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Never Stand Still

Faculty of Arts and Social Sciences

An exploratory study of risks to stability in
foster and kinship care in NSW: final report

Marilyn McHugh

Social Policy Research Centre, UNSW
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Social Policy Research Centre
Level 2, John Goodsell Building
University of New South Wales,
UNSW Sydney 2052 Australia

Tel: +61 (2) 9385 7800
Fax: +61 (2) 9385 7838
Email: sprc@unsw.edu.au

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Author

Marilyn McHugh

Contact for follow up

Dr Marilyn McHugh, Social Policy Research Centre: ph: 9385 7829; email: m.mchugh@unsw.edu.au

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- Managerial and non-managerial staff (survey)

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Dedication

To Pat, my good and wise friend, greatly admired and loved. Her support, and loyalty was always there and she made the more difficult times easier.

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Executive Summary

This report describes an exploratory study on various aspects and risks to stability in foster and kinship placements. The first stage of the study was in-depth interviews with 33 carers: 20 kinship and 13 foster carers. Most carers were female (n=30) and three were male. Sixty-six children and young people were being cared for by the 33 carers. Except for six carers all were receiving either a *Statutory Care Allowance* (foster carers) or *Supported Care Allowance* (kinship carers). The second component was an online survey with managerial/non-managerial agency staff (n=37) in New South Wales (NSW) with experience in OOHC policies and programs. The aim of the interviews and survey was to obtain the perspective of respondents in relation to a number of aspects of foster and kinship care. The project's overall aim was to answer key questions around placement stability.

Q1. What factors, singularly or together, support the concept of stability in care placements?

Risk factors to placement stability were evident in this study and while some aspects of care were difficult and stressful to handle, foster and kinship carers persevered with placements, indicating clearly through their words and actions their strong commitment to the foster/kin children in their care.

Carer stories demonstrated that regardless of placement circumstances, most adapted well to the age, needs of children, and requested placement type (e.g. long-term). A limited foster carer pool available and the seldom use of family group conferencing for kinship placements, meant several foster and kinship carers, were not selected as the 'most appropriate' carer for particular children placed with them. Rather it was carer availability and/or willingness to take a child that appeared to dominate most placements.

The complexity of some children's needs and high numbers of children with specific carers - factors which can lead to placement instability - appeared to be more of a stress factor for kinship carers. Only kinship carers intimated placements were at times, at risk. Many kinship carers were older, the majority presenting with little formal agency (i.e. caseworker) support. They coped, some not easily, with challenging situations as they arose (e.g. death/separation/divorce of partner/spouse, birth children's substance abuse problems, children's challenging behaviours, own and children's medical conditions, and changing children's schools).

Being with a government or non-government agency did not appear to be a specific issue, as the majority of carers were with the government agency *Family and Community Services* (previously known as DoCS). Carers' experience and relationships with individual caseworkers was mixed; some had nothing but praise for individual workers, while others were highly negative. While kinship carers may have similar, if not a higher need, for caseworker's support, some were inclined to comment that they were glad the department was not involved in their family's life. On the other hand some were 'desperate' and dismayed that no one was available to provide information, support and services to meet children's needs.

Carer employment, considered a risk factor for stability, was an issue. In this study some carers were financially disadvantaged (i.e. less well off) by having to make changes to paid work arrangements. Some, but not all, had come to terms with their decisions to lessen paid work hours, change jobs or quit work altogether. The major reason for labour market changes was carer recognition that they had to be 'available' to meet the needs of foster/kin children. For some receipt of a carer allowance was a form of compensation for lost wages from paid work.

The role of Courts impacted on placement stability for some foster carers, particularly when orders for children's placement were changed or delayed. Uncertainty existed for some kinship carers around a lack of orders. Those without an order were concerned at where children would go, if something happened to them. High legal costs in applications for court orders were evident for some grandparents. Limited knowledge of the ramifications (i.e. loss of support) of taking *Parental Responsibility* was evident for two grandmothers. While stressful to carers in varying degrees, most appeared to have coped and adapted to their particular circumstances, despite the issues they faced.

Q2. What, if any, are the main differences between foster and kinship care, in relation to placement stability?

While there were many similarities in the events/situations that affected all carers throughout their placements, there were some subtle differences between foster and kinship carers that increased the likelihood of, or foreshadowed, risks to stability. Kinship placements were often unplanned and carers unprepared to take children. Many kinship placements appeared to be without the direct involvement of authorities, though some families were 'known' and had been involved with child protection agencies and the police. With 'planned' placements, some kinship carers were pleased with support offered by caseworkers, while other carers received no support and were left to fend for themselves.

It was many years before some kinship carers were assessed. Placements where no assessment, or a minimal assessment is conducted on carer family appropriateness, presents a risk to stability and also to child safety. Few studies have assessed safety concerns for children in kinship care. Because the majority of placements are monitored infrequently, little is known about quality of care. Risks to stability are a strong possibility for carers lacking financial resources and appropriate information, and for whom support is not provided, either initially or on an ongoing basis.

Compared to foster carers, many kinship carers appeared totally unprepared for the impact on family relationships, when children were placed. Many carers indicated high levels of stress and strain from trying to keep family members 'onside', while handling related children's often challenging behaviours with little support. Aboriginal families, with larger numbers of both birth children and related children in their care, appeared to struggle the most, again with minimal formal support.

The receipt of a carer allowance for kinship carers appeared more precarious than the allowance provided to foster carers. Without the allowance many kinship carers, reliant on income support payments, acknowledged they would struggle financially. Some carers were highly concerned at proposed reforms to kinship care programs in

NSW, especially the risk of losing the allowance. For this group the loss of a carer allowance would risk placement stability.

Many kinship carers, without caseworkers, did not know who to turn to when they needed help with children's issues. To assist with stability, kinship carers initially need a caseworker/agency to provide information and access to financial/non-financial support. Throughout the life cycle of the placement kinship carers need to know who they can contact, if assistance is required. While not the case at present, ongoing training/information sessions or learning groups for kinship carers would benefit stability and should be commenced around the initial placement stage.

Obtaining respite was problematic for foster/kinship carers. All carers need a break from constant caring, but older, more vulnerable kinship carers are at higher risk of placement instability, when respite is unavailable. Without agency support for kinship placements, carer need for respite is unrecognised and unmet.

Q3. What 'resources' do kinship carers (predominantly grandparents) utilise in managing relationships within highly charged family dynamics, provide adequate and safe care to children, and cope with the challenges presented by 'parenting again'?

It is difficult to speak with a degree of equanimity about the perceived value of support groups for many kinship carers interviewed in this study. Feeling alone and socially isolated impacted on many grandparents and related carers. Some were of the opinion that joining and belonging to a group had 'saved' their lives. This finding provides the strongest indication of the situation of older, more vulnerable carers, without adequate information and resources, lacking someone to listen to their stories and share their often fraught and difficult lives, which few in the wider community appear to understand.

Family and sometimes friends were supportive, but an understanding of their situation and the ability to obtain relevant information appeared, in carers' opinions, to be best provided by other empathetic grandparent carers. At times it appeared debatable as to how reliable and up to date such information might be.

The concept of older carers 'parenting again' should not be taken lightly. For many kinship carers there was a continuation and increase in daily housework chores and child care routines, with little time to be involved as their contemporaries were with, for example, reduced housework, more leisure activities, holidays, hobbies and time for themselves. Parenting again also requires older carers to make significant changes in the way they conform/adapt to contemporary practices around parenting, child discipline and education.

Q4. What is the impact on older carers, providing care for extensive periods of time and do kinship carers, compared to foster carers, have the physical and emotional capacity to meet children's needs?

The emotional health of some kinship carers appeared tenuous. In this study, it was kinship carers who spoke of feeling, that at times, they would have liked to 'walk away' from their caring responsibilities, 'given children back' to the department, or

let children 'go' to another family. Carers in the study acknowledged their daily struggles openly, with many indicating an inner strength and resilience that enabled them to overcome difficult periods and provide placement continuity and stability.

Grief, loss, guilt, shame and anger for many kinship carers appeared to be unresolved issues. The 'double-bind' for carers - torn in their feelings towards birth children, whose actions have resulted in their children coming into care, but trying to support them regardless of the circumstances - was evident in many carer stories. These are not issues that impact on foster carers and yet they stay unresolved for many kinship carers. This issue begs the question, who is responsible for addressing grandparent carers' emotional needs and well-being? At what point does reduced carer well-being impact on the quality of care being provided, and as a consequence risks children's sense of well-being?

Kinship carers appear to have more serious health concerns than those indicated by the foster carers. Most felt their poorer health status was due to 'age problems' and not because of caring for related children. Their stories however, make it clear their health status was at risk from their caring role. Not having energy and feeling tired was an issue for many. It not difficult to imagine the increased stress and strain on carers from lacking energy and continuously feeling tired, and the risk to stability when, due to age and health issues, it all becomes 'too hard'. It was kinship carers who were concerned about what might happen to children if they could no longer provide care.

Added together, Stage 1 of this exploratory study indicates that despite the commitment of carers, kinship compared to foster care, may have substantially more risks to placement stability. A combination of any of these risks, or the exacerbation of a current single risk, e.g. carer ill-health or stress, could put any placement at risk of breakdown.

Stage II – Survey respondents

For aspects on stability that could be compared between carer interviews and survey respondents, there was no particular dissonance between foster carers' lived experiences with fostered children (in Section 1) and the opinions from survey respondents on the attitudes, skills and insights needed by foster carers in providing stable placements.

In several areas addressed by the survey, respondents with kinship care experience, acknowledged the many constraints and vulnerabilities that kinship carers faced in providing stable care and the need to develop carer skills and insight by providing specific training, education/support and respite. Respondents' recognition of what kinship carers require, while a positive sign, denies the reality of programs that do not always meet their needs and therefore those of children. The statement by one respondent that once children are placed, child protection workers often reduce their involvement and support, which undermines a family's ability to trust and work cooperatively, was evident in this study. Some tension was evident with survey respondents who indicated a number of negative attitudes towards kinship placements. These tensions were mirrored in carer stories of not wanting to be involved with

agency workers. Specific training for workers and carers involved in kinship placements may go some way in ameliorating these tensions.

Respondent's comments on fostered children's actions and reactions, in relation to contact/access visits, and birth parent behaviour around contact was informative as the views of children in care and birth parents were not included in the study. The concerns expressed by respondents, around foster carer's negative attitudes to contact with birth parents, were not supported in the carer interviews. There was some evidence from kinship carer interviews, that not all children were having contact with parents and wider family members, though it was unclear why this was happening.

Awareness of identity issues for kinship carers, their emotional responses to their circumstances and the need to encourage kinship carers to attend support groups was identified by many respondents.

Respondents, in general, were keen to debunk the myth that kinship carers do not need support and noted that adequate resources (financial and non-financial) need to be made available for this group of carers, because of their additional vulnerabilities and the challenges of family relationships. Respondents noted the need for workers to provide, a less directive and more collaborative approach, in meeting the needs of kinship families.

Respondents provided a mixed response as to why restoration/reunification was less likely to occur for children in kinship care. The significance of long-term court orders for children in kinship care and limited caseworker involvement in placements, evident from the carer interviews and supported by respondents' comments, appears to indicate that restoration is not a high policy consideration for children in kinship care.

The survey responses concluded with comments/suggestions on 'best practice' in ensuring placement stability in foster and/or kinship care' and reflected many of the responses to various aspects discussed throughout the survey.

Concluding remarks

As noted in the introduction the percentage of children being placed in kinship care (47 per cent in Australia is significant and is now higher than the use of foster care (44%). Despite the paradoxical finding in this study of highly stable long-standing kinship placements there did appear to be greater risks to stability for kinship than for foster care placements. While the study was not able to isolate a particular dominant risk to stability, any number of aspects, separately or linked together, give reason for concern.

Common themes suggested by all carers for keeping placements stable were providing children with routines and boundaries; developing/maintaining strong relationships (with workers, family and birth family); receiving respite; and being supported by workers.

Survey respondents noted that adequate resources need to be made available for kinship carers. They suggested a different approach be taken by workers in meeting the unique needs of kinship families.

State jurisdictions, through legislation, policy and programs aim to protect children in care, provide placement stability, ensure their well-being and safety and meet their needs. Legislation and policy provides the framework for using kinship care as the preferred option to maximise these outcomes. If this is the case, why is this option less supported than other options? The disjuncture between policy and practice in this area can have grave consequences. Kinship carers, predominantly older grandparents, provide care. Why are they expected to do this under circumstances (i.e. lack of support/services) that put their wellbeing and the children's at greater risk, than say that of foster carers and fostered children?

It is difficult to find words that convey the incredible tenacity, resilience, determination and commitment of foster and kinship carers interviewed in this study. While there were many issues that the carers, particularly the kinship carers wanted to discuss, they were not complaining about what had happened to their lives.

Overwhelming evidence from this study, and many others, find that many kinship carers appear to require more information and support, not less. It may be time to consider whether, in the proposed 2012 NSW reforms to child protection, more attention is given to ways that acknowledge (with financial and non-financial support) the significant contribution to society, being provided by kinship carers, rather than suggesting that after two years they can 'self-regulate', however this is to be interpreted. Kinship care is not a static phenomenon; rather it is a changing, challenging and complex experience, occurring over long periods of time for many kinship families. Circumstances and situations will change, sometimes for the better sometimes for the worse, over the lifecycle of these families. To suggest that after 'two years' kinship carers can go it alone with the parenting responsibilities they face is somewhat facile, and needs to be seriously questioned.

The unresolved debate on the appropriate roles and responsibilities for state and family, in relation to the care of children in kinship care is one that is not going to go away. It requires the input of others to move the debate along.

Glossary

AbSec	Aboriginal Child, Family & Community Care State Secretariat (NSW)
ACPP	Aboriginal Child Placement Principle
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
ADD	Attention deficit disorder
ADHD	Attention deficit hyperactivity disorder
CCNSW	Connecting Carers NSW
DoCS	Department of Community Services (New South Wales)
FaCS	Family and Community Services (New South Wales)
FaHCSIA	Family & Housing Community Services and Indigenous Affairs
FTB	Family Tax Benefit
NSW	New South Wales
ODD	Oppositional Defiant Disorder
OOHC	Out-of-home care
PADP	Physical Aids for the Disabled
PR	Parental Responsibility
SNAICC	Secretariat of National Aboriginal and Islander Child Care
SPRC	Social Policy Research Centre
TEP	Teenage Education Payment
TBS	The Benevolent Society
UNSW	University of New South Wales
UK	United Kingdom
US	United States

1 Introduction and Background

This study on placement stability for children in out-of-home care (OOHC) is a University of New South Wales (UNSW) post-doctoral research fellowship funded by the UNSW Foundation and the Benevolent Society (TBS) and conducted at the Social Policy Research Centre (SPRC). The study focuses on foster and kinship/relative care and its main aim is to examine aspects of care in relation to placement stability.¹

1.1 Care and carers

In 2012 there were 39,621 children in OOHC. Home based care - foster (44%) and kinship care (47%) - are the two main placement types used by statutory authorities for children, have been removed from their parent's care, mainly due to abuse and neglect. A small percentage of children, usually with complex needs, are in residential care. Foster carers are not related to the children and kinship carers usually are related. In most cases (90%) children in OOHC have a care and protection order of some kind and foster and kinship carers with children on orders are designated as 'formal' carers (AIHW, 2013).

Over the last decade the increasing use of kinship care is significant; rising from 40 per cent of all home-based placements in 2003 to 47 percent in 2013. NSW has the highest use of kinship care with 56 per cent of all children placed in this type of care (AIHW, 2003, 2013). Nationally and internationally kinship care is seen as the 'preferred' and 'less obtrusive' option when children need to be placed in care. An overview of US and UK studies found this preference based on the substantial benefits for children including:

- feeling loved, cared for and valued;
- maintaining identity and feeling settled because they were with family;
- fewer placement moves; and
- maintenance of contact with family and friends
- higher placement stability than in foster care (Mackiewicz, 2009: 2).

In regard to stability, a follow-up of placements in a UK study of children in foster ($n=128$) and kinship ($n=142$) care found nearly three quarters (72 per cent) of children in kinship care were still in their original placement compared to just over half (57 per cent) of children in foster care (Farmer, 2009). Foster and kinship carers share many similarities, for example, a commonly shared aspect of both foster and kinship care is its gendered nature, with most primary carers of children, predominantly women. However, there is also a clear distinction in the characteristics and circumstances of foster and kinship carers with studies from a number of countries, including Australia (Hunt, 2008; McHugh, 2009; Nixon, 2007; Taussig and Clyman, 2011; Yardley, Mason and Watson, 2009) indicating that kinship carers, compared to foster carers, are perceived as a 'vulnerable' group as they are often:

¹ For ease of discussion the term 'kinship' will be used throughout the report when kinship/relative care is discussed

- older, single females;
- financially disadvantaged;
- in poorer health;
- less knowledgeable about child development and modern parenting practices;
- less well-educated; and
- experiencing financial hardship and overcrowding when caring.

Despite national and international findings that carers sustain significant financial, physical and emotional costs, one of the most persistent themes emerging in kinship care studies is that statutory (formal) kinship carers, compared to foster carers, are less likely to receive support (including allocated caseworkers, case plans, annual review, training and services) and monitoring, to ensure children's and carers' needs are met (Falconier et al., 2010; Farmer and Moyers, 2008; Geen, 2004; Hunt, Waterhouse and Lutman, 2008; McHugh and valentine, 2010; Spence, 2004; Vampani, 2004; Yardley, Mason and Watson, 2009). Nationally there is also concern that whilst most children placed in OOHHC are eventually reunited with their families this is not the case for kinship care, particularly in NSW, where children in these placements tend to stay longer in care (Gallard, 2010)

An overview of 62 international studies of foster and kinship care, found that 'kinship care is faced with its fair share of controversial issues', including inequitable levels of support, both financial and non-financial, contentious carer assessment and approval processes (licensing); ad hoc approaches to placement supervision/monitoring; and a lack of contact guidelines (Winocur, Holton and Valentine, 2009).

Reasons suggested by researchers (Brennan et al., 2013; Ehrle and Geen, 2002; Leos-Urbel, Bess and Geen, 2002; McHugh and valentine, 2010) for low levels of support, services and monitoring, provided to statutory kinship carers include:

- Carer unawareness of entitlement to support/services;
- Carer reliance/preference for informal sources of support;
- Fear or resentment of child welfare agencies by carers;
- Agencies' perceptions that kinship care is 'different' from foster care and is less easily managed
- An unresolved debate on the appropriate roles and responsibilities for state and family in relation to the care of children;
- Worker perception that kinship carers prefer limited contact with agencies;
- Government concern that providing support and services may significantly increase the kinship care population (i.e. perverse incentive).

Research suggests that given the often unplanned and crisis driven nature of kinship placements, the poor socio-economic circumstances of older carers and the lack of carer assessment and training, there may be a requirement, if not a necessity to actually provide more not less support, than that provided to foster carers (Boetto, 2010; Geen, 2004; Gleeson, Donnell and Bonecutter, 1997; Warren-Adamson, 2009; Waterhouse, 2001). Poor support and service provision for kinship care placements, it is argued is: 'a reality that threatens to compromise the quality of care' (Falconier et al., 2010: 415).

1.2 Placement stability

There is no unambiguous definition of what constitutes placement stability (Christiansen, Havik and Anderssen, 2010). Harden (2004: 31) suggests that: ‘family stability is best viewed as a process of caregiving practices that, when present, can greatly facilitate healthy child development’. The critical link (or relationship) between child and carer family in regard to stability is heightened by the researcher who concludes that: ‘Providing stable and nurturing families can bolster resilience of children in care and ameliorate negative impacts on their development’ (Harden 2004: 31). Implied in this connection is a ‘good’ fit, or integration, of a child within a carer family (Leathers, 2006). A similar description of placement stability states:

Placement stability could be conceptualized as the maintenance of continuity in a child’s living situation in terms of the adults he or she lives with (and increasingly the ability of a child to grow up with siblings). (Pecora, 2010:4)

The importance of placement stability emphasised in Australian studies (Bromfield, Higgins, Higgins, and Richardson 1997; Lamont, 2011; O’Neill, Forbes, Tregeagle, Cox, and Humphreys, 2010) and in the US (Jones, 2010; Pecora, 2010; Wulczyn, 2010) indicates that stable placements:

1. Minimise child stress, emotional pain and trauma;
2. Decrease attachment issues and emotional and behavioural disorders;
3. Decrease school changes and increasing high school graduation;
4. Minimise service disruption to agencies, reducing carer stress and encouraging carer retention;
5. Increase likelihood of attachment and positive relationships with other adults; and;
6. Help ensure the educational, physical, and mental health needs will be assessed and addressed in a timely and consistent manner.

The focus in this study is on factors contributing to ongoing stability *within* a placement (Christiansen, Havik and Anderssen, 2010; James, 2004; Newton, Litrownik, and Landsverk, 2000). Placement stability is a complex topic with numerous risk factors that separately or linked together, can impinge on placement stability, including:

1. Characteristics of children
 2. Characteristics of carers
 3. Care type
 4. Agency type
 5. Relationships
 6. Courts
 7. Support.
- 1) *Children*: Risk factors connected to children relate to the size of sibling groups requiring care, ages and/or degree of complexity of needs. Children in foster and kinship care who are older (11+ years) and children who present with challenging behaviours (e.g. aggressiveness, destructiveness, over activity)

emotional or mental health problems are found to have less stable placements (Christiansen, Havik and Anderssen, 2010; Farmer and Moyers, 2008; Frederico, Jackson and Black, 2010; Leathers, 2006; McCrae, 2010; NSW, DoCS, 2007; Wulczyn, Kogan, and Harden, 2003; Zinn, DeCoursey, Goerge, and Courtney, 2006).

- 2) *Carers*: Many western countries, including Australia, struggle to recruit and retain a sufficient pool of foster carers (Smyth and Eardley, 2008). Selection from a limited pool of carers, results in placements with any 'available' carer, rather than matching the most appropriate carer to the child, and may lead to placement instability (Brouwer, 2009; Cashmore, 2000; McHugh et al., 2004). For kinship care, the use of family group conferencing is seen as a good approach, in determining the most appropriate carer for a related child (McHugh, 2009). Carer characteristics are considered important with older, experienced and committed carers having been found to provide more stable placements (NSW, DoCS, 2007). Risk factors that have the potential to limit carer capacity include: the paid employment of the foster mother; being a single carer household; and foster carer having own children living at home (Zinn et al., 2006). For kinship carers having a poor relationship with a birth family and carers who are isolated with poor extended family and social relationships are at risk (McCrae, 2011). Other limiting factors are where foster carers' own children are close in age to fostered child or where foster carer's birth children are young (pre-schoolers) (Christiansen, Havik and Anderssen, 2010; NSW, DoCS, 2007).
- 3) *Care type*: Many studies suggest kinship care is a better predictor of placement stability, than foster care (Courtney and Needell, 1999; Farmer and Moyers, 2008; Harden, 2004; McCrae, 2011; NSW, DoCS, 2007; Zinn et al., 2006). However, somewhat contradictory findings in this regard come from other studies. Fernandez (1996) found that in New South Wales (NSW) Aboriginal children (overrepresented in kinship care) experienced higher levels of placement instability and were restored to birth families at a slower rate than non-Aboriginal children. In the UK Ward (2009) found placements with relatives (kinship care) (45%) were more likely to disrupt than foster carer placements (24%) or residential care placements (28%). In contrast a study in four English Local Authorities of kin ($n=141$) and foster ($n=128$) care placements found that: 'Overall, there were no differences in the quality or disruption levels of kin and unrelated [foster] placements' (Farmer and Moyers, 2008: 93). One study involving a world-wide review of 62 studies found evidence suggesting that the children in kinship care did better in behavioural development, mental health functioning, and placement stability. Children in foster care had better permanency outcomes and better access to required services (Winocur, Holton and Valentine, 2009: 4).
- 4) *Agency*: While there is little detailed research (O'Neill, et al., 2010) on the differences in placement stability between agencies, one report suggests that agency type (i.e. government or non-government), programs and practices; adequacy of resources (including staff levels and allocated case numbers) can impact on placement stability. A survey of carers (75 % government & 18 %

non-government carers) in New South Wales (n=942) found many (73%) of government carers, frustrated with the agency, citing variation of practice between regions, poor communication, lack of respect and constant change of caseworkers (ACWA, 2011). Studies indicate that multidimensional treatment foster homes, usually provided by non-government agencies, are more likely to create stability for children (particularly adolescents) than more traditional foster placements (Frederico, Jackson and Black, 2010; Koob and Love, 2010; KPMG, 2010; Wulczyn et al., 2003; Zinn et al., 2006). With the current transfer of NSW OOHC programs from government to non-government agencies, of value to the OOHC sector would be an understanding the nuances and subtleties between government and non-government services in relation to placement stability.

