community by making sure that Indian child welfare determinations are not based on a white, middle-class standard which in many cases forecloses placement with (an) Indian family” (Limb & Brown, 2008, p. 100).

*The U.S. Supreme Court Decision, Miller v. Youakim (1979).* Another policy event that promoted kinship care came in 1979 when the U.S. Supreme Court ruled in Miller v. Youakim. This ruling required “states to provide relatives caring for children in state custody with the same financial support as non-relative foster parents, if they meet the same licensing standards and the case meets all other standards for claiming federal matching funds (Hegar & Scannapieco, 1995; Gleeson, 1996). Previously, states had
prohibited relatives that care for their kin from receiving the higher foster care rates (Hegar & Scannapieco, 1995).

The Adoption Assistance Act and Child Welfare Act of 1980. The provisions of the Adoption Assistance and Child Welfare Act of 1980 included having required States to make adoption assistance payments, which take into account the circumstances of the adopting parents and the child, to parents who adopt a child who is AFDC-eligible and is a child with special needs which includes defining a child with special needs as a child who cannot be returned to the parent's home, has a special condition such that the child cannot be placed without providing assistance, and has not been able to be placed without assistance. As a requirement to receive Federal foster care matching funds, that States make "reasonable efforts" to prevent removal of the child from the home and return those who have been removed as soon as possible. In addition, required participating States have to establish reunification and preventive programs for all in foster care. The State has to place a child in the least restrictive setting and, if the child will benefit, one that is close to the parent's home. The court or agency is required to review the status of a child in any nonpermanent setting every six months to determine what is in the best interest of the child, with most emphasis placed on returning the child home as soon as possible. The court or administrative body has to determine the child's future status, whether it is a return to parents, adoption, or continued foster care, within 18 months after initial placement into foster care (Child Welfare Information Gateway, 2009). “The 1989 statutory revision of Social Services Law § 392 added the placement of children with relatives or other suitable persons as a permissible disposition, to promote family stability.
by allowing placement with relatives, extended family members or persons like them, as an alternative to foster care” (Frankel, 2007, p. 336). The Personal Responsibility and Work Opportunity Act of 1996 as it relates to kinship care, this act “requires states to consider giving preference to an adult relative over a non-related caregiver when determining a foster care placement for a child, provided that the relative caregiver meets all relevant state child protection standards” (Scannapieco & Hegar, 2002, p. 316; NASW, 2005, p. 6).

The Adoption and Safe Families Act (AFSA) of 1997. “The provisions of the Adoption and Safe Families Act of 1997 require states to hold kinship caregivers responsible for meeting the same regulations as non-relative caregivers if they were to qualify for federal funding. The law also made official an ideological shift that had been seeping into the child welfare community for years: the emerging preference for moving children out of foster care as quickly as possible, into homes where they have a legal connection to the adults, which is, adoption or reunification (Hurley, 2008). This act also required states to initiate termination of parental rights when a child has been in foster care for 15 to 22 months or in cases of serious criminal abuse, allows an exception when the child is placed with a relative (at the option of the state) (Scannapieco & Hegar, 2002; Percora, Whittaker, Maluccio, & Barth, 2000).

Kinship Caregiver Support Act of 2007. The Kinship Caregiver Support Act, introduced this year in both the House (H.R. 2188) and the Senate (S. 661), would provide assistance to relatives who become the legal guardians of children in foster care. The legislation would: Require notice to be given to relatives of children who enter foster
care and authorize states to establish separate licensing standards and regulations for relative guardians; establish a Kinship Navigator Program to help relative guardians navigate their way through available programs and services; and maintain existing federal financial assistance for foster children for relatives who choose to become their legal guardians (Lester & Vamvas, 2007).

**Kinship Care Verses Non-Kin Foster Care**

When a child is displaced or cannot live in the home of their biological parent(s), the child may be placed under the jurisdiction of the juvenile court, section 300 of the California Welfare and Institution Code (WIC, n.d.). When this occurs, the child may be placed in a temporary home or out-of-home placement. There are a variety of settings in which the child may be placed, which include: public or private kinship care, foster family care, therapeutic foster family care, and group home or institutional care. There are also more formal and permanent arrangements, such as guardianship and adoption. A child’s placement is largely dependent upon his/her needs (Downs, Moore, McFadden, Michaud, & Costin, 2004). As the needs of the child increase, the more restrictive the setting may be to ensure the health safety and welfare of the child.

As more and more children enter into the public child welfare system, agencies seek to place them with relatives as the first choice for placement. This type of placement is termed kinship care. Kinship care is defined by the California Department of Social services in terms of relative relationship. “Relative” means an adult who is related to the child by blood, adoption, or affinity within the fifth degree of kinship, including stepparents, stepsiblings, and all relatives whose status is proceeded by the words "great,"
"great-great," or "grand," or the spouse of any of these persons, even if the marriage was terminated by death or dissolution ... only the following relatives shall be given preferential consideration for the placement of the child: an adult who is a grandparent, aunt, uncle, or sibling (CDSS on Kinship Care, 2007). This differs from traditional foster care in that the caregivers are not related, and the children have been removed from their biological, adoptive, or guardian caregivers by the state. “Federal law requires that children who are removed from their families be placed in the least restrictive setting that will meet their needs and, to the extent possible, allow them to remain in their own schools and communities” (Reed, & Karpilow, 2002, p. 18). One such way to do this is to place the child with a relative. In this chapter, the focus will be on public kinship foster care verses private kinship care, where the child is put in “a formal placement involving courts and child welfare agencies” (DiNitto, 2007, p. 423). As will be demonstrated by the research, kinship foster care providers face a number of challenges and barriers that foster care providers do not. Geen (2003) stated:

Since the early 1980s, states’ use of kin as foster parents has grown rapidly, yet there is very little information available on how and when local child welfare agencies use kin as foster parents, how agencies approach to kinship care differs from their approach to traditional foster care, and how local kinship care policies and practices vary across states (p. 1).

This lack of understanding makes it difficult to determine the effectiveness of kinship care in ensuring child safety, promoting permanency of their living situation, and enhancing their well-being (Geen, 2003). In other words, there is a conflict with the goals
of the child welfare system, then how can the needs of the kin care providers be adequately understood? There are a number of indicators that suggests that kinship caregivers are at a disadvantage when choosing to care for their relatives. According to the research of Geen, Hegar and Scannapieco, 1995, almost all of the data collected suggests that kinship care providers “are significantly poorer than non-kin foster parents” (p. 209). Other variables that contribute to the poverty experienced include a less formal education than non-kin; 32% of kinship care providers have less than a high school education compared to 9% of non-kin providers. Kinship care providers also tend to be single, between 48 and 62%, compared with 21 to 37% of non-kin (Geen, 2003).

Kinship providers also tend to care for large sibling groups, and tend to be older in age (Scannapieco & Hegar, 2002; Geen, 2003). There are a significant number of caregivers that are grandparents, over the age of 60 when providing care for their kin (Hegar & Scannapieco, 1995; Geen, 2003). As such, research suggests that the older caregivers lack the energy, are often not in good health, and lack the resources necessary to properly care for the child due to fixed incomes and economic hardships (Bratteli, Bjelde, & Pigatti, 2008; DiNitto, 2007). As we will later discuss, many kinship care providers also are unprepared and in most cases untrained to deal with the physical or mental challenges of the child. All these variables demonstrate the need to increase supports to kinship care providers to adequately care for the child placed in their care.

Aging Caregivers/Grandparents

According to Shlonsky, A., Dawson, W., Choi, Y., Piccus, W., & Cardona, P. (2004), there are “Countless instances of kinship care have been documented over the
centuries, and extended family care has been a common practice in the African-American community dating back at least as far as the time of legal slavery in this country (p. 4). In many of those cases, their biological grandparents cared for children. “The formal use of relatives as a foster care resource in California and across the nation has steadily increased since the mid 1980’s” (Shlonsky et al., p. 4). Today, approximately 150,000 foster care children, one-third of all foster care children (known to Child Protective Services) are being cared for by relatives (Raphel, 2008). According to DiNitto (2007), grandparents were the caretakers in half of all formal state-supervised kinship care cases. More often than not, grandparents are determined to be the most suitable placement, and are often the first to step up and assume the caretaker role. Relatives of children are assumed to be already attached to them, and therefore have a sense of love or familial obligation that provides a different motivation for providing care (Chang, & Liles, 2007).

