Fairy godparents and fake kin: Exploring non-familial kinship care ('kith care')

Diversity in kinship care Research Series Report 1:
Non-familial kinship care

THE UNIVERSITY OF
MELBOURNE

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Cover: Margaret's family includes herself, her two adult daughters, her two sons, her grandson, and the three grandchildren of her former husband. (Sketch photo reproduced with everyone's permission.)

It's a portrait we had done. At first the children were only here on a temporary thing … in January it will be three years … But for two and a half years I had the three kids in my lounge room. One slept on the couch, one slept on a mattress on the floor and the other one had a foam fold-out couch. [When] they all got beds you'd think they'd won TattsLotto.

Image facing page 1: James (12) and Aiden (9) are close brothers living together in kinship care; their two younger brothers are in another kinship care arrangement nearby. James and Aiden say they are extremely grateful to be able to live together, and feel loved and supported by their carer.

Foreword

Kinship care is the fastest growing form of out-of-home care in Victoria. This is not without good reason—there is research to suggest that children who remain with kin are less likely to experience the trauma of separation and more likely to remain connected to their families, friends and cultures. Managed and supported well, kinship care is best-placed to promote the rights and wellbeing of children requiring care.

As this report reveals, there are many instances where non-familial kinship placements can be successful and enduring. This is a testament to the dedication and altruism of many carers, who devote themselves to nurturing and supporting children who have experienced abuse or neglect. While many of these carers cite the reward of seeing vulnerable children thrive and flourish in their care as their motivation, it is also clear that these arrangements often come at a high personal and financial cost to them.

However, this report also highlights some aspects of the kinship care model that suggest that the system is, in fact, not always managed and supported well. It specifically explores the circumstances of a significant number of children and non-familial carers who are thrown together, generally in the context of an emergency, and left to manage long-term care with minimal support and oversight. It tells stories of children being placed with people they barely know, in living arrangements that have not been properly assessed for their safety and suitability. This not only places children at an unacceptable risk of harm, but is also unfair to carers who may not be willing or equipped to support a young person's care in the long-term.

As pressures on the child protection system continue to increase, so too will demand for appropriate care arrangements for children who cannot remain at home safely. Alongside foster care, kinship care is key to meeting demand for care that is safe, familiar and culturally connected. It is important—for carers and children alike—that the kinship model shift to a form of care that is fully recognised, remunerated and supported. It needs to be flexible enough to recognise the diversity of relationships and care arrangements that kinship care supports. But most importantly, it needs to be centred around the rights, safety and needs of children.

Liana Buchanan
Principal Commissioner for Children and Young People

"Children need compassion, care and understanding, but most of all … they need belonging. And as we think of meeting that challenge, we should remember that there many pathways to that warm place called 'belonging'."

(Gilligan, 2006)

Glossary

Children	'Children' is here frequently used to refer to people aged 0–18 years.
Young people	'Young people' refers to the teenagers and young adults who participated in this study.
Kinship care	Family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature (United Nations, 2010).
Informal kinship care	Kinship care that has been arranged privately within a family.
Formal (statutory) kinship care	Kinship care authorised by child protection; such placements normally attract a carer allowance.
DHS, DHHS, the Department	Department of Human Services (DHS), the former name of the current Victorian Department of Health and Human Services (DHHS), the Department responsible for child protection. The term 'DHS' is still commonly heard.
Kinship care assessment Part A and Part B	**Part A** of a kinship care assessment: a brief assessment required to be conducted within two weeks of the commencement of placement. **Part B**: a more thorough assessment required to be completed within six weeks of the commencement of placement.
CRIS	The electronic Departmental child protection database that includes details of all children subject to statutory intervention.
Stability plan	A plan for stable long-term out of home care for a child required under the Children, Youth and Families Act 2005 once a child has been in care for 1–2 years (depending on their age). It may include details of the proposed long-term placement, or the type of carer to be sought; the appropriate Court order that best supports this; contact with parents and siblings, requirements for meeting the child's developmental needs; and other relevant matters.
Permanent care	Care authorised by a Permanent Care Order of the Children's Court which grants custody and guardianship to the caregiving family.
Quality of Care report	A concern registered about a child or young person's safety, stability or development within their out of home care placement and investigated by DHHS.
Working With Children (WWC) check	A legal requirement for people doing child-related work. That includes checking a person's criminal record and in some cases, professional conduct determinations and findings.

Executive summary

Kinship care – the care of children by relatives or family friends – is a relatively new option for children subject to protective orders. Both changing ideology and a shortage of alternative placements have led to numbers in kinship care in Victoria rapidly increasing year on year. The growing research literature focuses particularly on grandparents as the most visible cohort of kinship carers. Little attention has been paid to care by family friends (non-familial kinship care) – a gap that this research study sought to address. A search was conducted for relevant administrative data that might provide information about the prevalence and stability of non-familial kinship care. It was determined that the prevalence of non-familial kinship care arrangements is as yet unknown, both within Victoria and across Australia.

The experiences of young people, carers and kinship care support workers were explored through interviews, focus groups and a small survey. Carers and support staff provided many examples of secure long-term non-familial care and evident benefits for children, despite significant unmet needs for support. On the other hand, kinship support staff also described numbers of unsatisfactory care arrangements, and some that were frankly unsuitable. Several areas of problematic practice were evident. Many cases were described where statutory care arrangements had been struck with people who had little or no relationship with children, yet were deemed to be kinship care placements. Superficial and delayed assessments were reportedly common. Care was seen to have frequently commenced as an emergency short-term arrangement but allowed to drift to indefinite care or breakdown without due consideration of the needs of children and carers. Many arrangements were observed to have broken down quickly. Paradoxically, there also were indications that the stability planning process could threaten a stable long-term care arrangement by initiating a further search for extended family care years later, whether or not relatives under consideration had a significant relationship with the child.

A number of discrepancies in standards and support between kinship care and foster care were raised. Carers spoke of delays in being referred for support; a lack of access to information about children's backgrounds; care allowances that failed to recognise children's additional needs; and limited access to training about the impact of trauma. Many carers were aware that their entitlements for financial and non-financial support would have been considerably greater had they been authorised as foster carers.

In earlier years, statutory non-familial carers were regarded as (specific) foster carers, and were afforded thorough assessment and ongoing support, with all placements receiving active support and management. Less than onefifth of children in statutory kinship care in Victoria currently receive case management and carer supervision and support from community organisations; due to high child protection workloads, many have become 'unallocated cases' within the child protection service. It should go without saying that all children in statutory care need the protection of robust carer assessment and support, and active case planning and management.

The results of this study suggest that some non-familial kinship care represents an unofficial redefinition of potential foster carers as kinship carers, with resulting neglect of the proper assessment and management of children's care. An acute lack of placement alternatives, and a lack of capacity to undertake thorough and timely caregiver assessments, combine to provide fertile ground for inadequate and potentially abusive care. Such arrangements cannot meet minimum standards for the protection of vulnerable children. There is a need to rethink the notion of so-called 'kith care' or non-familial kinship care, and to acknowledge that carers with little pre-existing relationship to children are providing foster care rather than kinship care, and should be managed as such. To reinstate the practice of specific foster care assessments in these circumstances would, however, necessitate generating an increased range of options for emergency care to allow time for thorough pre-care assessment.

Kinship care, whether by family or 'family friends', is not a panacea for protective care. However with proper assessment, financial and non-financial support, it has proved to be an excellent option for many children in need, and rightly the placement of choice.

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"Kinship care may often be called 'family and friends care', but there is as yet little in the literature about care by friends as opposed to family (whether or not 'blood' related) … What kinds of arrangements exist, and how (if at all) are they different?"

(Pitcher, 2014)

Chapter 1

Background

> Children need compassion, care and understanding, but most of all … they need belonging. And as we think of meeting that challenge, we should remember that there many pathways to that warm place called "belonging". With our heads and our hearts, with the respect born of rights and with the love born of commitment, we can get closer to helping children blossom. We can work to guide children on the path from hurt to hope, on the path from harm to healing, on the path to "belonging" (Gilligan, 2006, p.44).

Kinship care is defined as 'family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature' (United Nations, 2010, p.6). At its best, it represents an altruistic gift of care from adults to children in significant need (Testa & Shook Slack, 2002). Increasingly, the public is hearing about the many grandparents deeply committed to raising grandchildren despite their own stress, fatigue and financial privation. While it is widely believed that most kinship carers are grandparents, the facts are less clear. An unknown number of people designated as statutory kinship carers are individuals whose lives have crossed paths with children in need and have taken these children into their home despite a lack of familial obligation.

Our interest in non-familial kinship care was initially piqued by the survey of statutory kinship carers in Victoria for our 2010 *Family Links* research project exploring family contact in kinship care (Kiraly & Humphreys, 2016). One-fifth of the 430 respondents were not related to the children in their care. An extraordinary range of connections between these carers and children were recorded. However, despite having been classified as kinship carers by child protection, some carers maintained that they were not kinship carers but foster carers. Several comments on the survey forms raised questions about these placements.

> The young person was someone who lived in the area. I only knew her to say hello to, before she became homeless and then moved in with me.

> I don't believe I've had any support. They just dropped the girls off and made a run for it (Carer for children of a 'friend of a friend').

To date, non-familial kinship care appears to have been of no particular concern to policymakers, support groups or researchers. Many grandparent care organisations include other relative carers as members and non-familial kinship carers are also normally accepted, but rarely mentioned on brochures or websites. No other research studies that focused specifically on this group have been identified, a fact commented on by Hedin (Hedin, Höjer, & Brunnberg, 2011). However, two studies that compared placement stability in different forms of out of home care (Perry, Daly, & Kotler, 2012 in Canada; Sallnas, Vinnerljung, & Westermark, 2004 in Sweden) both identified non-familial kinship care placements as having a significantly higher breakdown rate than familial care – a rate closer to that of foster care. Perry et al (2012) concluded that 'further investigation of this distinction would be valuable' (page 465). The editor of *Inside Kinship Care* (Pitcher, 2014) also commented on non-familial kinship care (in the UK, known as 'friends care'):

> Kinship care may often be called 'family and friends care', but there is as yet little in the literature about care by friends as opposed to family (whether or not 'blood' related). Does the age of the child matter? Or the degree of permanence? Are family-type roles, such as godparents, different to neighbours or parents of school friends? What kinds of arrangements exist, and how (if at all) are they different? (Pitcher, 2014, p.251)

This research study set out to take the first steps in filling the knowledge gap about statutory non-familial kinship care.

Out of home care, attachment and the psychological parent

Bowlby (1953, p.13) first articulated the concept of attachment, defining it as a 'warm, intimate and continuous relationship' between a child and their mother or mother-figure'.

He suggested that most young infants form more than one attachment; that the number is not limitless; and that attachments are not all equivalent or interchangeable but hierarchical, usually with a principal attachment figure (Cassidy & Shaver, 1999, p.181). Infants can therefore be simultaneously attached to parents and an alternative carer. The term *psychological parent* was introduced by Goldstein, Freud, and Solnit (1973) to describe a person with a parental relationship to a child that includes ongoing, loving care regardless of familial ties, thus including foster carers and kinship carers. These writers argued that courts should recognise children's bonds with their psychological parents as essential to healthy development, and work to preserve them. Significantly, they argued that courts should favour this relationship over connection to a biological parent with whom the child does not have such a bond.

The concepts of *attachment* and the *psychological parent* are thus central to children's relationships with their carers, whether parents or others. For longer-term care to work well, carers need to become psychological parents. When care starts young and is longstanding, children will often form a strong attachment to their psychological parents, the severing of which may be traumatic. A late return to familial care may or may not be in children's best interests. However, despite these concepts having longstanding recognition in psychological practice, their recognition in legal proceedings remains inconsistent.

Non-familial kinship care arrangements (both informal and statutory) that become long-term are sometimes described as fictive or constructed families. Society tends however to privilege natural family bonds, and recognition of families thus constructed may be uncertain. Non-familial kinship care families may thus live in a shadowland, one on which this research project aims to shine a light.

Recent developments in out of home care in Australia

Australia was early by world standards in taking action with regard to the damaging effects of institutional care on children. By 1990 most large congregate care had disappeared, progressively replaced by foster care and small group residential units that included 'family group homes' with live-in staff, and residential units with care staff working 8–12 hour shifts. Residential units with capacity for up to twelve children specifically for reception care were established, but were quickly supplanted by the requirement that all small residential units and foster care placements should be available for emergency placements. In time, small group residential care was also seen as problematic, and in Victoria the number of such units was dramatically reduced in the 1990s. Pressure for emergency, short and long term placements thus accrued to foster care and its variants at a time when recruitment of foster carers was becoming increasingly difficult. Placement emergencies skyrocketed, especially for adolescents, exacerbating the need to establish expensive, unsatisfactory contingency arrangements such as single child residential units, and care arrangements by casual staff located in motels.

Increased consideration of protective care within the child's wider family and friendship network was influenced in part by the growing family preservation movement (Berrick, Barth, & Needell, 1994). In the United States there was increasing concern to see African American children remain within family and community, and in Australia, similarly, growing awareness of the importance of family and community to Aboriginal children (Brown, Cohon, & Wheeler, 2002; Human Rights and Equal Opportunity Commission, 1997). However it would appear that in addition to ideological changes, the possibility of statutory care being provided by relatives and family friends gained recognition in large part to help fill the vacuum left by residential care closures. As in other countries, policy change in favour of kinship care appears to have largely followed practice rather than leading it (Ainsworth & Maluccio, 1998; Boetto, 2010; Broad, 2004; del Valle, López, Montserrat, & Bravo, 2009; McFadden, 1998; Smyth & Eardley, 2007).

> The juxtaposition of the philosophical shift to the family continuity paradigm of maintaining significant family and kinship ties, and a desperate need for more placement resources created the phenomenon of a sudden pendulum swing towards kinship care. The placement of last resort had become the placement of choice (McFadden, 1998, p.8)

Locally, professional perspectives thus gradually changed, and the trope, 'The apple doesn't fall far from the tree' was replaced with, 'If they're with family, they're safe' (Geen, 2003, p.15; Spence, 2004, p.271). Across the country, child welfare legislation was progressively modified to preference placing children with family and friends, and kinship carers became eligible for care allowances similar to foster carers. However, while usage of protective kinship care soared, policy and programmatic guidelines and data systems are still at an early stage.

Kinship care – benefits and challenges

Significant benefits of kinship care as compared with other forms of out of home care have been identified. A systematic review of outcomes for children in kinship care by Winokur, Holtan, and Batchelder (2014) found that kinship care affords greater placement stability, and that children placed in kinship care have better wellbeing than children in foster care. A literature review by Nixon (2008) also concluded that kinship care is more stable than foster care, and at least as safe. Nixon noted other benefits as the perceived normality of the family environment and the familiarity and maintenance of a range of family relationships. However, research samples are frequently established opportunistically, and some are therefore biased according to sources of recruitment, such as grandparent support organisations (Kiraly, 2015): for example, placement stability tends to be associated with care by grandparents rather than other relatives (Farmer & Moyers, 2008; Hunt, Waterhouse, & Lutman, 2008) or non-familial kinship carer (Perry et al., 2012; Sallnas et al., 2004). Connolly (2003) also warned that relatively low reports of abuse may not equate with children's safety, as incidents of concern may be underreported in kinship care due to less vigilant supervision of placements than in foster care.

Ironically, the identified benefits of kinship care accrue to children despite a more vulnerable carer cohort than foster carers. It has been frequently noted that kinship carers are generally older, poorer and more often single, and have more health problems than foster carers (Connolly, 2003; Cuddeback, 2004). The stress kinship carers experience from multiple sources and their need for support have been overwhelmingly identified (for example, Boetto, 2010; Farmer & Moyers, 2008; Hunt, Waterhouse, & Lutman, 2010; Kiraly, 2015).

The statutory kinship care program in Victoria

Kinship care came into being as a new statutory care entity in Victoria in the late 1990s. Before this time, some children under a statutory order were placed under a 'reside where directed' clause with people known to them, without the carer being formally assessed or financially supported. Where the need for care was seen as longer-term, some care arrangements were treated as 'specific foster care' placements. This usually entailed children being in temporary care elsewhere while the foster care assessment took place. Approved persons would then receive accreditation as foster carers for specific children, and become part of a foster care program of supervision and support. The fact that kinship care could embrace both 'kith and kin' allowed for greater numbers of immediate emergency placements when family was not available without the lead time required for foster care assessment, and practice with regard to 'family friends' gradually changed towards immediate placement under the rubric of kinship care.

Numbers of children in statutory kinship care in Victoria have risen steadily since the year 2000 (Australian Institute of Health and Welfare, 2010). A statutory kinship care support program in the community sector was established in 2010 with capacity to provide casework support to 750 children, around one-third of children in kinship care at that time (Australian Institute of Health and Welfare, 2011). Assessment of such placements remained a child protection responsibility. Since 2010, numbers in statutory kinship care in Victoria have risen further, more than doubling by 2016 (Australian Institute of Health and Welfare, 2011, 2017), but there has been only a marginal increase in capacity for casework support within community sector kinship care programs.

The current kinship care service model is very different from foster care. In addition to the foster care support program in the community sector comprising extended carer assessment and training and ongoing casework, foster carers are paid an allowance according to a scale based on the needs of the child. By contrast, kinship carers are rarely authorised to receive more than the lowest level of the carer allowance. The assumption that a strong

pre-existing child-adult relationship is inherently protective, also appears to justify a 'light touch' approach to both assessment and support. The current assessment protocol involves a brief assessment (**Part A**) to be made within two weeks of care commencing, followed by a thorough assessment **(Part B)** within six weeks. However the child protection service continues to struggle under resource limitations, acute workload pressures and continuing high staff turnover, all of which have compromised execution of the assessment protocol. The 2015–2016 Review of the Kinship Care Program indicated that the quality and timeliness of Departmental child protection kinship carer assessments were variable, and monitoring and support of placements was lacking (Choahan, 2017). Recent attention to these concerns suggests the prospect of some improvements in due course.

Terms used for non-familial kinship care

Terms used more or less synonymously with kinship care are *relative care*, or *kith and kin care* (Australia); *family and friends care* (UK); and *relative care* or *kinship foster care* (especially USA). Australian Aboriginal people are less likely to make a distinction between relatives and other people in a social network, sometimes simply referring to all non-parental care as 'foster care'.

Fictive kin is a term used by anthropologists and ethnographers to describe forms of kinship or social ties that are not based on blood or marriage-type relationships. Several terms have been identified that describe kinship care with fictive kin and individuals known through community connections. In Sweden, Sallnas, Vinnerljung, & Westermark (2004) used the term 'network foster homes'; Perry, Daly, & Kotler, (2012) in Canada used 'unrelated nominal kin'. The British term is 'friends care'. The term 'community kinship' is in use in Queensland, Australia, however in Victoria, the expression 'kith and kin' has been disaggregated such that this group are known as 'kith carers'. Interestingly, while originating in Scotland, the term 'kith care' is not used there, or elsewhere in the United Kingdom.

Due to local usage, a number of quotes in this report include the term 'kith', however the term 'non-familial kinship carers' is generally used. We recognise that this is also an unsatisfactory term, implying as it does the lack of an alternative identity rather than recognition of the unique characteristics of this group of carers. A new term may be needed to recognise the gift of care by such people to children with whom they have developed an affinity.

Methodology

The project aimed to explore non-familial kinship care arrangements in Victoria and to inform policymakers and practitioners about the findings. Specific research questions were:

1. What is the prevalence of non-familial kinship care in Victoria, both informal and statutory?

2. What are the characteristics of statutory non-familial kinship care arrangements?

    *   How are they similar and different to familial kinship care?
    *   How stable are statutory non-familial kinship care arrangements as compared with familial kinship care arrangements?

3. What are the support needs of non-familial kinship carers and children in their care?

How are these similar and different to those of familial kinship carers?

What support do they receive, and what if any unmet support needs do they have?

The project received approval from the University of Melbourne Human Research Ethics Committee.

Methods

1. Search for and analysis of relevant administrative data.

2. Online and hard copy survey via Survey Monkey.

3. Interviews with non-familial kinship carers, and young people with experience of non-familial kinship care. Eleven of the carers interviewed were also survey respondents.

4. Reanalysis of transcripts of interviews with carers and young people from the 2010 *Family Links* research project (with participants' consent).

5. Focus groups with kinship care support staff.

Participants were recruited via Victorian kinship care support services in community service organisations. Meetings of the periodic Kinship Services Forum of the Centre for Excellence in Child and Family Services were central to the recruitment effort. A $40 gift voucher was provided to carers and young people interviewed.

Analysis

Administrative data was analysed using Microsoft Excel; survey data was analysed within Survey Monkey and Microsoft Excel.

Focus groups and interviews were recorded and transcribed. Transcripts were coded using the NVivo software package to identify and classify material in relation to the research questions. New codes were added as relevant issues emerged from the data. Themes were identified from the coded material and organized to develop an overall picture of non-familial kinship care.

Limitations of the research

We also did not have access to Departmental databases to access the majority of kinship carers who are not referred to community organisations. Thus, the reach of the carer survey was limited to the minority of carers receiving support from community organisations, and only a small number of responses were received. Conclusions from the survey are therefore limited.

We also did not have permission to interview young people on statutory orders, thus a primary limitation of this research was the small number of young people interviewed. Further research in this area should aim to present a fuller picture by seeking permission to interview young people under statutory protection orders.

"Analysis of Victorian child protection data indicates that the proportion of statutory kinship carers who are not family members remains unknown, and the relative stability of familial and non-familial kinship care cannot yet be determined."

Chapter 2

Prevalence of non-familial kinship care

This chapter describes the search of administrative datasets for information about the prevalence and stability of familial and non-familial kinship care. Australian datasets were explored with a particular focus on Victoria.

Seven datasets were explored. On request, three extracts from databases were provided:

1. Extract from the DHHS child protection (CRIS) database.

2. Customised tables derived from the 2011 Australian census.

3. Extract from the Australian Department of Social Services (DSS) Centrelink database.

Details of the search for relevant data are presented in Table 1.

