

# A Framework of Practice for Implementing a Kinship Care Program

FINAL REPORT

Report for:  
The Benevolent Society

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## Executive Summary

The aim of this study is to provide a framework to guide the implementation of statutory kinship services by the Benevolent Society. The countries included in the study are Australia, Canada, New Zealand, Norway, United Kingdom and United States of America.

In the first stage of the study the key focus of the study was on consultations with stakeholders and reviewing the literature on models and tools exemplifying ‘good’ ‘best’ or ‘promising’ practice in kinship care. Given the lack of evidence base around many of the models and tools discussed in this report the advantages and disadvantages of most models and tools, at this stage, is judged to be speculative. The emphasis in the report therefore is on promising practices and key messages from the field.

The second stage of the study involved four focus groups with kinship carers. The aim of the groups was to obtain the perspectives of kinship carers in relation to a number of specific aspects of kinship care. The main aspects of kinship care reviewed in the literature, and considered by stakeholders and carers in the focus groups, included:

- family group conferencing;
- carer assessment;
- carer training;
- carer support (financial)
- carer support (non-financial);
- contact and access; and
- carer support groups.

Attention was also paid in the study to research around birth parents of children in kinship placements, children in kinship care, and training for workers in kinship care.

*Family Group Conferencing:* Jurisdictions in all countries support as ‘good’ practice the model of family group conferencing or family decision making when children are being taken into care and throughout the child’s placement when decisions are being made. National and international research indicates that conferencing or meetings are important to enable families and young people, with the assistance of trained staff, to reach a consensus on the most appropriate kinship care placement. There is also evidence that agencies benefit from a dedicated worker specialising in kinship placements. The use of genograms and family mapping, undertaken in the early stages of the care proceedings, is also strongly supported as part of the family group conferencing process. In relation to the placement of Indigenous children promising practice is the use of specific Aboriginal family decision making models (VACCA, 2008a).

*Carer assessment:* The assessment process for relative/kinship carers is highly variable across Australian jurisdictions with a number of States currently (April, 2009) developing new assessment tools. A number of tools used for assessing kinship carers in Australian and elsewhere appear to be variations or adaptations of tools used for assessing foster carers. Researchers suggest that a specific assessment tool that is sensitive, inclusive, and respectful of the skills and knowledge of a kinship carer be given consideration. UK research suggests that central to the assessment process is the

identification of needs and the creation of a service package (i.e. case plan) that must be followed up by regular supervision and regular review meetings (Hunt, 2008; O'Brien, 2001; Waterhouse 2001).

In discussing the assessment of carers for Aboriginal children several stakeholders/consultants emphasise the importance of including an Aboriginal worker/agency in the decision-making process and to give particular attention to the views and preference of Aboriginal birth parents in relation as to who is to care for the child. The use of cultural support plans supporting Indigenous children's identity and connection to their land and culture is also seen as good practice.

*Carer training:* It is clear from the discussion around training that most workers, agencies and organisations regard training as critical in assisting kinship carers to increase their skills and knowledge. There is much debate over 'how' and 'when' training should be initially provided but there is strong support that training needs to be ongoing to meet the fluidity of needs of kin children and carers. Foster carer training is supported as a model of good practice for kinship carers. The issue of specific training to support Indigenous and non-Indigenous kinship carers is highlighted.

*Carer financial support:* Relative/kinship carers in all Australian jurisdictions (where the child is under guardianship to the State) are provided with the same level of allowances as foster carers. In most other jurisdictions (except UK and US) statutory kinship carers are provided with the same level of carer allowance provided to foster carers. It also appears that in several jurisdictions carer are eligible for reimbursement of costs for various goods and services.

*Carer non-financial support:* In the literature there appears to be widespread agreement that all statutory kinship placements should be supported and supervised. There is some debate as to whether all kinship families require the same level of support. Providing kinship carers with adequate information about roles, responsibilities and entitlements is seen as essential. The reality, that it is 'family' who provides the care, appears to influence how both carers and workers perceive kinship care and the support that is 'offered' (or not) by workers and 'accepted' (or not) by families. Research indicates that most kinship care placements benefit from access to services, including respite services (e.g. child care, social/recreational activities and camps).

*Contact:* In both the literature and consultations with stakeholders contact between carers and birth parents is seen as the most problematic area of kinship care. Contact is generally perceived as 'difficult' when relationships between carers and birth parents are poor or acrimonious. Research indicates that when family relationships are positive contact helps with placement stability; and is beneficial to children's emotional and social development. In relation to decision-making around contact it is important to consider the views of both children and birth parents. To ensure the safety of children and carers in some placements supervised access visits in suitable venues should be offered to kinship carers.

*Support groups:* Support groups for grandparent raising their grandchildren and other kinship carers have become widespread throughout all the countries examined in this report. The nature, size and activities for group members are highly variable. The

concept of 'self-help' is a strong component of the groups. Some groups are voluntary and informal and some form part of a community program with paid facilitators. In general grandparents appear to gain significant benefits by belonging and participating in a group. The groups can serve a number of functions including providing training and information forums to assist/support grandparents and other relative/kinship carers. From the limited information available for this study it appears that more thought needs to be given to finding a suitable alternative to 'support groups' for Aboriginal kinship families.

*Birth family research:* While there is limited research on birth families whose children are in kinship care there is a clear message that birth parents need to be involved and supported to maintain an ongoing relationship with their children. The critical importance of strengthening and supporting the birth parents of Indigenous children after they have been removed to ensure that the child can maintain their connection to family is also noted.

*Young people in kinship care research:* The importance of researchers engaging with young people in kinship care is highlighted in a number of studies. The benefits for young people in care being with 'family' were substantial. A number of negative aspects were however perceived by young people and require consideration. The important observation made by young people in a stakeholder's forum and a manager from an Aboriginal agency that kinship care is not an appropriate option for all children and young people requiring an out-of home care placement needs to be heeded.

*Training for kinship workers:* This study could find little evidence (except for cultural training for non-Indigenous workers supervising/monitoring Indigenous kinship placements) that there is any specific training for workers providing statutory kinship care services in Australia. The need for training for workers in several areas, in addition to an attitudinal change in developing better relationships with kinship/relative carers, is highlighted in a number of UK and US studies. The importance of specific training for non-Indigenous staff working with Indigenous families is addressed in three key documents (Victorian Government, 2008; Bamblett and Lewis 2007; Hutchins et al., 2007).

*Focus groups with kinship carers:* Four focus groups were conducted with kinship carers – two Indigenous and two non-Indigenous.<sup>1</sup> Two groups were conducted in south west of Sydney and two were held in regional areas of NSW. In total, 36 carers attended the four groups. Kinship carers in the groups were a diverse collection of formal and informal carers.

Family group conferencing or family decision making had not been a process experienced by any carer in the groups. In relation to assessment some carers were assessed early in the placement while others were assessed, sometimes years later, when they applied for financial support from DoCS. Some carers were not assessed at all. Few of the assessed carers had an allocated caseworker. For carers with case plans

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<sup>1</sup> The attendance by Aboriginal kinship carers at the two groups was low - only four carers in total. Due to the small numbers a separate analysis was not conducted on the data from the Aboriginal carers.

few were happy with their implementation. Many carers expressed a need for more than phone contact with a caseworker. For carers, who at some period had an allocated caseworker, the caseworker's support was appreciated and valued. No carer had been provided with a Resource Guide when they became kinship carers.

Carers who had a better understanding of the 'system' were those who had received either the initial foster carer training (*Shared Stories Shared Lives*) or ongoing foster care training (e.g. seminars/forums). These carers also had a better sense of identity as a 'carer' than others who were quite wary of being perceived as a 'carer' or having any connection with DoCS. The numbers of Aboriginal carers at the groups were too few to make any specific suggestions around training for Aboriginal kinship carers.

Access to the *Supported Care Allowance* was seen as a bonus for the kinship carers who received it and was highly valued. In relation to services, while the provision/access was highly variable, some carers were more than satisfied with the services they had received through DoCS and other agencies. Due to long waiting lists for public services other carers were struggling to meet the needs of the children in their care.

Using respite services was a contentious issue for grandparent carers. Some carers (often of younger grandchildren) were reluctant to take advantage of a 'break', unless it was with another family member, or someone the children already knew. For older children, camps and vacation care provided necessary reprieves for carers, while camps for the whole kinship family were appreciated by other carers. Being able to access home help was seen as a benefit to carers as it would ease the burden of additional housework and cooking caused when children came to live in their home. The provision of childcare, either through the Department of Community Services (DoCS) or the Commonwealth, assisted carers in paid employment. Even with access to child care, some carers were prevented from continuing their paid work due to the number of children in their care, needing to moving to another area, or being unable to maintain two roles - that of a paid and unpaid worker (i.e. a carer).

Contact with birth parents for kinship carers was mixed. It worked well when family relationships were good. Where family relationships were acrimonious, or other grandparents of siblings (with different fathers or mothers) contested custody/contact orders, access was more problematic. Infrequent or non-existent contact occurred when either a parent (or parents) was incarcerated or when a parent (or parents) simply made no attempt to keep in touch. Some carers noted the necessity for supervised contact visits, either because of fears for the child's (or carer's) safety, or because carers were fearful that children would be 'taken' from their care when on a contact visit.

The discussion with carers around same or different treatment compared to foster carers found one group in favour of all carers being treated the same while another group wanted separate treatment as kinship carers. A third group thought the issue was not about same or separate treatment it was more about how all carers should be treated. If the baseline was 'equal' treatment for all carers then nuances and subtleties, based on circumstances and needs should apply, not the title 'kinship' or 'foster', in front of the name 'carer'.

For carers who belonged to and regularly attended a support groups there was a sense of camaraderie, understanding and shared knowledge among the carers. The ‘support’ of most value to carers in groups, was being able to let ‘everything’ out, share their experiences, and to know that their stories would be listened to uncritically.



## Glossary

<b>AbSec</b>	Aboriginal Child, Family & Community Care State Secretariat (NSW).
<b>ACPP</b>	Aboriginal Child Placement Principle.
<b>ACT</b>	Australian Capital Territory.
<b>BAAF</b>	British Association for Adoption and Fostering.
<b>CFP</b>	Casey Family Programs.
<b>CWLC</b>	Child Welfare League of Canada.
<b>CAS</b>	Children's Aid Society (Canada).
<b>CYF</b>	Children, Youth and Family.
<b>CWLA</b>	Children's Welfare League of America.
<b>CSC</b>	Community Service Centre.
<b>CSO</b>	Community Service Organisations.
<b>DCSF</b>	Department for Children Schools and Families.
<b>DoCS</b>	Department of Community Services, New South Wales.
<b>DFC</b>	Department of Families and Communities.
<b>DHHS</b>	Department for Health and Human Services, Tasmania
<b>DHS</b>	Department of Human Services, Victoria.
<b>FIN</b>	Family Inclusion Network
<b>FGP</b>	Family Group Conferencing.
<b>FDM</b>	Family Decision Making.
<b>FHS</b>	Foster Home Services.
<b>GRG</b>	Grandparent Raising Grandchildren (Tas)
<b>GRG Trust</b>	Grandparents raising Grandchildren Charitable Trust (NZ)
<b>NT</b>	Northern Territory.
<b>NSW</b>	New South Wales.
<b>OOHC</b>	Out-of-home care.
<b>PANOC</b>	Physical Abuse and Neglect of Children, a community-based child-protection therapy team.
<b>PRIDE</b>	Pre-Service Training for Prospective Resource Families.
<b>QATSICCP</b>	Queensland Aboriginal and Torres Strait Islander Child Protection Partnership.
<b>Qld</b>	Queensland.
<b>SA</b>	South Australia.
<b>SNAICC</b>	Secretariat of National Aboriginal and Islander Child Care.
<b>SPRC</b>	Social Policy Research Centre.
<b>SNCC</b>	Springwood Neighbourhood Community Centre
<b>Tas</b>	Tasmania.
<b>Triple P</b>	Positive Parenting Program.
<b>tFN</b>	the Fostering Network (UK)
<b>UK</b>	United Kingdom
<b>US</b>	United States
<b>VACCA</b>	Victorian Aboriginal Child Care Association
<b>Vic</b>	Victoria.
<b>WA</b>	Western Australia.

# 1 Introduction and Background

## 1.1 Introduction: The research project

This study examines models of statutory kinship care in Australia and in a number of selected countries. Statutory (formal) kinship care is defined as court-ordered out-of-home care (OOHC) by extended family members, friends or members of a child's tribe or clan. It was commissioned by the Benevolent Society and undertaken by a researcher based at the Social Policy Research Centre (SPRC) at the University of New South Wales. The study commenced in March 2009 and was completed in June 2009.

Until 2009 the Department of Community Services (DoCS) was one of the main providers of statutory relative/kinship care services in NSW, with a small number of Aboriginal child care agencies providing similar services for Aboriginal families. The Benevolent Society is one of the first non-government agencies in NSW to receive funding to implement a kinship care program for Indigenous and non-Indigenous children in statutory kinship care.

## 1.2 The purpose of this project

The aim of the project is to examine models of kinship care in Australian jurisdictions and in a small number of other countries – Canada, New Zealand, Norway and the United Kingdom – in order to identify examples of 'promising' or 'best' practice. Of importance in the study are the tools (e.g. kinship care assessment tool) and frameworks used in assessing/approving and supporting statutory kinship care placements.

## 1.3 Background to the project

Statutory or formal kinship care is the fastest growing form of out-of-home care (OOHC) placement in Australia and internationally (DoCS, 2007; Spence, 2004). Despite its increasing use in Australia there is very little Australian research evidence supporting its use as a statutory OOHC option (Mackiewicz, 2009). A recent survey of statutory kinship carers (n=50) by the Department of Human Services (DHS) in Victoria highlighted some of the issues, difficulties and ways of coping by kinship carers (DHS, 2007b). The areas identified by the carers were broad-ranging and, in summary, included the following aspects:

- *When placements were being decided, carers required:* realistic appraisals of the demands and impact of the placement; scoping of the child's future needs; knowledge about handling family reactions and future family relationships; and understanding of the birth parents' involvement and contact.
- *Carers noted a number of difficulties in kinship care:* financial stresses; changes in lifestyle; demands on time/energy; managing family relationships; accessing services (e.g. respite, information on rights/responsibilities); finding carer groups; meeting children's needs; and arranging/supervising contact with birth parents.
- *What worked well for carers in placements:* ability to provide normality/boundaries/love for a child; providing family connections/identity for a child; involvement of the wider family in discussions/planning; extended family's support (emotional/practical); well-managed contact with birth

parents (including monitored access centres); and specific supports/services for children and support/services (e.g. parenting programs) for birth parents.

- *What carers wanted from workers*: maturity, experience, understanding and respect; appreciation of a carer's situation/story; understanding the carer's mixed emotions/divided loyalties with parents and grandchildren; ability to involve extended family in decisions/planning; and an understanding of drug/alcohol addiction.
- *Where carers went for help* (in order of priority): schools and health centres; support groups; social workers; information sites (e.g. booklets/websites; phone contact; and mental health and drug services (DHS, 2007b: 20-24).

Echoing many of the Victorian carers' responses above, an overview by Mackiewicz (2009) of studies in the United Kingdom (UK) and the United States of America (US) found substantial benefits for children and young people in kinship care, including:

- feeling loved, cared for and valued;
- maintaining a sense of identity and belonging and feeling settled because they were with family;
- more stable placements than for children placed with foster carers;
- fewer placement moves; and
- maintenance of contact with family and friends (Mackiewicz, 2009: 2).

In relation to what kinship carers required from child welfare departments/agencies, Mackiewicz (2009) also found similarities with the Victorian research. Carers wanted:

- acknowledgment and recognition for what they do;
- access to the same services as foster carers;
- improved information and transparent criteria for services; and
- adequate financial support (Mackiewicz, 2009: 3).

Despite the fact that kinship care is widely perceived to be beneficial for children and young people, it is acknowledged by scholars nationally and internationally that there is limited research evidence that children and young people achieve better long-term outcomes by being placed in kinship rather than in foster care. However, recent studies have been strongly supportive of its use in relation to a number of specific short- to medium-term outcomes for children and young people.

One study involving a world-wide review of 62 studies looked at outcomes for children in both forms of statutory care, foster and kinship care. The aim of the project was to determine if the studies could tell which kind of placement was better. The researchers found evidence suggesting that the children in kinship care did better in behavioural development, mental health functioning, and placement stability, while the children in foster care had better permanency outcomes and better access to the services they need (Winocur, Holton and Valentine, 2009: 4).

The writers suggested consideration be given to increased levels of caseworker involvement and service delivery, in order to make kinship care more effective. They argued, however, that this must be weighed against kin caregivers' independence, as many resented the fact that child welfare departments were involved in their lives. While the researchers were supportive of the use of kinship care, they also supported the continuing use of foster care. They argued that foster care was a viable and

essential OOHC option for children where kinship care was not in the best interests of the child or family (Winocur, Holton and Valentine, 2009).

The writers also found that “kinship care is faced with its fair share of controversial issues”, including inequitable levels of support, both financial and non-financial (e.g. services); contentious carer assessment and approval processes (licensing); ad hoc approaches to supervision/monitoring of placements; and a lack of guidelines around contact between children and their birth parents (Winocur, Holton and Valentine, 2009).

A second US study on outcomes for children, conducted by the Centre for Law and Social Policy (Conway and Hutson, 2007) found in favour of kinship care. The research found that, in comparison with children placed in foster care, children placed with kinship carers:

- had fewer placement changes;
- were more likely to be kept with their siblings;
- were less likely to re-enter foster care after periods of being reunited with their birth parents;
- had better scores on a range of physical, cognitive and skill-based domains;
- had more positive perceptions of their placements; and,
- tended to be rated by teachers and carers with fewer behavioural problems (Conway and Hutson, 2007: 3-5).

A study conducted in the UK (Farmer and Moyers, 2008) also compared the effects of kin and foster care placements. The study involved 270 children (141 kin and 128 foster placements), and found that children placed with family and friends (kinship care) did just as well as those placed with general foster carers. The children were shown to be doing well and to be happy to be with members of their families, with the important advantage that their placements lasted longer.

There are a number of other studies of kinship care, however, that have found that, despite the benefits for children, “outcomes” for kinship carers are not always positive. There are systemic issues and concerns more generally that can have a negative impact on kinship carers (Broad, 2004; Farmer and Moyers 2008; Laws, 2001; Nixon, 2007, 2008; Wheal, 2001; Winocur, Holton and Valentine, 2009). As well as the issues identified by Winocur, Holton and Valentine (2009) (see above), a number of research studies in the UK have found that kinship carers were often:

- the child’s grandparents (usually single maternal grandmothers) (Farmer and Moyers, 2008; Hunt, 2008; Nixon, 2007);
- older and poorer than most foster carers (Nixon, 2007);
- in poorer health compared to most foster carers (Hunt, 2008; Nixon, 2007);
- less knowledgeable about child development and modern parenting practices (Nixon, 2007);
- receiving less support (financial and non-financial) than foster carers (Nixon, 2007; Tapsfield, 2001);
- less well-educated and more disadvantaged (Hunt, 2008); and
- experiencing financial hardship and overcrowding (Hunt, 2008).

Nonetheless, kinship carers were highly committed to the care of their grandchildren (Nixon, 2007). Broad (2004) found most kinship carers (42) valued kinship care because of their close ties to and love for the young person, a desire to support the birth parents, and a belief that kin care was the best option for children. This writer also found that “Kinship carers valued social work support and wanted more, not less, contact with social services” (Broad 2004: 220). While acknowledging the benefits they and the children gained, all carers mentioned negative aspects of full-time caring, for example:

- insufficient money;
- loss of lifestyle;
- overcrowding;
- problems due to age or ill- health; and
- having to manage the challenging behaviours of the children (Broad, 2004).

Another UK study involving 10 kin carers found that they had experienced difficulties with their own children (e.g. jealousy, quarrelling), and that they had had trouble coping with the challenging behaviours of the children and with the demanding nature of caring. The ongoing contact with birth parents was also problematic for some children. Several carers expressed anger about the mother’s inconsistent behaviour (i.e. missing visits) and the way it affected the children deeply (Laws, 2001: 117-119).

*Observation:* Due to the limited number of Australian kinship care studies, it is not possible to say unequivocally that the issues and concerns for Australian children and kinship carers are the same as those found in other western countries. Countries have different legislation, child care services, socio-economic pressures, history and culture, and hence may take different approaches to developing models, tools and frameworks for the provision of statutory kinship care. It is more than likely, however, that approaches taken in different countries to carer assessment and training, financial support, service provision and contact/access arrangements with birth family members, would share a number of common elements. It is in the context of assuming there are a number of shared perspectives with other jurisdictions, that this framework guiding the implementation of kinship care services in NSW by The Benevolent Society is outlined.

#### **1.4 Methodology**

This section of the report discusses the methodological approach taken in the study. It was a short, intensive project (12 weeks) and a mixed methods approach was adopted, with data from three separate sources: selected literature; consultations/interviews with key stakeholders; and focus groups with carers.

The Benevolent Society worked in partnership with the Aboriginal Child, Family & Community Care State Secretariat (AbSec) (NSW) to ensure the methodology and approach was appropriate for Indigenous people. AbSec is an incorporated not-for-profit community organisation. Among its various roles it auspices the Aboriginal Statewide Foster Care Support Service that provides foster/kinship carer support groups and maintains a register of Indigenous foster and kinship carers.

The project had two stages. The first consisted of an overview of selected literature from Australia, Canada, New Zealand and Norway, focusing on recent (2000-2009)

material concerned with kinship care policy and practice, both nationally and internationally. The studies and material were drawn from a number of sources including published/unpublished material in Australia, UK, US, Canada and New Zealand, as well as internet-based information. Due to time limitations, only selected literature was used to examine the provision of kinship care services in the UK. Moreover, initially the project was not intended to include examples of ‘promising’ or ‘best’ practice in the US. But in the course of the research it became apparent that two specific publications were of value in considering tools (e.g. kinship care assessment) and frameworks for assessing/approving/supporting statutory kinship care placements: Casey Family Programs (CFP) (2007) *Supporting Kinship Care: Promising Practices and Lessons Learned*; and Child Welfare League of America (CWLA) (2000) *Standards of Excellence for Kinship Care Services*.

In addition, this first stage involved consultations about ‘best’ practice with a number of stakeholders (organisational representatives) in the named countries. For Australia they included staff in child-welfare departments in most state and territory governments; staff in Indigenous and non-Indigenous OOHC services (agencies); and facilitators of support groups for kinship carers. Other stakeholders consulted for the project were from New Zealand, Canada and Norway.

The study was not intended to audit kinship care policy and practice exhaustively on a state-by-state or country-by-country basis. The objective was to ascertain what could be discovered about the current status of statutory kinship care policy and practice through contacts in each state/country and selected literature.

The key focus was on models and tools exemplifying ‘good’ ‘best’ or ‘promising’ practice in kinship care. But given the lack of evidence for many of the practice models and tools examined in the study, any suggestions about their advantages and disadvantages can only be speculative at this stage. So rather than focusing on ‘best’ practice as such, this study can do no more than highlight promising practice and key messages from the research.

Time limitations precluded writing up a separate review of the most recent research literature. Instead, findings from the national and international research studies and other material are woven throughout the sections of the report where it is most appropriate and relevant to do so. There were multiple sources of knowledge, evidence and experience identified as important in kinship care, and these were used to develop a framework, based on promising practices and key messages, to guide the Benevolent Society in the implementation processes of its kinship care program.

The second stage of this project involved four focus groups, two with Indigenous and two with non-Indigenous carers in the Sydney metropolitan area and in a regional area of NSW. The aim of the focus groups was to obtain the perspectives of kinship carers in relation to a number of specific aspects of kinship care.

The main aspects of kinship care considered in the focus groups included:

- family group conferencing;
- carer assessment;
- carer training;
- carer support (financial)

- carer support (non-financial);
- contact and access; and
- carer support groups.

The research project was approved by the University of New South Wales Human Research Ethics Committee.

### **Sampling techniques**

The sampling strategies used in this project included:

- a 'sample of convenience', i.e. requesting kinship care agencies and services (including government welfare departments) to respond to a request for information;
- use of a number of websites that allow requests for information on various topic areas to be circulated to members, thus identifying a number of key stakeholder members within Australia, New Zealand, Norway and Canada;
- contacting some participants (individuals and agencies) directly after a web-based search (nationally and internationally) of kinship care providers;
- snowball sampling predominantly by email contact (with personalisation in each request) with key stakeholders from Indigenous and non-Indigenous agencies (government and non-government), services and organisations; and
- use of organisations to invite carers to attend the focus groups.

A list of topics relating to the main aspects of kinship care was used a guide with stakeholders and consultants.

All participants contacted had been involved in the provision of kinship care services and were cognisant of specific aspects of policy/practice. For example,

- government departments provided information on kinship policy and programs;
- managers of agencies implementing kinship care programs explained aspects of 'best' practice; and
- project officers/workers in grandparent/kinship support groups discussed, based on their experiences, what 'best' practice might look like in supporting kinship placements.

Amongst the information provided were many examples of unclear policy and poor practice, and these aspects are also highlighted in the report. This finding is not uncommon in the OOHC sector, which is often marked by high staff turnover, limited resources and a lack of ongoing project funding.

The strength of this sampling strategy was that most of the participants who responded were experienced and knowledgeable in the area. Some provided additional material and also suggested other sources to contact for further information.

The limitation of this approach was that, due to the project's short time frame, it was not possible to obtain representative samples of providers of kinship care services in the Australian states/territories and the various countries included in the study. Unfortunately, not all agencies/people approached responded to a request for

information in the time allowed for consultation. A further limitation is that the perspectives of young people were not included. The Benevolent Society plans to consult with young people in kinship care later in 2009.

Despite these limitations, what was evident from the consultations with adult participants was a good understanding of policy and practice in the various jurisdictions, and how current policy/practice was impacting on kinship placements. In addition, a number of front-line project officers and workers showed an acute awareness of the issues, and made valuable suggestions about what might constitute 'best' or 'better' practice in a number of aspects of kinship-care provision.

### **Consultations with stakeholders**

Stakeholders were selected on the basis of information provided by the researcher's network of researchers, colleagues and workers involved in kinship care. Other contact details were provided by members of the project's committee – staff at The Benevolent Society – and by Paula Hayden (consultant).

Most of the information was provided via email responses, although there were a number of participants who preferred to be interviewed by phone. All the phone interviewees agreed to the taping and transcribing of the interviews. A kinship care team suggested I attend one of their regular staff meetings. The manager and three caseworkers were interviewed and the interview was taped with their permission. One manager of an OOHC team in a regional area was also interviewed in her office and gave permission to tape the interview.

The topics addressed in the interviews were concerned with understanding the statutory kinship-care policies and programs operating in various jurisdictions, and the consultants'/stakeholders' perceptions of best practice. All interviewed stakeholders were assured of confidentiality and no direct quotes in the report are attributed to specific individuals or agencies/organisations.

### **Focus groups with kinship carers (Indigenous)<sup>2</sup>**

On behalf of the Benevolent Society, AbSec agreed to organise and be involved in the Indigenous focus groups and to invite Indigenous carers to attend. The Manager of AbSec Projects contacted a support group of kinship carers in the Sydney metropolitan area, and another in a regional area, and asked them to participate in a focus group. This was agreed and the two groups took place in May 2009.

### **Focus groups with kinship carers (non-Indigenous)**

Approaches were made to two regional program directors where support groups for *Grandparents Caring for Grandchildren* (kinship/relative carers) are facilitated on a

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<sup>2</sup> The author acknowledges the diversity of Aboriginal and Torres Strait Islander peoples, who have different languages, cultures, histories and perspectives. For ease of reference, this report refers to Aboriginal and Torres Strait Islander peoples collectively as Indigenous people except where specific organisations/agencies use the term, 'Aboriginal'.



regular basis: the Springwood Neighbourhood Centre, *Kinship Care Regional Project*; and DAISI, *Grandcarer Initiative* at Lismore. The co-ordinators of both projects agreed to ask a number of grandparent/kinship carers involved in support groups to participate in two focus groups for the study. Two groups were conducted in May 2009.

All carers were sent a letter explaining the project and inviting them to attend a group. On arrival at their group, carers were asked to complete a short 'carer form' containing questions about their personal characteristics (e.g. age, marital status, labour force participation, household income, etc.), numbers of birth children, and numbers of kin children in their care. Permission was sought to transcribe the sessions and all carers were given \$25.00 to reimburse them for their travel costs in attending the meeting. Each of the four groups ran for approximately 90 minutes.

### **The structure of this report**

The first section of the report provided the introduction, background and methodology for the study.

The second section examines the legislation and policy around statutory kinship care in a number of countries. All countries (and jurisdictions within countries) included in the study used a variety of names to define kinship care. Within this report, the term *kinship care* is interchangeable with: relative/kinship care; kin care; relative care; extended family care; relative and friend care; kinship foster care; and relative foster care. The term *foster care* is used when discussing traditional foster care by non-related people (i.e. "stranger" care). The second section also includes demographics on the numbers of children in statutory kinship care, including information (where available) on children from non-Indigenous and Indigenous backgrounds.