According to DiNitto (2007), “the Census Bureau reported that in 2000, 2.4 million grandparents had been the primary caregivers of at least one grandchild for 5 years or more” (p. 423). In the United States, African American children comprise the second largest ethnic group in foster care at 32%, after white, non-Hispanic children at 41% in 2006 per U.S. Department of Health and Human Services, and the largest group in kinship foster care (Schwartz, 2008). African American grandmothers have played a very strong role in socializing and caring for their grandchildren, and are often the primary caregivers (Schwartz, 2008). According to the U.S. Census Bureau the average age range of grandparents in the United States raising their grandchildren is 50-59 (Simmons & Lawler Dye, 2003). Many of the grandparents who have risen to the task of
caring for their grandchildren, may have done so due to a variety of reasons. More commonly, children are removed from their biological parents due to situations involving one or more of the following issues: child maltreatment, child neglect, child abuse, sexual abuse, and/or substance abuse (Downs, Moore, McFadden, Michaud, & Costin, 2004). The risk factors for children tend to increase when the grandparent is, despite all good intentions, ill-equipped to care for the child themselves, but feel obligated due to their obligation to the family.

Over the years, researchers determined that children placed with grandparents present significant risks due to the age, health/medical issues, energy levels, unrealistic expectations, and finances of the grandparent (Berrick, 1997; DiNitto, 2007). In some cases, grandparents may be unprepared, and have unrealistic expectations of what the child’s needs involve or what the endeavor may entail. The Report to Congress on Kinship Care (2000) stated that:

Most kinship caregivers are grandparents who have not had parenting duties for some time and who may be apprehensive about raising a child at this stage in their lives…If they have become involved due to the abuse or neglect of a child, they may be forced to acknowledge the problems of the child they raised and may question their own parenting skills (p. 34).

They tend to focus on discipline and behavior management rather than on education and developmental aspects of parenting (Barth, Geen, Webb, Wall, Gibbons, & Craig, 2008). When put in this position, grandparents are required to deal with dual role of grandparent and parent and learn to balance them both (Schwartz, 2008). This
reinforces the need for increased supervision to ensure the children receive the maximum amount of supports available to meet their needs whether mental, physical, financial, or the like.

Many grandparents suffer from crippling or debilitating illnesses that may impact their ability to properly care for their kin. Studies have shown that kinship caregivers are more likely to report being in poorer health than non-kin foster parents (Berrick, 1997; Scannapieco & Hegar, 2002; Geen, 2003). A number of studies have also looked at how the care taking responsibilities have impacted the health of the grandparent, and have found that their health as actually worsened due to the increased stressors of caring for a grandchild(ren) (Whitley, Kelley, & Sipe, 2001). In a study by Minkler, Roe, and Price (1993), found that, one-third of their sample of 72 African American grandmothers indicated that their health had worsened since beginning care giving and many directly attributed this to their care giving responsibilities. In addition, care giving was directly associated with high levels of anxiety and depression, physical ailments, and smoking and alcohol consumption amongst grandparent caregivers (Whitley, Kelley, & Sipe, 2001).

The questionable physical ability of the grandparent coupled with the individual’s apprehensiveness about caring for the child can create significant challenges with stability and placement disruptions. Becoming a parent for the second time could potentially bring physical and mental health challenges for the caregiver, which could ultimately impact the child’s safety, health and well being, and potentially impact the stability of the placement. Many children are removed from care due to increased risk
factors, stressors, and safety challenges in the home. We strive to reduce placement
disruption, and seek to keep children out of the foster system and safe in the arms of their
families, however the research shows that children continue to be rushed into unsafe
environments with untrained, ill-equipped family members, without the support,
supervision, and ongoing oversight of social services.

Licensing

Just as there are variations in kinship and foster care standards, licensing and
payment policies also differ amongst the states (Bratteli, Bjelde, & Pigatti, 2008). Federal
policy gives States broad discretion with whom they will license as kin foster parents,
how they will supervise them, and how they will provide financial compensation (Bratteli
et al.). In some instances, these variations could have significant bearing on a kin’s
willingness to step forward to “rescue” the relative based on either strict licensing
requirements and/or the level of involvement or imposition of child welfare agencies or
courts (Report to the Congress on Kinship Foster Care, 2000). In many instances,
caregivers opt to avoid agency or court involvement to avoid any unnecessary intrusion
into the family. However, without such involvement or oversight, issues of health and
safety cannot be properly monitored. The research reflects that licensure not only
provides a better opportunity for assessment of needs by county agencies, but also
provides more access to a number of resources.

In many cases, relatives are the first line of defense in providing care for children
who have been displaced from their biological parents. Although there is no legal
obligation, relatives often assume the role of caregiver and exercise their responsibility to
their extended family members (Berrick, 1998). Many children are taken into care without court or agency involvement in process. In these cases, relatives are not required to be licensed and are presumed to be able to adequately care for the child and meet their basic needs. In some states, child welfare authorities recognize kin as foster caregivers within the child welfare system only if they meet the same standards, and participate in training and become licensed in the same manner as foster parents (Bratteli, Bjelde, & Pigatti, 2008; Berrick, 1998).

The standards by which kin caregiver’s are assessed, varies from state-to-state (Waters & Geen, 1999). Each states has the flexibility to develop individualized guidelines based on the lack of federal guidance imposed (Bratteli, Bjelde, & Pigatti, 2008). States that have the strictest standards require kinship foster caregivers to meet the same standards as non-kin caregivers, and must be fully licensed (Waters & Geen, 1999; Jantz, Geen, Bess, Andrews, & Russell, 2002). Those that are fully licensed are said to enjoy the same benefits, supports, supervision, and intervention as non-kin foster families, which includes foster care maintenance payments, respite childcare, and other support services (Waters & Boots, 1999). In states that are less stringent in their requirements, kinship care providers can meet some of the standards as long as they do not jeopardize the safety of the child (U.S. GAO, 1999). In California, kin that take a child into their care, at minimum, will be required to have their home inspected and approved by a county social worker (California Alliance, Foster Care and Adoptions in California Fact Sheet, n.d.). They are not required to receive any special annual training, or attend foster parent support groups (U.S. GAO, 1999). In some instances, states will
allow relatives to care for their children with minimal standards and minimal supervision, and licensure is not required (Jantz, Geen, Bess, Andrews, & Russell, 2002). Many states offer flexible requirements for kinship care and have more than one licensing option for kinship homes (Waters & Geen, 1999; Boots & Geen, 1999; Jantz, Geen, Bess, Andrews, & Russell, 2002; Bratteli, Bjelde, & Pigatti, 2008).

**Financial Support**

Financial support and licensure are closely connected in terms of kinship resources, both of which have been longstanding issues that continue to be at the forefront of debate. Without question, most relative caregivers are willing to care for the children placed in their care, but many require financial help in order to meet the children’s needs (Conway & Hutson, 2007). Grandparents are frequently chosen to take responsibility for the child, and often to not have the financial resources to properly provide for basic needs due to fixed incomes and limited funding resources. The requirements for qualifying for financial resources often create limitations for caregivers largely due to eligibility and other factors affecting incomes. The primary problem is that there are different licensing and payment policies for each state, and therefore payment eligibility may vary.

Kinship providers need financial support for a variety of reasons that are all relevant to the care of the child. Clothing resources may be needed to assist the child in transitioning to the new placement and for the duration of care as the child grows. In placement changes, the child may also be required to change school, which may require additional needs such as uniforms or for special occasions (Scannapieco & Hegar, 2002).
Caregivers may also require additional assistance to pay for transportation for family visits, doctor or dental visits, or school events. If a child has additional mental health or specialized care needs that require frequent transporting, this may require multiple trips. Wear and tear to the vehicle or home must also considered when family size or dynamics change.

Whether a child is formally or informally placed in the care of a relative, they may qualify for some level of financial resources. Qualifying for the financial support as a kinship care provider is mostly contingent upon whether or not they are licensed. Depending upon the licensing options provided by the state, caregivers may or may not qualify for available funding. If the caregiver is fully licensed as a kinship foster care provider they are afforded the same or similar foster care payments of non-kin caregivers (Boots, & Geen, 1999). If unlicensed, the caregiver must seek out their own financial resources, which is often limited and scarce, especially in those homes where grandparents are the primary providers. Some caregivers are also caring for other children, putting further strain on the available resources. Many take on the task despite the barriers or hardships to the family. If the caregiver does qualify for funding, it is often considerably less than if they were in unrelated family foster homes or in other types of placements (Hegar & Scannapieco, 1995).

According to Kinship providers may receive funding from a range of state and federal sources (Scannapieco & Hegar, 2002). Title IV-E funding is one source that caregiver may qualify for if they are licensed. States are required to provide foster care payments to kin caring for Title IV-E eligible children, if they meet specific licensing
requirements (Bratteli, Bjelde, Pigatti, 2008). However, if providers do not meet the licensing requirements, the state can determine if financial assistance will be provided to them from another funding source. If the caregiver is unlicensed, but the child is eligible for federal welfare assistance, they may receive limited assistance that falls under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWOR) of 1996 (Scannapieco & Hegar, 2002).