Table 1: Administrative datasets explored

Australian Institute of Health & Welfare (AIHW)	Preliminary data about the carer relationship from four Australian jurisdictions appeared in for the first time in the AIHW 2015−2016 Child Protection Report (Australian Institute of Health and Welfare, 2017).
Victorian Department of Health and Human Services (DHHS)	CRIS is the Victorian child protection database that records information about children subject to child protection investigations. The extract of data provided included information about the relationship between children and their kinship carers, and start and end dates of placements.
2011 Australian Census of Population and Housing (ABS)	The Census of Population and Housing conducted by the Australian Bureau of Statistics (http://www.abs.gov.au/websitedbs/D3310114.nsf/Home/Census) includes information about the usual place of residence[a] of every individual on the designated census night. Customised tables provided included proxy data about the prevalence of kinship care arrangements and associated demographic characteristics.
Australian Department of Social Services (DSS) – Centrelink	The extract of de-identified electronic case file data about recipients of Centrelink carer payments regarding the relationship between carers and children in their care was provided. However, DSS analysts commented that the data was not of great clarity, and urged cautioned in drawing conclusions from it. The extract indicated that that the overwhelming majority of carer payments (97%) were provided to identified parents of children. Few carers (1%) were identified as unrelated to children for whom they were providing care[b]. Numbers were too small to derive reliable numbers of payments to kinship carers in Victoria. (DSS data analysts, personal communications October 2014).
Taskforce 1000	A dataset of Aboriginal children in care in Victoria in 2014−2015 not available for perusal.
Household, Income and Labour Dynamics in Australia (HILDA) Survey	The HILDA Survey is a household-based panel study conducted by the Melbourne Institute of Applied Economic and Social Research. This survey collects information about economic and personal well-being, labour market dynamics and family life. However, there are only 30−40 children in each Wave of data collection, and most children are living with parents. The data pool was thus too small to derive rates of familial and non-familial kinship care (Melbourne Institute of Applied Economic and Social Research, University of Melbourne, personal communication February 2016).
Longitudinal Study of Australia's Children (LSAC)	*Growing Up in Australia: The Longitudinal Study of Australian Children (LSAC)* is a major study following the development of 10,000 children and families from all parts of Australia and investigating the contribution of children's social, economic and cultural environments to their adjustment and wellbeing. A major aim is to identify policy opportunities for improving support for children and their families. The dataset was not of sufficient size to identify numbers of unrelated children in the care of kinship carers. Further, the carer identification is self-identification and may not be exclusive (AIFS, personal communication November 2014).

a. Usual place of residence is defined as the address at which a person lives or intends to live for six months plus.
b. This 1% does not include step-parents, foster carers or adoptive carers of children.

Children's relationship with carer − statutory kinship care in Australia

The 2017 Child Protection Report (Australian Institute of Health and Welfare, 2017) presented preliminary data about the relationship between carer and child on 30 June 2016 in four Australian jurisdictions: Queensland, South Australia, Tasmania and the Australian Capital Territory. Supplementary Table S36 (here presented as Table 2 with this writer's highlights) reports that three-quarters (75.8%) of the 5,074 children in these four jurisdictions were living with relatives: nearly half (48.1%) were with their grandparents, and over one-quarter (27.7%) with

other relatives. Nearly one-quarter (24.1%) were either in non-familial care (17.5%) or 'Other' care (6.6%). Table S36 Note (d) below refers to another 916 children excluded because the relationship between kinship carer and child was unknown. (These 916 children, 15% of the overall number, were included in Supplementary Table S35 not quoted here.) It cannot be assumed that the excluded cases were spread proportionately across the relationship categories. This report of carer relationships is therefore regarded as a best first estimate.

Table 2: Excerpt from 2017 Child Protection Report Supplementary Data

Preliminary analyses, children in relative/kinship placements at 30 June 2016, by relationship of relative/kinship carer (AIHW 2017, Table S36)

Relationship of relative/kinship carer	Number	%
Grandparent	2,442	48.1
Aunt/uncle	1,121	22.1
Sibling	80	1.6
Other Relative	205	4.0
Non-familial relationship	887	17.5
Other Indigenous kinship relationship	6	0.1
Other	333	6.6
Total	5,074	100.0

Notes:

a. This table includes data for Qld, SA, Tas, and the ACT.

b. The relationship between an authorised relative/kinship carer and a relative/kinship child placed in their care can be full, half, step or through adoption.

c. For households containing more than one authorised relative/kinship carer, only the relationship of the carer identified as the 'primary' carer is recorded.

d. Placements where the relationship of relative/kinship carer is unknown have been excluded from this table.

Children's relationship with carer — statutory kinship care in Victoria

The CRIS data extract provided included information about the relationship between children and kinship carers for the six years 2010 to 2015 and associated *Placement Commencement* and *Placement End* dates.

Technicalities

CRIS contains fields for the *Role* of an individual in a child's life and the *Relationship* between an individual and a child, whether as family or another non-family relationship. Completion of the *Role* field is mandatory, but completion of the *Relationship* field is not. The *Role* menu option *Caregiver — Kinship* covers kinship carers with both familial and non-familial relationships with children in their care. There are some historical records where the *Role* of kinship carer was recorded as the *Relationship Caregiver — primary* rather than as *Role Caregiver — kinship*.

An individual recorded in the *Relationship* field may also be recorded as having the *Role* of Caregiver. Where no *Relationship* has been recorded for the child's caregiver, no inference can be drawn about the type of relationship the caregiver may have with the child.

Findings and conclusions

Data obtained is presented in Table 3. Over the years 2010 to 2015, less than half the children (34% to 42%) were identified as having a familial relationship with their caregivers. Around

one-quarter of children (21% to 29%) were identified as living with their grandparents. A very small number of children (1% to 2%) were recorded as being cared for by non-familial kinship carers (menu options *Friend* or *Non-family*). Ones and twos were recorded as living with carers described as *Services Worker* or *Neighbour*. The most frequent descriptors that appeared in the *Relationships* Table were *Caregiver kinship* (22% to 47%) and *Caregiver – primary* (reducing from 28% to 5% over the six years). Together, these two categories accounted for 51 percent to 59 percent of entries. This means that in the majority of cases, while the mandatory *Role* field was completed, the non-mandatory *Relationship* field was not. It may be speculated that the *Relationship* field was more frequently completed where carers were relatives (for example, grandparents) of the child rather than where they were non-familial. If this were the case, the appearance of the terms *Caregiver kinship* and the older discontinued term of *Caregiver – primary* in this data field might reflect more non-familial kinship care than familial care arrangements. However, there is no way of knowing whether this assumption is reasonable.

Inconclusive data therefore resulted from the completion of the *Relationship* field not being mandatory. Thus, the proportion of statutory kinship carers in Victoria who are not family members remains unknown, and the relative stability of familial and non-familial kinship care cannot be determined. The achievement of reliable national figures in the AIHW annual Child Protection report will depend on the capacity of Victoria as well as several other jurisdictions to provide this data.

Table 3: Relationship between statutory kinship carers and children in Victoria (active placements at 30 June)

Year	2010	2011	2012	2013	2014	2015
Relationship entries	**Count of children in placements at 30 June**					
Grandparents	472	622	795	846	975	1352
Great-grandparents	8	10	18	25	29	32
Aunts/uncles	173	212	299	296	318	406
Cousins	12	13	24	17	15	21
Siblings	18	18	13	18	19	35
Other related	70	78	89	112	116	122
Friends and 'non-family'	33	46	64	60	63	81
'Caregiver' categories	1185	1256	1478	1870	2253	2579
Indeterminate entries	240	126	89	53	49	38
Apparent errors	14	15	21	20	13	24
Total	2225	2396	2890	3317	3850	4690
Percentage of children in placements at 30 June						
Children for whom entries in the Relationship field were familial options	34%	40%	43%	40%	38%	42%
Children for whom entries in the **Relationship** Table appeared as the role of *caregiver kinship* or *caregiver – primary*	53%	52%	51%	56%	59%	55%
Children for whom entries in the **Relationship** Table were *friends* or *non–family*	1%	2%	2%	2%	2%	2%
Indeterminate entries	10%	5%	3%	2%	1%	1%

(Summary of CRIS data extract provided.)

Children's relationship with carer – households in Victoria with children in kinship care

Customised tables derived from Australian census data were requested from the Australian Bureau of Statistics primarily to derive proxy data about the ages of kinship carers for another research project. However some of the Victorian data was also relevant to this project and is thus presented here. It includes households involved in both informal and statutory kinship care.

Technicalities

The Australian census questionnaire does not include a question about which individuals are primary caregivers of children in a household. Further, due to the way raw data from the survey questionnaires is processed, it is not possible to derive the specific family relationship between children under 15 years and the Family/Household Reference person (RPIP)[1]. The effort to derive relevant data about kinship care was thus challenging. We made the assumption that the RPIP and/or partner (where present) would have a primary role in the care of children in the household; either or both might be a homemaker and/or breadwinner. This assumption could not be made for multi-generational households, as primary responsibility for the care of children might fall to individuals in either adult generation. Multi-generational households were therefore excluded from the analysis, inevitably eliminating some households where kinship care could be taking place. We also excluded two-generational households with adults who could be the parents of children identified as 'related' or 'unrelated'[2] to the RPIP. The census data thus provides an underestimate of the extent of kinship care in Victoria, both familial and non-familial. Detailed specifications of our analysis are available from the writer.

Findings and conclusions

A total of 10,852 two-generational households in Victoria included 'related children' (children related as family to the RPIP and/or any partner) and/or 'unrelated children' (that is, not related to the RPIP and/or any partner). One-fifth (21%) of these households included unrelated children. Kinship households with RPIPs in the age range 31 to 59 years had a relatively higher proportion of children (31%) identified as unrelated than households where RPIPs were in younger (16%) or older (7%) age brackets (Table 4).

Table 4: Two generational households in Victoria with children related as kin, or unrelated

	Age of RPIP			Total
	<31	31–59	60+	
Households with unrelated children	387 (16%)	1734 (31%)	204 (7%)	2325 (21%)
Households with children related as kin	2018 (84%)	3866 (69%)	2643 (93%)	8527 (79%)
Total kinship care households	2405 (100%)	5600 (100%)	2847 (100%)	10852 (100%)

(Source: ABS 2011 Census of Population and Housing Customised tables)

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1. The **Family/Household Reference Person Indicator** (RPIP) records the person who is used as the basis for determining the familial and non-familial relationships within a household. It is usually the person who has identified as Person One on the Household form.
2. Formally fostered or adopted children are excluded from the category of 'unrelated children'.

Six percent (603) of the 10,852 kinship care households included indigenous children (Table 5). These households were almost equally likely to have an indigenous RPIP and/or partner (49%) as a non-indigenous RPIP and any partner (51%). One-quarter (25%) of the households where neither the RPIP and/or any partner were indigenous included indigenous children described as unrelated. By comparison, in the kinship households with an indigenous RPIP and/or partner, kinship children were almost always described as family members; only four percent (13) included children described as unrelated. This may reflect the customary practice in many indigenous families that deems technically unrelated children being cared for to be family members.

There were also a small number of kinship households (73) where the RPIP and/or partner was indigenous but children being cared for were not indigenous. Over half (44) of these households included children described as unrelated.

Table 5: Two generational households in Victoria that included indigenous children either related as kin or unrelated

Households with indigenous children	RPIP and/or any partner indigenous	RPIP & any partner not indigenous	Total
Households with unrelated children	13 (4%)	77 (25%)	90 (15%)
Households with children related as kin	284 (96%)	229 (75%)	513 (85%)
Total kinship care households	297 (100%)	306 (100%)	603 (100%)

(Source: ABS 2011 Census of Population and Housing Customised tables)

Limitations

Proxy figures for the prevalence of kinship care derived from census data are subject to significant qualification. As mentioned above, the exclusion of multi-generational households and other households has necessarily led to an underestimate of households with kinship children. A new census question about primary care responsibilities for children would be needed in order to determine more accurately the number of households with kinship care arrangements. And as seen, data about indigenous children and families may be complicated by cultural definitions of family relationships that differ from (mainstream) census definitions.

We also note that census data does not provide reasons for the presence of 'kinship' children in households. In addition to parental incapacity and/or abuse, children may be with alternative carers for reasons such as education and parents' absence for work.

Summary

Three of the seven datasets explored yielded data relevant to the exploration of numbers in non-familial kinship care. The 2017 AIHW Child Protection Report provided preliminary data about the relationship between statutory kinship carers and children from about one-fifth of all children in kinship care in Australia (not including Victoria). Three-quarters were reported to be living with extended family members, of which nearly half were with grandparents. Nearly one-quarter of the children were reported to be with either 'non-family' or 'other' kinship carers. However, it was noted that there was also some missing data in the four jurisdictions from which this data was collected. Child protection databases across the country need further development before the number of children in statutory non-familial kinship care in Australia can be accurately determined.

Our analysis of Victorian child protection data has indicated that carer relationship data is not yet reliably available due to completion of the *Relationship* data field not being mandatory. It was therefore also not possible to determine the relative stability of familial and non-familial kinship care in Victoria.

The Australian census does not include a question about primary care responsibilities for children resident in a household, however proxy data from the 2011 Australian census suggested that there were at least 10,852 two generational households in Victoria that included kinship care arrangements (both informal and statutory). One-fifth of these households involved children who were not related as family (nor fostered or adopted). Around six percent of the 10,852 households included indigenous children, with approximately half these households involving an indigenous person in a caring role. These figures are necessarily an underestimate, as for technical reasons multi-generational households had to be excluded from the analysis. The census also does not include the reasons for kinship children's care; thus it is not possible to know what proportion of such care arrangements may be due to child abuse or other trauma.

In conclusion, there is currently very limited data available about the numbers of children in kinship care (both informal and statutory) in Victoria, and in Australia more generally.

"DHS said: 'You are probably the closest person to the children. Could you please take care of them?' I said: 'That's fine. I will do whatever it takes to take care of them'. I didn't think twice, because I don't see why I shouldn't."

Will, age 26

Chapter 3

Participants in interviews and focus groups

This chapter provides background information about the kinship support workers, carers and young people who participated in the study. Five focus groups for support workers were conducted. Twenty-one carers and seven young people were interviewed; these interviews thus formed the major part of this study. Voluntary participation in research is understood to favour those whose lives are more settled (Hunt, Waterhouse, & Lutman, 2008; Messing, 2006), and it is assumed that this bias pertained to the young people and carers who participated in this study. Nevertheless, all the young people spoke of having experienced considerable trauma in their lives, and the carers had all endured significant challenges. Support workers provided a breadth of experience to complement the in-depth perspective of participants with lived experience.

The historical interviews

Three interviews with non-familial carers and four with young people (in or ex non-familial kinship care) were conducted during the 2010 *Family Links* kinship care research project (Kiraly & Humphreys, 2013, 2016) in anticipation of the current study. These participants' experiences pre-dated the establishment of the statutory kinship care program in Victoria as separate from foster care. Two carer couples had had specific foster care assessments, with the children remaining in temporary care while assessments were completed, and the third had commenced caring informally. All three primary carers had met the children through their workplace: one was a teacher, one a youth worker, and one was running a small business. Three of the young people had been in the care of the youth worker interviewed, and one had been in the care of a church minister. The historical cases allow for some comparison of current and earlier practice regarding the assessment and support of non-familial care arrangements.

Focus groups – kinship support workers

Four of the five focus groups were held in the Melbourne metropolitan area and one in a regional town (Table 6). Participants' experience in kinship care support ranged from a few months to 15 years; many thus had a wealth of experience in the field.

Table 6: Focus groups

Hosting organisation	Participants
OzChild	11
Mirabel Foundation	7
Anchor Foster Care with Anglicare Eastern Region	7
Centre for Excellence in Child and Family Welfare	3
St Lukes Anglicare, Bendigo	2
Total focus group participants	30

Interviews with young people

There were five young men and two young women. Two were born overseas, but both had spent most of their lives in Australia. None were Indigenous. Five were in their teens (age 14 to 19) and one was 24. A man aged 40 was interviewed in the *Family Links* study despite being an outlier by age; he belonged to the first of two generations of children who had been with the same carer. He was included because of his capacity to reflect on his own care experience and that of his siblings and nephews, and to relate these experiences to his later work as a social worker in child protection. The three young people interviewed for the present study were variously in the care of a school counsellor, a school friend's parent, and a family friend.

Interviews with kinship carers

Demographic characteristics

The carers ranged in age from 25 to 78 years, with most between 40 and 59. In one case the primary carer and her husband were interviewed together. Half (12) were single, including all three male carers and nine of the female carers. Four were looking after unrelated Aboriginal children. Half (10) of the carers were looking after more than one child (Table 7).

All but three care arrangements were long-term. All except one carer had at least one other adult relative living in the household at commencement of placement. The contribution of carers' domestic partners and family members was frequently mentioned.

Table 7: Demographic characteristics of carers interviewed

Gender and marital/ partnered status of carers	Partnered (primary carer designated as female)	9
	Single women	9
	Single men	3
Age of primary carer at interview	20–29	3
	30–39	3
	40–49	5
	50–59	8
	60–69	1
	70–79	1
Non-familial kinship children in household at commencement of care	1 child	11
	2 children	3
	3–4 children	7
Total children in household at commencement of care	1 child	6
	2 children	4
	3–4 children	6
	5–7 children	5
Indigenous status	Carer Aboriginal, children Aboriginal	2
	Non-indigenous carer, Aboriginal children (one with children's Aboriginal uncle co-residing)	2
	Carer not indigenous, spouse Aboriginal, child not indigenous	1
	Households with no indigenous members	16
Total carers		21

A number of overlapping cohorts of carers are described below.

Carers of large groups of children

Seven women were caring for 3 or 4 additional children; five were single. Five had children or grandchildren of their own in their care, making a total of 5, 6 or 7 children in their households. Concern to see siblings remain together was a key motivation of these carers. A couple with three children took on their care of four children of family friends who died. Two women who were working with children had each cared for multiple children over time. Both had met the first children through their work and went on to care for children of the second generation. Both these women were single and had no biological children. One of these two had initially taken in a sibling group of three children little known to her as an emergency measure, anticipating a short stay. Two others had taken on the grandchildren of people known to them in addition to their own children and/or grandchildren.

In addition, one family with three children of their own, and another with four, had each taken in the school friend of one of their children.

There were two extraordinary placements of multiple children with some striking similarities. The primary carers were both family day care providers who also undertook some overnight emergency care. Each had provided emergency care for a sibling group who all had disabilities and associated mental health and behavioural issues. There was no pre-existing relationship with the children in either case, and in both cases short-term care ended up as permanent

care for four siblings. One carer was a single Aboriginal woman who had a qualification in disability services; the children she cared for were also Aboriginal. The other carer and her husband both had experience in residential child care. Their own three children (two under eighteen) were still at home when care of the additional children began.

> Yeah ... I was working as a family day care provider. Received a phone call asking me if I would take a baby for one night and ... she was 15 days old. Mum had [had a] psychotic episode when she was born. I had never met ... didn't know the family at all ... We've moved to permanent placement in 2010 and then in 2011 Peter was born and they contacted me if I could take Peter. (Elizabeth).

Fictive grandmothers

Six women became grandparent figures to children, five of whom were single. (Four of were also part of the cohort of carers with large groups of children.) One was an 'ex-step-grandmother' with had little prior involvement in the children's lives; another was caring for her three grandchildren as well as three grandchildren of her friend and neighbour (carer described below). Another woman had the long-term care of a child whom her own daughter had previously looked after; and a couple were caring for their granddaughter's half-sister as well as their own granddaughter. As described above, two women, both single and without biological children, had each cared for two generations of children over time. (Two other carers with adult children have not been included in this cohort.)

Children's services staff

Seven carers had met the children through their workplace. Two were teachers and one was a school counsellor (carer described below); there was a social worker, a youth worker and two family day care providers. These carers had variously taken on one to four children. Most were in their thirties and forties at the commencement of care.

In addition, two carers had the care of children whom a family member had met through their human services work. One cared for a boy whose mother had been counselled by the carer's own mother. Another had the care of an infant that her daughter had looked after in a child care centre and subsequently as a kinship carer until circumstances rendered her unable to continue.

Young carers

Five young people became carers in their twenties, including two of the three male carers. Three were single, one young woman and two young men. These care arrangements all emerged through family friendships or similar. One young man took on a teenage boy he had mentored, and the other young man took on two young boys of a friend and employee of his parents (carer described below). A young single mother with an infant took on the infant son of her 'cultural sister'. One very young couple took on the care of the little brother of her employee. Another young couple with three children of their own took on the four children of family friends who died including a baby, making six children under 13 years. While the three single young carers all took the primary role with care of the children, they all had other family members living in the home and providing backup support.

Carers of Aboriginal children

Four women were looking after Aboriginal children; three were single. Two were themselves Aboriginal. One was a young mother, looking after an additional boy whose own mother was deemed by culture to be her sister. The other was the sole carer of four children with disabilities mentioned above. One non-indigenous carer (mentioned above) was a teacher who had met children in need at school and subsequently looked after two generations of children. The other non-indigenous carer had the assistance of the children's (Aboriginal) uncle who had moved in as a boarder to help. Both these carers had strong relationships with the children's families and respect for their culture. Three of these four families, including both Aboriginal carers, were experiencing significant financial stress.

A fifth family included a non-indigenous woman and her Aboriginal husband who were raising their Aboriginal granddaughter and her non-Aboriginal half-sister.

Male carers

There were three male carers, two of whom were in their twenties. All three were working full-time. One young man together with his sister were looking after a boy he had previously mentored, following breakdown of his care with his grandmother. Another young man was the primary carer of two young sons of a family friend; he was living with his parents and adult nieces (carer described below). The third man and his wife assumed care of the newborn baby of a childhood friend's partner, however his wife died when the child was two. He subsequently became the little girl's permanent carer. He enjoyed considerable support from his mother and a family friend.

A portrait of three carers

Three carers who illustrate some common characteristics of the carers are described below.

Tania

Tania was in her mid-50s and lived in a three bedroom house in suburban Melbourne. She was raising her three grandchildren and her neighbour's three grandchildren who were at school with her own grandchildren; the six ranged in age from infancy to early adolescence. Her adult son also lived at home. Her neighbour had been caring for her own three grandchildren for a short time, but found herself unable to continue. Reunification with the children's mother was still being discussed but did not appear imminent. At the time of interview nearly two years had passed.

Tania was working part-time in a special school and also studying part-time. Finances were tight. She said she managed her large household with structure and routine, however reported that despite this the children had surprised her by telling the child protection worker that they have fun with her. Both groups of children had frequent visits with their mothers which were sometimes challenging. Other challenges included managing children's at times destructive behavior. Despite the demands of care, Tania derived satisfaction from giving the children a grounding in the basics of life.

