2007

A COMPARISON OF CHILD OUTCOMES RELATING KINSHIP AND FOSTER CARE: IMPLICATIONS FOR NEGLECTED CHILDREN

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(Spine title: Kinship And Foster Care: Outcomes For Neglected Children)

(Thesis Format: Monograph)

by

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Graduate Program in Education

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Education

Faculty of Graduate Studies
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ABSTRACT

This study investigated the efficacy of kinship care as an alternative to traditional foster care with neglected children. A retrospective file review of case files provided by the London-Middlesex Children's Aid Society (CAS), were examined along with two additional questionnaires assessing child outcomes and quality of kinship care. CAS caseworkers assessed both the kinship and foster care groups as representing equal levels of risk. Results suggested that neglected children placed in kinship care were rated as having better school- and behaviour-related outcomes contrasted with neglected children in foster care. This trend was identified at both the 3- and 6-month follow-up periods. Statistically significant differences were found in all areas except with the 6-month school-related outcome measure. The quality of the kinship care placements was evaluated. On average they were rated as above satisfactory. Implications for the CAS, counsellors, and future research directions are discussed.

KEYWORDS: KINSHIP CARE, FOSTER CARE, NEGLECT

ACKNOWLDGEMENTS

First I would like to express my gratitude to my thesis supervisor Dr. Alan Leschied, whose guidance, patience, and positive encouragement helped me get through one of the most difficult tasks I have ever encountered in my academic career. I am grateful because this experience has helped me become a better critical thinker and develop a great appreciation for research and its potential for practical application.

I would also like to express appreciation to my family and friends who helped support me when I felt overwhelmed or stricken with self-doubt. A special thanks goes to the London Middlesex Children's Aid Society for supplying the data for my study. Their hard work and dedication to child protection is the driving force behind this research topic.

Lastly I would like to thank the One who consistently shows me that no matter how daunting the task, with faith anything is possible.

TABLE OF CONTENTS

LIST OF TABLES

TABLE OF FIGURES

LIST OF APPENDICES

Introduction

There is a foster care crisis currently taking place in Ontario's child welfare system (Trocme et al, 20001). According to Curtis, Dale, and Kendall (1999) too many children are staying in foster care for too long. As well, there has been a decline in the number of nonkin foster parent spaces available for children who are being admitted to care (Geen, 2004). One solution to the foster care crisis is to decrease the number of children living in out-of-home care (Curtis et al., 1999). Thus, it is best to place children in an environment with permanency with appropriate care so that the well-being and future outcomes of these children are enhanced.

The purpose of this study was to investigate the efficacy of kinship care as an alternative to traditional nonkin foster care. Kinship care is similar to nonkin foster care except that the foster parents are either relatives or close family friends of the child. It is believed that many of the hardships related to the separation and environmental change often associated with traditional foster care, would be minimized if not eliminated if children were to be placed with familiar caregivers.

Neglected children were the population of interest in this study. Neglect is the most common form of child maltreatment (Trocmé et al., 2005). Outcomes of these children in nonkin foster care were compared to those in kinship care. The following literature review summarizes research on these issues thereby establishing a framework for the study.

Literature Review

Foster care shelters children in a family-like environment while parents are assisted in correcting whatever family condition led to the child maltreatment and

subsequently to the need for foster care services (Curtis et al., 1999). While most children return home after being fostered, unfortunately many do not. It is this population of children who remain in care that is concerning. These children need constant out-of-home residence until they are old enough to care for themselves. Financial support is required to fund these placements that house children without permanent homes.

There has been an increase in the number of referrals and admissions to child protection agencies. In Ontario child protection is delivered by 53 independent Children Aid Societies (CAS) (Trocmé et al., 2005). The number of children placed in care has increased 16% from 2001 and consequently so has the CAS's net expenditures (Ontario Association of Children's Aid Societies, 2005). The need for alternatives to traditional foster care is essential in decreasing the demands on the child protection agencies to find residences for these children.

In 2003, 235,315 Canadian child maltreatment cases were investigated, of which 49% were substantiated (Trocmé et al., 2005). This is a 78% increase from the 1998 number of 135, 573 cases. Although the increase in investigations could be the result of numerous factors such as increased societal and professional awareness, it is also possible that the rate of child maltreatment has increased. Nevertheless, the responsibility of child safety still lies in the hands of the CAS. Child maltreatment consists of five categories: physical abuse, sexual abuse, neglect, emotional maltreatment, and exposure to domestic violence. However neglect remains the most reported form of child maltreatment (Trocmé et al., 2005) and many of these children require an out of home placement such as foster care. The following section summarizes the literature related to the provision of foster care for children who experience maltreatment.

Foster Care

Foster care is intended to improve children's outcomes because it removes them from a pathogenic home and places them in an environment where supervision is increased (Jonson-Reid, 2002). Reunification with the birth family is the optimal outcome of foster care placements (Kerman, Wildfire, & Barth, 2002). However, when return to the birth family is not possible (i.e. when reunification compromises the child's safety), adoption is the next permanent alternative (Kerman et al., 2002).

Traditional nonkin foster care typically includes 24-hour supervision by caregivers in private homes that are licensed and monitored by child welfare agencies (Curtis et al., 1999). Traditionally foster care was viewed as a long-term settlement (Strijker, Zandberg, & van der Meulen, 2005). Currently there is more than one type of foster care. Examples include, temporary foster care, treatment foster care, along with long-term foster care. Temporary foster care is a limited living arrangement, where the duration of the child's stay is a maximum of three months (Strijker et al., 2005). Treatment foster care is also known as specialized or therapeutic foster care. This is an intensive form of foster care that provides specially trained and supported foster parents to children with serious emotional difficulties (Cross, Leavey, Mosley, White, & Andreas, 2004). Treatment foster care is a temporary arrangement, the goal of which is to prepare the children for the most appropriate permanent life situation whether it is reunification, adoption, or independent living (Cross et al., 2004). Children and youth may also enter regular foster care if a permanency option is not available, conversely, children may have to enter a more intensive program, such as residential or hospital treatment (Cross et al., 2004).

Limitations to Foster Care

Although the goal of foster care is to ensure the safety of children and promote a positive family-like setting, this is not always the case. In general, youth in out-of-home care are at a higher risk of mental health problems because of child abuse and neglect, termination of relationships with biological parents, placement experiences, lack of preparation for independent living, and multiple family problems (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Shin, 2005). Older youth in the foster care system may have a higher rate of psychiatric disorders (e.g. major depression and PTSD) compared to youth within the community (McMillen et al., 2005). This may be the result of the family's psychiatric history, child maltreatment, and the disruption of life often associated with being involved with the foster care system. Stein, Evans, Mazumdar and Rae-Grant (1996) found that children in foster care exhibited almost as many behavioural symptoms as children assessed in a children's mental health centre, and both groups scored significantly higher relative to community norms. These findings suggest that children in CAS and those in children's mental health centres come from the same population of children. They also found that receipt of social assistance was most consistently correlated with psychiatric disorder in these children (Stein et al., 1996). Therefore pre-existing family and child risk factors may be responsible for foster children's problems (Stein et al., 1996).

When maltreated children are removed from home and placed in foster care, they may suffer further due to the inability to separate from the birth family in a healthy way (Clausen et al., 1998). These children experience feelings of rejection, guilt, hostility, anger, abandonment, shame and disassociative reactions in response to the loss of a

familiar environment and the separation from family and community (Clausen et al., 1998). Youth who become old enough to move out and exit the child welfare system face numerous challenges if they do not find a legal family for life, given that the transition from foster care to independent living requires substantial social, emotional, and material resources (Kerman et al., 2002). Kerman et al. (2002) investigated the outcomes of youth in long term foster care compared to adopted youth. They found that adoptees and children who remained in foster care into young adulthood were functioning better relative to those who left at age 18 or younger.

The primary disadvantage of living in foster care is the instability of placements. Children in foster care are more likely to live in more than one foster home (Newton, Litrownik, & Landsverk, 2000). Research shows that this instability can be detrimental to a child's mental state. Newton et al. (2000) examined the behaviour of children and youth in foster care and found that unstable placement histories contribute negatively to both internalizing (e.g., depression) and externalizing (e.g., aggression) behaviours. Children placed in foster care, because of additional behaviour problems, are more likely to have later juvenile arrests (Jonson-Reid, 2002). A study conducted by Jonson-Reid (2002) investigated whether child welfare services moderate the relationship between child maltreatment and delinquency. Findings from this study showed that non-white children who received in-home child welfare services had a lower risk of incident in juvenile corrections than those receiving no services.

Schofield and Beek (2005) conducted a longitudinal qualitative study, the purpose of which was to discuss the challenges in long-term foster care and the skills needed to provide a secure base for children with a history of neglect, abuse, and psychosocial

adversity. Interviews with children were conducted to elicit views of their family, relationships, school, friendships and activities in both phases (initial entry and 3-year follow-up). Results suggested that the skills needed to provide a secure base were: promotion of trust in caregiver availability; promotion of reflective function, which is the ability to think about their own minds and the minds of others; promotion of self-esteem; promotion of family membership; and promotion of autonomy. The article only depicted comments that agreed with the proposed model, compromising its objectivity. Although these recommendations to promote a secure base are theoretically valuable, these skills are not often practiced. This could be a result of many things such as child behavioural problems that exceed the foster parent's manageability, or the lack of support.

Child Neglect

According to the Ontario Association of Children's Aid Societies (Ontario Association of Children's Aid Societies, 2005), neglect occurs when a caregiver fails to provide basic needs for children such as adequate food, sleep, safety, supervision, clothing or medical treatment. Thus, the child's safety and development may be jeopardized by their caregiver's acts of omission. According to the 2003 Canadian Incidence Study (CIS), neglect was the most frequently investigated category of maltreatment and approximately 40% of child neglect investigations were substantiated in Canada (Trocmé et al., 2005). The CIS identified eight types of neglect: failure to supervise resulting in physical harm; failure to supervise resulting in sexual abuse; physical neglect; medical neglect; failure to provide psychological/psychiatric treatment; permitting criminal behaviour; abandonment; and educational neglect (Trocmé et al., 2005). Failure to supervise a child resulting in physical harm and physical neglect were

the top two investigated forms of neglect (Trocmé et al., 2005). Neglected children constitute a significant portion of the maltreatment cases that CAS's manage. If neglect is not the primary purpose of investigation, it is often associated with the other forms of maltreatment.

The trauma associated with maltreatment not only affects children's daily functioning, it can also affect their entire course of development (Finzi, Ram, Har-Even, Shnit, & Weizman, 2001). Neglected children not only have blunted affect but are more generally withdrawn from social interactions with peers, easily victimized, more dependent, anxious, and unpopular, and possess less social competence (Finzi et al., 2001). Hildyard and Wolfe (2002) conducted a literature review to investigate how child neglect affects children's development. This review was organized into three developmental periods (infancy/preschool, school-aged/younger adolescence, and older adolescence/adults) and within each period, three developmental processes (cognitive, social-emotional, and behavioural) were explored. The results showed that during the infancy/preschool period, children showed that cognitively, there were problems in expressive and receptive language and that neglect alone was more problematic for language than abuse and neglect together. Emotionally, these children could have problems with emotion regulation in compliance issues (i.e., neglected children were more likely than abused children to express anger rather than compliance when asked to do something). Behaviourally, neglected children were more likely to have insecure attachment and negative mental representations of the self and others. During the school-aged/younger adolescence period, neglected children showed lower academic achievement than abused children. Emotionally, they continued to have negative mental

representations of the self and others and internalized problems. Behaviourally they were socially withdrawn, aggressive, disruptive, and uncooperative (but not as significantly as physically abused peers). Lastly, during the older adolescence/adult period, they received lower scores on intelligence tests and were at risk for personality disorders in early adulthood. Behaviourally, there was a correlation with delinquency, adult criminal behaviour, and violent criminal behaviour. Overall, this study concluded that because neglected children failed to achieve important milestones, they continued to be challenged by normal developmental tasks.