In some states, they are said to give “considerable latitude in how to implement Temporary Assistance to Needy Families (TANF) under this act,” meaning that not all caregivers will qualify for this cash aid dependent upon the state policies. Research suggests that there are several funding sources available, however with such strict and variable requirements, providers are at the mercy of their respective states. This also assumes the caregivers, licensed or unlicensed are aware of the assistance they may be eligible to receive (Bratteli, Bjelde, Pigatti, 2008).

Child Welfare policy has done little to recognize the funding issues facing kinship caregivers (Schwartz, 2002). Despite the diversity in federal and state policies on funding, most states do not provide as much financial support to kin caregivers as to non-kin caregivers (Schwartz, 2002). The need for equality in this area is growing increasingly more critical to the health safety and welfare of the children placed in relative care. As suggested, the number of children being placed in out-of-home care with relative is on the rise. The level of financial support provided to the caregivers often determines whether or not the child can be plucked from the system and placed in relative care. Many caregivers are willing and wanting to take responsibility for the child, but
often does not possess the financial resources to sustain them in their care. Equalizing the level of resources, financial and otherwise, will increase the chances for permanency and stability in relative homes and reduce the likelihood of disrupted placements.

Training

Kinship care families require services of training specifically geared towards the vulnerable populations. As the needs of the child increase, so does the need for some level of training to ensure appropriate care. Federal and state resources, however, have not kept pace with the needs of these families or the children placed in their care (Glisson 1996). Within the Kinship/Non-kinship care, some common themes consist of children being in great risk for developing problems which may include behavioral and emotional problems that may derive from a poverty stricken background and/or parents developing mental health problems. Many of the problems youth face today whether in kinship or non-kinship care tend to surface at the school, hindering their place of learning. Also, children in kinship care are less likely than children in non-kinship care to be referred for mental health services or receive mental health services (Berrick, Barth, & Needell, 1994). Cuddleback & Orme (2002) identified that there is considerable evidence that foster parents receive less than adequate training, however kinship care receives even less services such as training when comparing to non-kinship care.

Many kinship care providers receive little or no preparation prior to placement of children in their care, receive limited formal training, lack resources, and have a lack of understanding about the child welfare system compared to non-kinship care providers. As mentioned in the above literature, due to the special needs of children removed from their
parents and placed in foster care who have experienced abuse, neglect, and maltreatment, the development of extraordinary parenting skills of foster families requires a commensurate effort by child welfare experts (Herczog, Van Pagee, & Pasztor, 2001). Pre-service training requirements are lacking in many states for kinship care providers, and some states do not require or provide training (Christenson & McMurtry, 2007).

Since kinship and non-kinship caregiver’s needs aren’t being met, several community colleges and online trainings have surfaced to potentially prepare caregivers with an enriched understanding of the clinical aspects of children’s behaviors and trauma that may have been associated with it. Today’s foster, kinship, and adoptive parents are increasingly turning to the Internet to find and connect with each other (Pacifici, Delaney, White, Cummings, & Nelson, 2006). Pacifici et al, discuss currently Foster Parent College offering online trainings and DVD’s that include trainings that include but not limited to, Anger Outburst, Eating Disorders, Fire setting, lying, positive parenting I and II, Reactive Attachment Disorder, Running away, Safe parenting, Self-harm and sexualized behaviors. A pilot study of a course delivered on DVD found the approach to be effective in improving parents’ clinical knowledge and self-perception in relation to children’s anger outburst (Pacifici, Delaney, White, Cummings, & Nelson, 2006).

Supervision and Oversight

When a child enters the welfare system, they are assigned to a caseworker that is required by law to ensure safety, well-being, and permanent living arrangements of the children (Child Welfare Information Gateway, 2005). The caseworker provides this care via routine supervision and monitoring of the family home. “Caseworkers are required to
visit foster children in order to, among other things, monitor the quality of the care they are receiving and determine whether the children or caregivers have any unmet service needs” (U.S. GAO, 1999, p. 17). Research suggests that support and supervision of kin caregivers is not equitable to that of non-relative foster parents, in fact, California caseworkers are required to visit foster child at least once a month, however after a survey was completed of both caregivers in Illinois and California, the researchers found that caseworkers visited children in kinship care less often on average than children in other foster care settings. Supporting this assertion, significant differences have been found between social worker visits to kinship care homes and family foster homes, with adolescents in kinship care homes receiving an average 2.4 visits less per year than adolescents living with non-kin caretakers (NAIARC, 2004).

As we will discuss later, when a caseworker does not have adequate ongoing contact with the care providers, whether kinship or foster care, realistically they are unable to adequately assess their needs. According to Berrick (1988) “kinship foster parents receive less support, fewer services, and less contact with child welfare workers than foster family parents receive” (p.77). This being said, kin caregivers may have challenges in obtaining the support, and be limited in their knowledge about locating and accessing the resources. Additionally, “accessing public benefits is the one difficulty that angers caregivers the most, often leading them to feel unappreciated for the work they are doing..” (McLean & Thomas, 1996, p. 496). Finally, in Szolnoki & Cahn (2002) study found that “caregivers have a range of needs and that … change over time. At initial placement caregivers have a greater need for tangible supports and legal and financial
resources to get set up and prepare for what is usually a sudden placement” (p. 4). Unlike non-kin foster parents, kinship caregivers usually receive little, if any, advance preparation for their role.

Unfortunately, California does not require that caseworkers provide the same level of supervision for children in kinship care as for those placed in non-kin care (Geen, 2002). This variable raises question as to the quality of care and safety being provided in kinship or relative placements. According to Geen (2002), a leading child welfare researcher, “kin typically have less experience with the child welfare system, may not have completed foster parent training …[and] may require even greater support and supervision than non-kin caregiver’s” (p. 139). Despite findings that children in kinship care do have developmental, emotional, and physical difficulties, kin caregivers self-report significantly fewer number of contacts with social service agencies and workers than do their non-kin foster care counterparts (National AIA Resource Center (NAIARC), 2004).

Child Welfare League of America on Kinship Care Best Practices (1996) suggests that child welfare agencies should respond to requests from kinship families in order to assist them in providing care and protection for their children. When the child is already living with kin and assistance is requested, the agency should provide information and referral, help the family to access needed services or offer direct assistance, such as a family assessment or family services, if appropriate.
Kinship Care – Quality of Care / Child Abuse and Maltreatment

One such issue that may arise is the safety of the child. Kinship care was originally frowned upon because it “left the child unavailable for adoption or was believed to increase the risk of recurring maltreatment due to ease of access by the abusive parent” (DiNitto, 2007, p. 422). Furthermore, DiNitto (2007) “research has shown that children cared for by relatives are no more likely to be re-abused or incur repeated maltreatment than children placed with non-relatives” (p. 423). In fact, they are able to maintain a sense of family and ethnic identity, and are often able to remain in their community of origin when placed into care (Shlonsky, Dawson, Choi, Piccus, & Cardona, 2004). The issue of child abuse in out-of-home care is not well documented in the literature, and is often observed only through the media.

There is therefore very little research available on the quality of out-of-home care, and has been questioned for decades, and more recently, kinship care has joined the discussion (Barth, Green, Webb, Wall, Gibbons, & Craig, 2008). As suggested, most of the resources available include the media, provider case information, and single accounts in the form of essays and videos. “The public is often exposed to tales of very poor – sometimes murderous – foster care” (Barth, Green, Webb, Wall, Gibbons, & Craig, 2008, p. 7). Kinship care is less often the focus of this expose’, but it is becoming more apparent that not all children are suited for placement with relatives. This may be due to lack of available family members, age and health of the family member(s), criminal history of the family, or other factors that reduce the likelihood that a child could thrive in that environment. One study conducted by Gulpta (2008) determined that “although
kinship can provide a good home environment, it is not a panacea (p. 24-25). A core group of children examined (between 5% and 7% of the 113 used in the study) “that not have positive experiences of kinship care” (Gultpa, 2008, p. 24-25). However, the study determined that there were “protective and risk factors” that increased the potential for success, which included “children who were placed at a young age,” single carer such as a grandparent,” and “where the placement was instigated by the carer…The age of the child had the greatest predictive value” (p. 24-25). This study also reinforced the need for consistent and adequate assessments, ongoing communication, and increased financial and other support provisions (Gupta, 2008).