For ease of discussion, data for the various countries are presented in alphabetical order: Australia, Canada, New Zealand, Norway, UK, and US. The discussion for each country is based on information provided by departmental staff members, departmental websites, and published research. Information provided by stakeholders and consultants contacted for the project is also included.

The higher rates of Indigenous children in OOHC compared with other children is a well-known phenomenon, and throughout the report particular attention is given to policy and practice for Indigenous kinship families in the national and international jurisdictions considered for the study.

The third section discusses several aspects of kinship care provision: family group conferencing; carer assessment; carer training; carer support (financial and non-financial); and contact and carer support groups. The fourth section examines the limited research on the birth parents of children in kinship placements, children's participation in kinship care research, and training for workers in kinship care. Section five presents the main findings from the four focus groups with kinship carers.

In all sections of the report, whenever a model, tool, concept or procedure used in a specific jurisdiction (or by an agency/organisation) is thought to be a 'promising practice' or a 'key message' in assisting the development of a framework for improved or 'best' practice, it is noted in the text as '**Promising Practice**' or '**Key Message**'.

## 2 Legislation and policy for statutory kinship care

### Australia

This section of the report discusses the provision of statutory kinship services in all Australian jurisdictions.<sup>3</sup> It provides a statistical picture of the use of kinship care, and a brief overview of legislation and policy covering statutory kinship care services in specific jurisdictions. All Australian states and territories<sup>4</sup> administer similar OOHC programs for children who can no longer live with their birth parents. Placements in OOHC (predominantly foster and kinship care) are managed by a statutory authority and/or by non-government agencies.

*Numbers in care:* Child abuse and neglect in Australia is of continuing concern. Data from the Australian Institute of Health and Welfare (2009) indicates that the number of children in OOHC has been increasing every year since the mid-1990s. At 30 June 2008, 31,166 children and young people were in OOHC nationally. Approximately 94 per cent of those children were in home-based care, while the other 6 per cent were placed either in family group homes (0.3%), in residential care (4.8%), in independent living (0.5%) or in another type of placement (0.5%) (AIHW, 2009).

Of all the countries examined for this study, Australia was found to have the highest use of statutory kinship care. Of children in home-based OOHC in Australia in 2008, 47.7 per cent (14,878) were with foster carers and 45 per cent (14,015) were with relative/kin carers. One per cent (356) were in other types of home-based care (AIHW, 2009).

In Australia there are significant numbers of Indigenous children in OOHC. Over 25 per cent (9,074) of all children in OOHC are Indigenous. In all jurisdictions there are higher rates of Indigenous children in OOHC than of other children. The national rate of Indigenous children in OOHC was almost nine times the rate for other children (AIHW, 2009, 58, 63).<sup>5</sup>

The use of relative/kinship care as an OOHC option is different in each jurisdiction, and in general there are more Indigenous than non-Indigenous children in kinship care placements. NSW has the highest percentages of both Indigenous (67.8%) and non-Indigenous children (51.9%) placed with relative/kin. The Northern Territory has the lowest percentage of both Indigenous children (18.5%) and non-Indigenous children (17.1%) placed in relative/kin care (Table 1).

The higher use of kinship care for Indigenous children in Australia is a reflection of the emphasis in all jurisdictions on the implementation of the Aboriginal Child

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<sup>3</sup> The researcher was unable to make contact with departmental staff in the ACT in the period set aside for consulting stakeholders. The analysis therefore does not include information on statutory kinship care in the ACT.

<sup>4</sup> For ease of discussion 'states and territories' will henceforth be referred to as 'states'.

<sup>5</sup> Approximately 2 per cent of the Australian population identify themselves as being of Indigenous (Aboriginal or Torres Strait Islander) origin.

Placement Principle (ACPP). The Principle (NSW) has the following order of preference for the placement of Indigenous children:

1. child is placed in the care of a member of the child's extended family;
2. child is placed in the care of a member of the Aboriginal community to which the child belongs;
3. child is placed in the care of a member of some other Aboriginal family residing in the vicinity of the child's usual place of residence;
4. child is placed in the care of a suitable person approved by the Director-General after consultation with:
  - (i) members of the child's extended family, as recognised by the Aboriginal community to which the child belongs; and
  - (ii) such Aboriginal welfare organisations as are appropriate in relation to the child (Law Reform Commission, NSW, 2009).

Adherence to the Principle varies between the jurisdictions. NSW has the highest percentage (84.5%) of children placed with Indigenous relative/kin (or other Indigenous carer (e.g. foster) or Indigenous residential care), followed by Western Australia (78.5%), South Australia (77.6%), Victoria (67.9%), Australian Capital Territory (66.3%), Queensland (56.7%), Northern Territory (48.0%), and Tasmania (35.3%) (Productivity Commission, 2009: Table15A.22.).

**Table 1: Children in out-of-home care placed with relatives/kin by Indigenous status, 30 June, 2009**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Number of children at 30 June										
Indigenous	no.	2 926	279	767	651	229	30	35	52	4 969
Non-Indigenous	no.	4 797	1 548	1 479	485	434	150	133	20	9 046
All children	no.	7 723	1 827	2 246	1 136	663	180	168	72	14 015
As a proportion of all children in out-of-home care by Indigenous status at 30 June										
Indigenous	%	67.8	42.3	36.8	60.4	49.0	29.4	43.2	18.5	54.8
Non-Indigenous	%	51.9	35.2	32.3	33.0	31.6	26.7	38.7	17.1	40.9
All children	%	56.9	36.1	33.7	44.6	36.0	27.1	39.5	18.1	45.0

Source: Productivity Commission, 2009, Table15A.21

All Australian States have legislation covering child-welfare matters, including the provision of OOHC services (foster and kinship care, residential and group homes). Legislation in most Australian jurisdictions emphasises the "least intrusive" option and/or the use of relative/kin as the preferred option when placing a child in OOHC. The various jurisdictions use a range of terms and definitions for "kinship care", and all recognise the significance to the child of relatives or extended family members. The focus of the following discussion is on statutory or formal kinship care, although from time to time reference is made to informal or private kinship care because of the merging of both forms of care in policy discussion.

Due to the time-limited nature of the project, it was not possible to provide a complete summary of legislation, policy and guidelines for every state in relation to kinship

care.<sup>6</sup> The report provides two examples (NSW and Victoria) of legislation/policy that highlight the somewhat ambiguous position of statutory kinship (or relative) care.

1) *NSW*: The legislation covering child welfare matters in NSW is the *Children and Young Persons (Care and Protection) Act 1998*. As noted by the Children's Guardian (2008) the Act does not refer to kinship or relative care. The only mention of kinship care in the Act is in relation to the Aboriginal Child and Young Person Placement Principle. Only under certain circumstances does the Act include the provision of relative care as OOHC. Indeed, Section 135 of the Act even specifies that "out-of-home care" does *not* include:

(a1) any care provided by a relative of a child or young person unless:

- (i) the Minister has parental responsibility for the child or young person by virtue of an order of the Children's Court, or
- (ii) the child or young person is in the care of the Director-General.

It is of interest to note that in NSW separate definitions are provided for relative care and kinship care. 'Relative care' is defined as the care of a child or young person by an extended family member whose relationship is defined by the *Children and Young Persons (Care and Protection) Regulation 2000*, under Part 2, clause 5. A child or young person is "related" to, or a "relative" of, another person, for the purposes of the Act:

- (a) if the child or young person is the child, step-child, grandchild, brother, sister, step-brother, step-sister, uncle, aunt, niece or nephew (whether by consanguinity or affinity) of the other person, or
- (b) if the other person has parental responsibility for the child or young person (but not including the Minister or a person who has parental responsibility other than in his or her personal capacity), or
- (c) if the child or young person has been placed in the care or custody of the other person in accordance with the *Adoption of Children Act 1965* (DoCS, 2007:3-4).

In relation to kinship care the NSW Act does not include a definition. For policy purposes the NSW department responsible for child welfare matters, the Department of Community Services (DoCS), has defined kinship care flexibly, to embody different meanings for different cultural groups with regard to social relationships, personal family connections, and expectations of responsibilities and behaviour. Kinship care is defined as:

Care with a person who is not a relative of a child or young person, but who shares a cultural, tribal and/or community connection that is recognised by that child or young person's family and community.  
(DoCS, 2007:4)

Despite the somewhat unclear meaning of relative/kinship care in the NSW Act, DoCS implements a substantial statutory relative/kinship care program across the

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<sup>6</sup> Interested readers are referred to Eardley and Smyth (2006) and Mason et al., (2002) for more detailed information on legislation, policy and guidelines for all Australian states and territories.

state, and requires the provision of such care to comply with the Act in the same way as it requires foster care to comply (DoCS, 2007).

In 2007 DoCS developed a relative/kinship care service model, based on best practice, outlining the assessment, supports, monitoring and supervision requirements for relative/kinship carers (DoCS, 2007). Given the high use of relative/kinship care for Indigenous children in NSW, it is surprising that the service model does not include a separate section on Indigenous kinship care. The model acknowledges that “the application of a relative/kinship care model to Aboriginal and Torres Strait Islander communities will differ in certain aspects from a generic service model”, but very little detail is provided in how the model for Aboriginal and Torres Strait Islander people is to differ (DoCS, 2007:3).

Three specific points are made in the model in relation to Indigenous kinship care:

1. the *Step by Step* Aboriginal Assessment tool should be used when assessing Aboriginal kinship carers (this tool was originally designed for assessing foster *not* kinship carers);<sup>7</sup>
2. kinship care services should implement the cultural placement principles of the Act, including those relating to culture, language, religion and other components of diversity, and the Aboriginal and Torres Strait Islander principles of self-determination, participation and placement; and
3. kinship services should use family decision making/engagement principles to make placement and other decisions, and to identify supports, particularly for children and young people from Aboriginal and Torres Strait Islander (and culturally and linguistically diverse) backgrounds (DoCS, 2007).

In DoCS’ *Out-of-home Care Service Provision Guidelines* it is noted that when Aboriginal children come into care they must be placed according to the Aboriginal Child Placement Principle. In seeking a placement for a child, Aboriginal workers and organisations should always be consulted (DoCS 2008b).

Until 2009 DoCS was the main provider of statutory relative/kinship care services in NSW, with a small number of Aboriginal child care agencies providing similar services for Aboriginal families. From 2009, a relative/kinship care program will be implemented in NSW by a non-government agency, the Benevolent Society.

2) *Victoria*: Two pieces of legislation cover child-welfare matters in Victoria: the *Child Wellbeing and Safety Act 2005* and the *Children, Youth and Families Act 2005*. The *Children, Youth and Families Act 2005* introduced a policy shift from foster care as the main option for children requiring OOHC to statutory (formal) and non-statutory (private) kinship care. The Act requires that, before any other option, consideration is to be given to placing a child or young person with an appropriate family member or person significant to the child. In relation to Indigenous children, the application of the *Aboriginal Child Care Agreement* similar to the ACPP (NSW) is mandated. The use of statutory kinship care in Victoria has significantly increased in recent years (DHS, 2007a: 10). It now represents 36.1 per cent of all statutory placements (Table 1).

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<sup>7</sup> Step by Step is a competency-based resource for assessing potential foster carers developed by staff at the Association of Children’s Welfare Agencies, NSW.

Until 2005, kinship care was excluded from the definition of OOHC in the Victorian legislation (CECFW, 2006: 24). Despite the shift in 2005 from foster to statutory kinship care, it is not clear from current policy and practice whether kinship care is still part of a family preservation model, or whether it has moved in a significant way into the OOHC service model (Joyce, McRae, Pitman, 2008; Gounas and Evans, 2007: 17). Similar to other jurisdictions (see below) which are adapting/changing their OOHC model to reflect the greater use of statutory kinship care, the Victorian Department of Human Services (DHS) is currently (April 2009) revising its kinship care policy and service delivery system. The aim of the changes is to reflect the increasing use of statutory kinship care and to bring some consistency into the current highly variable service provision to statutory kinship carers (DHS, 2007a).

A new mainstream kinship program model for children in statutory kinship care is to be introduced in a number of regional areas in Victoria in July 2009. A small number of Indigenous organisations are to test some elements/components of the mainstream model as part of the concurrent process of developing an Indigenous kinship model for Victoria (DHS: 2009).<sup>8</sup>

In Victoria most OOHC (both foster and residential) is outsourced to 35 non-government Community Service Organisations (CSO). Currently, only six CSO care services (April 2009) provide kinship care programs (McConachy, 2008: 10; Gounas and Evans, 2007),<sup>9</sup> but additional CSO-based kinship care services are to be developed in the roll-out of the new kinship model in July 2009. These services are to provide information and advice, family services and placement support to both private (non-statutory) and statutory kinship carers.

Child welfare departments in other jurisdictions (SA, WA and the NT) are also developing a raft of policy and operational procedures for statutory relative/kinship care. Policies are to include new carer assessment and training tools and practice frameworks (Maudie, 2009; Ding, 2009; Jackson, 2009). In Tasmania and Queensland, however, statutory kinship/relative care appears to have been absorbed into/or placed alongside general foster-care services, without specific policy and operational procedures for kinship care services.

## **Canada**

Canada has 10 provinces and three territories each with its own child-welfare policies and practices. In relation to kinship care, there are indications that it is increasingly being used by child-welfare agencies as the first option when placing a child. One researcher suggests that three factors are seen to be driving the move to kinship care:

1. There are more children coming into care.
2. Fewer foster homes are available and kinship care is a growing resource for agencies.

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<sup>8</sup> In Victoria *private* kinship care (sometimes called “informal” or “non-Statutory” kinship care) is the term used for those arrangements where children are cared for by relatives without any Child Protection intervention.

<sup>9</sup> In relation to kinship care practice, an overview of three small studies with CSOs in Victoria is provided in Appendix B.

3. Since the mid-eighties, there has been an emphasis in most provincial Child Welfare Acts that the preferred option, when placing a child in care, is to consider a relative or a person with whom the child already has a significant relationship (Kufeldt, 2002).

As is the case in Australia, there is limited research into statutory kinship care (Hawkins and Millard, 2008). Another similarity with the Australian situation is the fact that policies and practice guidelines on kinship care vary widely across the various jurisdictions, with many provinces only in the early stages of policy/practice development (Fuller-Thomson, 2005: 10; Gough, 2006:2).

*Numbers in kinship care:* There is no published statistical data nationally on the numbers of children in care (foster and kinship) in Canada. One researcher estimated that in 2006 there were 66,000 children in care in Canada (Blackstock, 2007; 84). Indigenous communities in Canada refer to themselves as Aboriginal or First Nations people. As in Australia, there are significant numbers of Aboriginal children in OOHC.<sup>10</sup> While these children represent 5 per cent of the child population in Canada, they are 38 per cent (25,000) of the 66,000 children in care (Blackstock, 2007).

As is the case with Australia's Indigenous people, it is a traditional First Nations custom for the care of children to be provided by the wider family. There is no national data on the numbers of Aboriginal children placed with Aboriginal families, but the Canadian Census (1998) provided some indication of the percentage of First Nation grandparents caring for their grandchildren. While First Nations people comprise only 2.8 per cent of the total population and 1.4 per cent of the Canadian population 45 years and over, more than 17 per cent of care-giving grandparents were Aboriginal (Fuller-Thompson, 2005: 11, 21).

Autonomy and self-government in child welfare matters is important for all Indigenous peoples. In Canada, unlike in Australia, Aboriginal autonomy and self-government in relation to a number of areas, including child welfare, has been handed over to some First Nations people. This transfer of service delivery from government child-welfare systems to some Aboriginal communities has led to the development of culturally appropriate child and family service models. These new models ensure that Aboriginal communities are involved in welfare plans for their children (Blackstock, 2007: 84; Liebesman, 2004: 5-6). Manitoba, for example, leads the way in allowing for the provision of child and family services (including child protection) for First Nations children through Aboriginal agencies. In this province, First Nations people have sole authority and responsibility to care for all their children.

In a number of provinces First Nations and Aboriginal peoples work in partnership with authorities to design laws, policies and standards that recognise the specificity of Indigenous people's needs, and the benefits of local control over children's services and decision-making: "In many instances in legislation, but otherwise in practice, the importance of including Aboriginal agencies in all aspects of decision-making with respect to Aboriginal children is recognised" (Liebesman, 2004: 6-7).

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<sup>10</sup> The term Aboriginal is used to describe the diversity of First Nations (Status and non-Status), Inuit and Metis people in Canada

The following discussion on kinship care in Canada focuses on three provinces: Manitoba, Newfoundland and Labrador, and Ontario. In Manitoba, as in all Canadian provinces, there is a shortage of family foster homes (CWLC, 2007). The number of children in care has increased substantially in the last five years. There are currently about 6,629 children in the care of child and family services. This represents a 17 per cent increase since 2003 (5,533). The proportion of children and youth in care who are Aboriginal is 81 per cent. Predictions of children in care, based on population trends and the overrepresentation of Aboriginal children, are that the numbers will continue to increase (Office of the Children's Advocate, 2009).

The child-welfare system in Manitoba comes under the *Child and Family Services Authorities Act 2003*. The Act created and mandated four Child Welfare Authorities, three of which are Aboriginal. The Authorities coordinate child welfare services, oversee service delivery, and ensure culturally appropriate standards and practices consistent with the legislation (CWLC, 2007: 27).

In Newfoundland (and Labrador) the *Child, Youth and Family Services Act 1998* covers child protection services. In relation to First Nations communities in Labrador, the Inuit people have a self-government agreement with the province. While child-welfare services are provided through local regional health authorities, the Inuit government must be notified of any court proceedings involving an Inuit child (CWLC, 2007: 16).

While the term "kinship care" is not used in Newfoundland, child-welfare legislation recognises the importance of relatives and others significant to the child. The province's least intrusive program is the *Child Welfare Allowance Program* which provides "relatives or significant others" with support and financial services if they are willing to provide care and capable of doing so. Children who receive service under this program are *not* in the care or custody of the department (Child, Youth & Family Services). In other circumstances children may be placed in the statutory care of the department. In Newfoundland around 30 per cent of Aboriginal children and 25 per cent of non-Aboriginal children in statutory care are placed with relatives/significant others (Anderson, 2009).

In Ontario legislation covering child welfare matters is the *Child and Family Services Act 1998*. The Act gives Children's Aid Societies (CAS) (non-government) the exclusive jurisdiction to provide child-protection/child-welfare services in the province. Ontario has 53 CASs including six Aboriginal child and family organisations. The Act recognises the culture, heritage and traditions of Aboriginal people, and their concept of the extended family. The Act states that, wherever possible, Aboriginal people should be entitled to provide their own child and family services. For the care of Aboriginal children and young people, the Act recognises "customary care" (care of an Aboriginal child by a person according to the custom of the child's band or native Community) (CWLC, 2007 24-26).

In one CAS a pilot kinship care program was established in 2004. Central to the program's success, stated the manager, was that the staff brought with them their previous experience and background from intake, family and children's services. In the period 2004-2009 the kinship care team has maintained the same staff, with the manager commenting that the workers in the program were "passionate about kinship care" (Roblin, 2009).



## **New Zealand**

*New Zealand legislation:* National legislation (*Children, Young Persons, and Their Families Act 1989*) governs child welfare. The Act addresses child protection issues for all children including Māori children. Embedded in the legislation is a focus on Indigenous cultural values for Māori children in care. The Act enshrines the rights of children to be cared for by their family, whanau (kin group), hapu (extended kin group with many whanau), iwi (descent group with many hapu) or family group. The Act ‘attempts to give effect to principles of Māori self-determination by prioritising and emphasising the involvement of Māori family with decisions which affect Māori children’ (Liebsman 2004: 10). In New Zealand kinship carers are usually referred to as ‘family/whanau caregivers’. As with Australia and Canada, there is an increasing use of kinship care as an OOHC option but very little research in the area (Worrall, 2009).

Māori make up around 14 per cent of the New Zealand population. Like Australia’s Indigenous children, Māori children are more likely to be in OOHC than are other children. In 2004, around 40 per cent of the 4, 674 children in care were Māori. By 2008, the percentage of children in care who were Māori had risen to almost half (48%) of all children in care. Over half (53%) of the Māori children in care were with kin compared to 31 per cent of Pakeha (white) (Worrall, 2008).

## **Norway**

Norway has a relatively short history of using statutory kinship care as an option for children requiring care. The change in policy under the *Child Protection Act 1992* was formally introduced in 2004. In 2006 there were approximately 15 per cent of children in statutory kinship care (Holton, 2008). Kinship care is defined as ‘‘a care placement with a person or family who are relatives of the child/birth parents or with somebody already known to the child/parents’’. In principle is not defined differently from other foster care. The Act provides for three categories of care placement:

1. *Private or family arrangements:* parental responsibility stays with the parents but care is provided by a carer family. Social services are rarely involved and no financial support is provided.
2. *Placement in co-operation with the child’s parents:* In cooperation with social services, birth parents place a child in a foster home. The option of kinship care (family foster care) is explored and the choice of carer has to be accepted by the parents. Carers are assessed/approved by social services. Parents have full parental responsibility, but delegate daily care of their child to the foster/kinship carer. Parents may at any time bring their child back home. The foster/kinship home is followed up and supervised by social services. Full financial allowance is normally given to foster/kinship parents and extra support is provided according to the assessment. This type of placement is normally used when the assessed time of care is less than two years (e.g. when parents are taking part in treatment for drug abuse, mental illness, etc.).
3. *Placement by court order (public care):* When parents do not consent to having the child placed, social services can claim custodial care through the courts and kinship care is the first option explored. The choice of a foster/kinship home is made by social services, but parents and child have the right to have their views/wishes considered before a final decision is made. The foster/kinship home is assessed, approved, followed up and supervised by

social services. Full financial allowance is given and extra support is provided according to assessment.

Information on statutory kinship care in Norway was provided by a consultant in a foster service at Bufetat in Stavanger city (Rogaland County). Bufetat Foster Home Services (FHS) is part of the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) that is responsible for child welfare and assists local authorities with foster and kinship care services. FHS recruits foster carers, finds foster homes for the social services, assesses kinship-care foster homes, and provides foster homes with general training and guidance. Rogaland County is the leading region in Norway in the use of kinship care and has approximately 450 foster homes. Approximately 80 children are placed annually in foster homes. In 2008 more children (57%) were placed in kinship care than foster care. The consultant stated that:

It is our general impression that the number of kinship carers at national level is slightly increasing because the law requires social services to first assess possible family and network carers [and] the public is more aware of their right to be assessed when such a situation occurs (Aas, 2009).

### **United Kingdom**

In the UK, children placed in care due to risk of harm are called “looked after” children. The term “family and friends foster care” is commonly used when referring to children in approved relative care (Hunt, 2008), although it is also called relative care, network care, kin care and kinship care. For this section on the UK, the term “kinship foster care/carers” will be used”.

Local authorities in England, Scotland, Northern Ireland and Wales have a statutory duty to safeguard and promote the welfare of children under new child welfare legislation enacted in the UK, the *Children and Young Persons Act 2008*. As with the earlier legislation, the *Children Act 1989*, the new Act states that, when children cannot live with their birth parents, priority is to be given to placing children with a relative or friend unless it is impractical or inconsistent with the child’s welfare. However, despite this priority, there is evidence to suggest that only 57 per cent of placements are given this consideration (DCSF, 2008).

Many researchers have commented upon the lack of policy frameworks underpinning the provision of kinship foster care in the UK, noting that levels of use of kinship foster care differ considerably between local authorities (Farmer and Moyers, 2008; Hunt, Waterhouse and Lutman, 2008; Tapsfield 2001; Broad, 2004). One study found that policies on kin care either did not exist or they were being developed on an ad hoc basis. Managers and policy-makers in some authorities were finding developing policy was more complex than first envisaged (Farmer and Moyers, 2008: 25-26). In 2008 the government announced that it was developing a new framework for statutory kinship foster care. The new framework is to include an assessment tool to ensure the issues most relevant to kinship foster carers are addressed. It is also intended to clarify the criteria for financial support for kinship foster carers (DCSF, 2008).

The numbers of children and young people who are being ‘looked after’ are increasing. In 2007, there were 81,000 children and young people under the age of 18 in the care of local authorities in England, an increase of 18 per cent since 1997. The

use of statutory kinship foster care has also grown in all jurisdictions. In England placements in kinship foster care rose from 12 per cent in 2006 to approximately 17 per cent (7,500) of all foster placements (DCSF, 2008; Nixon, 2007). In Scotland in 2007-2008 there were 2,094 children living in formal (statutory) kinship foster care placements (tFN – BAAF, 2008a). In Ireland the number of children in kinship foster care rose from 16 per cent in the mid-1990s to 33 per cent in 2006 (O’Sullivan and Breen, 2008: 32).

Some researchers (e.g. Farmer and Moyers, 2008) have suggested that in some local authorities in England as many as 40 per cent of all foster placements are in formal kinship placements. These writers found there was little knowledge of how kin placements were working or of which placements were successful, and there was little evidence of when kin care should not be used (Farmer and Moyers, 2008: 13). Tapsfield (2001:87) found that variations in the use of kinship foster care did not appear to reflect variations in need, but rather, the particular authority where children lived.

### **United States of America**

In the United States (US) both *The Personal Responsibility and Work Opportunity Reconciliation Act 1996* and the *Adoption and Safe Families Act 1997* promote and support kinship care. The legislation requires the states to give preference to family members when placement options are being considered for a child requiring care (Winocur, Holton and Valentine, 2009: 8-9). In most states kinship carers are typically subject to the same state approval or licensing requirements as foster carers, and may receive financial assistance through state or federal OOHC programs.

The US has national legislation specifically for Indigenous peoples (Native Americans): the *Indian Child Welfare Act 1978* (ICWA). The legislation represents a high level of transfer of decision-making authority to Indigenous people incorporating principles of self-determination. The Act regulates welfare with respect to Native American children and tribal courts have authority over Indian child welfare. Legislative, administration and judicial decision-making is with Indian tribes when the children live or have their permanent homes on a reservation. In foster care or adoption for Indian children, a preferred order of placement is set out in the Indian Child Placement Principle (similar to the Aboriginal Child Placement Principle). ‘‘The ICWA is often referred to as a model for consideration by Indigenous people in other countries’’ (Liebesman, 2004: 7-8, 14).

Kinship services in the US, as elsewhere, comprise formal (i.e. public) and informal care. One researcher estimated that there were between two and 2.5 million children in informal kinship care, and the ‘best’ estimate for children in public kinship care is over half a million (540,000) According to this researcher, the use of statutory kinship care increased from the late 1980s to the early 1990s, but levelled off in the mid- to late-1990s and has stayed relatively stable since that time (Geen 2008).

*Observation:* In all the countries included in this study, child-welfare legislation either promotes or mandates the use of statutory kinship care for children requiring care when their parents can no longer care for them. Most jurisdictions report increases in the numbers of children coming into care, and an increased usage of statutory kinship care, although there are some jurisdictions, for example in the UK, that note the

absence of specific policy frameworks for kinship care. In most jurisdictions kinship care appears to be included as part of the general OOHC programs. In all countries with Indigenous children it is notable that they are highly over-represented in the numbers of children in OOHC.

The next section of this report focuses on six key aspects of kinship care provision, and discusses the tools and models used within the countries included in this study. The discussion is organised in the following sequence, beginning with family group conferencing, followed by carer assessment, training, and support (financial and non-financial), then contact with birth parents, and finally carer support groups.

### **3 Models and tools in kinship care**

To understand how kinship care services are differentiated from foster care services in the various jurisdictions the following discussion focuses on the different criteria applying to the assessment, training and support of kinship carers (Indigenous and non-Indigenous) compared to foster carers. In some respects kinship and foster care have many similarities however kinship carers unlike foster carers are rarely assessed/approved/trained before children are placed with them. How best to address these differences is indicated by the variety of models and tools used in different jurisdictions.

Kinship carers are also differentiated from foster carers in the type of groups that they participate in to assist them in their role as carers. Many foster carers are members of State foster care associations or foster parent support networks and have the option of attending support groups and receiving ongoing training through the association or network. Anecdotally, it is known that in NSW that while there is no obvious barrier to their involvement, few kinship carers participate in foster carer support groups or attend ongoing carer training.

Support groups for kinship carers have evolved through the emergence of *Grandparents Caring for Grandchildren Support Services* across the country. These services, many partially funded by governments (Federal and State) and partially voluntary, are forming an integral aspect of the support being provided for kinship carers both statutory (formal) and non-statutory (informal). The proliferation of grandparent support groups as a mechanism to reduce the caregiver burden, stress and isolation has been observed by Australian researchers. Few of these programs however have been formally evaluated and researchers have found little evidence indicating whether participation in the groups ‘stimulates lasting change’ in relieving the burden, stress and isolation of care giving. Researchers in one Australian study stressed the need for a cohesive conceptual framework for understanding the role of grandparent carers and elements of intervention and service provision that would be most effective for particular groups of grandparent carers (e.g. carers of younger or older adolescents, carers of sibling groups, carers of children from interracial-marriages) (Horne et al., 2007: 80-82).

#### **3.1 Family group conferencing/family decision making**

Decisions around who is best placed to take a child in a relative/kinship care situation are ideally made through family group conferencing (FGC) or family decision-making (FDM) models. In both these approaches family members are brought together and, through facilitated decision-making with agency workers, plans are developed that address a child’s need for safety, protection, permanence and well-being with a family member or with wider kin. Originally developed in New Zealand in the field of child welfare and youth justice, the use of FGC as good practice for protecting children ‘has grown exponentially throughout the world’ (Merkel-Holguin, cited in Mirsky, 2003).