- 5) *Relationships*: Other factors related to placement stability for both foster and kinship care includes personal relationship development (e.g. attachment and connection) between children and carer families over time. Other relationships bearing on placement stability include those between workers, carers, children, birth parents and carers' birth children (Christiansen, Havik and Anderssen, 2010; Harden, 2004; Leathers, 2006; Selwyn, 2010; Sinclair and Wilson, 2003; Thompson and McPherson, 2011). Encouraging family ties by facilitating access/contact with birth and extended family, and maintaining those relationships over time, is seen as significant for stability and continuity (Fernandez, 1996; Palmer, 1996; Selwyn, 2010). Keeping foster/kinship children at the same school, and maintaining their relationships with friends and social groups, also assists placement stability (Unrau, Seita and Putney, 2008).
- 6) *Courts*: US researchers suggest that the courts play a 'key and often overlooked role' in achieving stability for children in care. Extensive delays in decision-making or changes to court orders for children can result in unsettled placements leading to instability (Allen and Bissell, 2004; Ward, 2009). Australian research found high legal costs for some kinship carers, involved in applying for *Parenting Orders* (Backhouse, 2008; Brennan et al., 2013). UK research with a large sample of kinship carers (n=394) also found substantial legal costs for carers and even with local authority involvement with the carer family, three quarters (76%) felt they did not have enough understanding of their legal situation to make an informed decision (Aziz, Roth & Lindley, 2012).
- 7) *Support*: How the needs of foster/kinship carers and children in their care are met are crucial elements in assisting placement stability. Zinn et al., (2006) described two types of required support: child-specific and placement-specific services. Children's needs are often age-specific and based on histories of past trauma and impact of abuse and neglect. Their main types of support/services include health services (particularly mental health services), optical, dental, educational, therapeutic services (e.g. counselling, speech, physiotherapy, occupational) and recreational activities (AFCA, 2001; McHugh, 2002; Sinclair & Wilson, 2003; Zinn et al., 2006). Placement-specific services include casework, case planning and management, carer supervision and

support and ongoing carer training/education including attendance at support groups (McHugh, 2002, 2009; McHugh and valentine, 2010).

Project design

As noted above, the more vulnerable circumstances of kinship carers, and the different (i.e. lesser) treatment accorded to them by agencies, lead to an interest in understanding how kinship placements can be ‘more’ stable, than foster care. Of interest also was how the numerous factors, described above, separately or linked together, impinge on placement stability. Are some more important than others? Key questions for the exploratory project included:

1. What factors, singularly or together, support the concept of stability in care placements?
2. What, if any, are the main differences between foster and kinship care, in relation to placement stability?
3. What ‘resources’ do kinship carers (predominantly grandparents) utilise in managing relationships within highly charged family dynamics, provide adequate and safe care to children, and cope with the challenges presented by ‘parenting’ again?
4. What is the impact on older carers, providing care for extensive periods of time and do kinship carers, compared to foster carers, have the physical and emotional capacity to meet children’s needs?

The perspectives of carers and workers are seen as key in addressing these questions and carer interviews and a worker survey are tools used to incorporate their views.

1.3 Methodology

This section of the report discusses the methodological approach taken in the study. The project had two components: interviews with NSW foster and kinship carers (Aboriginal and non-Aboriginal)² and an online survey with managerial/non-managerial agency staff. Thirty three carers, 20 kinship and 13 foster, all from New South Wales (NSW), were interviewed. Carers were also asked to complete a short form on their personal characteristics (e.g. age, marital status, labour force participation, household income, etc.) numbers of birth children, and numbers of foster/kin children in their care (see Appendix 1).

The interview schedules for foster and kinship carers covered a number of topics. It began with asking how children came into care and then progressed through a series of open-ended questions, based on research findings, of important factors in placement stability. Prompts were used throughout the interviews to broaden carers’

² The author acknowledges the diversity of Australian Aboriginal and Torres Strait Islander peoples, who have different languages, cultures, histories and perspectives. For ease of reference, this report refers to Aboriginal and Torres Strait Islander peoples collectively as Indigenous people except where specific organisations/agencies use the term, ‘Aboriginal’, as is the case more generally in NSW.

responses. The topics covered additional areas to those mentioned in the report's introduction and included:

- Family relationships and contact/access arrangements;
- Identity and role issues around being a carer;
- Support and services (covered children's health and education);
- Support (financial);
- Carer health and well-being and spouse/partner's health;
- Positive and negative aspects of stability; and
- Specific issues for Aboriginal foster carers (see Appendix 2).

The second component was an online survey with managerial/non-managerial agency staff with experience in OOHC policies and programs. Thirty seven staff from agencies in NSW (two respondents were from Victoria) responded to the survey. The aim of the survey was to obtain the perspective of respondents in relation to a number of aspects of foster and kinship care (see Appendix 3). Respondents were asked to briefly describe their background in OOHC, their current role and time in that position, and whether they were with a government or non-government agency. A series of open ended questions covered the following topic areas:

- placement stability;
- contact /access arrangements with birth families;
- family relationships, identity and roles;
- formal and informal services and support; and
- specific cultural and community issues for Indigenous carers.

The data, from interviews and the survey, were analysed by emerging themes and key points. Quotes by carers and workers were grouped under specific topic areas.

Literature

A review on the available literature on aspects of placement stability (Australian and international) was conducted. Due to the large international and local literature, the purpose of these searches was to identify primarily new studies and reports. Wherever possible, there was a focus on Australian material. Use was made of academic databases (Social Abstracts) and Family & Society Studies Worldwide, as well as the National Child Protection Clearinghouse (Australia) and other web-based literature linking the concept of stability to aspects of OOHC placements and academic and grey literature on Aboriginal and Torres Strait Islander carers and ethnic minority/culturally and linguistically diverse carers (Australian and international). The report does not include a systematic literature review of the national and international literature; rather throughout the report use is made of material relevant to the area being discussed.

Sampling techniques

Sampling strategies included:

- Several organisations facilitated foster/kinship carers' participation in an interview. The criteria for carers to participate were that they had been

providing care for at least one child for more than 12 months. Carers Organisations who facilitated access included: *Connecting Carers*, NSW, the Benevolent Society and the Aboriginal Child, Family and Community Care State Secretariat (AbSec). All carers were sent a letter of invitation and interviews were arranged via email or phone contact. All carers received a gift voucher for participating. Most interviews took on average 60 minutes and were conducted in a carer's home, community centre or by phone. All interviewees agreed to the taping and transcribing of the interviews. Around 50 per cent of all interviewed carers lived in a rural or regional location in NSW.

- The NSW Association of Child Welfare Agencies agreed to invite their members to participate in the survey. Direct personal approaches via email was also made to individuals (known to the researcher) working in the OOHC sector. All survey respondents were anonymous.
- Ethics approval was received for the project from UNSW Ethics and consent was obtained from all carers to transcribe the interview data.

Study limitations.

The study has number of limitations. Firstly it is not a representative sample of carers or workers. Due to funding resources it was only possible to interview a limited number of NSW based carers and the survey was circulated to OOHC staff only in NSW. The number of survey responses ($n=37$) were considered sufficient in gaining an adequate perspective of worker attitudes, feelings, beliefs and practice in relation to aspects of foster and kinship care placement stability.

Ideally in investigating placement stability it would have been beneficial to focus on placement that had broken down and examine the various aspects that had led to this outcome. A complication of this approach would be to 'find' and interview foster and kinship carers, who may well have 'exited' the OOHC system after a placement breakdown. Focussing on what might well be regarded as carers with 'stable' placements however, was seen as useful and enlightening as the carer stories indicate there are several aspects in fostering/kinship care where risks to stability are evident, and these are discussed at length throughout the report. A further limitation to the study is that the perspectives of young people in foster/kinship care and birth parents were not included in this study.

Despite the limitations the strength of this sampling strategy was that most participants (carers and workers) who responded were experienced and knowledgeable in their area. The survey respondents indicated a good understanding of policy and practice in their jurisdictions and how current policy/practice was impacting on placements, particularly kinship placements. In addition, respondents made valuable suggestions about what might constitute 'best' or 'better' practice in relation to placement stability.

The structure of this report

The first section of the report provided the introduction, background and methodology for the study. The second section provides an analysis of the survey respondents.

2 Interviews with foster and kinship carers

Kinship carers: As noted in the introduction to this report, foster and kinship carers in New South Wales, as in other jurisdictions, share many similarities and some differences. A distinction, requiring clarification, is the blurring of boundaries between formal and informal kinship care. As explained in a recent study with grandparent carers, and summarised here, there are three ways children can come into the care of relatives:

The first is via *Parenting Orders*, which can be made by the Family Court of Australia or the Federal Magistrates Court ... The second way ... is via child protection services; in NSW ... the child may be allocated to the *Parental Responsibility* of the Minister, the grandparent, or another individual such as another relative. However, in an indeterminate number of cases, child services may simply withdraw and grandparents may never apply for formal custody of the child ... The third way in which grandparents may come to exercise parental responsibility for a grandchild is informally; that is, as a result of familial discussion and decision making. Children may be placed with grandparents by parents, or grandparents may feel the need to step in and take parental responsibility in situations where they believe the child is being abused, neglected or mistreated. (Brennan et al., 2013: 17).

In any of these scenarios kinship carers may be known (or not) to child welfare/protection authorities. Some carers, while not viewed by the department as formal statutory carers, may similar to foster carers, be assessed as eligible for financial support (e.g. *Supported Care Allowance*). Kinship carers, particularly those in receipt of an allowance, may also apply to the department for additional assistance (e.g. request funding for services/goods to met children's needs) some successfully, others not.

A further haziness in kinship care, that became apparent in this study, is that birth parent/s of child/ren in care may return to live, often for short periods, with the carer family. Depending on agency awareness of the change in family circumstances, little may change, in the day-to-day life of the carer. New relationships formed by a birth parent, and/or a return to substance abuse, may lead to some birth parents being asked, or choosing to leave, a carer's home.

In addition, unlike foster care, children in kinship care (formal and informal) often do not 'age out' of the system (e.g. leave the carer's home), when they turn 18 and the long-term court orders no longer applies. Rather, young people may continue to live in their current housing arrangements, into the late teens or early twenties, with some changes (i.e. diminution) of the carer role.

In Australia kinship care, compared to foster care, is more commonly used for placing children from Indigenous families. Of the 37,287 children in OOHC at June 30, 2011, 52 per cent of all Indigenous children were in relative/kinship care compared to 43 per cent of all non-Indigenous children (Australian Productivity Commission, 2012: Table 15a.17). There is minimal research on Indigenous grandparents caring for their

grandchildren (kinship care) (Kiraly, 2011). Their higher socio-economic disadvantage, compared to other families in Australia, has been noted by researchers. Smyth and Eardley (2008) citing Brandon (2004) found that in 2001, this household type had the second lowest gross household income, after lone mother households, and 'had proportionately much higher rates of poor dwelling conditions than other household types' (Smyth and Eardley, 2008: 10).

Despite their circumstances, it appears that Aboriginal grandparents, when asked, or required to do so, accept the placement of grandchildren. While acknowledging the 'strong cultural imperative to provide care for children in need within Aboriginal communities', Humphries, Kiraly and Connelly (2012) argues that 'While this is a key strength of communities, it can lead to families accepting the care of children even when overwhelmed with their own difficulties' (ibid: 2). Interviewed carers in this project include Aboriginal grandparents.

The initial intention in this study was to interview only statutory (i.e. formal) foster and kinship carers. However, reflecting the discussion above on the blurring between the formal/informal status of kinship care, it was not until sometime into the interview, when court orders were being discussed, that it became apparent that a few kinship carers were informal carers. The sample of kinship carers therefore comprises both formal and informal kinship carers and includes two kinship carers providing long-term care, where children (aged 18+) were still living with them. The researcher's approach was that data collected from all the kinship carers was not only valid for the study, but enlightening, in investigating placement stability. The next section discusses an analysis of the quantitative data from the carer forms followed by an analysis of qualitative data from the carer interviews.

2.1 Characteristics of carers, children & placements

Cultural characteristics: Thirty-three carers were interviewed for the project: 20 kinship and 13 foster carers. Nine carers either identified as Aboriginal, or were married/partnered with an Aboriginal person. Of the nine Aboriginal carers, one was a partner in a same-sex foster carer couple and eight provided kinship care.

Gender & marital status: The majority of primary foster carers are female and it was mainly primary carers who responded to a request for an interview. Thirty were female and three were male. Nineteen were married/partnered couples (including two same-sex couples) and two were single carers. Of the 12 single parents, 11 were kinship carers. Most ($n=12$) of the interviewed grandparent carers were maternal grandparents.

Carer age: The age group of the carer cohort was highly variable ranging from 28 to 76 years. Sixteen carers were aged under 55 years and 17 carers were older than 55. The age range for foster carers was slightly less (34-71 years) than for kinship carers (28-76 years).

Children in care: Sixty-one children and young people were being cared for by the 33 carers: $n=20$ foster and $n=41$ kinship³. The average number of children per foster

³ These numbers do not include carers' birth children still living in carer families' home.

carer was 1.5 and for kinship carers it was 2.3. Foster carers were more likely to be caring for younger aged (0-10 years) children (n=14) compared to kinship carers, were the majority of children (n=27) were aged between 5 and 15 years. Kinship carers also had the majority (n=7) of older children (16+) compared to just one foster carer with a child 16 years.

The number of children being cared for ranged from 1 to five children with two kinship carers caring for related children who had aged out of care (18 years+). One Aboriginal carer, with five related children, was caring for three children (her husband's brother's children) and two grandchildren. The father of the two grandchildren of this carer also lived in the grandparent's home (due to relationship breakdown).

Type of Court Order/foster carer: Of the 13 foster carers, eight were providing long-term care and one short-term care. Two cared for several children, some on long- and others on short-term orders. Two carers, one who provided respite only and another, a short-term carer, did not at the time of interview, have foster children in their care.

Type of Court Order/kinship carer: Fifteen of the 20 kinship carers had a long-term order for most, but not all, of the children in their care. Of the 15, one carer had a long-term order for a grandchild, but no order for her cousin's child.

In relation to four kinship carers, one was applying for *Parenting Order* through the Family Court; the second had an Interim Order through the Family Court, with a Final Order (long-term) pending. The third kinship carer, caring for her grandchild for 10 years, had no court order, and the fourth was caring for two grandchildren, on a voluntary basis (mother incarcerated). Restoration was currently being trialled for a grandchild, who for 11 years had been in the long-term care of his grandmother. The birth mother had successfully appealed the long-term order and the grandmother, at time of interview, was having regular court-ordered access.

Whilst the majority of foster/kin children in this sample appeared to be in long-term placements, it was of interest that no kinship carer had a short-term order for any child in their care. It was not clear whether this is the predominant approach to the use of kinship care but it does find resonance with studies that suggest that children in statutory kinship placements 'remain in OOHc longer and are reunified with their parents at lower rates than children in traditional foster care' (Blakey, 2012: 103)

Kinship carer relationship to children in care: The carer's relationship to the child was highly varied. Thirteen of the 20 kinship carers were grandparents (one of the 13 was a great-grandmother), one a cousin, one a step-aunt, one an aunt and one a great-aunt. Four kinship carers, three Aboriginal and one non-Aboriginal, had different relationships with the related children in their care. One carer had a grandchild and a cousin's child; another carer was a grandmother to two and an aunt to another; the third carer was a grandparent to one child and an aunty of three children; and the fourth had a grandson and a great-grandson in her care. Seven of the kinship carers, four of whom were Aboriginal, had related children, not necessarily siblings from the same family, come into their care at different times. It is speculated that once carers are 'known' to have taken the care of related children then, at a later date, other relatives or agencies, request that additional children are placed with them.

Time caring/foster carers: Overall, the longest period of time fostering was one carer fostering for 33 years. Six carers had fostered for between five and 15 years and six had fostered between 16 months and four years. The length of time, caring for the children currently in their care, at the time of interview varied. For four carers the period ranged from nine to 18 months and for another seven carers between 2-11 years. Two foster carers (one respite, one short-term) had no children in their care at time of interview.

Time caring/kinship carers: In general most kinship carers had been caring for their related children substantially longer, than foster carers. Over half (n=11) had the same related children in their care for 10 years or more. Eight had cared for the same children between three and nine years and one had cared for two children for 18 months.

Carer birth children: Four foster carers had no birth children. The number of birth children for other carers ranged from 1-5. One Aboriginal kinship carer had 7 birth children and one foster carer had eight children (three birth, four step and one adopted child). Seven carers had own children living at home; of the seven, four had adult children who had returned home after a relationship breakdown.

Labour force participation and household income: In relation to labour force participation the majority (n=21) of primary carers were either retired or not in the labour market. Three carers were full-time workers (two foster and one kinship); nine were in part-time work (six foster and three kinship). A salary/wage was the main form of household income for 13 carer families. Eleven households were in receipt of some type of income support payment; and five households had retirement income. Main source of income for four households was combined salary/income support payments.

Financial support: All except six carers were receiving either the *Statutory Care Allowance* (foster carers) or *Supported Care Allowance* (kinship carers). Four carers (two foster and two kinship carers) were receiving higher levels of allowances to assist with children's higher needs. Six carers were not receiving an allowance as children had aged out of care for two carers; two foster and one kinship carer were without a child in their care at time of interview; and one placement was voluntary. Most carers on allowances also received *Family Tax Benefit* (FTB), either *FTB A* and/or *FTB B* and two carers received a *Carer Allowance* (Commonwealth Payments)⁴.

The next section of the report presents an analysis of the data from the qualitative interviews. The various sections closely follow the carer interview schedule (see Appendix 2). While the numbers of Aboriginal carers was small, in some sections it was important to highlight their responses, separate from other discussion. The focus

⁴ *Family Tax Benefit Part A* - helps with the cost of raising the children.

Family Tax Benefit Part B - provides extra assistance to single parent families and to families with one main income where one parent chooses to stay at home or balance some paid work with caring for their children.

Carer Allowance is a supplementary payment for people who provide additional daily care and attention for an adult or child with a disability or medical condition.

of the analysis is on ascertaining whether events, occurring in relation to certain aspects of placements, increased the likelihood of, or foreshadowed risks to, stability.

2.2 How children came into the care of foster and kinship families

Foster families: The mode of entry into care varied as did the ‘fit’ between the types of placement required and the availability of appropriate carers. Six foster carers, providing ‘respite’, ‘emergency’ or ‘short-term’ care had children placed for longer periods than initially proposed, with most taking on their long-term care when requested. Some children came from a failed foster placement or a failed restoration attempts and one child was a failed adoption. Some children in large (e.g. four children) sibling groups were placed with different carers; sometimes another foster or a kinship carer.

A reassuring theme, evident in carers’ decisions to accept children outside their agreed placement type was their adaptability and commitment, when requested to take on children’s long-term care. Three excerpts from carer interviews indicate how carers adapt to specific situations and make a commitment to children. One story relates to a carer couple with one birth child who had been providing regular respite two weekends a month for children from two families. At one point the couple were asked to take two children for a ‘couple of weeks’. Four years later the children were still with the couple. The carer explained that the court case for the children was delayed for months. When orders were finalised the carers were asked if they would take the two children long-term (i.e. till they turned 18 years). At the time this was problematic as the foster mother explained:

We said we’d keep [younger child] but not the older one because he was 13 by this stage and he was sort of outside our age range that we’d applied for in the first place. As the time went on ... and on ... and on ... and they couldn't find him a home, he then asked us if he could stay. [We agreed] he’s been here ever since as well.

Two years later the couple were asked to take a third sibling of the two fostered children. The youngest sibling had experienced a series of multiple placements (n=6). The carer said: ‘When he came here, we just said, “Right, the buck stops here.” He’s been here ever since’. These three children are part of a sibling group of six children all in care.

In another example two school aged foster children were placed with a carer couple, initially as respite for the parents. Due to concerns by Department about the ability of the parents to care, an application for long-term orders for both children was made. After 18 months the court granted the order and the couple agreed to take the children long-term and the children have been with them for 3.5.years.

The third story is about a baby (5 weeks) placed with a carer couple. The couple initially agreed to provide respite care while restoration was attempted. When restoration attempts failed after eight months, a long-term order was made for the child and the couple agreed to take the child till she was 18 years. When asked what made the couple decide to take on the baby’s long-term care the foster mother said: ‘I have no idea. I think attachment ... absolutely ... I just needed to protect her for what she’d already been through’.

Non-Aboriginal kinship families: How children came into the care of their relatives was very different from foster carers. For eight of the 12 non-Aboriginal kinship carers, related children were placed (or left) with them by the birth parent/s with two of the seven being voluntary placements. For several placements, some occurring a decade or more ago, it appeared there was departmental and/or police involvement. Four of the seven were approached by the department to take related children with carers noting that they were not formally assessed till they sought financial support from the department. Often this was after the child (or children) had been in their care for some time, years later, in some cases.

Parental substance abuse problems led most of the kin children, coming into the care, usually of their grandparent/s. Incarceration of one or both birthparents, parent's mental health issues, domestic violence concerns and children's challenging behaviours were other reasons for children's placements. Both national and international studies indicate that the main reasons children are in kinship care is due to parental substance abuse and/or mental health problems (Ehrle and Geen, 2002; Falconnier et al., 2010; Nixon, 2007; Worrall, 2006; Yardley, Mason and Watson, 2009).

Four kinship carers' stories indicate the theme of complexity evident in kinship placements (e.g. complicated family dynamics, court interventions, poor health, increasing age, low income) and likely risks to placement stability. The first carer, a single aunt, was 'given' her sister's baby (aged 6 months) as the mother (single parent) could not care for the child. The aunt has a Family Court *Parenting Order* for the child. Some ten years into the niece's placement the carer was asked to take two of four grandchildren needing care, due to her daughter's substance abuse problems. At the time no order was made for these children. After seven months, the two children returned to the birth mother who then moved interstate. Within a short period, the children were removed again from the mother's care and placed back with the grandmother. The grandmother was given a 12 month local court order from the state where the mother resided. Six years later, no court order has been made in the jurisdiction (NSW) where the children now reside. The grandmother would like legal custody of the two primary school-aged children as she said:

There comes a time when we have to consider what happens ...if anything happens to me ... who do I give the children to? I can't make a will out and put down that I want the children to go to my other daughter because I've got no legal right to put that on paper. Now, I'm nearly 56, my health has been a bit of an issue recently. So I said, "I need to think about the future."

The carer, who has children's mother's agreement, plans to ask her solicitor to 'get something in writing ...because I can't make final decisions about the children'.

The second single carer, now in her mid-sixties, had a 6 week old grandchild (now 16 years) placed by the department. Some years later, two half-siblings of the first child were also placed with the grandmother. Eighteen months into the siblings placement the grandmother required hospitalisation and the two half-siblings were placed in foster care. The elder grandchild stayed with a neighbour till the grandmother returned home. The half-siblings were moved from foster care and placed with their Aboriginal

father (separated from the mother, non-Aboriginal). The grandmother was unsuccessful in applying to the Children's Court for custody of the two grandchildren (legal costs \$9,000). The grandmother was told her application was unsuccessful because of her health and age:

Because of my health and they said I'm too old. I must have been in my late fifties. Plus my health; they played on that, plus he's Aboriginal, the father of the other two little ones ... they prefer them [grandchildren] to be with the Aboriginal community.

The siblings have contact once a month and the grandmother rings them once a week.

In the third instance two grandchildren we placed with their grandparents and when a third sibling was born the grandparents, now in their 60s, were reluctant to take the baby. The grandmother said she thought they were too old but when the baby was placed in foster care she thought:

I can't do this. I can't split these kids up. They'll never forgive me. I want to bring them up as a family. So we rang DoCS and said, "Look, we'll take the baby."⁵

Twelve months of court proceedings lead to the grandparents having PR for the three children long-term (till 18 years of age).

The fourth carer, a grandmother, had a grandchild placed by the department. Initially the grandmother and an aunt on the child's father side had a shared custody arrangement. Over a two-year period local courts and the Federal Magistrates' courts were involved over issues related to the birth parents (substance abuse & domestic violence) and also with extended family members over custody arrangements for the child. To date the grandparents have spent over \$50,000 on solicitor's fees and are applying for a *Parenting Order* through the Family Court. If this order is appealed by the birth parents the grandmother said further legal costs will leave them with no cash savings.

Aboriginal kinship families: The eight Aboriginal kinship carers had equally complicated family stories. Compared to their non-Aboriginal counterparts however, carers were more likely to have larger numbers of birth children. For example, one carer had two children, three had three, three had five and one carer had seven birth children. In comparison, the non-Aboriginal carers' birth children's numbers ranged from five carers with two, six with three, and one carer with four birth children. Three of the stories indicate that having larger numbers of birth children (some independent young adults), while impacting of family relationships, did not appear to impinge on the capacity of Aboriginal carers to take related children into their care.