Tania had little formal or informal support, however had occasionally called on family or friends for child care. She considered some statutory requirements made normal life difficult, such as the necessity for everyone in contact with the children to undergo police records checks. She wished to see greater consultation and better communications about arrangements for the children's care, particularly parental contact.

> It was hard because we knew that the children were then going to get separated. I ended up putting my hand up and saying – the children went to school with my children so it meant that they wouldn't have to change schools. I mean it's hard enough without all those extra [things] ... <You'd have to be nuts to take on another three Tania wouldn't you?> [Laughter.] I'm beginning to think so now, particularly, because when I first put my hand up they said it was probably only for three months and now nearly 21 months [laughs].

Frances

Frances was a school counsellor. She and her husband had three children of their own, two independent adults and a teenage daughter at home. She had previously provided care informally for a number of local children. She had not previously met Melissa, the twelve year old whose care she took on in a crisis, however had counselled Melissa's sister and was thus aware of the family's circumstances. Her husband had met Melissa through coaching a local netball team, but did not know her well. The couple agreed to care for Melissa temporarily until another placement could be found. When the placement did not eventuate they agreed to continue pending family reunification which was anticipated to be in the short term. Melissa was seventeen at the time of interview, and had been with them for five years.

Frances described the challenges of providing sensitive care for Melissa with little detailed information about her earlier life. Melissa had struggled with divided loyalties between her own mother and Frances's family, and had tested the couple's patience over participation in family activities, nevertheless had settled in gradually. Over the years she made good progress at school. However in later years she had rejected Frances's family and all that she felt it stood for. She left school, told Frances and her husband that she hated them, and ran away briefly. The couple both found this period very distressing yet remained supportive of Melissa, and were helping her move to living independently. They still considered her to be part of their family and had offered her the option of returning to live with them in the future.

> It has been a good experience. As I said, it has been up and down, and it's been a great learning curve for both myself and my husband. In fact we'll probably go on to be trained foster carers ... in Melissa's hissy-fit time she was sort here off and on two or three days and the house did feel quite quiet without her about. My husband and I were like, 'Oh gosh it is quite quiet'. Over the last week we have had another young person living with us who has been homeless.

Will

Will was one of five who became carers in their twenties. He was the youngest child of a large immigrant family, arriving in Australia as a baby. He and the two young boys in his care, Tim and Ed, were living in rural Victoria with his mother and father (who spoke no English), and his two young adult nieces. Tim and Ed's mother had previously worked in his parents' restaurant, and had become a family friend. Will said that he had always gravitated towards children, and had been very involved in the care of his nieces when younger. He had spent time with Tim and Ed while they were still living with their mother, and had offered to take them for a few days when their mother needed a break. During this time he was called by the police investigating an incident of neglect of the boys' baby sister, and was asked to also take the baby until her father was found. The children's mother subsequently disappeared, and the boys' father was unknown. At interview, Will had been caring for Tim and Ed for three years, and considered that they were likely to be part of his family until they grew up. He described them as well-behaved boys who enjoyed school.

Will took the primary role in looking after the boys, including addressing Tim's health problems and Ed being bullied at school. He organised his shift work around them as far as possible. His mother cooked the family meals and his father picked them up from school if Will was working.

Will had a partner living elsewhere with her own daughter; the boys called her 'auntie'. The couple planned to marry but were waiting until they could afford a house of their own to which they intended to take Tim, Ed, and Will's own parents. He had aspirations to run his own restaurant, having previously worked in his parents' business.

Will felt that he received what support he needed from within his family and his partner; he considered that a young kinship carer would struggle to provide care alone. He saw it as advantageous that they all shared a cultural background that values strong family ties and respect for elders. He considered that it was important to show strong leadership to the children by setting rules and expectations for their behavior.

> DHS found the boys and they put onto a court order. Saying that, 'You may seem like you are probably the only closest person to the two children. Could you please take care of them?' I'm, 'That's fine. I will do whatever it takes to take care of them'. I may not be a father to them, but I could at least be an uncle. I didn't think twice, because I don't see why I shouldn't … I'm like, 'That's not a good ideal life for them'… They address me as uncle; they can't address me as father, because they know (Will, age 26).

"My thought about kith is, they must feel so unacknowledged and under the radar. Because of kinship being considered to be grandparents only, they just have no representation, they have no presence … they don't belong anywhere and they don't have a tribe. So they must feel very adrift."

Chapter 4

The nature of non-familial kinship care

Introduction

This chapter describes the largest component of the study, the interviews and focus groups. Themes include the nature of pre-existing connections between carers and children; security and belonging; differences between familial and non-familial kinship care; the issues about carer assessments; and perceived disparities between program standards in kinship care and foster care. The chapter concludes with some discussion of the nature and definition of non-familial kinship care. A cross-cutting theme is the nature of the supports that this unique group of kinship carers need - sometimes similar to other kinship carers, and sometimes different.

Language as spoken sometimes includes incomplete thoughts, thus words implied but not stated have occasionally been added in square brackets. The interviewers' comments are identified by angle brackets. Carers and young people interviewed are identified by pseudonyms and minimal details where relevant. In some cases, particularly identifying details have been changed. Quotes from kinship support workers are not specifically identified.

Extensive quotes have been used in this chapter to privilege the voices of young people, kinship carers and support workers.

Pre-existing connections between carers and children

As stated in Chapter 1, the definition of kinship care specifies a close pre-existing relationship between children and their caregivers where the relationship is not familial. The nature of relationships between children and their carers was thus a key focus of this investigation.

Five of the seven young people interviewed had a significant pre-existing relationship with their carer. One had not met the primary carer but was superficially acquainted with the primary carer's husband through sporting activities. The seventh had been one of three very young siblings taken in by a youth worker who hardly knew them at a time of crisis.

The young people generally saw care by familiar people as preferable.

> Well it's different being here because I've known them my whole life. But last year I was living with my best friend. I lived there for two to three months and I noticed there was no relationship between me and the parents. So it was just really hard (Kyle).

Of the 21 carers interviewed, two-thirds did not know the children well prior to care, and only one-third identified as family friends. Three carers had had no contact with the children prior to care (not including infant placements). There were eight newborn infants placed with non-familial carers, two of whom were placed temporarily pending other arrangements, and three who joined their siblings in long-term care.

Half the care arrangements (11 of 21) emanated from the carers' employment connections to the children (Table 8). The strength of the pre-existing relationship tended to be stronger when they were family friends or the like than when they had met through the carers' work with children.

Several workers considered the pre-existing connection between children and carers to be the most important aspect of non-familial kinship care.

> I think it boils down to some social recognition and validation of the placement, that you don't have to be blood-related. It's the emotional connection [that] is the important part and their recognition of that; and then they should have equal rights with other carers.

Nevertheless, support workers described successful placements based both on solid pre-existing relationships and on tenuous connections. Many successful long-term care arrangements were described.

> We had a case where the child became a part of the teacher's family. His mother died and the whole school community supported this child and family. The child ended up living with his prep grade teacher and it became a kinship care placement, then it eventually went to permanent care. It was a very successful placement.

> I can think of one that was wonderful really, and that person's now 19 years old. When we started working with him, he called her 'auntie', but she was a neighbour when he came into her care as a toddler. So pretty much most of his life he has lived with her ... she is and has always been a very committed carer for this kid who's had a lot of struggles in his life. She's his number one advocate. <Do you know how they got together?> The mother had dropped him off for babysitting and didn't come back.

The criteria for successful placements are not always predictable

Occasionally, successful kinship care arrangements were observed to happen idiosyncratically, such as the one described by a support worker.

> Eva was about eight, of [non-Caucasian] background ... she was often on her own, neglected, roaming around. There was a church nearby and she'd go there and listen to people singing and talking. Obviously it was warm and people gave her attention. This went on for a couple of years. She met this ... woman, Hana, [who] herself had darker skin, and sat next to her one day and said 'I want you to be my Mum. You look similar to my Mum and I think you would be a good Mum.' Slowly, slowly, Eva would go and stay at Hana's house, she would have respite, I guess. Hana would cook things for her, she would help Eva with schoolwork, and she ended up being Eva's kinship carer. Hana was absolutely amazing, she was just so in tune with Eva's needs, very creative as well; she got Eva involved in dance. Eva was about ten when I met her. Hana told me this story, and Eva described very similarly what she had said to Hana. They ended up going to permanent care.

Table 8: Pre-existing connections between carers interviewed and children in their care

Nature of carers' pre-existing connection to children	Connection via workplace or similar	11
	Family friend or similar	7
	Parent of child's school friend	3
	Total	**21**
Relationship – direct carer to child, or through children's parents	Carer or carer's family member directly with child[a]	12
	Carer or carer's family member with parent or other relative of child[b]	9
	Total	**21**
Strength of children's pre-existing relationship to carers[c]	Children very well known to carer	4
	Children and carer had spent considerable time together	3
	Small amount of previous day or overnight visiting	2
	Children and carers had met on occasion	7
	Little previous contact	3
	No previous contact	3
	Newborn baby (five with family friend of parent; three placed with siblings; two temporary short-term care)	8

a. Connection via school (6), day care (3), youth program (1); other (2).
b. Carers connected via family friendship or similar (6) and/or work connection (3).
c. Total is more than 21 as the various children had different pre-existing relationships with the same carer.

Considerable concern was however expressed about instances where the pre-existing relationship was tenuous, or at times frankly non-existent. Many such placements were reported to be insecure. It was suggested that non-familial care arrangements were often rapid responses to placement emergencies and a shortage of alternatives. Assessments in these circumstances were frequently seen to lack thoroughness and objectivity.

> When I was working in DHS on the investigations team it's like 'Go, go, go, get things done. There's no other option, what have you got?'... So you're putting them with friends and their [friends'] parents ... There's no options with resi, there's no options with foster care, and [like] a friendship through school turns into a kith placement – they never turn into a foster care ... The Department will call them up and say 'Look, can you take him for three weeks while we sort this out?' and then the order gets extended ... because there's nothing else ... I think it's a systemic problem.

> A 12 year old boy [in country town] knew one person,, so he ... got put on a train to Melbourne ... arrived at his friend's, and this young man of 24 said, 'Look mate, sorry you can't stay here, I've just got a new baby'. His neighbour happened to drop in and she said 'I'll take you' ... And so he'd been with this neighbour for over a month and DHS hadn't been back in contact with them. They've done the initial police check.

> From my experience with a lot of kith placements – a couple of them have stated they felt headhunted by the Department, and that as much as they want to care for the young person, they then felt that the young person was dumped and then all [the carers'] rights, their opinions, they're just completely disregarded. I've had previous experience in the country, and there is definitely a lack of carers available, and I've found that they'll do the assessment but, like [another participant] said, it's like they kind of have to pass them, because there's nowhere else to put the kids. And it's too expensive for the Department to fund them to be in residential care.

Security and belonging

The intention of a kinship care placement is to provide children with a sense of belonging in a safe, familiar environment. Many care arrangements providing nurturing and stability were described; however support workers had also seen many unstable placements.

Several of the young people had had many previous placements. Many expressed relief at feeling secure in their current placement and having a supportive caring relationship.

> I've known her since I was born ... It's a roof over my head that seems stable (Kyle).

> <In your teens you had some feeling of 'Where's my father, and how could he just go?'> Yes, and I think it was because Karmel was always the significant person there, I think that's what made it okay (Victor).

> It was a family that I'd never seen before. Fully functional working family and that's what I loved, and I told Nina about my problems, about DHS and all that stuff, and she said she'll foster me ... Having security, having someone ... who is like a mother figure or just someone to listen, emotionally (Tas).

> It's just like a normal family, like a mother-daughter relationship. It has its ups and downs (Kylie, 17 years).

Almost all the carers interviewed displayed high levels of commitment to the children, despite many having constrained finances and housing. All but two expected to be looking after the children into adulthood. Elizabeth, an indigenous woman, described the four children in her care as her own children:

> I have a 24 year old daughter. I'm a sole parent ... So I have a son who's just turned ten, a son who will be nine in May, a daughter who will be eight in July and a four year turning four next month. <So the youngest, four ... are in your care?> Yeah. (Elizabeth).

> Since we've been trying to get permanent care, we've said to Kara all along, 'You are just one of us, that's it, end of story. You'll be treated the same, we expect your behaviour to be same and just go from there'. <She is a very lucky girl.> We're lucky as well (Kirsten).

When asked to describe the best things about their role, carers invariably cited the satisfaction of being able to give children new opportunities and help them develop. More than one carer echoed the phrase 'helping children blossom' quoted at the beginning of Chapter 1 (Gilligan, 2006, p.44).

> I found it really good, and Eddie's just like he's always been there. Watching him change has been amazing. The transformation in him has just been incredible (Lucy).

> It's the enjoyment we're getting out of watching her just blossom ... Kara had never seen the beach before. I nearly burst into tears ... she ran down and then she got to the water and stopped. Then she said, 'What's in there?' I said 'Well, if you take one more step, you will be', but when she saw the other girls run in – you could see this look on her face ... [and she] said to me, 'You know I've never seen the beach. I've seen pictures, but I've never seen it'. I just said to her, 'Kara you should have told me, I would have taken you weeks ago' (Kirsten).

> I get satisfaction knowing that I'm giving them a grounding for those ... basics and the routine ... I know they told DHS, 'Oh, yeah, we have fun at Tania's'' and all the rest of it. I said to [DHS], 'Really'? They sort of looked at me, and I said, 'Well, I wouldn't have said that we really have fun. By the time we come home from school and we do all the reading, we do the spelling, we do whatever, we have baths and tea and then it's bedtime.' (Tania).

> We're saying all the negatives and the hard part and the difficulties and everything, but that the positives are that you see these children just blossom ... with love and care and food – the basic things in life. You see them just do things that you think they would never have achieved in their lives and they're now achievable. So I think that's pretty important. Yeah, there is a satisfaction ... otherwise you wouldn't do it. You get something out of it as well, don't you, as well as they're getting something out of it (Tracey, caring for four children with disabilities).

Carers described the various and sometimes idiosyncratic ways children described their place in their fictive family.

> Ryan will still refer to me as his pretend Grandma. 'Okay, I'm happy with that if that's what you want to call me'. He goes, 'No because my Mum's real Mum is dead'. I said, 'Yes we know that'. He goes, 'So you're not really my Nan, you're only my pretend Nan'. The kids do like to bring it up that I'm really not their Nan ... It is [the truth] and what they've been through, I'm not going to go arguing with kids over who I am (Bernadette, caring for grandchildren of ex-husband).

> When she talks about Leonie [her mother] she says 'Yes, you're my Mum, and Mummy Leonie, she's my part-time Mum'. She's just slotted in. We treat her as a grandchild. The only time we actually pointed it out ... was in court, when I reminded her that she was our step-granddaughter. She wouldn't have any idea that we weren't her grandparents. [But] she knows a lot more than what we give her credit for (Katherine, caring for grandchild and grandchild's half-sister).

> She doesn't see Lina much but I say 'That's your tummy Mum'. But she says, 'I like the Mummy with the glasses better', which is Denise [Tom's deceased wife]. In her mind, [it's] her Mummy [Denise] who died, and I'm her Daddy. But I've really tried to make sure she knows her past, because I think it will be very important in the future (Tom, with four year old child in his care since newborn).

> They were walking up to [their new] school and they said to [my husband] John, 'We're going to change our names. We're not going to use Smith'. John said, 'Oh my God, what are you going to use?' They said 'We can use Oakley [Beth's surname] because we can spell it'. They couldn't spell [John's surname]. John said 'Well you'd better get used to it' – the school was just up the road. He said 'What's your name?' 'Nadine Oakley.' 'Penny Oakley.' They were calling out the names for the roll. 'Nadine Oakley? Have we got a Nadine Oakley here? Have we got a Penny Oakley here?' Like for the first week [after that], every single thing in the house had their names on it. They would go 'Stop! Write your name, write your name' (Beth, teacher).

Security in non-familial placements was not always the case. Many unstable care arrangements were also mentioned by kinship support workers.

> Often young people at high school – I can think of five, where the kids are just couch-surfing, going from friend to friend to friend … while we're waiting for that long term foster care option for this kid. And I don't really think [DHS] would necessarily be looking that hard for a placement because there is always another friend at school. There's how[ever] many kids in their year level, and they just go round and around.

> There was a family with lots of children … the word went out in the community that these kids need somewhere to live and some local teachers put up their hands to take a couple of them without knowing them … some [went] to some other family in a country town. It was like 'We can't take them all', and someone else said 'Oh I'll take a few of them', [people who had] never met them before … There was a friend from school, and that broke down really badly, and then someone else from a different year level said 'Oh well I'll care for the kid'. They just got passed around and passed around.

> I have experience with one young person that had had 19 placements in fifteen years, and the two and a half years I worked with the young person she had 5 placements, 4 of which were kith. So a placement would break down, the next person would put their hand up, at school, 'I'll do it. I can do it better, I understand trauma'. The lack of understanding of the impact of trauma would quite often cause the placement to break down. Then the next person put her hand up, the next person … Kith carers mean well, and I wonder whether it is rushed too quickly, just having a roof over their head.

Numbers of reports about poor quality care were described by support workers, as well as some difficulty in getting children removed from unsatisfactory placements. *Quality of Care* refers to the process in which care concerns are formally reported and investigated. Support workers claimed that such reports occurred quite frequently in non-familial placements, sometimes repeatedly in relation to one placement. Some serious concerns were raised.

> Two cases on my team have broken down outright … and we knew they were very, very shaky. The amount of Quality of Care [reports] that we had to instigate, which is a crippling process, it's quite punitive. It would be interesting to do some research on the numbers comparatively, if kith carers have more of it, they possibly do.

> Those are situations with multitudes of Quality of Care [Reports] … [It would be better] if they have comprehensive assessments before the kids even went there, or they don't go there and then go into foster care. But I think because of their time constraints … that's not quite their thing is it?

> One kith placement [were] ... ex-babysitters of the child ... the placement was just awful ... squalor, filthy, faeces, left there for days. There were other issues as well ... a lot of scapegoating of the child, multiple issues ... they just weren't able to provide proper care. The case went to Quality of Care, but child protection decided to leave the child there. Because she had been there so long there was quite a lot of defensiveness ... that they wouldn't have made a mistake like that. We had to fight really hard to get evidence that we weren't being middle-class and judgmental ... that was definitely the implication ... I still can't believe it. We go in a lot of homes that are less than ideal, but this was just another whole level again.

> So we're accepting that the benefits outweigh the negatives. We're accepting that it's better for them to be with their family or a community member, but that the house is going to be disgusting, they're going to have health ramifications, the carer might be mentally ill. We have to sit with that as an agency going, 'This is okay' ... But it's also embarrassing because the State's saying 'We've got to take a child out of a bad situation', but you just put them in such another not suitable situation.

Children's sense of belonging to a fictive family was not without challenges, even in some secure long-term care arrangements. A number of carers found that their families were not always recognised as having the legitimacy of 'natural' families. Challenges emanated from the community, from family members themselves, or even from the authorities who sanctioned the care arrangements.

> We had to keep telling our story to people and we didn't want to. We just wanted to be accepted as a family, a big family, and this is who we are (Stephanie, caring for four children of friends in addition to her own three).

> I'd told [daughter] off about something that she had done or said to Kara and she said, 'Why are you protecting her, she's not even your child?' I remember absolutely being gob smacked and having a big sit down with her about how that would make Kara feel (Kirsten).

Frances (described in Chapter 3), spoke of the way in which her young charge felt torn between Frances' family and a rejecting mother for whom she nevertheless yearned.

> I would think that she'll always be a part of the family, and I think she will always see herself that way too, in varying degrees ... One of the things she kept saying, 'You're not my biological family'. We know and understand that. I kept saying, 'Look, families take all sorts of shapes and sizes'. On a good day she knows it, on a bad day she just wants her own biological family. We would love that for her too. I've just always said that I do believe her Mum does love her, she's just not well enough to be able to care for her in the way she needs.

Lina, a non-indigenous teacher, had been customarily adopted into Lesley's Aboriginal family, and had provided care for Lesley's children in partnership with the family. However, when Lesley rescinded recognition of Lina, the Aboriginal community also turned against her.

> So Lesley took me around the town and introduced me to every Aboriginal person as: 'This is Charlene's other Mum' ... [But then] Charlene became pregnant and Lesley thought, 'I'm going to be Nana to this child, and she's not going to'. She did this big turn ... The kids weren't to call me Mum any more ... I'm going, 'Well, three years later is a bit late for that don't you think?" ... It was just like I had become a white person now.

It appeared that children's belonging in a secure, long-term fictive family could also be later challenged by case planning processes. Two instances were described in which delayed stability planning posed a potential threat to children's secure attachments to their carers. Six year old Tilly had been in Ingrid's care for five years when stability planning took place. Over the five years Tilly's wider family had shown no interest in her; nevertheless, a potential transfer to biological family members whether or not known to the little girl appeared to be prioritised over her attachment to Ingrid. The ensuing disturbance in Tilly's relationship with Ingrid only settled once it was clear that various relatives who suddenly came forward were actually unable to provide permanent care.

> I suppose when I'm called 'kith' I get really annoyed because in actual fact I am Tilly's family, as she sees it. We have been like that since she was fourteen months old ... As soon as the decision was made 'Yes, she's going to live with you Ingrid', the rest of the family that were out there came into her life. Tilly herself has had difficulty since that time ... So we got to the stage where – now I feel like I'm a carer rather than family. I think the stress ... was when I twigged that DHS couldn't say they believed that it was best if Tilly was with me ... You've got access with Mum happening or not, Dad or not, access with [former carer], phone calls from Mum, the grandparents. Then I got a phone call from the aunty, could she see Tilly. [Also] the great-grandparents ... Tilly and my relationship changed in that time because I'm saying 'You've got to go here, you've got to go there'. 'No I'm not.' 'Yeah, you've got to.' (Ingrid).

Will (described in Chapter 3) had provided care for two abandoned children for three years, and anticipated that the children would be with him until adulthood. However, he did not expect that case planning would necessarily confirm the care arrangement as permanent.

> We've got another order coming up from the court, this September. I'm not sure – it's still under DHS. I'm still primary carer, but I don't have full authority of – how would I say it? I have guardianship. But I don't have full authority of making big decisions, if you know what I mean. <Have they talked to you about a permanent care order?> No they haven't. Most likely it will stay like this for a while, because the permanent carer is still blood-related, I think? I think they still want to try and locate the mother because they are still hoping there is a possibility that the mother will try.