Schumacher, Smith Slep and Heyman (2001) conducted a literature review to investigate the risk factors associated with child neglect. The risk factors that were explored were: demographic variables, age of parent, race, sex, socioeconomic status/education, family structure, self-esteem, impulsivity, parental annoyance, psychopathology, social support, stress, maternal expectations, and attributions of child behaviour. They concluded that the only demographic variable with moderate to strong effect sizes was fertility (i.e., greater number of live births, more pregnancies, and more unplanned conceptions). Moderate to strong effects were found for the correlation between neglect and maternal self-esteem, impulsivity, substance abuse diagnosis, lack of support, daily stress, child behaviour problems, family variables, and community variables. Lounds, Borkowski and Whitman (2006) showed that the risk for neglecting children is heightened when the mother is a teenager at the time of birth of the child and when she comes from a lower socioeconomic family. Results showed that there was a relationship between histories of neglect and neglect potential.

Another possible cause of child neglect includes ecological influences. It is possible that run-down, impoverished, and more unfriendly neighbourhoods create low morale and stress (Crosson-Tower, 1999). Neglected children with unmet needs are isolated from those who have learned to participate in society; therefore, they seek out others with similar backgrounds and begin the pattern again with their children (Crosson-Tower, 1999). It is imperative that those children who are victims of neglect receive an intervention where they are introduced to caregivers who are positive role models and can create a safe and loving environment particularly when economic and environmental conditions cannot be readily altered.

Attachment Theory

Attachment relationships are fundamental to individual functioning at all ages (Crittenden & Ainsworth, 1989). Attachment theory suggests that infants are genetically predisposed to form attachments at a critical point in their lives (Bowlby, 1982). The primary purpose of attachment is to promote the protection and survival of the young. According to this theory, the etiology of psychological disturbance is viewed in the context of early relationships with caregivers (Milan & Pinderhughes, 2000). Bowlby (1982) suggests that the nature and quality of this attachment relationship is largely determined by the caregiver's emotional availability and responsiveness to the child's need for a "secure base". The infant develops internalized representations of others and the self, based on the degree of the caretaker's availability and responsiveness to needs (Bowlby, 1982). Internal representations are formed through dyadic interactions between mother and child. Attachment theory suggests that infants form a repertoire of behavioural skills and affective responses that will reflect, reinforce, and modify these

internal representations in subsequent interactions (Bowlby, 1982). How attachments are formed in early childhood shapes the organization of a child's beliefs and expectations about subsequent transactions with the environment (Milan & Pinderhughes, 2000). Bowlby (1982) believes that children's early experiences with caregivers lead to generalisations about adults' availability.

Crittenden and Ainsworth (1989) delineated three styles of attachment: secure, anxious/ambivalent, and avoidant. Securely attached infants are more confident of the availability of their mother and more likely to use her as a secure base. These infants demonstrate less fear in new situations, develop better problem-solving abilities, and show more cooperation and empathy in interpersonal relationships, more ego resiliency, and better cognitive performance (Crittenden & Ainsworth, 1989). Ambivalent infants react with heightened expressions of both attachment and anger. These children in subsequent social situations can be withdrawn and vulnerable to threats of separation (Crittenden & Ainsworth, 1989). Avoidant infants express avoidance and detachment. These children's avoidant behaviour is a defence mechanism against prolonged unresponsiveness to the infant's attachment needs (Crittenden & Ainsworth, 1989). This may later lead to emotional insulation, lack of empathy, and antisocial and aggressive behaviour (Crittenden & Ainsworth, 1989).

Attachment Theory and Child Neglect

Attachment theory provides an explanation of the potential psychopathology experienced by children through both the effects of maltreatment and the disruption of a healthy child-parent affectional bond (Finzi et al., 2001). A study conducted by Finzi et al. (2001) compared physically abused and physically neglected children and examined

the impact of these forms of maltreatment on the children's attachment styles. The results of this study showed that abused children were characterized by the avoidant attachment style and had higher scores for aggression. Neglected children were characterized by the anxious/ambivalent attachment style and were lower in aggression than the physically abused children. They suggest that in order to break the cycle of abuse and neglect, special intervention programs are needed to help these children handle their emotional distress and social maladaptation and to change the caregiving environment.

For children with a dysfunctional primary caregiver, establishing a positive relationship with an alternative adult may be one mechanism by which children sustain or return to a productive life course (Milan & Pinderhughes, 2000). Most children entering foster care have experienced dysfunctional relationships within their family. They are likely to approach the foster care experience with impaired representations of themselves and their relationships (Milan & Pinderhughes, 2000). Also foster care, because of its instability, is expected to aggravate children's mental health problems, thus impeding foster children's ability to form meaningful attachments (Newton et al., 2000). A study conducted by Milan and Pinderhughes (2000) found that children with the most negative mental representations at entry to foster care also felt less positive affect toward, and had less desire for, proximity with their new foster mothers. Morton and Browne (1998) believe that it is the caregiving relationship that is transmitted across the generations rather than the maltreatment. Research that investigates the intergenerational transmission of child maltreatment, find that a significant proportion of participants have a parent who was also involved with child welfare services or was a victim of child maltreatment as a child (Hurley, Chiodo, Leschied, & Whitehead, in press; Lounds,

Borkowski, & Whitman, 2006). It has been found that individuals who break the intergenerational cycle of maltreatment tend to have someone somewhere in their lives who provided them with the love and/or support which facilitated a personal sense of worth (Morton & Browne, 1998). It is evident that the children placed in out-of-home care need this support in order to achieve better outcomes for themselves and for their possible future families. It is possible that kinship care arrangements, provided that the caregiver is deemed appropriate and safe, may assist in breaking this intergenerational cycle.

Kinship Care

Kinship care is offered as an alternative to traditional foster care. It is defined as any living arrangement in which children do not live with either of their biological parents, but instead are cared for by relatives or someone who has a relationship with the family (Geen, 2004). The definition of kin can go beyond that of a genetic relative and may include relationships, such as godparents, family friends, or anyone with a strong emotional bond to the child (Geen, 2004). There are two types of kinship care, formal and informal. Formal kinship care refers to caregiving arrangements organized by a child welfare agency. Informal kinship care implies that the kinship arrangement was organized in the absence of a child welfare agency (Geen, 2004). It is difficult to estimate how many kinship arrangements are informal, but the rate is predicted to be one and a half times greater than formal arrangements (Ehrle & Geen, 2002). Children in kinship care are more likely than children in nonkin foster care to have been removed from their parents' homes due to abuse and neglect, but more predominantly for neglect (Cuddeback, 2004; Geen, 2004).

Kin caregivers face a multitude of obstacles that are less common in typical foster caregivers. Kin caregivers tend to be older and poorer than nonkin foster parents (Geen, 2004). They are often required to provide the same nurturance and support for children in their care as nonkin foster parents provide, but with fewer resources, greater stressors, and limited preparation (Geen, 2004). In certain jurisdictions, there is evidence that kinship caregivers are more likely to be of African heritage, unemployed, and of a lower socioeconomic status compared with nonkinship caregivers (Chipman, Wells, & Johnson, 2002; Cuddeback, 2004; Ehrle & Geen, 2002). Most kin caregivers tend to be grandparents and thus report more limitations in daily activities, increased depression, lower levels of marital satisfaction, and poorer health compared to grandparents not caring for their grandchildren (Cuddeback, 2004). The developmental lifespan of the grandparents can be in conflict with their roles as full-time parents because their role should be low maintenance and supplemental; instead it is high maintenance with fewer resources (physically, mentally, financially, and socially) (Lawrence-Webb, Okundaye, & Hafner, 2003). Some of the grandparents have serious health problems that are not taken into consideration when placing children in kinship care (Lawrence-Webb et al., 2003).

There are some theoretical advantages to kinship care, which include: continuity of family identity and knowledge, access to relatives other than the kinship caregiver, continuity of life within the ethnic, religious, and racial community of origin, and caregivers familiarity of the child based on pre-existing relationships (Cuddeback, 2004; Geen, 2004). Children are more likely to have their emotional, spiritual, and nurturance needs met, and children in kinship care do not experience the same level of trauma

normally associated with foster care because they remain in the extended family (Cuddeback, 2004). Kinship placements tend to be more stable than other types of placements (Chipman et al., 2002). Messing's (2005) study interviewing children in kinship, reflected children's fear of entering the foster care system. They did not view residence with their caregiver as a move outside of their "family". Overall these qualities that kinship arrangements offer may prove to alleviate the behavioural problems that are often seen in children who are placed in nonkin foster care settings.

Chipman et al. (2002) conducted a qualitative study to discuss: the views on quality care, the factors to consider in the selection of evaluation of kinship placements, and opinions of how kinship and nonkinship foster care differ. Twenty-four focus group interviews were planned with samples of kinship caregivers, children in kinship care, and caseworkers of children placed in kinship settings. Twelve group results were examined. The topics discussed included: placement in kinship care, screening and licensing standards, protection of the child from continued maltreatment, discipline, caregiver's age and health, important kinship care outcomes, and intervening factors in the quality of care. Results suggested that caseworkers focused on child safety and permanency issues and that caregivers focused on the ability to provide children with love and moral and spiritual guidance. They agreed that caregivers must meet the child's need and that age was of relatively less importance, however, physical and mental health should be more important. Both caregivers and caseworkers felt that agencies should correct power imbalances by involving caregivers more fully in the case planning process (Chipman et al., 2002). Kinship children expressed preferences for employed and financially stable caregivers (Chipman et al., 2002). One limitation of this study was the

underrepresentation of certain groups such as Native Americans and those from rural settings, which decreases the generalizability of the results. Overall, this article described a comprehensive approach to assist children in the care of kin.

There is evidence to show that youth in kinship care not only stay in out-of-home care longer than youth in nonkinship care, but they also reunify at a lesser rate (Shore, Sim, Le Prohn, & Keller, 2002). In order for a relative to adopt their grandchild, niece, or nephew, it requires the termination of parental rights of the relative's children, sisters or brothers (Link, 1996). This may prove to be a moral dilemma for these relatives. Link (1996) conducted a longitudinal study investigating permanency planning for 525 children placed in kinship care in Erie County, New York. She found that the children in kinship care did stay longer with their relatives than the children placed in traditional foster care. Also, the younger the child when placed in out-of-home care, the more likely that the child had been adopted or had been placed for adoption. However this study did conclude that many children were indeed adopted or had plans for adoption by their relatives during the timeframe of data collection. She then discusses the unique financial challenges that kinship caregivers face if adoption is to be considered.

The limitations to kinship care are evident when analysing the practices and policies of the framework. Some observers argue that kin should not be paid for caring for a related child since such care is part of familial responsibility (Geen, 2004). Kinship foster families receive less training, fewer services, and less support than nonkinship foster families (Cuddeback, 2004). Research shows that child welfare workers tend to supervise kinship care families less closely than nonkin foster families (Geen & Berrick, 2002).There is a debate how child welfare agencies should financially support kin, as

well as how well kinship care meets the child welfare goals of safety, permanency, and well-being (Geen & Berrick, 2002). Lorkovich, Piccola, Groza, Brindo, and Marks (2004) conducted a literature review to examine kinship care and discuss why it is better than other out-of-home care placement. They concluded that the benefits of kinship care include: a reduction of the trauma associated with separation, reinforcement of children's sense of identity and self-esteem, increased stability, a reduction of the stigma associated with foster care, and promotion of sibling relationships. The barriers included: inconsistent definition of kin, insufficient information for caregivers to make informed decisions, and lack of financial and social service supports to help caregivers maintain care of children. Child welfare workers, administrators, and policy makers struggle with understanding to what degree relatives, particularly grandparents, may have either contributed to abuse and neglect by birthparents or experienced some of the same problems when they were parents (Lorkovich et al., 2004). This article suggests that kinship care can be a viable alternative to foster care if efficient policy and practices are created.