⁵ DoCS (NSW, Department of Community Services) is now FaCS (NSW Family and Community Services). Most interviewed carers referred to the department as DoCS and for ease of discussion this acronym has been left in the carer quotes.

One Aboriginal carer couple with three adult birth children, caring for four grandchildren, spoke of the department's concern when the fourth grandchild was placed sometime after the other children. Initially the agency was concerned that placing a fourth child would place too much stress on the couple, but agreed to a 'temporary' placement with the couple until another carer was found. The grandparents, wanting to keep the siblings together, were not happy with this arrangement. The agency arranged for an 'independent psychologist' to assess the family situation to ensure: 'it wasn't too much strain on us having the fourth child' said the grandmother. The placement was approved and the four grandchildren are in the long-term care of their grandparents.

The second carer (single), with five birth children all living at home, received a call from her sister, living in another state, asking if she could take two of her nieces' children. The carer after discussion with her children agreed to take the two children. It took over 12 months for the children to be transferred into the care of their great-aunt due, said the great-aunt, to a lack of 'communication' between the agencies, staff turnover and 'lost' paper work. In the intervening period (12 months) the children were placed with a non-Indigenous carer and after pressure on the agency by the great aunt arrangements were made for her to 'pick up' the children. The two children have been with the carer for nine years.

The third story is of a single carer, with three birth children, who over time has had two grandchildren and then a great-grandchild placed with her. The department had been involved with the carer's family for some time when the two young grandchildren were placed. When the eldest grandchild was a teenager (14 yrs) he became a father and the young couple (grandson, partner and baby) lived with the grandmother for four years, till they separated. The grandson (now 18 yrs) and his child (4 yrs) (carer's great-grandson) continue to live with the carer.

Summary: Some foster placements were not well planned and appeared to rely on the availability of a 'bed' as the driving force in the placement. Foster carers taking on placements, outside of what they had agreed to, highlights agencies' difficulties in finding enough carers to provide different types of care, as well as the possible mismatching of carer to child, due to a small pool of available carers. For other carers, despite extensive delays in final court orders, attachments which had developed between child/carers were sustained. While these carers' stories indicate a positive response to final court decisions by keeping foster children with them, it cannot be assumed that this will happen in all situations.

For some kinship placements there also appeared to be little planning around finding the most 'appropriate' family member to care. In situations where an agency was involved with a placement only two carers mentioned other family members being involved in a decision around who was best placed to care for the child. For kinship carers, the situation with court orders was similar but different. Delays in orders; no orders being made; and costs incurred in taking matters to court for failed applications, appeared stressful to carers.

Supporting literature: While not an issue with this sample of carers the importance of 'good' matching of foster carer to child, in relation to stability, has been highlighted in a number of studies. Similarly, Family Group Conferencing is seen as the preferred

option when ascertaining the most appropriate person to care for a child in kinship care (Brouwer, 2009; Cashmore, 2000; McHugh, et al., 2004; McHugh 2009; Smyth and Eardley, 2008). The importance of carer commitment to children in their care, found in this study, is supported by research, with one study with foster carers ($n=50$) indicating:

Foster parents' attitudes related to the care of their foster children play a critical role in their capacity to provide foster children with a placement experience that is stable and nurturing. Several factors were identified which are central to the foster parenting role, the most robust of which was foster parents' attachment/commitment to their children. (Harden et al., 2008: 890)

2.3 Practical consequences for families taking on foster/kinship care.

For foster and kinship care the beginning of a placement is a critical period where children's and carers' needs for resources (e.g. household goods and services and items for children) can be high. Changes to carers' housing (e.g. refurbishment, renovations, etc), the purchase of additional household items (beds, wardrobes, etc), and/or vehicles are often necessary when statutory foster/kinship children are placed. NSW FaCS, in addition to providing carers with an allowance, may assist carers with establishment costs of placements.⁶

Foster families: For six of the 13 foster carers financial assistance was received, for refurbishment or furniture items, for their current foster children. Other carers, some with 'spare' bedrooms, did not ask for establishment costs while some carers preferred to make their own arrangements, either for renovations or when purchasing larger vehicles. One couple, with three of six siblings, required a larger vehicle, to transport the six, as they frequently spend time together. They asked the department for financial assistance with the vehicle's costs, but were refused.

For some carers, particularly those with children with high and complex needs, extra funding that assists with placement stability, is provided. For one carer, whose foster child is wheel chair bound, extensions to the house have been carried out to accommodate the teenager's needs. Over the 11 years the child has been with the carer the department has purchased a special purpose vehicle and electric wheelchair to assist the child and carer. PADP (Physical Aids for the Disabled) has met other requirements of the child.

Kinship families: Compared to the foster carers, many kinship carers when children were placed were unaware of, or were told they were not entitled to receive, additional financial support from the department. Sixteen of the 20 carers received no additional financial support for refurbishments, or additional household items, when

⁶ For short to medium term placements, a payment of up to \$350 can be made for items identified in the first two weeks of the placement based on the child or young person's needs. For longer term placement, up to \$1,400 is available for approved items (NSW FaCS, 2012).

related children were placed. A few carers said they did not require assistance as they had available space and spare furniture.

A lack of financial resources and a lack of knowledge about what support was available for carers negatively impacted on some kinship carers. One younger carer couple (with two young birth children at the time) moved after taking on related children. The couple, in a two-bed townhouse, converted the garage into a bedroom/rumpus room, when the first related child was placed. When the child's sibling was placed the couple sold and bought a larger house with additional bedrooms, and upgraded their vehicle to a seven seater. The carer said the family received no financial assistance from the department to assist with rehousing or vehicle costs.

In another instance, when a single grandmother, in her early sixties, had two grandchildren placed, she had bedroom furniture, but little else. When the grandmother approached the department for assistance for additional furniture she was told she was not entitled to any funding, as the children were a voluntary placement. When she joined a support group the carer found out about organisations that could have helped. At the time she felt she had no choice, but to use her savings:

This is probably what you find with a lot of our generation when you speak to us ... your pride gets in the way sometimes and you think: 'Oh, I'm not going to go through that, I'll just do it, use the savings and we'll just do what we have to do'.

A single grandparent, who agreed to take two grandchildren, living in another state, explained how delays in processing the children's documentation by child protection workers was stressful and costly. She did not receive any support, because the 'paperwork' was not processed in a timely fashion:

They flew them up with an officer ... she came and checked the place out. She gave them to me and then she left. All they came with was the clothes they were wearing and a little bag with jammies in it. I didn't even have nappies, bottles, nothing. They didn't even offer. I had to go second-hand shopping looking for a cot, another bed. I went to [charity] and they helped me with furniture as well. I didn't go to DoCS because it was still to do with [name of other state]. They [DoCS] couldn't help me at all because it wasn't their case yet. *They didn't have the paperwork?* No.

For two carers the department provided children with beds and wardrobes. A third couple received no financial assistance when renovating from a three to a five-bed house to accommodate two grandchildren. When a third child (a sibling) was placed the caseworker provided a 'refurbishment payment', which surprised the grandmother:

When she told me, in fact, she gave me a copy of all the things I was entitled to, I was dumbfounded to find I was entitled to money for refurbishing.

After discussion with the department the grandmother received additional payments for all three children. An Aboriginal carer couple who, over a period of time, had four grandchildren placed, were also provided with ‘establishment money’ to purchase beds and bedding for the children. The grandmother said:

We were quite happy, like we went to a grandparents support group and there were some horror stories about other people not being able to get any help through DoCS, so we were lucky I think.

Summary: When it came to gaining additional financial assistance to support the initial placement, kinship carers appeared to have fared less well than foster carers. Support offered to some kinship families by workers appeared to be provided on an ‘ad hoc’ basis, and being ‘lucky’ in receiving required additional financial assistance does not auger well for coherency in OOHC policy and practice. Such an approach exacerbates the stress and strain for kinship carers at the beginning of a placement and is not conducive to assisting with stability.

Supporting literature: Though it was not provided to some kinship carers in this study, research indicates that substantial support is critical in the first six months of placements, as this is a particularly vulnerable period for children and carers. Studies indicate that all carers need caseworker support in building ‘positive’ relationships with children, with kinship carers requiring information on how to access appropriate services and support and who to contact when help is required (McHugh et al., 2004; McHugh, 2009; Selwyn, 2010; Valentine et al., 2013; Yardley, Mason and Watson, 2009; Wulczyne et al., 2003).

2.4 Impact on family relationships for foster/kinship carers

Foster families: Foster and kinship carers were asked if being a carer had impacted on their relationships with family and others. Ten of the 13 foster carers said that their relationships were the same or better. Two of the ten carers said fostering had brought the family/couple closer together with one younger mother, with a long-term placement of two siblings, explaining the benefits to the couple’s extended families:

Both parent’s sides were very excited to welcome two little kids into the family, and all we hear is that they don’t see them enough!

Two foster carers spoke of their own adult birth children being concerned at first, but after getting to know the foster children, were much more accepting. When asked why the children were initially unhappy one carer said:

‘Other’ children were going to be taking up my time so I’d be doing stuff with the foster children rather than with them.

Two carers mentioned married daughters appeared jealous when they began fostering and when one of the carers was asked to stop fostering, to help care for the daughter’s child, she said: ‘no, this is our life’. In another situation, from time to time, a carer’s husband takes their elder teenage son, who does not ‘get on’ with the fostered children, away to ‘keep the peace’ in the family.

Non-Aboriginal kinship families: Stress and strain in family relationships/circumstances was an evident theme for kinship families. The impact of providing care for related children was, compared to foster carers, of a different order for kinship carers (Aboriginal and non-Aboriginal).

Four non-Aboriginal carers stated that there had been no major issues in family relationships since taking on the care of related children. For eight non-Aboriginal carers, the capacity to provide stable care was hindered by changed family circumstances, relationships and their changed identity.

A single grandmother, whose husband died shortly after two grandchildren were placed, said:

I've got to admit that for about six months I ran on autopilot. I didn't think, didn't grieve, just did what I had to do for the kids, fed them, clothed them, gave them a hug if they needed a hug but that was about it, I couldn't cope.

When asked how she managed to maintain the placement, she said it was due to her family and neighbours: 'I've got a very good support system there'. Another carer, with two grandchildren and a niece, stated that her husband had been supportive of the first placement (their niece). Shortly before the two granddaughters were placed the marital relationship broke down, and the grandfather left the home and family.

Another grandmother who was granted custody of her grandson divorced her husband. She explained why:

My husband was a violent man. *Towards you?* Yeah, so I divorced him not long ... I think [baby] was about the 20 month at the time I got custody. *Were you fearful about what might happen to the child?* Well, I didn't want him ending up like him.

One grandfather carer, in his mid-seventies, said that taking on the care of two grandsons had a 'devastating effect' on the couple:

I was deliriously happy at being grandad and I stopped being the grandad – I lost the grandchildren and became a parent again and I didn't want that. We were retired, but suddenly there are two children living in the house with you. Suddenly you've got to get up at 7 in the morning and make breakfast; you've got to be around when the boys come home from school. There's washing and ironing and cleaning and shopping and ... suddenly you realise that you're not 23 anymore. It becomes hard work whereas in the past when the kids came to stay it was play time.

The grandfather, with some sadness, remembered a conversation, where a comment made to the placed grandsons by another grandchild, was overheard: 'When grandad and grandma became your mum and dad, we all lost our grandma and grandad; because they don't come and see us anymore'.

A grandmother in her mid-fifties, caring for three grandchildren, said the impact of the placement on her family was 'huge. She had spoken with her husband at length before the children were placed, as she 'knew' it would happen one day. She said to her husband: 'This is going to be a hard road ...a really hard road':

There's times when he could walk ... I can see it. When they first come to us and he didn't understand why the anger was there. The frustrating part about it is that we *were* grandparents. Then we were given these children and all these rules which I can understand have to be put in place and you've got to tick the boxes, but all at once your fears are, "If I don't do the right thing DoCS will come and take them from me too." *Were you worried about that?* Totally, because their father didn't make it very easy ... nor did their real mum.

Another grandmother, in her mid-seventies, said after the three children were placed over a decade ago, she was not sure how she managed:

When I look back I really don't know how I did it. I think you just get out of bed and you do it. If you stop to think about it you probably wouldn't. It was difficult because two of the kids had a lot of problems.

The grandmother said her husband (grandfather) struggled to come to terms with his daughter's substance abuse issues:

He never coped with it real well. Even now ... I don't think our relationship's as good as it was before all this happened.

A younger couple (wife, a cousin of the placed child) with two pre-school children, said they were very clear on how they were going to handle the situation when the child was placed. The wife (pregnant at the time) said that while they both agreed on the placement, they did not try to influence one another: 'If we felt that we couldn't do it then that was it'. Fortunately the carer's husband got on very well with his wife's young cousin and the wife said this was very important in relation to the stability of the placement

It wouldn't have happened if they didn't. I think perseverance was the really big thing because it took us a long time to accept that [child] was a part of our family and that - he wasn't taking anything away from our children and our relationship with our children. It was a really hard time with having a baby ... because we were going through court at the same time. And [cousin] was really bad at that time. [husband] was having to leave work to go and pick him up from school because the school had called the police. It was kind of like, "What are we doing this for? He doesn't care, he's not going to change," sort of thing. It was a really hard time.

Was there a point where you and your husband said, "We can't do this anymore?" Yeah, absolutely, almost on a weekly basis.

How did you get through these crisis periods? Well, I think a couple of time we went, 'Okay, fine. Let's not do it.' We would say to one another: 'You have to tell him that he can't live with us anymore.' How do you this to a 12 year old who hasn't done anything wrong?

Aboriginal kinship families: The eight Aboriginal kinship carers had similar experiences, though the data analysis appears to indicate that having larger numbers of birth children and, as a consequence, larger numbers of grandchildren, exacerbated the impact on family relationships. One grandmother of four grandchildren in her care experienced a 'mixed' impact. She said that even though it's stressful, their new caring role had brought her husband and herself closer together. She felt however, that sometimes her older son was 'a bit jealous'. Similarly a grandmother of five birth children, who took on the care of her grandson, said he was readily accepted into the family. However issues arose among the other grandchildren, when a nephew was placed with their grandmother. While issues between the children have settled the carer appeared concerned by ongoing relationship dynamics:

It all takes time and they're sort of OK, they know how it's all set up. It may sound like I know what I'm doing, but most times it's just not as good as it sounds. *Not quite as straightforward as you'd like to think?* No, no.

Another single grandmother, with five birth children, three of whom were teenagers living at home, said when the two grandchildren were placed:

It's been hard, really, really hard on them. But I try and make it easy for them. I reassure my kids, if you help me, then I'll help you and then we can get through this, so we're all together.

A single grandmother caring for her older grandson for a decade and a half noted that the placement of a young great-grandson:

Caused a little bit of 'disruption' for the want of better words, because of the fact that [great grandson] does have a disability which I've been trying to get [grandson] to understand.

One grandmother, in her late forties, took on the care of her two grandchildren. The two children were not the biological children of her husband. Initially the placement brought the couple closer together, but having young children meant the grandmother stopped going out to clubs with her husband. After a while, when she realised that he was drinking heavily and she had stopped completely, she said sadly: 'you know there's nothing worse than being sober with a drunk'. The grandmother also continued to support the children's birth parents, even though as she said: 'it was hard ... the early days were really, really bad'. The stress and strain on the couple's relationship however, led to the breakdown of the marriage.

The marriage breakdown of a grandparent couple's child resulted in their son returning home with two of his four young children. The grandmother, already caring for three nephews/nieces at the time, said her four adult birth children were concerned for her well-being. The carer's greatest worry is that her other grandchildren have

missed out on seeing their grandparents. She said: 'That has impacted on them absolutely horrendously and I feel very, very, very guilty about that'. The carer went on to explain that:

When you've got kids that have got behavioural problems and one has absolutely enormous behavioural problems; they [birth children] don't really want their kids mixing with that. I think sometimes they worry about my wellbeing more than anything and, as I said, there's been some times where they sort of felt a bit left out or they feel that their kids are being left out. *You're conscious of that?* Oh, I'm super conscious of that but what can I do? What can I do? I say to them, "Well, what do you want me to do? Tell me what you want me to do. Tell me what you think I can do" and nobody can give me an answer.

Summary: In relation to carer families, relationship dynamics appear to have a highly negative impact on Aboriginal families, with risks to stability of the placements. It is suggested that this is due, in no small part, to Aboriginal parents having to 'negotiate' relationships with greater numbers of birth children, grandchildren and great-grandchildren.

While the stress and strain brought on by placements affected many carers, the emotional intensity for kinship families appeared to be of a higher order than for foster carers. This may, in part, be due to the 'unplanned' nature of many placements and a lack of carer understanding of what will eventuate, once the children are in their care. It may also reflect a lack of training or preparation for kinship carers and other family members. In policy terms, the fact that kinship carers are 'related' to the child, appears to be a reason (if not an excuse) for agencies not providing carer families with access to counselling, support and /or training/education, to enable them to work through family relationship issues.

Supporting literature: A Queensland study with foster (n=61) and informal kinship carers (n=53) found grandparent carers, compared with foster carers, experienced considerably more stress in their caring role with grandparents receiving significantly less emotional and practical support (Harnett, Dawe and Russell, 2012). Argent (2009) indicated the types of tensions arising between family members when children are placed with kin. Conflicts, rivalries, resentments, blaming and shaming are not uncommon among family members when kinship placements occur. One UK study found that twice as many kinship carers (16%), compared to foster carers (7%), stating that they received no support from their immediate family, with data confirming a high degree of tension and conflict, and for some kinship carers, outright hostility (Sykes et al., 2002). Findings from another UK study indicated that kinship carers valued social work support 'and wanted more, not less, contact with social services, to talk through family and relationship issues, especially about internal family relationship matters'. (Broad, 2001: 39-40).

Several studies, with African-American grandparents parenting again, whose socio-economic circumstances and cultural values around the importance of 'family' are similar to Australian Aboriginal grandparents, found grandparents experienced significant levels of stress when they did not have appropriate family supports

(Brown, Cohon and Wheeler, 2002). A related study, with Kenyan grandmothers of grandchildren, found emotional/social support from friends, family, and professional helpers moderated grandparents stress, enhanced self-esteem and increased grandparents' positive appraisal of stressful situations (Oburu & Palmerus, 2005).

2.5 Labour force status of foster/kinship carers

The presence of dependent children had a significant impact on carers' working lives reducing the amount of income previously coming into the household.

Foster families: Many foster carers experienced difficulty in maintaining their labour force status once they began fostering or having their own children. Having young dependent children resulted in two carers giving up paid work prior to fostering. For the other eleven carers a variety of circumstances led to a change in labour force status.

Seven of the carers were in carer couples. For one carer, her husband's longer working hours and inability for the couple to: 'get things done; see each other; give the foster child 'extra' attention and things like that' led to her giving up paid work. The carer, with three foster children, noted that it was hard for her to give up her job as she had 'always worked'. Another carer, who had worked from home two days a week as a hairdresser, gave up that job due to the demands of fostering. She now works around 15 hours a week in her husband's business. Similarly, another carer with two foster children, works from home as the administrative officer for the family farm. Previously, she had been a family day care worker, but found the increasing 'rules and regulations' and increasing 'paper work' had changed the nature of the job. As she needed more permanent hours, another carer who previously worked as a casual teacher's aide, took on a part-time shop assistant role.

Two same sex couples changed work schedules and/or jobs, to enable one carer in the couple, to be available during the day for the foster children. One of the interviewed carers said that the first 12 months of the placement was very difficult for them:

But we weathered that and we knew that we were doing the right thing for us and for the kids and for the family as a unit, and managed that adjustment. And this year things have been a little bit easier, we're not having to work as hard, we're on top of things.

After becoming a foster carer one single carer changed from office work to working from home, allowing her to work on the days when the two pre-school age children are in day care:

I think the turning point for the three of us definitely has been me leaving work. I think the timing of that was great and we're calmer, we're happier; it's just a nicer environment.

An older single carer, with a teenage foster child with severe disabilities, retired when it became too difficult combining fostering with her role as a hospital unit manager. Her retirement, occurring five years earlier than planned, meant her weekly super payments were lower than anticipated. Only one carer, with one fostered child,

maintained her job in an early childhood centre with the foster child attending the centre where she worked.

Kinship families: Similar to foster carers, some kinship carers had difficulty maintaining paid employment when related children were placed. Ten kinship carers had already retired, or were not in employment, when children were placed. Five carers gave up work due to caring responsibilities. The aunt, in one carer couple (in their early thirties) with two birth children, found it difficult to maintain her job (personal trainer) when a nephew was placed; when the second nephew was placed six months later, she found paid work 'just impossible'.

Prior to taking her grandchild, a second carer, a married grandmother (in her mid-forties) had a full-time professional position. With 'a very traumatised little girl' the grandmother resigned her position because it was too difficult to provide care for the child and go to work. Similarly, an Aboriginal single carer (great, great aunty to two children in her care), with five birth children, gave up full-time work and study when the two were placed. She said: 'I was really pissed off with that. I gave up my life and my job. I gave up everything'. Explaining why she left her job, she said:

It didn't work, because I was getting phone calls from the teachers, he's done this, he's done that, he's up on the roof there. He's throwing things, he's smashing things. I thought what's going on here. I tried part time and that's when I was doing the course and it didn't work. I gave up my job to look after the two kids.

Another single grandmother gave up paid work when her grandson was placed. The carer, in her mid-fifties at the time, had a part time position (night shift). When asked how she felt about leaving her position she said: 'You just have to ... I was enjoying my work'. A carer couple (in their mid-fifties), both receiving income support, and caring for four grandchildren, said: 'we both would have been happy to keep working and just have our lives but we've decided that the children need us'. The couple, working when the first two grandchildren were placed had a third and then fourth grandchild placed with them. The grandmother took 12 months leave from her position; then the grandfather took redundancy and became the 'house husband', while his wife went back to work. The grandmother got a job closer to home but after three years had to leave to help care for the four grandchildren.

Five carers continued working after children were placed. One young married carer (late twenties), pregnant with her second child was working part-time, when her cousin was placed. The carer returned to part-time work after maternity leave and continues working. A single grandmother, now in her early seventies, had a paper run which she continued doing when her grandson was placed in her care, many years ago. She said

It wasn't very much paid employment but I did work. *You didn't have to give up your job to care for [name]*? No, no, I worked around him. When he was young he used to come with me.

For an Aboriginal carer couple in their early fifties, the wife went to work when the related child started school. After a second younger child, a nephew, was placed with

the couple, the couple had to ‘juggle’ work times to be home when the bus arrived from child care. A single Aboriginal grandmother in her mid sixties, with two related children in her care, is on a *Carer Support Pension* and works casually as a research assistant. The fifth carer, a single Aboriginal carer of two related children, said that though at times it was a struggle to work and care, she had good work colleagues and counselling to help her get through:

Sometimes you get really tired and you just want to lie in bed and sometimes I don’t want to get up for work. But, you know, you have to do it because the bills aren’t going to be paid ... and work’s been my saviour. I work with a really good group of people so they’ve been very supportive, plus I use the *Women in Counselling Program* as well. They will pay for six sessions for counselling support.

Summary: In the group of foster/kinship carers, maintaining paid work whilst caring for children was, or became too difficult, to maintain. Some foster carers were ‘flexible’ in finding other paid work that ‘fitted’ with their caring role. Seeing children as their first priority reflected a commitment and recognition by foster and kinship carers, that in keeping placements stable, they needed to ‘be there’ for children. A consequence for many unemployed carers, particularly single carers, results in a reliance on income support. Without the state government allowance many, particularly kinship carers, would struggle and undoubtedly, some with limited financial resources would be unable to meet children’s needs. Other implications for carer families’ non-participation in labour market work are loss of superannuation, and other entitlements such as holiday, sick or long service leave.

Supporting material: A UK study with kinship carers (n=493) found only one in eight carers continued to work as before with a third of carers (34%) giving up work permanently and four percent giving up temporarily (Aziz, Roth, & Lindley, 2012). A survey with kinship carers (n=1800) in the UK found almost half of employed kinship carers gave up work when children were placed and three in 10 reduced their hours (Gautier and Wellard, 2012). An Australian study with kinship carers (n= 332) found just on a third (29.5 per cent) reporting a change in both their and their partner’s hours of work, with most working less, or not at all (Brenan et al., 2013).

2.6 Contact arrangements in foster/kinship families

Foster families: All foster children of 11 interviewed foster carers had various contact arrangements with birth parent/s, siblings and/or other extended family members. For some children the contact was ‘court-ordered supervised parental contact’ several times a year. For others it was irregular, informal contact with one or both birth parents, organised by the carers. Six of the 11 foster carers interacted with fostered children’s birth parents and/or other family members, with birth family coming to a carer’s home, or meeting together in a ‘neutral’ setting.