There is even less research available in gathering the child’s perspective of out-of-home care, which may give greater insight into how well the child welfare system is working. The available literature on foster children’s perspectives of out-of-home placements, but also “highlighted their demographic characteristics, their physical and mental health status, and case outcomes” (Fox & Berrick, 2007, p. 23). Findings were “reviewed in relation with the four child welfare goals: 1) Protecting Children from Harm; 2) Fostering Children’s Well-Being; 3) Supporting Children’s Families; and 4) Promoting Permanence” (Fox & Berrick, 2007, p. 23). They gathered their information indirectly from caregivers, social workers, case records, and administrative systems.

The child’s perspective of out-of-home care is “significantly underrepresented …in the research literature … and in day-to-day child welfare practice” (Fox & Berrick, 2007, p. 47). As social workers we tend to steer clear of the voice that calls from behind the scenes to deal with the immediate crisis in front of us, instead of reaching out and
standing by the values in which we practice. The study assist us in seeing that there are things that occur in foster and kinship care of which we are completely unaware, including issues of abuse, maltreatment, safety, and exposure to community violence. There were only two studies that “have investigated children’s self reported experiences with maltreatment in care, both of which were retrospective” (Fox & Berrick, 2007, p. 34).

In a follow up study, 61 adult individuals were interviewed between the years of 1951 and 1969, 40% reported experiencing severe physical punishment, but not necessarily confirmed cases of abuse, in at least one foster home during their tenure in the system. In another follow up study, 106 young adults from the Casey Foster Program young adults were interviewed between 1966 and 1984, and 25% reported that they experienced severe physical punishment in their Casey homes of longest stay. The study also determined that 15% of the total sample of participants reported sexual abuse. These finding prompted the foster care agency to more thoroughly screen the potential caregivers, and caseworkers should have more contact with foster children and become more skilled in establishing trust with children, maintaining privacy during child-worker conversations, and recognizing signs of abuse (Fox & Berrick, 2007).

It is a failure of the system to not pursue the “unique insights” of the child, which could perhaps significantly influence or “contribute to the development of child welfare practice, planning, and policy” (p. 24). Fox and Berrick (2007) identified that “the potential for foster children to assist in developing a richer understandings of the system is considerable, but largely unrealized” (p. 47). Including the child’s perspective into day-
to-day practice would provide us with an invaluable opportunity to improve circumstances for the most vulnerable yet most valued consumers of child welfare services.

*Mental Health*

Children who are in the foster care system are at higher risk of experiencing mental health issues given the social, familial and environmental history. Foster care children are frequently transitioned into foster care with poverty stricken backgrounds, cultural deprivation and family disruption. It’s without question that children in foster care are at higher risk of developing psychological problems. Previous studies have verified that psychological disorders are, indeed frequent among foster children (Grube, 1978). Many children have experienced some form of trauma associated with neglect and abuse. Studies indicate that foster children were at some point neglected and/or abused: some children come into care because their primary caregivers became unavailable due to psychiatric hospitalization or incarceration (McIntyre & Keesler 1986).

McIntyre and Keesler (1986) found that even the circumstances associated with foster experience, however, are thought to be impediments to healthy psychological development: “Foster placement changes often occurs, biological family contacts are often infrequent and unpredictable, changes in the members of foster household occur, and even the placement is uncertain” (p. 287). Youth in foster care tend to have developmental, behavioral and emotional problems. Foster youth lack comprehensive mental health screening which go unnoticed and become adults with high rates of emotional and behavioral disorders. Studies also suggest that of the 40% of youth in
foster care, up to 80% of these children exhibit a serious behavioral or mental health problems requiring intervention (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998).

Due to the disruptions in the children’s’ development, children with mental health challenges need additional services and appropriate interventions that most kin caregivers lack. Kin caregivers face greater challenges when seeking mental health services for their children. With the challenges in obtaining support, kin caregivers are very limited in seeking out mental health and often become discouraged. Children who live in foster care are 2.5 times more likely to experience an emotional or behavioral disorder compared to children in the general population (Garwood & Close, 2001).

Many kin caregivers do not receive adequate training or supervision, if any, when dealing with children with emotional and behavioral problems. One intervention used mental health providers to treat emotional and behavioral problems is intensive home and community-based services for children. Both types of services: (a) target youth with serious emotional disturbance, (b) utilize an individualized assessment and treatment planning process, (c) intervene in the child’s natural environment through home- or community-based service delivery, (d) target retention of the child in the home setting, (e) involve caregivers, families, and other important adults as key parts of the treatment team, (f) target multiple relevant life domains, and (g) focus on the child and family’s strengths, including cultural considerations (Burns, Schoenwald, Burchard, Faw, & Santos, 2000). Mental health services are very limited to foster caregivers, and more often than none the services aren’t designed to address the individuals need.
Authors discuss that most foster youth are provided with the Medicaid reimbursed mental health service. The types of mental health services include clinical based psychotherapy or types of residential treatment facilities. It’s important to assess for services that will be least restrictive for the youth. Despite the pressing mental health need of the youth in foster care, a recent review of literature found a lack of mental health services designed specifically for this population (Craven & Lee, 2006).

Access to Resources

Access to community resources to address additional needs is often overlooked within kinship care providers. According to child welfare workers, agencies also find it very difficult to provide and coordinate services for kinship care providers (Geen, 2002). Although the research suggests that most kin caregivers are eligible to receive the same services as non-kin caregivers, most are not offered the support, do not request the support, and ultimately receive fewer services (Geen, 2002). Most kinship providers are left on their own and less often access services available to them. If the child does not have mental health challenges, the support is even less apparent. The research also states that kin often do not receive the benefits and services that they are eligible for from non-child welfare agencies. For example, many kin caregivers are either unaware or lack the knowledge of the services for which the child may qualify. Unbeknownst to many, all kin who do not receive foster payments for a child from a welfare agency are eligible for child-only TANF assistance (Geen, 2002). Additionally, many kin who are eligible for Medicaid health insurance coverage, food stamps, childcare subsidies, or housing assistance fail to receive the assistance. The cause of such significant errors is often
placed on the caseworker that is often overworked, has extremely high caseloads, and has very little time to complete the paperwork necessary to start the process. As mentioned in earlier text, the majority of kinship caregivers are grandparents. With lack of resources, grandparents report more stress by taking on the parenting responsibilities full-time.

While some families may be entitled to Temporary Assistance to Needy Families (TANF) cash benefits, the monthly payments are typically nominal and insufficient for adequate housing, clothing and feeding children (McCubbin, Thompson, & McCubbin, 1996). Kinship care providers in most cases do not receive the level of compensation as non-relatives foster parents. Public policy related to foster care payments need to address the financial needs of formal and informal kinship providers. Clearly if this population of kinship providers lack adequate resources, physical stamina, and emotional stability necessary to raise children, the already overburdened child protective services system will need to absorb an even larger number of foster care children (Whitley, Kelley, & Sipe, 2000). It is critical for programs to address the health care needs of grandparent’s kinship caregivers as well as screen for psychological distress (Whitley, Kelley, and Sipe, 2000 stated that “program strategies that strengthen grandparents’ social support and family resources are essential” (p. 320). Moreover, support groups are growing nationwide due to the psychological distress, stressful experiences and lacking of coping skills due to not being provided the necessary accessibility to resources to care for the kinship foster youth.
Summary

The research strongly suggests that when a family member is willing and wanting to care for a family member the supports should be there. When there is evidence to show that placement permanence is greater in kinship homes than in foster homes, all efforts should be taken to ensure that it is successful. Kinship care providers should be required to have the same licensing requirements, training, and oversight that the foster care population enjoys. Funding should be equitable at minimum for the first year to ensure stability, reduce the chances of placement disruptions, and to ensure that the child’s needs are adequately met via assistance with accessing and locating community resources.

Child protective services claim to be committed to the safety and welfare of every child, committed to reunifying children whenever possible with their families, and committed to providing every means necessary to make this possible. However, there is evidence to prove that social service workers are overwhelmed, overworked, and not entirely devoted to the cause.

Social workers have a commitment to the clients they serve and should support the client in maximizing their own potential. Commitment and values should also be required of the government that asserts that they are committed to a reduction in the maltreatment of children, committed to finding safe and happy homes for every child, and are doing “everything possible” in the name of the child. However, at the rate at which children are entering the system, the values appear to have shifted. The urgency to place children in homes without proper regulation, training, cultural consideration, and oversight supersedes their commitment to the child’s well being. It should not be a
wonder that the problem has gotten so out of hand, and that the children that we are
supposed to protect are placed in questionable, unhealthy, and high risk environments at
no fault of their own.

If a child is placed with an educated, trained, and otherwise capable family
member, it would likely result in a more successful outcome. It will reduce the number of
placement changes, keep the child with his/her family, and reduce the chances of the
child getting lost in the system. Curing the problem may not be entirely possible, but
making these changes and gaining public support may limit the chances for re-entry into
the system, reduce loss of placement, and could potentially slow the growing population.
Streamlining the requirements for training and licensure, increasing the funding for the
first year of kinship placements, and increasing the oversight could reduce the need for
foster care involvement in otherwise salvageable circumstances.