Foster Care versus Kinship Care

There have been inconsistent results when comparing the outcomes of children in the care of kin versus those in the care of nonkin. Research has shown that kinship children show both more and less behavioural issues than their comparative sample of nonkin foster children.

Benedict, Zuravin, and Stallings (1996) conducted a follow-up study to investigate whether the type of out-of-home care setting (kin or nonrelative) was associated with adult functioning (education, employment, and physical and mental

health status). They interviewed 214 participants from their phase 1 study that investigated the characteristics of family foster homes of children in care that were associated with maltreatment while in care. For phase 2, they concluded that there were no significant differences in adult functioning between the two groups. They were functioning similar in terms of education, current employment, physical and mental health, risk taking behaviours, and stresses and supports in their lives. However, social service records reported significant differences in functioning while the participants were in care. More children with kin stayed in their first setting and were significantly less likely to have developmental or behavioural problems. Behaviour and attendance problems were reported significantly more with nonrelative children. Benedict et al. (1996) hypothesized that kinship caregivers cannot provide the level of care that is expected from nonrelative caregivers, and relate to poorer outcomes. Kin tend to have poorer health, fewer economic resources, or fewer services offered to them. A limitation in this study was the fact that it was unknown how many participants from both the maltreated and nonmaltreated groups (phase 1) were used in phase 2. If a higher proportion of maltreated participants were used, then the results in phase 2 would be affected. Also, there was a reliance on subjective answers for sensitive questions which may have influenced the results.

Shore et al. (2002) conducted a study evaluating teacher ratings of problem behaviours exhibited in school by youth in kinship and nonkinship foster care. The Teacher Report Form was used to rate the children. Three between-group comparisons were made: kinship vs. general population, nonkinship vs. general population, and kinship vs. nonkinship. Their results show that teacher reports of problem behaviours for

children in foster care, regardless of kinship status, were not very different from a normative sample of children. When comparing the kinship group to the nonkinship group, the youth in kinship care had significantly higher scores on the delinquent behaviour scale when compared to the youths in nonkinship care. Again, because of the limited sample used in this study, the results cannot be generalized to children in the public child welfare agencies. Another limitation was that maltreatment history was not taken into consideration, which could affect the result pattern found. Overall, the researchers concluded that youths in kinship care are doing well both in school and in home, as compared to both youths in nonkinship placements and the general population (Shore et al., 2002).

Keller et al. (2001) completed a cross-sectional study evaluating the behaviour of kinship foster children in comparison to nonrelative foster children and children in the general population. The Child Behaviour Checklist was administered to 240 children, 28% (kinship foster care) and 72% (nonrelative foster care). The results showed that children in kinship foster care demonstrated fewer problem behaviours than nonrelative foster care children. These children also seemed to show similar levels of behaviour when compared to children in the general population, whereas nonrelative foster children demonstrated lower levels of competence and higher levels of problematic behaviours when compared to children from the general population. However, because this study used children from a private child protection agency, the results cannot be applied outside of that population. Also, the history of the children makes it impossible to confirm that kinship care or nonrelative foster care contributes to the behavioural outcomes.

Contrary to expectations, kinship care has not been shown to enhance reunification rates. Rates of reunification are similar for both children placed with kin and nonkin; however, the pace of reunification is slower for children placed with kin (Berrick, 1998). Geen (2004) suggests that lower rates of reunification may be the result of reduced motivation among birth parents when children are placed with kin. It's also possible that reunification is a less likely option for children in kinship care because they are more likely than children in traditional foster care to be victims of abuse and neglect, with birth parents as the perpetrators. Nevertheless, these findings may be offset by the fact that youth in kinship care who do reunify, tend to re-enter care at a lower rate than youth in nonkin care (Courtney, Piliavin, & Wright, 1997).

Research has also shown that kin care providers are less likely to adopt or accept legal custody (Berrick, Barth, & Needell, 1994; Geen, 2004). Testa, Shook, Cohen, and Woods (1996) showed that the most common reason for kin caregivers not to adopt was the thought that the child was too old. Financial constraints were the second most common reason (Testa et al., 1996). Taking legal custody or guardianship of a child causes many kinship families to lose financial support (Lorkovich et al., 2004). However the limitations associated with kinship care is expected to diminish once kinship care providers receive the same support from child welfare agencies as traditional foster parents (Geen, 2004).

Focus of Current Study

The foster care crisis is of great concern because more children are being placed in out-of-home care placements than in the past (Curtis et al., 1999). There are also

declining numbers of foster care spaces available for these children (Curtis et al., 1999). Alternative out-of-home placements are required.

Although children living in abusive and neglectful homes may not have a choice on how they are raised, once they are placed in out-of-home care they are supposed to be given the opportunity to attain a "better life", whether through familial intervention and reunification or perhaps adoption. Unfortunately this "better life" is not often achieved due to the many limitations associated with foster care settings as described in the literature. Children in foster care may not necessarily achieve better future outcomes than if left at home. The attachment theory proposes that the parent-child relationship along with a secure base contributes to improved social and interpersonal behaviour. Therefore it is important that the intergenerational cycle is broken among these children so that maltreatment and unproductive attachment styles are not propagated. An abused or neglected child requires a safe and stable home where they will be given the attention and security they need to develop effective behaviours and skills.

Not only may kinship care offer alleviation to the foster care crisis, but it may also help improve a maltreated child's future outcomes. The literature describes both the advantages and obstacles concerning children who are placed in kinship care. However, it remains unclear whether or not kinship care is more beneficial for children compared to nonkin traditional foster care. Since the population of children most often placed in kinship care are those that have suffered neglect, it is this group that this study will explore. This study will investigate the efficacy of formal kinship care compared to traditional foster care among neglected children.

Most of the literature concerning the efficacy of kinship care has been completed outside of Canada. This study was one of the first to be conducted within Canada. The findings showcase the differences unique to Canadian culture. The research question addressed was: What are the characteristics of children entering foster care versus kinship care? By reviewing the CAS case files of neglected children placed in either kin or nonkin arrangements, the differences and similarities of these children were identified and compared. Understanding whether or not one type of placement is more beneficial for the child than another, provides insight into where further research attention should be directed to and possible policy formation.

Hypothesis

This study proposed that neglected children would show better outcomes when placed in kinship care compared to traditional nonkin foster care. Outcomes were measured and compared by the level of school and behaviour-related issues as they related to child well-being.

Method

Study Design

This study was comprised of three stages in the analysis. The first was a descriptive field study. Two groups of neglected children under the care of a child protection agency, those in kinship care and those in foster care, were compared based on categorical demographic variables (i.e., age, gender, child welfare history, etc). The second stage of the analysis was a retrospective longitudinal follow-up study, where outcomes from qualifying participants were analyzed based on a series of relevant outcome measures. Third, the quality of kinship care was evaluated relative to the children's outcomes while they were in care.

Participants

This study employed participants from the CAS of London-Middlesex. Neglected foster care children (n = 267) were selected from a larger sample of child protection cases drawn from a previous study (Hurley et al., in press). Neglected kinship care children (n = 34) were selected from all the CAS kinship care case files opened in 2005 and 2006.

The CAS designation code that identifies the primary reason a child comes into care, the primary eligibility code, was used to identify participants who were victims of neglect. The primary eligibility spectrum code is designated by CAS caseworkers upon admission. Child victims of neglect in the current study were defined as those whose code consisted of: harm by omission, emotional harm, abandonment/separation, or (insufficient) caregiver capacity.

Of these two groups, 34 (M = 44.1%, F = 55.9%) foster care cases and 31 kinship care cases (M = 58.1%, F = 41.9%) were selected reflecting outcome data at a 3-month

follow-up time period after their initial admission to care. Following 6-months of care, outcome data were collected once again. One hundred forty-six foster care cases (M = 45.2%, F = 54.8%) and 21 kinship care cases (M = 57.1%, F = 42.9%) were used.

Twenty-five kinship care cases (M = 68%, F = 32%) were used for the analysis of quality of care at the 3-month period. Seventeen kinship care cases (M = 70.6%, F = 29.4%) were used for the quality of care at the 6-month period.

A preliminary analysis of the data retrieval instrument revealed trends between the kinship and foster care groups (Table 1 and 2). Overall, kinship care children tended to have their CAS file opened at a younger age when compared to foster care children. On average kinship care children enter the CAS system at the age of 3.7 years (SD = 4.2 years) while foster care children enter at the age of 6.7 years (SD = 5.3 years). However on average the CAS is involved with kinship care children for a longer period of time prior to placement, 64.0 months (SD = 52.9 months); foster care children are involved on average 40.7 years (SD = 46.8 months). A higher percentage of kinship care children showed evidence of Attention Deficit Disorder (27.3%), Conduct Disorder (28.1%), and to be on medication for an adjustment related disorder (57.6%). However there were no major differences on the mean overall risk assessment (M=3.75, SD = 0.95) for foster care and M= 3.70, SD = 0.73, for kinship care, and a mean cumulative risk assessment of M= 34.2, SD = 11.7 for foster care, and M = 35.4, SD = 13.1, for kinship care. Therefore although neglected kinship care children appear to enter care earlier and have more behavioural concerns, overall they are at the same level of risk when the CAS becomes involved.

Of the kinship caregivers, 56.7% were grandparents (Graph 1).

Table 1

Continuous Items Collected from Data Retrieval Instrument

Item	Foster Care (N = 267) M	Foster Care (N = 267) SD	Kinship Care (N = 34) M	Kinship Care (N = 34) SD
Age at time of case opening (years)	6.7	5.3	3.7	4.2
Age of admission to care (years)	6.7[a]	5.4	5.3[a]	4.5
Length of time of CAS involvement with the family (months)	66.5[b]	76.5	76.6[c]	62.3
Length of time of CAS involvement with the child (months)	40.7	46.8	64.0[c]	52.9
Mean overall risk assessment given by social worker (score range is 0 to 4)	3.75	0.95	3.70[a]	0.73
Mean cumulative risk assessment (total ORAM score out of 88)	34.2	11.7	35.4[a]	13.1

[a] 1 participant missing data. [b] 2 participants missing data. [c] 4 participants missing data

Table 2

Categorical Items Collected from Data Retrieval Instrument

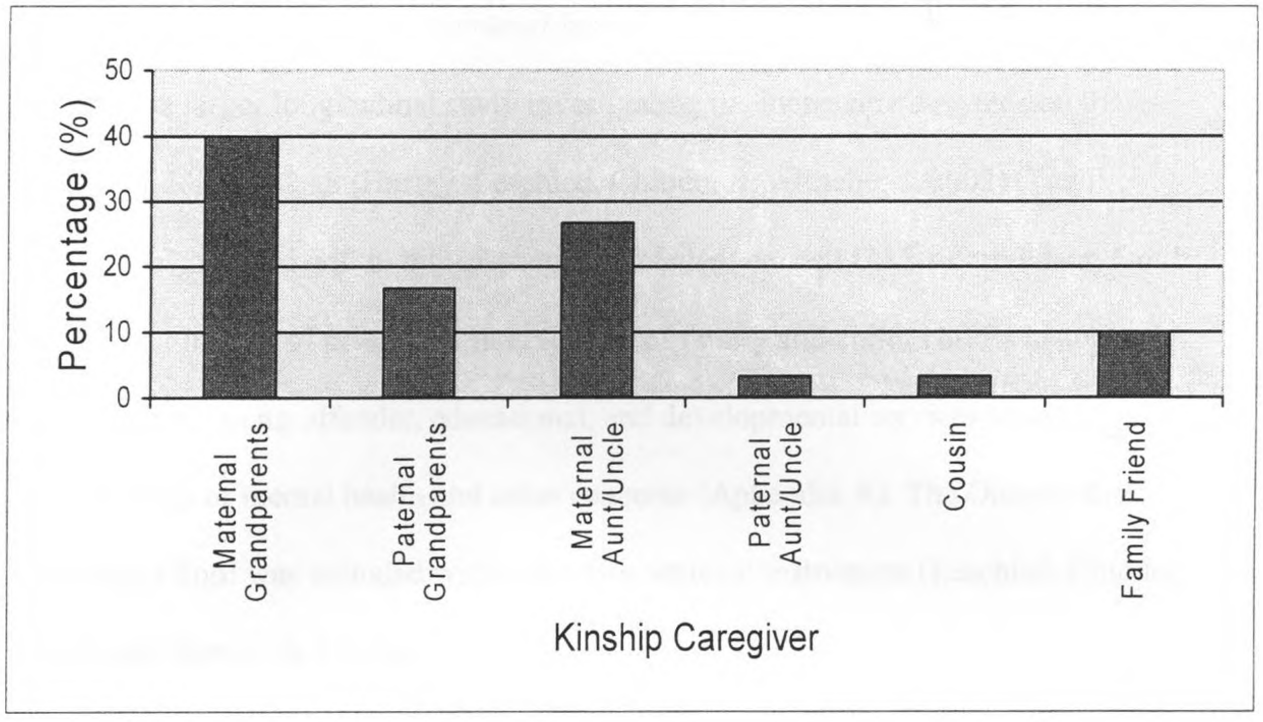
Item	Foster Care (N = 267) %	Kinship Care (N = 34) %
Gender:		
Male	47.9	52.9
Female	52.1	47.1
Was primary caregiver on social assistance at the time of referral? (% Yes responses)	62.9[a]	75.8[b]
Family arrangement at the time of initial CAS inquiry:		
Single mother	29.2	48.5[b]
Single father	3.4	
Married birth parents	12.4	12.1