Differences between familial and non-familial care

> When I went down to Mirabel I did notice that there was a lot of grandparents there and it sort of felt a bit sort of, 'Ooh, gees', you know (Natalie).

A prime focus of this study was to identify differences between 'kith care' and familial kinship care, and implications for case management and support. In addition to the challenges to the identity of 'kith' families, a number of other differences were raised.

The young people themselves saw a clear difference. Despite being positive about their current care, some indicated that they would still have preferred to be in their extended family.

> It'd be different because you would still have your family by your side (Melissa).

> I believe living with any family member is better than a non-family member … I would prefer to live with family, like an aunty or uncle or a Nan or Pop than someone else I don't know [so well]. Not only, [but] your Mum or whoever loves you, your Dad, would prefer you to be with a family member than with someone else you don't know (Tas).

> We were always pretty much split up … It was very hard for me not really knowing [my brothers] … My caregiver couldn't take care of Simon because he was too young for her work. So it was some of the difficulty in being in my care placement, it's a cost of where I am (Grace).

Support workers also commented on differences between familial and non-familial kinship care. Some considered that a positive aspect of non-familial care was that carers were not part of an extended family embroiled in longstanding conflict with children's parents, or under an intense sense of obligation to assume care of the children.

> They're free of that grief and angst that happens. They didn't have a role in it.

> In one case … it was purely altruistic reasons more so than a responsibility … they didn't do it because they felt obliged. At the time for them it was the right thing to do. That's good.

On the other hand, it was also suggested that family carers generally felt a greater commitment to persisting through challenging times; and that the altruism of 'kith' carers was not always unconditional.

> Kin placements, there's that biological connection, that sense of obligation to do it. Whereas the kith carers, yes they want to offer the child a home but they don't necessarily have that same sense of obligation.

> There's no stability underneath a kith placement. You can say, 'Look you don't have to be here' … there are no ramifications.

> One thing that does distinguish [some] kith carers often … from kin carers is that fact that there's different motivations. Everyone wants the best outcome for the child but it's a bit altruistic. 'The system shouldn't expect too much of me because I'm offering this child a home … I'm doing this out of the kindness of my heart, giving this child a bed and a roof, so why are you demanding all these things, and yet at the same time you're not supporting me like a foster care program?'

Some non-familial carers were observed to be closely attuned to the children's needs, while others were seen as too different from the children's parents to understand their situations. Such carers were observed to be less willing to engage with children's families and to facilitate family contact.

> She was from the area, she was on the verge of child protection in her own life for her children and she had child protection involved growing up. So she knew the area, she knew of the family, she knew of this kid for a long time. And she was able to engage the father really quite positively … and had him round for dinners and at Christmas and that kind of thing. So she was able to make that really positive connection.

> We've got one who's in a kith placement and they're a [well] functioning family and they just can't comprehend why a parent would do that to their child. And therefore [carer] has a lot of anger around that family situation and tries to limit [family contact].

> I find that the kith carers don't want to take on [children's parental contact] as a responsibility, and actually will just refuse most of the time. I don't think we've had one that's ever managed contact themselves.

> Kith carers will sometimes cut off the biological parents particularly … if they want to be Mum and Dad, and [in effect say,] 'You'll be fine if you get love and care from us'…

Several support workers commented that non-familial kinship carers had greater expectations about reimbursement for costs of care than family carers. A small number of carers interviewed also expressed this view.

> I think you need to support people. I didn't mind digging in to my own pocket for my own children for childcare, because we go well in comparison to what I earn in a day, it was neither here nor there … But at the same time, I shouldn't have to be sacrificing for a child that's not mine, I don't know (Karen).

Both carers and support workers saw the lack of family history and knowledge of children's traumatic experiences as a particular issue for non-familial carers. This affected carers' capacity to understand children and respond appropriately to their needs.

> I see families where children are just placed without the knowledge of what these children have been through and what to do.

> It could be that you get asked at a doctor's, 'Is this hereditary?' 'Well I don't know actually. I couldn't tell you.' Or when they were little – 'When they were a baby – did they have this?' 'I don't know that either.' You haven't got that history (Lucy).

> [Melissa, age 12] was fearing abandonment. Someone would knock on the door when she first come and she'd hide in the cupboard. It was that sort of stuff I wasn't prepared for. I guess you know what your own kids are capable of and how they'll react. But I had this child that I had no history on, apart from knowing she had come out of an abusive situation. I really didn't have any idea how she would react – and had to manage that. About twelve months ago we did [receive training about trauma] and that was good, but that wasn't offered right back at the start. So we were really unaware. I certainly didn't expect a reaction of her crying on the street saying, 'Please don't make me go [alone] to the newsagent'. I was thinking that was going to be a nice experience for her (Frances).

Carers identified areas in which their families' support needs differed from those of familial carers. The impact of a non-familial child on carers' own children was mentioned, including sharing parent's attention, sharing bedrooms, and adjusting to increased financial restrictions on activities. The need for respite from the care of additional children was mentioned.

> You just haven't got the family support that they think that you have. Because they think you're kin, that you're related ... So therefore you're involved in all their family and they're part of your family. But in actual fact you have your family and they have their family. They're not related at all – so you don't have that support in that way, and the kids don't have that support (Elizabeth, caring for four children with disabilities).

> We were at the swimming pool and the lifeguard wouldn't allow [my son] to go in the deep end of the swimming pool because I was up the shallow end with Scott. My youngest son got to really resent Scott because he was holding him back (Karen).

> A lot of things are offered to Kaye in particular. But when you come into a family of non-family carers ... my kids have had to learn how to live with another person in the house, which has had a few challenges. I think maybe they should have offered ... a bit of assistance for the other kids. 'Are you struggling with this? Do you want to see a counsellor?' At no point were my children ever asked (Kirsten).

> When we heard it's actually going to be permanent care, I set up once a month respite care with that teacher who had known her through primary school. That has been probably the one critical thing that's allowed it to really work for my husband and I. We were about to be empty nesters when Melissa came, so we just felt we needed once a month where we knew we didn't have Melissa for that weekend. It was really good for her to have another significant family in her life (Frances).

A lack of early planning for the duration of care was frequently raised as an issue by both carers and support workers. As seen in the two cases previously mentioned, delayed stability planning potentially threatened children's secure care. However in many other cases it appeared that non-familial carers were implicitly assumed to be committed to long-term care as if the children were biological family members, including into adulthood if necessary. Many care arrangements were reported to commence on a short-term emergency basis and then continue indefinitely or until they broke down, without specific care planning.

> Child protection asked if she could stay there for a couple of weeks until they found a permanent place and that's just where it ended and she just never left.

> 'We've got to do a police check, we've got to [do this and that]' and they're just like, 'What, what? I just said I'd just have the kid overnight.'

> I had one carer who was calling me regularly ... I think she had four teenage boys in that house. The child's behaviour was really challenging. She didn't want him to feel badly done by financially so she was shelling out for all sorts of things for him and he was sitting back expecting it because she was doing it for the other kids. She actually wanted him to go, but there was nowhere for him to go at all. She'd been ringing child protection, they weren't really interested. She was desperate, she said 'It's affecting my marriage, the friendship with the kid has completely gone out the window', and she had some issues with some of her own kids. There was no other family ... That just really was very negative for him.

The two cases of large sibling groups of children with disabilities described in Chapter 3 were of particular concern regarding a lack of case planning and associated support. Tracey and her husband faced retirement with continuing care of the four young people who were now approaching adulthood but unable to become independent, and with whom she had no pre-existing relationship.

> I'm 55 and my husband's 62 looking towards retiring, but we can't retire. That's probably a reality that we need to be facing. Because the oldest is nearly 16, we're going to be caring for them for a long time ... There is a [house] system, people with disabilities where they do have staff in attendance. But the list is so long ... We need it within the next two years and I can't see it happening. We're trying to set something up for their future now so that they're not just kicked out and left. And then as we retire how can we fund that? (Tracey).

Assessment of care arrangements

As described in Chapter 1, the practice of *post hoc* assessment of statutory kinship care arrangements in two parts, **Part A** and **Part B**, has emerged from the need to make emergency placements without lead time for pre-assessment. Two of the carers interviewed were assessed prior to placement while the children were in temporary care, in one case re-exposing the child to drug use in her extended family. The other carers had all been assessed following placement.

Significant concerns about timing and quality of assessments were reported by both carers and support workers. Carers were asked whether they thought authorities would have known if they had been unsuitable. Only three carers considered that their assessment had been thorough enough to determine this.

> <Do you think they did enough to know you were a suitable person to have the kids?> I think so. A lot of it was based about evidence of who you were. You had to have referees, and they had to be non-family people that had known you for three to five years. They needed to know the whole family. They did police checks on everybody (Katherine).

Three other carers described their assessments as satisfactory given their particular circumstances (for example, one was already an approved carer for her grand-children).

Most (16) of the carers interviewed had some sort of child-related service experience. Several suggested that their employment record had been used as a proxy measure of suitability; there were mixed attitudes to this.

> I think they probably would have known with us, because I had worked in that [residential care] field. My husband had also worked in that field and had worked for DHS (Tracey, family day carer; carer for four children with disabilities).

> They knew I was a teacher and then working as a social worker and I think that probably [counted] ... and they'd spoken to [young man's two previous carers] about me ... (Sam, social worker).

However, other carers and a number of support workers expressed concern about the assumption that human services experience indicated suitability. A particular concern related to residential care workers. Examples were given in more than one focus group of residential care workers who were wrongly assessed to be suitable.

> This woman saw herself as a professional and knew all about the training, so she pretty much saw herself as a foster carer. We advocated quite hard with the Department...to get her into the foster care program within our organization, also just based on the children's needs and finances and 'flexipacks'... that come with that ... But it never got converted to foster care ... Subsequently over the last years each of the kids have come out of that placement ... she couldn't cope with adolescents ... They thought because they were resi-trained they would be able to manage, but...resi is such a different track.

> Throughout my career I've seen a number of times where kids who have been in residential care have been placed with resi workers... In some cases they have gone through a foster care process, and I think those have worked so much better than the ones where they've said 'Yes, I'd like to do this', and then [there's a] very minimal Part A assessment and then the child's there ... It is such a different thing going from employment [where] you can then go home and not be around the kids, to having the child in our home as your child now; they need that preparation time. You need to know what you're getting into.

Many carers also expressed concern about their lack of thorough assessment. Stephanie, who with her husband assumed the care of a sibling group of four alongside their own three, commented:

> I think because someone said 'We'll take on four', they just jumped at it straightaway. I can't believe how easily we got them (Stephanie).

> I never did [have an assessment]. I actually had to ring the department to get them to come out. The family support worker brought the kids to me on that Friday. Then nothing happened ... so I actually rang the department and said, 'What's happening?' So they came out...but we'd been to the court for the custody order before they even realised I was in my forties and I didn't have a partner. [Later, worker] was saying, 'Well we wouldn't have placed the children with you if we'd known that (laughs) ... Then they come back and said 'Oh, we've got another child now'. [It was as if they said] 'You're nearly fifty and you still don't have a partner, here, have another one'. [Subsequently] we just went to permanent placement without further assessments (Elizabeth, carer of four children with disabilities).

> I've had a police check, so what? That's what makes me angry...How do they know what my health is like? Like when Tilly was first placed with me I was so sick, and it took me a good ten weeks to shake off a lung infection, but how do they know? Then they had to do a police check... and I'm saying, 'This is ridiculous' ... But the thing is that I love a beer, absolutely ... but I get annoyed, for Tilly, because how do they know [that I don't have a problem with drink]? (Ingrid, single teacher in her sixties caring for an infant).

> I think they made huge assumptions about me when they first came out. They made comments like 'Oh, you've got a beautiful home' and all this sort of stuff. My home is not that fancy, but I guess it was just neat and tidy ... Then I actually found out about a week later that they hadn't even put in the police checks ... I guess they were taking a lot on face value, because they certainly didn't go back and [say], 'Oh hang on a second, are these people suitable?'... I don't even know if or when they met [my husband], but certainly not in the first few visits (Karen, teacher).

The assessment tools themselves were a source of concern to support workers. **Part A** was said to be overly focused on environmental safety, with little attention to the suitability of the prospective primary carer and other people in the home. It was reported to sometimes be done by telephone rather than by a home visit, and frequently to be delayed.

> The Part A's the Department do are very flimsy usually, they're really only environmental checks. It's not really very comprehensive.

A support worker mentioned the assessment of a care arrangement for a very disturbed preschooler, once again with a family day carer:

> Yeah it was a Part A and we just sat around the table, answered some brief answers for brief questions, and I took a couple of notes because there wasn't room on that piece of paper, and I said to the DHS worker, 'Would you like me just to type those up and I'll email them to you?' and that was it, done. We were in the house and she had a quick look around. It was very well set up because it was a family day care [home], so I can understand that they could quickly tick off a lot of [environmental] stuff … because of that. Yeah but the husband wasn't there. [So the child protection worker hadn't met the husband?] No, no.

Part B, designed to be a more comprehensive assessment, was also seen to be frequently both superficial and delayed, and to have with a bias towards approval of carers in order to avoid the need to find another placement and move children. It was reported that **Part B** had in some instances been undertaken by the carer completing a self-assessment checklist.

> I've always been concerned about the level of initial assessment that is done. I understand the first one has to occur quite quickly, [but] I don't know how many placements [we've had where] we've been told 'These are great, fantastic', and you go in and oh my, it's just inadequate. I had one case with the assessment, I walked in thinking 'Wow, this is going to be a really great placement', and it was one of the worst placements I've ever seen … When I went and said, 'What are we doing about this?' [protective worker] said, 'Oh no, we decided to cut our losses with that.'

> This is, I suppose, a growing frustration because now we've got changes in the legislation coming in that mean we're going to move towards permanency quicker, but how can we move towards permanency quicker when we're not doing proper assessments in the first place? Are we going to have all these permanent placements that are not functional long-term and not in the child's best interests?

More thorough pre-assessments were widely advocated by support workers. Supportive, collaborative ways of assessing kinship carers were suggested.

> What's sensible is that you engage with potential carers and you say, 'I'm not testing you, I'm not measuring you. I'm working out…does it work for the child, does it work for you?' If you engage in that way, then it's not 'Have you got sufficient motivation?' It's, 'You have put your hand up, but are you going to be able to do this?'

> I suppose having an accreditation process allows you to see where the challenges are within that kith family and put some resources in, as opposed to just, 'Let's put the child there and then wait and see what happens'.

> The church family that we were working with, if they'd gone through the [proper] assessment process, they would have picked up that this is going to really test their kids and they're going to find this difficult.

> So we start with the tricky bits because then we've got the carers at a state where we can work with them to negotiate that. Whereas if you just do it the other way, you're almost saying, 'Well, here you go. We don't know nothing about you...nothing about your parenting. There's no resources here, just have this child.'

> I used to work in foster care and we used to do full foster care assessments. We used to call them Defacto Foster Placements. I actually think it was a good thing. The children wouldn't be moved...still do the training and assessment and then maybe some allowances made, [maybe they] weren't quite the same standard, but they felt supported, they felt validated. But I don't know if they do that anymore.

Many participants commented on the contrast between foster care assessments and non-familial kinship care assessments.

> I know our foster care workers just shake their heads because they have such a huge accreditation process for their carers, and then we have someone in the community who says, 'I'll be a carer', and they jump, 'Here's this child with your Part A assessment' … But the reality is that had they gone through a formal foster care system, they probably wouldn't have got there.

> It's so difficult because I've come from a foster care background, so I know the standards that we uphold in a different placement type. Why is it so much lower in kinship? I feel like it's a movable target. If DHS really seriously look at their assessment, I don't think they'd make as many placements.

Alternative short-term care arrangements were seen to sometimes be needed to enable thorough assessments to take place.

> If the standard was you put them in an 'interim foster' until you did a thorough assessment … would be somewhat ideal – letting the child know it's an interim placement, keep in contact with those carers who are prospective. As opposed to [just] putting them there and then we all are scared to do anything because … there's that … connection [now in place].

> If you look at models such as in Britain there they call it kinship foster care, they're all trained, even the grandparents, before the children go in … <Where do the children live while that's happening?> In short-term foster care.

> Kith carers mean well, and I wonder [if] it is rushed too quickly, just [to have] a roof over their head. Is it better to be somewhere, like I know it's never ideal for kids to be in residential care, or ... in a hotel room with a child protection worker until they find somewhere. But in the long run if it's going to take six weeks extra, is that doing less harm as opposed to 18 placements?

> I did read ... that kinship care placements were more stable if they were preceded by a foster care placement. So the child's in foster care, the potential carers are assessed and it's 'Yes or no', which is not what we say, it's 'Yes or [Yes]' ... So it [would be] a considered placement like a foster care placement. But we don't have that option of emergency care anymore.

Program standards in non-familial kinship care and foster care

> You know, a foster carer can't put a foot wrong, but kinship carers ... there's two standards of care. There's foster care, and kinship care.

There were many observations like the one above that suggested foster carers were readily sanctioned for apparent breaches of care standards, but kinship carers were not. In addition to issues of carer assessment, a number of other areas of disparity between kinship care and foster care standards were mentioned. One such was the opportunity to receive training, particularly about the impact of trauma. A lack of training was observed by both support workers and carers as leading to difficulties in understanding children's behaviours and responding appropriately.

> [If you'd become a formal foster carer, would that have made a difference?] Well, I would have had the training and the support. See, we didn't have a worker the way it was done (Elizabeth, carer of four children with disabilities).

> A teacher took a child from Grade Four and hadn't known him before, but probably didn't know about the whole trauma history, or thought she could deal with it, but [this was] a child with significant issues. At first it seemed to be going okay but then he killed her parrot. So the placement broke down that day, because [there was] no understanding this child was so traumatised and had taken it out on this creature....because of whatever had been enacted on him. Sometimes they can't step back and understand what those dynamics are, they aren't trauma-informed – they're not trained in the outset.

> I guess foster carers get all intensive education and then an intensive accreditation process. So [kinship programs] don't have either of those two things.

> Maybe kith more so [than kin], if there's no relationship or a minimal one that you would barely call kith, but in general I'd advocate for both [kith and kin] to have training...so a meeting here and there, a couple of home visits, a few more indepth conversations around attachment would be very useful.

> The six year old is very bad emotionally at the moment, not wanting to go to school, crying and – which is really [out of] character for her. But on the weekend she asked how her Daddy died, so they're needing to know how, that he hung himself. But I can't answer that for her. I'm just beside myself on what to say...I've got thrown into this, and it's just overwhelming (Natalie).

Lower standards were observed in the criteria for approval as kinship carers as opposed to foster carers. A kinship support worker mentioned a residential care worker who had been approved as a foster carer, but was not permitted to foster a little boy she had been working with because she did not have a fence around her property. She was subsequently approved as a kinship carer for two young children. One of the carers interviewed who had provided statutory kinship care to several young people later applied to become a foster carer, but was rejected.

> So because it was school holidays we took him for two weeks. Ten years later – on and off, on and off. I've done a course for [foster care] as well... Then they process you to see if you're good enough to have a kid. They came and said they decided not to go through with me. Because they reckon I'm emotional, because a couple of times they've showed us videos and they had tissues there for us, so of course you get teary when you see some stuff... 'I'm sorry', I said to the lady, 'I thought that doing this job, part of it is to have a heart, that's why you take them in the first place'. (Nina)

More disturbingly, incidents were described in which de-registered foster carers had continued caring by being recategorised as kinship carers.

> **Support worker 1:** To highlight how different kinship is to foster care – we knew of this case of a single foster carer, and she had three children. Then she became deregistered as a foster carer, but she argued with the courts. Because the court said 'We're going to take the children off [you]', but she argued, 'Actually I'd like to be a kinship carer or kith carer because I've had an attachment to the children.' She was allowed to keep the children on the basis of being a kith carer. She became deregistered as a foster carer. There were reasons for the deregistration obviously. Of course the concerns haven't been addressed. They're still there.
> **Support worker 2:** Yes, that does happen a lot with this sort of thing.
> **Support worker 1:** There are [other] times when agencies make a decision, because of Quality of Care issues, that this carer's not an appropriate carer for the agency. But DHS may say 'Yeah but they can fit the kinship carer [category]'... I've seen it at least three times.
> **Support worker 3:** We've had it too. I suppose the [foster care] accreditation is so much more rigid than the assessment for kinship.

Instances were also mentioned in which foster carers were redefined as kinship carers when children returned for a second placement.

> He came into foster care...but then it broke down...but this couple tracked him and provided respite care for him...he's now living in [a unit in] their backyard...it was defined by the department as kinship care...where a strong relationship is built up in foster care [it] gets reinterpreted.

Kinship care or foster care?

A support worker described a non-familial kinship care arrangement that was made with a foster care applicant who had no pre-existing relationship with a little girl, in the absence of a thorough search for extended family.

> Gracie was considered to be in a kith placement, but now she's in a [familial] kinship placement. It was really interesting because when I asked what the connection is to the kith carer ... how it was explained to me is that Anna, the kith carer, she is best friends with the wife of the ... grandson, stepson's something – I don't know [laughter from other participants]. So Anna was best friends with the stepson's wife's mother, something like that. So this little girl Gracie – her paternal grandmother, actually, steppaternal grandmother, her son's wife was best friends with this kith carer Anna. So I still don't understand it.

> Anna and her husband were in the whole process of foster carer training. Then her friend, who's the wife of the step-blah-blah-blah, told her there is this little girl Gracie that needs a home, and Anna said 'Well all right, we'll take her because we're in the process of this whole foster carer training'. She thought it was going to be a foster care placement and then she was told it's actually considered a kith placement. When they said there was no training provided, less money and all that kind of stuff, she was very confused about that. 'I never signed up for this, I thought I was signing up for foster care'.

> Anna knew nothing about Gracie she had a little child of her own. So this kith carer was telling me ...'I have no connection at all to this, I know nothing about this family. Why am I not considered the foster carer? I thought I was going to be a foster carer, I don't understand what this kith stuff is.'

> I only worked with them for a short period, and then luckily maternal grandparents were found somehow. Then when Annie realised that there are maternal grandparents willing to look after Gracie [she said], 'Why wasn't she placed with them? I think it's a much better placement for her.' Then the whole process started with placing Gracie with her maternal grandparents – so now Gracie is with the grandparents.