The purpose of this study is to demonstrate that there are significant gaps and
areas of inequality in the system of care for children in kinship care. The hope is that this
study will contribute to the current research available by continuing to address the needs
of kinship caregivers and identify strategies to make positive changes within the system
of care.
Chapter 3

METHODOLOGY

Introduction

This chapter describes the methodology used in conducting the current study. It includes the description of the research design, the sample population, instrumentation used, data gathering procedures, and a brief discussion of the data analysis. It concludes with a discussion of the steps taken to protect human rights of the research subject.

Researchers were interested in examining the needs of kinship care providers. The idea set forth by the researchers was to gain a snapshot of where strengths and weaknesses are located in the system of kinship care in order to further kinship care practices. The survey questionnaire was designed by the researchers in effort to gain knowledge of the direct connection between lack of support for kinship care providers and their ability to adequately care for the child.

Research Design

The study design these researchers utilized was an exploratory quantitative survey. These researchers focused on needs of kinship care providers. The survey design was appropriate for the study because it allowed access to working professionals in the field of kinship care who provide direct support to kinship care providers and working close with CPS social workers. The survey was very accessible to the professionals that were able complete the survey via email link at a convenient time for the clinicians that would not conflict their working schedule. The questionnaire was designed by the researchers in an effort to gain knowledge on the direct connections between lack of
support for kinship care providers and their ability to adequately care for the child. The idea set forth by the researchers was to gain a snapshot of where strengths and weaknesses are located in the system of kinship care in order to further kinship care practices. It is hoped that the results of this survey will direct county agencies to combine their resources and expertise in the most effective ways to ensure that kinship care providers are receiving the appropriate level of resources and training in order to adequately prepare in caring for children.

**Study Participants**

The participants included 40-60 professionals with a degree of a Bachelor level or higher and working in kinship care. Subjects were obtained through the use of a snowball sample. The working professionals are employed with River Oak Center for Children whom work on a regular basis with kinship care providers and also Child Protective Services social workers. All working professionals obtained have the duties and roles as Clinicians and Facilitators who provide direct services to client and families. They provide case management, psychiatric, counseling and rehabilitation services to working population. The sample population was gathered using a non-probability sampling method referred to as snowball sampling. Non-probability sampling is a non-random sampling method that allows the researcher to select the sample according to the nature of the research and the phenomena being studied (Bryman, 2004; Marlow, 2005). This type of sampling method is limited in terms of representativeness because the probability of each element of the population being included in the study is unknown (Marlow, 2005).
Snowball sampling is a method in which the researcher identifies some members of the population being studied and then uses these individuals to establish contacts with others in the population (Anastas & MacDonald, 1994; Bryman, 2004; Marlow, 2005). For this study, the researchers contacted professionals who fit the specified criteria who agreed to participate. The snowball sampling method has advantages and disadvantages. One of the advantages is that it allows access to a population that might not otherwise be easily accessible (Anastas & MacDonald, 1994; Marlow, 2005). One of the disadvantages of snowball sampling includes the likelihood that the sample will not be representative of the population (Bryman, 2004). Because those recruited for the study through snowball sampling share some type of relationship with the original respondents, a potential for bias being reflected or magnified in the snowball method is possible (Anastas & MacDonald, 1994).

Instrumentation

A survey designed by these researchers, based on review of literature, was the instrument used for data collection. Fifty-Five identical surveys were emailed to professionals containing a cover letter and a brief description of the consent form. After reading the cover letter participants were able to follow a link to the full version of the informed consent. Survey monkey was used as an online secured website that assisted researchers with facilitating surveys to working professionals. The professionals would click the link and would direct them to survey monkey website where professionals were able to take a secure survey online.
The questionnaire consisted of two parts. One part consisted of 15 questions covering different factors associated with the needs of kinship care providers. Part two consisted of 4 general questions pertaining to the participant’s educational level and also work experience with kinship care.

_Data Gathering Procedures_

To begin gathering data, the researcher approached those individuals who were personally known to have experience working with clients and families in kinship care. The researchers explained they were conducting research to satisfy a master’s thesis requirement and explained that the purpose of the study was to examine the needs of kinship care providers. Each potential participant was asked if he/she would be willing to participate in the study. The interview process was briefly explained and a date and time were established for the participants to receive the link to the online survey. Each subsequent study participant who was referred to the researcher through snowball sampling was contacted via email.

“Survey Monkey” was used to administer the questionnaires offering SSL encryption to all accounts. With the SSL VeriSign Certificate Version 3, 128-bit encryption, researchers were able to send encrypted URL’s to participants. All the research data was kept secure using “Survey Monkey”, which has physical and environmental controls to protect the data. The surveys were stored at Sungard Inc. Surveys were also kept in a locked cage, which requires entry with a passcode and biometric recognition.
Data Analysis

Researchers used an excel spreadsheet created by Survey Monkey to download the data into SPSS. The data was downloaded onto SPSS and analyzed for patterns, themes, descriptors, associations, and correlations.

Protection of Human Subjects

As required by California State University, Sacramento, a human subjects application was submitted to the committee for the Protection of Human Subjects from the Division of Social Work. This committee approved the proposed study and determined the project as “No Risk” (approval number 09-10-084). The approval was received prior to the collection of any research data.

Informed consent was obtained from the professionals prior to completion of online survey, a detailed consent form was provided which informed the professionals of the proposed study, conditions of participation, risks and benefits of participation, confidentiality issues and the voluntary nature of the study (appendix B). Professionals were asked to complete a survey (see appendix B), which asked questions pertaining to the client’s needs, programs needs, as well as the effectiveness of the program. Professionals were also asked questions that pertained to their experience in working with the kinship care population.
Chapter 4

FINDINGS

Introduction

This chapter presents the study findings resulting from the analysis of the data collected. Overall, the researchers received 45 completed online surveys out of 55 who were asked to participate. This discussion of the findings is organized into: “The professionals views on importance of kinship care providers being licensed to care for kin”; “The professionals views on foster parent training;” “Professionals perspective of the importance of financial support;” “The importance of regular visits from a social worker;” “The importance of visits from social workers if child has mental health of physical challenges;” “Professionals years of experience” and the mean value to questions asked to professionals working with the kinship care population.

Survey Results

One of the questions asked to the professionals was “The importance of kinship care providers being licensed to care for a kin.” Thirteen respondents (28.9%) identified with kinship care providers being “Licensed” as being Very Important; nine respondents (20.0%) identified with being Important; seven (15.6%) indentified with Neutral; twelve (26.7%) with Somewhat Important; and four respondents indentified as Not Important (8.9 %). These responses indicate a wide range of professional disciplines, and it exhibits an eclectic balance of perspectives within this sample of participants). In some instances, these variations could have significant bearing on a kin’s willingness to step forward to “rescue” the relative based on either strict licensing requirements and/or the level of
involvement or imposition of child welfare agencies or courts (Report to the Congress on Kinship Foster Care, 2000, p. 20). In many instances, caregivers opt to avoid agency or court involvement to avoid any unnecessary intrusion into the family. However, without such involvement or oversight, issues of health and safety cannot be properly monitored.

The research reflects that licensure not only provides a better opportunity for assessment of needs by county agencies, but also provides more access to a number of resources, see table 1 below for further illustration.

Table 1

*The professionals’ views on the importance of Kinship Care Providers being “licensed” to care for a Kin*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not important</td>
<td>4</td>
<td>8.9</td>
<td>8.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>12</td>
<td>26.7</td>
<td>26.7</td>
<td>35.6</td>
</tr>
<tr>
<td>Neutral</td>
<td>7</td>
<td>15.6</td>
<td>15.6</td>
<td>51.1</td>
</tr>
<tr>
<td>Important</td>
<td>9</td>
<td>20.0</td>
<td>20.0</td>
<td>71.1</td>
</tr>
<tr>
<td>Very Important</td>
<td>13</td>
<td>28.9</td>
<td>28.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>100.0</td>
<td>100.0</td>
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</table>
Respondents were asked on their views of foster parent training for kinship care providers, and the results are as follows: Twenty Five (55.6%) identified with Very Important; twelve identified with (26.7%); one (2.2%) with Neutral; and seven (15.6%) with “Somewhat Important.”

Within the Kinship/Non-kinship care, some common themes consist of children being in great risk for developing problems which may include behavioral and emotional problems, that may derive from a poverty stricken background and/or parents developing
mental health problems. Many of the problems youth face today whether in kinship or non-kinship care tend to surface at the school, hindering their place of learning. Also, children in kinship care are less likely than children in non-kinship care to be referred for mental health services or receive mental health services as described in table 2 (Berrick, Barth, & Needell, 1994).