Common-law birth parents	11.6	30.3
Extended family	5.2	3.0
Other	38.2	6.1
Primary caregiver at the time of initial CAS inquiry:		
Mother	79.8	93.9[b]
Father	11.2	3.0
Extended family	6.0	3.0
Other	3.0	
Individual identified as presenting the greatest risk to child at the time of referral:		
Mother	59.4[b]	82.4
Father	9.0	2.9
Mother and Father	13.1	11.8
Extended Family	3.4	
Other	15.1	2.9
Has child ever been involved with a children's mental health service (% Yes responses)	29.2	33.3[c]
Evidence to suggest that the child has Attention Deficit Disorder (% Yes responses)	14.6	27.3[b]
Evidence to suggest that the child has Conduct Disorder (% Yes responses)	7.5	28.1[d]
Is child currently on or has ever been on medication for an adjustment related disorder? (% Yes responses)	13.9	21.2[b]
Has primary caregiver been formally diagnosed with a major mental disorder? (% Yes responses)	46.8	57.6[b]
Depression	11.2	5.3
Post-Partum Depression	0.8	10.5
Anxiety	4.8	5.3
Bipolar Disorder	8.8	
Substance Abuse	24.0	31.6
Other	50.4	47.3

[a] 16 participants missing data. [b] 1 participant missing data. [c] 4 participants missing data. [d] 2 participants missing data

Figure 1

Percent Breakdown of Kinship Caregivers



At the time of CAS initial inquiry, kinship care children tend to come from a single, mother family arrangement, 48.5% versus 29.2% for foster care children respectively. Consequently, mothers are the ones more often identified as the individual presenting the greatest risk to the child (82.4% for kinship care and 59.4% for foster care). There are more kinship care primary caregivers on social assistance (75.8%) compared to foster care primary caregivers (62.9%). Forty-seven percent of foster primary caregivers and 57.6% of kinship primary caregivers have been formally diagnosed with a major mental disorder. For both groups, substance abuse was the most commonly diagnosed mental disorder, 24.0% for foster care and 31.6% for kinship care. The second most commonly diagnosed mental disorder was depression for foster care

caregivers (11.2%) and post-partum depression for kinship care caregivers (10.5%).

Materials

Children in Care Data Retrieval Instrument. This data collection protocol was created for a larger longitudinal study investigating the increasing demands on the London-Middlesex CAS (Hurley, Leschied, Chiodo, & Whitehead, 2002). The information collected within this instrument included: current CAS referral data; family information; history of prior CAS intervention of family and child; child's history with mental health, young offender, educational, and developmental services system; and family history of mental health and other concerns (Appendix A). The Ontario Risk Assessment Tool was included within the data retrieval instrument (Leschied, Chiodo, Whitehead, Hurley, & Marshall, 2003).

Ontario Risk Assessment Tool. This risk instrument is utilized by the CAS to measure level of risk in different aspects of the child and family's life. There are 22 risk elements subdivided into five assessment categories: caregiver influence, child's influence, family influence, intervention influence, and abuse/neglect influence (Ontario Association of Children Aid Societies (OACAS), 2000). Each element includes a five-level scale, with the severity increasing from zero to four (Ontario Association of Children Aid Societies (OACAS), 2000). (Appendix B). A total score based on these individual ratings was calculated for use in the present study.

Case Plan Outcomes Associated with Kinship Care Questionnaire. This questionnaire contained both three-month and six-month kinship care outcome data. Child well-being was considered as it relates to both school and behaviour while the child was in care. There are two school-related items and 30 behaviour-related items. Each

item is rated on a four-level scale, where a score of 0 means there is no evidence of the problem and 3 means that it is a severe problem. A total score was also generated for each of the school and behaviour sections (Appendix C)

Quality of Kinship Care Protocol. This is a 56-item protocol that rates the extent to which a kinship care placement is related to factors consistent with a successful placement for the child. For each item, the scale ranges from 1 (placement is not supportive) to 7 (placement is extremely supportive for both the child and for reunification). (Appendix D)

Procedure

A retrospective file review of case files was provided by the research team, taking place at the London-Middlesex CAS. Four trained research assistants under the supervision of a project manager collected the kinship care data. The research assistants received the same data collection training to ensure that the interrater reliability was enhanced. Any concerns were brought to the attention of the project manager and solutions were discussed amongst all researchers for consensus. Foster care data were provided from a previous study that used participants from the same CAS. The outcome and quality of care questionnaires were completed by the CAS caseworkers.

Statistical Analyses

Frequencies and percentages were calculated for the descriptive characteristics in each group (kinship and foster). Chi-square and one-way analysis of variance (ANOVA) analyses were performed on the selected data retrieval items to determine statistical significance between the two groups of out-of-home care placements. ANOVA's were

used to determine the statistically significant differences between the mean total school-related and behaviour-related outcome scores.

Mean total scores were generated for the quality of kinship care questionnaire and a multiple regression analysis was performed with the totals from the outcome questionnaire (both school-related and behaviour-related). This was done to determine whether a particular outcome measure was correlated with the total quality of kinship score.

Results

The purpose of this study was to determine whether neglected children placed in kinship care showed better outcomes compared to neglected children placed in foster care. Secondarily the quality of kinship care was assessed and statistically correlated with the outcome measures to determine whether a specific outcome measure item is predictive of quality care while in kinship care.

Outcome Measures

All items on the outcome questionnaire were rated on a 4-point scale (0 to 4), where low scores indicated there was no evidence of the experience and high scores indicated there was evidence of the behaviour. Follow-up outcomes, both school-related and behaviour-related, were measured after the child was in care for three months and then again at six months (Tables 3-6)

School-Related Items. Overall, ratings for neglected children placed in kinship care had more improved ratings at the 3-month follow-up period, $M = 0.58$, $SD = 1.41$ relative to those placed in foster care, $M = 1.53$, $SD = 1.76$, with a significant difference between means $F(1, 63) = 5.68$, $p = 0.05$. This trend was also seen at the 6-month follow-up period, kinship care $M = 0.38$, $SD = 1.12$ and foster care, $M = 1.21$, $SD = 2.01$, although was not statistically significant, $F(1, 165) = 3.83$, *ns*.

Behaviour-Related Items. Raters also examined behavioural items with neglected children placed in kinship care and those placed in traditional foster care. Neglected children in kinship care had lower rates of behaviour problems at the 3-month follow-up period, $M = 4.74$, $SD = 6.14$, relative to traditional foster care, $M = 13.41$, $SD = 12.49$, $F(1, 63) = 12.24$, $p = 0.01$. At the 6-month follow-up, kinship care children were rated as

having lower rates of behaviour problems, $M = 3.14$, $SD = 5.39$ compared to neglected children in traditional foster care, $M = 10.33$, $SD = 12.75$, $F(1, 165) = 6.48$, $p = 0.05$

At the 3-month period 73.5% of the kinship children were returned home.

Table 3

Child Wellbeing – Outcome Measures after 3 Months of Out-of-Home Care

Child Well-Being	Foster Care (N = 34)		Kinship Care (N = 31)	
	M	SD	M	SD
School-related	1. 53	1.76	0.58	1.41
Behaviour-related	13.41	12.49	4.74	6.14

Table 4

Child Wellbeing – Outcome Measures after 6 Months of Out-of-Home Care

Child Well-Being	Foster Care (N = 146)		Kinship Care (N = 21)	
	M	SD	M	SD
School-related	1.21	2.01	0.38	1.12
Behaviour-related	10.33	12.75	3.14	5.39

Table 5

School-Related Outcome Items

	3 Months				6 Months			
	Foster Care (N = 34)		Kinship Care (N = 31)		Foster Care (N = 146)		Kinship Care (N = 21)	
Item	M	SD	M	SD	M	SD	M	SD
Child experiences school-related problems	1.00	1.13	0.42	0.16	0.73	1.18	0.29	0.72
Child experiencing truancy	0.53	1.08	0.85	0.64	0.48	1.02	0.10	0.44

Table 6

Behaviour-Related Outcome Items

	3 Months				6 Months			
	Foster Care (N = 35)		Kinship Care (N = 31)		Foster Care (N = 146)		Kinship Care (N = 21)	
Item	M	SD	M	SD	M	SD	M	SD
Child is physically aggressive	1.18	1.24	0.19	0.60	0.77	1.14	0.14	0.48
Child is verbally aggressive	0.97	1.17	0.32	0.70	0.55	1.04	0.29	0.78
Child abuses alcohol	0.18	0.63	0.00	0.00	0.17	0.65	0.00	0.00
Child behaves destructively	0.59	0.99	0.13	0.50	0.45	0.91	0.14	0.48
Child is anxious/fearful/clingy	0.65	1.04	0.48	0.77	0.66	1.06	0.29	0.56
Child abuses drugs	0.29	0.87	0.03	0.18	0.18	0.66	0.00	0.00
Child has eating difficulties	0.44	0.93	0.13	0.34	0.24	0.71	0.05	0.22
Child sets fires	0.03	0.17	0.00	0.00	0.01	0.08	0.00	0.00
Child behaves in hostile manner	0.65	1.07	0.16	0.58	0.45	0.93	0.14	0.65

Child is hyperactive	0.65	1.23	0.35	0.84	0.55	1.06	0.29	0.78
Child lies compulsively	0.56	1.02	0.07	0.36	0.36	0.85	0.10	0.44
Child behaves manipulatively	0.59	1.02	0.16	0.45	0.46	0.88	0.19	0.51
Child is non-compliant	1.26	1.31	0.45	0.85	0.84	1.18	0.33	0.80
Child is experiencing night terrors	0.12	0.54	0.03	0.18	0.03	0.22	0.00	0.00
Child is perceptually handicapped	0.00	0.00	0.07	0.36	0.01	0.12	0.00	0.00
Child has experienced problems with peers	0.97	1.14	0.13	0.56	0.52	0.97	0.14	0.65
Child is experiencing day care-related problems	0.09	0.51	0.13	0.43	0.11	0.46	0.10	0.44
Child has been deprived socially	0.59	1.13	0.16	0.45	0.37	0.89	0.19	0.51
Child smokes	0.12	0.54	0.00	0.00	0.17	0.66	0.00	0.00
Child runs away	0.41	0.92	0.13	0.56	0.33	0.86	0.00	0.00
Child is suicidal or engages in self-harm behaviours	0.32	0.91	0.10	0.40	0.27	0.77	0.05	0.22
Child is experiencing separation anxiety	0.15	0.61	0.19	0.40	0.29	0.73	0.10	0.30
Child sexually misbehaves	0.44	1.02	0.19	0.75	0.31	0.80	0.00	0.00
Child has sleeping problems	0.12	0.48	0.10	0.40	0.25	0.66	0.05	0.22
Child steals	0.15	0.44	0.00	0.00	0.23	0.65	0.00	0.00
Child swears	0.38	0.92	0.10	0.54	0.29	0.84	0.05	0.22
Child experiences temper tantrums	0.56	1.02	0.26	0.73	0.51	0.98	0.14	0.48
Child behaves violently	0.76	1.05	0.23	0.67	0.55	1.01	0.10	0.44
Child is withdrawn or depressed	0.18	0.46	0.32	0.70	0.27	0.68	0.24	0.62
Child is whinny	0.03	0.17	0.13	0.43	0.14	0.48	0.05	0.22

Quality of Kinship Care

Overall the average total of quality of care score was $M = 346.8$, $SD = 26.4$, out of a possible total of 392. A multiple regression was used to determine whether there was a relationship between the quality of care total score and the total scores of the school-related and behaviour-related outcomes at the 3-month and 6-month follow-up periods. The analysis revealed no significant relationship between the total quality score and either outcome measures at both time periods (Table 7).