In the sample it was not unusual for fostered children to have a sibling (or siblings) with another carer (foster or kinship). Where it was geographically feasible, contact was organised by carers to enable siblings groups to spend time together. For example, the two foster children of one carer have two older siblings placed elsewhere. The four siblings, all in long-term placements, are ‘close’ and the carers

arrange visits on an irregular monthly visits. All four siblings have contact with the parents (separated) four times a year. The interviewed foster carer of two of the four children stated, that the parent's contact worked well, as not seeing them more often, meant visits were not 'overly disruptive'.

Most, but not all carers spoke of contact with family members being beneficial, with children enjoying visits and having good relationships with various family members. In one situation, six siblings in long-term care, placed with two foster families, have regular contact together. Parental contact occurs one day a month with phone contact between visits. The interviewed carer of three of the siblings thought the parental contact was too frequent, but said it was necessary, as the birth father gave the department a 'hard time' if the children did not ring on a regular basis. When asked why she was not in favour of the frequent contact she said:

It's just too much all the time. When they first came to us, they had a couple of months where they didn't have contact and that meant they could settle down and begin their lives again without the pressure of seeing people that had hurt them.

Only two fostered children had no contact with one of their parents due to the parent's mental illness. For another two children, a birth parent had died since they had been placed in care. One of the children, whose father died, has ongoing contact with a maternal grandmother, but not 'officially' with her mother. The carer however, 'knows' that the mother sees the child on weekends when the child stays at the grandmother's home. The foster carer appreciated the grandmother's difficulties in enforcing boundaries around contact. She said:

I can totally see because ... this is *my place*. When you're related that place is *their place* and I can see why it's so hard for this grandma to say I want to have my granddaughter, which means you can't come around and then ... *And then she has to choose between her birth child and her grandchild?* Nobody can.

Blended families complicated some children's lives making contact difficult. One carer spoke of a fostered child's contact arrangement of monthly supervised visits with birth parents, and irregular contact with half-siblings (a brother and sister). The three siblings were all placed in care at the same time with the child's half-siblings placed with their birth father, living in another state. The youngest child (5 years of age at the time) was placed in foster care. Many years later the child, now a teenager, has resumed regular contact with her older half-brother and has irregular contact with the older half-sister in another state. The carer spoke of the trauma suffered by the young child:

Not only did she lose her parents she lost her siblings ... the siblings always protected her ... she's got a very close bond with her [half] brother and her sister.

Kinship families: Contact arrangements for 41 children in kinship placements were highly varied. Only three kinship carers mentioned that contact was court-ordered, though it appeared that five children were having regular supervised visits with one or

other birth parent, which may have been court-ordered. Two children had no contact with their birth mothers and eight children had no contact with either a birth or step-father. One child had no contact with either his mother or father.

The father of three grandchildren had died whilst they were in the care of their grandparents. Eleven children's contact with one or both birth parents was either 'spasmodic' or 'irregular'. Two children had no personal contact with their birth mother (living in another state) but received regular phone calls, cards and presents.

Contact for other children in kinship placements was often by phone with birth parents and occasional visits in school holidays. Some children spent weekends with a parent and/or half siblings on a regular basis. Mention was made of seven children having ongoing contact either with half-siblings; siblings in the care of another carer or with their other grandparents.

Contact and setting boundaries for some birthparents, was not as straightforward for kinship as for foster carers. Difficulties in setting boundaries and supervising contact were noted by a grandmother, who said:

I couldn't keep doing this when her parents were dropping in and coming around. That's when I had trouble. Relative and kinship carers need an awful lot more help with people that will do contact. I have to supervise them. I would love somebody else to do it.

Summary: Personal contact with birth parents and other family members occurred for many foster and kin children. Contact, with one or other parent, appeared less likely for some children in kinship carer compared to those in foster care, with contact for 11 children in kinship care being 'spasmodic' or 'irregular' and eight children having no contact with their birth/step father. This, in part, may be due to some children in the sample having spent many years in care and over time ties to birth parents may have weakened, or young people may have chosen to have less contact. Whether kinship carers influence, or pressure, children not to see one or other parent cannot be dismissed. Also it may be assumed that when kinship placements are unsupervised by agencies, no 'pressure' is applied to kin to maintain ongoing contact, and no assistance or supervision is offered to families to ensure contact occurs. Little mention, except for one carer (see above), was made about 'problematic' contact. This may be due to the longevity of some kinship placements where contact issues have been resolved over time.

Supporting literature: Reasons suggested in the summary above, may have been influential in relation to unproblematic contact/access visits, which is of interest, as research indicates that contact with birth parents, particularly where there is conflict, is one of the most problematic aspects of kinship care and can contribute to the poorer health of grandmothers (Falconnier et al., 2010; Goodman, et al., 2008; McHugh, 2009). A Spanish study with young people (n=67) aged 18-28 years who had lived in kinship arrangements (predominantly with grandparents) found low frequency of contact with birth family and concluded: 'This finding coincides with those of other national studies reflecting the scarce importance given to support and follow-up for kinship care' (del Valle et al., 2011). The Spanish study supports the findings from this study.

For children in foster care Barnardos (2012:1-2) suggests that ‘unrealistic contact regimes can jeopardise children’s chance for a stable placement’ and for children in long-term care: ‘contact must be designed so that it does not interfere with the child developing attachments to the new family’.

2.7 Support for foster/kinship families

Financial Support

Foster families and a Carer Allowance: Eleven of the 13 with foster children currently in their care were receiving an allowance. Carers discussed the importance of the financial assistance they received for fostering. Seven of the 11 foster carers stated the allowance was very important and without it, they would have been unable to foster. Carers receiving the Commonwealth benefit FTB A and/or B also said that this money was useful in helping to meet children’s needs.

For a carer couple, with two birth children and five foster children, the allowance was hugely important: ‘We couldn’t manage without the allowances. There’s never enough’. For one same sex couple the allowance allowed them to balance their budget without only one of the couple having to work full time: ‘It allowed us to have [carer name] to become the full time carer, to spend that first 12 months bonding and attaching’. Two mothers who had given up their full-time work commented on the benefits of doing so. One said: ‘I’m at home now and it’s a happy environment. I think you can ‘give’, by knowing that there’s that money (i.e. carer allowance) there to help you along’. The other foster mother noted that when she worked full-time it was much easier financially. The allowance had been used for children’s holiday costs and to buy them ‘special things’. One reason this carer left he paid work was because of the youngest foster child. She said: It’s more important that we have that allowance, to make sure that everything is running smoothly’.

Two carers used the allowance for fostered children’s child care costs, before and after school care costs, and vacation care costs. Another carer of two pre-school age children was ‘saving’ the allowance for the children’s private school education, saying: ‘the most important things is to give them the best education they can have’.

Although the eleven foster carers said that overall, they were managing financially, three were concerned about the future, in relation to their finances. Two with teenage foster children said that they were concerned about the changes to the allowance for teenagers and how difficult it would be to manage once the teenagers has access to their own allowance.⁷ One carer on a reduced allowance, whose 16 year old foster child received a Commonwealth benefit, said that they were debating who would be

⁷ Carers with young people in care who turn 16 receive a reduced CA payment as young people in this age category may be eligible, if they leave school, for a Commonwealth benefit in their own right. Carers of young people who continue with school/training however are entitled to receive an additional payment (Teenage Education Payment (TEP)) of similar value to the Commonwealth benefit. TEP is classified as an additional allowance for carers to assist the carer to keep the young person in school or training.

responsible for meeting certain costs. Another carer, planning to adopt one of her fostered children and aware that the levels of adoption allowance⁸ had been cut, said:

Well it's scary knowing that I've just given up work and with the new adoption policy coming in to know that that \$400 (i.e. carer allowance) was my 'pay' to stay at home with [child's name].

The carer went on to say that if another foster child was not placed with her after the adoption, she may have to find paid work, to assist with family finances.

Kinship families and Supported Care Allowance: Sixteen kinship carers received a allowance. All were managing financially but said that without the money they would have been unlikely to cope. A single grandmother carer, caring for a grandchild for 14 years, had a great-grandchild placed with her four years ago. It was only two years ago, when speaking with a worker from the *Aboriginal Medical Service (AMS)*, about the disabilities and issues with her great-grandchild, that she was informed that she was entitled to an allowance. The grandmother, reliant on income support payments *Parenting Payment*⁹ and FTB said: 'I was really struggling ... it took a while to come through, but when it did, it made a huge difference'.

Due to a lack of information about entitlement to the carer allowance, when children were placed, not all carers received financial assistance. One grandmother who cared for both a niece (for 16 years) and two grandchildren (for 6 years) said:

I never ever knew for 12 years that I could get help for looking after my niece. It wasn't until I got involved with the grandparents [group] and [name] said, "You should be getting payments for [niece]. So when they come out to check the girls [the grandchildren] you need to introduce them to [niece]" So I did and then they [FaCS] told me that I should have been having payments right from the start.

One carer, who late in the child's placement found she was entitled to an allowance said:

Oh, wow, so good! All our savings had gone by that time and when you start having to pay \$120 half hour sessions (e.g. counselling) and then we had to take her to private tutoring, we got nothing for it, school fees, clothe her, feed her. The first year at high school, the school fees were nearly \$7,000. It was a lot of money to find.

When asked the importance of the allowance, a younger married carer (3 birth children) of two nephews replied: 'We couldn't survive without it'. When asked if she

⁸ From January 1, 2012, the Post-Adoption Allowance of around \$16,000, provided to foster parents who adopted a child in their care, was reduced to an annual payment of \$1,500.

⁹ *Parenting Payment* is a Commonwealth benefit provided to parents, grandparents, or foster carers if they are single and care for a child aged less than eight (or have a partner and care for a child aged less than six) and also the recipient/s' income and assets are below certain amounts.

had any issues in accessing the payments she responded: ‘Getting it set up was really hard and a really long process. I was made to feel I was ‘dirt’ for even asking for it’. The carer expressed concern that she may lose the payments for one child as his annual review has not been completed by the department:

That’s why I was ringing DoCS to find out about it because I was told if we don’t get the review done, then payments stop.

Six carers were concerned about their future financial position with three worried that the allowance might be cut. One older Aboriginal grandmother stated:

Well I think without it, if that money was ever to stop, I’m not saying I wouldn’t be able to keep him, because money is not everything, but it’d be a struggle ... just on a pension ...

A younger carer of two school aged children concerned at any proposed changes to the current policy said: ‘They might decide to stop our care allowance. That would cause a major problem with us’. Another grandmother said:

I’m a bit worried that they might start cutting out the DoCS payments, or cutting them down, or taking them off kinship carers, you know, things like that, I’m worried all those sorts of things could happen.

Summary: For both foster and kinship carers the provision of financial support by way of carer allowances were very important. Many kinship carers had little or no knowledge of entitlement to financial support until someone, often outside the department, brought it to their attention. Concern was expressed by both groups of carers, to recent changes, proposed changes to entitlement to allowances, with the removal of allowances all together for some kinship carers.¹⁰ If these changes occurred the prospect of managing financially was daunting to carers and for those on low incomes, likely to threaten placement stability.

Supporting literature: Financial support for carers is critical for placement stability. Barnardos (2012:2) suggests that in relation to foster care: ‘payment directly affects the number of people coming forward to care and also keeps the incentive to keep caring and keep placements stable’.

The importance of ongoing financial support for all carers, but particularly kinship carers, cannot be overemphasised. In the US research on the stability of kinship placements, classified as *Subsidised Guardianship* (families receive a financial subsidy to aid in the child’s upbringing), suggests that when ongoing financial

¹⁰ The 2012 FACS’s Discussion Paper (*‘Child protection: Legislative reform proposals’*) Proposal 8 suggests introducing:

- self-regulation of supported care placements by some supported carers to limit the intrusion of FACS (FaCS) in stable relative and kinship placements
- a two-year cap on the duration of supported care placements to achieve greater permanency and stability through permanent legal orders for these children and young people.

Though not clear, the implication of these reforms are that the allowance may cease after two years.

support and post-placement services are provided there is less likelihood of placement instability:

Few ruptures occur when states formally appoint kin as legal guardians and provide financial subsidies and post-permanency supports; the placements without such assistance are less stable. (Testa, 2004 cited in Howard and Berzin, 2012: 42)

Non-financial support

For ease of discussion on foster and kinship families' receipt of non-financial support, the following sub-section 'support for foster and kinship families' is broken down into four sub-components, including:

- Caseworker support
- Support groups
- Information and training
- Family, friends and foster carer support.

Summaries are presented at the end of each sub-component and supporting literature at the end of the section.

Caseworker support and foster families: Ten of the 13 foster carers spoke about their caseworker support. Four of the 13 commented that their current caseworker was 'good'. One carer reflecting on the relationship with her worker said:

I don't know that she supports *me* per se. To be honest, I think that's a gap in the fostering world. Everybody is sort of focused on the kids ... but I don't think there's an advocate for the carers.

Three carers, with both short- and long-term placements, had mixed feelings around caseworker support. The first carer commented that she has a 'very good' caseworker for her short-term placements but the long-term foster child, with severe disabilities has been without a caseworker for 7-8 months. This experienced carer has a good relationship with the agency manager and was sanguine about her situation saying:

Because I know what I want and what I'm doing I think it's been okay. But it would be nice to have a case worker that you know you can ring. The one I had before was excellent.

A second experienced carer was very satisfied with the caseworker of one short-term child but does not have a caseworker for long-term child, noting wryly 'unless you're a really needy carer [you are] on your own, there's just not enough... [workers]'. While conscious of caseworkers' caseloads she commented: if we don't work as a team, the team is not going to work'.

For a third carer (with four foster children) the two long-term children have no caseworker. The worker involved with the two long-term children previously was according to the carer: 'awesome. I've been blessed to have her'. The age (i.e. young) and inexperience, of the two short-term children's caseworker, was of concern to the carer as she noted:

It's been everything in my will to keep it positive, positive, positive towards the case worker, because sometimes I feel that he is not doing enough for this child (age 6 years). 'Let me organise the counselling; let me do this, if you haven't got time to do it, let me do it'. *Has he let you do that?* No, so nothing has happened, she has not had any counselling whatsoever, not even when her dad died.

One carer couple, with a non-government agency, had five caseworkers over a two-year period. They found the younger age and inexperience of some caseworkers problematic with caseworkers 'over promising and under delivering many times' letting the couple down and making the placement unstable. After an agency meeting a new worker was appointed: 'She seems to be really good; she seems to be on top of everything', said one carer.

For two carers being assertive with agency/worker was important. One carer, without a caseworker for three children, explained that 'new' case plans were due. With no caseworker and the agency manager on 'personal leave' she said: 'we basically just get on with it and we tell [the agency] what we're doing'. The second carer, concerned with poorly planned transition processes, told the caseworker she was not prepared to let children be moved without a 'proper' transition process. With her current placement, moving intrastate to a kinship carer not well known by the child, she was prepared to drive half-way for several family contact visits, before the child was moved. She said:

There's no hurry. I just want her to be able to settle properly. We need time for our family and the child [to adjust]. I got very angry about that, the fact that they just expected this child to come out of our family and go back into their family and not have a transition.

Caseworker support and kinship families: Nine of the 12 non-Aboriginal kinship carers were without a caseworker. Three of the nine carers were 'not eligible' for caseworker support as one provided voluntary care and older children of two carers had recently 'aged out' of the formal system. One grandmother thought that there should be 'a resource person' available to all kinship carers when children were first placed, as it was so confusing in the first few weeks, and the carers were unsure about the length of the placement.¹¹ The grandmother said:

That's an unbalancing time ... the children are very unstable too. They're not sure if they're actually going to stay with Nan and Pop. "Is DoCS going to come and take us again? If I don't do the right thing or if I do the wrong thing will DoCS come and take us from Nan and Pop's too?"

One younger married carer, (three birth children) caring for two nephews (one with challenging behaviours) was told she was not entitled to a caseworker. She said: 'I

¹¹ Centrelink has six grandparent advisors to provide information and help (by phone or in person) on Commonwealth payments and other services (<http://www.humanservices.gov.au/customer/services/centrelink/grandparent-advisers>)

would like to have a caseworker, somebody I can talk to about things'. When she sought financial assistance for the eldest boy's psychiatric visits the agency informed her she had to use her carer allowance to pay specialist's bills. She said:

At \$180 a visit, I just couldn't do it. So I approached the school and the psychiatrist to write a letter explaining why they were important and then send all that back to DoCS. For the extra psych visits they pay half.

Three kinship carers, currently without caseworkers, received 'one-off' financial assistance from FaCS, with purchasing children's furniture and a computer. Not having a caseworker was welcomed by one grandparent who said:

In one respect I was glad. I didn't have them over my shoulder. I can't stand that. I know what I'm doing. I've been a parent before.

Despite her parental knowledge the grandmother struggled when the grandchild began to have 'problems' in high school. Tutoring was arranged by the grandmother but the teenager refused to attend. When he threatened to self-harm the grandmother contacted a mental health counsellor and the police. The carer said the school counsellor saw the boy: 'Once or twice, it just didn't do any good'. The boy continued truanting and was suspended from the school.

Three non-Aboriginal carers spoke favourably about their caseworker relationship. One carer of a grandchild said that while in the initial placement stages her caseworker was 'good', she felt she was under 'their microscope'. The carer was grateful for agency assistance when 'problems' arose with the child's birth mother. She said: 'They were a strong back-up there'. The grandmother, now with minimal agency contact, has a case plan, and is happy with her agency relationship.

A grandfather, in a carer couple, said that when two grandchildren were first placed a caseworker helped them get the children settled. Some years later, the couple joined a support group and found out that they were entitled to financial support. The couple began receiving a carer allowance for both boys and an establishment payment for each child. The grandfather said: 'That was a lifesaver. All our savings went in the first two years; everything that we'd saved went'.

Similarly another grandmother, in a carer couple, with three grandchildren, said her relationship with agency workers was good: 'I've been very lucky with DoCS, maybe because we've tried to treat them fair as well'.

Caseworker support and Aboriginal kinship families Aboriginal carers felt they were not given enough information, about the support they were entitled to, when related children were placed. Seven of the eight Aboriginal kinship carers said they had irregular caseworker contact, or 'knew' a caseworker they could call, if they needed support. One Aboriginal carer said 'Somebody rings me once in a while'. Two of the Aboriginal carer spoke of their ambivalence about being involved with the agency with one saying:

I'm not a fan of DoCS at all. Look, if I can avoid them, I do. I try to sort it all out myself but if I call for help, it's because I need it and I need it now. The last episode when he had the 'blow-out' at school, they were absolutely fantastic but other times, it's just very slow in coming. The case worker we have at the moment has never clapped eyes on the children. *It's all been by phone?* Yes.

Another carer spoke of her mixed experience with caseworkers: 'We've had quite a few case workers that didn't give us any credit for knowing how to bring up and look after a child'.

One grandchild had recently been restored to his mother. The grandchild, aged 12 years (has autism and highly challenging behaviours) and had lived with his grandmother for 11 years. After a successful court order application he was living with his mother. The child's caseworker is in regular contact with the grandmother about the grandchild, who attends a special school, and receives mental health and medical services. The grandmother, who does not have a good relationship with her daughter, has monthly court-ordered contact visits with her grandson. The grandmother, aged 66, explained that at a meeting with the psychiatrist's it was decided that the grandmother 'could not manage the child's behaviour' and that influenced the court's decision to return the child to his mother's care. Even when it is judged to be in a child's best interest to be restored the process can be traumatic for both child and carer. When the child was removed from the grandmother's care it was not explained to him where he was going and he said to the caseworker " 'doesn't Nana love me anymore?' After the child was removed the grandmother explained 'I was just so depressed'.

Summary: All carers had mixed experiences in relation to, either having a caseworker; having one they were happy with; or one they felt they could contact if needed. Caseworker support for some foster carers, particularly those with long-term placements, appeared inadequate, though being experienced and knowledgeable, helped carers to cope do what they thought important for children. Some kinship carers were ambivalent about having a caseworker involved in their family lives, though others were pleased to have a worker, they thought was 'good'. Kinship carers were less likely to say that they had a caseworker and the lack of caseworker support, appeared to have been detrimental for some carers, as they had little understanding of the support, they may have been entitled to receive.

Support groups and foster families: Twelve of the 13 foster carers spoke of their participation (or lack of) in carer support groups. Four of the 11 either, did not belong to a group or had tried one, but found it did not 'suit' them. Work commitments for two of four carers prevented them from participating in groups, often held during the day. One of the four said: 'I think I'd probably benefit from it, it's just a matter of finding one that's at a time [that suits]'. One same sex carer who found belonging a same-sex group did not work for him and his partner said he often spoke with other carers by phone and: 'we've met a lot of gay carers where we live, so through our own networks we've met them. Informally it's much easier'.

One carer of a child with severe disabilities attends both a disability support and a foster carer support group. The disability support group was most helpful as the group

provided useful information and enabled exchange/repair of equipment for disabled children. At the foster carers support group she shares information about caring for a child with disabilities.

Two carers in a country town attend a support group once a month. One group takes the form of a weekly play group meeting for carers with pre-school age children. Three carers from a coastal town regularly attend a group and enjoyed the experience. One carer believed all carers should attend training/support groups and another said 'you never know enough'. The third carer, was involved in running the group and outlined the work undertaken by *Connecting Carers* in building up relationships between foster and kinship carers¹². The group provided training and had developed a system where carers utilised one another for respite when needed, and camps were held regularly for kinship families.

Support groups and kinship families: Fourteen kinship carers were in a support group and being able to be part of a group was beneficial as one grandmother explained:

This grandparents' group was my lifesaver because I could go there, I could burst into tears, I could cry and if I've had a bad day with [name of child], a typical two year old at that time - I could say 'I could have killed her today' and not be afraid that 'Oh God, they're going to go and ring DoCS and take her off me', because nothing goes out of that room. I could go there and I could listen to the others and feel well, it's not just me.

Another grandmother advised by a caseworker to attend a group said she found it: 'a bit scary but I needed it; I need to go'. Through the group she and her grandchild made friends, went on camps, and become involved in other social activities. The carer and child have maintained their friendships with group members. As a teenager her grandson has become a 'volunteer leader' involved in school camps for younger children in kinship care. Six other grandparents told similar stories about valuing their group with one grandfather stating:

The group, that we belong to, has been a lifesaver. The worst thing in the world, that happens when you first get these children, is that you think you are the only person in the world in this position. Through the group ... realising that there's such a huge spectrum of people in this situation certainly makes it more [bearable].

This sentiment was echoed by another carer who valued the group solidarity: 'To know that I'm not alone'. When one kinship carer was asked who provided the best support she replied: 'That's a hard question. I don't really know. I think the grandparents' support group saved my life'.

¹² Connecting Carers NSW (CCNSW) gives Foster, Kinship and Relative Carers across NSW access to free ongoing training, education and peer support. Carers are provided with up-to-date advice and information to support them in caring for children and young people in Out of Home Care. (<http://www.connectingcarersnsw.com.au>)

A younger kinship carer (in her early 30s), not in a group, found most carers were older and said: 'We don't fit anywhere ... we get nothing from DoCS'. Being a child care worker, the carer feels she knows what the children need, but experienced difficulties: 'getting through the system and finding out where to get help'.

It was people in the grandparent group who told one grandmother that she was entitled to financial support: 'They [department] didn't tell us about the money, only the grandparents' group did'. At times setting up a support group was not that easy as a carer explained:

You know, in a country area, it's really, really difficult. In a small country area where everyone knows everyone, I've struggled to try and get support groups going. I've had morning teas, I've had all sorts of different things and, you know, you might get two ... and not much happens after that.

Some carers were wary of being in a group and 'being known' by FaCS workers. An initiative by a local Aboriginal agency supporting kinship carers has brought a number together to form a group. One carer who had been one hesitant to attend said:

I haven't had much to do with DoCS and I'd rather keep it that way because unless something drastic happens, I don't think they need to be involved in what I'm doing. Then they [Aboriginal Agency] explained what they were about and, yeah, we've been to a couple of meetings and stuff like that.

Summary: While foster carers were cognisant of the value of group participation, for many kinship carers, being part of support group was a stabilising influence: a 'lifesaver'. For these carers it meant being able to connect with like-minded people, who completely understood their feelings, concerns and emotions and were prepared to support and help one another. For a number of reasons some foster/kinship carers were hesitant about joining a group; others were disappointed when their group disbanded; or general disinterest by carers in some areas, meant a group did not happen. The younger age of some kinship carers was a barrier to feeling like they 'belonged' to the group of older carers, and for carers in paid work, group meeting times, were a barrier.

Information/training and foster families: In addition to gaining support and developing carer relationships ongoing training and information was provided at carer support groups. Over half the carers said they attended as many training sessions as they could, with one carer noting:

Even if one is about high school education and it didn't concern my children, I still went because I thought I might be able to pass the information on to one of the other carers that care for older kids.