Table 2

*Professionals View on Foster Parent Training for Kinship Care Providers*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somewhat important</td>
<td>7</td>
<td>15.6</td>
<td>15.6</td>
<td>15.6</td>
</tr>
<tr>
<td>Neutral</td>
<td>1</td>
<td>2.2</td>
<td>2.2</td>
<td>17.8</td>
</tr>
<tr>
<td>Important</td>
<td>12</td>
<td>26.7</td>
<td>26.7</td>
<td>44.4</td>
</tr>
<tr>
<td>Very important</td>
<td>25</td>
<td>55.6</td>
<td>55.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Respondents were asked on the importance of financial support in order to care for a child. Eighteen respondents (40.0%) indicated “Very Important;” nineteen respondents (42.2%); two (4.4%) responded being “Neutral;” and six (13.3%) reported “Somewhat Important.” In the literature it discusses financial support and licensure are closely connected in terms of kinship resources, both of which have been longstanding issues that continue to be at the forefront of debate. Without question, most relative caregivers are willing to care for the children placed in their care, but many require financial help in order to meet the children’s needs (Conway & Hutson, 2007).
Grandparents are frequently chosen to take responsibility for the child, and often to not have the financial resources to properly provide for basic needs due to fixed incomes and limited funding resources. The requirements for qualifying for financial resources often create limitations for caregivers largely due to eligibility and other factors affecting incomes. The primary problem is that there are different licensing and payment policies for each state, and therefore payment eligibility may vary, see table 3.

Table 3

*The Professionals Perspective on the Importance of Financial Support*

<table>
<thead>
<tr>
<th>Importance</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somewhat important</td>
<td>6</td>
<td>13.3</td>
<td>13.3</td>
<td>13.3</td>
</tr>
<tr>
<td>Neutral</td>
<td>2</td>
<td>4.4</td>
<td>4.4</td>
<td>17.8</td>
</tr>
<tr>
<td>Important</td>
<td>19</td>
<td>42.2</td>
<td>42.2</td>
<td>60.0</td>
</tr>
<tr>
<td>Very important</td>
<td>18</td>
<td>40.0</td>
<td>40.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Figure 3. The professionals’ perspective of the importance of financial support

Respondents were asked “The importance of visits from a social worker.”

Sixteen respondents (35.6%) reported “Very Important; thirteen (28.9%) reported “Important;” six (13.3%) reported “Neutral;” five (11.1%) reported “Somewhat Important;” and five (11.1%) reported “Not Important”). Research suggests that support and supervision of kin caregivers is not equitable to that of non-relative foster parents, in fact, California caseworkers are required to visit foster child at least once a month, however after a survey was completed of both caregivers in Illinois and California, the researchers found that caseworkers visited children in kinship care less often on average
than children in other foster care settings (1999, p.17). “Supporting this assertion, significant differences have been found between social worker visits to kinship care homes and family foster homes, with adolescents in kinship care homes receiving an average 2.4 visits less per year than adolescents living with non-kin caretakers” (NAIARC, 2004).

Table 4

The Importance of Regular Visits from Social Worker

<table>
<thead>
<tr>
<th>Importance</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not important</td>
<td>5</td>
<td>11.1</td>
<td>11.1</td>
<td>11.1</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>5</td>
<td>11.1</td>
<td>11.1</td>
<td>22.2</td>
</tr>
<tr>
<td>Neutral</td>
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<td>13.3</td>
<td>35.6</td>
</tr>
<tr>
<td>Important</td>
<td>13</td>
<td>28.9</td>
<td>28.9</td>
<td>64.4</td>
</tr>
<tr>
<td>Very important</td>
<td>16</td>
<td>35.6</td>
<td>35.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Respondents were asked to specify the importance to have more frequent visits from social workers if the child has mental or physical challenges. Eighteen (40%) respondents reported “Very Important;” fourteen (31.1%) reported “Important;” eight (17.8%) reported “Neutral;” and five (11.1%) reported “Somewhat Important.”

McIntyre and Keesler (1986) found that circumstances associated with foster experience, are thought to be impediments to healthy psychological development: “Foster placement changes often occurs, biological family contacts are often infrequent and unpredictable, changes in the members of Foster household occur, and even the placement is uncertain” (p. 287). Youth in foster care tend to have developmental,
behavioral and emotional problems. Foster youth lack comprehensive mental health screening which go unnoticed and become adults with high rates of emotional and behavioral disorders. Studies also suggest that of the 40% of youth in foster care, up to 80% of these children exhibit a serious behavioral or mental health problems requiring intervention (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998).

Table 5

*Importance of Frequent Visits from the Social Worker if the Child has Mental or Physical Challenges*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
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<td>Somewhat important</td>
<td>5</td>
<td>11.1</td>
<td>11.1</td>
<td>11.1</td>
</tr>
<tr>
<td>Neutral</td>
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<td>17.8</td>
<td>17.8</td>
<td>28.9</td>
</tr>
<tr>
<td>Important</td>
<td>14</td>
<td>31.1</td>
<td>31.1</td>
<td>60.0</td>
</tr>
<tr>
<td>Very important</td>
<td>18</td>
<td>40.0</td>
<td>40.0</td>
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<tr>
<td>Total</td>
<td>45</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Respondents were asked to specify the years of experience working as professionals in the field of kinship care. The descriptive statistics indicated that the Mean for years of experience in the field is 5.17 years. (N=41), see table 6.
Table 6

*Years of Experience with working with the Kinship Care Population*

<table>
<thead>
<tr>
<th>Years of Experience working in the field</th>
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<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
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<td>11.00</td>
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</table>

<table>
<thead>
<tr>
<th>N</th>
<th>41</th>
</tr>
</thead>
</table>

Table 7

*Descriptive Statistics*

<table>
<thead>
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<th>The importance of frequent visits from the social worker if the child has mental or physical challenges</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Professionals views on foster parent training for kinship care providers</th>
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<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Professionals perspective on importance of financial support</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td>4.0889</td>
<td>.99595</td>
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</table>

<table>
<thead>
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<th>The importance of regular visits from social worker</th>
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<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>45</td>
<td>1.00</td>
<td>5.00</td>
<td>3.6667</td>
<td>1.36515</td>
</tr>
</tbody>
</table>
The professionals views on importance to have regular communication with social worker

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>The professionals views on</td>
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<td>2.00</td>
<td>5.00</td>
<td>3.93</td>
<td>.96103</td>
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<tr>
<td>importance on specialized</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td>training for children with</td>
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<td>special needs</td>
<td></td>
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<td></td>
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</tbody>
</table>

N 36

The mean score for the category of “The importance of regular visits from social worker if a child has mental or physical challenges” was 4.0 on a scale of 5. On the category of “Professionals’ views on foster parent training for kinship care providers” was a mean score of 4.22 out of 5, this category ranked high with the professionals. Professionals’ perspective of the importance of financial support the mean value was 4.08 on the scale of 5. Professional views on the importance of regular visits from social worker were the mean value of only 3.66. This category demonstrated not to be as important to the professional in comparison to the other categories. With the category “The professionals” views on the importance to have regular communication with social worker,” the mean score was 3.93 on a scale of 5. Lastly “Professionals views” on the importance on specialized training for children with special needs received the highest mean score out of all the questions completed by the professionals of 4.65.
Chapter 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

There is an abundance of literature that supports the growing concern that indicates that without increased levels of services in place, the greater the likelihood of a disruption in placements, in some cases causing the removal of the child from care. Additional contributing factors to disrupted environments include mental health issues, child abuse and maltreatment, and lack of access to resources. There is a substantial need for equality in services provided to kinship caregivers as a means of adequately maintaining a child in their care. This study was undertaken in an attempt to better understand the needs of kinship care providers, reinforce equality in support services between kinship and foster care, and finally demonstrate a need to reform current kinship care policies.

Conclusions

It is hoped that this understanding will demonstrate the need for not only change, but also reinforce the need for equality in financial support, training, access to resources, and oversight and supervision for kinship care providers. The increase in support for kinship caregivers would greatly benefit the child who would otherwise get lost in the system. If the emphasis is indeed reunifying the child with family, this advocacy for change should support the goal. Family members who would otherwise not be able to afford taking in another child, would potentially step up to the plate if there was more financial support, training, services and oversight in place. We could also potentially see
a reduction in placement changes, and increases in guardianship or adoption if the child could secure a placement with family who was confident, capable, and well supported. These changes would likely reduce the number of stressors involved, when family members are given the chance to take in the relative kin, and who would otherwise not have the financial support or motivation to do so.