It was suggested that some non-familial care arrangements would be better set up and managed as foster care placements from the outset, and that some unsuitable carers were likely to be screened out in the process.

> I wonder if the model sometimes is a problem. We've had kith carers that really would have preferred to be in therapeutic foster care where they would have had far more money, far more support … all of that therapeutic input … It's actually quite difficult to sustain and support them … A lot of them we think should never have even arisen.

> I think in some cases, especially the school connection or the church connection, it's almost like they're going into being foster carers, but then they don't get the training or the level of support that foster carers would get. So there's not that lead-in. Through the foster care process you weed out quite a lot of people who are coming into it for very good reasons but … realise it's not for them. Like it's too difficult. It's hard work being a carer of any kind … So they have plenty of time to think and process that. Whereas [in kinship care] you pick someone, you go to the church and say 'Who can care for this kid?' Next day, the child's there. They're not prepared.

Financial support

Research in kinship care has frequently identified significant differences between financial support to foster carers and kinship carers. Participants reported that the current practice of treating non-familial carers with any pre-existing connection to a child as kinship carers disadvantaged these carers and children financially as in other ways.

Most of the carers interviewed were experiencing significant financial stress. A number had given up work or reduced their hours to provide the care children needed. Financial privations affected opportunities for everyone in the household.

> You're trying to get them back into the community and be living as normal a life as possible with their friends…but money is a big restriction. 'My friends go out to the movies and they're going to McDonalds. Can I go?' 'Well, we haven't got that much money this week, you actually can't go.' (Kylie).

Carers told many stories about having to battle for financial support and help with housing. A number mentioned agreements with child protection for financial support that was subsequently not forthcoming. There were many comments about the difficulty of finding information about entitlements, information that many felt should be provided at the outset. Some limitations in support were seen to be associated specifically with being non-familial carers. Explaining the carer's relationship to the children to those in authority was also an issue.

> After I found out about Centrelink I went and Centrelink said 'Oh no, we can't do payments, we need blah blah' … Once they were on the Medicare card I just went back and said 'Now I need to claim for these children'. As you know I'm not a grandparent so I'm not entitled to free child care … (Elizabeth, carer of four children with disabilities).

Natalie, a single woman in her 50s, gave up full-time work due to the impact on her health of caring for two small children, however quickly found herself in financial difficulties.

> I approached DHS purely because I thought maybe the children need to go back to their Mum, because I can't cope any more. Then they said to me 'Well, we can try and get higher payments for you but we have to prove that you need it.' How much more proof do they need that I'm struggling to be able to keep working and to keep the children? ... I wasn't getting any financial help until about eight months after I had the children.

There were a number of stories of overcrowding and poor quality housing where assistance was not available. The seven large family groups were all in crowded accommodation and made compromises about where people slept. A young woman being cared for in a family with four other children shared a bedroom with two of the girls, but had to keep her belongings in a different room. The carers were planning a house extension at their own expense; they commented that while they would receive a grant for orthodontic care if needed, such monies were not available to contribute to building costs. Elizabeth was sharing her bedroom with the youngest of the four children she was caring for, and her adult daughter was sleeping in the family room. Bernadette was living in a three bedroom house with her four children (two adults and two under 18), her daughter's baby, and her ex-husband's three grandchildren. For the two years until she was provided with backyard bungalows, the three additional children slept on the living room floor and she shared her bed with her youngest son.

> None of them had beds for two years. Once my daughter moved out, my son went out [to a bungalow] because his brother's out there too, and the two [girls] got the bedroom. They all got beds. The excitement in their faces was unbelievable.

A support worker described the disparity between financial support in kinship care and foster care with the following example:

> A grandma who was in her late sixties got five children, no supports by DHS. And she didn't know about her grandkids, she literally got a knock at the door one day, 'Can you take these children?' Between three and about fourteen, they were. [Whereas a] foster carer recently got a sibling of four, got a house, got a car, got case support, got brokerage, got new bedroom stuff. [She] has so much support, so much financial assistance. Then you've got a kinship carer dealing with five new kids, no parents involved, and there's no support.

This disparity in carer payments between non-familial kinship care and foster care was particularly clear in the cases of Elizabeth and Tracey, the two carers of multiple children with disabilities. Like most kinship carers, both these carers were receiving only the lowest level of care payment despite the children's additional needs; their financial circumstances were thus far below that of foster carers with similar responsibilities. Elizabeth reported that she 'went from earning $1,500 a week to earning nothing'. Tracey elaborated on her circumstances:

> There really isn't any [support] available to kinship care...Foster carers do...but as coming under the banner of a kinship carer, there's no resources. There's no money. Really there is no support network there at all ... That's the difficult part. Because when it all happened – it's all traumatic, it's all emotional ... no one's thinking clearly ... it's all of a sudden – my gosh we've got four kids ... cheaper to do it that way and they don't have to pay you as much money... [With work] at least you could survive and you didn't have that constant financial problem in the back of your head all the time. Just when you think you're getting on top of things and that, and then you're like, we're going to have to buy a bigger car – stuff like that. <And how do you do that?> You're like, well you just get another loan.

The nature of non-familial kinship care

> I think that's it, that they think you're actually related to these children.

Despite the identified differences between familial and non-familial care, many participants felt that there was a lack of clarity in their programs about the nature of 'kith' or non-familial kinship care. Some carers felt that their own understanding of their relationships was overlooked, and an alien identity had been imposed upon them. An example was mentioned of a woman looking after the child of her brother's ex-partner; she resented being seen by child protection as a family member as she understood herself not to be a relative. Another support worker mentioned a carer with the opposite view: he was the ex-partner of the child's grandmother, and was reported to be unhappy not to be acknowledged as a relative carer with what he felt to be his rights as a family member.

There were many other comments that suggested a lack of clarity about the concept and definition of non-familial kinship care.

> They told us they would go to court and the kids would be placed in our care. We didn't even know what a kinship carer was ... We didn't even know that we were actually under [kinship care] for years, so that's how we got put in that pocket. We didn't even know that's what it was called. (Tracey, carer of four young people with disabilities).

> Do you have a definition? Because we have quite a few where it's once removed, like 'former step-auntie'. We have another one similar – Dad was married to their mother but divorced, and then he married someone else, and she married someone else and had kids. But then he ended up with her kids from that [other] marriage, and he brought them up and it's a really successful placement.

> Well, is it out-of-home care? There's the debate about whether the grandparents' care is out-of-home care because it's actually a family home, isn't it? With the kith, is that more 'out-of-home care', because it's not the children's family home, is it? That's a different kind of concept I think. You wonder, extending it, like a step-grandparent, I can think of some carers who've been granny's ex-boyfriend, so we call him step-grandad? Is it really a kith? What is that? He's not with grandma anymore. I think conceptually it's confusing, you're not quite sure.

Carers' confusion between foster care and kinship care was frequently mentioned.

> They haven't been screened and assessed and trained like foster carers. So they're in that grey area.

> **Support worker 1:** I think in fact some of them do see themselves as foster [carers]
> **Support worker 2:** Yeah, they say it all the time. They use that language, yes.

More understanding of the nature of non-familial kinship care was seen to be needed, as was policy and practice to respond to carers' different and individual needs.

> My thought about kith is, they must feel so unacknowledged and under the radar. Because [of] kinship being considered to be grandparents only, they just have no representation, they have no presence. When you talk about the field of care they don't belong anywhere and they don't have a tribe. So they must feel very adrift.

> I think the assumption with kinship care is that by definition there needs to be a connection, and so the bargain is that you forgo some of the standard and the training and the structure for the sake of maintaining a connection and what that means for the child. Whether that's a good thing – well the problematic thing about kinship care is that it's all incredibly individual, because every relationship is different, every set of motivations are different. So you can't generalise about what's good and proper, it's very much you've got to look at every situation and see how it works for the child – well, for both. See how the bargain's been struck and whether it's going to work.

> I think they need to remake the system – if we're asking for impossible things, so that there's more subtlety so that there's not one pigeon-hole that they put kinship carers in. If you got that individual consideration I think a lot of the problems would fall [out] – well, and the practical backup that you actually had a different repertoire of options.

Summary

Young people, carers and support workers described great diversity in non-familial kinship care arrangements. Many examples of secure, long-term care were presented. Some non-familial kinship care arrangements were observed to be built on strong pre-existing relationships between children and their carers, and others on connections that were tenuous or even in some cases non-existent. While some placements with little pre-existing connection had become successful long-term care arrangements, many were seen as unstable or of short duration.

Many differences were described between familial and non-familial kinship care and the support each required. Some carers felt their families were seen as less valid than natural families; and some experienced challenges to their families' legitimacy.

A wide variety of quality of care was described. Unsatisfactory standards of care were often attributed to the need to find placements in emergencies when few alternatives existed. Thorough assessments appeared to have been frequently bypassed by the more recent practice of defining non-familial placements as kinship care rather than foster care.

Significant differences were identified between kinship care and foster care program standards. Non-familial carers were seen as disadvantaged with regard to both financial and non-financial support by being defined as kinship carers.

While familial kinship care is now a generally understood concept in child welfare, 'kith care' or non-familial kinship care appeared to be barely defined. There was evidently a lack of clear guidelines for when individuals offering care to unrelated children should be regarded as foster carers and when as kinship carers.

The many ways in which non-familial kinship care differs from familial care reveal the particular support needs of this group of carers and their charges. Motivation and commitment of family and non-family carers may be different. A careful assessment of the appropriateness and viability of proposed placements with non-relative carers protects both children and carers from unsuitable arrangements. Planning and review of children's care is critical: a non-familial placement may be variously suitable as an interim measure, for a short term, or for permanent care. Carers are likely to need more information about children's histories and family experiences than relatives if they are to respond sensitively to children's issues. Reimbursement for the costs of care should be determined by children's level of need regardless of whether a non-family carer has been designated a kinship carer or a foster carer. Above all, the marked differences between family and non-family care need to be acknowledged, and support provided accordingly.

"I have struggled with energy, finances and enthusiasm. I have often felt abandoned by the system that finally accepted these kids could not live with their parents. Although I love them dearly and would never not offer to have them, the impact on my life is enormous."

Chapter 5

Survey results: Carers and their experience

This chapter describes the results of the survey of non-familial kinship carers and concludes with a consideration of findings as they relate to those of the interviews and focus groups described in Chapter 4. As the sample is relatively small, responses are not reported as percentages of the total, and numbers should be interpreted with caution. Nevertheless, some strong trends emerged that support findings reported in Chapter 4.

Twenty-one carers completed the survey, twenty of whom were female. None were Aboriginal. Two thirds (14) lived in a rural or regional area, and the remaining third (7) in the Melbourne metropolitan area. Following a number of expressions of interest, 11 respondents were also interviewed.

Respondents comments are mostly reported in full, however a few very long comments have been abridged.

Personal circumstances

Carers ranged in age from their 30s to 70s. Half (11) were in the range 50–59 years (Figure 1). Just over one-third (8) had a spouse or domestic partner and a small number had another adult living in including adult children (Figure 2). Just over one-third (8) lived alone.

Fourteen carers described their health as good, five as fair and two as poor; two mentioned arthritis as a health problem.
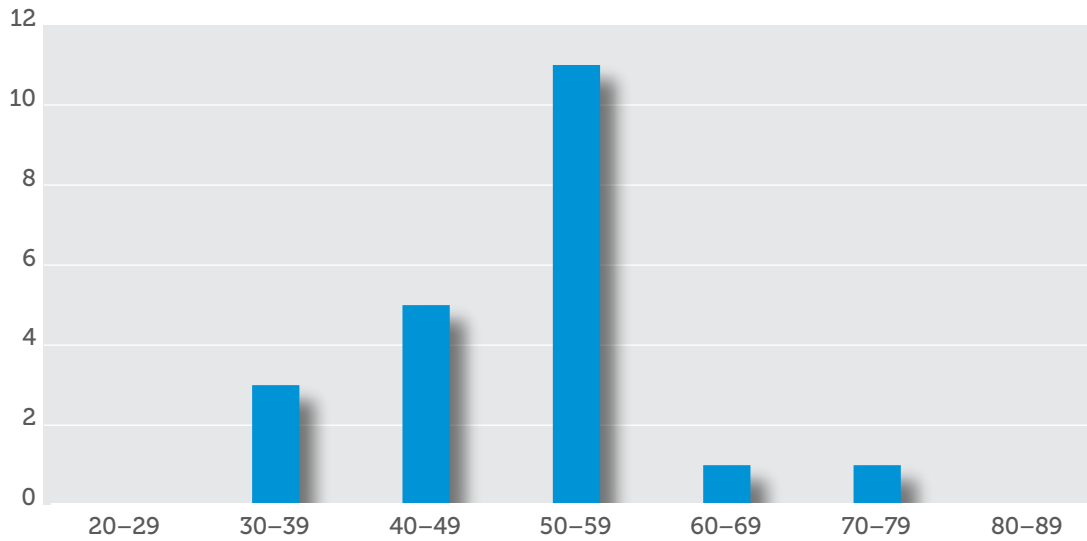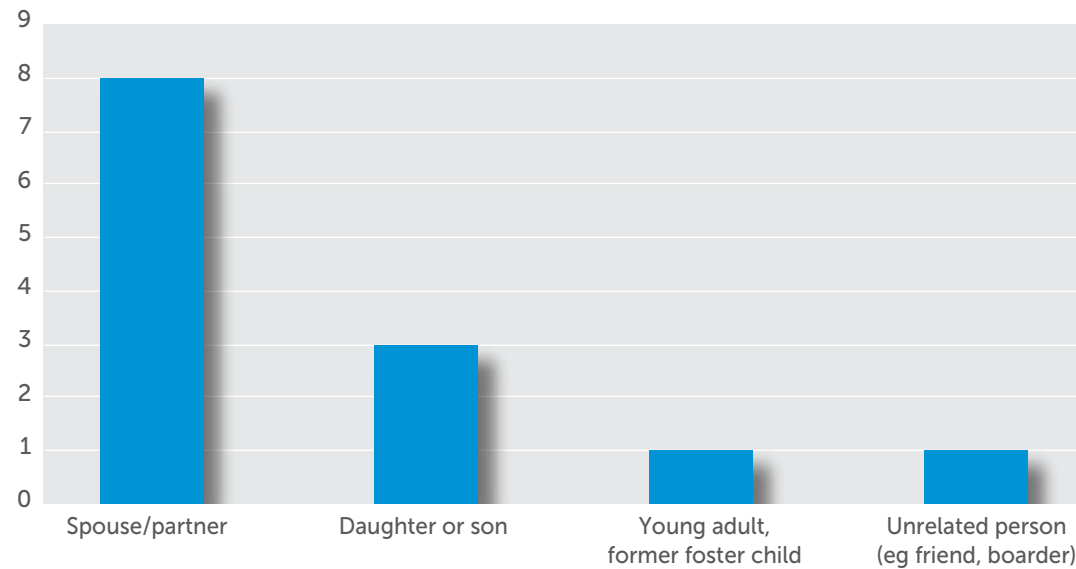
Figure 1: Age of survey respondents

Figure 2: Other adults in the household

Three carers were working full-time outside the home, and eight were engaged in part-time work. Eight were full-time home-makers (Figure 3). Several nominated more than one occupation or activity e.g. employment and studying, homemaking or voluntary work. Comments largely focused on restrictions to employment due to care responsibilities.

I work as a casual relief teacher. I am full time at present but generally on a casual basis.

I own my own business.

Carer (Three children with disabilities).

Full time carer, I had to quit my job due to the children's high needs.

> I was a full time teacher before these kids came to stay. Being full time, travelling one hour to work, having three kids at home was hard and very tiring. However, I found having traumatised kids at home put me under too much pressure at work, I needed to be home more, and so I've since given this career up.

Figure 3: Carers' occupations
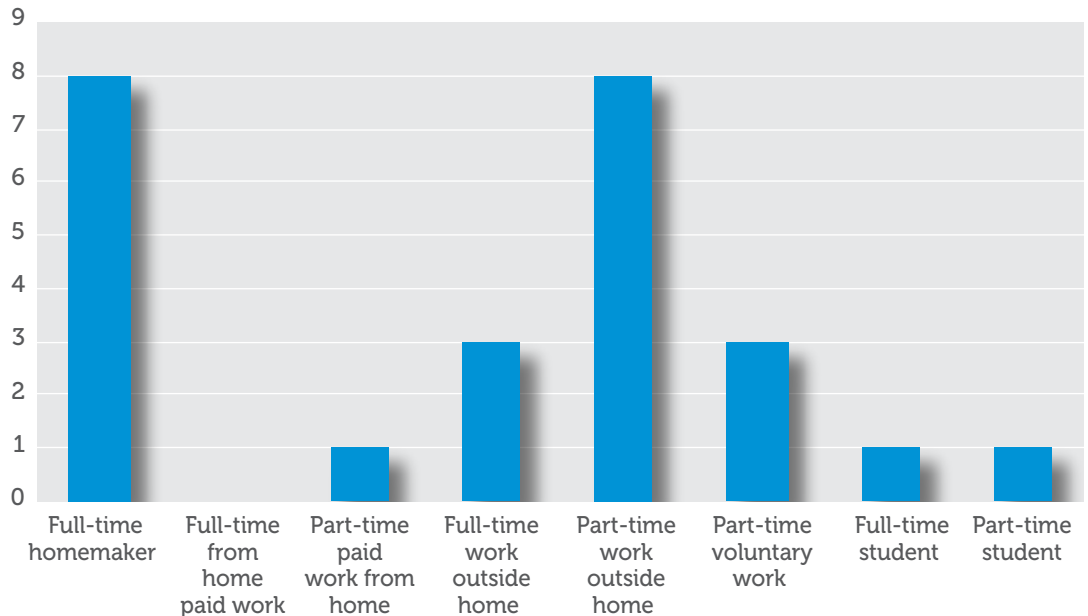
Finances and housing

Most household incomes were relatively low. Twelve carers had incomes below $50,000, and another five below $75,000. Only one was on a relatively high income (Figure 4). Over half the carers (12) indicated that they experienced hardship as a result of caring for the non-familial children, and most of the others indicated that they were financially limited in what they could do (Figure 5).

> I have had to rent a place in excess of $100 a week above that I would have without the child. I find that I cannot treat the child without doing same for my grandchildren, hence I need to think twice about swimming lessons etc.

> I was often out of pocket and I found this frustrating. I also could not buy the same quality for the child in care within the reimbursement i.e. quality uniform and shoes. I'm frustrated that it costs me $15 to put child in after school care and I receive $20 a day …

> We experience financial hardship but not just due to the kinship child, there are many more factors than that, we are a family of 7 which is expensive in itself, we have a mortgage, and living costs just keep rising, so I do not put that down to the kinship child.
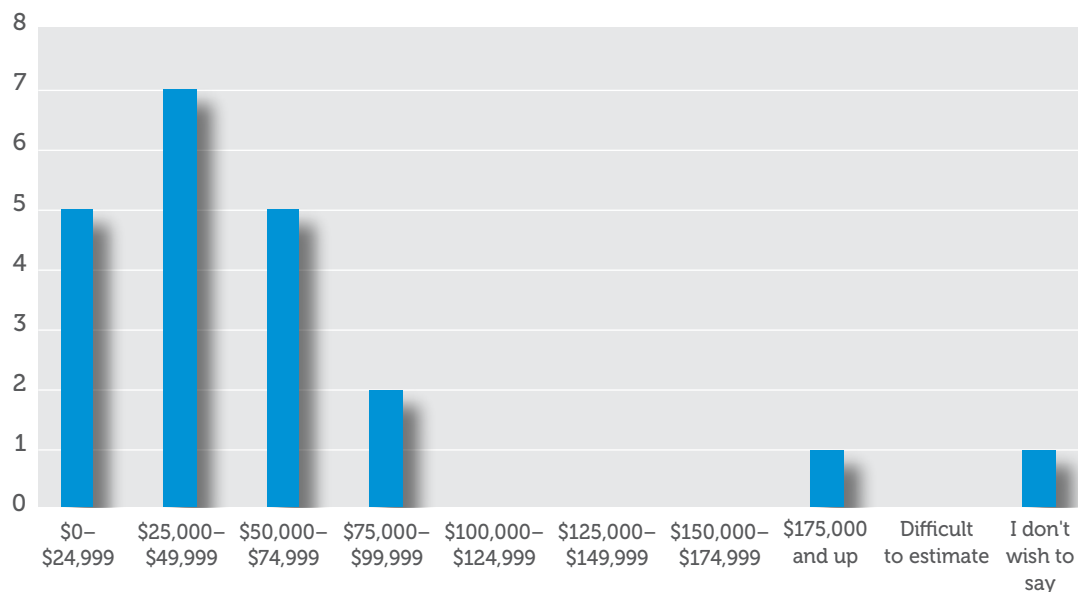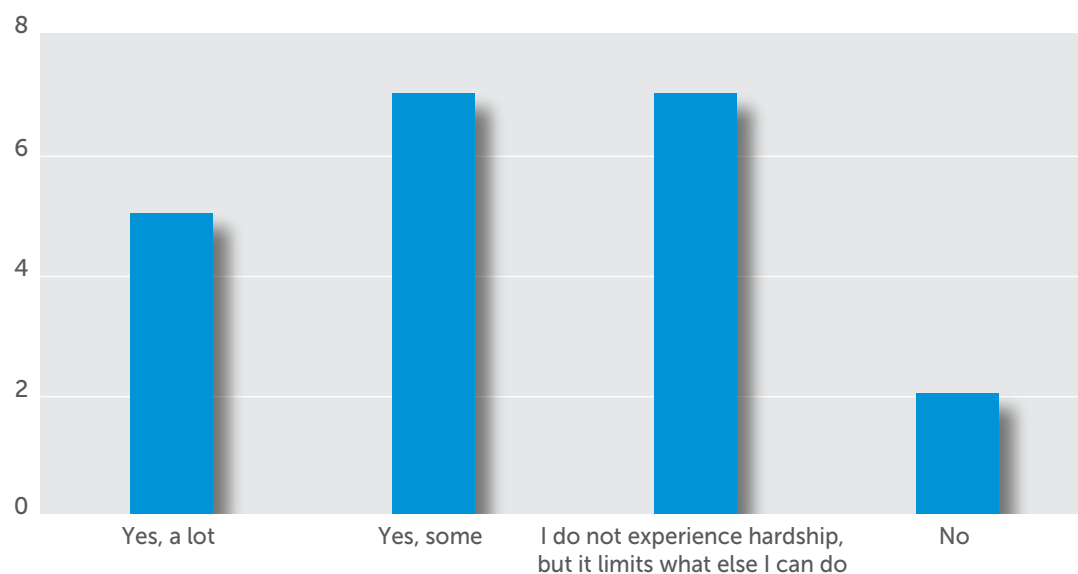
Figure 4: Household income after tax

Figure 5: Financial hardship as a result of caring for non-familial children

Over half the carers (13) described their housing as good or satisfactory. Seven suggested their home was crowded, and five that maintenance was needed. None reported very unsatisfactory housing conditions (Figure 6).