*Australia:* In relation to the use of FGC in Australian jurisdictions, it is unclear how regularly conferencing with families is used by child welfare agencies when decisions are being made around placement with kinship/relative carers. Recent work by Harris (2008) indicates that child welfare departments in all states except the NT had

implemented or conducted trials of FGC. In four States – SA, the ACT, Tasmania and Queensland – legislation allows, or requires, that a conference be offered in child protection matters or where a care and protection order is being sought (Harris, 2008: 6).

In a review of conferencing, Harris (2008) found little consistency its use. Although SA, Tasmania and the ACT indicated the number of times conferencing for child protection matters was used (in 2005-06), it was not clear from the figures what proportion of child protection cases were involved in conferences compared to those that were not. Victoria also reported using conferencing, but the problem here was that its use was variable across different regions and no figures could be provided for the state as a whole. Legislation (2006) in Queensland mandated the use of conferencing in the case-planning process, but there were no figures available on the frequency of its use at the time of the review. Conferencing was not used by NSW, the NT and WA during the period 2005-06 (Harris, 2008: 7).

Despite this, in NSW the use of conferencing appears, at least in policy, to be the preferred approach for identifying potential kinship/relative carers. In documents available on the DoCS website – *Out-of-Home Care Service Model: Relative Kinship Care* (2007) and the *Out-of-Home Care Service Provision Guidelines* (2008) – it is suggested that the preferred model to be used in recruiting relative/kinship carers is FGC or FDM. The documents explain that conferencing involves consulting with a child’s known relatives and community members:

- to gain an understanding of relationships between the family and their community;
- to identify potential relative/kinship carers; and
- to provide information to potential carers about the child or young person’s specific needs.

The model emphasises that for placement decisions, particularly for Aboriginal children, FDM is to be used. Similarly, at other times during the placement when important decisions are being discussed, the participation of the child, young person, their family, significant others and relative/kinship carers, is required (DoCS, 2007:6-10; DoCS, 2008a: 24). Similarly in Victoria, when placement decisions are being made for Aboriginal children, legislation mandates the use of conferencing (DHS, 2007a; see also Higgins, Bromfield and Richardson, 2005:58).

**Promising Practice:** An inquiry into child protection services in NSW in 2008 suggested that greater use should be made of the practice of conferencing in child protection matters, preferably by trained staff from non-government agencies or otherwise by trained DoCS staff. ‘The benefits are obvious and include improved participation by the children and families in the decision making process’ (Wood, 2008: 12.128).

A casework manager in NSW consulted for this project explained that conferencing was not always used in relative/kinship placement decisions because of the crisis-driven nature of child protection. Given that there was often an immediate need to remove children, there was not always time to check with the whole family about potential kin carers. Usually the worker asked the birth parent/s or checked the system for information on file for other family members. Often parents were very reluctant to

disclose any information to workers at the time their children were being placed in care. It was at court proceedings that other family members with a connection to the parents or an attachment to the child sometimes came forward to be the carer of the child. This was not always well received if the child had been with another family member for a period prior to the court proceedings.

Another manager of OOHC services in a large regional town explained that FGC had been used extensively by departmental workers in the past, but it had been found to be very time-consuming and complex and the Department did not have enough resources to continue doing it. A further difficulty in rural-regional areas noted by this manager was that it was more difficult to arrange for FGC due to the geographical distances to be covered in bringing family members together. Aboriginal families in particular did not always have transport to attend meetings, and sometimes invited people did not turn up and meetings had to be rescheduled.

The manager noted that the use of FGC was especially complex for Aboriginal families. Often there were numerous family members (e.g. 20-30 people) who wanted to be involved in the decision-making process, and several family meetings would have to take place before a decision could be reached. Further complexity occurred when both the maternal and paternal sides of the family had their own idea of who should be the most appropriate carer; ultimately a family assessment has to be carried out and it is DoCS who makes the final decision. The manager noted that often it became too impractical to pursue FGC.

**Promising Practice:** The manager of OOHC services in a large regional town noted that best practice required the children to be consulted in the decision-making process (if age appropriate). In addition, in the case of Aboriginal families, an Aboriginal caseworker or other Aboriginal representation should be present to support family members and to advise the agency staff.

**Promising Practice:** A staff officer in a Queensland Aboriginal Agency noted the importance of family mapping ('genogram') to gain an understanding of a child's family and community networks. Mapping should occur when a child first enters the child-protection system, as the knowledge can preserve family connections that are important to the child but which may not be otherwise known about.

**Promising Practice:** The Victorian Aboriginal Child Care Agency recommends the use of the *Dhum Djirri Aboriginal Family Decision Making Program* when an Aboriginal child or young person becomes involved in the child protection system.<sup>11</sup> The aim of the program is to bring together family members, extended family, Elders, significant people in the child's life, the child/young person (where appropriate), a child protection officer and professionals, to meet and make decisions about the child/young person's safety and well-being. The program is run by an Aboriginal convenor from VACCA and a DHS convenor and an Elder from the Program is present and involved. The meeting has three steps:

- Step I. Information sharing

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<sup>11</sup> Dhum Djirri – Wurundjeri words meaning to gather and unite.

- Step 2: Private time – making the plan
- Step 3: Reconvening.

When an agreement is reached it is adopted by Child Protection as a guide to future planning in relation to the child. All attending the meeting are given copy of the plan. The department (DHS) if involved will support the family in implementing the plan. The convenors stay in touch with the family and the professionals and monitor progress. If successful after 3 months the program finishes. The benefits of the program are that ‘It is respectful of culturally appropriate processes and places culture and community at the heart of the decision-making process’. (VACCA, 2008a)

To date there does not appear to have been any research conducted in Australia on the outcomes of conferencing in relation to child-protection matters in general or, more specifically, in relation to relative/kinship placements, either for Indigenous or for non-Indigenous families.

*Canada:* In Canada conferencing is being used by a number of child-welfare departments. In Newfoundland and Labrador, when a decision is being made to place a child in statutory care, the worker is required to involve the child, the family and other support networks (e.g. at a family meeting) to ascertain if there may be a family member or individual significant to the child who could meet the child’s placement needs (Newfoundland Government, 2009).

In Ontario the Manger of Research & Program Evaluation in one CAS noted that the agency has begun to use conferencing as a general practice tool. Conferencing is used in deciding who should be the kinship carer and in resolving issues of access/contact with other family members. Conferencing has been piloted in one CAS’s branch with great success and has now been implemented throughout all the agencies and is being used more generally, for example:

- by the agency’s Intake Services (e.g. in child protection case);
- when closing a child-protection case;
- at the time of transfer of a child within the child-protection system; and,
- when a youth ages out of the child-protection system to widen the circle of supports at the time of transition (Goodman, 2009).

**Promising Practice:** A ‘Family Finding’ position has been created in the CAS with the kinship care program to track down family or kin of children entering care. A variety of avenues is used to find extended family (e.g. accessing Ministry of Transport data to track people through their driving licence). While not always successful in finding a kinship placement, the service has been successful in connecting a child with a family member in 98 per cent of cases (Mackiewicz, 2009).

Writers who examined the use of conferencing in CASs in Ontario found: ‘Satisfaction with the FGC process is a critical aspect of success and implementation of the plan that is generated from the family conference’ (Leschied et al., 2007: ix).<sup>12</sup>

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<sup>12</sup> This source (Leschied et al., 2007) contains a detailed discussion on the benefits of FGC for kinship care placements in Ontario, Canada.



Conferencing has been found to be highly adaptable across cultures, and allows for the empowerment of families with a renewal and strengthening of family ties. In relation to child-protection matters for Aboriginal families in Canada, conferencing has been introduced, although with some ambivalence. On the positive side, one researcher (Liebsman, 2004) found that FGC ensures that:

- birth parents are part of the solution for the child;
- birth parents are not marginalised by the system in the decision-making process;
- FGC participants act responsibly; and
- participants devise useful plans for the child.

On the negative side, Liebsman (2004) notes that critics have found that:

- conferencing can lack safeguards of due process and legal representation;
- the process may be seen as unfair by some participants;
- too much responsibility may be apportioned to the family without services/supports put in place to support them; and
- power imbalances and gender inequities are often not addressed by FGC approaches (Liebsman, 2004: 32).

*New Zealand:* Legislation in 1989 introduced a unique feature to child-welfare matters. It mandated the use of a FGC model based on the decision-making models and values of Māori people. The aim of a FGC is to empower families to make decisions that are in the best interests of children when they become involved in the care system. FGCs are seen to have enormous value in family-led decision-making for a child at risk.

In New Zealand, conferencing is an ongoing process used when deciding on care for a child if they cannot remain with their parents, either temporarily or permanently. For example, further decisions regarding permanency, or changes in the plans, are attended to at court review meetings which also involve the families in the planning and decision-making (Walker, 2009). In the consultation process for this study, a departmental officer explained that FGCs are not held in every instance when a child comes into care, although if a case involves proven child abuse then by law a FGC has to take place. The consultant noted that at times a good and safe decision was found through a family/whanau meeting and not a FGC. At other times, children can be placed with their grandparents without any formal meeting taking place (Connolly, 2007).

Connolly (2007) suggests that, important as the FGC model is, conferencing does not of itself contribute to good outcomes for children in the longer term: 'it is what happens next [post-conference] that is of greatest importance to good outcomes for children' (Connolly, 2007: 13).

*Norway:* Conferencing is being utilised for kinship care placements in Norway, though its use is not widespread. The model was trialled in Hedmark County during 2006-08 with 17 children being placed with kinship carers. To encourage its wider use the Ministry of Child and Family Affairs is providing FGC training in all municipalities in Norway.

According to the Norwegian consultant for this study, the reluctance by social services to use conferencing more frequently may be due to the time and effort it takes to establish the group and/or because workers do not think they will be able to find a suitable kinship carer. The consultant thought that one of the main barriers to the use of conferencing was the mindset of professional social workers who did not understand or accept that kinship care can be the best solution for the child (Aas, 2009).

*United Kingdom:* The use of conferencing for children coming into (and already in care) has been implemented with the *Children and Young Persons Act 2008* (Morgan, 2008; Thoburn, 2008). In November 2006 the Department of Children, Schools and Families launched a *Family Group Conference Toolkit* to equip managers and practitioners with the necessary skills to develop the FGC model (DCSF, 2008). To date the use of FGC has been found to be variable and there is no consistent approach being used by local authorities for kinship placements (Family Rights Group, 2007; Hunt, Waterhouse and Lutman, 2008; Nixon, 2007).

In Ireland, O'Brien (2001: 90) found that, despite the potential offered by FGC, there is still resistance by some local authorities to use them. Other researchers indicate that it is not only authorities who are resistant to the use of conferencing. A study with kinship foster carers found only five of 37 carers supported its use, with most indicating the distinct possibility of inter-family conflict/difficulties in the conferencing process (Hunt, Waterhouse and Lutman, 2008: 129, 289).

The use of FGC has long been regarded by writers as a model of good practice (Broad, 2001; Nixon, 2001, Tapsfield, 2001). Nixon (2007: 44) found research into conferencing indicated high user satisfaction; a higher likelihood of children being placed with extended family; better placement stability; and better understanding of the child's family/friendship network.

**Key Message:** Waterhouse (2001: 45) suggests that appointing a dedicated family placement officer to specialise in kinship placements would be of benefit to agencies.

**Promising Practice:** An important element of conferencing is family mapping. A mapping (or genogram) of the child's extended family can be undertaken in the early stage of the care proceedings or as family members are brought together. The mapping exercise should include the location and contact details of all relevant family members (including separated birth fathers). After identifying all potential carers and ascertaining who is important to the child, suitable people should then be invited to participate in the formal decision-making process of conferencing (Hunt, Waterhouse and Lutman, 2008; Greeff, 2001; Waterhouse, 2001; Pitcher, 2001).

**Key Message:** Broad (2004) found that young people, carers and social workers thought that the kinship care placements that work best, are those 'that are consensual, and in many cases initiated by the extended family themselves'. The researcher suggest that in assessing the most appropriate placements for a child 'family group meetings are likely to continue to be the most appropriate mechanism for making kinship care placements' (Broad, 2004: 221).

In Scotland the government supports the use of FGC in discussing the capacity of family to care for a child. Conferencing is currently used in 17 local authorities in

Scotland. The strategy is seen as important in emphasising the central role of the child and family in the decision-making process, and in building partnership and trust between family members and professionals (Scottish Government, 2007: 8-10).

*United States:* In the US material from CFP (2007) and the CWLA (2000) present a similar perspective on the importance of conferencing for kinship placements. CWLA (2000) suggests that finding a potential carer requires a family-centred casework approach involving the *active* participation (e.g. family meetings/conferencing) of the whole family.

**Promising Practice:** The use of ‘genograms’ (i.e. family mapping) is suggested as a useful practice in identifying relatives and significant others in the child’s life (CFP, 2000; CWLA, 2007).

Identifying relatives should commence at the time of a child’s initial contact (e.g. intake/assessment) with departmental officers and continue through each stage of decision-making including after a child has already been placed. Gaining an understanding of the perspectives/relationships/needs of parents, children and kin can be key to the success of maintaining family connections and safe, stable placements (CFP, 2007: 25, 31; see also Scannapieco and Hegar, 2002: 318-319).

*Observation:* Jurisdictions in all countries support the FGC/FDM model as ‘good’ practice at the time when children are being taken into care, and throughout the child’s placement whenever decisions need to be made.

### 3.2 Carer assessment

*Australia:* In NSW, the DoCS guidelines on the assessment of relative/kinship carers indicate that carers are to be assessed in the same way and as comprehensively as foster carers are. The assessment is to focus on the carer's capacity to meet the child's needs and on the provision of a safe and nurturing environment. The assessment model does suggest that, when the carer is already known to the child, the assessment 'may be less structured and less detailed than for general foster carers', although in what areas the assessment can be less structured/less detailed is not outlined. Managers and workers in NSW interviewed for this study said that two tools are used for assessing kinship carers. One tool is the *Assessment and Approval of Authorised Relative Carers* and the other is *Step by Step*. The *Step by Step* Aboriginal Assessment tool is used for Aboriginal kinship carers. The *Step by Step* tools were originally designed to be used for assessing foster, not kinship carers. The assessment process includes individual training, and the resource and support needs appropriate for the role of the relative/kinship carer, with needs to be documented in the child's case plan (DoCS, 2007:7).

A NSW departmental casework manager consulted for this project commented that, while the assessment tool is basically the same as that used for foster carers, the aspect that requires more attention for kinship carers is the relationship between the carer and the birth parents, and the complications of those relationships. The manager also noted that it was not unusual for a formal assessment process to take place sometime after the child had been with the carer, and that consideration had to be given to this fact when the assessment took place.

Another casework manager said that, among the issues of concern arising in assessments that were conducted after the child had been with the carer for some time, were the placements that probably should not have been made in the first place. In some situations, training helped to bring up issues carers may not have been aware of (e.g. difficult behaviours), or support services that may be required (e.g. counselling, mediation). The manager noted that those doing the assessments needed to focus on the motivations of the potential carers, in order to establish that the carers really 'cared about' the child and were not just trying to appease the birth parents. Establishing the amount of previous contact between the child and the carer was also important, as it could reveal the level of attachment /bond between the two.

This casework manager also said that, sometimes in that first stage of the assessment, carers would say the 'right' things to the worker rather than what they really thought, and that it was not till later that other important aspects might be discussed (e.g. difficulties with ongoing relationships). Finding out who else spent time in the carer's home was also important and often led to further checks being made on other adults coming into the household. Sometimes carers showed a lack of insight into certain issues around caring, and it was only some time later in follow-up visits that their attitudes become apparent.

Another DoCS manager of OOHC services interviewed for the project was based in a large country town in NSW with a large Indigenous population. There were approximately 400 children in OOHC, around one-third in kinship care placements. The manager explained that the procedure for assessing kinship carers involved two caseworkers visiting the family to assess the environment and surrounds of the home,

and to make sure the family had enough bedrooms/accommodation for the children. The assessment was not as comprehensive as a foster carer's assessment, although probity checks (e.g. criminal record/police) were carried out on all adults living in the proposed home. The manager commented that, while information was gathered on the family constellation and on the family dynamics, the assessment was quite unobtrusive in comparison with the assessment of a foster carer. The process took a "good couple of hours" and then the probity checks were carried out. The template used focused on the family's financial circumstances, employment status, sources of income and health status.

The manager noted that in an "ideal" situation an assessed child requiring an OOHC placement was first placed with a foster carer until an assessment with kin could be carried out. While this did not always occur, it was the preferred option so that checks could be carried out on the nominated person who had agreed to take the child. The manager noted that, even though the town was quite large, knowledge about proposed kin carers is relatively easy to obtain within the family's community. In general it took around two weeks for the checks and assessment to be carried out.

In relation to assessing Aboriginal kinship carers, a casework manager in an Aboriginal agency said that workers used the Aboriginal version of *Step by Step*. The manager explained how assessments were conducted:

- most relative/kinship assessments were conducted in a relatively short period of time with 1-2 visits to the carer home;
- police checks were carried out;
- information on the potential carer family was sourced from other Aboriginal community members and agencies (e.g. health) who had involvement with the family;
- carer motivation was not seen as an issue, as all Aboriginal children are seen as 'kin' and part of the family;
- if doubts or concerns arose, the assessment period was extended until the issues were resolved to the agency's satisfaction;
- a genogram of the family was important when decisions were being made about the most appropriate kinship carer; and
- where possible the agency placed the child with the family member nominated by the birth parents.

The manager said that, when the nominated or potential Aboriginal kinship carer was from interstate and unknown in the local community, contact was made with Aboriginal agencies in the place where the person lived. This allowed information (i.e. local knowledge) to be obtained to ascertain if there were any issues or concerns that needed to be addressed before the placement was made. If there was feuding between families in the local community, the department was usually requested to carry out the assessment. The manager noted that it was important to maintain their credibility with the Aboriginal community and not be seen to taking sides.

A manager of an OOHC program in a large regional town in NSW commented that in the case of mixed parentage, it was not uncommon for someone from the non-Aboriginal parent's family to offer to take the child, but due to the necessity to adhere to the ACPP a placement was first sought with the Aboriginal parent's family. If no suitable Aboriginal member was found, either inside or outside the local community,

then consideration was given to the non-Aboriginal side of the family. The manager observed that it was a time-intensive process and one likely to generate conflict, and that, while the processes were taking place, a placement for the child was sought with an Aboriginal foster carer.

The importance of cultural plans for Aboriginal children in care has been highlighted by a number of researchers. In a recent study of carers (both Aboriginal and non-Aboriginal) of Aboriginal children in NSW, the Ombudsman found very little evidence of cultural support planning. For carers managed by an Aboriginal OOHC service, there appeared to be a greater level of support and guidance around cultural issues than was provided to carers managed by the DoCS. The report by the Ombudsman suggested that guidance around cultural issues should be provided, not only to the non-Aboriginal carers of Aboriginal children, but also to the Aboriginal carers, who may not have a good understanding of that particular child's cultural connections (NSW Ombudsman, 2008a: 33-36).

**Promising Practice:** NSW DoCS is currently developing a *Cultural Support Case Plan (CSCP)* for Aboriginal children in care. The aim of the CSCP is to gather cultural information to enable culturally appropriate placement decisions to be made by workers and 'to engage carers in the maintenance of a child's or young person's Aboriginal identity by identifying key cultural events, family connections and services' (DoCS, 2008a: 17).

The NSW Ombudsman also noted (2008b) that carers managed by an Aboriginal OOHC service provided a better level of support and guidance around cultural issues for Aboriginal children. The important role that Aboriginal-specific agencies can play in the lives of Aboriginal children in care was highlighted in the recent report by Wood (2008). The report acknowledged the importance of partnerships between non-Aboriginal service organisations and Aboriginal organisations, and of shared responsibility in child protection and the provision of OOHC services. A national policy to guide the implementation of such partnerships has been developed by the Secretariat for National Aboriginal and Islander Child Care (SNAICC). The, *Service Development, Cultural Respect and Service Access Policy* (2008) aims to empower Aboriginal communities to have a central role in the decisions that affect the protection and wellbeing of their own children.

**Promising Practice:** SNAICC's *Service Development, Cultural Respect and Service Access Policy* (2008) provides details of how existing non-Aboriginal community service organisations in Australia can partner (i.e. pool resources, expertise and knowledge and work together) with local Aboriginal agencies to develop new service models and programs for Aboriginal families and communities. Under the policy a new network of Aboriginal-controlled community organisations would be established to operate culturally safe programs, including out-of-home care services.

*Victoria:* In Victoria a new carer-assessment framework for kinship/relative carers is being developed by the DHS. The framework has four main aspects and is based on the practice principles of four cycles in working with families – comprising information-gathering, analysis and planning, action, and review:

1. *Initial Placement Assessment:* (within seven days) comprising a home visit, a risk/safety assessment and a police check.

2. *Family Assessment*: (within two months) comprising a family meeting with extended family to consider: the most appropriate placement; the child's wishes; the carer's support needs; practical arrangements around contact; possible family re-unification; and changes in family relationships. Following this assessment, the carer family is to be linked to resources based on the needs of the child and carer.
3. *Longer-Term Assessment*: Following the court order a further assessment with carer and family is to be conducted to ascertain: the longer-term needs of child; any family relationship issues; the child's view of the future; and the ongoing relationship with birth parents; as well as to review and adjust the carer's needs for respite/support.
4. *Permanency*: Assessment of the future living situation is to include discussion with carer, parent, child and family covering all aspects relevant to determining a permanent situation for the child (DHS, 2007a: 30).

In SA, kinship carers are assessed differently from foster carers, who receive a more rigorous assessment. Relative/kinship carers currently complete a *Provisional Registration Initial Safety Check Assessment* that remains in place for up to three months. The Department of Families and Communities (DFC) is currently (April 2009) working towards a relative (non-Aboriginal) and kinship (Aboriginal) competency-based assessment tool, with specific practice guidance for culturally-competent intervention assessment and support (Maudie, 2009).

In Queensland, both kinship carers and foster carers are assessed and provisionally approved for a set period of time (60-90 days) before a more substantive application must be completed. When placements are being considered, children are to be included in the decision-making process and to be fully informed of all details of their care plan (as long as they have the level of maturity and the ability to understand).

The Indigenous Child Placement Principle states that when placing an Indigenous child in Queensland, a 'Recognised Entity' (i.e. Aboriginal agency) must be provided with the opportunity to participate in the decision-making process about the person in whose care the child should be placed (e.g. Indigenous relative or person of significance to the child) (Child Safety Practice Manual, 2009). Some concern has been expressed, however, at the lack of adherence to the Principle for Indigenous children, with adherence decreasing from 77 per cent in 1997 to 56.7 per cent in 2009 (QATSICCP: 2007; AIHW, 2009).

**Promising Practice:** A worker in a Queensland Aboriginal agency commented that at times the search for an Aboriginal kinship placement was cursory, and that, given the crisis-driven nature of the process, workers often took the easiest route by placing the child with a non-Indigenous carer. The officer suggested that what the system required was 'bridging' placements. The officer argued that it should be possible to have small family group homes run by Indigenous people to act as bridging placements with connections to foster carers to take the child (short-term) if finding an Indigenous relative took time.

**Promising Practice:** Queensland is the only Australian State that has policy provisions for specialist kinship care for children with special and/or high needs. There are two options: *specialist kinship care* and *specific response care*. For children with moderate to extreme needs *specialist kinship care* is a placement option that

enables the child to remain with kin. Additional supports (available as required) include access to therapy, additional casework, support and respite. For children with complex to extreme needs there is the option of *Specific Response Care*, a model of care where a kinship (or foster) carer is employed and paid a wage by a licensed service to provide intensive, therapeutic, home-based full-time care to a child (Child Safety Practice Manual, 2009).

**Promising Practice:** For Aboriginal and Torres Strait Islander youth (in small remote Queensland communities) an innovative practice in out-of-home care is being used. The model allows for young people to stay in their community with Aboriginal and Torres Strait Islander carers. Young people (12-17 years) are placed in a 'safe house': a residential service providing a 24 hour houseparent model of care with additional rostered staff. This placement type is also considered as a viable option for keeping large sibling groups together (Child Safety Practice Manual, 2009).

In Tasmania kinship carers are subject to similar assessment and approval processes as foster carers.

In the NT potential Family Carers (i.e. relative/kinship carers) are initially given a short assessment. A full carer assessment is conducted only if the placement is to be of 12 weeks or more duration. The Family Care policy is currently (April 2009) under review by the Department of Health and Community Services in relation to the timing of carer assessment. In addition policy is to be clarified around Indigenous carer assessment. The various tools to support the assessment process are also being reviewed to provide consistency across the Territory.

Scapin (2003) notes that the assessment of kinship carers in the NT is quite different from the traditional assessment of foster carers, which usually occurs prior to the placement of the child and is completely separate from placement casework. The writer observes that in remote or smaller locations in the Territory, it commonly happens that: 'the assessment process frequently runs concurrently with the casework during consultations with the family'. This approach is consistent with the exchange model of casework practice and fits closely with an assessment model that changes the emphasis from 'approving' carers to 'enabling' carers to provide care for the child (Scapin, 2003: 21; see also Waterhouse, 2001).

**Promising Practice:** A carer assessment model that changes the emphasis from 'approving' to 'enabling' carers to provide care for the child includes the completion of a genogram, allows a worker to gain an understanding of the family history, family constellation and social network. In the process information is provided to the family about the agency and the role of the workers and the carers. This process allows workers:

- to activate and mobilise resources for the carer family;
- to obtain approval and provide support to the carer; and
- to construct a framework/case plan of support for the carer family (Scapin, 2003).

In the Territory a prime consideration when implementing the ACPP for an Aboriginal child entering the OOHHC system is that Aboriginal families are to be consulted and actively involved in the intervention and decision-making process. Part



of this process includes hosting a family meeting where the child's genogram is mapped (Jackson, 2009).

In the Territory family mapping for Aboriginal families is regarded as crucial in placement decisions:

Family networks are "huge" and intersect with "skin" relationships such that many people are responsible for the care of the child and have to be involved in decision-making about that child. It is critical that these relationships are mapped out in a genogram (Williams and Satour 2005).

For Aboriginal children the preferred option in family decision-making is the involvement of an Aboriginal worker who has appropriate knowledge and experience of the child's cultural background. Identifying and including family members with appropriate responsibilities and relationships to the child is also critical in this process. The Aboriginal worker's role is to provide advice on cultural issues, family politics and customary law, and to assist the department and the families to reach an agreed decision. An 'agreed' decision is crucial in this process, as placement decisions that are not in accordance with family views may break down due to a lack of support for the carer from the family and community (Williams and Satour, 2005).

In WA the provision of relative care is in a state of transition (April 2009). A new carer assessment guide/format is due to be released later this year. The new tool for relative-carer assessment will be similar for that for general foster carers, and the assessment will be competency-based. A key difference in relative-carer assessment is the use of an 'interim' assessment to enable the placement of relative children in an emergency. It is not clear whether there is to be a separate Indigenous carer-assessment tool (Ding, 2009).

**Promising Practice:** A senior officer from Aboriginal Services, WA Department for Child Protection consulted for this project noted the importance of having an Aboriginal worker involved in the family-decision-making process with Aboriginal families. In addition she said it was crucial to include the specific views of the parents of the child in regard to who was to care for the child. Based on her experience she has found:

Where the views of the parents have been disregarded and the Department has made the decision (based on their view of appropriate carers) and when the child leave the Department's care they end up with NOTHING. No department, no family, no ties, no connections and no way of making up for the time that they have missed out on their culture and family. They are lost between both worlds.

The need for departmental policies that acknowledge the cultural differences in Indigenous and non-Indigenous child rearing practices was emphasised by the officer from Aboriginal Services. She spoke of the difficulties for an Aboriginal family where children, already at risk of harm, were being cared for by kin and a decision was made to conduct a formal assessment of the carer family. She noted:

It is hard for Aboriginal people to understand that they need to be assessed to prove to a non-Indigenous person that they can look after a member of their family when they have been caring for that person their whole life anyway. It is difficult at times to get our carers to understand the Department's policies and practices.

*Canada:* In Manitoba kinship, carers and foster carers have the same assessment/home study model. Both have access to the same training and there is little training specific to kinship carers. There are two categories of licensing for carers:

1. foster/kinship care; and
2. place of safety (specific to a particular child).

The place of safety licensing is not as rigorous as licensing for foster/kinship carers, as it is oriented to the particular placement of a child who may already be in the home of the kinship carer. In practice, assessors usually exercise some leeway with kinship providers. There is a package of information and requirements to license a short-term place of safety (usually child-specific), and these requirements are quite basic (abuse registry checks, letter of reference, etc.). If a child remains in the home for more than six months, a kinship family is expected to complete the regular assessment/home study process for foster/kinship carers. Indigenous agencies, under the Aboriginal Child Welfare Authorities, are expected to pay special attention to cultural factors in their assessments of kinship carers for Indigenous children (McKenzie, 2009).