Recommendations

For practice considerations at the micro level there should be improved awareness among children who are in the foster care system who are at a higher risk of experiencing mental health issues given the social, familial and environmental history. Foster care children are frequently transitioned into foster care with poverty stricken backgrounds, cultural deprivation and family disruption. It’s without question that children in foster care are at higher risk of developing psychological problems. Previous studies have verified that psychological disorders are, indeed frequent among foster children (Grube, 1978). Many children have experienced some form of trauma associated with neglect and abuse. Studies indicate that foster children were at some point neglected and/or abused: some children come into care because their primary caregivers became unavailable due to psychiatric hospitalization or incarceration (McIntyre & Keesler, 1986).

At the mezzo level, family member’s access to community resources to address additional needs is often overlooked within kinship care providers. According to child welfare workers, agencies also find it very difficult to provide and coordinate services for kinship care providers (Geen, 2002). Although the research suggests that most kin caregivers are eligible to receive the same services as non-kin caregivers, most are not
offered the support, do not request the support, and ultimately receive fewer services (Geen, 2002). Most kinship providers are left on their own and less often access services available to them. If the child does not have mental health challenges, the support is even less apparent. The research also states that kin often do not receive the benefits and services that they are eligible for from non-child welfare agencies. For example, many kin caregivers are either unaware or lack the knowledge of the services for which the child may qualify. Unbeknownst to many, all kin who do not receive foster payments for a child from a welfare agency are eligible for child-only TANF assistance (Geen, 2002). Additionally, many kin who are eligible for Medicaid health insurance coverage, food stamps, childcare subsidies, or housing assistance fail to receive the assistance. The cause of such significant errors is often placed on the caseworker that is often overworked, has extremely high caseloads, and has very little time to complete the paperwork necessary to start the process.

At the macro level, lawmakers and resource allocators have to be made aware of Kinship care families’ requiring services of training specifically geared towards the vulnerable populations. As the needs of the child increase, so does the need for some level of training to ensure appropriate care. Federal and state resources, however, have not kept pace with the needs of these families or the children placed in their care (Glisson 1996). One study reviewed was, “Training and Services for Kinship and NonKinship Foster Families”. This article sought out to review the literature on the trainings and services provided to kinship and non-kinship families. Within the Kinship/Non-kinship care, some common themes consist of children being in great risk for developing
problems which may include behavioral and emotional problems that may derive from a poverty stricken background and/or parents developing mental health problems. Many of the problems youth face today whether in kinship or non-kinship care tend to surface at the school, hindering their place of learning. Also, children in kinship care are less likely than children in non-kinship care to be referred for mental health services or receive mental health services (Berrick, Barth, & Needell, 1994). Authors Cuddleback & Orme (2002) identified that there is considerable evidence that foster parents receive less than adequate training, however kinship care receives even less services such as training when comparing to non-kinship care (Hegar & Scannapieco, 1995, p. 209).

Many kinship care providers receive little or no preparation prior to placement of children in their care, receive limited formal training, lack resources, and have a lack of understanding about the child welfare system compared to non-kinship care providers. As mentioned in the above literature, due to the special needs of children removed from their parents and placed in foster care who have experienced abuse, neglect, and maltreatment, the development of extraordinary parenting skills of foster families requires a commensurate effort by child welfare experts (Herczog, Van Pagee, & Pasztor, 2001). Pre-service training requirements are lacking in many states for kinship care providers, and some states do not require or provide training (Christenson, B., & McMurtry, J., 2007).

One of the research areas that need further exploration at the micro level is the limited awareness on the lack of information on the process in which local child welfare agencies determine to utilize kin as foster parents and how kinship care differs from
foster care. By having the lack of understanding with kinship care it present problems with ensuring a child’s safety and also promoting permanency of their living situation and most importantly their well-being.

With mezzo level considerations, we need to understand how researchers determined that children placed with grandparents present significant risks due to the age, health/medical issues, energy levels, unrealistic expectations, and finances of the grandparent (Berrick, 1997; DiNitto, 2007). In some cases, grandparents may be unprepared, and have unrealistic expectations of what the child’s needs involve or what the endeavor may entail. “Most kinship caregivers are grandparents who have not had parenting duties for some time and who may be apprehensive about raising a child at this stage in their lives…If they have become involved due to the abuse or neglect of a child, they may be forced to acknowledge the problems of the child they raised and may question their own parenting skills” (Report to Congress on Kinship Care, 2000, p. 34). They tend to focus on discipline and behavior management rather than on education and developmental aspects of parenting (Barth, Geen, Webb, Wall, Gibbons, & Craig, 2008). When put in this position, grandparents are required to deal with dual role of grandparent and parent and learn to balance them both (Schwartz, 2008). This reinforces the need for increased supervision to ensure the children receive the maximum amount of supports available to meet their needs whether mental, physical, financial, or the like.

On a macro level, more research is needed on the child welfare policy, in which it has done little to recognize the funding issues facing kinship caregivers. Despite the diversity in federal and state policies on funding, most states do not provide as much
financial support to kin caregivers as to non-kin caregivers (Schwartz, 2002). The need for equality in this area is growing increasingly more critical to the health safety and welfare of the children placed in relative care. As suggested, the number of children being placed in out-of-home care with relative is on the rise. The level of financial support provided to the caregivers often determines whether or not the child can be plucked from the system and placed in relative care. Many caregivers are willing and wanting to take responsibility for the child, but often do not possess the financial resources to sustain them in their care. Equalizing the level of resources, financial and otherwise, will increase the chances for permanency and stability in relative homes and reduce the likelihood of disrupted placements.

One of the areas of policy that need further exploration at the micro level is the level of awareness in that children would be the largest population that would benefit from being placed with kin. If a child is placed with an educated, trained, and otherwise capable family member, it would likely result in a more successful outcome. It will reduce the number of placement changes, keep the child with his/her family, and reduce the chances of the child getting lost in the system. With mezzo level considerations, we need to understand how there is evidence to show that placement permanence is greater in kinship homes than in foster homes, all efforts should be taken to ensure that it is successful. Kinship care providers should be required to have the same licensing requirements, training, and oversight that the foster care population enjoys. Funding should be equitable for the first year to ensure stability, reduce the chances of placement disruptions, and to ensure that the child’s needs are adequately met via assistance with
accessing and locating community resources. Child protective services claim to be committed to safety and welfare of every child. Committed to reunifying children whenever possible with their families, and providing a means necessary to make this possible. However, there is evidence to prove that they (social workers) are overwhelmed, overworked, and not entirely committed to the cause.

On a macro level, we need to understand how the present system of child welfare system makes this very difficult for kinship caregivers to obtain adequate supports to sustain a child in care. Child welfare policies have been at the forefront of debate, and hotly scrutinized for its inability to keep children safe. The kinship care system itself is struggling to determine whether this is a viable option. Not all family members are capable. Not all family members may be appropriate due to the family history.

The ideal situation may be to provide services to the family to support the needs (e.g. mental/emotional, financial, etc.); however, the research continues to show that the support is not there. According to an article written by members of the Urban Institute, 31% of the children in voluntary kinship care and 43% of the children in private kinship care live in families with incomes less than the federal poverty level (Malm, K. et al., 2003). If the family determines that they cannot take the child due to these challenges child ultimately becomes the custody of the state. As this suggests advocacy is vital to change. Research from previous sections of this study show a potential of micro level practices when looking at Kinship Care in the context of theory and application. System’s theory focuses on individuals as part of and incorporating other systems (Payne, 2005). System interact with each other in a variety of ways, and exploring these ways helps to
understand how individuals interact with other people in families and communities and in the wider social environments (Payne, 2005). As a social worker, systems theory is extremely important in working with families in order to understand what influences help or hinder family functioning. Within Kinship care, systems theory addresses the complex nature of the family and its connection with larger supportive systems.

Kinship care is the result of a disrupted system. Once a child has been removed from the home, he or she is dumped into the larger systems at work including court systems, county systems such as child protective services, and out-of-home or family-based placements. Examples of out-of-home placements include: family foster care, treatment foster care, kinship care, institutional care, and group home care (Downs, Moore, McFadden, Michaud, & Costin, 2004). When a child has been removed, they may be placed by county or state agencies such as child protective services (CPS), which seek to place the child in the least restrictive setting possible. Most often agencies try and locate family relatives as a means of keeping the child within the family if deemed.