One long-term foster carer, who regularly attends her support group, believes all carers should have to attend ongoing training. For her, contact/discussions with other carers at groups/meetings, and sharing fostering experiences with other carers, was

interesting and useful. One regular attendee spoke of the benefits to her and her husband in understanding her foster child's behaviour:

Just doing these courses, like mental health courses, it gives you an insight into why he's doing these things. *Do you think that makes it easier?* Yeah, definitely, because if I hadn't known and hadn't learnt that these things can happen, we might have given up on it. *Do you think that might have happened?* Oh, there have been occasions when we've sort of felt, 'Oh, God, we've had enough, we can't do this anymore'.

But you sleep on it and the next morning he gets up and he's a loving little boy and you think; 'Right, okay, we'll give it another go'. There has been one occasion where we had to send him away for some respite for a few days, to give not just us a break, but his other two brothers as well. He still has his problems and I think he always will but, on the whole, I tend to ignore, or try to ignore, some of it now.

Four carers felt that they had no particular need for specific training at this stage and four others mentioned that their paid work prevented them attending training. Changing to 'working at home' allowed one carer to attend training on positive parenting, connections and access visits saying she found the sessions 'really good'.

Fitting training around paid work was highlighted by one carer couple when they experienced problems with their agency. A lack of response to carer requests for support lead to difficulties between the workers and carers with fear on the carer's part that the agency might remove the child from their care. The carers requested training to assist them and the placement continued.

Information/training for kinship families: Support groups were also a source of valuable information for kinship carers. One grandmother remarked:

That's what people need, a group that's going to stay, that's self-supportive, that's there for each other. Yeah, it's fantastic. They gave me a lot of information that I didn't know. It was very helpful.

Finding the 'point of entry' to understand what carers 'need to know' was highlighted by a grandmother who said:

I thought when I went to Centrelink to organise *Parenting Payment*, that's the point of entry because most grandparents would go there to organise some sort of family tax benefit. That should be the point where have the paperwork and information and say 'okay, there's these support groups you can go to'.

At the time of placement, which can be made in a 'crisis' period for families, having access to any information would have benefitted a grandmother:

I think one of the saddest things is we wished we'd had far more information up front when we were in disaster mode: That's when we could have done with some help, somebody who could have come and guided us through the process.

Although it happened well after the child was placed (Aboriginal women, caring for grandchild for 14 years) a carer appreciated the introduction of carer information sessions provided by an Aboriginal agency in her area:

Did you find it helpful? Oh, yeah, because there were things there that I didn't know. I could have asked for support, especially when the child comes to you, what you're entitled to and all of that.

Another carer regretted not having the important information she needed, before accepting PR of her grandchildren, and as a consequence, losing the support she had been receiving:

If I knew that back when we were looking at taking the children on, I probably wouldn't have signed the papers as quick as I did to take 100 per cent custody (PR), because while they're in DoCS's care, they get everything.

The provision of workers by the Department of Family and Housing, Community Services, Indigenous Affairs (FaHCSIA) to assist grandparents taking on the care of grandchildren was appreciated by one carer.¹³ The carer said: '[name of worker] was my saviour when she came in, because she was fantastic.' The grandmother was put in touch with Mirabel and Connecting Carers and found both organisations very helpful.¹⁴

Training was seen as important by some kinship carers. A younger carer (with two related children with special needs) stated that she would really appreciate more training:

It's been a really hard battle with getting the help that I've needed, going between doctors and paediatricians and psychiatrists ... to get where we are now, it's been hard work.

For one grandmother, being involved with a support group and recognising the needs of carers, had motivated her to volunteer in assisting and training others in the group:

I've done courses. I'm getting Certificate IV in Community Services and I've done all these other workshops and certificates.

¹³ In December 2011 the Commonwealth Government introduced a new program *My Time for Grandparents* peer support groups in 25 locations around Australia to assist grandparent carers. If FaCS are involved with the initial placement information, advice and support around roles, responsibilities and entitlements should be provided to kinship carers.

¹⁴ The Mirabel Foundation assists children in the care of extended family (kinship care) due to parental illicit drug use (<http://www.mirabelfoundation.org.au/>)

One younger carer (part-time worker with three birth children) caring for her cousin, said she finds it difficult to attend training. Three carers, who were going 'okay', said they did not require any training. One who had done some foster carer training said of the parenting course she attended: 'The Triple P that was too basic ...these kids need more'.¹⁵ Three carers who had attended foster carers' training sessions found them helpful. One Aboriginal carer hoped to attend training on sexuality to help her teenage grandson. Keen to understand what she should be doing another carer said:

I did a lot of research and I go to everything and I got very involved with the grandparents' group. That has kept me going and understanding lots of things. I have asked, 'Can I do the foster carer's training' Why isn't that there for the grandparents? Why isn't there training in the first five or eight weeks of you being given these children. *Do you think there should be training for kinship carers?* Yes. I do.

Summary: Foster carers valued being offered ongoing training. Appropriate information and required training was not as easily accessed by kinship carers, many of whom wished they had known more, at the beginning of placements and as it progressed. A need for specific training was highlighted by kinship carers. Not knowing the ramifications of making decisions, before all the facts were understood, was seen by one grandmother as detrimental to the decision-making process.

Family, friends and other carer support for foster families: Twelve of the 13 foster carers spoke of the importance of support from spouses/partners and extended family members, friends and other foster carers. A strong theme in this section was evidence of a lack of available respite.

One foster carer, with two birth children, who took on her first long-term placement (baby 6 weeks) spoke with great feeling about the relationship she formed with another carer when she needed respite. She found the older, more experienced carer a great support, saying: 'She was like my mum ... she was amazing ... she was what got me through, absolutely'. A single carer of two children in a long-term placement, with good support from friends, also has a close relationship with the foster carer of the two foster children's' siblings, saying she was one of her best supports.

The value of being able to obtain respite and/or babysitting through other foster carers or family was mentioned by seven carers. Mostly respite arrangements were informal though one same-sex couple had a formal arrangement. The couple lost contact with many friends, when they moved from the inner city to the outer suburbs, to buy a home and provide foster care. They have respite one weekend every month with the child going to the same local foster carer family. The carer said it took many months of negotiations with the agency to organise the respite.

¹⁵ The Triple P (Positive Parenting Program) is well known and used to help people with children's behaviour, prevent problems developing and build strong, healthy relationships (<http://www.triplep.net/glo-en/home>).

One experienced foster carer said she had another carer she is very happy to leave young foster children with and returns the favour when needed. Initially she was helping the new carer (in part-time work) with her first foster child by providing one day a week respite (work-related). The carers are happy with the arrangement and have remained good friends and respite buddies. The experienced carer also mentors other 'new' carers, saying she receives a lot of satisfaction from seeing them adjust to their fostering role. With her husband, they socialise (e.g. BBQs; picnics, coffee, etc) with other foster carers and do what they can to support them.

A single carer, in early sixties, who provides both short- and long-term care spoke of the value of *Home Care* when she reached a point where she needed extra assistance for a teenage foster child (wheel-chair bound). The service is provided three mornings a week to assist with dressing and five nights per week to assist with bathing. It took carer three years to obtain the evening service which was necessary due to lifting a growing teenager and the increasing age of the carer. *Home Care* also provides two hours house cleaning per week.¹⁶

Family, friends and other carer support for kinship families: Eleven of the 20 carers spoke of the good support offered by family, friends and carers, with many developing friendships with other carers. Three of the 11 spoke of people in their church being close and supportive. Occasional respite/babysitting was a common feature of family/friends support.

One carer (couple + 3 birth children + 2 kinship children) noted that they did not have many friends anymore, it was just family who supported them. One carer with two grandchildren and a niece, felt neglected when friends avoided her:

When I took the children on I lost a lot of friends ... they didn't want me taking the kids over there. I was very distraught ... because I had three children it was a different thing. I never got invited. So, yeah, it was very disappointing because that's when I did feel alone.

The grandmother became a volunteer support worker for the local grandparents and kinship carers' support service and refers carers to services/workshops and advocates on their behalf. Family days (e.g. picnics, BBQs and bowling) are held by the service and these social activities have led to grandchildren and grandparents becoming close friends with other families.

Two Aboriginal carers, both with several adult birth children, said that they did not have good support from their families. Another Aboriginal carer said that many of her friends no longer had young children in their care and she did not expect them to be very supportive as 'they've lived a life without kids'. Her own ill-health and problematic relationships with some relatives, of the children in her care, was of concern to another Aboriginal carer.

¹⁶ *Home Care Service* of NSW subsidised by the Australian and NSW governments helps people with disability, older people and their carers to live independently in their own homes (http://www.adhc.nsw.gov.au/individuals/help_at_home/home_care_service)

The lack of available respite was as evident for kinship carers as it was for foster carers. Eight kinship carers emphasised the difficulties faced, in obtaining a break. The dilemma facing grandparent carers was explained succinctly by one:

You think about it, a parent of a child, if they want to go out to a meeting or have dinner or something, where do they go? To the grandparents! But when the grandparents have got the grandchildren where do they go?

One carer said some grandparents feared asking the department for respite, as they would have been judged as 'not coping', and worried that children might be removed from their care. She said the respite was needed, not just to give the carers a break, but to enable the children in their care to be with other children in their age group, and have a weekend away occasionally. This was especially important for grandparents with younger children, she said, as some carers did not have wider family who could take children, or any younger people who might help.

One single carer, (two related children) in her mid-sixties and needing respite noted that when her great-grandson was placed the caseworker put everything in place: 'I had a good case plan, but then she went and I just didn't get the support that I had with her'. Extended family was utilised by one Aboriginal aunt, whose three nieces/nephews went to their grandmother some week-ends, so she could have: 'peace and quiet'.

Another Aboriginal carer, whose grandchild has a number of medical conditions, has two hours of weekly respite, camps for the child twice a year and occasional outings in school holidays. She spoke of the simple pleasure of having a 'break':

It gives me breathing space, which you need, you have to have.
Even just to do shopping ... to do that on my own is nice.

A younger married woman caring for three birth children and two nephews, said 'respite would be great 'every now and then'. The couple are planning a weekend break with a grandmother looking after three and a sister another child. The baby is going with the parents. When asked if it was difficult to arrange holidays she said: 'Well we don't have holidays. I haven't had holidays for years'.

One Aboriginal grandmother said

You get a bit selfish sometimes and think, "Oh, why me?" I would lie to you if I said I didn't sit in the corner sometimes and have a howl and feel a bit sorry for myself but, you know, you have a cup of coffee and you get up and keep going. At times, somebody needs to step in to say to us, 'You need to have a couple of weeks and you need to go away.' With kinship carers, they hang in there because of pressure to keep families together.

Summary family, friends, and other carers: Being supported by family, friends and other carers appeared critical to the stability of foster and kinship placements. Some carers had worked hard at finding the 'right' solution for themselves, especially in

regards to respite arrangements. Kinship carers, on the other hand, struggled to find ‘someone’ to give them much needed respite to continue caring.

Supporting literature The lack of non-financial support for kinship carers, noted in the report’s introduction, was evident in this study. For those who ‘found’ the types of support they needed the benefits were evident. Findings from a US study with grandparent carers (n=133) study concurs with this finding:

Grandparents ... benefit from formal assistance through reductions in role-related stress and enhancements to quality of life ... grandparents seem to be responding positively to assistance in the form of support groups, health services, legal and social services as well as to recreational programs for children, which could provide respite from caregiver obligations ... some custodial grandparents are reluctant to seek or accept help from community organizations or government agencies. (Gerard, Landry-Meyer and Roe, 2006: 375-6)

The reluctance of kinship carers to trust ‘formal assistance’ was also found in an Australian study, which identified barriers to seeking assistance and information, stemming from ‘shame or fear of intervention’ and a desire to maintain family privacy (Brennan et al., 2013: 65). The study suggests that sensitive and responsive policies need to be developed to meet the information needs of this unique and diverse group of carers (valentine et al., 2013). UK research indicates that even when carers sought assistance, their needs were not met. One study found 56 percent of kinship carers (n=493) who received help from their local authority, were dissatisfied (Aziz, Royh & Lindley, 2012). Another UK study with informal kinship carers and kin children (n=80) found that close to three-quarters (73%) of carers who had requested support or advice from Children’s Services, only one quarter received the support/advice requested (Farmer, Selwyn and Meakings, 2013). Other research suggests: ‘services should be more visible, accessible, affordable, and tailored specifically to the unique needs of grandparent caregivers’. (Gerard, Landry-Meyer and Roe, 2006: 376)

Of critical importance in relation to placement stability is support offered by ‘good’ social work and a sense of worker continuity. As found in this study staff turnover and/or change of caseworker adversely impacts on carers (and children) (McHugh et al., 2004; Sinclair and Wilson, 2003; Ward 2009). UK research found increased foster carer retention when carers were treated as part of the OOHC team and receiving support from family, friends and other foster carers was more likely to provide successful and stable placements (Jones, 2010; Pecora, 2010: SCIE, 2011). Two important aspects of carer support is having a timely response to phone calls and having accurate and complete information about the child (ACWA, 2011).

A recent study in Victoria found carer respite was essential for placement stability and to prevent placement breakdown. The study noted that respite benefits carers and children. In noting the current unmet need for respite care for kinship carers the study found demand for respite care was predicted to increase by most (83 per cent) respondents (Borenstein, 2012: 33; Borenstein and McNamara, 2013). Other Victorian research also found respite was a major problem for Aboriginal carers, who were often older, single, in poorer health and caring for more children than non-

Aboriginal caregivers of Aboriginal children (Humphries, Kiraly and Connolly, 2012). Without caseworker involvement it is likely that the respite needs of many kinship carers will be unrecognised and unmet.

In relation to training, kinship carers in most Australian jurisdictions, are not required to attend initial or ongoing training, but are encouraged to do so. Some kinship carers resent or feel intimidated when training is suggested. Researchers suggest that training should be discussed sensitively and put in the context of providing support, and to overcome any barriers, they suggest that the phrase 'educational support' be used instead of 'training' (Glass and Honeycutt, 2010). Research suggests carers would welcome specific training on grief and loss. Information on the OOHC sector/child protection system, Family/Children's Courts and carer entitlements need to be provided to carers. Specific training could include attachment/trauma theory; coping with role conflict, and understanding family and peer support development (McConaghy, 2008).

UK evidence suggests that kinship carers' attendance at training increases placement longevity (see McHugh, 2009; McHugh and valentine, 2010). US research found kinship carers who completed the PRIDE foster carer training program had a better understanding and willingness to work with birth families (Falconnier et al., 2010: 418). The importance of kinship care training in relation to child safety was also highlighted by US research (Cawthon, 2008: 14)

Support groups are beneficial for foster and kinship carers, in overcoming isolation, providing information, support and resources and are particularly important for kinship carers in meeting their needs for emotional health, education and peer support. All jurisdictions in Australia have kinship support groups and it is not unusual for both formal and informal kinship carers to utilise them (McHugh, 2009; McHugh and valentine, 2010; Yardley, Mason and Watson, 2009). In the US and UK, their value is also recognised with networks of grandparent groups increasing (Generations United, 2004; Grandparents Association, 2013). Having a network of friends and family who can assist with respite and understand the kinship carer's experiences is also of great importance (McConachy, 2008)

A lack of carer respite is well documented in Australian and UK studies. A study by Farmer and Moyers (2008) found only 11 kinship carers (8%) in their study received regular respite. The important connection between respite and maintaining child safety, placement stability and permanency and preventing further abuse and neglect has been noted by Jerve (2008).

2.8 Identity and lifestyle changes: foster and kinship families

Foster families: Most foster carers spoke of changes to their lifestyle when they began fostering. Social life, travel and holidays were often curtailed due to caring responsibilities and friendships changed for some carers with friends with different lifestyles (i.e. no dependent children). Two carers commented that some friendships had grown stronger because of their fostering commitment, with one saying: 'It's definitely sorted out some friendships but made others stronger'. Another said; 'you do find [out] who your friends are'!

Two male same-sex couples, who had not raised children before fostering, said their lives had changed dramatically, with some friends/acquaintances querying their decision. For one of these carers the hardest part has been involvement with the 'system': 'Having to comply with countless meetings, check-ups, diarising, lobbying, case managers, workers changing – those sorts of things'. The two same-sex couples found the process of fostering/parenting somewhat challenging with one carer commenting: 'it was a bit of a shock [having to] get a kid up, get him ready for school, take him to school'. Another male primary carer said that while: 'all parenting can be difficult at times, I really embrace playing the father role and the dad in the family network'.

Female carers identified with the role of being a 'mother' or 'mum' to fostered children and did not feel their identity had changed. Several carers were adamant that though their lives/lifestyle had changed they were not missing coffees/lunches with friends. One carer's comment reflected other carers' attitudes: 'I've got kids that I need to care for and that's important to me'.

Kinship families: For kinship carers the impact of becoming a kinship carer was strongly related to changed identity and changed role. A strong theme emanating from the discussion around identity and role was around sadness and loss of who they had once been; loss of friendships; and loss of lifestyle.

One carer said that many friends just disappeared: 'I guess they don't want to know you'. Friends think 'you shouldn't be bringing that child up, it's *her* child, it's not *your* child'. In comparison a carer spoke of her 'luck' with friends: 'I haven't lost any friends, they've all been very supportive. They weren't too surprised of everything that was happening at the time.'

The change in their role to being a 'parent again' was not only difficult, but also painful, as two carers made clear:

1. How can I explain it? It takes a while to slip into that parenting thing. You can't take the grandparent hat off straightaway. You find that you are overcompensating and it takes a while. It takes a few months to sort of suddenly realise, I've been trying to be a grandparent and be a pal, and I can't do this, I'm now mum. I've got to - even though I'm Nan to them, I'm in the mum role.
2. I always wanted to be a grandmother, always. When they're 'given' to you, you're not a nanny anymore, and being on your own, you're a mum and dad as well. It's hard being the mum role because you lose the nanny role. That's the saddest part. I think it's been a real sad part because it was something I always wanted.

These carers' sentiments echo the voice of the grandfather quoted earlier in the report, who said:

I was deliriously happy at being grandad and I stopped being the grandad – I lost the grandchildren and became a parent again and I didn't want that.

Parenting again brought some difficulties for kinship carers. Parenting was problematic for grandparents due to the change in disciplining (e.g. no smacking) children, some struggled with the education system and the different way children were taught, with one carer noting:

It's a different parenting style to when I had my own children. I think it's harder with everything that goes on now with kids ... and schooling; the way they teach them is a lot different too.

The age difference between many grandparents and other children's parents meant forming relationships with their grandchildren's friends' parents was difficult. Continuing household work was a burden for some with one grandmother commented that the things she missed the most was not having time to garden:

Instead of getting up in the morning and just making one bed and just straightening up; you're every day doing housework again, like you did when you had kids. That does tire me out. Some days I think, "God, I'm so sick of this. I've kept doing housework for 57 years'. I just don't seem to get out in the garden much at all lately.

She then added this comment: 'I guess I like being a parent. I enjoy the kids ... [but] there are times when I could walk out on them'. Three younger kinship carers felt the loss of their working lives when taking on related children. One grandmother said: 'I miss my career. I miss the intellectual stimulus I think, more than anything'. Another carer who gave up her job as a state public servant was angry at the loss of the job she enjoyed: 'I really loved it and they used to fly me all over the state to country areas and things like that'.

Seven of the eight Aboriginal kinship carers spoke of the loss of lifestyle and friends after taking on their related children with one grandmother stating:

Nobody really understands your situation. 'Girls' my age are now out playing bowls, playing bingo, going off on girl weekends and I've got none of that. I'm at home with the kids. I try and do a little bit of the school [but] you know you're 60-years old, the mind's willing but the body won't do it. *Do you get tired easily?* Oh, God, yes.

Some Aboriginal carers had always cared for family and for children and saw little difference in their role. Comments from two grandmothers highlight the strong identity of some Aboriginal women as 'mothers':

1. Well, to be quite honest I don't think I ever stopped being a mum. I reared my kids and I reared some of my cousin's kids. Since I started having my kids, there's never been a time that I've had no kids.

2. I've always been mum, like my kids, grandkids ... mum, gran, because they [all] called me mum and I'm just mum'.

Two Aboriginal grandmothers spoke movingly, of the importance of children being with 'family' when they came into care as due to their own family background, they had a good understanding of the children's circumstances:

1. Listen to the kids and just be there for them.... and where they're coming from ... it hasn't been very stable and there's been a lot of noise, a lot of drinking and everything else. It's taken [name of child] a while to settle in, we have our arguments. We're a pretty normal family. It might sound easy but it's not and it's not as straight forward as you think. But we're at a stage now where we can live with one another [laughs] all together!
2. I've come from a big family and we've always had people around us. I've never slept in a bed by myself until my husband. When I was a kid growing up we just looked out for one another and if they needed help, we helped out. Now, it's sort of easier, I don't drink, I don't smoke, and I don't do drugs. I didn't have a very good life when I was growing up. I try to offer something different and I think that's working okay.

Kinship carer's emotional reactions: It was during the discussion on changed roles and identity, that the raw and mixed emotional response of grandparents to their situations was most evident. Relating their emotional responses to stressful periods in their lives provided insights, into how these experiences affected and shaped them. In coming to terms with their changed lives and the trauma and loss they felt, grandparents were torn and somewhat confused between trying to do the right thing for birth children and grandchildren, as two grandmothers explained:

- 1) Grandparents have nobody. I'm looking after my grandchildren and loving them. My son got involved with drugs and alcohol. But he's still my son. So then I'm dealing with that ... with DoCS ... with court orders and court papers or whatever else. I'm doing everything I'm supposed to do. You're looking after his [son] children and giving them all the support that they need and you're angry with your son. Then he's calling for help because he's been put in gaol. It's a huge load on a grandparent because *they* are your children ... *these* are your grandchildren.
- 2) The hard bits were not upsetting your daughter or disappointing anybody. That was the hard part of it ... saying 'well you can only see him so often'. She didn't sort of disagree with that but I'd rather my daughter had had her son. But it wouldn't have been in [child's] best interest. She agreed with that.

One grandmother (with 4 adult birth children) spoke movingly how she felt when asked to care for three grandchildren:

You feel every emotion ... because you want the best for your children. They've all been successful except for our youngest daughter. So you feel upset she's wasted her life. She's thrown it away. She's missed the best years of her life and you can't get them back. So you're angry because she's involved with this [substance abuse]. You're angry that your husband doesn't understand. You're angry because your kids think you don't know what you're doing and that's what happened.

Anger was also a reoccurring emotion for another carer:

The hardest bits are probably - for me is when you're actually talking to your grandchildren about their parents. It's really hard because you get really angry with your own children. The anger can come out onto the children at different times where you don't want that to happen. It's huge ...yes, constant.

Some grandparents struggled to understand why they were 'parenting again'. At times, they blame themselves for circumstances beyond their control. One grandfather said: 'You despair; you get despondent and depressed and you feel ashamed and guilty that this has happened to your family'. Similarly a grandmother who joined a kinship support group said:

I thought, 'I'm not the only one in this boat'. I was feeling pretty guilty, that maybe I'd done something really wrong in bringing up my daughter. It was choices that she made as she got older and got involved in drugs and alcohol. So they [carer group] said to me, 'No, don't beat yourself up' ... 'this is where you need to go and get some help.' Centrelink told me to go to DoCS so I did.

Another grandmother having a difficult time coping with the behaviour of her adolescent granddaughter said:

I got to the point with the 12 year old, I actually marched her back into DoCS two years ago. I was giving her back. I couldn't cope with it any longer. (Child received mental health counselling that is continuing and is with her grandmother).

Summary: Carer responses to changes to identity and lifestyle were different. Foster carers spoke of lifestyle and friendship changes with a degree of equanimity with carers seeing little difference in their role with fostered children. Foster carers appeared comfortable with their carer identity and aware of the importance of what they were doing.

Some difference was evident between the non-Aboriginal and Aboriginal kinship carers in relation to their role. Non-Aboriginal kinship carers spoke of the difficulty in switching roles, from grandparent to parent, though some Aboriginal women maintained their strong identity as a 'mother figure' regardless of their familial connection to children in their care. Despite this strong identity however both groups

of kinship carers regretted the loss of previous lifestyle and friends. One kinship carer, echoing many others, said: ‘nobody really understands your situation’.

All kinship carers, particularly those who had previously worked, acknowledged the fact that they missed the life they once had, before children were placed. Feeling ‘sick’ of continuing housework and feeling ‘tired’ were not uncommon sentiments and being older and ‘out of touch’ with current parenting practices and education systems was of concern to some kinship carers.

Supporting literature: The responses of two same-sex foster couples (see above) to role changes was of interest as little is known, particularly in Australia, about the experiences of same-sex couples who foster (Downs and James, 2006; Lavner, Waterman and Peplau, 2012). Changed roles for kinship carers ($n=22$), in one Australian study, were found to be significant. Respondents noted that they were starting all over, becoming full-time parents again, and putting their lives on hold (Yardley, Mason and Watson, 2009). A US study ($n=21$) found grandparents sad and resentful at the loss of their traditional role (Landry-Meyer and Newman, 2004).