In Newfoundland, once a carer has been found a preliminary assessment process is used to expedite the approval process. Final approval of the carer has to be completed within 30 days of the preliminary assessment. The preliminary assessment includes:

- home visit and interviews with all persons in the home;
- child, youth and family services record check;
- verbal police checks on all persons 12 years of age and over;
- two verbal non-relative references;
- one verbal collateral reference (school if applicable); and
- determining the wishes of the child and the relationship that exists between the child and relative (or significant other) being considered for approval (Newfoundland Government, 2009).

In Ontario the *Safe* (Structured Analysis Family Evaluation) home study is the tool used to assess families including foster carers and kinship foster carers. It has a pre-formatted report and includes a Psychosocial Inventory, which looks at psychosocial factors and mitigating circumstances in the assessment of each of the carers. It is divided into five sections as follows:

1. Factual reporting.
2. Family description.
3. Psychosocial inventory.
4. Psychosocial evaluation report.
5. Placement recommendations (Goodman, 2009).

One criticism of the home study stated by one of the managers interviewed from this study was that the tool was not particularly culturally sensitive. The manager noted

some of the unique differences in kin families compared with foster carers: '[the families] are not always financially stable, their personal histories are not always ideal [but] they already know the child they will be caring for. Their role as a relative changes to the role of a parent, which is key to how they will manage this change' (Roblin, 2009).

**Promising Practice:** The carer assessment tool Safe (initially developed for adoption purposes) was adapted by the CAS agency team (Ontario) to be kinship specific. The CAS kinship care program manager noted: 'I really like the tool as it is strength based and gives workers a good understanding of where people's limitations are and where their strengths exist' (Roblin, 2009).

*New Zealand:* Findings from a Department of Children, Youth and Family (CYF) survey of foster and kin caregivers in 2006 led to the revision of the caregiver assessment and approval framework to make it more appropriate for kinship carers. A further initiative developed by the department was the introduction of a health and education assessment for children entering care. The aim of this assessment is to ensure that agencies implementing OOHC services for children identify their needs to ensure health and education needs are met. As researchers note this allows for 'the gathering information for the family to assist decision-making, particularly in family group conferencing' (Rankin and Mills, 2008: 35).

The formal aspects of the assessment process are the same for non-family/whanau caregivers and family/whanau caregivers. Police, referee checks, background departmental information checks, assessment of home and physical environment, and social work interviews, are carried out for both groups. There are slight differences such as a separate application form for family/whanau caregivers. A medical report is also required for non-family/whanau caregivers, but with the family/whanau caregiver applicant medical assessment can be done directly in discussion and where there are any concerns the social worker will seek permission to get a written report from the applicant's doctor. Apart from the formal aspects (basic safety checks), the assessment process for family/whanau caregivers reflects the basic differences in this type of care from non-family caregiving. The interview/discussion with family is intended to be a joint exploration of the needs of the child and the caregiver's needs with respect to their support of the child.

*Norway:* The assessment of kinship foster carers in Norway is similar to assessment of other foster carers. The main tool used for kinship carers is the 'recruiting report' designed by Foster Home Services, which focuses on the special issues and possible vulnerabilities of kinship carers. In addition, as for other foster carers, health and police certificates have to be obtained.

*United Kingdom:* In relation to carer assessment in the UK, two writers found that kinship foster care had been grafted onto the existing system of children's services. In some authorities kin care was often not even regarded as part of the fostering services at all. As a consequence, there were few policy and practice documents on kinship care, and it was not clear how kinship foster carers should be assessed (Farmer and Moyers, 2008: 17). Other UK researchers have suggested that the assessment of kinship foster carers is a complex area of practice that can be more time-consuming and challenging than assessing foster carers more generally. Of critical importance in

the assessment process is the parenting capacity/competency of the kinship foster carers (Hunt, 2008; Hunt, Waterhouse and Lutman, 2008).

**Key Message:** Several researchers in the UK suggest that both practitioners and carers want an assessment format specifically designed for kinship placements (Hunt, 2008; Hunt, Waterhouse and Lutman, 2008; O'Brien, 2001; Pitcher, 2001; Waterhouse, 2001).

**Key Message:** In discussing what a kinship foster care assessment should focus on Hunt (2008: 4-5) cites the work of Doolan and Nixon, 2004 who found that 'carers resented the concentration on risk and wanted a sensitive, inclusive, respectful process that valued their skills and knowledge'.

In recognition of the particular relationship between the child and the carer (often already existing), researchers suggest that there needs to be some 'flexibility' in the assessment process, while ensuring that the safety and well-being of the child is not compromised. Suggested areas where a more flexible approach could apply are in relation to the accommodation, health and age of kinship foster carers. (Flynn, 2001; O'Brien, 2001; Hunt, Waterhouse and Lutman, 2008; Wheal, 2001).

The use of a more flexible but rigorous and supportive approach has been suggested by Pitcher (2001). This researcher emphasised that approval standards for relatives could be different, but that did not mean they were lower. Workers involved in a 'supportive' assessment should focus on the following aspects:

- gauging the ability of the relatives to meet the needs of the child;
- discounting early in the process people unsuited to meet the child's needs;
- being honest with relatives and sharing ideas;
- identifying support needs of the placement;
- ensuring relatives understand why the assessment is needed and why particular areas are covered;
- being friendly, informal, reliable and consistent;
- acknowledging differences in age, experience, race and beliefs (e.g. religion) and
- acknowledging the relative's concerns fears and other things happening in their lives in regard to the placement (Pitcher, 2001: 108).

To ensure the assessment is rigorous Pitcher (2001) suggested the following points be observed:

- information on the family/child should come from a variety of sources/people;
- the value of assessments carried out over weeks/months is that workers can gauge how carers respond and behave in relation to various events;
- an ongoing record of observations/feelings by the worker in relation to the assessment should be retained;
- a second person/worker is useful in the early assessment period especially where hard questions are being asked;
- potential carers can contribute to the assessment process by writing or speaking about their childhood;
- worker needs to adapt/reflect/revise as assessment moves through its phases; and

- the worker needs to remain objective in relation to the differences between self and the persons being assessed (Pitcher, 2001: 108-109).

**Promising Practice:** Elements of a ‘good’ assessment model suggested by three researchers in the UK are that the model should be based on an information exchange, in which the social worker acts as a resource for families ... working with the family in an empowering and collaborative way. Assessments should move from ‘approving’ to ‘enabling’ relatives to care. Central to the assessment process is the identification of needs and the creation of a service package (i.e. case plan) that must be followed up by regular supervision and regular review meetings (Hunt, 2008; O’Brien, 2001; Waterhouse 2001).

*Scotland:* Policy and practice developments around kinship foster care in Scotland are in a state of flux. In response to a report prepared by the Fostering Network (tFN) and British Association for Adoption and Fostering (BAAF) Task Group, the Scottish Government is to implement an interim assessment/approval tool for kinship foster carers. As well as a number of ongoing policy and practice developments around ‘looked after’ children in Scotland, the assessment tool is to be reviewed in late 2009 (tFN – BAAF, 2008a).

The tool consists of two components – the *Child’s Plan in Kinship Care* based on ‘My World’ *Assessment Triangle*, and the *Child’s Plan and the Kinship Carer Assessment*. Of interest in the carer assessment are the four timed stages when various tasks are carried out and agreements negotiated:

- the initial stage (within three working days of placement), for the *Emergency Clearance Tasks and Agreement*;
- stage two (within six weeks of the placement) incorporates the *Intermediate Agreement* with kinship foster carers to meet the child’s needs;
- within three months the third stage the *Kinship Placement Confirmation Meeting* is held; and
- within six months of placement the fourth stage, the *Permanent Placement Discussion*, occurs (tFN BAAF, 2008b: 9-19).

The Task Group noted that in many ways assessment process was more like an assessment for family support than for foster care. Echoing the work of English researchers, the Task Group argued that the assessment of kinship foster carers ‘should identify what services and supports the carers need to care for the child rather than an assessment of their key competencies’ (tFN-BAAF, 2008b: 30).

**Key Message:** In many ways, similar to a family assessment, the worker/s after satisfying themselves that carers can provide adequate and safe care, should identify ‘the strengths and pressures on the kinship family, weigh these, and work to identify where supports are needed’ (Tfn-BAAF, 2008b: 30).

*United States:* In assessing kinship carers, the CWLA (2000) suggests taking a family-centred casework approach. This approach centres on conducting assessments *with* families rather than *of* families and respects cultural values as key factors in the decision-making process. The assessment provides a framework to guide professional discussion and establish the case plan for services and supports for children and kin

families. Depending on their age, developmental status, and maturity, children should actively engage in the assessment process. Family-centred assessments focus on:

- valuing a family's strengths and expertise (see also Flynn, 2001: 132);
- taking into account the nature and quality of family relationships;
- being inclusive rather than exclusive;
- being timely, thorough, and ongoing;
- addressing risk factors and treatment needs;
- being racially, ethnically and culturally competent; and
- addressing the willingness and ability of the prospective kinship caregiver to provide a safe, stable, nurturing home, and to meet the child's developmental and safety needs (CWLA, 2000: 22-28).

Like the UK research, the US literature also notes the importance of using a more flexible approach in kinship care assessment. For CWLA (2000) flexibility does not apply to standards in relation to child protection and safety (including police checks), but it does apply when 'needs' are being assessed in relation to the child and carer. For example, flexibility can be applied:

- in the case of the size and structure of the kinship carer's home, the number of bedrooms and the amount of furniture (based on age/developmental needs of the child for privacy and space); and
- in the case of requirements relating to the age and health of the kinship carer (as long as the age/special needs of the child are accounted for).

Financial assistance should be provided to families to prepare the home to meet a child's practical needs (e.g. bed, bedding, furniture, etc) (CWLA, 2000: 46-47).

The CFP (2007) noted the realignment of roles for children, birth parents and caregivers and wider kin members. This change in roles can cause difficult transitions for those involved, and in the assessment process it is seen as important to discuss the responsibilities of, expectations for, and rights of birth families, kinship carers and children in the process.

**Promising Practice:** The approval process for kinship carers can be occurring time of crisis for the family. One strategy that lessens stress and helps people understand the processes they will be asked to go through is to provide potential caregivers with detailed information on the various processes<sup>13</sup> (CFP, 2007: 27).

**Promising Practice:** Strategies used to successfully negotiate the initial period of the placement and maintain family connection include promoting opportunities for carers and birth parents to spend time together in the transition stages to discuss the child's routine, likes, dislikes, bedtime routines and discuss how the child is doing. This process can also be settling for the child to see parents/caregivers interacting (CFP, 2000; 36; see also Jerve, 2008).

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<sup>13</sup> The strategy of providing potential/prospective kinship carers with information and advice *before* the assessment process is also suggested by Eboji (Research in Practice, 2008: 15).

**Key Message:** CWLA observes that kinship caregivers are essential partners in all planning and implementation processes. Although kinship caregivers may become part of the formal child welfare system, they are, first and foremost family members caring for family and not ‘providers’ of a service. Kinship carers either caring for a child prior to involvement with a child welfare agency or after assessment may not consider the living arrangements as a ‘placement’ (CWLA, 2000).

*Observation:* The assessment process for relative/kinship carers is highly variable across Australian jurisdictions, with a number of States currently (April, 2009) developing new assessment tools. A number of tools used for assessing kinship carers in Australia and elsewhere appear to be variations or adaptations of tools used for assessing foster carers. In discussing the assessment of carers for Aboriginal children, several stakeholders/consultants emphasised the importance of including an Aboriginal worker/agency in the decision-making process, and of giving particular attention to the views and preferences of Aboriginal birth parents in relation to who is to care for the child.

### 3.3 Carer training

*Australia:* In NSW kinship carers are not required to attend training, either initial or ongoing. DoCS's *Service Model for Kinship Carers* suggests that workers assess individual training needs appropriate for the role of a relative/kinship carer, document these in the child's or young person's case plan, and provide or arrange information/training sessions as required. In relation to Aboriginal kinship placements, training is to be provided to both workers and carers to ensure that casework practice and carer support is culturally responsive to Aboriginal issues (DoCS, 2007).

**Promising Practice:** DoCS's staff consulted for this project noted that there is a definite need for kinship carers (Indigenous and non-Indigenous) to be offered training. A senior caseworker (Care and Support Team) in a Community Service Centre (CSC) in the Sydney metropolitan area found two training programs: a modified version of *Shared Stories and Shared Lives*<sup>14</sup> and the *Triple P (Positive Parenting Program)* had been well received by non-Aboriginal kinship carers. The CSC, in conjunction with workers in an Aboriginal agency, plans to implement an adapted version of *Triple P* training for their Aboriginal kinship carers this year.

One caseworker, who had used *Triple P* with both kinship (i.e. grandparents) and foster carer groups, thought at first there were differences between the two groups. The behaviour problems of the children of kinship carers did not appear to be as severe as those of foster carers. The worker felt, however, that this was partly due to the grandparent's perceptions of what counted as good and bad behaviour. For example, one grandmother who said she had no behaviour problems found when she came to the training group that her pre-school grandchild's regularly late bedtimes (around 11pm) were not appropriate. The caseworker thought that owing to their stage in life and their age, grandmothers would put up with behaviours that other younger carers would not tolerate.

The caseworker found in the training sessions that some grandparents expressed an enormous sense of resentment and stress that they could not be a grandparent to their grandchildren – they had to be a parent instead. The caseworker noted that the 'stress management' module of *Triple P* was well received by kinship carers. The worker noted that the 'guilt' around being involved with DoCS was 'huge' for grandparents and caused strain on family relationships. The worker suggested that 'stress management' was an area of training that should be provided to all kinship carers because of the benefits of being able to discuss their role and their expectations of themselves and the children's expectations of them as kinship carers. The issue of meeting the specific needs of the kinship carers of adolescent children was brought up by another consultant for this study (a regional project officer of carer support groups). This project officer will be arranging a grandparent/relative carer parenting program later this year for carers of adolescents. The group is to be run by the child and adolescent mental health team, with the project officer supporting the workers.

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<sup>14</sup> In NSW many OOHC agencies use *Shared Stories Shared Lives* for training foster carers. The package is widely used as the main carer training material.



**Key Message:** A community project officer (NSW) felt the word ‘training’ was inappropriate for kinship carers and often undermined a carer’s sense of self and worth. Kinship carers already feel guilty and unhappy and believe that they must have done something wrong to be in the current situation. They have already parented but now feel that their parenting was inadequate. The worker suggested that ‘support’ or ‘help’ in dealing with the challenges that children can bring would be more appropriate terminology. Based on her experiences, working with grandparents, the officer thought training should include:

- an understanding of the modern education system/curriculum;
- an understanding of grief and trauma in children and ways that carers can help children deal with their changed world; and
- deal with the carer’s own trauma and ongoing grief.

A manager of OOHC services in a large regional town said that currently no training was provided for the agency’s kinship carers (either Indigenous or non-Indigenous). The manager believed this would change if recommendations from Wood (2008) report were implemented. The agency’s kinship carers are offered foster carer training but they rarely attend. The manager suggested that part of the reason kinship carers do not want to be involved in training is because they know the child and they know the family and they do not think they need it: ‘some people don’t like to be told how to parent, they think they know how to be parents’, she wryly observed.

In relation to training for Aboriginal kinship carers, a ‘needs analysis study’ of Aboriginal kinship carers by departmental workers in one region in NSW found that, while carers had received *Shared Stories Shared Lives*, no ongoing training had been provided (Kirby et al., 2008). One outcome from the study was the implementation of organised ongoing training and training sessions for the carers, based on the identified needs. A further outcome was the decision by the Aboriginal workers to assist carers in the region to set up and take ownership of their own carer-support groups. In addition, workers planned to arrange special camps for kinship carers to allow them to workshop ideas, to attend training sessions and to meet with other carers (Kirby et al., 2008).

**Promising Practice:** The need for Aboriginal foster parents to have access to Aboriginal specific parenting programs designed and implemented in collaboration with Aboriginal Communities has been recognised by the department (DoCS.) The department is implementing *Our Carers Our Kids* a training package for Aboriginal foster carers (DoCS, 2008a: 22). In light of the training needs for kinship carers noted by other stakeholders, consideration should be given by the department to extending *Our Carers Our Kids* training to Aboriginal kinship carers.

A manager of an Aboriginal agency consulted for the project explained that training is provided on a regular basis for all kinship carers in the local area (as well as foster carers). It has also been possible for the agency to send some carers to the Indigenous Conferences in OOHC to further their knowledge. All Aboriginal child care agencies in NSW conduct training for their carers in their local areas.

**Promising Practice:** All carers attached to the Aboriginal child care agency (NSW) who attend training are reimbursed for attendance (\$50 for a half-day and \$100 for a full day). The manager noted that this strategy has ensured attendance by kinship

carers is high and the strategy has been instrumental in increasing the understanding and skills of the carers in many aspects of caring for children.

**Promising Practice:** A staff officer from a Queensland Aboriginal Agency noted that the department had developed a DVD for kinship carers. The officer stated that training using DVDs should be considered for kinship carers. In general the officer thought that training should be part of a carer's support package and the allocated worker on regular home visits should provide one-on-one training/advice/information.

In Victoria, departmental kinship/relative carers are not required to participate either in initial training or in ongoing training, but kinship carers with at least one CSO (Berry Street, Hume) were required to attend training. The CSO expected the kinship carers to complete the required sessions in the first 12 months of placement, and then to attend two further training sessions within a three-year period (McConaghy, 2008).

In SA, all foster carers, including kinship carers, are required to complete initial (induction) training prior to becoming a carer, kinship carers have a degree of flexibility about when they attend their induction training. Carers are expected to work toward the attainment of initial training within the three-month time frame of *Provisional Registration*. In addition, ongoing training is currently (April 2009) being offered to relative/kin carers via two SA non-government agencies.

A SA study of grandparents caring for grandchildren found that some of them were experiencing significant levels of stress in their caring role, and suggested that they be offered counselling and parent-training programs (Dunne and Kettler, 2007: 344). In 2009 the department (DFC) appointed a new team (Assessment Training and Review) to address the training needs of relative/kin carers. In addition Relative Kinship Care Program workers were to receive training on key aspects of caring for children (Maudie, 2009).

In Queensland and Tasmania, kinship carers are not required to attend training, but they can participate in pre-service and ongoing training to assist them in meeting their support and learning needs (Child Safety Practice Manual, 2009; DHHS, 2009). In WA, kinship carers do not have the same 'preparation training' as general foster carers. Currently (April, 2009) kinship carers have access to a training package called 'Supportive Learning' which is delivered in small groups or one-on-one (Ding, 2009).

In the NT, the training package provided for all foster and Family Carers (predominantly Aboriginal) in the Territory is '*Our Carers Our Kids*', based on the NSW training program for Indigenous carers. It includes Aboriginal family stories and reiterates the importance of Aboriginal children retaining family, community and cultural ties. The Territory consultant noted that the department had responsibility for providing ongoing training opportunities to family carers (Jackson, 2009).

*Canada:* In Newfoundland, caregivers ('family and significant others') are offered a standardised nine-week training course – PRIDE (*Pre-service Training for Prospective Resource Families*) – but they are not required to participate. Unlike foster carers, family caregivers do not have to undertake annual reviews, but there is an assumption that changes affecting the care of the child will be documented and assessed during the social worker's regular visits with the family (Newfoundland Government, 2009).

In Ontario and Manitoba, kinship foster carers are required to attend PRIDE prior to becoming a care provider. The training assists potential caregivers to prepare for the multifaceted system of child welfare, while also exploring areas such as loss, grief and family access in a group environment. This is a requirement for all potential new foster parents, kinship foster carers and adoptive parents.<sup>15</sup> The following topics are among those included in the training:

- issues related to family access;
- coping with adolescent behaviour;
- creating boundaries, and avoiding triangulation and split loyalties;
- family disruption and transitions when a kin child is placed;
- advocating for the kin child;
- education and special needs of kin children; and
- carer responsibilities and worker roles (Goodman, 2009).

The manager of the Kinship Care Program noted that requiring kinship foster carers to attend 'pre-service' training when the kin child was already placed with them created an anomalous situation. The agency provides extensive ongoing carer training and invites/encourages the agency's kinship foster carers to attend alongside foster and adoptive families (Roblin, 2009).

**Promising Practice:** In reflecting on the practice of kinship and foster carers attending joint training the manager of the Kinship Care Program (Ontario) commented:

I am mixed in my thoughts about this. I believe there is a richness that comes from them [kinship carers] learning about others experiences (e.g. getting to know foster parents, adoptive parents) and most importantly the foster and adoptive families getting to know kinship families (it is one way to break down the barriers to preconceived [negative] beliefs about kinship care families). We've found that since we have had them together people are being more open to the idea of having other options [kinship care] for placement of children. On the other hand it has been identified that kinship carers would like to have more kinship specific training and I agree that there are definitely unique considerations (Roblin, 2009).

The CAS agency has not as yet developed specific training for its kinship carers, but the manager pointed out that there were kinship-specific training manuals available (e.g. CWLA).<sup>16</sup>

**Promising Practice:** The Manager of the kinship care program (Ontario) noted that their agency conducts three different generic programs providing behavioural and/or therapeutic support to carers. The manager noted:

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<sup>15</sup> The PRIDE model is currently implemented in seven Canadian provinces/territories (CWLC: 2003).

<sup>16</sup> CWLA: *Supporting the Kinship Triad: A Training Curriculum* (available for purchase) <http://www.cwla.org/pubs/pubdetails.asp?PUBID=7336>.

The kinship care program utilizes these programs slightly more than our foster care system. I believe that it is what has saved several of our kinship placements from breakdown. We have been very successful with our homes and have had a very low breakdown rate. (Roblin, 2009).

*New Zealand:* Currently family/whanau caregivers are encouraged to attend the training available to foster caregivers. A departmental officer explained that they are currently developing more appropriate training modules to better meet the needs of family/whanau caregivers.<sup>17</sup> The proposed training can be delivered in a variety of settings, which research indicates are more appropriate venues for family/whanau caregivers, including peer support groups (Mills and Usher 1997).

**Promising Practice:** Worrall (2009) suggests that culturally appropriate in-service training should be compulsory for all family/whanau caregivers of Māori children with a care order as it would assist carers to provide a culturally strong and safe care environment for the children (Worrall, 2009).

*Norway carer training:* PRIDE is used for recruiting and training foster carers in Norway and it has been adapted for use with kinship caregivers. The 20-hour training program is provided by FHS before the placement has been approved, or as soon as possible afterwards. In relation to ongoing training, FHS offer an annual weekend course for kinship carers covering different subjects.

**Promising Practice:** It has been the Norwegian agency's experience that some kinship carers are reluctant to take part in training. FHS is encouraging social services to make training compulsory for kinship carers and include it as part of the approval process. FHS has found that kinship carers are more motivated to attend training when special training is offered for them (Aas, 2009).

*United Kingdom:* Researchers have found that unless kin carers are assessed/approved as foster carers, few receive any initial or ongoing training (Wheal, 2001; Farmer and Moyers, 2008). One UK study has examined the effects of kinship carer training and placement disruption. The researchers found that, in one local authority where there were no placement disruptions, more kin carers were approved as foster carers (96% compared to 75%) and more showed high levels of commitment (79% compared to 52% ) (Farmer and Moyers 2008: 79).<sup>18</sup> Hunt (2008:6) suggests that carer education/training needs should be addressed at the assessment stage, and the emphasis should be on developing the carers' skills and knowledge.

The Fostering Network (previously the National Foster Care Association) and the Family Rights Groups have produced training and resource material for relative

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<sup>17</sup> A training manual for kinship carers has been written (April 2009) for Child, Youth and Family (CYF) and may be made available on the CYF website (Worrall, 2009).

<sup>18</sup> Farmer and Moyers (2008) suggest that the one local authority where no placement disruptions had occurred may have been due to chance as placement numbers were low (20 compared with 39, 38 and 30 in the other three local authorities).

caregivers.<sup>19</sup> Flynn (2001) noted that the training package material treated relative caregivers and foster carers equally, and attempted to find ‘common ground’ between them to enable them to work within *existing* local authority systems, rather than attempting to change those systems to suit relative caregivers. The researcher found that the training materials focussed on:

Procedures, legal aspects of caring, and relationships with the local authority and [not] the identification of resources and supports, and the clarification of the relationships between the kinship foster carers and social services. (Flynn, 2001: 130)

The researcher believed not attending to these important aspects was a significant omission as having access to information on rights and responsibilities were important aspects for carers. Other areas where the researcher thought carers required training were in understanding the changing nature of their role and changes in relationships – issues not addressed in the UK training material (Flynn, 2001:130).

**Promising Practice:** The Scottish Government (2007) has investigated the training requirements for kinship foster carers and suggested that, in general, training for kinship foster carers should be similar to that provided for general foster carers. The report provided examples of suggested good practice in training and supporting kinship foster carers including:

- monthly drop-in groups (training to be provided);
- on-line training; and
- using experienced foster/kinship foster carers to deliver training (Scottish Government, 2007: 25, 26).

*United States:* The paper by CFP (2007) says that mandatory training provided early in the placement has been found useful in providing a venue for carers to meet and network with other carers while learning to understand aspects of statutory care (e.g. navigating the system, legal issues, etc). The provision of transport and child care is also seen as important in encouraging carers to attend a group (CFP, 2007: 47-49, 71-73).

**Promising Practice:** Training session/seminars for kinship carers are seen as useful in assisting the ongoing development of agency policy, programs and practice. Carers can complete surveys and provide input/feedback (e.g. in face-to-face meetings or in groups) on the services/support they have received or need to access. A further important strategy for agencies wishing to solicit feedback from kinship carers outside their own areas, is to develop and build good relationships with directors of regional programs hosting other grandparent support groups (CFP, 2007: 52, 56, 60).

Additional important resources that can be utilised to assist kinship caregivers are community partners: faith-based organisations, places of worship, community providers of health services, foster care associations, local councils, child care centres, schools, and associations for people from specific cultural backgrounds.

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<sup>19</sup> Publications for ‘Family and Friends Carers’ are available for purchase through the Fostering Network (<http://www.fostering.net/resources/subjects/family-and-friends-foster-care>) and Family Rights Group ([http://www.frg.org.uk/reports\\_family\\_and\\_friends\\_care.html](http://www.frg.org.uk/reports_family_and_friends_care.html))

**Promising Practice:** Engaging with community partners (e.g. at local inter-agency meetings) is a strategy that allows workers to provide knowledge about kinship families and their needs and to break down negative stereotypes around the suitability of kin as caregivers (CFP, 2007: 61-63).

CWLA suggest a more professional approach to training and conducting family assessments of kinship carers. CWLA (2000) has a model for training kinship carer givers (*Tradition of Caring (Kinship PRIDE): Information, Resources, and Support for Kinship Families*). The training model contains a facilitator's guide for conducting training, and a guide (i.e. tool) for conducting family assessments. The training involves 27 hours (nine sessions), with modules focussing on:

- general kinship care issues;
- supporting healthy child growth and development;
- accessing needed resources;
- addressing changes in family dynamics;
- promoting children's needs for lifelong connections; and
- understanding and navigating the formal child welfare system.

In addition, CWLA (2000) suggest that agencies provide educational resources for kinship carers, such as workshops, seminars, and discussion groups. Ongoing kinship-specific training may also be of benefit to kinship carers in the following areas:

- addressing issues specific to parenting for the second time;
- understanding relationships between kinship children and other children in the household;
- resolving/mediating family conflict;
- addressing the medical, emotional and educational needs of children;
- accessing financial support and resources;
- addressing cultural, ethnic and religious orientations; and
- working as a member of a team (CWLA 2000: 64).

*Observation:* It is clear from the discussion around training that most workers, agencies and organisations regard training as critical in assisting kinship carers to increase their skills and knowledge. There is much debate over 'how' and 'when' training should be initially provided, but there is strong support for the view that training needs to be ongoing to meet the changing needs of kin children and carers. Foster-carer training is supported as a model of good practice, but there is no general agreement on specific training modules for kinship carers.

### 3.4 Financial support for kinship carers.

*Australia:* In NSW, allowances provided for relative/kinship carers are the same level as those for foster carers: *Statutory Care Allowance* is provided to kinship carers where parental responsibility is with the Minister, and *Supported Care Allowance* to other kinship carers (same levels of payment). The payment regimes for kinship carers includes provisions for higher rates for children with high and complex needs, as well as additional financial support for goods and services (e.g. medical needs, counselling, assistance with birth family contact) (Insideout, 2006).

When DoCS introduced the new carer payment system in 2006, with payments applying both to statutory relative/kinship carers and foster carers, a community project officer of a kinship-care program noted that this change was of enormous benefit to the grandparent carers. One unfortunate aspect of the policy change, however, was that not all grandparents caring for grandchildren in statutory care were made aware of the change or of their entitlement to payment. Many did not receive payments until they came into contact with the community program or spoke with other grandparent carers.

In the case of additional financial support, a community project officer of a kinship-care program in northern NSW noted that carers were often not aware that they could be entitled to receive financial assistance (establishment fee of \$1400) to meet the 'standards' required by the department (e.g. bedding and equipment for the kin children). The project officer was involved with around 140 carers in support groups. She had found from speaking with carers that individual managers and workers took a very variable approach in the provision of additional financial support, and that standards around required bedding and equipment for kin children were sometimes more strongly enforced by some workers than by others.