> I have been amazed at how destructive these kids have become and find it hard to keep up with the maintenance both financially and physically.

> There are seven of us in a 3-bedroom home, my husband and I in one room, two children in another room and then three in the last room, DHS have offered us a program called Kids Under Cover, where they will put a bungalow in the back yard worth $40,000. We have turned this down as I do not want to have to kick one of the kids outside. When we asked whether they would put that money towards an extension instead, we were told 'No'. So we remain crowded.

Figure 6: Housing
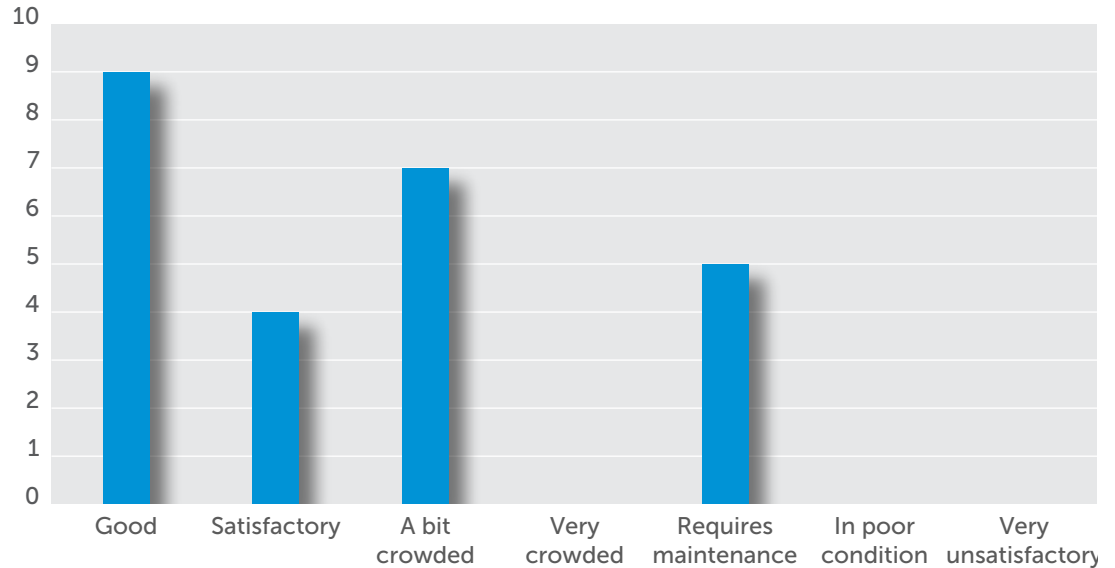
The children

A total of 39 children were being cared for by the 21 carers.

Ten carers had one kinship child, five had 2, five had 3 and one had 4. Half the carers (10) also had other children in their care; three carers had 1 other child, four had 2, two had 3, and one had 4[3]. Five of the households thus included 3 children and six households included 4, 5 or 6 children. In two households, 3 children were the carers' grandchildren. (Figure 7).

Figure 7: Total number of children in household

Children in household

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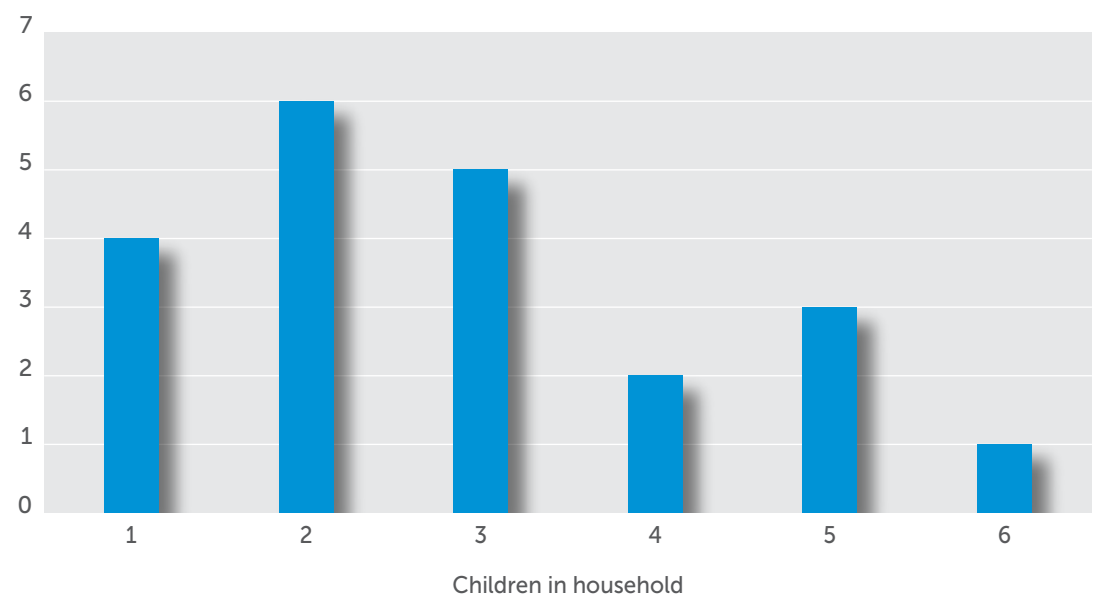
3   Adult children of carers are not included in this count.

One-third (13) of the children were Aboriginal; this included one single child, one pair of siblings, two sibling groups of 3, and one sibling group of 4. All the Aboriginal children were being cared for by non-Aboriginal carers. A non-Aboriginal carer and her Aboriginal husband were caring for a non-Aboriginal child, the half-sister of their Aboriginal granddaughter who was also in their care.

One-third (12) of the children were reported to have special needs or a disability.

> Intellectual disability, mental health issues, difficulties with activities of daily living (all 3 children), autism (1 child).

> ADD [Attention deficit disorder].

> Intellectual disability. ADHD.

> All 3 have low IQ. 'Children 2 and 3' also have ADHD.

> There is no recognised disability with any of these children, however, their social/emotional development and learning at school has been affected as a result of the neglect and trauma they faced early in their lives. This is particularly evident for Child 3, the youngest.

How carers came to be looking after non-familial children

Around half (10) of the care arrangements were the result of friendships or neighbourly relations with one or more members of the child's family, or previous informal daytime or overnight babysitting. Three carers were connected to the children via family members without themselves being relatives. The following comments are a selection where care was based on relatively close connections.

> I was a friend of the mother, the mother's parents were both unwell with their own problems and were unable to care for the grand kids.

> She was a neighbour's child who I looked after informally on and off for a number of years before it became full time.

> [Carer] cared for [boy's] mother when she was a teenager so had a family attachment.

> [My] daughter looked after child in child care from 6 weeks old, then did respite for child's foster carer. I was living with my daughter and when my daughter moved out (new partner and family) I maintained contact and respite for foster carer. When child removed from foster carer, DHS called me with initial request to look after child for the night, then 3 days, then extended to a few weeks … After one year family DHS initiated a family conference, decided to place child with me.

> My son asked me to consider caring for [school friend]. After discussing with spouse and then DHS phoned me.

In six cases there was little or no previous family or community connection. Two of these carers were Family Day Carer providers, one of whom was also approved as an emergency foster carer. Another was a newly approved foster carer. Two were school staff, and one carer responded to a general call to the friends and community of the family. These six comments are reproduced in full to illustrate the variety of ways in which care has come about.

> Providing family day care for then 15 day old girl. Brothers started with me ten weeks later. Children placed with me three months after baby started family day care. Parents disappeared. Department contacted me when fourth child born.

> [Wife] was employed for two years as the family day carer and emergency carers for the four siblings. Following the physical assault of the infant by the partner of the children's mother, the four children came into the full-time care of the carers via emergency foster care. The carers pursued the care of the children via child protection. The children continued in the long-term placement with the carers. The older sibling has returned to the care of his father when he turned 18 years of age.

> Applied to become foster carers as we could not have children and couldn't go through adoption – undertook foster care training and there were two children to care for.

> I work as a chaplain at a secondary college and the young person needed somewhere to live. I offered for the young person to stay with me until something more permanent could be sorted, she has now been with us almost 5 years.

> I was a teacher's aide with 'Child 1'. Because of suicidal issues I gave her my contact details if she needed to chat. One day DHS contacted me and asked if I would care for the three siblings. I said 'probably', and had the kids 2 hours later.

> The parents asked their friends/community if anyone would be willing to take on some of their children. We thought about it and offered.

How well carers knew the children prior to care

Carers said they knew just under half the children (17 out of 39) 'well' or 'very well' prior to taking on their care. Carers knew seven children 'to some extent', and nine 'hardly at all' or 'not at all' (Figure 8).

> Child always celebrated family occasions with us, she saw us as extended family.

> I had known her older brother through secondary school.

> 'Child 3' was a baby when I left [interstate], so I didn't have as strong a bond with him. It took 18-24 months for him to finally trust that I was going to keep him safe, loved him and would look out for him.

Figure 8: How well carers knew the children prior to care (count of children)
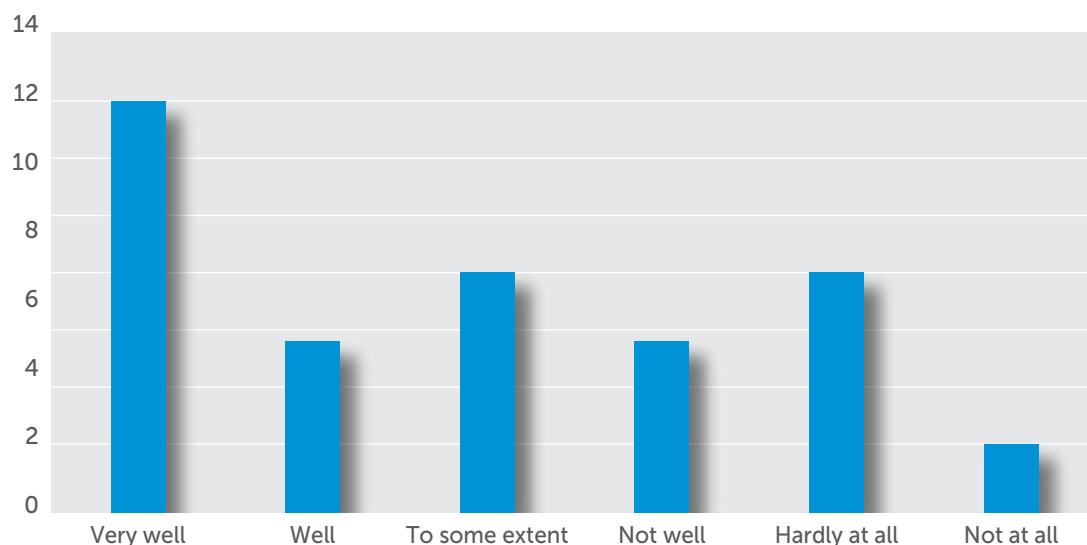
Court orders and children's case plans

The care of 23 children was by Children's Court Orders, 12 by Family Court Orders, and 3 were not subject to a Court order. One carer (with 1 child) was unsure about what Order governed care of the child. Thirteen carers reported that they knew the case plan decisions children in their care (22 children). Two carers did not know the case plans (6 children), and six were unsure (11 children).

> Not a lot of communication with DHS.

> I believe the child will stay with me permanently, but not sure of court orders.

> The child has been returned.

> Because there aren't court orders these formalities, case plans, care plans, etc, are not part of my experience of kinship care.

Eleven carers agreed with the children's case plans, two disagreed and three were unsure.

> I'm frustrated that DHS prioritises this case as low. I don't like the policy with regard to returning children, it is disempowering and not looking at the child's best interests.

> Don't agree with access conditions child is unsupervised (unsafe for child).

> The permanent care plan which I was told could not be changed, is being changed.

Length of care

Half the children (21) had been with their carers for three years or more, and one-quarter (11) for 12 years. Five children had been with their carer for less than one year (Figure 9).

Figure 9: Length of time children had been with their carers
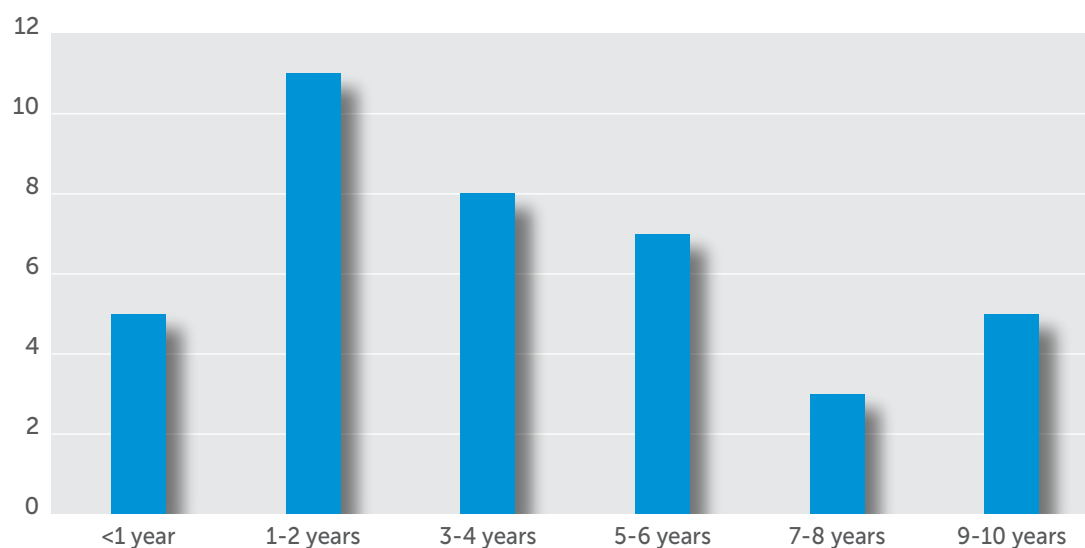
Most carers expected the care arrangement to be long-term, although some were unsure as to how long this was likely to be. Care was envisaged to be short-term for only two children (Figure 10). A small number of carers indicated that long-term care would require greater support.

> She has become a part of the family and I would expect that to continue; so ongoing.

> She has fitted in with our family beautifully, so we now consider her one of ours.

> ... as child sees my family as second family [my] daughter as second Mum, and [my daughter's] children as siblings, as I am 60, hopefully if I cannot continue ... she may be placed with my daughter.

> Definitely require ongoing support from a service to manage the placement needs.

Figure 10: Expected length of care for children
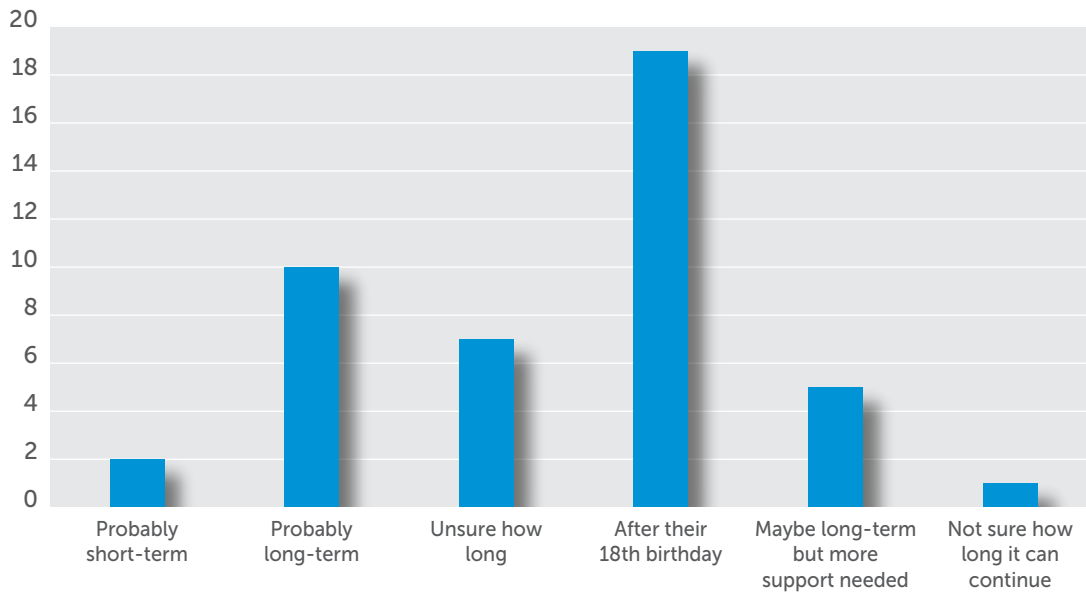
Kinship carer assessment process

As described in Chapter 1, Departmental guidelines require that a full assessment (Part A and Part B) should be completed within six weeks of commencement of placement. Given the length of placements, assessments should have been completed for at least 16 of the 21 carers. With regard to compliance, survey responses echoed comments about carer assessment reported in Chapter 4. Only six carers reported having had a complete kinship care assessment. Seven were not sure what assessment they had had, and five were not aware of having had an assessment. Just over half (15) reported that they had undergone a police records check (Figure 11). One carer who selected the options 'I am not aware of having had an assessment to be a kinship carer' and 'I have had a police records check' commented:

> It's been seven years of caring for child.

Other comments:

> We did an informal arrangement for 6 weeks whereby we had no police checks. Child returned home and then back to us for 2 weeks before DHS became involved and the police checks were done.
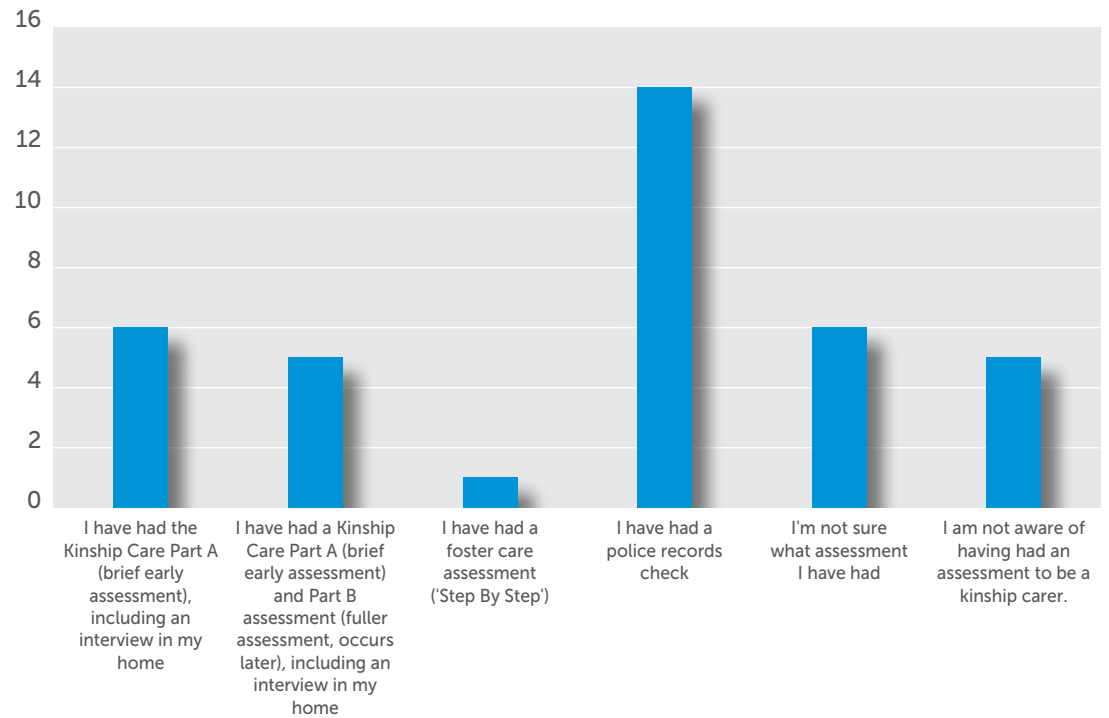
> Police check was 3 years ago.

> I was a [day] child care provider for the children so already had police checks, WWC, home safety checks and training around children's development (no knowledge of trauma).

> I am unsure what the assessment was called, but we did have an interview in our home.

Figure 11: Assessment of carers

Experience of caring for the children

Responses about experiences were mixed (Figure 12). It was noted that the carers who made the more negative comments also made positive comments about the rewards of providing care (reported below).

Contact with parents who are separated, new found grandparents, aunties, great grandparents is overwhelming at times.

Sometimes rewarding. My own children often resented the child. As the child stayed with us twice and the second time I felt railroaded, I also had feelings of resentment and I felt unappreciated.

We wouldn't change anything.

Heart breaking. Fulfilling.

We have all grown as a family through the ups and downs.

Caring for the kids was easy, the hard part was the relatives.

> Because I am older I have struggled with energy, finances and enthusiasm. I have often felt abandoned by the system that finally accepted these kids could not live with their parents. Although I love them dearly and would never not offer to have them, the impact on my life is enormous. I no longer feel like I have a social life, career, my health or fitness as a priority and of course the financial load is scary at this age. The impact on my relationship has meant that I really don't have a partner anymore, but a boyfriend. We each have our own houses and live our own lives that intersect on occasions. My hope is that I am not going to end up bitter and resentful from this season in my life.

> I have found caring for the young person all the things [in Figure 11], as it was with my own children, but also a great privilege. However there is an extra layer with a young person in your care that does make the task more challenging. A lot of that has to do with past experience, abuse, identity and values. This is where the challenges come in, in building self worth and sense of belonging.