Table 7

Pearson Correlation of Quality of Kinship Care as Predicted by Child Well-being Outcomes

3 Months (N = 25)						6 Months (N = 17)					
School-Related Outcomes			Behaviour-Related Outcomes			School-Related Outcomes			Behaviour-Related Outcomes		
R	*t*	*p*	R	*t*	*p*	R	*t*	*p*	R	*T*	*p*
-.31	-2.01	0.06	-.004	1.25	0.22	0.08	0.35	0.73	0.02	-1.98	0.85

Discussion

The purpose of this study was to determine the efficacy of kinship care as an alternative to traditional foster care for children coming to the attention of a child welfare agency because of neglect through evaluation and comparison of relevant behavioural and emotional outcomes. Child well-being as it pertains to school and behaviour problems was used as the measures of outcomes. Children who were victims of neglect were the participants. Literature has indicated that neglect is the most common form of maltreatment coming to the attention of children's aid societies (Trocmé et al., 2005). Results from this study showed that neglected children placed in kinship care had better outcomes in both the school-related and behaviour-related domains contrasted with neglected children in foster care. This trend was viewed at both the 3-month and 6-month follow-up periods. Statistically significant differences were found in all areas except with the 6-month school-related outcome measure. The quality of the kinship care placements was evaluated and the results showed that on average the quality of kin care placements was above satisfactory. However the level of quality in care was not predictive of kinship outcomes. This discussion will outline the relevance of these findings in the context of previous literature and the contribution to child welfare planning and practice with kinship care programs.

Major Findings Related to Previous Literature

The goal of out-of-home care is to remove a child victim of maltreatment from their pathogenic home and place them in an environment where they can temporarily experience a family-like setting. Once parents receive appropriate assistance and can effectively ameliorate the difficulties in their living situation, reunification of the child in

their home is the ideal outcome. Unfortunately children placed in foster care settings are not always reunified with their parents and they spend most of their childhood and adolescence in out-of-home care (Newton et al., 2000). If reunification is not possible, adoption is the next desirable outcome. However research has shown some limitations associated with foster care. A foster child not only has to face the social, emotional, and possible physical challenges of being a victim of maltreatment, but they must also deal with the fact that they are separated from their family in an unhealthy way (Clausen et al., 1998).

Kinship care is a form of out-of-home care where the primary caregiver is a member of, or has a close relationship with, the child's family. Kinship care arrangements are thought to minimize the stigma associated with being removed from home. It also allows for the child to preserve cultural, ethnic, religious, and familial identities (Cuddeback, 2004; Geen, 2004). These are characteristics that are not necessarily guaranteed to be maintained when a child is placed in foster care.

There is limited research available regarding the children and families of kinship care compared to traditional foster care. This study is unprecedented within Ontario; therefore the descriptive results serve to provide original information of these neglected children and their families. One study of significance comparing children placed in kinship care versus foster care was conducted by Benedict, Zuravin, and Stallings (1996). The outcome measures used were education, employment, and physical and mental health status in adulthood. Although the results did not show any differences between the two groups in adulthood, these authors did note that in childhood, the kinship group showed fewer developmental, behavioural, and attendance at school problems than the

foster group. Keller et al. (2001) showed that kinship care children had similar levels of problem behaviours as children in the general population, which was lower than children in foster care. The current study compared outcomes of child wellbeing in school and behaviour. On average, the kinship and foster care children were 5.3 and 6.7 years old at the time of the case opening, and on average, CAS was involved with the child for 64.0 and 40.7 months respectively. Therefore the school related outcomes may prove to be less informative since these children are predominantly in early elementary school. The behavioural outcomes however showed significant differences between the groups. Children in kinship care scored lower on the outcome questionnaire, indicative of little or no evidence of the particular behavioural disorder being described. This result was seen at both the 3-month and 6-month follow-up periods. Specific items in the outcome measure are of particular importance. The current study's results agree with some previous research in that kinship care children were rated as having fewer and less severe behavioural difficulties than foster care children (Benedict et al., 1996; Keller et al., 2001).

3-month follow-up. For the two items used to provide the school-related measure, the item "child experiences school-related problems" had a larger average score difference than the item "child experiencing truancy" between the two groups. In the behavioural outcome measure, the item "child is physically aggressive" had the largest average score difference between kinship care (M = 0.19) and foster care (M = 1.18). Other items that showed a mean score difference of 0.50 or greater were: child is verbally aggressive, child is non-compliant, child has experienced problems with peers, and child behaves violently. The data reflects that foster children were identified as having a more

difficult time adjusting to their environmental change. It is probable that the difficulties that foster care children have with their peers may be a result of the negative stigma associated with out-of-home care.

6-month follow-up. At this time period the school-related items contained the same trend reflected at the 3-month follow-up. The difference between the groups however was statistically significant. Similar to the 3-month period, the item "child is physically aggressive" had the largest difference in score between the groups in the behavioural outcome measure. In the majority of the behavioural items, item scores were higher at the 3-month interval than at the 6-month interval for both groups. However the items: child is experiencing separation anxiety, child has sleeping problems, child steals, and child is whiney increased between the two follow-up periods for the foster care group. It is likely that separation anxiety would increase in the foster care group as a result of the continuous involvement with an unfamiliar environment particularity if cultural, ethnic, or familial needs are not being met.

Children. Seventy-two percent of the children in kinship and foster care had neglect listed as the primary reason for referral. This percentage agrees with statistics provided by CAS's that deem neglect as the most common form of maltreatment. Shore et al. (2002) showed that kinship care children also exhibit behavioural problems, which is likely because these children experience similar maltreatment as foster care children before they are placed in out-of-home care. The present study showed that slightly more kinship care (33%) than foster care (29%) children have been involved with a children's mental health service. The current study also found that kinship care children were more likely to show evidence of an Attention Deficit Disorder, a Conduct Disorder, and have

been on medication for an adjustment related disorder. These results imply that kinship care children have more behavioural and mental health concerns relative to their comparative group prior to admission into CAS care. A possible cause for this trend is that for these participants kinship care was not the first intervention used, so these children may have experienced greater placement instability. At the 3-month follow-up period, 73.5% of the neglected children placed in kinship care were returned home. In the current study there was no traditional foster care information to compare reunification rates to.

Caregivers. This study showed that there are differences, although not statistically significant, between the families from which these samples are drawn. At the time of CAS involvement, the kinship group was almost 1.5 times more likely to have a single parent family arrangement. Consequently the primary caregiver presenting the greatest risk was the mother for 82.4% of the kinship group and 59.4% of the foster care group. Original primary caregivers for the foster group had a lower likelihood of being on social assistance, 62.9% versus 75.8% for the kinship care group. Forty-six percent of the caregivers in the foster group and 57.6% of the caregivers in the kinship group have been formally diagnosed with a major mental disorder. Substance abuse followed by depression, both clinical and post partum, were the two major mental disorders for both groups. These results suggest that the neglected kinship group came from less stable families reflecting more severe emotional and economic challenges. The average risk assessment however, derived from the Ontario Risk Assessment Tool, showed no significant difference between kinship and foster care children, $M = 3.70$ and $M = 3.75$

respectively. This implies that CAS caseworkers assessed the level of overall risk between these two groups, as relatively equal.

The quality of kinship care questionnaire completed by the caseworkers focused predominantly on the capacity of the caregiver to provide and sustain adequate care for the neglected child. The average total on the questionnaire was 346.8 out of a possible total score of 392. Higher scores indicate a perceived higher quality of care. These results imply that the neglected kinship children in this sample were receiving a high level of quality care. Similar to the results reported by Cuddeback (2004) and Geen (2004), this study found that more than half of the kin caregivers were grandparents.

Implications of Findings for Child Protection

Currently there are increasing numbers of children that require out-of-home care while the quantity of foster care placements are decreasing (Curtis et al., 1999). According to the Ontario Association of Children Aid Societies (2005) there has been an increase in the net expenditures for child welfare. Therefore an effective solution is required to not only ensure the safety and security of these maltreated children, but to reduce the potential service pressures on the child protection system. Ultimately as with any human service, prevention strategies are preferred to intervention strategies; the goal of preventing maltreatment is preferred to the goal of removing a child from an unsafe environment. Morton and Browne (1998) believe that it is the actual caregiving relationship rather than the maltreatment itself that is transmitted across the generations. If this is the case then it would be ideal to focus attention on the salvation of the child-parent bond. Although it may not be possible for this bond to occur between a child and an abusive parent, this bond is more likely to be maintained between kinship caregiver

and child rather than foster (i.e. stranger) caregiver and child. Morton and Browne (1998) found that the intergenerational cycle of maltreatment tends to be fractured when someone in the maltreated child's life provides love and support that improves self-worth. This development is more readily transferred within a kinship care arrangement.

The results of the current study imply that neglected children may have more successful school and behaviour-related outcomes when placed in a kinship care family arrangement than in traditional foster care. It is possible that if kinship care children are better adjusted at home and in school as children and adolescents, then they will have better outcomes in adulthood. The necessity to help financially support out-of-home caregivers is one cause for the increase in CAS expenditures. Currently compensation for kinship caregivers within Canada is a highly contentious issue. In the long-term it is possible that expenditures could decrease since children placed in kinship care will display better long term outcomes and arrest the cycle of maltreatment across the generations. Longitudinal studies however are awaited before more definitive statements regarding the long term effects of kinship care can be made. As well research shows that although children placed in kinship care may reunify at a slower pace, these children are also more likely to have stable placements when they continue in kinship care (Courtney et al., 1997). However in the current study approximately three-quarters of the kinship children were reunified with their parents by the end of three months in care. It was also found that the kinship group had both the child and family involved with CAS for a longer period of time than the foster care group, which is contrary to the implications stated. However this may be due to the fact that kinship care arrangements are relatively

new to the London Middlesex CAS and therefore not the first considered option for out-of-home care.

These findings suggest that CAS's may want to put more focus into placing children within kinship care arrangements. The kinship placement decision should be the primary consideration rather than a secondary one. This would enable the child to receive the most successful and beneficial intervention as soon as possible.

Implications for Counsellors

It is important for those in the helping profession to understand the challenges that children in kinship care may be facing. Similar to children in traditional foster care, kinship care children have to contend with being separated from their family and familiar environment.