In Victoria, statutory relative/kinship carers receive the same ongoing basic carer payments as foster carers. All statutory kinship care placements converted to permanent care placements continue receiving carer payments until the child in care turns 18. Private (informal) kinship carers do not receive financial support, even though they are involved with DHS (Champion, 2009).

In SA, foster and statutory relative/kinship carers receive the same level of financial (carer allowance) support. Relative/kinship carers can receive additional funding (up to \$5,000) for furniture/equipment, training courses and/or home supports (e.g. housekeeping/gardening, respite options, maintenance of cultural/kinship connections) (Maudie, 2009).

In Queensland statutory relative/kinship and foster carers receive the following:

- the same fortnightly caring allowance;
- a regional and remote loading when applicable;
- a high support needs allowance for assessed, eligible children;
- an establishment and/or start up allowance; and,
- reimbursement of approved expenditure on child-related costs, based on the child's needs and eligibility criteria (Child Safety Practice Manual, 2009).

In Tasmania statutory relative/kinship carers are reimbursed at the same rate as foster carers. They may receive additional reimbursement if a child has a disability, a medical condition, or a behavioural or other problem (DHHS, 2009). A project officer for a grandparent project interviewed for this study noted that the department appears to have a policy of encouraging grandparents to request guardianship of their grandchildren. This means that carers may receive less financial support from the department and have to pay court costs (most grandparents have assets so legal aid is not an option). When birth parents (usually through legal aid) contest guardianship applications, this increases the grandparents' legal costs. This scenario of workers 'encouraging' grandparents to seek parental responsibility (i.e. guardianship) was also noted by a project officer in NSW.

In the NT if the kin child is in the care of the Minister, registered Family Carers are provided with a carer allowance (Jackson, 2009). In WA, policy mandates that relative carers receive the same financial support as general foster carers (Ding, 2009).<sup>20</sup>

*Canada:* In Manitoba, Newfoundland and Ontario, kinship carers receive the same allowance as foster carers (McKenzie, 2009; Goodman, 2009; Newfoundland Government, 2009). In Newfoundland, additional funds are available to kinship placements for social/recreational activities for the child, and for vacations and the costs associated with access. Funding may also be available for carers to attend meetings, training and workshops (Newfoundland Government, 2009). In Ontario, kin foster carers do not receive the same entitlements as regular foster carers, e.g. the bonus for years of experience and credits for training. Only the basic rate is paid, however unique the treatment needed by the child, although kin foster carers are eligible for some additional expenses, e.g. child care (Goodman, 2009). CAS believes that kin foster carers should receive the same level of allowances as regular foster carers, as they are required by the government to meet the same standards and regulations (Goodman, 2009).

*New Zealand:* Prior to April 2009, only some departmental kin caregivers were eligible to receive the *Unsupported Child Benefit*, and it was an amount considerably lower than that provided to foster carers. From that date, however, all departmental kin caregivers have been able to claim the *Foster Care Allowance* (Worrall, 2009).

*Norway:* An allowance, similar to the foster care allowance, is provided to all kinship carers (Aas, 2009).

*United Kingdom:* The UK has a complicated and confusing *Fostering Services Regulations* system for remunerating kin foster carers. The study by Farmer and Moyers (2008) found that the amount of financial support kin carers received depended on the type of order or the regulation under which the placement was made. Kin who were approved as foster carers received a higher level of fostering allowance, and some received agency support. Decisions around levels of financial support appeared to be made on an ad hoc basis and were inconsistent from one local authority to another. As is the case in Australian jurisdictions, kinship carers are often urged by workers in their authority to apply for residence orders (i.e. guardianship),

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<sup>20</sup> The term 'kinship' is not used in policy documents in WA.



with a consequent loss of entitlement to carer allowance and agency support. Extra payments for children's birthdays and holidays available to foster carers were not usually provided for kinship foster carers (Farmer and Moyers 2008: 113).

The UK government has acknowledged that the payment system is complicated and confusing by including in the *Children and Young Persons Act 2008* provisions for improving the financial, practical and social work services available to kinship foster carers. Scotland is also in the process of providing parity of financial support for kinship foster carers of children in statutory care (Scottish Government, 2007: 22). It is proposed that by 2011 all local authorities are to provide their kinship foster carers with the same financial support (carer allowance) as foster carers.

**Promising Practice:** In relation to financial support for kinship carers and to ensure best practice and quality in kinship care, the Scottish government is proposing that:

- all carers receive an annual training entitlement (with child care) to cover travel, attendance and any loss of salary costs;
- an annual 'retainer fee' be provided for a number of days, when the carer needs a holiday or short break away from their care responsibilities;
- a 24-hour support service be provided to ensure that carers receive relevant advice and support at the time it is needed; and
- a one-off fund be provided to ensure a speedy response to a carer's need for replacements and repairs, and for investment in larger, one-off items to enable carers to provide an improved service to the children in their care (Scottish Government, 2007: 33).

*United States:* The situation in the US is similar to that in the UK, in that remuneration for kinship care is variable from one state to another.

**Key Message:** CFP argues that, regardless of who has legal guardianship of the child (the carer or the state), adequate and ongoing financial assistance for kinship carers is essential to maintain placement stability (CFP, 2007: 50).

*Observation:* It is an important finding that relative/kinship carers in all Australian jurisdictions are provided with the same level of allowance as foster carers (where the child is under guardianship to the state). Previous research had found that the level of allowance available to formal kinship carers varied from one jurisdiction to another, and that it was usually lower than that provided to foster carers (Mason et al., 2002: 42). In all the other jurisdictions investigated in this study (except the UK and the US), statutory kinship carers were found to be provided with the same level of carer allowance as that of foster carers. It also appears that in several jurisdictions carers are eligible for reimbursement of costs for goods and services.

### 3.5 Non-financial support for kinship carers.

*Australia:* In NSW, it is departmental policy that casework support, case management and caseworker contact for statutory relative/kinship carers (where parental responsibility is with the Minister) is to be the same as that offered to foster carers. DoCS's *Kinship and Relative Care Service Model* states that carers are to be offered support in managing/facilitating family contact arrangements; to be provided with respite; and to have peer support (e.g. support groups) arranged. Statutory relative/kinship carers who are under stress are to be offered other additional support and services, and if shown to be necessary on the basis of a thorough needs assessment, specialist support services are to be provided to meet a kin child's special needs (e.g. psychologist, speech pathologist, medical specialist, educational programs) (DoCS, 2007:8; DoCS, 2008b:12).

Non-statutory kinship carers (i.e. those who receive the *Supported Care Allowance*, where parental responsibility is with the carer) are not as well supported, as they receive only the financial assistance provided to all carers, plus an annual review (DoCS, 2008b: 35). It was evident from consultations with the staff of several CSCs that most carers receiving *Supported Care Allowance* were not 'active' cases (i.e. they had no allocated caseworkers), no case plans were in place, and few carers had been offered an annual review. A manager of OOHc services in a large regional town said that, from March 2009, reviews of children in kinship care placements where carers receive a *Supported Care Allowance* will take place only once every five years rather than every 12 months. Reviews of case plans for kinship placements will be at the discretion of Case Managers. This change in policy in NSW would appear to be in the direction of offering even less support and monitoring of children, and less attention to required changes to case plans, than before.

One worker from a non-government agency, who was interviewed for this project, said that she had recently conducted a number of kinship carer assessments for DoCS (under contract). When she followed up the assessed carers, she found that all were receiving financial remuneration at the basic rate of payment although not all were receiving regular casework support. Though carers had requested training, none had been offered and no carers had joined support groups. Another case worker said that their office found that the '80/20 rule' applied, i.e. only a relatively small number of kinship placements (20%) were constantly coming to the attention of workers for ongoing support.

The manager of an Aboriginal kinship services agency (NSW) noted that support issues for Aboriginal kinship carers tended to be more problematic than for foster carers. Concerns around some kinship placements included, for example, one carer couple (adult son living in the home) where the number of kin children (6+) placed with the couple had over-stretched the capacity of the carer to meet the needs of the children. It had become necessary to break the group into two, with the older children (adolescents) being placed separately from the younger preschool-aged children. Additional supports were put in place to ensure the varying needs of all children were being met.

**Key Message:** Concerns for Aboriginal kinship carers noted by the manager of a NSW Aboriginal agency included:

- advancing age and health needs which impacted on caring;
- aged grandmothers and aunts caring for large sibling groups;
- aged grandmothers and aunts with responsibility for chronically-ill spouses as well as kin children; and
- carers' lifestyles completely 'turned around' with the demands of, and responsibilities for, very young kin children impacting in a detrimental way on their energy and stress levels.

**Promising Practice:** In the Aboriginal agency (NSW) all children in kinship (and foster) care had an initial health assessment and an annual check-up/assessment with a General Practitioner in the agency's office. The Aboriginal agency was closely linked to an Aboriginal health service, and they were extensively involved in assisting with the health and therapeutic needs of kinship children. To assist all kinship (and foster) carers, monthly weekend respite camps were provided, and vacation care was organised in school holidays.

Two community project officers in different areas of NSW spoke of their programs supporting grandparents raising grandchildren. Both provided activities and camps for kinship families and separate camps for kin children. Family-based activities (e.g. picnics, bush walks) and supervised activities were provided for kin children in school holidays. The value of these programs was in the respite they offered grandparents and the opportunity to make connections with others in similar circumstances, thus helping to break down kinship families' social isolation.

**Promising Practice:** Two community programs (for grandparents raising grandchildren in NSW), offering social/recreational programs for kinship families and providing limited respite for carers, have been well received by grandparents and by the young people in kin care.

Currently (April 2009) in Victoria, there appears to be no specific policy provision for support for departmental kinship placements, and research has found that in practice there is little support and few services (e.g. allocated caseworkers) for statutory kinship/relative carers (Champion, 2009). Other research has found that only limited casework and support can be provided to kinship carers until the placement is settled (CECFW, 2006: 16). However, kinship care placements that were managed by one of the six non-government agencies (CSOs) were found to receive a high level of ongoing support, (McConachy, 2008).

In SA, kinship/relative carers are entitled to the same level of support as foster carers when the department has guardianship of the child (90% of all kinship placements in 2004) (Maudie, 2009). In Queensland, kinship carers' general support needs, based on the needs of the child, are negotiated as part of the carer-support plans and recorded in the placement agreements. Support is to be provided for the child and carer for the duration of the placement (Child Safety Practice Manual, 2009).

In Tasmania, too, kinship carers are entitled to receive a similar level of support to that offered to foster carers (DHHS, 2009). A project officer of a grandparent project noted that, as a result of a new initiative in the department (following a recent review), kinship care placements were now being contacted every six weeks. The project officer observed that, for some grandparents, the increased supervision was regarded as 'surveillance' of kin families and was resented, while for others, the

increased engagement with workers had allowed for an assessment and resolution of unmet needs.

Assessed and registered Family Carers in the NT are also entitled to receive a similar level of support as foster carers. Each child in the Minister's care has a plan that must include: the needs of the child; how these will be met; and details about placement arrangements (Jackson, 2009). Research in the Territory suggests that higher levels of support may be required for Aboriginal kinship carers, as Family Carers are generally the grandmothers or other single females from the maternal family. As with Aboriginal carers more generally, they are often on low incomes, in poor health and caring for a number of children as well as other family members (Williams and Satour, 2005).

In WA, relative carers are increasingly receiving the same level of support as general foster carers (Ding, 2009). From 2007-2008 the WA Government made provision for an average of 10 days of respite care per year for relative (and foster) carers. There is no evidence to indicate whether this respite is actually being provided, or whether it is being taken up by carers.

*Canada:* In Manitoba, kinship carers are eligible for the same level of social work support as foster carers (McKenzie, 2009). For Newfoundland, little was noted in the guidelines in relation to support services for kinship carers, except that respite may be available to approved caregivers and funded child care for employed carers (Newfoundland Government, 2009). In Ontario, kinship foster parents receive similar services to foster carers. Services can include access to Placement Support Workers and/or Foster Placement Support Workers (i.e. employed experienced foster parents provide support and advice regarding child management, budgeting, working with a multi-player team, etc.) (Goodman, 2009).

In Ontario, all kinship foster homes have a resource worker who visits (i.e. monitors) the caregivers in the home approximately every six weeks or whenever they request assistance. The manager of the kinship care program said that regulations for monitoring all kinship homes were passed two years ago in Ontario. They were introduced due to a small number of situations where children were seriously harmed because of a lack of assessment and monitoring (Roblin, 2009). The resource worker is responsible for ensuring that the caregiver meets all licensing requirements (as required by the Ministry), while providing support and resources when needed. Kinship placements vary in their needs and requirements depending on numerous variables. These variables include the children's needs, age, as well as the kin caregiver's abilities, financial support, extended support network, etc. The standards of supervision and monitoring are similar to the level of supervision required for licensed regular foster homes (Goodman, 2009).

**Key Message:** Staff on the kinship care program in the CAS reported that, in the initial stages of placement, kinship caregivers appreciated a high level of monitoring and assistance. Over time some carers could get by with less, but there were always those who had fairly high needs (Roblin, 2009).

*New Zealand care support (non-financial):* A departmental survey found that kin caregivers were reluctant to approach the department (CYF) for support, and that they only did so as a last resort. The survey also found that not all kinship placements were

supervised by a social worker, and that, for carers who had obtained legal guardianship of their kin children, there was little or no involvement with the department (CYF, 2007). Worrall (2009) suggests that, like the practice in the CAS kinship care program (above), supporting, supervising/monitoring all kin care placements is important.

**Promising Practice:** A New Zealand researcher suggests that ongoing support services (e.g. counselling) for kinship carers should be provided by the voluntary sector and referrals made to child and family support services for other supports. All support services (e.g. medical, dental, educational, clothing, holiday & gift allowances) provided to foster carers should also be offered to kin caregivers. In relation to respite for kin/whanau caregivers good practice would be providing respite services (e.g. funded before- and after-school care and child care) similar to foster carers (Worrall 2005, 2009).

*Norway:* In Norway, legislation mandates that monitoring is to be provided for kinship care placements, just as it is for other foster placements. The Norwegian consultant for this study noted, however, that it was the agency's impression that less monitoring and follow-up was provided to kinship carers than to other foster carers. Kinship carers, like foster carers in general, are also entitled to receive support and services based on their needs. In practice, stated the consultant: 'kinship carers appear to receive less support (i.e. less guidance and home visiting) possibly because they are left more to themselves and/or request less support/services'. National figures for Norway in 2007 indicated that 41 per cent of foster carers received additional support, whereas only 20 per cent of kinship carers did (Aas, 2009).

**Key Message:** The Norwegian consultant opined that one reason for the 'lesser' support received by kinship carers is because kinship carers preferred to see themselves not as 'carers' but more as grandparents, aunts/uncles, etc.[and] possibly social workers saw an opportunity for reduced follow up work compared to other carers (Aas, 2009).

*United Kingdom:* Numerous UK studies report that kinship placements require support but that there is a lack of support/services (including support groups) offered both to the kinship foster carers and to their children (DCSF, 2008; Doolan and Nixon 2004; Farmer and Moyers, 2008; Hunt, Waterhouse and Lutman, 2008; O'Brien, 2000).

**Key Message:** Researchers (UK) found that kinship foster carers were uncertain of what type of services/support they were entitled to or how to access them. They suggest that information on entitlements and all other types of support be provided to kin when they agree to provide care (Hunt, 2008:5; Hunt, Waterhouse and Lutman, 2008: 185). All the issues, that foster carers were concerned about, have been found by researchers to be similar, if not heightened, for kinship foster carers. Similar to foster carers, kinship foster carers want to feel valued and to be shown respect and consideration (Hunt, Waterhouse and Lutman, 2008: 178-9; Laws, 2001: 124).

A recent study found that only four out of 141 kin carers did not want involvement with children's services or social workers. Indeed, carers with approved residency orders (i.e. guardianship), when their case was closed and no further financial or non-financial assistance was provided, reported a sense of isolation and aloneness when

they no longer had access to departmental workers (Farmer and Moyers 2008: 120-121).

**Promising Practice:** One UK study found that social support (i.e. from family/friends) for kinship foster carers was important. Support received by the carers was usually emotional rather than practical, and many would have liked respite or babysitting to relieve the burden of constant caring. The study found that placement stability for kinship placements appeared in some cases to depend on the provision of sustained support.

For those families where the placement broke down, the common factor that might have made a difference was 'help in dealing with the child's behaviour and/or managing its impact on the rest of the family'. For vulnerable kinship families 'better service provision might have improved the chances of the placement lasting' (Hunt, Waterhouse and Lutman, 2008: 173, 206-207).

**Key Message:** The value of 'family' providing care for their kin was highlighted in a UK study where researchers found that once relatives cared for a child it was other family members that were asked to take on the child if the present carer was no longer able to continue. Quite often it was the family who organised contingency plans if required (Farmer and Moyers, 2008: 48).

O'Brien (2000; 2001) found in studies with Irish kin families that the level of need for support varied over time. The studies also found that high levels of support needs were connected to the demographic profile of the carer network (e.g. older age, lower socio-economic circumstances, poorer health, and a tendency towards multiple placements).

**Promising Practice:** Researchers suggest a need for frameworks which distinguish kinship families requiring high levels of supervision/support from those requiring low levels. Such frameworks could guide policy and practice in determining the services/support required for specific placements, and in evaluating outcomes for families based on the provision of varying levels and types of services/support (Hunt, Waterhouse and Lutman, 2008; O'Brien, 2001).

*United States:* The CFP paper (2007) notes that the child welfare system is not always viewed in a positive light by families who become involved with it. The importance of promoting trust and establishing a strong relationship between workers and the family as the care plan is developed cannot be overemphasised.

**Promising Practice:** Good practice is implementing a care plan (agreed to by child, birth parents and caregivers) that provides culturally appropriate, relevant services to meet the needs of the child and carers. Important roles required of agency workers to help caregivers to obtain resources and services are facilitation and advocacy with face-to-face meetings providing specific information. Alongside the care plan (and on an ongoing basis), carers should be provided with fact sheets, brochures and guides on available services and supports. Gaining the views of experienced kinship caregivers about what is relevant and valuable information is a good strategy, as are regular newsletters for disseminating information, providing updates of relevance and interest, and promoting mentoring programs for kinship carers (CFP, 2007: 41-46).

The CWLA (2000) also emphasised culturally specific services/supports for the placement, and also noted the importance of the care plan. If the child is Indigenous, the child's community should be involved in the assessment/service process. The care plan for kinship placements may need to consider the following services/support:

- *For children:* Services may be required to meet the physical, mental, emotional and educational needs of children including preventive and rehabilitative health care (e.g. vision, hearing and dental checks), mental health evaluation, and counselling services. Educational assessment, planning and assistance may also be required. Support groups for children may be beneficial.
- *For carers:* Carers may need legal assistance, parenting support, housing assistance, health care, child care, respite care, counselling, support, and help with understanding and dealing with their adult children (the birth parents). Information (including written material) on services/supports should be provided. Carers should be encouraged to join support groups.
- *For birth parents:* Parents may require services related to the problems (e.g. substance abuse) that led to the placement of their children. They may also require assistance in enhancing parenting skills, in dealing with feelings of loss, anger and separation, and in planning for reunification or other permanency options for their children. Support groups may also be of value for birth parents (CWLA, 2000: 54).

**Promising Practice:** Agency workers should provide ongoing monitoring of the health, safety and well-being of all children in statutory kinship care placements. To ascertain the service/support needs of the kinship family, regular contact should be maintained through visits to the child and the carer by the caseworker at least once a month, and telephone contacts as needed (CWLA, 2000: 48).

*Observation:* In relation to support for kinship families, there appears to be widespread agreement that all statutory kinship placements should be supported and supervised. There does, however, appear to be some debate as to whether all kinship families require the same level of support. Providing kinship carers with adequate information about roles, responsibilities and entitlements is seen as essential. The reality, that it is 'family' who is providing the care, appears to influence how both carers and workers perceive kinship care and the support that is 'offered' (or not) by workers and 'accepted' (or not) by families. For all carers it does appear that respite is appreciated and is of benefit to kinship carers.

### 3.6 Contact and access with birth parents

*Australia:* Most consultants in Australian jurisdictions that provided information on kinship care noted that contact with birth parents was the most problematic aspect. A case manager of a NSW CSC said that it was critical in the assessment process for workers to focus on understanding the relationships between birth families and carers, and the complications of those relationships. In this manager's experience, kinship assessments were not being done well and there were numerous families with contact orders that were just untenable. 'The orders put kinship carers under a lot of pressure in facilitating contact that they probably should not be facilitating. This is a common occurrence'. In summarising the issue, the manager said kinship families had two extremes:

On the one side they are totally melded as a whole family, which creates possible risk of harm for the children. Or the kin carers can't stand the birth parents and do not want to facilitate contact. In the circumstances our workers note it is very hard for all involved to be neutral about what has happened.

This perspective was repeated by a Tasmanian project officer of a program supporting grandparents. She said when acrimonious relationships existed, many grandparents did not want anything to do with birth parents unless there was a Family (or Child) Court order for contact. From this project officer's experience in working with grandparents, she had found it was not unusual for contact orders to be breached by both birth parents and grandparents.

A manager of OOHC services in a large regional town found longstanding generational conflict within the wider family exacerbated difficulties around contact. Sometimes departmental workers had the responsibility for implementing a court-ordered contact order and 'controlled' the contact between parents and children and in contentious cases supervised the visit. The manager commented that kinship placements with their high emotional content were more complex and difficult to manage than foster care.

A staff officer from a Queensland Aboriginal Agency noted that parents' substance abuse problems made it difficult for grandparents to deal with unsupervised contact, as it raised concerns about the safety of the child. Among a menu of services that could be provided to support access visits, she suggested supervised contact was the best option. These views were echoed by a facilitator of grandparent support groups, who found that grandparents were conflicted and stressed by contact orders. They had to obey the order, but they felt that, when doing so they were endangering the children. In relation to Aboriginal kinship placements, the worker suggested that supervised contact centres appropriate for Indigenous people were the best option for *all* very young Indigenous children (worker emphasis). A Victorian child-welfare centre recommends that contact/access may require the involvement of trained mediators to support families with potentially complicated and/or dangerous access situations (CECFW, 2006: 26-27).

Other Australian research has also found that contact with birth parents was challenging for carers due to conflictual relationships, and that departmental workers were not always helpful in resolving tensions. The authors suggest that additional support is required by carers to manage contact, with practical steps needed around



arranging supervised contact, designated supervision places, and structured activities for contact visits (Higgins et al., 2006:7).

**Key Message:** A review of studies around contact in kinship care placements (Scott, O'Neill and Minge, 2006) found several key aspects noted by writers:

1. Consideration should be given to children's views on contact and its frequency, and these views should be noted in the child's case plan.
2. It is not possible to provide hard and fast age-related guidelines for contact.
3. More frequent contact is important initially to lessen a child's sense of abandonment and to ensure the parent-child attachment is maintained.
4. Infants and toddlers may need more frequent contact (2-3 times weekly) to retain the memory of their parents.
5. Older children have more capacity to remember and to better understand their parents' attendance (or not) at contact visits, and weekly contact may be enough to sustain a parental relationship (Hess & Proch, 1988; Robson & Hudd, 1994, cited in Scott, O'Neill and Minge, 2006).

**Promising Practice:** One worker in this project observed that fast food restaurants (e.g. McDonalds) were common venues for supervised contact visits, but that they were inappropriate, and activity-based centres for children were a better option.

*Canada:* The consultants in Ontario also noted access and visitation could be a 'challenging issue' for kinship care families. In the ideal situation, when contact is amicable, birth families are allowed access visits in the carer's home. Relationships, however, were not always amicable, as birth families were torn over the decision to place the children with kin, or they resented not being able to parent themselves. Where relationships were tense, the CAS managers noted that carers were sometimes offered additional support and training to manage supervision

**Key Message:** Experience has shown the CAS agencies that using kin to monitor access could put them in unfair and potentially unsafe situations. The consultants suggested that issues around unsafe/problematic access should be discussed thoroughly during the assessment process. In some cases a visitation center or neutral place could be necessary, depending on supervision requirements (Goodman, 2009; Roblin, 2009).

*New Zealand:* The New Zealand consultants for the project echoed the views of the Australian and Canadian stakeholders, noting that birth parents' mental illness could cause concerns around access visits. It sometimes happened that grandparents caring for their grandchildren were also supporting the children's parents in their homes, although little was known about the dynamics of these situations.

*Norway:* Like the Canadian consultant, the Norwegian consultant noted that identifying possible family conflicts was an important part of the assessment process, as 'heavy' conflicts were the main reason for not approving family/kinship carers. Social services provide assistance to kinship carers where family conflicts occur, and assist birth parents when the aim is to return the child to the birth parents (Aas, 2009).

*United Kingdom:* In the UK, several studies have found contact problematic when relationships between birth parents and kinship carers were poor or acrimonious (Farmer and Moyers, 2008; Hunt, Waterhouse and Lutman, 2008; Laws, 2001; Nixon, 2007 Wheal, 2001). In these circumstances, enforcing contact orders often disturbed

and distressed the children, and this presented problems for carers, both before and after the visits with birth parents (Farmer and Moyers, 2008: 171-173).

Two UK studies found that mothers were more likely to maintain ongoing contact with their children than fathers were, and that when contact occurred it was more likely to be with the maternal side of the family (Farmer and Moyers, 2008: 65; Hunt, Waterhouse and Lutman, 2008: 252). One study of both kinship and foster carers found that more kin carers (54%) experienced difficulties with contact than did foster carers (16%), with kin carers more often supervising contact (43%) than foster carers (16%). The researchers found that help managing difficult contact visits was the main reason for carers wanting ongoing involvement with children's services (Farmer and Moyers 2008: 66-68).

**Key Message:** One UK researcher said that mediation services and skilled intervention were required to assist the relationships, when contact situations between kinship family members were difficult (Stogdon, 2001: 154).

**Key Message:** Other UK research found that exclusion and marginalisation of the birth parents from decision-making and case planning appeared to be factors which changed co-operative family networks into distressed/conflictual relationships (O'Brien, 2000: 208).

**Key Message:** There is some research showing that, when kin family relationships are positive, contact with birth and other relatives is more 'natural' and happens more frequently than when children are in foster care. This research found that kinship carers went to greater lengths than foster carers to make sure contact happened, and that contact helped with placement stability and was beneficial to the children's emotional and social development (Nixon, 2007:48-49).

*Observation:* Both the literature and the stakeholders consulted for this study see contact between carers and birth parents as the most problematic area of kinship care. Contact is generally perceived as 'difficult' when relationships between carers and birth parents are poor or acrimonious. In relation to decision-making around contact, it is important to consider the views of children and birth parents, as well as those of carers. To ensure the safety of children and carers in some placements, supervised access visits in suitable venues should be offered.

### 3.7 Carer support groups

In NSW, there are a number of kinship support groups across the state, mostly grandparents caring for grandchildren. Some are small stand-alone groups run by volunteer grandparents, and others are part of funded regional projects set up by community service organisations with paid facilitators who organise, advocate and inform carers, both in the support groups and as individual members.

Groups consist of both formal and informal grandparent carers, and they meet in various venues—in carer's homes, at Neighbourhood Centres and Family Support Centres, or at other local community organisations. There is no definitive source giving the exact number of grandparent support groups in NSW, although Grandparents raising Grandchildren NSW lists 48 carer support groups (Indigenous and non-Indigenous) across the state, AbSec has 36 constituted Aboriginal foster and kinship carer support groups, and the Samaritans Foundation has established 11 support groups.

A community project officer facilitating a kinship care regional project in northern NSW, who was interviewed for this project, discussed several aspects involved in facilitating support groups of kinship carers. She said:

- Groups are about 'communities of interest not communities of suffering'.
- They usually run for two hours. The first hour is devoted to an activity not connected with caring issues. If there is an urgent matter for a carer, the worker and carer go elsewhere to discuss it. Others in the group, aware of what is happening, go ahead with the activity.
- Morning tea follows and the second hour is a 'talking circle' for people who want to talk about issues or need to get help. Participants can stay or leave. Sometimes only the worker and one carer stay; at other times, carers will join in if they feel strong enough to listen, share and help.
- Care is taken when introducing new members not to discuss 'heartrending and harrowing stories' at the initial meeting, as some carers come once to a meeting and then never again.
- Through the groups many carers form personal relationships with other carers. They often pick one another up when attending the group, take someone out shopping, and on occasions mind each others' children.

Another project officer of a regional project said that a kinship care program on the Central Coast (NSW) was formed in 2006 because of community demand for support for grandparents with the full-time care of their grandchildren. At the time the project was established (with one part-time paid project officer), there were two volunteer support groups already in existence and operating under the auspices of a charitable body. The worker contacted both groups and explained the project to their carers. Initially the grandparents were reluctant to become involved with the program. The project officer found the initial suspicion understandable, as it was based on the grandparents' negative experiences dealing with government departments and child welfare.

Over time, a strategy devised by the project officer encouraged the grandparents to set the priorities and help manage the program. Twelve grandparent carers were invited to join a steering committee representing six local areas. The committee proposed the

terms of reference and took the proposal back to the local groups of carers for consultation. Giving the carers ownership of the program proved to be very productive, said the project officer, as carers wanted to be involved and they had many very good ideas about how the program should look. Most of the grandparents in the groups were statutory kinship carers, although few had any involvement with DoCS. This lack of contact between grandparent families and DoCS had historical antecedents, said the project officer. In times past, once a kinship carer had been assessed and the child placed, the file was closed. No caseworkers were allocated to these families and most became ‘inactive’ cases. It was the project officer’s belief that the majority of the grandparents in the groups were still ‘inactive’ cases.