Figure 12: Carers' experience of caring for non-familial children
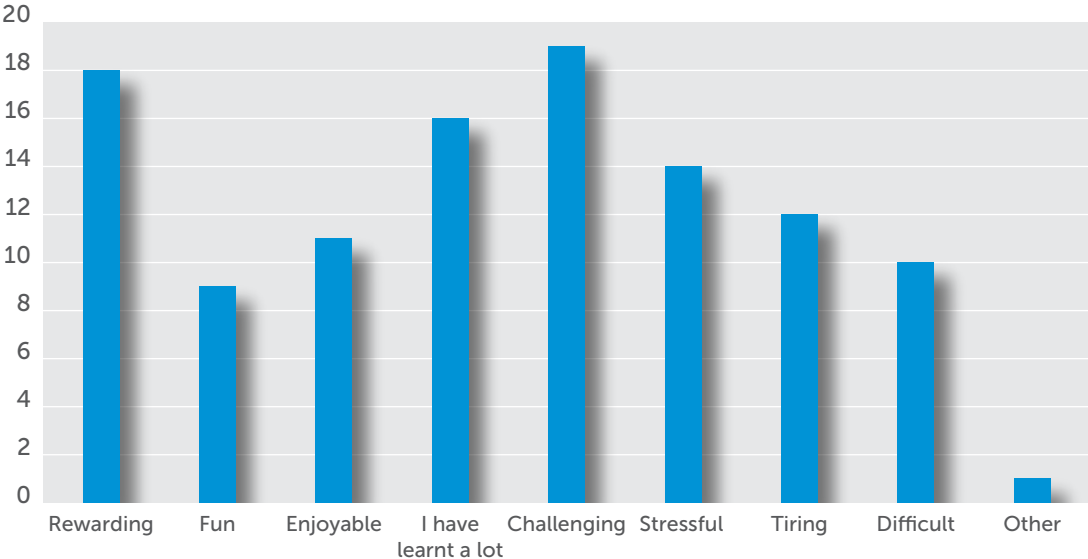
Carers' satisfaction with the development or progress of the children

Responses to this question were also mixed (Figure 13). Comments focused on carers' concerns.

> Child 1 has become independent beyond his age expectancy. Child 2 bottles up her emotions and problems. So although everything looks okay on the surface, I fear that the effects of trauma will explode to the surface in the near future. Child 3 has had massive improvements at school both academically and socially ... partly due to the awesome support networks of the school. However, when he has a meltdown, he will often end up threatening suicide, rocking in a foetal position.

> Academically, socially great … emotionally difficult at times.

> Child wore night nappies which he soiled some times and he refused showers and hair washing, not consistent with his age.

> Child 1 has low self-esteem although she is gifted at school work. Child 2 is on medication for attention deficit issues.

> Trying to get treatment for both boys. Children's progress goes up and down.

Figure 13: Carers' satisfaction with children's development or progress
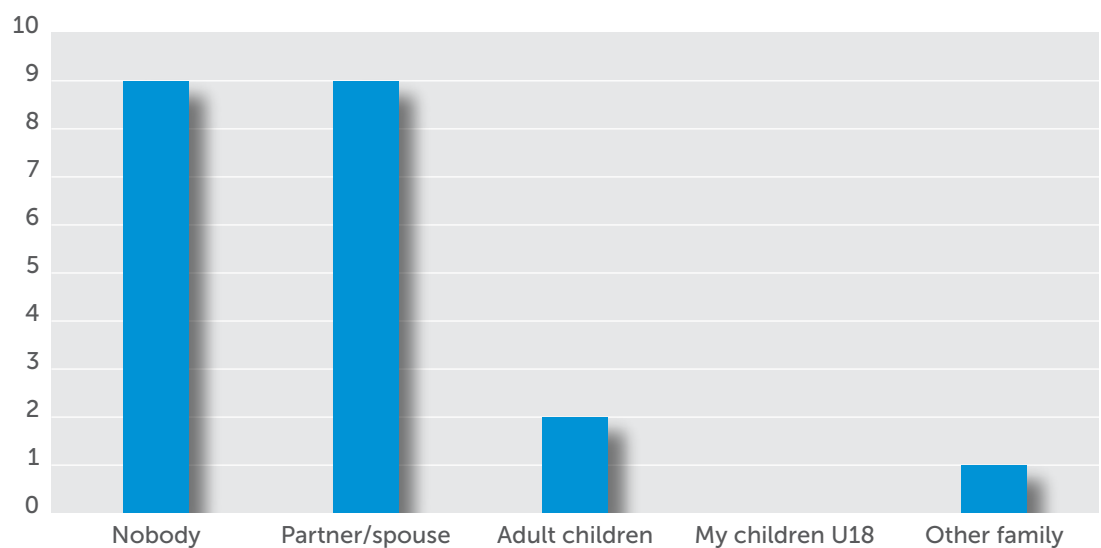
Rewards of caring

Carers were asked about the greatest rewards of being a (non-familial) kinship carer. Despite the many challenges mentioned elsewhere, responses to this question were plentiful. There were a number of comments that reflected the primary goal of care being able to keep children safe in a supportive family environment. The strongest theme however was the satisfaction of seeing children grow and develop well through the gift of nurturing care. Interwoven through comments was the joy and satisfaction of giving children a sense of belonging and normality.

Keeping children safe and supported

> Being able to provide the continued support for the child in an environment that she knows she is safe in and considered family.

> That I saved her from abuse.

> Instil values and morals and those actually being reflected in the children's behaviour. Providing a safe home and see the kids develop.

> Knowing the children are safe and happy.

> I want to give them the best start in life that they missed out on. Being about to help them, but I need to understand them.

Seeing children thrive and develop positively

Just knowing that all the children have been able to stay together. I believe they have benefitted from having routine in their lives and have seen huge improvement in their schooling. It is beautiful seeing the relationship they have with one another.

It is a joy to see these kids begin to thrive. They all have achieved at school and in the sporting fields and I'm grateful for the opportunity to see them flourish and have some part in that. However, I know this has not only been my doing but with the help of moments with extended family, a great support organisation (Mirabel) who have helped the kids remember what it is like to be a kid again. Having not had kids of my own I'm thankful to have been able to love these ones in a family type relationship.

I was very satisfied that my routine and expectations had very positive effects on the child's behaviour. When the mother wasn't involved the child was a joy.

Seeing the child become a member of the family, watching her meet all her milestones, blossom into a happy healthy child who is succeeding at school.

To see him change into such a great young person and to see him meet his goals.

I get to bring him up and point him in the right direction in life.

Being able to provide a normal, stable home environment and seeing the growth and development in the children.

Watching her grow and develop into a mature young person that has the ability and understanding to know how to make good choices. Observing her make good choices and watching her build resilience when things don't always work out. Watching her grow into our family and that sense of belonging grow.

There is so much reward; just watching a child flourish and become a really happy person, her goals in life have changed, she used to hate school and now she enjoys it, her grades have skyrocketed. It's rewarding to see her proud of herself and who she is and to know that you were a part of that change. She has learned to be a child again.

To watch the children excel in school, develop and have positive relationships.

Giving the kids everyday experiences my kids took for granted as normal.

Other comments

Hard to say!

Hugs and cuddles.

I am 'Mum'. They are 'my babies'. We are a family.

The most difficult issues in providing care

Many comments were made about the difficulties of providing care to children who have experienced trauma. Comments have been grouped somewhat by the interconnected themes of children's behavioural challenges, difficulties relating to children's parents, and lack of support by the Department and other services.

Challenges of children's behaviour

Child refusing to go to school.

Negotiating with [young person] about things he doesn't want to do but he has to do. There has to be a bit of give and take.

The most difficult issue was the pecking order amongst our children and the kinship child, when you have two children the same age that have been friends for years and suddenly they are expected to be sisters, they were both trying to be the 'good' child to get my attention, this was both exhausting and hard work. Thankfully this only lasted six months.

Not knowing how to help the oldest boy. His needs are so high that I'm overwhelmed daily. Lack of support. Lack of respite.

Dealing with certain behaviours and attitudes, it can be exhaustive. Being there for her unconditionally. Her lack of valuing herself or any belongings. It has at times caused relationship strains with my partner.

Child's behaviour.

Difficulties relating to children's parents

They have been quite destructive and there is a fair bit of damage in my house. It is also difficult for them when they come back after access as there are absolutely no rules or routine when with Mum.

Guiding and supporting on the death of their Dad and been removed from Mum's care without contact with Mum.

All three having additional needs. BUT more so, the family CRAP.

[Child 1] – Difficulties surrounding father – verbal threats. [Child 2] – family interference and [child's] behavioural issues.

Helping him to understand that he is safe here – it's not like how it was with his father – believing that I'm not going anywhere.

When mother stopped coming. Children don't understand.

The maternal grandmother, she would ring up to seven times a day.

Dealing with the mother and in particular the mother's selfish actions. Finding support to deal with frustrations.

> The ongoing conflict with mother, where she is constantly undermining my authority with the kids. When the kids misbehave or make poor choices, being able to keep separate my reactions to them from my reactions to their mother and the twenty years' worth of poor choices. With the eldest now heading down a path of substance abuse, dropping out of school and having no goals for his future, it breaks my heart to think about all the love, time, energy, resources I've put into this family with seemingly little positive results at the end. It is difficult not to blame myself, or feel like a failure when the kids then head off track.

Lack of support by the Department and other services

> Accessing services in the beginning to get assistance to get her school ready. Speech, behaviour, personal skills, confidence.

> Not knowing for over twelve months what was to take place re placement, dealing with angry foster carer from whom the child was removed, dealing with weekly access or phone calls from child's family who do not get on. It has changed the dynamics of my family, now my daughters see child as a younger sibling, they question my capabilities when we differ in opinion, they get angry with the difficulties I face beyond caring for the child, that is, DHS, child's family demands etc.

> Dealing with DHS.

> DHS.

> Lack of knowledge. Lack of support.

Stresses of care

Carers were also asked about sources of stress as a result of caring for the children. Major sources of stress were cited as children's challenging behaviour (15), followed by tiredness (10), challenge of welfare/support systems (9), stress from conflict with the children (8), conflict with children's family members (8), children's physical or mental ill-health (8) and financial difficulties (8) (Figure 14).

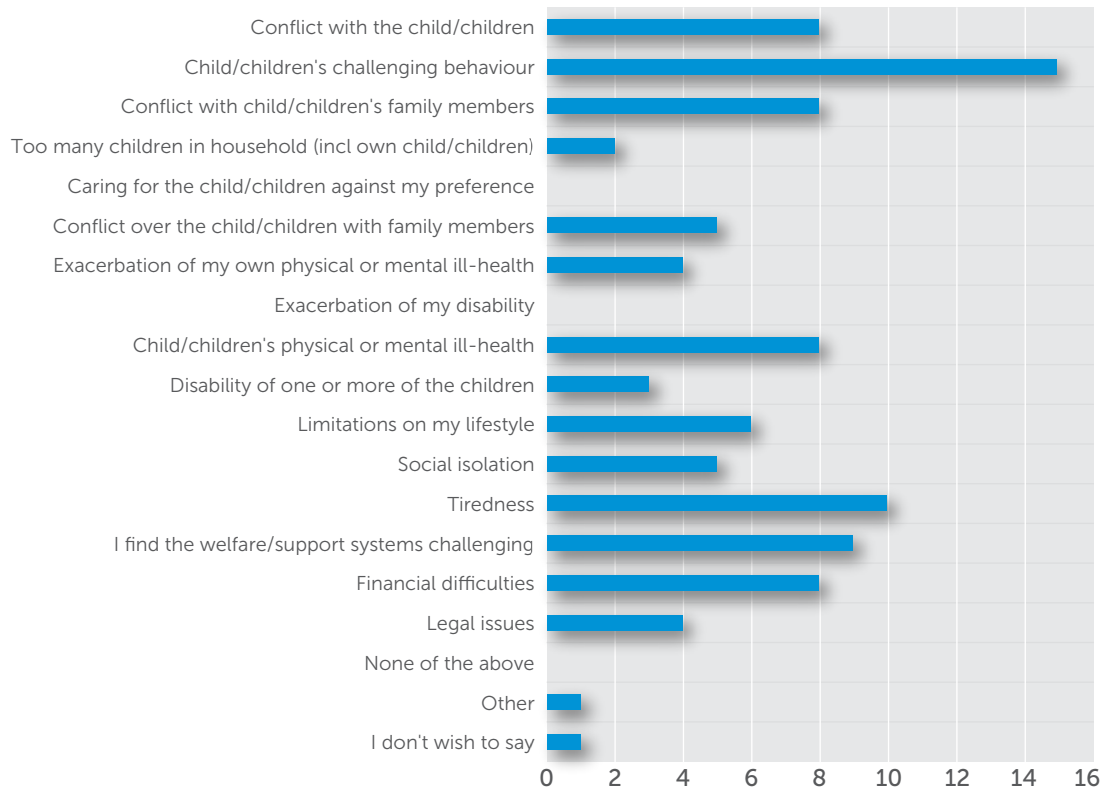> My own grown-up children feel I don't do enough for them because of these other children.

> … I also hate the connection to the mother….I don't feel that the carer reimbursement is sufficient to cover the costs of the child as I am forced to find care for the child in order to work and then it cost my family not only time and emotional energy, but financially.

> The Department create much stress.

> DHS.

Figure 14: Sources of stress for carers

Chart data (horizontal bar chart, x-axis 0 to 16):

Source of stress	Value
Conflict with the child/children	8
Child/children's challenging behaviour	15
Conflict with child/children's family members	8
Too many children in household (incl own child/children)	2
Caring for the child/children against my preference	0
Conflict over the child/children with family members	5
Exacerbation of my own physical or mental ill-health	4
Exacerbation of my disability	0
Child/children's physical or mental ill-health	8
Disability of one or more of the children	3
Limitations on my lifestyle	6
Social isolation	5
Tiredness	10
I find the welfare/support systems challenging	9
Financial difficulties	8
Legal issues	4
None of the above	0
Other	1
I don't wish to say	1

Support with care of the children

Half (11) of the carers had support from a spouse and/or adult children (Figure 15). Just over half (12) received some assistance with care from people outside of the household (Figure 16). However, nearly half (9) received no assistance from within the household, and half (11) received no external support. Reflecting the way survey respondents were recruited, most (17) had support from a kinship worker and/or child protection and one-third (7) had received some sort of counselling service (Figure 17).

> I am primarily the children's caregiver as hubby works long hours.

> [My adult child] helps out.

Figure 15: Who in the household shares care of the children
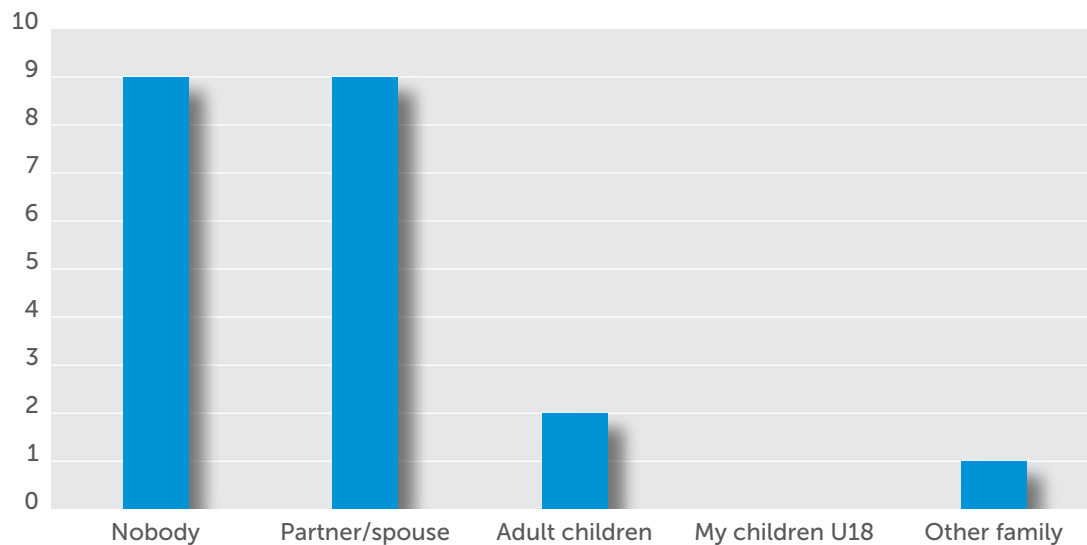
Figure 16: Help with care from people outside the household
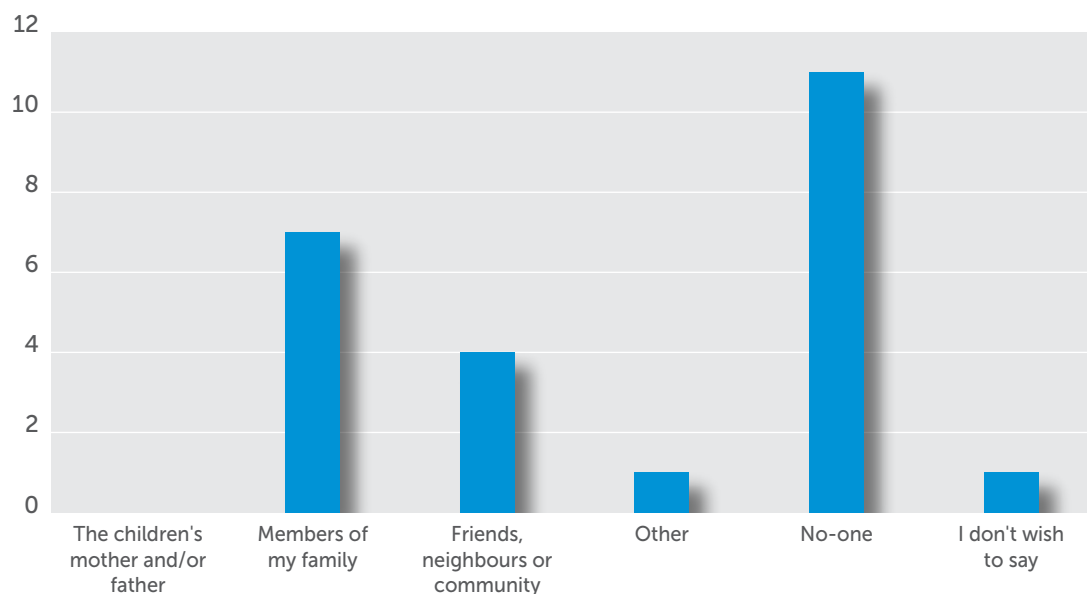
> Daughters who live independently with partners and family

> My Mum and mother-in-law looked after the children after school until I got home from school. While my Mum was away for six weeks I used after-school care. I also used other friends and child's family (aunt) to provide respite during school holidays.

> DHS-checked child care workers.

> I do have a couple of friends who help out occasionally, but generally pay for childcare, assistance in the house.

Figure 17: Other support carers have received
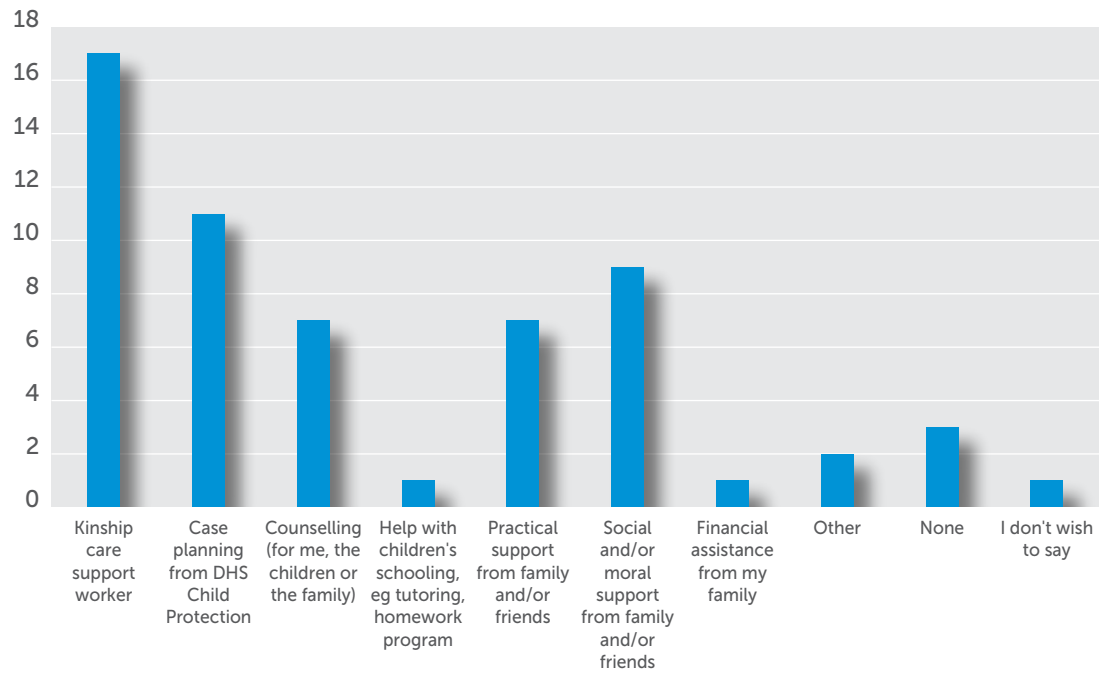
Figure 18: Help not received that would make a difference
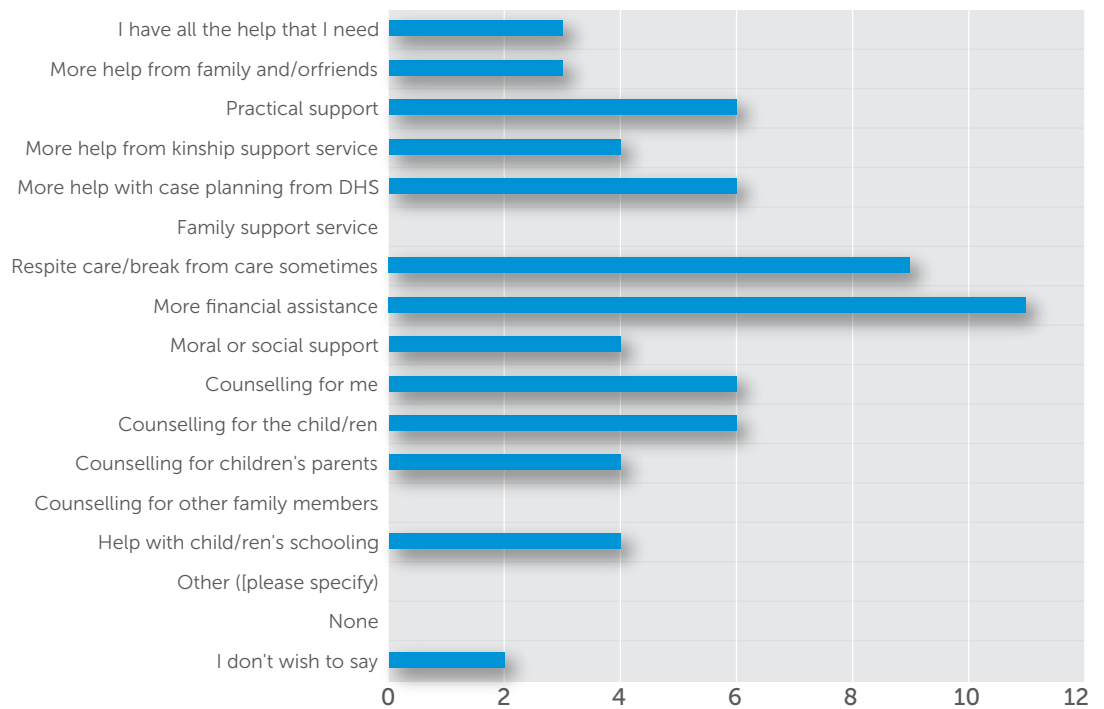
Carers commented on many different sources of assistance that would make a difference to their lives. The most frequent of these were greater financial assistance (11), respite care or breaks from care (9), practical support (6), personal counselling (6), and counselling for the children (6) (Figure 18). Comments reflected the lack of Departmental resources available to support kinship carers.