Finzi, Ram, Har-Evan and Wiezman (2001) found that neglected children may have blunted affect as a result of years of deprivation. They are also likely to struggle with a lack of social competence resulting from a lack of acquired social skills at home (Finzi et al., 2001). Neglect is particularly detrimental since it may interfere with normal childhood development (Hildyard & Wolfe, 2002). Therefore counsellors should be aware that these children may have these behavioural and developmental challenges before they start the counselling process.

Attachment theory predicts that a child who has a disrupted or dysfunctional child-parent bond has an increased risk of psychopathology (Finzi et al., 2001). Although children may be living with an abusive parent, they may still have an attachment to them, albeit unhealthy. Unfortunately this bond is harder to create particularly since the foster home and caregiver may differ in many ways. Research has suggested that culture,

religion, familial and social relationships are more likely to be maintained when a child is placed in kinship care.

The comparative preliminary descriptive analysis showed that kinship care children are more likely to have behaviour related issues as well as have a parent who has been diagnosed with a major mental disorder. Substance abuse and post-partum depression were the two most likely kind of major mental disorder diagnosed within original caregivers in the kinship group. Thus counsellors should be aware of the possible genetic and environmental causes that may contribute to children who are placed in out-of-home care. Milan and Pinderhughes (2000) believe that a positive relationship with a primary caregiver is necessary for the child to have a productive life. As well the bond between counsellor and neglected child could augment this life productivity.

Lastly, counsellors should be aware of the role that placement instability has on the development of child behaviour and emotional well-being (Newton et al., 2000). A child who experiences frequent placement changes may be less likely to form close attachments and may express minimal trust of authority-type figures.

Limitations to Current Study

Although the current study attempted to provide accurate comparative outcome data for kinship care and foster care arrangements, there were some limitations associated with this study.

Due to the novelty of formal kinship care arrangements with London-Middlesex CAS, the number of participants was limited. The sample size consisted of all the children who were placed in kinship care arrangements from September 2005 through to

September 2006. The sub-sample was then further reduced to those children who were deemed victims of neglect. Future research should replicate the study with a larger sample size to increase the power of the statistical significance. Subsequently the results may not be generalizable to all kinship care children since the sample was drawn for a specific population.

This study did not test for attachment style specifically so no definitive conclusions can be made regarding this important developmental construct. It is unclear whether it is the caregiver-child bond specifically that is the helpful characteristic within kinship care arrangements or whether it is other familial factors within the kinship care arrangement that is having a positive effect.

The use of a random study design is the most effective way to make group comparisons. However due to the extremely challenging nature of randomly placing children in either the kinship care or foster group, randomized designs in this context may not be feasible or even ethically viable. Future research may benefit from using a matched-group design based on significant characteristics such as age, gender, type of maltreatment, length in out of-home care.

Future Research

The data used in the current study was collected over an approximately 15 month period. Outcome measures were evaluated at the 3-month and 6-month time periods. Future studies should continue to employ such useful follow-up data for even longer periods of time. A longer term comparative assessment of these outcome measures would help to evaluate whether the current preliminary findings continue into adulthood. Reunification and stability levels should be collected for both the foster care and kinship

care groups to discern whether the current kinship care reunification results are atypical. Although the focus of the current study was on children in kinship care, what is unclear is whether the future prognosis of foster care children is a result of the maltreatment or the type and quality of the out-of-home care received. Research should also continue to focus on kinship children regarding their attachment styles and the caregiver-child bond. These results would augment the findings associated the intergenerational transmission of maltreatment.

Future research should also consider focusing on different types of outcome measures that will be relevant as the participants develop into later adolescence and adulthood. Variables such as employment, education, social, emotional, and behavioural functioning should be included.

Summary

Consistent with previous findings, the present study found that neglected children placed in kinship care were rated as having less severe and less frequent problems as they relate to school and behaviour compared to a similar group of neglected children placed in traditional foster care (Benedict et al., 1996; Keller et al., 2001). This result was found both at the 3-month and 6-month follow up periods. Kinship caregivers were rated overall as providing a higher than satisfactory level of quality care. It is possible that an increased provision of kinship care could not only improve outcomes with neglected children but also contribute to a lessening in the demand for an already resource-burdened child protection system. It is also likely that, if a child who has experienced neglect is given the opportunity to thrive in a healthier environment, then their future outcomes will be better and hence the intergenerational transmission of maltreatment

may be addressed. Further research is required to evaluate such long term outcomes with maltreated children placed in kinship care arrangements.

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Appendix A

Data Retrieval Instrument

DATA RETRIEVAL INSTRUMENT

Adapted for the Family Group Decision Making and Kinship Care Evaluations

Alan Leschied Ph.D., Dermot Hurley M.S.W., Paul Whitehead Ph.D., and Debbie Chiodo, M.A.

ITEM

1. CAS File ID _ _ _ _
2. Child Case ID _ _ _ _ _ _ _ _
3. Family Case ID _ _ _ _ _
3b. Primary Eligibility Spectrum Code: _ _ _

4. Year of Referral _ _ _ _ (1995 or 2001)

5. Date of Birth _ _ _ _ _ _ (D/M/Y)

6. Age in months at time of case opening _ _ _

7. Age in months at time of case closing _ _ _

Current Referral Data

Data for the purposes of the following sections will be based on the most intrusive level of intervention for the youth through the CAS

8. Date of Initial Inquiry to CAS _ _ _ _ _ _ *(D/M/Y)*

9. Date of Admission to Care _ _ _ _ _ _ *(D/M/Y)*

10. Number of months following initial inquiry to care (8 minus 9) _ _ _

11. Age at time of admission to care _ _ _ (In months)

12. Gender _ _ (male= 1; female = 2)

13. Type of current CAS Intervention

Counselling/Parent ___
Counselling/Child ___
Foster Care ___
Group Home ___
Failed to engage family ___
No intervention provided ___
Other (state) ___ _____

14. Source of referral to CAS

Child ___
Parent ___
Extended Family ___
Neighbour ___
School ___
Physician ___
Other agency ___
Anonymous reporting ___
Friend ___
Police ___
Unknown ___
Other (state) ___ _____

15. Disposition of case with CAS

Contact / No follow-up ___
Investigation completed ___
(Allegation not substantiated) ___
Brief assessment/intervention ___
(less than 30 days/file closed)
Case opened for monitoring ___
Counselling with CAS ___
Referral to another children's service ___
Temporary care agreement ___
Crown wardship ___

16. Was child/family on waiting list to be seen by a children's service or family agency at the time of CAS referral? ___ (Yes = 1, No =2,)

17. If yes to above, specify which agency (s) _____

18. Was child/family being seen by a children's service/family agency at the time of CAS referral? ____ (Yes = 1, No= 2)

19. If yes to above, specify which agency (s) _____

20. Was primary caregiver on social assistance at the time of referral? ___ (Yes = 1, No =2, Don't know =3)

21. If yes, identify. ___ (Welfare = 1 Social Assistance =2)

22. Occupation of primary caregiver at time of inquiry

Professional __
Managerial __
Skilled(trade) __
Unskilled __
Unemployed __
Unknown __
If other, specify _____

Family Information

Parental Information (99 = unknown)

23. Biological mom's age __ (at time of child's birth)
24. Biological father's age __ (at time of child's birth)
25. Mother's age at time of first born __
26. Father's age at time of first born __

27. Country of origin of mother __ (See CAS country codes)
28. Country of origin of father __ (See CAS country codes)

Siblings

29. Number of full biological siblings residing in the home at initial inquiry ___
30. Number of siblings (any type) residing in the home at initial inquiry __
31. Number of siblings overall (any type) __

32. Gender of siblings Males __
Females __

33. Family arrangement at the time of Inquiry

Single care giver (mother) __
Single care giver (father) __
Single parent (never married) __
Birth parents together (common-law) __
Birth parents together (married) __
Step parenting arrangement (bio - Mother) __
Step parenting arrangement (bio father) __
Mother with partner __
Father with partner __
Separated biological parents/joint custody __
Adoption __
Extended Family __
Family Friend __
Foster Parents __

34. Primary caregiver at time of CAS initial inquiry

Mother __
Father __
Extended family __
Family friend __
Partner __
Other __ Specify_____

34 b. Individual identified as presenting greatest risk to child at time of referral.

Mother __
Father __
Extended family __
Family friend __
Mother's Partner __
Father's Partner __
Sibling (any type) __
Teacher/Person in authority __
Health Care Provider __
Babysitter __
Other __ Specify_____

35. Did child experience a death within the primary family? ___ (Yes=1, No=2)

36. If yes, indicate: ___ (Parent/Caregiver =1, Sibling =2,)

History of Prior CAS Intervention of Family and Child

*37.**Number of previous*** **family contacts *with CAS*** *(Prior to most intensive/intrusive disposition)*

0 ___ 1-10 ___ 11-20 ____ 21-30 ___ 31-40 ___ 41-50___ 50-+ ____

38. Number of previous *child implemented* interventions with CAS _ _ (00-99)

39. Number of planned *child* interventions with CAS _ _ (00-99)

40. Has *family* ever been involved in a prior CAS implemented intervention? ___ (Yes=1, No = 2,)

41. If yes, what type of prior CAS intervention? (note: within CAS care)

parent management training __
parent counselling __
child counseling __
Prior placement __
Other (state) __ _____

42. Number of prior *family* contacts with children's services *other than* CAS prior to CAS initial inquiry (Check one)

0 __ 1 -10 ___ 11-20 ____ 21-30 ___ 31-40 ___ 41-50___ 50-+ ____

43. Number of prior *child* contacts with children's services *other than* CAS prior to CAS initial inquiry (Check one)

0 __ 1-10 ___ 11-20 ____ 21-30 ___ 31-40 ___ 41-50___ 50-+ ____

44. Length of Time of CAS Involvement of the Family _ _ _ (Months)

45. Length of Time of CAS Involvement of the Child _ _ _ (Months)

46. Number of Admissions to CAS Residential Care (Check one)

0___ 1-3 ____ 4-6 ___ 7-9 ___ 10-12___ 12-+ ____

47. Previous parental/caregiver contact with CAS

As a child ___
As an adult ___
As a parent ___
Unknown ___

48. Was the biological father ever involved with CAS as a child? ____ (Yes = 1, No = 2, Don't Know =3)

49.If yes, what was the nature of that involvement?

Crown Ward ___
Temporary Care ___
Protection Order ___
Foster Care ___
Group Home ___
Counseling ___
Father's File not accessed ___

50. Was mother ever involved with CAS as a child? ____ (Yes = 1, No = 2, Don't Know =3)

51.If yes, what was the nature of that involvement?