There are approximately 150 grandparent families on the database of the Central Coast kinship program. Most groups meet monthly, but on any given day there will be 10-15 carers participating in a meeting, with the project officer eventually getting around to attend all the groups. Each group has formed a distinct entity and personality, and activities vary according to carer need. For example, one is a social group that has regular excursions and get-togethers. Another is very political and spends time working out ways of influencing government policy around grandparent issues. Contact has been made with the local member of parliament who has attended several meetings. This political group was very educational for the project officer, giving her a better understanding of grandparent issues and how they had been addressed.

She said that some of the groups had play groups associated with them because the majority of the members had preschool-aged children. She also said that the social side of the groups was very important in lessening isolation and that in many of the long-standing groups carers were comfortable talking about their grief issues. Many grandparents had significant life skills and past work histories (e.g. writers, artists, teachers, and other professional people), and ran their groups without facilitators—they were self-sufficient.

**Promising Practice:** The importance of encouraging the maintenance of existing grandparent support groups was noted by a regional co-ordinator of a kinship care program in the Blue Mountains (NSW). The co-ordinator commented that not all groups wanted, or needed, an ‘outsider’ (i.e. paid worker) to run their group. The co-ordinator offered facilitation and advocacy skills training to carers, in order to support and maintain existing grandparent support groups. The training provided by the local TAFE outreach worker was well received by grandparent carers, who were acting as group facilitators. Another strategy devised by the co-ordinator was to develop a resource kit for relative carers containing information on financial assistance, legal requirements and support services, as well as carer stories (Springwood Neighbourhood Centre, 2008).<sup>21</sup>

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<sup>21</sup> The *Resource Kit for Relative Carers* is available for downloading at <http://www.sncc.org.au>. (see also *Having a Voice & a Choice*, (2008) *Handbook for Relatives Raising Children*, New York, available for downloading <http://www.otda.state.ny.us/main/publications/4957.pdf>)

It was not unusual for the project officers interviewed to comment that significant numbers of non-Aboriginal grandparents in the grandparent support groups were caring for Aboriginal grandchildren. Workers found that there could be animosity between the two sets of grandparents, and it often took considerable skill to ensure the child had contact with both sets of grandparents. As the UK research had found, workers noted it was commonplace for grandchildren to be with their maternal grandparents.

The manager of an OOHC service in a large regional town said there were departmental foster carer support groups but no departmental support groups for kinship carers. Attempts had been made to organise kinship carer groups, but due to the geographical spread of carers it was difficult to bring them together on a regular basis. The manager said that many kinship carers supported one another through their own networks, and the CSC had provided two carer-support workers to assist both kinship and foster carers.

**Promising Practice:** Two workers interviewed for this study (one the manager of an Aboriginal agency and the other a non-Indigenous community project officer) both said that formal carer support groups did not work well with Aboriginal kinship carers. One tactic used by the Aboriginal manager to attract carers was to invite the agency's carers to a training forum (with carers paid to attend). Prior to the forum, there was time for carers to chat informally and make contact with other carers. The manager commented that Aboriginal carers did not like to have the focus on themselves when issues around kin children were being discussed. Forums allowed carers to listen and absorb advice and information in a group setting, and to make their own connections about its relevance to their kin children. This enabled carers to seek out a caseworker for the assistance they required at a time of their own choosing.

The non-Indigenous worker used a different strategy to engage Aboriginal kinship carers. She explained how she organised grandparent carer support groups and provided information that might be helpful to carers, when she was invited to attend an art group for Indigenous women where 11 of the 14 women were grandparents or aunties raising grandchildren (formally and informally). After her short talk, she and the women chatted about art and the women's paintings and had tea and cake. Towards the end of the meeting a grandmother asked if she could talk privately with the worker, and they went and sat outside under a tree. At the next meeting she attended, several more grandmothers asked to speak with her, and one-by-one they sat outside and discussed their issues as grandparent carers. She attended the group for several months, assisting and providing information to the women in this manner. She also attempted to establish a support group for kinship carers (Indigenous and non-Indigenous) at a community centre in town, but no one came. In her opinion it would require an Indigenous worker to attract Indigenous women.

In Victoria there are around 20 grandparent and relative support groups throughout the state. They provide a range of benefits to carers, including:

- practical information;
- discussion on parenting and child development;
- debriefings on the impact of caring;
- contact with other carers;
- sharing feelings of grief/shame;

- friendship and time out; and
- regular newsletters (DHS, 2007a: 26).

Other support groups for grandparents in Victoria are provided through *Relationships Australia*, *Grandparents Victoria* and the *Mirabel Foundation*. Among a range of other services, the *Mirabel Foundation* offers kinship carer support groups, therapeutic children's groups, recreational programs, respite care and family holidays, family camps, and advocacy.

A South Australian departmental officer said that there were strong support groups for relative/kinship carers in the state, led by relative-care support workers, some of which were facilitated by a non-government agency (Centacare). Relative/kinship carers also had access to *Grandparents FOR Grandchildren*, which provides assistance and services for grandparents (formal and informal carers), including advocacy at all levels of government. DFC has also funded, supported and helped establish a grandparent respite project, 'Time for Kids'. The aim of the project is to develop supports for long-term placements by providing respite care services for departmental relative/kinship carers (Maudie, 2009).

In Queensland, kinship carers can join local foster carer support groups or *KinKare* groups. *KinKare* is an independent community group that supports grandparent carers (formal and informal) through monthly newsletters, family social activities, and information and advice. *KinKare's* newsletter publishes information about local support groups (phone numbers/email contact) for both Indigenous and non-Indigenous carers (*KinKare*, 2009). Respite for informal grandparent carers (although not for statutory relative carers) is provided by a government-funded program, 'Time for Grandparents', which facilitates young people's involvement in local clubs and sports. Other local organisations (e.g. *Grandparents Raising Own Grandchildren* (GROG) and *Off Our Rockers*) provide grandparents with Queensland-specific referral, support, social contact and networking for grandparents raising grandchildren.

In Tasmania, a state-wide family support project, *Grandparents Raising Grandchildren* (Tasmania) (GRG), was established in 2005, funded by the Commonwealth government. The service's four family support workers identify grandparents' needs, provide support, and facilitate links to resources in the community. The service provides a monthly newsletter to members (232 in March 2009). The program's co-ordinator advocates for grandparents by writing reports and submissions to government departments, and by giving presentations (e.g. to the Family Law Council in 2008). Some groups are coordinated by grandparents and others by the program's family support workers (Ryan, 2009).

The consultant for the Tasmanian grandparent project discussed a number of difficulties trained facilitators had uncovered when they were introduced into existing grandparent groups. They found that many participants had little understanding of group dynamics and group behaviour, and that they were often unaware that some behaviour could be so intimidating to new carers that they didn't return to the group after their first visit. Conflict was also sometimes an issue within groups, and it became the facilitator's responsibility to ensure that no carer was harmed in any way. The consultant said that facilitators found that it was not unusual for group members to become stuck on the negatives of what had happened to their lives, dwelling on the

past and re-traumatising themselves. Facilitators also found that confidentiality, privacy and boundaries were not always being respected, and that it was important to point this out to people so that all participants understood and respected other members' privacy

**Promising Practice:** Two innovative strategies emerged from the Tasmanian GRG project. One was the establishment of a grandparent advisory council with seven members who are elected by carers in GRG, and who represent all the GRG grandparents in their region of the state. Carers bring issues to their particular member, who then meets with the council and the project co-ordinator to seek ways of resolving them. One of the council's approaches was to invite the state government Minister to a meeting to discuss a range of issues around grandparent carers and to seek solutions to issues relevant to state government policy. This proved very productive. The second GRG strategy was to provide information packs to Community Services Expo and other open days, explaining what grandparent carers did. The information packs also benefitted grandparents who were previously unaware of GRG and linked them to support groups (Ryan, 2009).

In Tasmania, *Grandpower Inc* also provides information, support, newsletters, telephone assistance, monthly meetings for grandparents raising grandchildren, and recreational activities (e.g. fun days) for grandparent families. The Tasmanian Government also provides funding for camps for grandparents and their grandchildren and, unlike the situation in Queensland (see above), these are available to both informal and formal kinship carers.

In the NT there are no support groups specifically for kinship carers (Jackson, 2009). WA has one grandparent-support organisation, *Wanslea Grandcare*, with support groups throughout the metropolitan area of Perth and services state-wide. The organisation has three interlinked components:

1. 1800 information line (for advice/information);
2. support services and opportunities for carers to link up with other grandparents; and
3. individual consultations for families with complex family matters (*Wanslea Grandcare*, 2009).

**Promising Practice:** A community project officer in NSW described a strategy to provide respite devised by one kinship carer support group. The group drew up a list of those prepared to be involved in providing respite for each another when someone needed a break. The carers also discussed the possibility of completing foster care training so that, when week-end respite was needed, they would be authorised carers who could take children who were under the Minister's parental responsibility. Both kinship and foster carers of children where parental responsibility lies with Minister, require approval from DoCS before children can have 'sleep-overs' at each others' houses.

*Canada:* As in Australia, caregiver support groups have been developed across Canada for grandparents (formal and informal). (These are called 'support circles' in British Columbia). Writers have argued that support groups are crucial to the emotional health of grandparents, as well as to their education and peer support. The benefits for participants include:

- information forums, e.g. on parenting skills, legal and custody issues, and education and financial issues;
- brochures/guides on accessing child care, camps and other services;
- sharing and exchanging experiences, advice, support and encouragement; and
- meeting/socialising/networking with other grandparents (Fuller-Thompson, 2005: 21; Hawkins and Millard, 2008: 9).

*New Zealand:* The *Grandparents raising Grandchildren Charitable Trust* (GRG Trust) was established in 1999 to meet the needs of grandparents and other kin caregivers. In February 2009 there were 3889 members in 49 self-initiated support groups in GRG run by voluntary co-ordinators. The convenor of the GRG Trust said that carers joined a group for support, friendship and sharing with other carers, and to learn and gain knowledge about kin care-giving. The Trust with some of the groups organised camps for kinship families. When setting up groups for grandparent carers, it was not always necessary to ‘reinvent the wheel’, the convenor said. It was sometimes possible to tap into another organisation which was already running a group and utilise their resources (GRG, 2009). The Trust provides a regular newsletter for all members and has produced a *Handbook for Grandparent Carers* (Worrall, 2007).

*Norway:* In Norway, the FHSs have established groups of family carers which meet once a month over a year and which function as carer support groups (Aas, 2009)

*United Kingdom:* The need for support groups for kin carers has also been noted by numerous researchers in the UK (O’Brien, 2000; Laws, 2001; Pitcher, 2001; Hunt, 2008; Hunt, Waterhouse and Lutman, 2008), although there is little published research on their use. Two organisations, the *Grandparents’ Association* and *Grandparents Plus*, offer advice, information and support to formal and informal grandparents caring for grandchildren. Both organisations provide a regular carer newsletter. In March 2008, *Grandparents Plus* launched the *Grandparents Raising Grandchildren Network* for grandparents to share experiences, agree on priorities, and draw up an action plan to present to government. Hunt (2009) noted that, at a stakeholder seminar at *Grandparents Plus* in January 2009, the UK government promised a ‘new framework for kinship foster care’.

*United States:* The CFP paper (2007) suggests that workers encourage carers to join pre-existing support groups for grandparents caring for grandchildren. Once carers are participating in a group, facilitators can gain an understanding of unmet carer need and service gaps. CFP found similar benefits to carers as the Canadian researchers (see above).

*Observation:* Support groups for grandparents raising their grandchildren were widespread throughout all the countries examined in this report, although their nature and size and the activities they provided for group members were found to be highly variable. The concept of ‘self-help’ was a strong component of the groups. Some groups were voluntary and informal, and some formed part of a community program with paid facilitators. In general grandparents appeared to gain significant benefits from belonging to and participating in the groups. The groups can serve a number of functions, including providing training and information forums to assist/support grandparents and other relative/kinship carers. From the limited information available



for this study, it appears that more thought needs to be given to finding a suitable alternative to 'support groups' for Aboriginal kinship families.

## 4 Research on practice in other areas of kinship care.

This fourth section of the report examines the available research on practice in relation to the birth parents of children in kinship placements, to the children themselves in kinship care, and to training for workers in kinship care. Similar to other sections in the report ‘Promising Practices’ and ‘Key messages’ are highlighted.

### 4.1 Birth parents of children in kinship placements

Very little research has been conducted, either in Australia or elsewhere, with the birth parents of children in statutory care (Cary et al., 2007; Harries, 2008; Mason et al., 2002; Nixon, 2007). Two recent UK studies found that gaining birth parents’ agreement to participate in research was very difficult (Farmer and Moyers, 2008; Hunt, Waterhouse and Lutman, 2008).

In this present study, a NSW CSC caseworker consulted for the project noted that: ‘DoCS does not offer any support to birth parents except to refer them to community services – that’s as far as it goes’. More widely, assistance for birth families of children in statutory care is provided by a community organisation called the *Family Inclusion Network* (FIN), which currently operates in WA, Queensland and NSW and is in the process of being established in other states. The aim of FIN is to provide a range of necessary services (e.g. case management, information, support) to birth parents and to grandparents whose children/grandchildren are in statutory care. Case management, information and support are provided by volunteers, and other services are also available (e.g. referrals to counselling, advocacy, legal advice). There are also support groups for birth parents. While recognising that not all children in care can return home, FIN is based on the belief that every parent is entitled to the best possible relationship with their children, regardless of the parent’s abilities to provide full-time care (Goerke, 2008).

**Key Message:** Research by FIN with the birth parents of children in care found that ‘Most of them live with unresolved anger, guilt, shame and despair – and their experiences have left them powerless and fearful of seeking assistance’. Feeling ‘demeaned and marginalised’ was a common theme, and ‘all expressed an overwhelming sense of powerlessness in relation to statutory bodies that entered their lives’. The birth parents ‘demonstrated that there was a need for them to be seen as people in need of support – not just for themselves but so they could continue, where possible to contribute positively to the lives of their children’ (Harries, 2008: 34).

**Key Message:** Similarly, a Victorian paper examining the long-term care and stability of children in kinship placements noted the importance of continuity of relationships with their biological family. The paper recommended that, where children/young people were placed in permanent care, the case plan include provisions for the birth families to maintain contact as appropriate, and to be supported in maintaining such contact (CECFW, 2006: 30).

A Tasmanian GRG project officer said that GRG had found that, when the birth parents shared a home with their own parents, and their anti-social activities put their children at risk of harm, the grandparents often assumed the care of their grandchildren. This discouraged birth parents from parenting their own children, and absolved them of any responsibility towards their care.

**Promising Practice:** When birth parents and grandparents share a home with a child at ‘risk of harm’, GRG Tasmania has devised the strategy of holding a family meeting to focus on the needs of the child. This was particularly important if grandparents were stressed or lacked the capacity to care. Children are assessed to establish their needs and any problematic areas (e.g. in health, education), and both services for children and support for the birth parents are put in place. While this strategy was not originally the aim of GRG, the need was recognised and the program was restructured to include this model of working with the extended family. The GRG project officer said that this had become an important aspect of their program where child protection was involved, and grandparents were being asked to care for the children as ‘respite’ for the birth parents when they had very little understanding of their rights and responsibilities.

**Promising Practice:** A small number of studies on Indigenous birth families of children in care note how important it is for Indigenous child-welfare services to implement the practice of working with, strengthening and supporting the child’s birth parents after the child is removed, so that the child can maintain their connection to family (Liebsman 2004: 27; SNAICC, 2008: 4).

Another report also found that, in light of the fact that most children in care want to be reunited with their families, both when they are still in care and when they leave, ongoing support for birth parents is essential if the bonds are to be sustained and some hope offered for reunification (Higgins, Bromfield and Richardson, 2005: 57). Work by Cuddeback (2004) found that children in kinship care were less likely than children in foster care to be reunified if their birth parents were excluded from ongoing decision-making and did not receive family preservation services (Cuddeback, 2004 cited in Winocur, Holton and Valentine, 2009: 10).

An overview of a number of UK and US studies (Nixon, 2007) found that:

- Mental health and substance-abuse problems for parents are increasingly common (especially in the USA), leading to the increased use of kinship care.
- Parental participation in decision-making is limited, particularly for fathers.
- Birth parents can have a significant impact on kinship care and it is important to involve them in making and supporting the placements.
- Parents have higher levels of contact when children are in kinship care.
- Carers’ perceptions of the birth parents co-operating with care plans and contact is associated with higher rates of reunification.
- Difficult relationships between birth parents and carers put pressure on placements (Nixon, 2007: 60).

A Canadian study addressed the value of good relationships between grandparents and their children (the birth parents). The research, with both grandparent carers (63) and workers (21) from a non-government agency, found that the grandparents were a significant resource for the workers. Grandparents who had reasonable relationships with the child’s parents helped the workers communicate with and gain access to the birth parents. Grandparents who were supportive of the agency’s involvement helped the parents to work with the agency’s worker (Gladstone and Brown, 2007). The importance of the ongoing relationships in the kinship triad has been noted by many researchers. One writer found that, at its best, the triad involves open, mutual co-operation and agreement around negotiations on what is best for the child. At its

worst, it is marked by conflict, tension and exclusion of one member or another (Greeff, 2001: 54-55).

**Promising Practice:** A *Strengths and Stressors Assessment Tool* has been developed by researchers in the USA to keep birth parents involved in the ongoing decision-making processes around children's placements (Berry and Cash, 2009). The tool provides continuous/ongoing family assessment for birth families where there is a child at risk of harm. The assessment is linked to case planning with services matched to the needs of the birth parents and child. The tool incorporates an ecological perspective organised in six domains: environment, social support, parental capabilities, family interactions, family safety, and child well-being.

The tool can be used to track the progress of the child for the birth family over the life of their case. For example, after the initial assessment the tool can be used at multiple points in time (e.g. 3- to 6-month intervals), or at key decision points, for example, when the restoration/reunification of the child is being planned. It can provide quick and specific information on positive and negative changes. Research indicates that 'improvements in domains on the strengths and stressors tool are correlated with positive case outcomes in child protection cases' (Berry and Cash, 2009: 52). Another researcher opined that the value of the tool is that 'it is designed specifically to aid assessment, planning of intervention and monitoring progress in relation to potential restoration' (Hansen, 2009: 54).

*Observation:* While there is limited research on birth families whose children are in kinship care, there is a clear message that birth parents need to be involved and supported to maintain their relationships with their children. Supporting an Indigenous child's birth parents after the child has been removed, to ensure that the child can maintain their connection to family, is noted as especially important.

## 4.2 Children's participation in kinship care research

Despite the recognition that speaking with young people about their experiences and 'what they want' is important, there has been limited research with children and young people in kinship care (Broad, 2004; Higgins, et al., 2005; Holton, 2008; Hunt, Waterhouse and Lutman, 2008; Messing, 2006; Morgan, 2008; Nixon, 2007). Nonetheless, there has been some research, and the following section discusses the findings from this research.

The views of young people were sought in Australia at a National Forum on Extended Family and Kinship Care (Face to Face, 2004). The young people's stakeholder group<sup>22</sup> provided a number of perspectives on being in kinship care:

- They wanted their stories listened to respectfully and their needs acknowledged and met.
- Consistency and stability in their lives were important concepts.
- Participation in decision-making was essential and they wanted to be familiar with the people making the decisions.
- Central issues were knowing their family (especially their brothers and sisters) and having contact with them, and knowing their culture and their identity.
- They wanted to be able to choose who they had contact with and when contact occurred.
- Because they were in kinship care, they did not feel they were in care but with family.
- Kinship care was not the best situation/placement for everyone (Face to Face, 2004).

An Aboriginal manager of a kinship/foster care program in regional NSW also observed that kinship care was not the best situation/placement for all children.

**Key Message:** Several observations were made by an Aboriginal manager of an Aboriginal child care agency (NSW):

- The age of the child and length of time before the child was removed from an abuse/neglect situation were crucial in kinship placements.
- The older the child, and the longer the harm had lasted before the young person was removed, tended to mean that kinship care was not an appropriate placement.
- The challenging and disruptive behaviours of young people for older kinship carers meant that placements were likely to fail, distressing all involved.
- Where older and younger kin children were placed together, the disruptive behaviours of the older children could have a bad influence on younger children.

The manager suggested that, for some older teenagers who were still attending school, an alternative placement such as a hostel or supported accommodation should be considered, with week-end visits to the relative family. One-on-one intensive therapeutic foster caring for a limited period of time before a kinship placement was

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<sup>22</sup> The number of young people who participated in this stakeholder group is unknown.

considered was a further strategy suggested by the manager. Currently, there is no access to intensive fostering services in the local area.

A regional project officer (NSW) said that the young people in kinship care involved in a community program had been consulted to find out what they wanted. They had suggested a plan for holiday activities, and this was implemented. The program's coordinator conducted a review of these holiday activities, and provided feedback about the benefits the young people gained from the activities (e.g. friendships, sharing stories, etc.). Given the positive findings of the review, the project officer plans to arrange for the young people in the community program to attend *Youth Insearch* (week-end camps run by the Lions Club, which target self-esteem and behaviour issues for young people).

A study conducted with 20 young people living with their grandparents in Perth, WA, found that the young people felt positive about being in their grandparents' care, and that they also felt a sense of belonging to the family (Hislop et al., 2004: 3-5).

**Promising Practice:** Four recommendations emerged from this research, in relation to improved practice for children in kinship care:

1. *Psychological assessment:* All children placed by child protection should receive a thorough psychological assessment and, if required, be provided with the appropriate services.
2. *Counselling/intervention:* Children with emotional/behavioural problems, due to abuse/neglect prior to being placed with grandparents, should be provided with counselling/intervention, and if necessary, grief therapy.
3. *Peer groups:* Children and young people should be given access to peer/social groups to assist them in developing resiliency.
4. *Reunification:* Where possible/appropriate opportunities should be provided for either permanent or temporary reunification with birth family (Hislop et al., 2004:7).

The study also found that for children and young people placed with extended family (e.g. grandparents) 'stability, safety and care, may actually improve [their] self-worth' (Hislop et al., 2004: 48).

**Promising Practice:** Australian researchers have noted the important practice of listening to the voices of children in kinship (and foster) care. Including the views of children at every stage of placement decision-making enhances their self-esteem and benefits them psychologically (Higgins, et al., 2005).

A Norwegian study of children in kinship care (Holton, 2008) explored the complexity of the relationships in kinship foster care, and the social integration of kinship foster children with their birth parents and the kinship foster family. The researcher found that kinship foster care encompassed many family types, and it was those family types where carers and parents 'experienced a sense of community and solidarity and have friendly relations among themselves' that best enabled the child to become socially integrated. Holton (2008) suggested that the most important relationship in kinship care placements was that between the biological mother and kinship foster mother, as 'they have a common responsibility for the child' (Holton, 2008: 1035).

In the UK, the Children's Rights Director conducted a survey of 136 children and young people in care. The survey asked the children for their views on how children are 'looked after' (including being placed with relatives), and what they thought should be included in the regulations for the new *Children and Young Persons Act 2008*. The Act mandates how children in care must be 'looked after' in the future. The report found that the children and young people were very pleased to be consulted about their views on the draft regulations. It also stressed the importance of placing children with extended family where possible (Morgan, 2008).

**Promising Practice:** In another UK study, researchers asked young people in kinship care to complete an Ecomap where they described their network of relationships (Hunt, Waterhouse and Lutman, 2008). The researchers found this a useful model for finding out which young people were at risk of social isolation. To identify vulnerable placements, the writers recommended the use of the *Strengths and Difficulties Questionnaire* (SDQ). This could be used to screen early and systematically for young people's emotional and behavioural problems, in order to ascertain the levels of support required

This study found no abnormal self-reported scores on the SDQ. The young people, who had been with their kinship carers for an average of 4.9 years, all appeared to have normal expectations about their future. Other positive themes emerging from the interviews with the young people were:

- a feeling of safety;
- reliance on and trust in the carer;
- a sense of permanence;
- closeness to carers and siblings;
- a lack of concern about their carers' ages, as long as carers were interested in and involved with them; and
- good links/relationships with their mothers.

A number of less positive themes for the young people also emerged:

- young people placed with carers who were single had smaller networks of relationships/friendships.
- there was a lack of contact/involvement with their fathers.
- social workers were peripheral to the young persons' lives.
- they had difficulty in explaining to friends about social service involvement in their lives (Hunt, Waterhouse and Lutman, 2008: 216, 221, 251).

Another UK study, this time with 16 children in kinship placements (all over seven years of age), found a small number of children who did not understand why they were living with kin. Some of those children blamed the kin carer or the children's services for the fact that they were not able to live with their parents (Farmer and Moyers, 2008).

**Promising Practice:** Farmer and Moyers (2008) note one reason why it might be difficult for kin to explain the situation to the children – they could feel responsible for it because they were the ones who had to report parents. As kin carers are usually unaware of how to approach the subject, the writers suggest that social workers and other professionals take responsibility for explaining to children why the placement happened. Life Story work is also a useful practice in helping children come to terms

with their past and remember all the people in their lives (Farmer and Moyers, 2008: 157-158).

A Californian study (Messing, 2006) conducted with 40 children in kinship care (aged 11-14 years) found:

- that the young people had little sense of stigma about being with their grandparents (the grandparents had legal custody in the case of 30 of these young people);
- that the children spoke of the importance of being with someone who loved them;
- that the children expressed conflicting feelings (resentment/hope) about their birth parents;
- that the children expressed disappointment with their parents in relation to 'missed' contact (i.e. when the parent failed to show up); and
- that most of the young people felt that the placement was a permanent one and spoke with fondness of their siblings and extended family.

The researcher concluded that for the children in kinship care:

'Their primary connections were not within the nuclear family; these children had a broader sense of familial relationships, and these relationships were of great importance to them' (Messing, 2006: 1431).

An earlier study in the UK (Broad, 2004), with 20 young people whose average age was 16, uncovered a number of themes, both positive and negative. On the positive side:

- nearly all the young people (19) were optimistic about their futures;
- most of the young people (17) viewed the changes in their living situations favourably; and
- three-quarters of the young people (15) felt safe and settled in their current situation, and a similar percentage had a positive sense of identity (14).

On the negative side:

- most of the young people (17) had had negative perceptions of their situations immediately prior to coming into care;
- six of the young people felt they were not being listened to;
- six did not think they had enough social work support; and
- five wished they had more contact with friends (Broad, 2004: 218).

**Promising Practice:** The CFP (2007) publication from the US suggested useful strategies for children in kinship care. One strategy concerned ways to enable potential caregivers to gain a better understanding of the child prior to the placement. Workers should spend time with children and ask them about their likes and dislikes their fears, and any particular preferences they might have, and provide the information in written form to the kinship caregiver. This strategy would both assist the transition process and help workers establish relationships with the children (CFP, 2007: 27). Secondly, the CFP (2007) suggested that workers attempt to encourage the young people in kinship care to become involved in agency committees and workgroups, and provide input/feedback to influence agency practice, programs and



culture. The authors acknowledged that this was a difficult strategy, but that it was a very useful one.

*Observation:* A number of studies highlight the importance of researchers engaging with the young people in kinship care. Those research projects which have done so have found that there are substantial benefits for young people when they are in care with ‘family’, although there are also negative aspects and these require consideration. Both young people in a stakeholder’s forum, and a manager from an Aboriginal agency, pointed out that kinship care is not always the most appropriate option for children and young people requiring an OOHC placement, and this is an important observation that needs to be heeded.

### 4.3 Worker training and kinship care

The role of the worker is crucial in the provision of kinship care services, and increasingly, researchers are paying attention to the attitudes, skills, experience and training required of staff working within the kinship triad of birth parents, carer and worker. In Australia, little attention has been given to the issue of the specific training required by agency staff providing kinship care services. An exception to this is the literature on cultural training for non-Indigenous workers who are supervising/monitoring Indigenous kinship placements (Victorian Government, 2008).

In 2007-2008, the Victorian Government commissioned VACCA to develop an *Aboriginal Cultural Competence Framework* to guide mainstream agencies/services in the development of management strategies, policies and direct practice with Aboriginal families and children. The document addresses the following aspects:

- an introduction to and explanation of the framework development;
- the importance of culture to Aboriginal people with reference to past and present child removal policies;
- the critical nature of culture for understanding the needs and best interests of Aboriginal children;
- key understandings and the conceptual framework behind the notion of Aboriginal cultural competence;
- engagement with Aboriginal children, families, communities and services by agencies in a culturally competent way which reflects the principles of Aboriginal self-determination; and
- Aboriginal culture in the context of principles concerning the child's best interests (Victorian Government, 2008).