The heightened emotional response from grandparent carers, highlighted above, has been found in other studies with custodial grandparents (Backhouse, 2008; Brennan et al., 2013; O’Neill, 2012). Unlike foster care, a particular feature in kinship care is the deep emotional impact on carers with related children. Research suggests that these heightened emotions cause tension and confusion for grandparents trying to juggle divided loyalties and attachments to children and grandchildren (Cawthon, 2008). These divided loyalties are described as a double-bind situation: ‘where emotions such as love, concern, and commitment for both the adult child and the grandchild create confusion, stress and frustration’ (White, 2009: 19; see also Campbell and Handy, 2011; Climo, Terry and Lay, 2002).

Feeling alone and/or socially isolated, a sub-theme evident in the kinship carers’ responses, was not uncommon. Studies have found the generation gap between grandparents and grandchildren, and the older age of grandparents, compared to other parents, create social barriers. Grandparents’ friends have other interests to child rearing; younger parents do not always relate well to older carers of similar aged children; grandparents struggle with meeting children’s educational needs (e.g. homework); and older age and infirmities prevents grandparents’ participation in some grandchildren’s activities (Bullock, 2004; Cuddeback, 2004).

As in US research, with African-American grandparents (Brown, Cohon and Wheeler, 2002), role change for Aboriginal grandparents was not as apparent, in that for many carers, it was a continuation of the role they had always played. As found in the US study, children moving between extended family households and the shared care of children and grandchildren are the ‘norm’ in many Aboriginal families (SNAICC, 2011).

2.9 Children’s health

Foster children: Most of the fostered children’s current health was stated by carers to be ‘excellent’, ‘good’, ‘robust’, or ‘not too bad’. Many carers noted that the emotional and physical health of most foster children had ‘improved’ or was ‘better’ since they

were placed. Carers mentioned foster children attending specialists, doctors, physiotherapists, dentists, counsellors and/or hospitals, at different periods during their time in care. Thirteen children had experienced a range of ailments or behavioural problems, and at least one child was currently receiving (or had received) treatment for:

- ADHD (attention deficit hyperactivity disorder);
- Asthma;
- Dental decay (2 children);
- Ear infection/hearing problem;
- Foetal alcohol syndrome;
- Bronchiolitis;
- Tonsillectomy/adenoidectomy;
- Deafness (wears hearing aids);
- Learning disability (3 children); and
- Developmental delay.

Two foster carers thought children in their care were as yet undiagnosed; one child with probable ADHD/ADD (attention deficit disorder) and another, a suspected drug-affected baby. The carer of one child, totally dependent quadriplegic, with hearing, vision and vocal impairments, said that the teenager was a very healthy child who attends a mainstream school (has a full-time teacher's aide).

Kin children: Of the 20 kinship carers, 18 stated that the children in their care were in general, in 'good' physical health. Six children had a range of physical health issues. Three were asthmatics, but carers said their conditions had improved as they grew older. One child had Type 1 diabetes and another was receiving speech therapy for a stutter. Two carers spoke of children who had required specialist dental work after coming into care. One carer, receiving financial assistance for the costs of ongoing specialist dental treatment, was dismayed when support was withdrawn when court-ordered PR was given to the grandparents.

Children in the care of two Aboriginal carers had serious health issues. One Aboriginal carer in discussing the health of her grandchild explained:

Overall he does have health issues, he's got perforated eardrums. He's also had a heart operation. He had three holes I think, in his heart. He is also a finicky eater. And he's very small for his age. He's been diagnosed as developmentally delayed.

A second Aboriginal carer also noted a number of health problems for her grandchild. The child, also born with a heart condition, required surgery. Over time the grandmother realised that the young child was not meeting all his developmental milestones. After a series of tests the child was diagnosed with a joint disease and allergies (carries an Epi-pen (Epinephrine Auto-Injector)) and has Asperger's Syndrome. The child (now 14 years) is prone to dislocations and fractures (12 over his lifetime) and the grandmother said the child is moderately disabled.

Eleven kinship carers spoke of children in their care having a range of 'psychological issues'. Eighteen children were on medication and/or were receiving counselling from psychiatrists/psychologists to assist with a variety of conditions including:

- Extremely challenging behaviours (2 children),
- Anxiety attacks (1 child)
- Autism (1 child)
- Post-traumatic stress (1 child)
- Attachment disorder (1 child)
- ADHD (5 children)
- ODD (Oppositional Defiant Disorder), (2 children); and
- ADD (5 children).

The psychological issues of children in kinship care in this study was exacerbated for some carers as children had been diagnosed with a combination of disorders, for example, post-traumatic stress, an attachment disorder and ODD for one child and for another child ADHD, ODD and ADD. For other carers more than one child in their care had mental health issues. For example, three of four grandchildren of one Aboriginal grandparent couple have behaviour problems which required monthly attendance at a Children's Hospital. The couple have found the services extremely helpful with the grandmother stating:

Oh they're brilliant. The best thing that ever happened to us.... just with strategies and things for their behaviour, because they've got different behaviour problems. [1st child] has ADHD and attachment disorder and [2nd child] has, he actually has post-traumatic stress as well as attachment disorder and ODD... but we can see the light at the end of the tunnel with him at the moment so that's good.

The four grandchildren attend an AMS. The grandmother said that the department referred the children for assessment and she was happy with the service:

In the past DoCS got them [AMS] to give them a complete check-up and send them [DoCS] a report. They see the paediatrician there [who] does a clinic. They've very thorough with the kids.

Even though receiving medical care/treatment some children's psychological issues were ongoing. An Aboriginal carer, who has cared for two related children for nine years, said both children: 'have ADD and are on medication'. One child is currently on three types of medication and the other child two. The youngest child also has behaviour problems (i.e. bullying).

Another Aboriginal carer noted that her grandchild's challenging behaviour was very difficult (i.e. aggressive and destructive). The child was due to be assessed at a city hospital and the carer was 'hopeful' that the child would be seen by a psychiatrist and followed up, when he returned home. She said: 'It has been a big struggle looking after him'.

When asked if the physical and mental health of the children in their care had improved since coming into their care, the responses from some kinship carers,

compared to the foster carers, were more tentative in affirming some positive changes for children. Nine carers, with children receiving ongoing treatment for a range of psychological disorders, were anxious about their conditions and associated challenging behaviours.

Two Aboriginal carers of children with both physical and psychological conditions, were highly concerned about the future of the children. One grandmother said the long-term outlook for the child was 'not good' and there was an expectation that he may not be able to live independently. The carer said that ADHC (Ageing, Disability and Home Care) is assisting the carer and when the boy turns 18 supported accommodation is available. The second Aboriginal grandmother said:

The three things he's got, all combined make it difficult. If he had just one of them, it would be okay. But the whole three of them make it confusing [joint disease, allergies, and Asperger's syndrome].

Summary: Carers' responses in relation to children's current health were surprisingly different with kinship carers indicating that the children in their care had a broader range of physical and mental conditions, than those in foster care. Some Aboriginal children in kinship care had more serious and chronic medical conditions, than fostered children. Combined psychological disorders of Aboriginal children in kinship care also appeared more prevalent and serious, than for the non-Aboriginal children in foster care. The findings suggest that kinship carers are more likely to require access to, and support from, a number of professionals and specialists to cope with the health needs of the children in their care.

Though sample numbers in this study are small the findings are in contrast to other studies of children in kinship care which have found kin children (in formal and informal care) had better behavioural and mental health functioning than children in foster care (Harnett et al., 2012; Richardson and Gleeson, 2012).

Supporting material: The health status of children in kinship in this sample is similar to US research, which found that children in kinship care (approximately 24% of formal care placements) have significant health vulnerabilities. In the US study, kin children were more likely than children in foster care, to have pre- and post-natal substance abuse exposure. Pre-natal drug exposure increases the risk of HIV, mental problems and developmental delays in children (Casey Family Programs, 2008; Falconnier et al., 2010; Keller et al., 2001). Another US study, examining the rate of mental health problems (i.e. emotional and behavioural problems) of children in kinship care, compared to children of traditional (i.e. foster) caregivers, found grandchildren with higher levels of behavioural and emotional disturbances than children in the overall U.S. population (Smith and Palmeri, 2007). Due to a lack of support US researchers suggest children in kinship care 'are potentially at great risk for significant unmet mental health needs' (Carpenter and Clyman, 2004: 675).

In Australia there are limited studies on children's health needs (Nathanson and Tzioumi, 2007; Tarren Sweeney and Hazel, 2006) in OOHC and only one specific study documenting Aboriginal children's health and well-being (Raman, Reynolds and Khan, 2011). One health study of a cohort of children (n=122) entering OOHC in

NSW found the cohort had higher levels of medical conditions than children in the general child population. On a range of health issues children in the OOHC cohort were more likely to have: abnormal vision (30 per cent Vs 7.4 per cent); hearing loss (26 per cent Vs 3.4 per cent); speech difficulty (33 per cent Vs 16.6 per cent) and emotional or behavioural problems (54 per cent Vs 31.4 per cent). Emotional and behavioural problems (54 per cent) were the highest health need of children in care (Nathanson and Tzioumi, 2007).¹⁷

An analysis of 100 Aboriginal children's health records from an OOHC clinic in south-western Sydney found Aboriginal children had a similar range of identified health needs as other children in care and school-aged children had additional health needs that impacted on their ability to learn (Raman, Reynolds and Khan, 2011: 806). The findings from this study (see below), on the connection between health needs of Aboriginal school aged children impacting on education outcomes, are similar to those of Raman et al., 2011 (see 2.10).

2.10 Education of children in foster/kinship care

Foster families: Eight foster carers discussed how school-aged foster children were getting on at school. Four carers said their children were doing well. One child, quadriplegic, with hearing, vision and vocal impairments, is 'very bright' and attends regular school with a full-time teacher's aide. For one teenager, a bullying incident at school was resolved after a meeting with the child's caseworker, school principal and the two children involved. The teenager is continuing with his education and the carer noted that school tests indicate he is getting good marks.

Within four other carer families some foster children were 'getting better' at school, while others were experiencing 'difficulties' with schools/teachers. For example, one carer with three foster siblings, all are 'behind' in their school work. The carer explained that one child with learning difficulties has tutoring and is coping 'quite well' at school; another sibling is in a reading and maths program; and the third child is repeating the first year of school. Another carer's foster child is in a composite class of 30 and the carer was of the opinion that because the child is 'rowdy and does not want to learn', the teacher is not coping well with the child. A third carer with three foster children commented that they all have their problems (i.e. behaviour and learning difficulties) but 'they're getting there'. The older child finds school 'difficult' and due to carer advocacy he is attending a special reading program.

Kin children: Twelve of the 20 kinship carers spoke of the educational progress of school-aged children. Children of six of the 12 kinship carers had changed school, mostly with positive outcomes. One grandmother said after her eldest grandchild changed school he settled well:

He's at senior high at the moment and he's doing exceptionally well. I've just been diagnosed with 'something' [emphysema] and I've been making out my bucket list, and the main one is that I'm going

¹⁷ No information was provided by the writers as to specific child numbers in foster and kinship care.

to see him graduate from uni. He's in Year 11 now and he's going to be the first grandchild to go to university.

The grandchild of another carer received numerous suspensions from school, and after an altercation with the deputy-principal, the boy was expelled in year 10. The boy attended an 'alternative community option' and completed Year 10 course work. The three children of another carer changed school, due to one grandchild being bullied at school by his peers, who knew he had been removed from his birth parents' care. All three are currently doing well at their new school.

Moving to another school occurred for one child, but not his sibling. For example, one carer changed the school for an older sibling as they were not happy with his progress while the younger sibling stayed. The carer explained that while the younger sibling has numerous 'issues' the school works with him and the family 'really well'.

An 11 year old nephew with ODD, had attended multiple schools, and when placed was in class for only four hours a day. After being placed by his aunt in a private school with a special program for 'difficult' children, he has transitioned into mainstream high school and is attending five days a week.

Two other kinship carers mentioned that their related children had 'struggled' at school. One required a teacher's aide and the other received remedial assistance to help with learning. The latter child (aged 16 years) has left school and has started an apprenticeship as a cabinetmaker/carpenter. Six carers spoke positively about their related children's progress at school. The made comments such as they were 'doing well' or 'going OK'.

Three non-Aboriginal kinship carers spoke of older related children, still living in their home, who had finished school. Two children had left in Year 10, one began an apprenticeship (retrenched after 2 years) and the other is in a training program and completing work experience. Young people in two other families had finished Year 12 with one currently at University and the other working.

An Aboriginal carer, who struggled with the behaviour of one, of her two nephews when he started school, received some initial help from the department and the AMS and then later in the placement was supported by a worker from an Aboriginal carer support agency. When the child was suspended for four months, the Aboriginal support worker liaised with the school, arranging for the child to return on a part-time basis. As the child settled down his school attendance increased and the carer feels he has improved.

Another young Aboriginal child changed school and while still 'struggling' his carer is very happy with the school, saying: 'They've been supportive from 'day one' with him and they understand where he's coming from'. His elder sibling also has learning difficulties. In primary he was placed in an *Intensive Education Program* and said the carer: 'that's now followed him onto high school, so he's getting support'.

Due to their special needs (i.e. psychological issues) six children (all boys) of six separate Aboriginal carers attended or were planning to attend special schools. One child, needing support, is transported daily, to and from school, and his great-

grandmother is happy with his progress. The grandmother of a boy in high school, attending a learning centre for four hours daily, said proudly: 'He's a very good artist, a very good drawer; really deadly he is'.

Another Aboriginal teenager (14 years), currently not attending school, is waiting for a place in a special education program. Through a respite program the teenager has become involved with the local youth radio station and works 'two shifts a week with the worker' said his grandmother who added: 'That has done wonders for his confidence'. A young autistic grandson, of another carer, is in a special school and is receiving remedial teaching. The Aboriginal carer of four related children has a grandson attending a special school. The two older related children were doing well at school and though the youngest child (a niece) 'had three white slips' [for bad behaviour], her aunt said 'she's starting to settle down'.

Summary: The educational status of children in care appeared strongly linked to their health status. Many children in kinship care with psychological conditions were attending special schools/programs or had changed schools. Due to carer advocacy and awareness of the importance of education for children, both foster and kinship carers had gone to considerable lengths, to ensure either: a 'change' of school; transfer to a special school; or enrolment in learning program or tutoring. Carers indicated high aspirations for children in achieving their potential.

Supporting literature Research (Staub et al., 2010) suggests avoiding school moves for children placed in care ensures greater educational success. However, as noted above it appears that, changing schools or transferring to a special school was the 'best' educational option for some children. Transportation funding and other school services/programs were promoting educational success, a similar finding to the research of Staub et al., 2010.

Little is known in Australia about the transition to adulthood for young people who have been in kinship care. A Spanish study with young people ($n=67$) aged 18-28 years who had lived in kinship arrangements (predominantly with grandparents) found high placement stability, with 90 per cent of placements continuing into adulthood. Of interest is the finding that during the care period most continued with schooling with just over a quarter (26 per cent) changing schools. At time of interview 22 per cent were studying, 57 per cent were in the labour market and 14 per cent were unemployed (del Valle et al., 2011)

2.11 The health of foster/kinship families

Foster families: Carers were asked about their health and whether there had been any change to their health, since commencing fostering. Nine said were in very good health. One carer of babies and young children felt that her health had 'probably improved. I'm more active, definitely more active with the children'. Except for a single carer, who has picked up younger foster children's coughs and colds, the nine said nothing had affected their health in time they had been fostering. A few carers said they felt they were getting a bit older and greyer and somewhat tired. One carer who has 'severe scoliosis' said she kept fit by walking every day.

Although not due to fostering, one married carer was taking anti-depressants after her grandparents and mother died within a short space of time. With two teenagers and five foster children she noted:

I'm probably running on empty quite a bit of the time. I've lost a lot of weight since I started doing this [fostering]. I just haven't got time to be thinking about too much. I mean, I'm dealing with three schools, a preschool. But I wouldn't have it any other way.

Another carer, with two foster children, whose health was 'about average' said she developed high blood pressure (prior to fostering) and took medication. The carer thought she was less stressed since leaving full-time work and beginning a casual/part-time position: 'I don't have the stress now of having to get everything ready in the morning and get everybody out the door at quarter to eight'.

Self care: All carers had an activity they participated in and many involved the foster children in their activities. Six carers said they walked daily. Eating 'well' was mentioned by three carers who also exercised to keep fit. Going to the gym, biking, swimming, fishing and gardening was mentioned by other carers. For one carer running around after five foster children kept her fit; she said she never had 'down time'.

Some carers said they loved reading and/or going to the beach for relaxation. Another said that between short-term placements she tried to pamper herself (i.e. facial and massage). One carer, a member of a local arts and crafts centre, spent a day there, once a month, serving customers or knitting or sewing with others. Five foster carers mentioned that since starting fostering, a particular sport (e.g. tennis, triathlon training, gym, and aerobics) had to be given up because of a lack of time to participate.

All foster carers with a husband/partner, except one, said that their health was good. The exception was a respite carer, in her early seventies, whose husband was unwell, and no longer able to assist her with fostering. A foster mother, with three foster children in long-term care, explained how becoming carers had benefitted both her and her husband:

I think it's been the lease of life to him, really. We had both got to the stage where you come home from work and you'd [just] sit down. Well, now, that doesn't happen.

Kinship families: Ten of the 20 kinship carers said their health was good but four of the 10 qualified this by saying they had a combination of medical and/or psychological conditions:

- Arthritis (2 carers);
- Anxiety/stress (2 carers);
- Depression (2 carers), and
- High blood pressure (1 carer).

For one Aboriginal carer, caring for two related children, her depression started when her husband died two years ago, and she found caring for children was difficult:

It really was not easy and there was a time there when I was thinking about... seriously ... about letting them go to another family. *How did you work through that?* I don't know. It just took a lot of effort. Oh, the girls [daughters] were very supportive and they just stepped in and they looked out for me. I couldn't function, really, properly for a long time. I'm just now starting to get where I think I'm now more able to cope.

Five kinship carers had required surgery and/or hospitalisation for an illness in the last few years. The surgery included: a shoulder reconstruction; removal of a kidney; abdominal surgery (on three occasions); and other operations (unknown). One carer who required abdominal surgery said she was currently in good health: 'I've come good. I'm fine. I get tired in the afternoon'. A second carer who became ill and spent time in hospital (2011) said: 'I'm back the way I should be'. The third carer, an Aboriginal aunt in her early fifties, with three related children in her care, had her kidney removed. She is still unwell and attending doctors and hospitals for further tests. An Aboriginal grandmother (mid-fifties) of four said her health was 'average' and commented:

I used to walk every day until I had the last lot of surgery twelve months ago and I couldn't do anything for a while and then I got out of the habit.

One carer who said she was 'fairly healthy' added that she was an asthmatic, had emphysema and also suffered from gout and arthritis. Seven carers who said their health was only 'average' had medical conditions including: a heart condition, diabetes (two carers - one insulin dependent), obesity, sleep apnoea, unexplained weight loss, rheumatoid arthritis and osteoarthritis.

For a third of the carers their health had stayed the same. Most kinship carers, whose health status had changed, said it was not due to their caring role, rather it was due to getting older and having problems associated with ageing (e.g. arthritis). One carer (50) however, commented that she became highly stressed after her young grandchild was placed and had to deal with the child's abusive and threatening birth parents. She commented: 'In terms of how has my health suffered, I've aged, certainly have aged'.

Self-care: Many kinship carers participated in a physical activity, including: exercise bike riding, treadmill walking, swimming, walking, bush care work, soccer, gym, Pilates, exercises, bowling, line dancing. Carers' comments illustrate the value they placed on these activities

I'm very active, not so much physically because the arthritis doesn't allow that, but I have my groups, my friends [support group] that I join. I also belong to another group that I call 'granny groups' - we knit for charity and I go to that every week.

A husband, in a carer couple in their mid-seventies, said 'we do everything in moderation. We go for a walk every so often, but I try to walk a mile in the morning'. A younger carer (mid-fifties) said she goes walking and does line dancing for two hours once a week: 'Absolutely love it. I have a good laugh. I get very exhausted. It's just great'. A carer in her mid-fifties who meditates said: 'Probably not as much as I should, but I do it'. An Aboriginal carer in her late forties said:

I go walking. I joined the [name] club at [Aboriginal agency] here and I go and exercise on Mondays and cooking on Tuesdays and today like Wednesday, I go to bowling and all that. It takes the stress out, because I just go and I just forget it.

Concern was expressed by four carers, that if anything happened to their health, they could not continue caring. An Aboriginal carer, in her mid-sixties, caring for a grandson and a great-grandson, noted that she had rheumatoid arthritis and osteoarthritis. She has asked her daughter, caring for the great grandson's siblings, if she would take the boy, if anything happened to her, and she has agreed. One carer, with three related children in her care is planning to return to gym workouts after completing a stress test. She explained why she felt it was necessary to get fit:

It has worked before so I'm hoping it'll work again. I'm just more positive because ... what happens to me? What happens to the girls? I have to stay healthy at least. With [granddaughter] she needs a lot of attention, not everyone is willing to take that on.

Another carer (early seventies), who did nothing to keep fit, worried that if she or her husband could no longer care, then the three grandchildren may have to go back to their mother, who has re-partnered and has two additional children. She added: 'But I am fit. I'm a very active person ... It's just harder to get down and get up'. An Aboriginal carer, in her mid-fifties, who with her husband cares for four grandchildren, and whose health had deteriorated said:

I haven't got the energy that I felt I had. I don't sleep a lot. I've had a couple of surgeries since we've had the children, but at the moment, apart from being overweight, I'm doing really well. We're both trying to look after ourselves and eat properly and that because you know there's no one else for the kids if anything happens to us.

Three carers due to current health problems did little physical exercise. One Aboriginal carer, in a carer couple, with five related children in her care, who had been ill recently, said she thought her health had improved due to 'chasing after' the children all the time :

I don't have time to do anything for myself. By the time you've run up and down stairs ... to the clothes line ... Household activity keeps you going. I enjoy gardening and I love sewing but I don't get to do that anymore ... my garden is probably my salvation.

Of the nine kinship carers with a partner/spouse six were in good health. The partners/spouse of three had a variety of chronic conditions: 'lung problems

(bronchitis) which is slowly getting worse'; another spouse has a heart condition (pacemaker inserted); and the third spouse was a 'borderline diabetic' and taking cholesterol medication. The wife in the third couple also commented:

We both take anti-depressants. *Can you tell me a little about what led to that?* Oh just, it was just getting hard for us to do everything. I've been off and on anti-depressants since we first started struggling with my daughter's addiction and then [husband] I could tell he was going downhill, he was fairly depressed and I made him go and talk to the GP about it and so he's on anti-depressants too now. *And do they help?* Yes, they do me [and] I can see the difference in him too.

Summary: Overall the health situation of kinship families was much poorer than for foster families. Most carers in both groups were participating in enjoyable activities. Kinship carers compared to foster carers expressed concern, as to who would care for their related children, if anything happened to them. They were also more conscious of getting older and having problems associated with ageing.

Supporting literature: Findings from US studies (Berrick, 2001; Chipman, Wells and Johnson, 2002; Harden et al., 2004; Minkler et al., 1997; Minkler & Fuller-Thompson, 1999) and in Australia (Yardley, Mason and Watson, 2009) found, kinship carers, compared to foster carers, experienced poorer health. The Australian study with kinship carers ($n=15$) noted carers reporting that, due to their age, caring impacted on mental (e.g. disturbing levels of stress) and physical health and aggravated existing health conditions. Five carers also spoke of broken sleep and extreme tiredness (Yardley, Mason and Watson, 2009). One UK study with kinship carers found 26% with a long-term illness or disability (Aziz, Roth and Lindley, 2012).

Numerous national and international studies have highlighted the stressors and strains affecting grandparents (predominantly grandmothers) carers, including depressive symptomatology, poor health and increased psychological and emotional stress (Backhouse and Graham, 2009; Brennan et al., 2013; COTA, 2003; Farmer and Moyers, 2008; Geen, 2004; Horner et al., 2007; NSCAW, 2009; Mission Australia, 2007; Yardley, Mason and Watson, 2009). One US study found grandparent carers had close to twice the rates of depression as other grandparents (25.1% vs. 14.5%) (Hayslip & Goldberg-Glen, 2000), and a Spanish study with kinship carers ($n=151$) and foster carers ($n=67$) found one in every four foster carers experienced an unhealthy level of stress. Compared to non-relative carers; the highest stress scores were those of kinship carers (Palacios and Jimenez, 2009).

2.12 Balance between care-work and self-care for foster/kinship families

Foster families: Seven of the 11 foster carers currently fostering were satisfied with the balance between fostering activities and time for themselves. Two of the seven commented that the activities that they shared with the foster children were of interest to them as well, so they thought their balance was 'fine'. One carer couple gave one another 'time out' for their own activities. Giving up paid work enabled two carers to

improve the balance in their life. One single carer, who paid for a babysitter once a week said that it 'had made a big difference' to the balance in her life.