Crown Ward ___
Temporary Care ___
Protection Order ___
Foster Care ___
Group Home ___
Counseling ___
Mother's File not ___
accessed

Child's History with the Mental Health, Young Offender, Educational, Developmental Services System

52. Secondary Assessments Available prior to or coincidental with current CAS Involvement

Mental Health _
Educational _
Medical _
None _
Other _ (state_____)

53. Prior contact with *other* Children's Services

Children's Mental Health __
Young Offender System __
Other (state) __ _____

54. If yes to Young Offender System

Has youth been charged __
Has youth been found guilty __
Was / has diversion been used __
Has there been a prior disposition __
If yes to above was disposition
Secure Custody __
Open Custody __
Probation __
Fine __
Community Restitution __

55. Has child ever been involved with a children's mental health service? __ (Yes= 1; No=2, Don't know =3)

56. If yes, was it

Family counselling __
Individual counselling __
Day treatment __
Inpatient/residential __
Other (state) __ _____

57. Has child been in an out of home placement prior to the current CAS involvement? ___ (Yes= 1; No=2, Don't know =3)

58. If yes, what type

Foster __
Group __
Custody __
Residential Treatment __
Hospital __ (Mental Health Service)
Extended Family __
Other (State) __ _____

59. Is the Childs primary concern one of these: (Select one)

Psychological (emotional) _____
Physiological _____
Behavioral _____
Other (State) _____
None _____

60. Is there evidence to suggest that the child has Attention Deficit Disorder? __ (Yes = 1; No = 2)

61. Is there evidence to suggest that the child Conduct Disorder? ___(Yes = 1; No = 2)

62. Is the child currently on medication, or have they ever been on medication for an adjustment related disorder? ____ (Yes = 1; No = 2,)

63. Is there evidence that the child has repeated a grade? ___ (Yes= 1, No = 2)

64. Has child/youth been expelled from school in the last 12 months? __ (Yes= 1; No= 2)

65. If yes, how many times? __ (99 = doesn't indicate)

66. Has child/youth *ever* been expelled from school? __ (Yes= 1; No= 2)

67. If yes, how many times? __ (99 = doesn't indicate)

68. Has child/youth been suspended from school in the last 12 months? __ (Yes= 1; No= 2)

69. If yes, how many times? __ (99 = doesn't indicate)

70. Has child/youth *ever* been suspended from school? __ (Yes= 1; No= 2,)

71. If yes, how many times? __ (99 = doesn't indicate)

72. Has chronic absence from school been identified? ___ (Yes=1, No = 2)

FAMILY HISTORY OF MENTAL HEALTH AND OTHER CONCERNS

73. Was biological father involved with a children's mental health center? ___ (Yes=1, No=2)

74. Was biological mother ever involved with a children's mental health center? ___ (Yes=1, No=2)

75. Was spousal violence ever an issue? ___ (Yes=1, No=2)

76. Was caregiver to child violence ever an issue? ____ (Yes=1, No=2)

77. Is either caregiver on the child abuse registry? ____ (Yes=1, No=2)

78. Have any of the child's caregivers been convicted of a criminal offense? ___ (Yes=1, No=2)

79. Has primary caregiver been *formally* diagnosed with a major mental disorder? ____ (Yes=1, No=2)

80. If yes, what was the nature of the disorder?

depression __
post partum depression __
anxiety __
bipolar disorder __
schizophrenia __
anti-social personality __
substance abuse __
Other __ (specify _____)

81. Is there file evidence *suggesting* the presence of a major mental disorder (in the absence of a formal diagnosis)? ____ (Yes=1, No=2)

82. If yes, what was the nature of the disorder?

depression __
post partum depression __
anxiety __
bipolar disorder __
schizophrenia __
anti-social personality __
substance abuse __
Other __ (specify _____)

83. Is there a history of a chronic medical condition in the primary caregiver? ___ (Yes=1, No=2)

84. Has family ever been considered homeless? ___ (Yes=1, No=2)

85. Are living conditions viewed as a relevant factor in the child/youth not being discharged from the care of the CAS ____(Yes=1, No=2)

THE FOLLOWING SECTION RELATES TO DEVELOPMENTALLY CHALLENGED CHILDREN (DC) RECEIVING SERVICE *THROUGH THE CAS*

86. Has child *ever* been involved with developmental services programs? ___ (Yes=1; No=2)

87. If yes, at what age did involvement first begin? _ _ (in years; birth = 00)

88. What was the nature of developmental services involvement?

In-home parent support __
Respite care __
Group home __
Other (state) __ _____
N/A __

THE FOLLOWING SECTION RELATES TO MEDICALLY FRAGILE CHILDREN (MFC) RECEIVING SERVICE THROUGH THE CAS

89. Is child considered medically fragile? ____ (Yes = 1; No = 2)

90. If yes, name the disorder. _____

91. Primary reason for referral of medically fragile child

No other available resource __
Diminished parenting capacity __
Request for respite care __
Other (state) __ _____

92. Has MFC previously received service from

Respite care __
Children's Hospital of Western Ontario __
CPRI __
Other residential resource __ Specify _____

Family Immigration

93. Was child exposed to war / trauma prior to immigration? ___(1= Yes; 2 = No)

94. Was there contact with a child welfare agency prior to immigration to Canada?
___ (1= Yes; 2 = No)

95. Length of time in Canada _ _ _ (months)

96. Does family identify itself as:

New Canadian __
Refugee __
Immigrant __
Neither __

CAS Court Involvement

97. Was court litigation required?

Yes __
No __

98. Did the court accept Primary CAS recommendation?

Yes __
No __
N/A __

99. If rejected, reason if any indicated?

_____

_____

Risk Information Summary

Risk Assessment Information (Ratings will be: 4, 3, 2, 1, 0, 9; See manual for detailed description for rating guidelines)

CG1: Caregiver Influence / Abuse – Neglect __
CG2: Caregiver Influence / Alcohol/Drug Use __
CG3: Caregiver Influence /Expectations of Child __
CG4: Caregiver Influence / Acceptance of Child __
CG5: Caregiver Influence /Physical Capacity to Care for Child __
CG6: Caregiver Influence / Mental/Emotional/Intellectual Capacity __

C1: Child's Influence / Child's Vulnerability __
C2: Child's Influence / Child's Response to Caregiver __
C3: Child's Influence / Child's Behaviour __
C4: Child's Influence / Child's Mental Health and Development __
C5: Child's Influence / Physical Health and Development __

F1: Family Influence / Family Violence __
F2: Family Influence / Ability to Cope with Stress __
F3: Family Influence / Availability of Social Supports __
F4: Family Influence / Living Conditions __
F5: Family Influence / Family Identity and Interactions __

I1: Intervention Influence / Caregiver's Motivation __
I2: Intervention Influence / Caregiver's Cooperation with Intervention __

A1: Abuse/Neglect Influence / Access to Child by Perpetrator __
A2: Abuse/Neglect Influence / Intention and Acknowledgement of responsibility __
A3: Abuse/Neglect Influence / Severity of Abuse/Neglect __
A4: Abuse/Neglect Influence / History of Abuse/Neglect Committed by present Caregivers __

100. Overall Risk Assessment __
101. Cumulative Risk Assessment Score (CG1-A4) __ __

102. Cumulative Risk Assessment Score by Social Worker __ __

103. Coder __ (Initials)

Appendix B

Summary of Areas for Risk on the Ontario Risk Assessment Tool

Summary of Areas for Risk on the Ontario Risk Assessment Tool

1. **Caregiver Influence**
   - Abuse/Neglect
   - Alcohol/Drug use
   - Expectations of child
   - Physical capacity to care for child
   - Mental/emotional/Intellectual capacity

2. **Child's Influence**
   - Child's vulnerability
   - Child's response to caregiver
   - Child's behaviour
   - Child's mental health and development
   - Physical health and development

3. **Family Influence**
   - Family violence
   - Ability to cope with stress
   - Availability of social supports
   - Living conditions
   - Family identity and interactions

4. **Intervention Influence**
   - Caregiver motivation
   - Caregiver's cooperation with intervention

5. **Abuse/Neglect**
   - Access to child perpetrator
   - Intention and acknowledgment of responsibility
   - Severity of abuse/neglect
   - History of abuse/neglect committed by present caregivers

Appendix C

Case Plan Outcomes Associated with Kinship Care Questionnaire

Case Plan Outcomes Associated with
Kinship Care
London and Middlesex Children's Aid Society

(Alan W. Leschied, PhD. C. Psych., University of Western Ontario)

Case Number _____

A. Case Plan Follow-up (Three Months)

1. Child Safety

a. Evidence of maltreatment since the last follow-up period
   Yes ____
   No ____

b. If yes, the nature of maltreatment was
   Physical ___
   Neglect ___
   Sexual ___
   Multiple forms of abuse ___
   There was a report but no substantiation of abuse ___
   There was no evidence of abuse ___

2. Child Well-being – School Related

a. Evidence to suggest the child experiences **school-related problems**
   (0= no evidence; 1= mild, 2=moderate, 3=severe). ____

b. Evidence to suggest the child was experiencing **truancy** _____
   (0= no evidence; 1= mild, 2=moderate, 3=severe).

Child Well-being –Behaviour Related

a. Evidence to suggest the child is **physically aggressive** _____
   (0= no evidence; 1= mild, 2=moderate, 3=severe).

b. Evidence to suggest the child is **verbally aggressive** _____
   (0= no evidence; 1= mild, 2=moderate, 3=severe).

c. Evidence to suggest the child abuses **alcohol** _____
   (0= no evidence; 1= mild, 2=moderate, 3=severe).

d. Evidence to suggest the child behaves **destructively** _____
   (0= no evidence; 1= mild, 2=moderate, 3=severe).

e. Evidence to suggest the child is **anxious/fearful/clingy** _____
   (0= no evidence; 1= mild, 2=moderate, 3=severe).

f. Evidence to suggest the child abuses **drugs** _____
   (0= no evidence; 1= mild, 2=moderate, 3=severe).

g. Evidence to suggest the child has **eating difficulties** _____
   (0= no evidence;1= mild, 2=moderate, 3=severe).

h. Evidence to suggest the child **sets fires** _____
   (0= no evidence;1= mild, 2=moderate, 3=severe).

i. Evidence to suggest the child behaves in a **hostile** manner _____
   (0= no evidence;1= mild, 2=moderate, 3=severe).

j. Evidence to suggest the child is **hyperactive** _____
   (0= no evidence; 1= mild, 2=moderate, 3=severe).

k. Evidence to suggest the child **lies compulsively** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).
l. Evidence to suggest the child **behaves manipulatively** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).
m. Evidence to suggest the child is **non-compliant** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
n. Evidence to suggest the child is experiencing **night terrors** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
o. Evidence to suggest the child is **perceptually handicapped** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
p. Evidence to suggest the child has experienced problems with **peers** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
q. Evidence to suggest the child is experiencing **day care-related problems** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
r. Evidence to suggest the child has been deprived **socially** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
s. Evidence to suggest the child **smokes** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
t. Evidence to suggest the child **runs away** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
u. Evidence to suggest the child is **suicidal** or engages in **self-harm behaviours** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
v. Evidence to suggest the child is experiencing **separation anxiety** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
w. Evidence to suggest the child **sexually misbehaves** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
x. Evidence to suggest the child has **sleeping problems** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).
y. Evidence to suggest the child **steals** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
z. Evidence to suggest the child **swears** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).
aa. Evidence to suggest the child experiences **temper tantrums** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).
bb. Evidence to suggest the child behaves **violently** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).
cc. Evidence to suggest the child is **withdrawn or depressed** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).
dd. Evidence to suggest the child is **whinny** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

3. Permanence

a. Has child been placed with biological family _____
(1= yes; 2=no)
b. Has child remained in same placement since previous follow-up _____

(1= yes; 2=no)

c. If child has been moved to another placement since previous follow-up – how many changes have occurred ___ ___
(does not include a return to the biological family)
(00-99)

4. Family and Community Support

a, Has family moved since last follow-up _____
(1= yes; 2=no)

b. If yes to above, how many moves ___ ___
(00-99)

c. Has child moved schools since last follow-up _____

d. If yes to above, how many school moves ___ ___
(00-99)

f. If child was removed from home, was an attempt made to place them within their

i. geographic community ____

ii. ethno-cultural background ____

iii. foster care inclusive within their families and friends ____

B. Case Plan Follow-up (Six Months)

1. Child Safety

a. Evidence of maltreatment since the last follow-up period
Yes ____
No ____

b. If yes, the nature of maltreatment was
Physical ___
Neglect ___
Sexual ___
Multiple forms of abuse ___
There was a report but no substantiation of abuse ___
There was no evidence of abuse ___

2. Child Well-being – School Related

a. Evidence to suggest the child experiences **school-related problems**
(0= no evidence; 1= mild, 2=moderate, 3=severe). ____

b. Evidence to suggest the child was experiencing **truancy** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

Child Well-being –Behaviour Related

a. Evidence to suggest the child is **physically aggressive** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

b. Evidence to suggest the child is **verbally aggressive** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

c. Evidence to suggest the child abuses **alcohol** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

d. Evidence to suggest the child behaves **destructively** _____

(0= no evidence; 1= mild, 2=moderate, 3=severe).