Bamblett and Lewis (2007) have described how the VACCA framework embodies principles of Indigenous self-determination (the second last point above), and explained how the principles can be implemented in the child welfare area. The writers say that the development of this framework of culturally-based programs and service standards aims to create a new culturally competent service system for Aboriginal and Torres Strait Islander children and families, intended to enable and enhance the trust and understanding between Aboriginal and Torres Strait Islander people on the one hand, and mainstream services and government on the other. The writers also argue that it is necessary to increase the capacity-building of Indigenous agencies, in order to allow these agencies to provide a full range of services, from prevention to various levels of intervention in child protection. Options for the training and skill development for Indigenous staff within child welfare agencies is also noted as a critical component of capacity-building (Bamblett and Lewis, 2007: 43, 49). Other researchers have also found that improved capacity-building and the employment of trained Indigenous agency staff allow for more appropriate support for Indigenous kinship and relative carers, and increase the likelihood of more stable and lasting placements (Higgins et al., 2005).

A paper by the Australian Research Alliance for Children & Youth on *Indigenous Early Learning and Care* (Hutchins et al., 2007) contains further useful training material for increasing the knowledge-base of those working with carers of young Indigenous children in kinship placements. The publication discusses the value of

good quality early learning and care for Aboriginal and Torres Strait Islander children.

**Promising Practice:** The value of the work by Hutchins et al., (2007) for non-Indigenous agencies providing kinship care services lies in the clear articulation of what needs to be considered to provide culturally safe Indigenous-specific programs and services for children. These programs focus on protective factors, the development of secure attachments and the provision of parental support (and respite) for kinship carers. The main characteristics of culturally safe programs and services are:

- the employment of Aboriginal and Torres Strait Islander staff, where possible;
- reflexive practice<sup>23</sup> by non-Indigenous workers;
- the importance of relationships to successful implementation;
- the recognition that extended family share the care;
- transport for carers/children to and from services;
- the incorporation of Aboriginal and Torres Strait Islander ways of knowing and being in the world;
- the role of history – acknowledging the past and learning together; and
- holistic ‘joined-up’ programs (Hutchins et al., 2007: 6-7, 46).

The writers also discuss Aboriginal and Torres Strait Islander people’s values, understandings and beliefs around child-rearing. While the main focus of the paper is on Indigenous early learning, the applicability to Indigenous children of early learning and care programs more generally is clearly spelt out. The paper highlights the benefits of child care services both for the children and for their caregivers. These include:

- acting as a family substitute when necessary;
- modelling (and monitoring) child-rearing strategies through relationships between caregivers (i.e. child care staff) and families;
- providing a venue for the development of social networks and the sharing of information between families, including through informal social activities;
- offering formal parent-education opportunities to increase parental skills and knowledge;
- providing links to other important community agencies, such as health, child protection, stress management, financial management; and

fostering the broader development of parents and extended family through participation in committees, etc. (Hutchins et al., 2007: 37-38).

**Promising Practice:** The discussion by Hutchins et al., (2007) on factors around culturally strong appropriate early learning and care for Aboriginal and Torres Strait Islander children is useful knowledge for the practice of non-Indigenous workers working with kinship families. The discussion includes:

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<sup>23</sup> Reflexive practice involves implementing programs for Indigenous children based on their Indigenous culture and not on preconceived, non-Indigenous notions of early learning strategies (Hutchins et al., 2007: 30).

- Indigenous people’s conceptions of childhood – the strong child;
- child development and identity formation;
- social behaviour and the role of Elders;
- culturally relevant learning environments;
- responsiveness and the right time for routines;
- language, literacy and early learning; and
- nutrition, physical health and illness (Hutchins et al., 2007: 37-44).

In the UK, several writers have addressed the issue of training for agency workers providing kinship care services, including workers’ perceptions of what is involved in kinship care (Broad, 2004; Hunt, 2008; Hunt, Waterhouse and Lutman, 2008; tFN–BAAF, 2008b; Waldman and Wheal 1999; Wheal 2001: 27).

In relation to the attitudes and perceptions, Hunt (2008) found that kinship care work was a challenging and a relatively unfamiliar area for agency staff. The study found that few local authorities provided training specifically for kinship care workers, and that practitioners felt less in control and more uncertain of their role, and tended to lack confidence in their skills, knowledge and ability to supervise kinship placements. Hunt (2008) concluded that practitioners did need special training and support to understand the unique features of kinship care. In the light of the growing evidence of the benefits to children of kinship care, workers needed to examine their attitudes and improve their skills in engaging with family networks (Hunt 2008:4-7).

Other writers (Hunt, Waterhouse and Lutman, 2008) found that, while social workers were ambivalent about the merits of kinship care, they did see that it could be beneficial for some children. The workers interviewed did say that kinship care could prove more challenging than, as well as different from, working with non-kin foster care. But only a quarter of the workers interviewed [n=24] had received specific training in kinship care. Over half (54%) said they would like specific training in the following three areas:

1. providing separate support for child and the carer;
2. evidence from the research; and
3. joint training with other kinship team members to understand different viewpoints (Hunt, Waterhouse and Lutman, 2008: 115 -116).

In relation to the differences between working with kin carers and working with foster carers, the workers made the following observations:

- Working with foster carers was more professional and more detached, with clear boundaries for carers.
- Kinship care relationships (loyalty, attachment) between birth and kin families impacted on the placement.
- Interacting and negotiating with kin carers required a more sensitive approach.
- Contact between the child, birth parents and kin carer was more problematic and harder to manage.
- Developing positive relationships and mutual trust between workers and kin carers was critical.
- Workers were divided over the question of whether kin carers could manage with less or more support than non-kin carers (Hunt, Waterhouse and Lutman, 2008: 118).

The critical importance of developing positive relationships and mutual trust between workers and kin carers was highlighted in the research by Farmer and Moyers (2008). Their study found that, unless there were positive working relationships between workers and carers, kin carers could resent the restrictions placed on them by children's services (in their terms, 'interference'), and refuse to cooperate with social workers. Some kin also placed difficulties in the way of regular contact with birth parents, or refused help for the children. The authors commented:

Overall when we looked at the cases where carers were extremely uncooperative or resentful of children's services, they were often families that later emerged as having provided particularly poor care. (Farmer and Moyers, 2008: 150)

**Promising Practice:** The authors suggested training covering both attitudes and skills in working with kinship families, as a way of increasing the numbers in kinship care placements and improving the confidence of caseworkers (Hunt, Waterhouse and Lutman, 2008: 159, 289).

The need for specific training for kinship workers has also been noted in the USA (CWLA, 2000; Peters, 2004). In setting standards of best practice in kinship care, CWLA (2000: 80) recommends that agency staff be experienced social workers with a good understanding of family-centred practice. Workers needed to be competent in working with families experiencing life crises, whose children may need to live in kinship care arrangements.

A study by Peters (2004) explored the attitudes towards, and experiences of, working within kinship care, of workers (n=50) who had completed a limited kinship-care training program (four hours). The workers were found to be cognisant of the social and psychological benefits for children of kinship care, and of the decreased stigma and the increased sense of family connection. They also said they knew that kinship care appeared to enhance the school performance of kin children, in comparison with children in foster care. Less positively, the workers observed that working within the kinship triad meant:

- a decrease in power;
- difficulties dealing with family dynamics;
- additional work in explaining the child-welfare system to kin carers;
- increased time required when working with the kinship family;
- fears about the quality of the kinship parenting (i.e. intergenerational dysfunction in families); and
- fears about child safety.

**Promising Practice:** One researcher has noted that the ambivalence of child-welfare administrators and policy makers has meant a failure to implement clear and coherent policy and practice frameworks around kinship care, and that this contributes to the workers' objections to the use of statutory kinship care (Peters, 2004: 615). This writer suggested that workers required training in relation to the following:

- their ambivalence towards kinship placements;
- any difficulties they have in working with triangles/triads;

- the need to develop empathetic approaches towards potential kinship carers; and
- the need to understand and work with family dynamics (e.g. working collaboratively while maintaining confidentiality).

*Observation:* This present study has found little evidence for the development of specific training for workers providing statutory kinship care services in Australia, except for cultural training for non-Indigenous workers supervising Indigenous kinship placements, which is addressed in three key documents (Victorian Government, 2008; Bamblett and Lewis 2007; Hutchins et al., 2007). A number of studies in the UK and USA have highlighted the need for training for workers in several areas, including attitudinal change for developing better relationships with kinship/relative carers. The final section of this report describes and discusses the findings from the focus groups with Indigenous and non-Indigenous carers.

## 5 Focus groups with kinship carers

In Stage II of the project four focus groups were conducted with kinship carers – two Indigenous and two non-Indigenous.<sup>24</sup> Two groups were conducted in south west of Sydney and two were held in regional areas of NSW. In total, 36 carers attended the four groups. Carers at the groups were caring for grandchildren under orders from the Children’s Court and the Family Court. Both groups of carers share similar issues and concerns and carers, regardless of their court order, were eager to attend the groups to have their stories heard and to listen to what other carers had to say. In the case of the four Indigenous kinship carers all were statutory kinship carers, though one who has also fostered, called herself a foster carer. The analysis of the data from the focus groups reflects the diversity of the carers who attended.

*Demographics:* Carer attending the groups completed a short form on their characteristics, e.g. age, marital status, labour force participation, etc. For each of the couples attending the groups, one carer provided the required information. Twenty-three forms were analysed.

Seventy per cent of the carers were married and 30 per cent were single parents (all females). Carers’ average age was 57 with the eldest being 74 years and the youngest 35 years. The 35-year-old was a married man, with one child from a previous relationship, who was caring for four unrelated children, one of whom was his godson.

Eighty per cent of the carers were retired or not in paid work. The main source of household income for approximately half was retirement income, with around half receiving income support payments. For three female carers, who were not in the labour force, the main source of household income was their husband’s salary/wage and one female carer’s income came from part-time work and a part income support payment. Only three carers had grown-up birth children still living at home, two had one each and one Indigenous carer, caring for a young nephew (six years), had three daughters (16, 20 and 24 years).

Only four carers were caring for a child who was not their grandchild. The relationships of the other kin children were: step-grandchild; godson; nephew; and three great-nephews. The highest number of kin children with any one carer was four (four carers), with an average of two children per carer family. The number of years the carers had been providing care to related children varied from one to 16 years, with an average of two years. Five of the 36 carers had been caring for their grandchildren for 10+ years.

*Topics:* The topics discussed with the carers included: conferencing or meetings prior to placement; assessment; training; financial and non-financial support; and contact with birth parents. Carers’ opinions were sought on how these particular aspects might be improved to enhance the roles the carers played.. Carers provided a range of experiences, some negative but also some very positive. In the course of the

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<sup>24</sup> The attendance by Aboriginal kinship carers at the two groups was low – only four carers in total. Due to the small numbers a separate analysis was not conducted on the data from the Aboriginal carers.

discussion, two other topic areas were highlighted: parenting orders/parental responsibility and child care. Carers were also asked whether they would like to be treated the same as foster carers, and their responses are at the end of this section.

*Parenting orders/parental responsibility:* Throughout the discussion with kinship carers, the terms ‘parental responsibility’ ‘guardianship’ ‘consent orders’ ‘custody’ and ‘parenting orders’ were used interchangeably by carers in explaining the legal arrangements for caring for their grandchildren. Their situation is extremely complicated when different siblings from one family come under different systems for protecting the welfare of children. There are two of these systems: the Family Court/Federal Magistrates Court (Commonwealth) and the Children’s Court (State). Apart from the fact that there are two different systems, there were particular aspects of each system which were confusing both to the kinship carers and to the researcher. For ease of understanding, definitions of ‘orders’ are provided for both systems. The first definition applies to the NSW State system, and the second to the Commonwealth system.

*Parental Responsibility:* If DoCS needs to protect the children, they will remove them from their parents and take formal action through the Children’s Court. The Children’s Court may make an order allocating parental responsibility of the child to the Minister or to another suitable person including a grandparent or other relative. Allocating parental responsibility to the Minister means that DoCS are responsible for ensuring a safe environment for the child but not for the day-to-day care, which is allocated to someone else – often the grandparents.

*Consent Order/Parenting Order:* Families can make their own arrangements regarding the care of children – often referred to as an ‘informal arrangement’ – without going to court. A ‘consent order’ is a written agreement which helps to clarify the arrangement within the family and can assist if any problems should arise regarding decisions to be made for the children. If parties (e.g. grandparents) are unable to reach an agreement with the parents then they can apply to the Family Court (or the Federal Magistrates Court) for a Parenting Order/s. The court will set out orders regarding where the child will live, who will have contact with the child and various parental responsibilities such as education, health care and discipline.

The Children’s Courts hear any proceedings involving child protection undertaken by DoCS. Any dispute that arises, for example, between kinship carers and the children’s parents, may start in the local courts but if it is contested it will move to the Federal Magistrates Court or the Family Court (*Grandparents Raising Grandchildren*, NSW, 2009).

At times, carers in all the focus groups expressed frustration and bewilderment as they tried to understand how the particular order/s they had affected the support and services for the children in their care. Not all grandparents in the focus groups were departmental (i.e. DoCS) carers. Some had orders through the Family Court or the Federal Magistrates Court. Some of the DoCS kinship carers had parental responsibility, while for others, the parental responsibility was with the Minister. There were kinship families where one child was placed through a Family Court order



while a sibling was placed under an order with DoCS. Some carers who had gone through the Family Court system were receiving financial support through DoCS.<sup>25</sup>

Several kinship carers were involved in legal contests over who was to care for the child, and for some carers this was a costly process (one carer was quoted \$20,000 to apply for custody of a grandchild). A number of grandparents noted that it was not uncommon for their children (birth parents) to be eligible for legal aid, while they were ineligible because of the levels of their income or assets. One carer with two grandchildren under the two systems explained: ‘Tens of thousands of dollars later we are still fighting this person [over contact]. He [grandson] was removed [from his birth family] at six months by the Family Court, so he’s still under the Family Court. Fortunately the girl [granddaughter], he can’t touch her because she came to us through children’s protection (i.e. DoCS)’.

From carers’ stories it became apparent that, although many kinship carers had expressed grave concerns to DoCS about the perceived risk of harm to grandchildren, the department had not intervened. One Aboriginal carer explained how stressful it was to report your own child to DoCS:

For us as grandparent carers, it is really hard to actually make a notification about your grandchildren against your own child. They [DoCS] need to place a bit of credibility on it. DoCS need to change the way they look at things because if they realised how hard it was to actually make those notifications ... you do not do it lightly!

A few carers mentioned that they had not applied for parental responsibility as they thought they would lose what little support they were getting. Even with orders some grandparent carers experienced problems with obtaining Medicare and Health Care Cards and obtaining birth certificates for grandchildren whose births had never been registered. Getting a grandchild’s surname changed (especially for children who never knew their fathers) was problematic for some carers.

*Family Group Conferencing:* Family group conferencing is recommended as a useful strategy when decisions are being made about the most appropriate placements for children taken into care. This topic generated wry amusement among carers in one large group (21 carers). No carer in this particular group had had a family meeting prior to having a child placed in their care, and many said that they were the ‘only ones’ available to take the children.

The strong commitment by family to looking after their own was highlighted throughout the discussion in all groups. Several carers referred to the crisis nature of

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<sup>25</sup> Normally, carers for children with orders through the federal system would not be eligible for the *Supported Care Allowance* (which is provided by the NSW state government). But carers outside the DoCS system are provided with the allowance under certain conditions, e.g. the child is likely to be at risk, of entering formal OOH, or homelessness, if financial assistance is not provided (<http://www.raisinggrandchildren.com.au/finance2.html>).

some kinship placements where, due to concerns of harm, they had personally removed the children from their parents' home. As one carer explained:

We just took our two grandchildren ourselves, I could not have let them stay one more night ... I did not have time to go to DoCS or do anything ... so we just decided.

The carer explained that they brought the children from Queensland and when they contacted DoCS, the department said 'they did not want to be involved'. Concerned about their legal position in relation to guardianship, the grandparents were assisted by a Legal Service (at no cost) to gain a consent order through the Federal Magistrates Court. Differing versions of this story were told by several grandparent carers in relation to the way in which they had obtained orders for their grandchildren. For grandparents who had to deal with two child welfare departments found the process was fraught with difficulties (as explained by one grandmother determined not to leave her grandchildren in foster care in another state).

*Assessment process:* Responses from carers to the assessment process elicited a hugely diverse set of stories. At one end of the spectrum was a small number who had never been assessed as kinship carers at all, and some, but not all, received DoCS' carer allowances. One carer who had not been assessed and was receiving income support (Family Tax Benefit) for the child said: 'Mine is by choice. I don't want to go down the DoCS road'. Another said, 'I don't think I've been assessed, they've given me the support [*Supported Care Allowance*] for the children ... we just sorted it out between us ... we just said we'd look after the kids'.

A small number of carers had initiated DoCS' involvement in removing the children. Some had been successful while others had had to take the matter to the Family Court. One couple who had 'pushed' DoCS to get their three grandchildren placed with them, said that they had never had an assessment: 'We got the children and then we went to court [Children's Court] over the next 12 months to obtain guardianship of the children'. The couple receive the *Supported Care Allowance* for the three children, and they were given the name of a caseworker. The carer kept in contact with the worker, mainly by phone, saying: 'I thought she was pretty good to us, really'.

Three of the 21 carers in one group had not been assessed early in the placement, but only after the children had been with them for some time. One carer who had been assessed 'later on' said: 'We didn't know about DoCS until we had the kids for quite a while ... about 10 months ... then we applied to DoCS for the money and then they assessed us'. A carer couple whose grandson had been in their care for 14 years were assessed in 2008 and received a letter in March 2009 saying they were approved. When asked how they felt about that, the grandmother said, 'We were excited!'

One example of an early assessment in a placement involved a carer couple who had found out that their grandchild was going 'in and out of foster care'. They asked the department (DoCS) if they could take their grandchild, and the department agreed, they were assessed and the child placed with them.

When asked about the assessment process carers responded both positively and negatively. One grandmother, whose two grandchildren had been with her for about four months, said she had approached DoCS to be assessed. DoCS arranged for a non-

government agency worker to assess the family. When asked how it was, she replied: 'It was fine, very quick, though. [They] just came in, asked how my husband's wages was ... said hello to [grandson] ... looked at [baby] then said, "Everything is fine" ... checked the police records'. When asked how long it took, she laughed and said, 'Probably 15 minutes'. Since the assessment (24 months ago), she has not had any contact with the department.

One carer had found the whole experience 'very personal' and quite intense. She said the 'lady psychologist' had interviewed the couple for about three hours: 'They wanted to know the nitty gritty of the whole family, quite amazing'. When asked how she found the process, she commented: 'Oh, it wasn't a problem because we were upfront about the whole thing, we've got nothing to hide'. Her two kin children aged 10 and 13 were also interviewed (separately). Another assessed carer who said the interviewer was 'quite pleasant' was unhappy about her 15-year-old granddaughter being interviewed 'in the bedroom with the door closed'. Two carers in the group whose children had been interviewed separately in closed rooms found that part of the assessment process 'offensive'.

*Accommodation:* During the assessment process, one carer who could not meet accommodation standards was told she had to move if she wanted to care for her grandson. The grandmother said that, after moving house, two of her older children had had to find alternative accommodation. The grandmother's daughter has since had another child who is also in the care of the grandmother. Another carer of four siblings (one girl, three boys) in a three-bedroom villa had to move (request from the department) to larger rental accommodation (a five-bedroom house) when the eldest child, a girl, turned eight. They received no assistance from the department for any of the costs involved in moving.

An Aboriginal carer, who initially had seven siblings (nephews/nieces) placed with her, was provided with a four-bedroom house through the Housing Commission, and half the cost of a van was paid for by the department as well. Beds and bedding were also supplied. Not surprisingly the carer (who had been working in a child care centre) had to give up work when the children were placed. All four Aboriginal carers in this study had found the assessment process 'fine', although one carer suggested that Aboriginal workers should always be involved in assessing Aboriginal carers. None of the kinship carers caring for Aboriginal children (the four Aboriginal carers and two of the non-Aboriginal carers) had cultural plans for the children in their care.

*Caseworkers and case plans:* After the assessment and the case plan discussion, most kinship carers rarely saw a caseworker to follow up with the agreed plan, or even knew if they had one. In the group of 21 carers, very few had case plans that were working to their satisfaction. As one explained:

Well, we haven't seen a caseworker since the assessment (12-18 months). The case plan they worked out for us they revoked on. So that [case plan] part of the assessment, it's just not happened.

Some carers were constantly being frustrated in their attempts to obtain caseworker support through their local CSC. One carer's story provides a good example:

When [granddaughter] first came to live with us the caseworker used to come and visit us, say, once a month, once every six weeks.

If we had any problems we could talk about it. And then we got a letter to say that this caseworker had gone and that she was no longer [granddaughter's] caseworker.

The carer contacted the department requesting another caseworker:

I just kept ringing up and demanding that I wanted a caseworker and then this other caseworker, I've only seen her once since Christmas [a five-month period] and she did send me out another case plan ... there are a list of things in there that are different to what they were to start with, so I'm hoping to get another meeting with them next month so we can sort it out.

For some carers, contact with caseworkers was marginal, with phone calls the main form of communication. A number of carers would have liked a caseworker to visit, so that some aspects that they were unsure about (e.g. contact) could be clarified. When caseworkers did become involved with the family, even for a short period, their support was appreciated. Two carers explained:

1. Generally you only have to see them once a year, but he [caseworker] would answer my questions; if I needed something he would make sure she [granddaughter] got it. So he was good, and now I don't have one [six months since worker left].
2. My case worker he was good for [grandson]. He used to take him off for an hour or so. He used to do something for [grandson] that he liked and it was good because [grandson] didn't really have a lot of role models in his life. And I think it was like the most progress [he ever made] ... and just like that ... at the end of October he called saying that he was moving on.

All four Aboriginal carers had reasonable relationships with their caseworkers. For one carer (four grandchildren) the relationship was 'up and down', but she could contact her any time she wanted to. The carer noted the positive aspects of having a caseworker: 'She calls around and she takes the kids out (e.g. bowling) and she organises camps every school holiday. I get two at Christmas time'. Two Aboriginal carers in a country town were having regular case conferences (six-monthly), and both commented that that had a preference for a non-Aboriginal caseworker due to privacy issues.

*Resource Guide:* No grandparent was provided with a Resource Guide when they became a kinship carer. Most seemed unaware of how to access information on their roles, rights and entitlements. One carer wryly observed: 'DoCS promise you the world ... the thing is, to me, they are lousy information givers'. When asked where information that would assist them should be available, carers suggested: notice boards at schools, libraries, community centres and doctors surgeries.<sup>26</sup>

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<sup>26</sup>Carers in all the focus groups were provided with information about a resource guide for grandparent carers available online.

*Training:* Four carers (two couples and two single parents) who had participated in foster-carer training (*Shared Stories Shared Lives*) were more confident and knowledgeable about the DoCS system. A member of one of the couples commented:

We tend to go to general foster carer things like, we go to foster carer morning teas, we go to the training courses, when we're at the foster carer morning teas we say, look if you've got any training courses out there ... we'll do it.

An Aboriginal kinship carer explained why she had completed foster carer training:

I have had lots of kids placed with me ... they were all related to me ... so DoCS would come and they say, 'Oh well, this is a kinship placement we don't have to do any more', and I said, 'I beg your pardon, they're placed here as a foster care placement and you will have to do more for the kids'.

Many carers expressed a need to participate in training. One carer commented that she went to as many information sessions as she could. She has also been to DoCS' training workshops noting that: 'We are just now allowed to attend'. When asked why she had not been able to attend before, she explained:

Well, I rang about two or three years ago because I had seen it in a newsletter and asked why can't I go? They said that this is only for foster carers ... but things have improved, but there are still particular meetings and training that we don't go to.

Another carer couple commented that were not offered any training but would have liked it. They had recently decided to become foster carers and, after applying to DoCS, they had completed *Shared Stories Shared Lives*. The husband noted that they now understood more about what had happened to them when they first had the children placed, and he observed; 'After, we thought, yes, we could have done that course then!'

Another carer noted that the local DoCS office is currently providing workshops for all carers. She explained:

There might be one on adolescent behaviour [or] on drug and alcohol. As a kin carer you are invited to all but you get to choose which one is most appropriate for you. And, on a score out of 10, I would give them about a nine on being informative and factual, and you come away feeling that you've learnt something.

For many in this particular group the availability of carer training was not something they were aware of. As two carers explained:

1. Yes I would if I knew about it. I don't know what you all are talking about with all these things, I've got no idea.
2. Well, this is all relatively new to me because I am an informal guardian. I had to pick up all my information from little ads in the paper or word of mouth. [That's] how I found this kinship group. So I've only managed to have a "leg in the door" because one of the girls will say to me, "Look, ring this number and ask

if you can come”. But because I’m under no obvious umbrella I have to personally seek out the workshops.

When asked if they would attend training if it was made available, one carer responded: ‘Yes, I’d like to be included and go to the ones that are relevant to me’. When other carers were asked if they would like to attend training there was generally a favourable response. Seven other kinship carers had attended carer training run by *Connecting Carers* (a DoCS-funded training project) in another town, with one carer noting: ‘That was very valuable’.

Some carers in another group had participated in the *Triple P Program*. One grandmother had had little success when she applied the training to her adolescent grandson, who said: ‘Don’t try it on me, it doesn’t work’. Other carers had benefitted from participating in Triple P, however, with one carer noting she had enjoyed the training and appreciated what she found out. She said: ‘I raised my kids too but when it comes to grandchildren it is different ... It’s a different generation ...It’s different thinking’. When asked if the training helped her understand what was ‘different’ she responded:

Yes, a lot more I suppose, to come around to their way of thinking ... which is very hard for a 60-year-old ... I think it really helped but it wasn’t enough. I ended up doing another training course through PANOC.<sup>27</sup>

One carer who was experiencing difficulties with her young grandchildren was pleased when she finally found some training for carers of children aged 2-12 years. She also sees a psychologist for the four-year-old with attachment disorder. The carer had also wanted to take part in other courses but found she was ineligible:

*Brighter Futures* is running courses that I need to go to but I am not allowed to go because I have a caseworker. My child [daughter] and my grandchild had to go early intervention preschool but I can’t. I reckon *Brighter Futures* has ‘everything’ that I need and DoCS won’t let me to go ... I need help to raise him.<sup>28</sup>

One Aboriginal carer noted that if training for Aboriginal kinship carers was not provided by an Aboriginal worker then having people who were culturally aware was a good strategy. The carer also suggested providing an Aboriginal person to facilitate the group would ‘help a lot, and I think causes a bit of respect as well’. Another Aboriginal carer noted that mixed training (non-Aboriginal and Aboriginal) could be intimidating and was not the best option for Aboriginal kinship carers. All four carers, one an approved foster carer, had participated in some ongoing training sessions.

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<sup>27</sup> PANOC: Physical Abuse and Neglect of Children, a community-based child-protection therapy team.

<sup>28</sup> Brighter Futures is a DoCS early intervention program providing targeted support to children ‘at risk of harm’ and their families. The program is for families whose children are *not* in OOHC (whether foster or relative/kinship).

An Aboriginal carer suggested that Aboriginal kinship carers should get similar training to foster carers, although kinship specific, as that would get kinship and foster carers 'on the same level'. However, her friend questioned whether this strategy would work:

I think there would be people who would be hesitant to be part of DoCS, like 'a DoCS foster carer', and in the Aboriginal community there will be people would not want to do that. You know they say all the time there is not enough Aboriginal foster carers, but we've all got our grandkids ... this is why we are not foster carers.

*Financial support:* It was clear that many carers lacked knowledge about eligibility for financial support for kinship children in statutory care. One carer whose granddaughter came into her care in January 2009 had not been assessed or provided with a *Supported Care Allowance*. Another grandfather whose grandchild had been with him for 12 years only found out about *Supported Care Allowance* when he met another kinship grandparent who explained it to him.

Many kinship carers in receipt of the *Supported Care Allowance* were extremely grateful. One grandfather of a couple who have had guardianship of their grandchildren for 14 years expressing his pleasure about receipt of the payment:

It goes up now [adjusted according to the Consumer Price Index] and we get it for both kids, thank goodness, and we're happy ... as far as DoCS are concerned ... they don't worry us and we don't worry them. So it's a win-win!

Another carer had previously been receiving the *Non-Parental Carer Allowance*. (This was replaced by the *Supported Care Allowance*, as a result of changes to eligibility for financial support for kinship carers introduced in 2006). This carer said: 'All of a sudden in comes this money [*Supported Care Allowance*] we just thought it is marvellous ... they did not ask or anything ... and it just started appearing in our bank account'.

The carers in one group commented that the *Supported Care Allowance* was sufficient for everyday costs but that it did not cover extra-curricular activities such as drama, dance, music, tennis lessons, football fees/clothing. They felt that a discretionary allowance of \$3000 per child per annum would meet the children's needs.

*Support (non-financial):* It was not unusual for carers to comment that their grandchildren required counselling, psychological or psychiatric services. Some had been successful in obtaining services (e.g. paediatrician, counsellor), whilst others were on extensive (six-month) wait lists to see specialists. Some carers had received limited financial assistance (the difference between the Medicare rebate and the psychologists' costs) from DoCS usually for 5-6 visits. Other carers noted that DoCS had paid their medical bills, while others had accessed community mental health

services and *Victims Services* for their grandchildren at minimal or no cost for treatment.<sup>29</sup>

One carer spoke of her counsellor at PANOC who helped when she first became a kinship carer. The carer explained, 'She's been with us for the long haul, she helps me manage [grandson]'. But other carers said that they had tried to access PANOC, but the services had long wait lists for appointments.