> I feel DHS do not take any of my concerns seriously. It is very difficult to make contact with them. They quite often don't return your calls for over a week which I feel is extremely unsatisfactory.

> As the child is not kin, I believe DHS should pay all medical and schooling costs, with recreational costs (not excessive), as the child I have has medical condition. I am made to feel embarrassed like I am asking for something excessive ... as I am near retirement I know I will face difficulties, or limit what I may have done if I had not had the child with me.

> More financial assistance to cover after school care. DHS didn't respond or were very slow to respond. When my kinship care worker went on leave I felt less able to express frustrations to her male replacement.

> Access to childcare similar to grandparent access would be valuable.

> Need play therapy.

Information and support carers would have liked at the outset

This question also elicited many responses. Two carers felt there was nothing else that they had needed. However, many comments centred on a lack of needed information about the care system and support services in general. Several comments were about a lack of knowledge of children's histories and how best to respond to traumatised children. There were further comments reflecting disappointment with the support available from the Department.

General

> Many things, including: dealing with traumatised children, DHS processes, early thorough assessments of each child, support services.

> A lot more information initially would have been great, how the system works and what my role in it would be.

> How long it would be before a decision made ... (12 months with continual assurance from DHS it wouldn't take long) re long term placement of the child. Unaware of difference between kin and foster and treatment of by DHS and Centrelink. I didn't know about support, e.g. child care arrangements as I work full time. Unaware of the emotional drain. Unaware of the difficulty of dealing with child's family. Psychologist support for me would have been good. There is a carers group which I may contact, unknown about this until recently.

> That her case plan worker would be visiting every month, meaning time off work for me. This is very time consuming when you already have a very busy life, I can understand the visits but why so regularly, especially considering the placement is going so well.

The need for information about trauma and children's families

We were well informed about trauma, caring challenges. Needed to know more about access challenges.

Trauma impact and best practice. (I got it wrong and any training I accessed, I paid for as well as childcare while I attended and loss of income.)

I would like to have known more about the child's parents.

History of the child.

Issues with the Department

That once the children have been placed DHS do not take carers into consideration when making any decisions.

DHS policy of returning children to their parent. That DHS is unsympathetic and unreliable.

That DHS would put all the appropriate supports in place to help me care for the children. Instead I have had to source my own support for the kids, while waiting for a kinship care service assist us. The children's behaviours deteriorated as a result of no support.

How hard DHS is to navigate on a daily basis.

Advice for anyone who may become a non-familial kinship carer

This question also elicited mixed responses. Many practical ways to access personal support were suggested. Some suggestions were about helpful personal attitudes. Sadly, two carers recommended 'Don't do it'.

Accessing personal support and information

Get the kinship carer book.

To make sure you have someone, family or friends that will partner with you in the journey. We have set up our own respite care which is one weekend a month and it has truly been the one thing that has made the journey sustainable, we love it and she enjoys going there. To also know that it is not going to be easy, but it can be rewarding.

Make sure you have support in place first. Guidelines in writing from DHS about what they can do to financially assist in the care of my children. Agreements from family etc. who can help with respite. Self-care needs are important.

Need to meet and talk to experienced carers, to expect the unexpected and realise your family dynamics will change forever.

Helpful attitudes and behaviours

Ask lots of questions. Be included in all decisions made.

Grow a thick skin. Don't take things personally.

Keep an open mind. Definitely have a go at it because it can be beneficial.

Give it your best shot. Be 100% on board. Everyone deserves to be loved and have a family.

Consider your own children's response being much stronger than you expect. The parent calls all the shots and has all the power. DHS is overworked, don't expect much.

To expect conflict between their own children and the kinship child until they work out the pecking order and until they work out that they are all loved equally, also to expect their case planner to visit very regularly. It is very time consuming, however having a child in your care, whether it be your own or a kinship child is extremely rewarding once all the teething issues have subsided.

Don't rely on the Department. Learn! Learn! Learn!

Don't do it

Don't do it – stress and trauma for all of your own family. Prepare to have all your relationships tested.

Don't do it.

Other comments

Finally, carers were given the opportunity to say anything they wished about their experience of caring. This question elicited further comments about the rewards of caring for children and carers' commitment to them, and more complaints about the Department.

DHS controls, but doesn't inform. Many steps are not followed re procedure and protocol.

Earlier option to go to case contracting with [community organisation]. DHS to be more supportive of Permanent Care.

> Sometimes I think the Department of Human Services do not understand what is really best for the child, they give you lots of advice, some of which is valid and some not so. For example, DHS said it was very important that our kinship child see her Dad, who at the time was serving time in prison for violent crimes. At no point had the child asked to see him or had the Dad asked to see her, they took her to see him anyway. After they had dropped her back, she had a meltdown about the whole occasion, she didn't know how to feel, and just sobbed. It's moments like this that DHS don't see, but we are left to pick up the pieces.

> We are very blessed and rewarded. We hope the children will choose to maintain our relationship past 18 years.

> It's rewarding – makes me happy to see him happy and grow up knowing what's right and wrong and starting to love himself again.

> I wouldn't give them up for the world.

> I love these children and want the best for them. It is hard though.

Summary

Half the carers who responded to the survey were in their fifties, with some younger and two older. Two-thirds were single, and at least one-third lived alone. Most were either full-time homemakers or working part-time. Most households were in the lower end of the income spectrum, and over half the carers were experiencing some financial hardship as a result of caring for the extra children.

Many of the survey findings echoed issues raised in the focus groups and interviews. As seen in Chapter 4, pathways to care were varied. Around half involved family or neighbourly relationships, and a few emanated from the carer's employment in children's services. As in Chapter 4, carers reported that in a number of cases there was little or no pre-existing relationship with the children or their families: less than half the children were reported to have known their carers well prior to care. Almost all the care arrangements were long-term. Again reflecting findings in Chapter 4, few carers were aware of having undergone a thorough assessment process.

Carers reported much stress in their lives. Particular sources of stress included children's additional needs and behavioural challenges, and contact with children's parents. There were many comments about the lack of adequate support from the Department. For many carers, there was nobody to help with the children either within or outside of the household. Half the carers wished for greater financial assistance. Other unmet needs included respite from care, practical support, counselling, and better information about a range of matters relating to children's care. Despite considerable stress and unmet needs, many carers commented on the rewards of providing care, in particular the joy of seeing children thrive and develop well.

"I think that's it, that they think you're actually related to these children."

Elizabeth, age 55

"It's the emotional connection that is the important part and the recognition of that; and then they should have equal rights with other carers."

Chapter 6

Fairy godparents or fake kin? Deconstructing 'kith care'

> I suppose when I'm called 'kith' I get really annoyed because in actual fact I am Tilly's family, as she sees it. We have been like that since she was 14 months old. (Ingrid)

> I think it boils down to some social recognition and validation of the placement, that you don't have to be blood-related. It's the emotional connection [that] is the important part and their recognition of that; and then they should have equal rights with other carers (kinship support worker).

Kinship care is defined as 'family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature' (United Nations, 2010, p.6). However strangers also sometimes go beyond expectations to provide altruistic care. The Biblical parable of the Good Samaritan tells the story of a stranger who goes out of his way to help a man injured in a robbery (The Bible, Luke 10:30–37). From this tale the term 'good samaritan' has entered the language to describe people who altruistically help others in need.

This study has identified nurturing fictive families built on strong pre-existing relationships, and others established with little or no previous contact – truly good samaritans. A number of carers described their joy at seeing children blossom in their care. Such stories might suggest that the pre-existing relationships between children and their carers were not important to outcomes. However, we know that carers in more settled circumstances volunteer for research more than those where relationships are troubled. Another side of the picture was revealed by kinship support workers who described many cases where ill-conceived care arrangements had led to poor care and multiple placement breakdowns. These experiences belie the current myth that kinship care is inherently good care.

The findings of this study demonstrate that 'kith care' is an ambiguous notion. As observed in two previous studies (Perry et al., 2012; Sallnas et al., 2004), many participating support workers viewed non-familial kinship care as closer in nature to foster care than to familial kinship care. However, in Victoria foster care and non-familial kinship care placements are managed very differently. Unlike in foster care, these 'kith' placements were usually made in an emergency prior to assessment taking place, and assessments were frequently both delayed and superficial. We heard of some reluctance on the part of authorities to address issues of poor quality of care. The carers we interviewed were almost all being supported by community kinship care programs, however the majority of kinship carers in Victoria do not receive such support. Their stories remain untold.

Legislation now designates kinship care as the preferred option for protective care (State of Victoria, 2005), however the increasing demand for placements has overwhelmed both familial kinship care and foster care. Many problems identified appear to emanate from the limited care options currently available, apart from those that can be found quickly and designated as kinship care. The kinship care practice of 'place first, assess later' appears to have emerged from the need to generate emergency care arrangements. When family options are exhausted, non-familial care arrangements of all sorts may now be subsumed into the presumed rosy world of kinship care. The assumption of a significant, inherently protective pre-existing relationship means that specific foster care assessments no longer take place. However we were told of many placements where the connection between children and a prospective carer was tenuous or even non-existent. Results of taking the kinship care pathway for such 'kith' placements are hit and miss. Sometimes the presence of good samaritans in our community results in brilliant care for vulnerable children; sometimes this practice leads to arrangements that risk further harming children. Where emergency placements are sustained, they may become long-term by default, whether or not this was the carer's initial expectation, at times exploiting the goodwill of community members. The mixed picture presented to us suggests that non-familial kinship care has become a poorly conceived and over-used 'add-on' to familial kinship care.

Placement assessment was an issue of particular concern to participants in this study, and stories of unsatisfactory assessments abounded. Support workers spoke of assessments focusing predominantly on the physical environment and the screening of criminal records; superficial 'tick-box' assessments; self-assessment as a stand-alone approach; assessments conducted by telephone; and assessments that overlooked household members, including the primary carer's spouse. A confirmatory bias in assessments appeared to be justified by the wish to ensure continuity of care, however much evidence points to an equally strong driver being the lack of available alternatives. We know that some kinship families are nurturing and stable, and that others have vulnerabilities not unlike those from which children were removed. Such assessment practice is patently insufficient to protect children.

The 2017 roll-out of Working With Children Checks (WWCs) for kinship carers is unlikely to do much to improve the chance of ensuring safe placements. Many people with a history in human services and no adverse employment or volunteer records nevertheless lack the specific skills and endurance needed for the 24/7 care of traumatised children. And many potential carers have no history in human service that a WWC could explore. A risk of WWCs is that they may provide a false sense of security, and thus support the idea that superficial assessment is adequate.

Foster care standards have been developed over many decades. By contrast, the policy and practice framework for statutory kinship care is slender. The absorption of non-familial placements into statutory kinship care without ensuring that such carers are genuinely 'close friends of the family known to the child' (United Nations, 2010) is an example of this. There are now two different tracks for approving non-family placements: as one social worker put it, 'kinship care is foster care by a back door'. Where carers and children are not well-known

to each other, there is a strong argument for conducting a specific foster care assessment as used to occur before kinship care was conceptualised as a separate type of 'out of home care'.

One support worker referred to research literature suggesting that a pre-placement in foster care improves the chances of success in a kinship care placement. A short-term pre-placement can afford time for both thorough exploration of the best familial and non-familial care options and impartial assessment of prospective carers (Gibson & Rinkel, 2012; Perry et al., 2012). Such an approach would not, however, be practicable without an increased range of emergency care options. Efforts to augment the foster care pool continue but are unlikely to deliver the total quantum of emergency care required. New emergency options need to be explored. This might include licensing of temporary, time-limited family or community carers with a mandate to return to court at the end of the license period; short-term facility-based care with live-in foster carers on a retainer; or redeveloping the family group home residential model for temporary care. If the crisis in emergency care is not addressed, it may be in so-called 'kith care' that our society's disregard for its most vulnerable members will next be exposed by scandal and inquiry.

Another implication of the poor conceptualisation of 'kith care' appears to be a lack of coherent case planning for the longer term. On one hand, we heard of emergency 'kith care' arrangements drifting into the long term without proper review and attention to carers' and children's needs. And yet contradictory practice was seen in two cases where delayed stability planning threatened to disrupt the long-term care of young children in favour of familial kinship care without due consideration of children's best interests. The *Children, Young Person and Families Act* provides for a stability plan to be developed after one to two years of out of home care. Decades after the work of Goldstein, Solnit and Freud (1973), it would appear that children's secure attachments to their psychological parents may still be at risk from ideology that preferences the notion of placing children with family members, whether or not known to children.

There is a statutory duty of care to carefully assess, supervise and support all statutory care arrangements, and to ensure that all children receive active case management when required for the duration of their protective Order. The diversity of 'kith' carers' connections to children, and their clear differences from familial kinship relationships, suggest the need for individualised attention to all such care arrangements. Non-familial carers also need detailed background information about children and the trauma histories, and early training about the impact of trauma. Foster care has long set standards for assessment and support of non-family carers, standards that the newer practice of 'kith care' threatens to undermine. A new paradigm is needed to ensure good quality non-familial placements. This might involve further development of policy for kinship care either separately from foster care as currently, or for a broader home-based care model including both foster care and kinship care but with greater attention to the diversity of circumstances, family dynamics, and support needs. Our recommendations suggest some directions for better practice.

This study also sought to determine for the first time the prevalence of non-familial kinship care and the relative stability of familial and non-familial kinship placements. It emerged that details of the carer-child relationship in Victorian child protection records were largely incomplete. Only around 40 percent of children in kinship carer were recorded as living with family members, a figure which suggests there may be significant numbers of non-familial kinship care arrangements. The 2017 AIHW Child Protection Report presented the first preliminary data from four Australian jurisdictions (not including Victoria) about the relationship between kinship carers and children, identifying that in these jurisdictions at least one-quarter of children in kinship care were living with non-family or 'other' kinship care. In order to collect such data for Victoria, completion of the relevant child protection database field needs to be made mandatory and the range of options to describe the carer-child relationship updated. This change would allow the Department to know for the first time how many statutory kinship

carers are grandparents, other relatives, and non-family individuals, and who the non-family people actually are. Importantly, the stability of non-familial kinship care could be compared with grandparent care and other types of familial care. If data thus obtained were consistent with international evidence that grandparent care is the most stable, and non-familial kinship care the least, this would underline the need for particular attention to the support of non-familial kinship placements. Such information is much needed if the State of Victoria is to be confident of providing stable, quality care to its most vulnerable children. We can no longer operate on the myths that kinship care and grandparent care are virtually synonymous or that all kinship care is good care. We need accurate information.

It is well-known that grandparent carers need a great deal more support for their caring role than currently available. What is less well-known is the involvement of other kinship carers, in particular those who are not family. This study has demonstrated that these care arrangements have support needs that are both similar and different from familial care and their particular needs should no longer be overlooked.

A lack of deep understanding of people and social phenomena is often associated with poor conceptualisation and unclear language. Better recognition of the existence, characteristics and support needs of non-familial kinship carers may commence with the adoption of more sensible terminology than 'kith'. Queensland may be leading the way here, having abandoned the term 'kith' for 'community kin'. We propose that Victoria should do the same.

We hope this study will improve recognition for those altruistic community members who step up to provide care to children in crisis, and who sometimes commit themselves to continue care into the longer term. More broadly, our work aims to provide momentum to the push to provide all children in care and their carers with support appropriate to their individual needs and circumstances. The December 2017 report *Investigation into the financial support provided to kinship carers* (Victorian Ombudsman, 2017) has also pointed to significant improvement needed in this particular area. Work on a new model of statutory kinship care in Victoria in late 2017 reflected concern to improve practice in the making, assessment and support of statutory kinship care placements. We remain hopeful that current efforts may lead to real improvement to the lives of children in kinship care, both economically and socially.

> I think they need to remake the system ... so that there's not one pigeon-hole that they put kinship carers in. If you got that individual consideration I think a lot of the problems would fall [out] – well, and the practical backup ... a different repertoire of options (kinship support worker).

See Chapter 7 on the following page
for recommendations.

"Emergency placements with people who do not have a significant pre-existing relationship to children should no longer be authorised under the statutory kinship care program."

Chapter 7

Recommendations

Collection of data

1. Data about the relationship between children in statutory kinship care and their carers should be collected via the DHHS child protection (CRIS) database. This can be achieved by making the carer *Relationship to child* field mandatory, and providing an appropriate range of options to describe familial and non-familial relationships.

2. Annual reports regarding the relationship between children and their carers and the stability of the different types of kinship care arrangements should be generated from the updated CRIS database. Priority should be given to expediting the provision of such reports to the Australian Institute of Health and Welfare so national data can be reported.

3. The University of Melbourne kinship care research team together with the National Children's Commissioner to continue advocacy with the Australian Bureau of Statistics regarding modifications to the Australian census to improved data available to inform policy:

   i. Minor modification to the algorithm used to analyse family relationship data such that the relationships between the Household Reference Person and each child in a household are reported.
   ii. Introduction of a new census question about responsibilities of the Household Reference Person for the care of children other than their biological or adopted children.

Approval of initial protective placements for children

4. Wherever possible, prospective kinship carers should assessed prior to placement.

5. Unless pre-assessed, non-familial placements with individuals who have a close pre-existing relationship with a child should be authorised by a Court to provide temporary care for 21 days while a complete kinship care assessment takes place and a Court report is

prepared. The Court should then decide to either approve the placement for longer-term care or to order the child's transfer to a more suitable placement.

6. Child protection should cease authorising emergency placements under the kinship care program with people who do not have a significant pre-existing relationship to children.

7. All placements with individuals who do not have a close pre-existing relationship with a child should be treated as foster care placements. A modified form of specific foster care assessment that can be completed within 21 days should be developed while the child is in approved temporary care. The assessment should include at least two home-based interviews involving all residents in the household; two standardised, documented verbal references from people who are not relatives of the carer; criminal records checks on all persons age 16 or over resident in the household; and a Working With Children check on the individual to be authorized as the primary carer. A comprehensive report of the assessment should include a recommendation regarding approval as a specific foster carer only, reasons for approval, and identified issues for support and monitoring.

8. Particular attention needs to be given to placement of indigenous children in non-familial kinship care to ensure the care arrangement proposed accords with the Aboriginal Child Placement Principle. A precondition should be that the pre-existing relationship between child and the proposed carer is a close one. Non-indigenous, non-familial kinship carers should be referred immediately upon placement for ongoing support by an indigenous kinship care service to help children remain in touch with family, community and culture, and to provide support with any crosscultural difficulties.

Temporary care options

9. A new range of pre-approved emergency care arrangements should be developed to allow for familial or non-familial kinship options to be fully explored and thoroughly assessed over a maximum of 90 days, after which the placement approval should lapse and the case return to Court. The following options should be considered:

   i. Licensing of 90 day temporary kinship care placements with people well-known to the child (family or non-family) while family searching takes place.
   ii. Facility based temporary care with pre-approved foster carers living in.
   iii. Redeveloped family group homes in the community sector providing temporary care with 24 hour live-in staff directly employed by the supervising service.

Case management and support of children in kinship care

10. When children are placed in non-familial kinship care, familial options should be thoroughly explored within 90 days of the commencement of care, with children's wishes a primary consideration.

11. Children's case plans should be updated at every change of care arrangement, including the anticipated duration of the new placement and action needed to secure suitable longer term care where required.

12. Case management of all children in statutory non-familial kinship care should be delegated to community services organisations to allow for ongoing active support and monitoring of children and carers.

13. Decisions regarding financial support for children in protective care should made according to a common protocol and provide equity regarding children's needs without regard to the type of placement involved.

14. Where statutory kinship care arrangements are seen to fall below acceptable standards and identified issues are not addressed within 14 days, children should be removed to approved temporary care and alternative arrangements made for their longer term care.

15. Stability plans should be implemented according to legislated timelines, and followed by permanent care assessments where appropriate. Where children remain in non-familial care that has been identified as secure and supportive for over two years, a permanent care assessment should involve a review of the wishes and ongoing support needs of children and carers, not an *ipso facto* reassessment of options for familial care.

Information for kinship carers

16. Priority should be given to providing detailed background information to non-familial carers about children's histories.

17. Access to information/training programs should be provided to all statutory carers equitably, with topics repeated each year. Consideration should be given to further integrated information/training sessions for all carers, as well as retaining options specifically tailored to foster carers and kinship carers. Priority should be given to information sessions about the impact of trauma and ways to respond to traumatised children.

Terminology

18. In order to better reflect the nature of non-familial kinship care, the term 'kith' currently in use in Victoria should be replaced by 'community kin'.

The model of statutory home based care

19. Consideration should be given to the development of an integrated model of home-based care to embrace foster care and kinship care. Such a model would involve equitable access to resources to support children's care, thorough assessment of all placements, and individualised support to children and their carers.

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Fairy godparents and fake kin takes a little recognised aspect of the growing area of kinship care and puts it under the spotlight. This research report explores the benefits for vulnerable children when altruistic community members assume the care of children they have met through their friendships, daily life and community connections. It also highlights the issues that may arise when insufficient support is afforded to these carers and children, issues that have the potential to place children at risk.

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More details about this research project can be found at: http://healthsciences.unimelb.edu.au/research2/social-work-research/ partnership-for-innovation-in-out-of-home-care/takes-a-village