Within the mezzo level, an important consideration for future practices consists of Kinship Care facilitating secure attachment and reinforcing the connections of the child to siblings, family, and cultures; reduces trauma children may experience when they are placed with strangers; reinforces the child’s sense of identity and self esteem; encourages families to consider and rely on their own family members as resources; and strengthens the ability of families to provide children the support they need (Gibbs and Muller, 2000). All of the benefits noted here center around the child’s well-being and preservation of connectedness or attachment with the family system.
The need to form secure attachments continues throughout life (Downs, Moore, McFadden, Michaud, & Costin, 2004). Kinship Care assists in this process by reinforcing family connections and relationships through the act of placing children with their relatives. However, many placements disrupt due to lack of supervision and oversight, resources and services, which contributes to the child’s lack of security and safety. This can be minimized if the stressors are reduced with the support of policy changes. Attachment theory best reinforces the benefits of kinship care, and need for greater attention to the needs of kinship providers in providing a safety, healthy, and supportive family foundations.

On a macro level, Children are generally brought to the attention of social service agencies because of complaints related to abuse (emotional, physical, or sexual) and neglect by parents or other caretakers (CWIG on Kinship Caregivers and the Child Welfare System, 2005; Downs, Moore, McFadden, Michaud, & Costin, 2004). When children are removed from the home, it can be emotionally traumatic and confusing. Children are frequently placed with relatives to reduce the level of trauma they may have experienced had they been placed with strangers (DiNitto, 2007). In most instances, children are able to adapt to the new environment with ease when they are given the opportunity to remain with family. Many of these children often require the support of mental health agencies to address the trauma and other psychological and behavioral issues that may result from the experience (Downs, Moore, McFadden, Michaud, & Costin, 2004).
APPENDICES
APPENDIX A

Invitation Letter

Dear Prospective Participant,

You are being asked to participate in a quantitative study that is to examine Kinship Care requirements as set forth by Kinship Care Policy, and developing a better understanding in the factors that may contribute to placement disruptions. This is a 19-question survey that is designed to acquire feedback from qualified professionals who work directly with individuals in Kinship Care. Participation in this study will take approximately 15 minutes but no more than 20 minutes. Your responses will be kept confidential to the degree permitted by the technology used. However, no absolute guarantees can be given for the confidentiality of electronic data.

Those respondents who complete the survey after reading the consent form will have responded completely voluntarily. You are not expected to participate in this study if you wish not to do so. Please note that if you complete an anonymous survey and submit it, researchers will be unable to remove anonymous data from the database, should you wish to withdrawal from the study.

Researchers do not anticipate any discomfort from taking this survey. This study is considered “No Risk”. However, if you have any questions, comments or concerns in regards to this research study, feel free to contact Xavier Maldonado & Wendy Rebentisch via email (JJMALDOX@YAHOO.COM & WREBENTISCH@YAHOO.COM) or Dr. Jude Antonyappan & Dr. Susan Taylor via email (Judea@csus.edu) & (Taylors@csus.edu)

By completing this online survey, you are agreeing to participate in the research. To access the survey simply click on the link below.

Thank you so much for your time and consideration in completing this survey.
APPENDIX B

Informed Consent to Participate

TITLE: A Quantitative Study to Examine the Needs of Kinship Care providers.

PURPOSE: The purpose of this study is to examine Kinship Care policy and to identify the problems that contribute to placement disruptions by examining client’s needs, the program’s needs, as well as the effectiveness of the program.

PROCEDURE: As a prospective participant of this study you will be asked to answer questions via an on-line survey regarding your perspectives on the client’s needs, the program’s needs, as well as the effectiveness of the program. Completing the questionnaire will take approximately 15 minutes, but no more than 20 minutes.

CONFIDENTIALITY: All the findings obtained from this study will be kept anonymous and confidential. “Your responses will be kept confidential to the degree permitted by the technology used. However, no absolute guarantees can be given for the confidentiality of electronic data”. Only the compiled group findings of all participants will be reflected in the final product. Your email address listed in this List Serv will not be shared with anyone at any point. The survey is completely anonymous and there are no markers or mechanisms that could identify your survey responses.

BENEFITS: You may gain additional insight into challenges that both you and Kinship Care providers experience in. You may not benefit from this study personally; however, it is hoped that the final product may assist professionals in get a better understanding in the challenges that Kinship Care provider’s experience.

RISKS: There is no risk or negative consequence for not returning the survey to the researcher. Those respondents who complete the survey after reading the consent form will have responded completely voluntarily. You are not expected to participate in this study if you wish not to do so. Please note that if you complete an anonymous survey and submit it, researchers will be unable to remove anonymous data from the database, should you wish to withdrawal from the study.

BILL OF RIGHTS FOR STUDY SUBJECTS

1. To be told what the study is trying to find out.
2. To be told what will happen to you and whether any of the procedures, drugs, or devices are different from what would be used in standard practice.
3. To be told about the frequent and/or the important risks, side effects, or discomforts of the things that will happen to you for research purposes.
4. To be told if you can expect any benefit from participating and, if so, what the benefit
might be.
5. To be told of other choices you have and how they may be better or worse than being in the study.
6. To be allowed to ask any questions concerning the study, both before agreeing to be involved and during the course of the study.
7. To be told what sort of medical treatment is available if any complications arise.
8. To refuse to participate at all, or to change your mind about participating after the study has started. This decision will not affect your right to receive the care you would receive if you were not in the study.
9. To receive a copy of the signed and dated consent form.
10. To be free of pressure when considering whether you wish to agree to be in the study.

CONSENT: I have read and understand this consent form and the Bill of Rights for Experimental Subjects. I have had a chance to ask questions about this research study. By completing this online survey, you are agreeing to participate in the research.

QUESTIONS: Researchers do not anticipate any discomfort from taking this survey. This study is considered “No Risk”.

If you have any questions, comments or concerns in regards to this research study, feel free to contact Xavier Maldonado & Wendy Rebentisch via email (JJMALDOX@YAHOO.COM & WREBENTISCH@YAHOO.COM) or Dr. Jude Antonyappan & Dr. Susan Taylor via email (Judea@csus.edu) & (Taylors@csus.edu).
### APPENDIX C

**SURVEY QUESTIONS**

(1) Not Important  (2) Somewhat Important  (3) Can’t say/Neutral  (4) Important  (5) Very Important

<table>
<thead>
<tr>
<th>Q:</th>
<th>Factors:</th>
<th>Level of Importance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>How important is being “licensed” to care for a kin?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>2.</td>
<td>How important is foster parent training in caring for a child?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>3.</td>
<td>How important is financial support in order to care for a child?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.</td>
<td>Is it important to have regular (weekly or monthly) visits from a social worker?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>5.</td>
<td>Is it important to have more frequent visits from the social worker if the child has mental or physical challenges?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>6.</td>
<td>How important is it to alleviate placement disruptions?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.</td>
<td>How important is being connected to the community for additional support?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>8.</td>
<td>How important is it to have regular communication with your social worker?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>9.</td>
<td>How important is it to have resource support from social services? (i.e. shoes, clothing, etc.)</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>10.</td>
<td>How important is it to have specialized training for children with special needs (mental/physical)?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>11.</td>
<td>How important is it to have advocacy support through social services?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>12.</td>
<td>How importance is equality in standards for kinship and foster care?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>13.</td>
<td>How important is social service involvement in the welfare of the child?</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>14.</td>
<td>How important is general support by social services in caring for a child placed with kin?</td>
<td>1 2 3 4 5</td>
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<tr>
<td>15.</td>
<td>How important is it for social services to intervene in a family (kin) conflict?</td>
<td>1 2 3 4 5</td>
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<tr>
<td>General Questions:</td>
<td></td>
<td></td>
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<td>----------------------------------------</td>
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<tr>
<td>16. What is your highest level of</td>
<td></td>
<td></td>
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<tr>
<td>education?</td>
<td></td>
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</tr>
<tr>
<td>A. Bachelor’s Degree</td>
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<tr>
<td>B. Master's Degree (MSW, MFT, MS, MA)</td>
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<tr>
<td>C. Doctorate (Ph.D. or Psy.D)</td>
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<tr>
<td>D. Medical Degree (M.D.)</td>
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<tr>
<td>17. Have you been working in Social</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services for at least 2 years?</td>
<td></td>
<td></td>
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<tr>
<td>Yes? How long?</td>
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<tr>
<td>18. Do you have regular contact with</td>
<td></td>
<td></td>
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<tr>
<td>kinship care providers?</td>
<td></td>
<td></td>
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<tr>
<td>YES  NO</td>
<td></td>
<td></td>
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<tr>
<td>19. Do you have adequate knowledge of</td>
<td></td>
<td></td>
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<tr>
<td>basic supports available to kinship</td>
<td></td>
<td></td>
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<tr>
<td>care providers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YES  NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES


http://www.socialworkers.org/practice/standards/

NASWChildWelfareStandards0905.pdf