Kinship families: The kinship carers were more guarded in their response as to whether they had a balance between caring activities and time for themselves. Seven out of the 20 said 'yes' or 'I think so' or 'I'm managing'. Others (three carers) were more equivocal saying 'whenever I can I do', or 'I'd like a little bit more time to myself', or 'I can't wait to have a day off so I can just sit around and do nothing'.

Ten carers without a good balance would have liked more time for themselves. As the following comments indicate carers, with more than two related children in their care, appeared to struggle in finding time for themselves:

I was used to being able to go away when I felt like it. My husband and I, we used to go away weekends ... Yeah, you can't do that. You don't get that respite. Even with the family backup it was still hard.

I've been under a psychologist because of all the stress and family issues. They said I need to take time for myself. So whenever I can, I do.

I just feel if I don't have a break from the kids within a few weeks ... I'm even [more] stressed because I think I'm tireder than I would be.

Well, I'm not satisfied with it but what can you do?

Two single carers commented that being 'on their own' was hard. At times they felt lonely and needed to contact someone in the family, just to have someone to talk to.

Summary: Foster carers appeared to have a much better balance between care work and self-care. Finding time for themselves and obtaining respite was more of an issue for kinship than foster carers and not having more time for themselves appeared to impact more on kinship than foster carers.

2.13 Carer suggestions for keeping placements stable

When asked for suggestions for keeping placements stable foster carers mentioned:

- Recognition of the importance of carer/child bonding/attachment.
- Treating children with respect.
- Providing rules, routines and boundaries.
- Having continuity of relationships with workers
- Having consistency from agency workers.
- Having good relationships with birth parents.
- Exercising tolerance and patience.
- Being open and honest with foster and own birth children.
- Having access to support.
- Receiving respite.
- Maintaining foster children's life story books.

When asked for suggestions for keeping placements stable kinship carers mentioned:

- Having some contact with DoCS including caseworker support.
- Maintaining strong family relationships including birth parents.
- Receiving respite.
- Receiving carer training.
- Being committed.
- Being assertive.
- Having supervised contact visits.
- Establishing routine and boundaries for children.
- Having a good understanding of social media (e.g. Facebook).

Common themes for stable placements for all carers were providing children with routines and boundaries; developing/maintaining strong relationships (with workers, family and birth family); receiving respite; and being supported by workers.

2.14 Key findings (Stage I)

The project's overall aim was to answer key questions around placement stability.

Q1. What factors, singularly or together, support the concept of stability in care placements?

Risk factors to placement stability were evident in this study and while some aspects of care were difficult and stressful to handle, foster and kinship carers persevered with placements, indicating clearly through their words and actions their strong commitment to the foster/kin children in their care.

Carer stories demonstrated that regardless of placement circumstances, most adapted well to the age, needs of children, and requested placement type (e.g. long-term). A limited foster carer pool available and the seldom use of family group conferencing for kinship placements, meant several foster and kinship carers, were not selected as the 'most appropriate' carer for particular children placed with them. Rather it was carer availability and/or willingness to take a child that appeared to dominate most placements.

The complexity of some children's needs and high numbers of children with specific carers - factors which can lead to placement instability - appeared to be more of a stress factor for kinship carers. Only kinship carers intimated placements were at times, at risk. Many kinship carers were older, the majority presenting with little formal agency (i.e. caseworker) support. They coped, some not easily, with challenging situations as they arose (e.g. death/separation/divorce of partner/spouse, birth children's substance abuse problems, children's challenging behaviours, own and children's medical conditions, and changing children's schools).

Being with a government or non-government agency did not appear to be a specific issue, as the majority of carers were with the government agency *Family and Community Services* (previously known as DoCS). Carers' experience and relationships with individual caseworkers was mixed; some had nothing but praise for individual workers, while others were highly negative. While kinship carers may have

similar, if not a higher need, for caseworker's support, some were inclined to comment that they were glad the department was not involved in their family's life. On the other hand some were 'desperate' and dismayed that no one was available to provide information, support and services to meet children's needs.

Carer employment, considered a risk factor for stability, was an issue. In this study some carers were financially disadvantaged (i.e. less well off) by having to make changes to paid work arrangements. Some, but not all, had come to terms with their decisions to lessen paid work hours, change jobs or quit work altogether. The major reason for labour market changes was carer recognition that they had to be 'available' to meet the needs of foster/kin children. For some receipt of a carer allowance was a form of compensation for lost wages from paid work.

The role of Courts impacted on placement stability for some foster carers, particularly when orders for children's placement were changed or delayed. Uncertainty existed for some kinship carers around a lack of orders. Those without an order were concerned at where children would go, if something happened to them. High legal costs in applications for court orders were evident for some grandparents. Limited knowledge of the ramifications (i.e. loss of support) of taking *Parental Responsibility* was evident for two grandmothers. While stressful to carers in varying degrees, most appeared to have coped and adapted to their particular circumstances, despite the issues they faced.

Q2. What, if any, are the main differences between foster and kinship care, in relation to placement stability?

While there were many similarities in the events/situations that affected all carers throughout their placements, there were some subtle differences between foster and kinship carers that increased the likelihood of, or foreshadowed, risks to stability. Kinship placements were often unplanned and carers unprepared to take children. Many kinship placements appeared to be without the direct involvement of authorities, though some families were 'known' and had been involved with child protection agencies and the police. With 'planned' placements, some kinship carers were pleased with support offered by caseworkers, while other carers received no support and were left to fend for themselves.

It was many years before some kinship carers were assessed. Placements where no assessment, or a minimal assessment is conducted on carer family appropriateness, presents a risk to stability and also to child safety. Few studies have assessed safety concerns for children in kinship care. Because the majority of placements are monitored infrequently, little is known about quality of care. Risks to stability are a strong possibility for carers lacking financial resources and appropriate information, and for whom support is not provided, either initially or on an ongoing basis.

Compared to foster carers, many kinship carers appeared totally unprepared for the impact on family relationships, when children were placed. Many carers indicated high levels of stress and strain from trying to keep family members 'onside', while handling related children's often challenging behaviours with little support. Aboriginal families, with larger numbers of both birth children and related children in their care, appeared to struggle the most, again with minimal formal support.

The receipt of a carer allowance for kinship carers appeared more precarious than the allowance provided to foster carers. Without the allowance many kinship carers, reliant on income support payments, acknowledged they would struggle financially. Some carers were highly concerned at proposed reforms to kinship care programs in NSW, especially the risk of losing the allowance. For this group the loss of a carer allowance would risk placement stability.

Many kinship carers, without caseworkers, did not know who to turn to when they needed help with children's issues. To assist with stability, kinship carers initially need a caseworker/agency to provide information and access to financial/non-financial support. Throughout the life cycle of the placement kinship carers need to know who they can contact, if assistance is required. While not the case at present, ongoing training/information sessions or learning groups for kinship carers would benefit stability and should be commenced around the initial placement stage.

Obtaining respite was problematic for foster/kinship carers. All carers need a break from constant caring, but older, more vulnerable kinship carers are at higher risk of placement instability, when respite is unavailable. Without agency support for kinship placements, carer need for respite is unrecognised and unmet.

Q3. What 'resources' do kinship carers (predominantly grandparents) utilise in managing relationships within highly charged family dynamics, provide adequate and safe care to children, and cope with the challenges presented by 'parenting again'?

It is difficult to speak with a degree of equanimity about the perceived value of support groups for many kinship carers interviewed in this study. Feeling alone and socially isolated impacted on many grandparents and related carers. Some were of the opinion that joining and belonging to a group had 'saved' their lives. This finding provides the strongest indication of the situation of older, more vulnerable carers, without adequate information and resources, lacking someone to listen to their stories and share their often fraught and difficult lives, which few in the wider community appear to understand.

Family and sometimes friends were supportive, but an understanding of their situation and the ability to obtain relevant information appeared, in carers' opinions, to be best provided by other empathetic grandparent carers. At times it appeared debatable as to how reliable and up to date such information might be.

The concept of older carers 'parenting again' should not be taken lightly. For many kinship carers there was a continuation and increase in daily housework chores and child care routines, with little time to be involved as their contemporaries were with, for example, reduced housework, more leisure activities, holidays, hobbies and time for themselves. Parenting again also requires older carers to make significant changes in the way they conform/adapt to contemporary practices around parenting, child discipline and education.

Q4. What is the impact on older carers, providing care for extensive periods of time and do kinship carers, compared to foster carers, have the physical and emotional capacity to meet children's needs?

The emotional health of some kinship carers appeared tenuous. In this study, it was kinship carers who spoke of feeling, that at times, they would have liked to 'walk away' from their caring responsibilities, 'given children back' to the department, or let children 'go' to another family. Carers in the study acknowledged their daily struggles openly, with many indicating an inner strength and resilience that enabled them to overcome difficult periods and provide placement continuity and stability.

Grief, loss, guilt, shame and anger for many kinship carers appeared to be unresolved issues. The 'double-bind' for carers - torn in their feelings towards birth children, whose actions have resulted in their children coming into care, but trying to support them regardless of the circumstances - was evident in many carer stories. These are not issues that impact on foster carers and yet they stay unresolved for many kinship carers. This issue begs the question, who is responsible for addressing grandparent carers' emotional needs and well-being? At what point does reduced carer well-being impact on the quality of care being provided, and as a consequence risks children's sense of well-being?

Kinship carers appear to have more serious health concerns than those indicated by the foster carers. Most felt their poorer health status was due to 'age problems' and not because of caring for related children. Their stories however, make it clear their health status was at risk from their caring role. Not having energy and feeling tired was an issue for many. It not difficult to imagine the increased stress and strain on carers from lacking energy and continuously feeling tired, and the risk to stability when, due to age and health issues, it all becomes 'too hard'. It was kinship carers who were concerned about what might happen to children if they could no longer provide care.

Stage 1 of this exploratory study indicates that despite the commitment of carers, kinship compared to foster care, may have substantially more risks to placement stability. A combination of any of these risks, or the exacerbation of a current single risk, e.g. carer ill-health or stress, could put any placement at risk of breakdown.

3 Stage II: Survey with Workers

The survey with workers consisted of 13 open-ended questions (see Appendix 3) Respondents were asked to describe their background in OOHC, their current role and time in this position, whether they were Aboriginal or non-Aboriginal, and whether they were with a government or non-government agency.

Cultural background: In total 37 responses were received of which 34 were used (3 carers inadvertently completed the survey). As the figures in Table 1 indicate most respondents were non-Aboriginal (n=23), one was Aboriginal and ten respondents failed to provide information on cultural background.

Table 1 Cultural background of survey respondents

Cultural background	Respondents
Non-Aboriginal	23
Aboriginal	1
Not stated/missing	10
Total	34

Current position: Most of the respondents were managers, senior caseworkers or caseworkers (n=24) in OOHC. All other respondents had background working in OOHC. Some were working in allied fields, for example, child protection, residential care or group homes. A few were in OOHC but not in casework (see Table 2).

Table 2 Current position of survey respondents

Current position	Respondents
Caseworker (11) Senior Caseworker (1)	12
Manager (Case Work; Recruitment/Retention; Programs)	12
Psychologist (1) Counsellor (1), Clinician (1)	3
Chief Executive Officer	1
Adoptive & permanent care professional	1
Mental health social worker	1
Adoptive & permanent care professional	1
Preschool Field Officer	1
Not stated/missing	2
Total	34

Years of experience: Most respondents (n=27) provided the overall time they had spent working in various capacities in the OOHC sector. Some reported on the time spent in their current role and overall time in OOHC. For ease of discussion and to

indicate the respondents' depth of experience in OHC, overall time spent in OOHC is provided in Table 3. The respondents were reasonably experienced with 13 having 10 or more years working in the OOHC sector, eight between 5 and 10 years, and six with less than five years of experience.

Table 3 Survey Respondents' Experience in OOHC

Years of Experience	Respondents
≤ 5	6
≥5 to ≤ 10	8
≥10 to ≤20	8
≥20	5
Not stated/missing	7
Total	34

Most survey respondents (**n**=15) currently worked for a non-government organisation and eight for government (FaCS). Six respondents had worked for both NGOs and government, but it was not clear from their response, where they currently worked. Five respondents did not provide information on agencies/organisations where they had worked, or were currently working.

Table 4 Survey Respondents' Agency Type

Type of agency	Number
Non-government organisation (NGO)	15
Government agency (FaCS)	8
NGO + government (FaCS)	6
Not stated/missing	5
Total	34

3.1 Aspects affecting placement stability for foster carers

In relation to placement stability, the main aspects affecting stability were in all respondents' opinions heavily focussed on the carers, their attitudes, skills and insight into the needs of fostered children. Of equal importance was carers having the support they needed from skilled workers and family members and education and training for carers. Two respondents' quotes provide examples of the necessity to focus on carer attitude and skills and highlight the value of support provided.

- (1) From my experience placement stability comes down to the attitude and skills of the carer largely. Resilient and child focussed carers are able to maintain even the most difficult placements by drawing on their internal and external supports. When carers have the mindset of commitment and provide a

framework that says to the child: "I will never ever give up on you no matter how hard this gets" that children settle eventually and connections are strengthened. This does take a huge focus on having 24 hour support for carers provided by skilled workers who know the carer and can work through issues with them.

- (2) The carers, I have observed, to be most successful in stability are those with insight into the needs of children once they enter OOHC, for example carers who have the capacity to look beyond the basic needs of children and advocate on their behalf. A second element is carer's capacity to seek information and support from caseworkers. Carers who keep communication lines open tend to meet the children's needs a lot better, as they are open to information exchange. Carers own support from their partners and extended family members is also a great factor that contributes to stability in placement as this contact also helps children feel part of the family and provides them with a sense of belonging.

Carers' attitude, skill and ability: Most respondents commented about important features pertaining to carers, workers and placements and the following section presents a summarised version of their responses. Included in the key values relating to their attitude, skill and ability were carers with:

- [Life] experience in addition to their own parenting.
- An understanding of the nature of fostering and not underestimating their capacity to meet the challenge of fostering.
- A commitment and primary motivation to care.
- An understanding of their rights and responsibilities.
- An ability to regularly seek information and support from caseworkers and develop 'good' relationships with workers.
- Capacity to cope with the 'bureaucratic departmental machinery' and inexperienced caseworkers.
- Openness, flexibility and insightful of child trauma and development.
- An ability to develop a trusting relationship with the child and manage children's behaviours 'with where they are at'.
- Realistic expectations of the child in relation to change.
- An ability to maintain connections with a child's biological family wherever safe to do.
- A strong network of support: family and/or other carers.
- Regard for self-care and own family life.

Agencies/workers: In relation to agencies and workers respondents discussed practical aspects they would assist with placement stability. A summary of key points included:

- Regular and open communication with all parties involved in the placement.
- Respond promptly to carer requests.
- Provide timely access to carer support.
- Visit carers in their homes.
- Provide respite as required.
- Provide relevant information about foster children and expected time frame of placement.
- Be readily accessible to carers of children with challenging behaviours.
- Offer intensive carer support through difficult periods of the placement.
- Support carers engaged with other ‘systems’ (e.g. education and health).
- Provide therapeutic input to carers’ own issues and triggers.
- Be aware of the ongoing physical and mental health of carers.
- Support carer’s own family life to ensure carer own health and well-being.

The placement: Respondents also mentioned aspects of placements that assist with stability. A summary of key points included:

- Ensure a ‘good’ match between family and foster child and conduct a comprehensive assessment of a child’s needs and plan to meet them.
- Consider the mix of ages of carer children and foster children on placement.
- Case plans to involve participation of birth families, carers and children.
- For Aboriginal children ensure adherence to the *Aboriginal Child Placement Principle*.
- Utilise other professionals (e.g. psychologists) early, rather than later, in the placement.
- Link carers to service providers.
- Assist carers with structuring placements (routines and boundaries) to ensure order and predictability.
- Utilise a team approach and acknowledge carers as equal team members.
- Staff retention provides continuity and sustains ongoing relationships.

Carer education and training: Carer education and training was seen as important in relation to stability and was mentioned 23 times throughout the responses. A quote from a casework manager in FaCS reflected a common theme:

In my experience, the carers who regularly attend training and support groups deal with the challenges of fostering much better than those who have limited contact with FACS. Unfortunately

some carers, who do not attend training or support groups despite repeated requests to do so, are often carers who complain that they receive no support from FACS.

A summary of important aspects of carer education/training included:

- Generalised training is essential but only deals with general issues.
- Carers need to be encouraged to attend ongoing training as training validates consistent carers and equips them with skills to assist with healing of neglect and abuse.
- Carers may require specialised training for specific situations and children (e.g. managing challenging behaviours; therapeutic parenting; contact; and trauma and attachment).
- Carers not used to (or available for) formal training session benefit from home-based individual support and training.
- Training and support is required by the whole carer family; not just the primary carer
- Train carers to recognise behaviours common to all children and those behaviours specific to children in OOHC.

Attendance at peer-based carer support groups was linked to carer training by some respondent with one caseworker noting:

Whether in foster or kinship care the involvement in support groups is crucial to receiving the correct information to assist in sustaining good care.

Other respondents suggested that workers should encourage foster/kinship carers to attend ongoing training, carer support group meetings and other organised carer events and address any fears/concerns carers may have in relation to attendance.

3.2 Aspects affecting placement stability for kinship carers

As with foster care, all respondents with kinship experience commented on significant aspects pertaining to carers, workers and placements and the following section presents a summarised version of their responses. The following discussion is based on 32 respondents as two respondents had no kinship care experience. A quote from an experienced caseworker sets the scene for kinship care:

In my experience as a case worker and carer support working with kinship/relative carers, there are some similarities and vast differences to caring for a child in statutory care. There needs to be extra work to look at placement stability in light of ongoing relationships with family. The training/education/support that we provide as an agency doesn't always translate to relative carers. Therefore relative care needs specific training/education/ support. We need to have consistency across all areas but we need to be realistic and tailor our expectations to relative carers. That doesn't

mean we compromise on our standards, but we need to also consider relative carers' life experiences and current circumstances.

In the following discussion the perceived value of kinship carers appeared more constrained (i.e. negatively based) than those around the values of foster carers (see above). The critical nature of family relationships, among other aspects impacting on stability, was highlighted by respondents:

- The relationship between the birth parent and kinship carer affects placement stability; kinship carers, at times, are unable to have appropriate barriers/boundaries between themselves, the child in care and birth parents.
- Lack of carer's parenting skills can hinder stability.
- Due to technological advances in education, relative carers can find it difficult to assist children with school work.
- Many placements 'suffer' as relative carers are unsupported carers left to their own devices and influenced by their peers.
- Carers can require more support and respite as they do not always have the education and resources of foster families.
- Placement breakdowns can be due to a lack of insight and acknowledgement of child protection issues by carers.
- Kinship carers are reluctant to seek support from groups.

More positive points were:

- Carers are more committed and more 'prepared' (i.e. they know the child).
- Kinship placements are enhanced by strong family ties.

Agencies/workers: In relation to agencies/workers assisting placement stability there was a belief by many, expressed succinctly by one caseworker that, the myth should be debunked, that kinship carers can care for children's complex needs 'just because they are family'. A summary of key points included:

- Provide professional, regular one-on-one support.
- Treat carers as the 'expert' and note their strengths.
- Have carers identify support needs, and tailor support service around them.
- Provide timely access to therapeutic service and support for kin children.
- Provide relevant information to ensure cohesive and amicable working relationships.
- Respite care is necessary to sustain placements.
- Carers require advocacy and representation in engaging with agency and departmental systems.
- Sensible court orders regarding contact with parents and other family members are required.

- Cultural awareness training of agency staff would aid stability.
- Strong case management systems are critical.

The placement: As with foster care, respondents also mentioned improving placement aspects to assist with kinship care stability, including the following points:

- The establishment phase of placements requires highly skilled workers.
- Thorough assessment of placement suitability should be paramount.
- Having PR can be important for stability.
- Ensure support groups are available to kinship placements.
- Financial assistance (including set-up and other costs) should be offered to formal and informal kinship placements.

Training/education: Training and education for kinship carers was mentioned by over a third (n=11) of the respondents, with one commenting:

Many placements are rarely supported by caseworker who could provide required carer information/education to prevent the likelihood of breakdown and accompanying distress for all involved.

Key points in relation to education and training included:

- Provide specific training/education/support to help carers understand children's behaviour.
- Provide training in legal [aspects] and roles of team /parties involved with children in care.
- Provide information sessions on specific/related subjects (e.g. attachment disorders, grief & loss).
- Provide training to assist carers maintain dual roles and relationships (i.e. between carers and family members) and understand extra strains/stresses.
- Provide training around contact and the role birth parents play in the children's lives).
- Training/education tends to be provided in a 'reactive' way for kinship carers, rather than 'proactively', as provided to foster carers from day one.

Respondents stated that the main aspects affecting stability in kinship care were a lack of support, services for children, carer education/training and support groups with one respondent stating: 'If these aspects are followed up, then any placement (kinship or 'other') would have an excellent chance of stability'.

3.3 Differences between foster and kinship care

Foster care: Respondents were asked to discuss the main difference between foster and kinship care. One respondent felt very strongly that:

There should be no differences between placements - all carers have same/similar rights and responsibilities. Stability in a kinship care

placement should be easier to achieve because the children placed with carers know their family history, religion and culture. This may not always be the case, but it is more likely to be the situation.

The responses to differences focussed on personal characteristics, skills and abilities of foster carers compared to kinship care and the higher likelihood of foster carers receiving support compared to kinship carers. A summary of key points included:

- In the initial placement, foster carers may have a longer and more difficult transition time to settle children in their new environment, though they may be more experienced and trained to care for traumatised children.
- On-going support for foster carers is a significant difference. Through observation and communication with caseworkers, carers begin the fostering process with a clear focus; having made a decision to go ahead with their application makes their motivation different from kinship carers.
- Foster carers work as a team with caseworkers and can receive respite care easier than relative/kinship carers.
- Legislation, case management practice and monitoring are features of fostering not kinship care.

The following points have the proviso at the beginning of each point 'compared to kinship care':

- Foster carers are more prepared, but often have higher expectations of the children.
- Foster carers expect to have more involvement in decision making but can be less willing to practically support placements (e.g. take children to multiple appointments, contact visits and attend meetings).
- Foster carers frequently faced with children's difficult challenging behaviour and without support are more inclined to end the placement.
- In foster care there is someone [the state] other than foster family who is ultimately responsible for the child.

Kinship care: Many responses emphasised the commitment and motivation of kinship carers and the belonging and sense of permanence for a child:

- Carers have a commitment to improve the children's outcomes. Not wanting children to enter foster care is a very powerful motivation to 'hang in there' when things are difficult.
- Kinship is 'family' so carers are more likely to struggle through challenging behaviours.
- Carers have a bond and history with the child and have a commitment to the child that is different to foster carers.
- A strong sense of family and knowledge of the children means carers are already highly motivated to care for children.
- The main difference is the sense of belonging and of permanence that can come with being in kinship care.

Four respondents emphasised responsibility, duty and choice in relation to caring for related children that is different from foster care:

- Kinship carers have a sense of responsibility (obligation) to care for a family member.
- Relative carers may already have an investment in, and sense of duty, to care for the child.
- Related family may take children through obligation, rather than ability and desire to care for children.
- Kinship families, dealing with the additional burdens of grief and loss, feel they have no choice but to accept. This difference in motivation, combined with lack of support is likely to impact on stability.

Other key points highlighted the vulnerable nature of kinship carers compared to foster carers:

- Kinship carers are more vulnerable as they are often older, single and have health and financial problems.
- Due to family conflict, kinship care is potentially more stressful than foster care.
- There is an assumption that kinship care is better than foster care, as it keeps the child in the family. The stress however, may be great on unprepared kinship carers, and the risk of ongoing abuse and neglect may be higher. This may also put pressure on family relationships, leading to instability and placement breakdown.
- Family loyalties can be challenged in extended families due to caring for related children.

Many respondents acknowledged the lack of support to kinship carers and the consequences of this inaction. Key points from this perspective included:

- Kinship carers have a deep connection to birth parents which presents complexities often unaddressed. Kinship carers are not monitored and often 'left to it' by agencies.
- Kinship carers receive significantly less support (financially and in terms of recognition of stress).
- It can be difficult for kinship families to deal with other family members (e.g. birth parents). Once children are placed, child protection workers often reduce their involvement and support, which undermines a family's ability to trust and work cooperatively.
- Kinship carers receive less financial, departmental and agency support once a placement is made permanent; anecdotally withdrawing support is a primary factor for many kinship carers resisting a permanent care order for their child.