Other carers said that family centres, school counsellors and psychologists had provided support to the grandchildren. Carers in one regional town noted that the local family centre ran a number of programs for children, and that it also provided support and respite for grandparent carers. One carer said that her granddaughter's school had a program called 'Seasons of Growth' for children dealing with hurt, loss or separation, that met once a week for 10 weeks. 'I would like to see that in more schools', she said.

Carers mentioned other support from DoCS such as additional financial assistance for purchasing car seats, children's beds, computers for children, school fees, school uniforms, camps and a washing machine. Some carers who had to travel long distances for contact had some of their transport costs (i.e. petrol) reimbursed.

Other carers were surprised to hear that DoCS provided additional financial support, and some carers had struggled initially to set their homes up when children arrived. One carer said: 'We had our three children sleeping on fold-up beds because we had a one-bedroom house'. Later, after the carers had been assessed, the grandparents had started building a new home, but DoCS 'did not offer any help at all to make a separate room or anything ... it was all our expense to do everything'.

Other carers who had moved to larger premises to accommodate the children asked for assistance with removal costs but were unsuccessful. In relation to education expenses for their kin children, some carers had received financial assistance for fees and/or uniforms while others had not. Clearly, the approach taken by case workers in considering whether or not to award additional costs is an ad hoc one, and this was evident in all the focus groups. Some carers said that costs that had been covered in a previous case plan, now had to be paid for out of the fortnightly allowance.

The two Aboriginal carers in a country town said that there was an Aboriginal health service that provided all the medical and dental services they required, and one carer said their kin child was seeing a psychiatrist monthly. Three children in one Aboriginal carer's household, all with Attention Deficit Hyperactivity Disorder, were receiving one-on-one tutoring and teaching at their school. Both carers said, however, that obtaining financial assistance for recreational activities for the kin children was more difficult.

*Respite:* Carers' access to respite was highly variable, and there were some carers who had never been offered any respite. Some carers said they would love to have a week-end away, while others said it would depend on what the grandchildren felt. Some

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<sup>29</sup> Victims Services (NSW Attorneys General) provides free face to face counselling to victims of violent crimes (including children suffering from trauma).



grandparents said they would not use respite because their very young grandchildren wouldn't know what was happening and would become upset. Other carers could not get away for a break because they were also caring for an elderly mother or father. One carer couple had five daughters, so they had been able to leave the grandchildren with their aunts when they needed to get away for a break.

Some carers had only one annual school holiday camp paid for by DoCS. Others sent their grandchildren 2-3 times each year at no cost to the carers. Some kinship families had attended a camp for kinship families organised and paid for by DAISI, and had a great time meeting other carers, sharing stories and enjoying themselves. Carers also mentioned Barnardos and Mirabel as two other organisations that provided activities for young people and respite for carers. Other carers mentioned the Springwood Neighbourhood Community Centre (SNCC) that provided recreational activities for young people. One carer observed:

[SNCC] does a wonderful job for us ... the children get out and everything ... quite frankly, we're pensioners with some super. They do not actually get the outings that our children got, plus we are older ... the rafting, they really like it.

A carer could sometimes take a break when another family member (usually a daughter) or a good friend (known to the children) offered to take the children. Alternatively, one carer in a couple would get away while the other grandparent looked after the children. When grandchildren were split between family members (e.g. grandmother and auntie) respite was harder to organise when the only option was the auntie already caring for 1-2 kin children. Other carers noted that other adults in the family had children of their own, so it was a 'big ask' for them to take additional children. Some carers said that other members of the extended family had been assessed by the department, so they could provide respite for the grandparents. One carer, who has vacation care for her granddaughter, said she also had a support worker who took the child to weekly dance classes, thus providing a two-hour break each week. Two carers suggested an innovative solution for respite:

1. Instead of putting money into respite I think they would be better putting someone into your home to help, because when I first got [granddaughter] I had the two boys for a month before. The house was in turmoil ... and to this day ... I don't know how I got to where I am today.
2. You would give somebody anything to come and say, 'I'll do your washing and vacuuming'. If they just put someone into your home and helped you in your home. I just think respite is not always the best thing for the kids.

One Aboriginal carer in a country town said that she was provided with access to respite, usually by another carer (foster), whenever she needed it. She also said, however, that camps and vacation care for kin children, which had been available in the past, were no longer being offered to the carers.

*Provision of child care:* Kinship carers who were in full-time employment when the children came into their care were reimbursed by the department for the costs of child

care. In one case DoCS paid for three days of care and the grandparents the other two. The grandmother gave up her paid work when the grandparents moved out of Sydney to give the granddaughter a 'better life'.

Another grandmother who stayed in paid work to help pay the child care costs for two grandsons had to give it up when she was asked to care for a third grandchild. She and her husband had found that caring for grandchildren changed their lifestyle. As she said:

We lost friends, we lost a whole lot of things ... we couldn't go out and nobody would ask us. We became a burden, we changed. Our issues were just focused on the children. People just walked away from us and it was terrible.

The couple decided to sell up and move up the coast where they had friends and family who could offer some support. The husband, now unemployed, regrets having to sell his business as he misses his workmates. Another carer had given up her job when she began receiving the carer allowance. She said that it had worked out 'OK' financially for her. Another carer said she gave up full-time work when she started caring for a nine-month-old child and realised she could not do both: 'I was 60 and I'm not wonder woman'.

Another grandparent carer, who was in part-time work and using day care for her grandchild, said that she could access 50 hours of paid child care per week, paid by Centrelink under the Commonwealth scheme to assist grandparents. Working-age carers said that DoCS provided them with a certificate saying that they were full-time carers of their grandchildren, so that they did not have to show they were looking for paid employment to receive benefits.

An Aboriginal carer gave up work so that she could attend school daily to support the teacher. The kin child in her care (nephew) has Oppositional Defiance Disorder and is only eligible for one hour a day with a teacher's aide, which the carer says is not enough.

*Contact/access with birth parents:* Commenting on the importance of contact with the children's birth parents, one carer said:

It took a long time and he [grandson] had a lot of issues, but the thing is, no matter what you say about their parents, they love them. I really feel that the contact with mum and dad is really important with my kids. And I've got a good relationship with mum and dad, and I really think the kids need to see if mum and dad are changing over time.

When parents lived locally, contact was regular and the carers were satisfied with the arrangements. For those kinship carers involved in court actions with the birth parents, contact could be acrimonious or didn't happen at all. Some kinship carers were fearful of contact. They were concerned that the birth parent would try and 'take the children back', either through court action or physically on a contact visit. Some birth parents made little or no attempt to keep in touch with their children, and this was upsetting for both the grandparents and the grandchildren. In other situations adolescent children did not want to maintain contact, and grandparents struggled to

ensure that court-ordered contact occurred. Some carers had negotiated changes to contact orders that worked better for the children and for the carers (formally through the Children's Court and informally with the department).

When birth parents lived in other parts of the state (or interstate), visits usually occurred in school holidays, with grandparents and/or birth parents travelling considerable distances to maintain contact. In many cases, DoCS assisted kinship parents or birth parents with the costs of petrol, train tickets, or overnight accommodation to enable visits to occur, although they did not always do so.

Contact was complicated when siblings had a different mother or father. For example, one carer said: 'My two have got the same father but different mothers. The father does have contact by phone occasionally, the eldest does go and see his mother on rare occasions and little one has no contact with her mother'. For other carers, contact was infrequent or non-existent, for example, one carer of a school-aged child explained: 'Mine hasn't had any contact with her mother since she was 16 months old, and the father she hasn't seen for nine years'.

Contact matters were even more complex when siblings of the same birth parents were split between two set of grandparents and the grandchildren were involved with two court systems (Family and Children's). For example, one grandparent with three grandchildren was caring for two of them, while the other one was with the other grandparents. She said:

My [grand]children haven't seen their mother for six years, [and] they haven't seen their father for a year because we're going through a [Family] court case at the moment.

This court case concerned the eldest of the three grandchildren. The youngest child was already with his other grandmother (the father's mother), 'so they're [the father and his parents] only fighting for their oldest child'. The custody of the middle child, who was on a 'protective order' with DoCS, was not in dispute.

A number of carers in one of the focus groups were using supervised access at a church-run visitation centre. One carer explained the benefits of the centre:

There is that safeguard available for contact on neutral ground where both parties arrive independently and leave independently while under supervision. And that may relieve a lot of people's concerns because that is a resource provided by DoCS.

When there was a good relationship between the birth parents and the grandparents, access was more informal, even though it was still supervised by the grandparents. The benefit of supervising the contact visits with the children's mother was evident for one Aboriginal grandmother, who commented:

In our position [caring for three grandchildren] if you do not supervise the kids' access, you do not have a visit to your daughter either ... in that way you actually get to have a family visit.

Another Aboriginal carer organised a picnic day once a year where all the family came together. She observed: 'Kids get to see both their mother and father and grandparents and great grandparents'.

*Same treatment as foster carers?* Carers were asked if they would like to be treated the same as foster carers, and they were evenly divided on the question. Some were of the opinion that 'We're happy as we are'. One carer observed, 'I think emotionally we're very different', and another said, 'My experience is that, as a kinship carer, I am treated with a lot more respect by DoCS'. Another carer felt that foster carers were terribly stigmatised. She said: 'I don't want that'. She was in agreement with numerous other kinship carers when she said, 'I want to be a grandmother *and* I'd like support'.

Others could see similarities between kinship and foster carers. She said, 'I think we should be treated all the same; it's the same situation; I think we should be equal'. Another carer, who could see that aspects of foster caring were different from kinship caring, said: 'I like the thing about being involved emotionally as a grandparent, but I think equality is the bottom line'. One kinship carer saw herself as 'being both, foster carer and kinship carer'. She observed:

I would like a case worker but I think we're well treated. We are pretty independent too and we sort of do a lot of things ourselves. We have the support group of kinship carers, it's nice to talk to them.

Another carer who *was* both a kinship and a foster carer thought that they were 'basically the same'. In her experience, she had found that if she was wanting anything for the children, foster or kin, she had to make her own arrangements: 'I go to the Family Centre, I go to the psychologist, but I use the public health system'. She had tried to get assistance for dental work for a child in her care, and because she was not sure what she was entitled to, she found the experience of asking for financial assistance unpleasant: 'You've really got to beg over the phone and you feel like it's a bit demeaning'. Another kinship carer shared her perspective:

I don't know because I am still not clear on how any of us should be treated. I mean, it does not matter [if] you are foster carer or grandmother, [if] you are not being treated [well] ... why bother?

Another carer made a very pertinent observation:

I think we're all equal. In my point of view you have to start with making the non-statutory carers the same as statutory carers.

An Aboriginal carer thought that all carers should receive the same treatment:

If the kids weren't with us, then they'd be with foster carers. They're still in the care of the Minster and it's better that they're with their family.

Two Aboriginal carers in a country town did not want to be treated the same as foster carers because they were 'family'. One carer observed: 'I'm raising him I'm not caring for him ... he's part of my family'.

*Grandparent support groups:* Carers found out about their grandparent support groups in a variety of ways. One carer commented: ‘Someone at the shopping centre said, “I understand your circumstances”, and said, ‘I think you’d be supported if you attended this group’. Another had received a letter from the school and a \$50 gift voucher from DAISI (a community organisation based at Lismore that supports grandparents raising grandchildren in many towns on the Far North Coast of NSW). Another said she found out about her support group from ‘reading little bits [of information] in the newspaper’. Most carers in the focus groups were receiving a regular newsletter from DAISI and/or from the facilitators of their specific support group. Of the four Aboriginal carers, only two regularly attended a support group.

Carers described the best thing about being in a grandparents’ support group. Two carers’ responses were similar;

1. Most of us lost our close friends ... they do not understand our situation. You cannot explain to them what you are going through. But grandparents who are doing it do, you can look at one of the grandparents and say, “You look like you’re not having a good week!” They can let everything out that has upset them and we’re not shocked. Everybody is there to support.
2. They [the other carers in the group] are not going to tell you what you need to do, how you should do it ... just simply somebody else to understand to listen..

And another carer: ‘I find it very helpful. I’d be lost without them’. An Aboriginal carer commented: ‘It’s good just to sit here and have a good yarn’. From time to time, the Aboriginal support group has had professionals from organisations (including DoCS) provide information to the group. One carer, who attends a support group regularly, and has provided mentoring for other kinship carers, observed:

We get some here who don’t see anyone anywhere else ... they’ve actually got someone to talk to [here]. From month to month they sit home by themselves, and then they come along here and they’ve got some way, you know, to let everything out.

Carers in one support group have a pool of clothing and toys. Items no longer required are made available to ‘new’ carers coming into the group or provided to carers whose children are growing up and have different needs and requirements.

*Observation:* The kinship carers in the focus groups were a diverse collection of formal and informal carers making it difficult to maintain a specific focus on issues and concerns for statutory kinship carers. From the discussion it was apparent that the carers had not participated in family group conferencing or family decision making prior to children being placed with them. Carers responded both positively and negatively to the assessment process. Some carers were assessed early in the placement. Others were assessed, sometimes years later, when they applied for financial support from DoCS. Few of the carers who had been assessed had an allocated caseworker. For carers with case plans few were happy with their implementation. Many carers expressed a need for more than phone contact with a caseworker. For carers, who at some period had an allocated caseworker, the caseworker’s support was appreciated and valued.

No grandparent had been provided with a Resource Guide when they became kinship carers. Many grandparents, particularly those with minimal contact with DoCS, had little understanding of some topics discussed in the groups. These carers were also not aware of how their particular designation of 'grandparent carer' fitted in the discussion.

Carers who had a better understanding of the 'system' were those who had received either the initial foster carer training (*Shared Stories Shared Lives*) or ongoing foster care training (e.g. seminars/forums). These carers also had a better sense of identity as a 'carer' than others who were quite wary of being perceived as a 'carer' or having any connection with DoCS. While only a speculative, it may be that training provides a focus on issues, concerns or behaviours, 'common' to most carers of abused and neglected children. A greater understanding on how to address or adapt to issues, concerns and behaviours arising from caring may be a supportive mechanism for carers. Knowing the system and having a better sense of identity appears to ease some stresses and strains evident in carers with no knowledge or no training. The numbers of Aboriginal carers at the groups were too few to make any specific suggestions around training for Aboriginal kinship carers.

Access to the *Supported Care Allowance* was a bonus for kinship carers and was highly valued. A point of discussion in the groups was the provision of accessible and affordable services for children. While highly variable, some carers were more than satisfied with the services they had received through DoCS and other agencies. Other carers were not as satisfied with services recommended to them and due to long waiting lists other carers were struggling to meet the needs of the children in their care.

Respite was a contentious issue as some carers (often of younger grandchildren) were reluctant to take advantage of a 'break', unless it was with another family member, or someone the children already knew. For older children, camps and vacation care provided necessary reprieves for carers, while camps for the whole kinship family were appreciated by other carers. An innovative strategy, suggested by two carers, was to offer grandparents help in the home. Home help would ease the burden of additional housework and cooking caused when children came to live in the grandparent's home. The provision of childcare, either through DoCS or the Commonwealth, assisted carers in paid employment. Even with child care, some carers were prevented from continuing their paid work due to the number of children in their care, moving to another area, or being unable to maintain two roles - that of a paid and unpaid worker (i.e. a carer).

There were four scenarios impacting on contact and access with birth parents. One, it worked well when family relationships were good. Where family relationships were acrimonious or other grandparents of siblings (with different fathers or mothers) contested custody/contact orders access was more problematic. Infrequent or non-existent contact was another scenario that occurred when either a parent (or parents) were incarcerated or when a parent (or parents) simply made no attempt to keep in touch. The fourth scenario was the necessity for supervised contact visits, either because of fears for the child's (or carer's) safety or because the grandparents were fearful that children would be 'taken' from their care when on a contact visit.

The discussion with carers around same or different treatment compared to foster carers revealed three perspectives. One group were in favour of all carers being treated the same while another group wanted separate treatment. A third group thought the issue was more to do with how all carers should be treated. If the baseline was 'equal' treatment for all carers then nuances and subtleties, based on circumstances and needs should apply, not the title, 'kinship' or 'foster', in front of the name 'carer'.

For carers who belonged to and regularly attended a grandparent support groups there was a sense of camaraderie and understanding among the carers. In its very simplest definition, the 'support' that was of most value to grandparents in the groups, was being able to let 'everything' out and to know that their stories would be listened to uncritically.

## 6 Conclusion

This study examined models of kinship care in Australian jurisdictions and in a small number of countries. The study found that statutory kinship care is a developing area of policy and practice and is the preferred option for placing children when they can no longer live with their parents. Where data was available it appears that Indigenous children are more likely to be placed with kin than non-Indigenous children. In a number of jurisdictions there was evidence of an increasing focus on specific policies and models for providing kinship services to Indigenous families.

In legislation, policy and programs for statutory kinship care the study found no major differences between Australian jurisdictions and other countries. In most aspects of kinship care provision the Australian jurisdictions are on a par with other countries in developing tools for assessing carers and applying models for training and supporting carers. In relation to financial support it was encouraging to find that all Australian jurisdictions were providing statutory kinship carers with the same level of allowances as foster carers.

A number of key issues were noted by the kinship carers in the focus groups.

- One of the key issues for all kinship carers who participated in the focus groups was a lack of information around their entitlements and access/availability of services (e.g. Resource Guide).
- Although the literature nationally and internationally supports the use of Family Group Conferencing to ensure the most appropriate placement for the child, few statutory carers had participated in this process.
- Carers themselves did not have strong opinions about what a kinship carer assessment should entail. From the discussion in the groups it was apparent that the processes involved in being assessed, the time (i.e. hours involved) taken for an assessment, and the timing (sometimes many years after a child had been placed) of when assessment took place was highly variable and inconsistent.
- Another issue for some statutory carers was a lack of access to a caseworker. It would appear that most statutory carers would benefit from more frequent contact with a caseworker. For those carers who, at some period in their caring role had a caseworker, their advice and support was appreciated and valued.
- Some statutory carers with little or minimal contact with the department appeared to be struggling to understand the 'system'. The main source of information for some carers was from other carers and it was not always accurate or up-to-date. Initial foster care training undertaken by some kinship carers appeared to be of benefit as they had a better understanding, not only of the system, but also of their identity as a carer. From the discussion in the groups it appeared that kinship carers would welcome the opportunity to undertake training (i.e. in areas that kinship carers required or were interested in).



- From the discussion it was apparent that some carers were having difficulties managing financially but for the carers receiving the *Supported Care Allowance* they appreciated the financial support and few made any negative comments as to its adequacy in meeting day-to-day needs of children in their care. The issue for some carers was finding the money for the ‘extras’ (e.g. participation in organised sports/recreational activities) for the children.
- Some carers were struggling to obtain the services that thought their children required though other carers, often with the assistance of their general practitioners, specific agency workers and school counsellors were managing reasonable well in accessing health and therapeutic services. An issue for some carers was a lack of a case plan outlining what the child needed in the placement and how these needs were to be met. For other carers the issue was having a case plan that was not being adhered to or that they were unhappy with.
- The availability and take-up of respite was a somewhat contentious issue. Grandparents of pre-school age and younger children preferred to use another family member or a friend known to the child or not take a break at all. Most grandparents of older grandchildren appeared to be able to access vacation care and a number spoke positively of the value of holiday camps for children and camps where the whole family met up with other kinship carer families.
- Being able to access child care for many of the grandparents did not appear to be a problem. Even with the availability of child care it was not surprisingly to find that the additional time and effort in took to care for grandchildren led to some grandparents giving up paid work and for others it prevented participation in the labour market.
- Contact and access visits were an issue for some grandparent carers when relationships with birth parents and other family members (e.g. other grandparents) were problematic.

Reflection on the promising practices and key messages emerging from this study suggest a number of areas where more needs to be done to improve current practices in the provision of statutory kinship care.

- Family group conferencing or family meetings, prior to a child being placed with a family member, are for many reasons strongly supported by researchers. In Australia however, the application of this policy appears to lag far behind what might be considered as ‘good’ practice. From the negative comments on the practice, by workers in this study, it appears that attitudinal change, additional resources and training for workers will be necessary to ensure that conferencing, where appropriate, takes place. For agencies implementing kinship care programs the use of a temporary foster care placement, while conferencing for a kinship care placement is arranged, may provide the impetus for workers and families to come together promptly to resolve the issue of which family member is most appropriate to care for the child.

- How kinship carers should be assessed and what tool should be used in the assessment process is far from clear in the Australian context. There appears from this study to be a plethora of different tools being used or currently developed by government and non-government agencies. Most, if not all, appear to be adaptations of foster carer assessment processes. A significant proportion of children appear to already be in a kinship placement when assessments are conducted. It is therefore critical that the development of a specific assessment tool, appropriate in the context of kinship care, is given top priority.
- From the discussion around training it was clear that, whatever it might be called, education/training for kinship carers is essential. The debate appears to be around the type of specific training that might work 'best' for kinship carers and when and where training should take place. What is important is that carers are given a clear and easily understood explanation as to why training is important and how it will assist them in caring for their grandchildren. What requires more emphasis is explaining to carers the value of being involved with professionals and workers and making links with other carers at training forums/sessions. It also needs to be made clear to kinship carers that training is not about their parenting skills per se, it is more about giving them the information and skills to enable them to best meet the needs (often poorly understood by carers) of the children in their care. As has been found in foster care research, kinship carers as they parent again, will probably be the best guides as to what specific ongoing training will benefit them the most.
- There appears to be widespread agreement that statutory kinship placements should be supported and supervised. There does, however, appear to be some debate as to whether all kinship families require the same level of support. As noted earlier in the report (see Horne et al., 2007) what is required is a cohesive conceptual framework for understanding the elements of intervention and service provision that are most effective for particular groups of grandparent carers (e.g. carers of younger or older adolescents, carers of sibling groups, carers of children from interracial-marriages, etc).
- In relation to contact/access visits and ensuring the safety of children and carers there is strong support for supervised access visits in suitable venues. Where appropriate and necessary the use of mediation services, counselling and skilled intervention by professionals are seen as useful tools in resolving conflictual relationships.
- The formation of grandparent support groups throughout Australia and in other jurisdictions appears to be one of the best supports for grandparent carers. The research indicates that in general grandparents appear to gain significant benefits from belonging to and participating in groups. The groups can serve a number of functions, including providing training and information forums to assist/support grandparents and other relative/kinship carers.
- From the limited information available for this study however, it appears that Indigenous organisations need to be consulted to determine a suitable

alternative to ‘support groups’ for Aboriginal kinship families many of whom live in geographically isolated areas. The consultation process with Indigenous agencies in this aspect and all in other elements of kinship care for Indigenous families cannot be over-emphasised.

- This present study found little evidence of specific training for agency workers providing statutory kinship care services in Australia. The one exception, was in relation to cultural training for non-Indigenous workers supervising Indigenous kinship placements (Victorian Government, 2008; Bamblett and Lewis 2007; Hutchins et al., 2007). Studies in the UK and USA have highlighted the need for training for workers in several areas, including attitudinal change for developing better relationships with kinship/relative carers.

In conclusion an important factor that appears to subtly influence the different approach with statutory kinship carers, compared to foster carers, is that kinship carers are ‘family’, they are not ‘service providers’. In the literature this factor is emphasised by the use of ‘flexibility’, which is not always explained fully, but is used when outlining how tools and models for kinship care should be implemented. That kinship carers are ‘family’ brings a degree of tension into relationships between workers and kinship carers. Evidence from the UK indicates that workers perceive kinship carers as more challenging to work with than foster carers, where roles and boundaries between workers and carers, are more clearly defined and understood.

A further important aspect, distinguishing kinship carers from foster carers, is their ongoing grief and guilt over what has happened to their family. This aspect appears to heighten the level of stress and strain on kinship carers. Knowing how to accommodate and manage guilt and grief and deal with tensions in relationships requires workers to take a different, more sensitive approach when dealing with kinship carers. These various factors highlight the need for specific training for workers to accept/acknowledge the differences between carers (foster and kin) and to develop better relationships with kinship carers and an improved understanding of their situations.

Finally the lack of evidence-based practice in Australia is blatantly obvious across all aspects of statutory kinship care, particularly in relation to research with children and young people in kinship care; working with birth families of children in care; and training for workers providing kinship services. In Australia in particular there are no substantial studies on the most appropriate models (training and support) and tools (assessment) to be used in statutory kinship care. There is also little research evidence on the outcomes for children in kinship care highlighting the need for additional studies in this important and growing area of out-of-home care practice.

## Appendix A: Non-government kinship care agencies

As with other aspects of kinship care services in Australia there is limited information on the provision of kinship care services by non-government agencies. This section of the report discusses research on the provision of kinship care services by three non-government CSOs in Victoria: (Campion and Borenstein, 2004; Joyce, McCrae and Pittman, 2008; McConaghy, 2008).

1. The perspectives and experiences of senior kinship workers were provided in one paper (Campion and Borenstein, 2004). The workers indicated a number of areas where the agency's practice had changed to better meet the needs of kinship carers. In relation to carer assessment the paper noted that it was not uncommon for kinship families to perceive the process as intrusive. To ameliorate this perception workers in a respectful way negotiated with the family about how the worker's role 'fitted' within the context of caring for the child in statutory care. In addition during the assessment process workers encouraged the families to share their stories with them. As a working relationship was developed with the family, the viability of the placement and the support needs of the family were determined.

For these kinship workers *flexibility* in thinking and working with the families was the key. A critical component of involvement with the families was focussing on essential elements that addressed whether a child would be able to develop and grow in a particular setting. In relation to practice they commented on the following aspects:

- Support for carers was tailored to meet specific needs, for example, setting up a carers' group; organising carers to attend a parenting group; addressing social isolation; advocating for carers; and being 'on call' to 'troubleshoot' emerging issues;
- The importance of existing family relationships was acknowledged by workers. A good understanding of these relationships allowed for predictions on how carers within a particular context of wider family relationships were able to balance the task of raising the child. Workers were required to act as intermediaries in negotiations in cases of conflictual family relationships;
- To improve and develop their practice and knowledge base the workers fostered ongoing partnerships with kinship workers in other agencies, the department and other relevant organisations; and
- In tracking kinship placements over several years workers found kinship care was not always appropriate. At times the worker's role was to advocate for a placement outside the kinship network while maintaining the continuity of the kinship network for the child (Campion and Borenstein, 2004: 4).

2. Oz Child, a Victorian non-government agency is a provider of foster (180) and kinship (70) placements. In relation to their kinship care placements Oz Child has found value in family meetings/conferencing in the early stages of involvement with a child at risk (Joyce, McCrae and Pittman, 2008:6).

In their paper the writers reflected on the ambiguous nature of kinship care in Victoria noting that there is no agreement about how registration standards for carers and levels of care are to be applied to kinship care placements. Different and inequitable funding formula for foster and kinship care placements impact on the level of support

provided to kinship carers. Extra financial support (e.g. for counselling, remedial educational resources, etc) that is available for children with special needs in foster care is not available for kinship carers with children with similar needs.

*Looking After Children* (LAC) (ongoing assessment and action records for children in care) plans in place for all foster care placements are not required by the department to be used for kinship care placements. The writers argue that without a LAC plan there is no systematic way of monitoring a kinship child's development (Joyce, McCrae and Pittman, 2008:6). Strong support has been given by other researchers for the implementation of LAC nationally as a tool to monitor the development and outcomes for all children in statutory care (Wise, 2009; Bromfield and Osborn, 2007). These writers suggest that the benefits of using LAC are that outcomes for children in care can be compared to data from national longitudinal surveys of the general population of children.

OZ Child suggests that current inequities around kinship care placements require resolution. They argue that non-government agencies implementing a kinship care program need to be funded to apply the same principles/processes that are applicable to foster care placements including:

- arranging care teams to conduct carer/child assessments and counselling;
- ensuring the safety and needs of the kin child are being met;
- providing an allocated caseworker for each kin child;
- providing case planning/management through a LAC plan; and
- applying Quality of Care guidelines (Joyce, McCrae and Pittman, 2008:6).

3. A study evaluating the Victorian Berry Street Kinship Care Program found carers were extremely satisfied with the 'skill, commitment and caring' of the agency's workers. The most important aspect of the program for the kinship carers was their relationship with their worker. The support offered to carers was seen as significant with home visits and phone contacts made on a monthly basis and other contact calls as needed. The frequency of home visits and contacts increased at times of stress or crisis (McConachy, 2008: 13-14). McConachy (2008) provided a number of key messages for the agency to consider for kinship placements. They included:

- Assist kinship carers to gain a sound and integrated understanding of their changed role;
- Ensure carers have a self-sustaining, non-professional network (e.g. carer support groups; other family members, etc);
- In addition to providing information link carers to professional services and other supports;
- Offer respite (e.g. camps for children and/or families) to carers;
- Facilitate peer support or informal mentoring (e.g. with an experienced kinship carer);
- Provide counselling services for carer and child;
- Facilitate an understanding of the Children's Court system/ processes;
- Provide an after-hours carer support service;
- Use family conferencing initially and when required throughout the placement;

- Promote carer recognition/validation through an annual caregiver review and seek feedback from carers; and
- Provide kinship specific training to carers (McConachy, 2008: 17-40).

The discussion on kinship care services in three non-government CSOs in Victoria reflects what has been discussed throughout this report by other researchers and consultants.

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