e. Evidence to suggest the child is **anxious/fearful/clingy** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

f. Evidence to suggest the child abuses **drugs** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

g. Evidence to suggest the child has **eating difficulties** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).

h. Evidence to suggest the child **sets fires** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).

i. Evidence to suggest the child behaves in a **hostile** manner _____
(0= no evidence;1= mild, 2=moderate, 3=severe).

j. Evidence to suggest the child is **hyperactive** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

k. Evidence to suggest the child **lies compulsively** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).

l. Evidence to suggest the child **behaves manipulatively** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).

m. Evidence to suggest the child is **non-compliant** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

n. Evidence to suggest the child is experiencing **night terrors** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

o. Evidence to suggest the child is **perceptually handicapped** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

p. Evidence to suggest the child has experienced problems with **peers** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

q. Evidence to suggest the child is experiencing **day care-related problems** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

r. Evidence to suggest the child has been deprived **socially** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

s. Evidence to suggest the child **smokes** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

t. Evidence to suggest the child **runs away** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

u. Evidence to suggest the child is **suicidal** or engages in **self-harm behaviours** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

v. Evidence to suggest the child is experiencing **separation anxiety** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

w. Evidence to suggest the child **sexually misbehaves** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

x. Evidence to suggest the child has **sleeping problems** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).

y. Evidence to suggest the child **steals** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

z. Evidence to suggest the child **swears** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).

aa. Evidence to suggest the child experiences **temper tantrums** _____

(0= no evidence;1= mild, 2=moderate, 3=severe).

bb. Evidence to suggest the child behaves **violently** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).

cc. Evidence to suggest the child is **withdrawn or depressed** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).

dd. Evidence to suggest the child is **whinny** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

3. Permanence

a. Has child been placed with biological family _____
(1= yes; 2=no)

b. Has child remained in same placement since previous follow-up _____
(1= yes; 2=no)

c. If child has been moved to another placement since previous follow-up – how many changes have occurred ___ ___
(does not include a return to the biological family)
(00-99)

4. Family and Community Support

a, Has family moved since last follow-up _____
(1= yes; 2=no)

b. If yes to above, how many moves ___ ___
(00-99)

c. Has child moved schools since last follow-up _____

d. If yes to above, how many school moves ___ ___
(00-99)

f. If child was removed from home, was an attempt made to place them within their

i. geographic community ____

ii. ethno-cultural background ____

iii. foster care inclusive within their families and friends

C. Case Plan Follow-up (Twelve Months)

1. Child Safety

a. Evidence of maltreatment since the last follow-up period
Yes ____
No ____

b. If yes, the nature of maltreatment was
Physical ___
Neglect ___
Sexual ___
Multiple forms of abuse ___
There was a report but no substantiation of abuse ___
There was no evidence of abuse ___

2. Child Well-being – School Related

a. Evidence to suggest the child experiences **school-related problems** (0= no evidence; 1= mild, 2=moderate, 3=severe). ____

b. Evidence to suggest the child was experiencing **truancy** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

Child Well-being –Behaviour Related

a. Evidence to suggest the child is **physically aggressive** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

b. Evidence to suggest the child is **verbally aggressive** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

c. Evidence to suggest the child abuses **alcohol** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

d. Evidence to suggest the child behaves **destructively** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

e. Evidence to suggest the child is **anxious/fearful/clingy** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

f. Evidence to suggest the child abuses **drugs** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

g. Evidence to suggest the child has **eating difficulties** _____ (0= no evidence;1= mild, 2=moderate, 3=severe).

h. Evidence to suggest the child **sets fires** _____ (0= no evidence;1= mild, 2=moderate, 3=severe).

i. Evidence to suggest the child behaves in a **hostile** manner _____ (0= no evidence;1= mild, 2=moderate, 3=severe).

j. Evidence to suggest the child is **hyperactive** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

k. Evidence to suggest the child **lies compulsively** _____ (0= no evidence;1= mild, 2=moderate, 3=severe).

l. Evidence to suggest the child **behaves manipulatively** _____ (0= no evidence;1= mild, 2=moderate, 3=severe).

m. Evidence to suggest the child is **non-compliant** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

n. Evidence to suggest the child is experiencing **night terrors** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

o. Evidence to suggest the child is **perceptually handicapped** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

p. Evidence to suggest the child has experienced problems with **peers** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

q. Evidence to suggest the child is experiencing **day care-related problems** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

r. Evidence to suggest the child has been deprived **socially** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

s. Evidence to suggest the child **smokes** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

t. Evidence to suggest the child **runs away** _____ (0= no evidence; 1= mild, 2=moderate, 3=severe).

u. Evidence to suggest the child is **suicidal** or engages in **self-harm behaviours** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
v. Evidence to suggest the child is experiencing **separation anxiety** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
w. Evidence to suggest the child **sexually misbehaves** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).
x. Evidence to suggest the child has **sleeping problems** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).
y. Evidence to suggest the child **steals** _____
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(0= no evidence;1= mild, 2=moderate, 3=severe).
bb. Evidence to suggest the child behaves **violently** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).
cc. Evidence to suggest the child is **withdrawn or depressed** _____
(0= no evidence;1= mild, 2=moderate, 3=severe).
dd. Evidence to suggest the child is **whinny** _____
(0= no evidence; 1= mild, 2=moderate, 3=severe).

3. Permanence

a. Has child been placed with biological family _____
(1= yes; 2=no)
b. Has child remained in same placement since previous follow-up _____
(1= yes; 2=no)
c. If child has been moved to another placement since previous follow-up – how many changes have occurred ___ ___
(does not include a return to the biological family)
(00-99)

4. Family and Community Support

a, Has family moved since last follow-up _____
(1= yes; 2=no)
b. If yes to above, how many moves ___ ___
(00-99)
c. Has child moved schools since last follow-up _____
d. If yes to above, how many school moves ___ ___
(00-99)
f. If child was removed from home, was an attempt made to place them within their
i. geographic community ____
ii. ethno-cultural background ____
iii. foster care inclusive within their families and friends

Appendix D

Quality of Kinship Care Protocol

File Number _____

Quality of Kinship Care Protocol

(Adapted from Chipman, R., Wells, S.J. & Johnson, M.A. (2002). The meaning of quality in kinship foster care: Caregiver, child, and worker perspectives. *Families in Society*, 83, 5/6, 508-520)

The purpose of this Protocol is to provide a rating of the extent to which the Kinship Care placement is related to factors consistent with a successful placement for the child. When indicating a score relative to each item, consider the extent to which the care giver is able to work toward a successful experience for the child while in placement that would lead to reunification with the child's natural parent(s).

For each item the scale ranges from 1 to 7

The anchor points for the scale are as follows:

1 - the placement is **not supportive** of a successful placement and reunification

4 - the placement is considered **neutral** in supportiveness and oriented toward reunification

7 - the placement is both **extremely supportive** of the child's placement and **extremely supportive** of reunification

1. **The caregiver shows willingness to work towards reunification**

   1 2 3 4 5 6 7

2. **The caregiver is motivated to work towards reunification**

   1 2 3 4 5 6 7

3. **The caregiver demonstrates a commitment to care for the child as long as necessary**

   1 2 3 4 5 6 7

4. **The caregiver demonstrates the capacity to protect the child from the biological parent**

   1 2 3 4 5 6 7

5. **The caregiver believes the maltreatment allegations against parent**

   1 2 3 4 5 6 7

6. **The caregiver has a family history reflecting the ability to provide high quality care for the child**

   1 2 3 4 5 6 7

7. **Protective services checks are provided on a routine basis**

   1 2 3 4 5 6 7

8. **Criminal records checks have been provided don the caregiver**

   1 2 3 4 5 6 7

9. **The child knows and has an existing relationship with the caregiver's children**

   1 2 3 4 5 6 7

10. **The caregiver's age relative to the child's needs is not a barrier to providing a consistent supportive relationship with the child**

    1 2 3 4 5 6 7

11. **The caregiver's health is not a problem relative to the child's needs**

    1 2 3 4 5 6 7

12. **The caregiver has a capacity to provide love towards the child**

    1 2 3 4 5 6 7

13. The caregiver demonstrates patience towards the child

1 2 3 4 5 6 7

14. The caregiver likes children

1 2 3 4 5 6 7

15. The caregiver is respectful towards children

1 2 3 4 5 6 7

16 The caregiver does not have a temper

1 2 3 4 5 6 7

17. The caregiver has a job

1 2 3 4 5 6 7

18. The caregiver has a child rearing history consistent with being a supportive parent

1 2 3 4 5 6 7

19. The caregiver demonstrates the capacity to provide stability and security

1 2 3 4 5 6 7

20. The child is allowed to bring possessions in to the caregiver's home

1 2 3 4 5 6 7

21. The caregiver demonstrates the capacity to provide structure and rules

1 2 3 4 5 6 7

22. The caregiver demonstrates the capacity to provide moral and spiritual guidance

1 2 3 4 5 6 7

23. The caregiver demonstrates the capacity to provide the child with direct supervision / daycare

1 2 3 4 5 6 7

24. The caregiver demonstrates the capacity and willingness to follow agency rules regarding discipline

1 2 3 4 5 6 7

25. The caregiver demonstrates the capacity to provide an adequate diet for the child

1 2 3 4 5 6 7

26. The caregiver demonstrates the capacity to provide adequate housing

1 2 3 4 5 6 7

27. The caregiver resides in a neighbourhood favourable for safety and supportiveness of the child

1 2 3 4 5 6 7

28. The caregiver demonstrates the capacity to provide basic safety

1 2 3 4 5 6 7

29. The caregiver has the ability to provide transportation

1 2 3 4 5 6 7

30. The caregiver has the financial capacity to provide for the child

1 2 3 4 5 6 7

31. The caregiver has a general family relationship supportive of the child's well-being

1 2 3 4 5 6 7

32. There is an absence of fighting or domestic violence in the caregiver's home

1 2 3 4 5 6 7

33. The caregiver is not involved in substance abuse

1 2 3 4 5 6 7

34. There is evidence for the availability of community and extended support for the placement

1 2 3 4 5 6 7

35. The caregiver demonstrates a commitment to the child

1 2 3 4 5 6 7

36. The caregiver sets boundaries with the birth parent

1 2 3 4 5 6 7

37. The caregiver has a relationship with the birth parent

1 2 3 4 5 6 7

38., The caregiver provides emotional support to the child

1 2 3 4 5 6 7

39. The caregiver insures that the child receives an education

1 2 3 4 5 6 7

40. The caregiver gives the child chores and responsibilities

1 2 3 4 5 6 7

41. The caregiver provides rules and structure

1 2 3 4 5 6 7

42. The caregiver insures that the child participates in age-appropriate extracurricular activities

1 2 3 4 5 6 7

43. The caregiver does not denigrate the birth parent

1 2 3 4 5 6 7

44. The caregiver participates in religious activity

1 2 3 4 5 6 7

45. The caregiver provides adequate supervision

1 2 3 4 5 6 7

46. The caregiver provides basic care

1 2 3 4 5 6 7

47. The caretaker insures that the child has adequate clothing

1 2 3 4 5 6 7

48. The caregiver insures that the child is healthy

1 2 3 4 5 6 7

49. The caregiver insures that the child's health and social service needs are met

1 2 3 4 5 6 7

50. The caregiver insures that the child has personal space in the household

1 2 3 4 5 6 7

51. The caregiver's interactions with the child are positive

1 2 3 4 5 6 7

52. There is evidence that the child uses kinship term to relate to the caregiver

1 2 3 4 5 6 7

53. There is evidence that the child expresses gratitude to the caregiver

1 2 3 4 5 6 7

54. There is evidence that the caregiver's attitude toward the child is positive

1 2 3 4 5 6 7

55. There is evidence that the caregiver treats the child like other children in the household

1 2 3 4 5 6 7

56. The caregiver insures that the child's integration within the household si successful

1 2 3 4 5 6 7

Appendix E

Thesis Proposal Approval