Respondents outlined what was needed for kinship carers and why it mattered. Key points included:

- Many kinship carers require added support to ensure the ongoing safety and wellbeing of the child.
- Kinship carers need to be treated as the ‘expert’ and receive more practical support in terms of financial and logistical arrangements. They often have little choice in becoming carers, requiring more trauma support/education.
- Complex issues relating to family of origin issues requires sensitivity. Support should be offered in a respectful way so that the family can work with the agency and not feel criticised or judged.
- Kinship carers require an understanding of placement implications, e.g. 'less time' for other grandchildren; less availability to provide support elsewhere for family; and dealing with hurt and anger associated with absent parents.
- With appropriate support, the high commitment by relative carers to maintain the placements will see it endure for long periods.

In relation to agency practice for foster and kinship care respondents emphasised two specific points:

- Accreditation (i.e. assessment) processes for 'stranger' (foster) and kinship care need to be totally different.
- A welfare agency needs to undertake fundamentally different roles in the two form of care.

3.4 Contact and access

Survey respondents discussed common issues around birth family contact and how they are resolved. One suggested that contact is not always a stabilising factor:

Family contact is one of the most un-stabilising factors in a child's placement, as they go through the grief process each time they see their family. This can threaten placement stability unless high levels of reassurance are given by both the birth family and carers.

Carer understanding of the importance of ‘good’ contact for children was noted by a respondent: ‘Children need consistency, realistic promises, and high levels of assurance of their value and worth’. Another respondent thought orders for contact were based more around adults’, not children’s, needs, adding that: ‘For placement stability, contact needs to be structured, formalised and set at a minimum number of times a year’. Survey respondents acknowledged some poor practice around contact/access for foster carers, including:

- Lack of consultation with carers around proposed dates/times of contact, particularly important for carers with long-term placements.
- Frequency of contact can undermine some placements and continues to be an issue in long-term placements.
- Carers not given timely advice of cancelled contact but expected to accept at ‘short notice’, changes to time/date of access/contact visits.

- Carers not advised about what happened (i.e. parent's behaviour and children's responses, etc) during access visits.

Key issues around contact impacting on the foster children included:

- Different people picking up children for access visits, and the emotional impact on children, due to frequently changing contact workers.
- Tension around children's needs versus birth parents' needs in relation to location/time frames and impact on children's routines with the carer family.
- Challenging behaviours of children before/after and during contact and their anger and emotion after parental visits.
- Children playing birth parents and carers against each other.
- Children's fear of abusive birth parents and children's feeling towards carers for facilitating such visits.
- Children's stressful experience of divided loyalties and loss.

Foster carer attitudes: Some concern was expressed by respondents in relation to the foster carers' negative attitudes towards birth parents and their feelings around the impact of contact on foster children. These concerns included:

- Carer negative judgement, feelings and sometimes fear of birth parents.
- Belief that the contact is difficult, unsettling and may damage the child.
- Inability to understand or manage a child or young person's escalation in behaviours before/after contact with birth parents.
- Worry/concern that contact reduces child's connection to carer.
- Lack of understanding around importance of family connection to foster children.
- Carer reticence to meet birth family can create split loyalties for foster children.

Birth parent behaviours: Respondents expressed concerns about birth parents who:

- Did not accept the carers.
- Turned every contact into a present feast.
- Broke promises to children and left carers to solve issues without being negative towards the birth family.
- Did not turn up for access creating problems for carers.

General concerns around contact: Some general concerns around contact and access were also provided; the key points noted were that:

- Court orders for contact can be unrealistic and bureaucratic and lack common sense so families (kinship or foster) do not comply which is not helpful in the long term. Orders do not take into consideration:

- Birth parents' current capacity, e.g. whether they are still actively substance dependent;
 - parents' own real wishes for how much contact they want and can manage and under what circumstances;
 - children's wishes about how much contact they want and under what circumstances; and
 - pressure on some caregivers with regard to managing and supervising parental contact.
- Too frequent contact can be destabilising to placements; frequency may need to be reduced allowing children to settle into their placement routines and be better able to cope with divided loyalties.
 - Agencies can experience difficulties in transporting children to access and co-ordinating transport workers.
 - Contact issues are complicated when non-qualified staff supervise contact.
 - OOHC providers complain about cost of providing contact and have financial incentive to reduce contact and thus reducing provider's costs.
 - Placements some distance from birth families, can create a myriad of hurdles for regular family/sibling contact, and can be a logistical nightmare to arrange.
 - There needs to be a clear plan around who will be present at visits and who will supervise (hear and see what eventuates).

Solutions in addressing contact /access issues: Respondents suggested a number of caseworker solutions addressing contact/access issues for foster and kinship carers including:

- To make contact work for children, caseworkers need to negotiate aspects with carers and birth parents, providing them with clear roles and responsibilities.
- Caseworkers need to explain importance of contact and provide support to birth parents to attend (e.g. provide transport, food, activity).
- Caseworkers can play a primary role in managing issues by supervising as many contact visits as possible. Best outcome for children occurs when the contact is 'facilitated' (i.e. assist birth parent/s to connect with child) rather than just supervising/watching by non-qualified staff.
- Caseworkers need to facilitate occasional contact, which includes carers who should be expected to meet birth parents (if deemed safe to do so); demonstrating positive relationships to avoid children having split loyalties.
- Provide training and support to carers experiencing challenging behaviours or unsettled children in relation to contact.
- Consultations, either through home visits and/or case conferences, to be organised between child, agency staff, carers and parents if issues arise.
- Children may require an impartial representative to ensure their needs around contact are understood.

- As birth parents may not always turn up to contact, experienced foster carers understand not to discuss parental visits with children, until they have been confirmed. Kinship carers can also face similar difficulties.

Kinship care contact issues: Some specific issues were identified for kinship carers. It was agreed by many respondents, that there is an expectation that kinship carers will facilitate contact/access with birth family, though foster carers are rarely expected to do so. In kinship care, frequency of access may be higher than is appropriate for some children, which can potentially impact on the placement stability. One respondent pointed to the differences in relation to contact for foster and kinship carers:

There are vastly different issues around contact and access for foster and relative/kinship care. For foster carers contact can often be initially about managing frequency, own feelings and management to ensure a child is enjoying contact. For kinship carers, it can be difficult to navigate around access and contact due to past issues with sons/daughters; this can be conflictual or there can be boundary issues.

Other respondents noted that 'divided loyalties' and issues with 'access' (a contentious word for some kinship carers) affected carers as well as children in kinship care:

Kinship carers have loyalties to their own children and have difficulties in understanding the necessity for contact orders. Conflict between carers and parents are common and need to be resolved early in the placement. More education regarding the purpose of contact is necessary for all carers.

Another respondent noted that contact can be problematic when kinship carers favour and encourage one birth parent's contact/access over another. A lack of contact with one side or another (paternal vs. maternal side) of the family can result in children not having their needs met in relation to contact. Kinship carers may have divided loyalties between different family members, said a respondent, making it difficult to manage contact arrangements: '[This] can cause children to be confused about where in the family they belong and also where their carer's loyalties lie'.

In addition, contact for children in kinship placement may not be 'easy' or 'safe' for children and/or their carers, as respondents commented:

- There may be serious issues between families such as conflict between natural parents and kin that make the contact difficult and unsafe for children; workers need to be proactive in bringing families together.
- Kinship carers are often on their own with potentially violent interactions.
- Sometimes the 'bad blood' between carers and birth family can make kinship placements unstable.

- Contact can result in conversations, issues and questions being raised that relate to pre-existing tensions in carer/birth parent relationship; exacerbated by carer looking after the parent's biological child.

3.5 Quality of family relationships affecting kinship placements

Discussants spoke of the many positive and negative aspects of family relationships in kinship care that can impact on stability. In the following section the positive aspects are outlined first, followed by the negative.

Positive aspects: Key points in positive aspects related to:

- The sense of belonging and normality in kinship care.
- Family culture, values and traditions are the same, or more similar, than foster care.
- Kinship carers can genuinely support the child's attachment to birth family, thereby reducing loyalty conflicts and maintain strong family connections.
- Positive relationships between carers and birth parents support stability.
- Sharing family information with young people especially in relation to their birth parents.
- The willingness of other extended family members to provide psychological support, respite and other assistance to the carer and the child in care.
- Carer capacity to integrate their grief and loss.
- Supporting families to deal with family conflicts, e.g. counselling, mediation, appropriate structuring of contact visits.
- Psychological and practical support by agency workers assisting carers with addressing issues early on, without waiting for possible placement breakdown.
- Aboriginal children having regular access visits and being provided with knowledge of family history, culture, rituals, and customs.
- Birth parents' capacity to reconcile themselves to their child being cared for by another family member.
- Sensible court orders that take into consideration the circumstances, needs and wishes of all parties.

Negative aspects: Respondents also spoke about negative aspects of kinship care that could hinder stability. Key points were related to:

- Carers not being child focussed or impartial to possible child protection issues that may arise in contact.
- Turbulent family history/conflict or carer inability to place child's needs and interests above the needs/interests of birth parents or other family members (i.e. divided loyalties) may mean the placement is not in the best interest of the child.
- Too much contact makes it difficult for children to settle.

- Grandparents experiencing difficulties/ambiguities in trying to meet children's and birth parents' needs at the same time.
- Carer difficulty in coping with competing needs and expectations (e.g. related to agency, birth family, carer and children).
- Competing demands on carer family (e.g. in relation to extended family, paid work, financial constraints, maintaining access/contact visits).
- Negative views or resentment by birth parents and other extended family over 'who' is caring may increase the likelihood of poor relationships.
- Intergenerational abuse issues that are not addressed.
- Workers unaware of birth parents pressuring carers to have more, or unsupervised, access.
- Carers' negative attitudes about OOHC workers/staff, especially FaCS.
- Carer/birth family conflict increases child's stress/conflict.
- Carer favouritism of one side of the child's family, over the other.
- Lack of communication and well negotiated case plans.
- Lack of staff resources to assist families through placement tensions.
- Effect on carer's children living at home (e.g. information provided, inclusion in discussion/decisions, sleeping arrangements and school attendance.)
- Birth parent/s mental health and drug and alcohol issues can cause carer stress/strain and at times carers suffer abuse from the parent/s.

Solutions to assist family relationships: Respondents suggested a number of solutions to assist relationships within families to support placement stability. Key solutions included:

- Using family group conferences to bring extended family members together to resolve differences and focus on children's best interests.
- Assessing how long term relationships with various family members will develop.
- Providing supervision of contact/relationship between carer (e.g. maternal side) and non-related parent (e.g. paternal side).
- Assess kin and extended family with the same degree of investigation as a non-kin care placement.
- Provide high quality professional support to kinship carers as placements are often more complex involving generational trauma.
- Provide good quality counselling to resolve 'historical family issues' between birth parents and kinship carer.
- Support to the carer and assistance with negotiation of the relationship is critical.

- Consult with carers re need for services; ensure carers are not disempowered by workers and have control (short of child protection limits) about using professional assistance.

3.6 Identity issues for children in kinship care

Respondents were asked to consider how children's identity issues in kinship care should be considered. Ten respondents recommended the use of life story books and/or implementing cultural care plans to help children understand their identity. Four respondents suggested that the way to promote a child's identity was through providing honest information about why they were not living with their parents. In relation to honesty two respondents thought that:

Open communication and trust are very important; children need to know that questions can be asked and that they know they are accepted/belong to the kinship carer's family.

Choosing words carefully - honest and accurate - but mindful of how the child might interpret them. Checking in with the child about what they understand the situation to be and correcting misunderstandings as quickly as possible - not making promises that can't be kept.

'Using stories, resources and other popular culture materials that reflect the experiences of kinship care families' were a helpful tool suggested one respondent. Activities for children, through kinship groups, could connect children to others in kinship care. Other respondents thought that education/training for kinship carers, provided by young adults who had been in kinship placements, could provide an understanding of how to address children's issues. Other family members, friends, mentors or counsellors could also assist children with identity issues.

If necessary caseworkers should 'follow up' to ensure identity issues are being attended to in relation to extended family members and culture. One respondent suggested focussing on what a child was good at, or interested in would, through encouragement and support in that area, help them develop a strong sense of self. Another respondent thought that: 'Being truthful in all situations strengthens the stability of the carer family unit' with another respondent recognising that: 'Children may need help coming to terms with their past traumatic and difficult relationships so that they can develop a positive self-image'.

Cultural issues were also important in relation to identity with two respondents noting:

For Aboriginal placements, identity is paramount. Identity and cultural needs should be included in the Care Plan and revisited occasionally.¹⁸

¹⁸ See Liebsman (2011) *Cultural Care for Aboriginal and Torres Strait Islander Children in Out of Home Care*, (http://www.snaicc.org.au/_uploads/rsfil/02727.pdf)

Issues of identity can be difficult to address when the child comes from vastly different ethnic backgrounds and religions. There are no guidelines about this, apart from Indigenous children. Often identity issue overshadows other issues for the child, such as attachment, stability and emotional issues.

3.7 Identity issues and role changes for kinship carers

Identity issues and role changes for kinship carers were also discussed by respondents. Difficulties with identity/role change were seen as having several aspects including:

- The issue is very hard to address as it is connected to ‘loss’ experienced in becoming a kinship carer.
- Grandparents can experience guilt and shame.
- Older grandparents can struggle with the physical side of caring.
- Can have a major impact health and financial needs and outlook, working life and retirement and how carers approach disciplining children.
- A lack of clarity around child protection issues.
- Carers’ friendship groups are often unable to understand or accommodate their changed circumstances.

Respondents suggested a number of methods to ameliorate the impact on identity/role changes for kinship carers. The majority of respondents spoke of the value of support groups. The key points included:

- Carers benefit from attending support groups; they are less likely to feel isolated and can be more at ease in contacting FACS for advice or services.
- Groups provide social opportunities to meet with others in similar situations and so they can share strategies.
- Carers need to have their feelings reactions/difficulties validated and normalised in groups.
- Support groups have a positive impact in reminding carers that they are not alone and can share experiences.
- Provide information at the beginning of the placement so carers are better informed about potential issues and their change of role.
- Refer carers to psychologist, counsellors and mediators as appropriate.
- Provide fuel voucher to help carers in country areas attend support groups.

Other practical measures suggested in supporting kinship carers in their new role included:

- Arrange housework assistance by an external agency; demonstrate to carers how to shop on-line and have groceries delivered, etc.
- Arrange childcare, vacation care, and educational support (e.g. tutoring).

- Ensure appropriate resources/services are available and able to be accessed.
- Respite provision.
- Support engagement with other family members around changed roles and relationships.
- Provide training/education around 'parenting children of different ages' and in 'parenting within a changed world'.

3.8 Carers not provided with support

In the survey it was suggested to respondents that kinship carers have been noted in research studies as 'missing out' on formal and informal supports and services including caseworker support. When asked how they saw the caseworker role in relation to supporting kinship compared to foster care placements, respondents were very forthright in their response. Four quotes exemplify the opinions of many respondents:

1. I agree with the above statement... the myth goes something like this 'if you are a kin carer then it's 'in your genes' to care for these children and you won't need as much help, support etc., as a non-family carer i.e. foster carer'. The OOHC system and management should be invited to dispel the myth. Caseworker resources should be delivered following a robust assessment of placement needs rather than mythical assumptions e.g. 'it's a kin placement so less case work is required'.
2. I absolutely agree with this statement - I believe that there is very limited support for kinship carers and a large amount of support for foster carers - there is a great chasm between the two. I think that kinship carers need access to similar training to foster carers such as trauma, attachment, positive behaviour management, etc.
3. The kinship carers that I have supported have clearly told me that the support 'has kept them sane' and allowed them to continue in their caring roles. Workers have told me how much work, having support in place, has saved them. They are able to focus on the parents, knowing that the carer is being supported.
4. There is no way at this stage the department can extend to adequately support kinship carers, as they are barely manage to provide minimal support for general foster carers. If we get resources maybe this can happen. I wish this can happen as we all know that this is false economy, as often unsupported kinship placement break down and the children end up in general foster care.

The role of the caseworker in kinship care: A number of respondents agreed that support should be offered by caseworkers to kinship carers and a summary of the main points included the following:

- Carers should be made aware of available financial and non-financial supports

- Supporting carers should be the same as supporting foster carers; the children have the same level of need and are often more complicated by complex birth family contact and informal contact arrangements.
- Carers need more support because of their additional vulnerabilities and the challenges of family relationships.

Some respondents differed on whether it was the ‘fault’ of carers that support was not offered/accepted while others thought it was the failure of the system (i.e. legislation, policy, programs) that prevented support being offered to the carers. Comments related to it being a ‘carer issue’ included the following:

- Kinship carers are less willing to engage with caseworker to the same level and frequency of foster carers.
- Though less likely to want FACS (DOCS) in their home after a placement has been settled, kinship can struggle with more complex family dynamics.
- If a crisis occurs, kinship carers with no agency relationship, have less knowledge about rights and responsibilities.
- When the kinship carer has PR and does not want to engage with Community Services they miss out on supports and services

Conversely, other respondents suggested that lacking support was a worker/resource issue:

- Due to lack of resources, children who are PR to the Minister will potentially be offered a service, ahead of children who are PR to a family member. In kinship placements where the Minister has PR there should be no distinction between kinship carers and foster carers.
- Often caseworkers step back in kinship care. It appears this may be due to respect for the family; support however, can be provided in a respectful manner.
- Casework loads are too high and caseworkers will direct their attention to a child who has ‘no one’, for example, a child in kinship care may have an aunt that loves and cares for them, it may not be perfect or ideal, but its love and it’s something.

Other respondents thought that there was a subtle difference in how support should be provided to kinship carers:

- Workers need to accept family are the experts, workers are to help support families navigate through the systems, provide access to information and where necessary training to meet their particular placement needs.
- The oversight role might be less in a kinship arrangement and the caseworker role might be less directive and more collaborative (i.e. helping the family members come to an agreement).
- These are totally different relationships and kin carers should always control the interaction.

- Support workers need additional training for this type of care as it is complex and difficult.

The supporting roles that respondents thought agencies and caseworkers should play with kinship carers included the following:

- Allow carers to determine the level of intervention and support; who to call if necessary and training availability. Caseworker support might be only one option in a support model.
- Carers may respond to professionals, other than identified agency caseworkers, and the caseworker role may be a 'linking in' support role.
- With child protection is a concern, the worker's role is to ensure children's safety and needs are being met (including cultural needs).
- Group support, peer mentoring and training may need to be explicitly focused towards kinship issues.
- Providing monthly home carer visits and/or regular telephone contact to monitor stability and to establish children's needs are being met.
- Provide carers with guidance around navigating systems e.g. health, education, etc.
- Provide carer advocacy as required and arrange respite.
- Caseworker support is required for long-term kinship care arrangements.

3.9 Maintaining children's cultural connections

Respondents were asked how agencies could support the maintenance of connections to culture, community and family, for Aboriginal children, placed in kinship and foster care. Just over half of the respondents (**n=18**) provided a response to the question. Ideally, respondents suggested placing all Aboriginal children with Aboriginal carers. Emphasis was also placed on ensuring that all Aboriginal children had a cultural care plans that was being implemented. Respondents noted it a caseworker's responsibility to ensure Aboriginal children had regular contact with close and extended family members. Other important roles for workers included:

- To facilitate children's cultural connections Aboriginal caseworkers, where possible, to provide non-Aboriginal carers of Aboriginal foster children with support and information.
- Provide Aboriginal elders and/or mentors for the children/family.
- Work collaboratively with Aboriginal caseworkers and Aboriginal services in accessing community resources and activities.
- Assess Aboriginal children's understanding of their culture and what they would like to know, or be involved in.
- Where age-appropriate, connect Aboriginal children and young people with cultural groups/activities of their choice.

- Provide additional training for all carers of Aboriginal children, encouraging carers to maintain strong connections with family or significant others.

3.10 Restoration/reunification for children in kinship care

It was suggested to respondents that research studies indicate that, compared to foster placements, children in kinship placements are less likely to be reunified/restored with their birth parents. Respondents provided a variety of responses as to why children in kinship placements were less likely to be reunified/restored. For two respondents it appeared that this occurred, by default and not design, as their quotes indicate:

1. There is a big push for children to be restored to their parents from foster care. With relative care the department doesn't need to get involved, therefore minimal resources are needed. Also the family often allows more contact with the child (regardless of agreement) and this perhaps satisfies the arrangement for the child to stay where they are. The placements are probably more stable, because family is able to put up with more difficult behaviours than most foster carers, and the placement does not fall apart. [Birth] parents would not contest the placement with the family, if they feel it is for the best outcome of the child.
2. It may be that in some cases reunification is less likely to take place because it is not in their [children's] best interests, and the kinship family is willing to hang in for the long haul and provide a better alternative. Children in foster care tend to have more placements, and as a result may become more difficult to manage, and end up going home because there is no satisfactory alternative placement for them.

Only one respondent disagreed with the premise stating:

My experience has been that probably about 70% have returned to their parent's care. The 30% that are still within kinship placements are due to parent death or incarceration or long term drug use.

Ten respondents agreed that children in kinship placements are less likely to go home. Notions of the critical place of 'family' in kinship placements and barriers to restoration dominated the key responses:

- Unlimited access/contact with birth parents satisfies some birth parents and the system views them as still being with family.
- As the children are in the family there is a perception that they do not need to be 'restored'.
- A kinship carer is able to build on a family foundation that foster carers are unable to do so.
- Generally kinship placements are more stable, less likely to break down and offer more stability for children generally. Children's identity is usually more

positively maintained due to existing knowledge and connection to family, and culture.

- Kinship care keeps children safe.

Other barriers to restoration were mentioned including:

- Children in kinship care may have a clearer understanding of why they are not living with their parents. Restoration can be compromised by negative relationships between carers and birth parents.
- Kinship carer's sense of 'ownership' appears to be stronger in kinship placements. As the child is with 'family' any decision [on restoration] is really up to the family not FaCS. The idea that a parent can improve and parent 'differently' than before appears to be harder to 'sell' to family members, who feel that they understand the situation better than outside agencies.
- Kinship carers have perhaps strong and emotional opinions about birth parents. Some families tend to stick with past perceptions of offspring/siblings' strengths/weaknesses even when change has occurred.
- Parents' ongoing drug and alcohol use, unemployment, inappropriate housing and limited supports can constrain restoration plans.

Respondents were divided around whether current policies and programs were facilitating restoration/reunification. Key points from respondents included:

- Restoration should only occur when it is in the best interest of the child and the child's safety and well-being can be ensured.
- Wording of court orders are crucial to stability as children have less likelihood of being restored if a long term order had been made.
- Until recently departmental practice did not support restoration and discussion was usually dismissed on the basis of 'permanency planning' (e.g. child settled in long-term placement).
- Kin placements are often ignored and receive little casework; as a consequence, the possibility of restoration is rarely considered.

3.11 Stability of kinship placements

It was suggested to respondents that some studies have found, in general, that kinship placements are more stable than foster care placements. Respondents were asked what their experience had been in this regard. Sixteen respondents agreed with the statement, six were not sure and four disagreed. The key points from those that agreed are outlined first, followed by the 'not sure' respondents, and lastly the responses of those that disagreed.

Kinship placements are more stable: Attachment, commitment and the nature of 'families' was highlighted in a summary of the responses by those who agreed that kinship placements were more stable because:

- They offer a strong sense of belonging and permanency for the child.

- Carers have greater investment in the child and are motivated by attachment and connection.
- With strong carer commitment children do not need to build new family relationships.
- Carers can sometimes tap into wider family support and the family system has more investment in placement success.
- The familial link may provide greater sense of responsibility and resolve in dealing with difficult issues that require persistence etc.
- Carers often have the family's life history and are able to impart that information to the child.
- When carers have PR in kinship they are able to make more decisions for themselves.
- Good relationships between carer and birth parent result in collaborative decision making about the child.
- Children are less involved with caseworkers so they do not feel 'different'.
- Children know they have been taken in out of love, not charity.
- Children's identity is usually more positively maintained within kinship care and there is often less stigma for a child in kinship care.

Three respondents also noted that:

- There are less 'emergency' breakdowns in kinship care arrangements compared to general foster care.
- Kinship placements are less likely to break down due to carer stress.
- Kinship care is usually the preferred option for agencies.

Three respondents while agreeing with the premise offered a somewhat more negative perspective than others. As to why the placements are more stable they noted it was due to:

- Kin not wanting to lose children to the [foster care] system.
- Grandparents often feeling that they have no choice, but to provide care for as long as children need it.
- Kinship carers 'putting up with more' challenging behaviours and high frequency of access with birth families.

Of the six respondents who were not sure whether kinship placements were more stable, one was hesitant to comment, as in her experience when PR was given to the carer, little was known about stability, unless the placement broke down. Two respondents were concerned with child protection issues and child safety in placement with one stating: 'Kinship families are often loosely monitored and children in kinship care have been exposed to original child protection concerns from the birth parents'. Another respondent was concerned at the quality of care in some kinship placements noting that: 'the care some children receive in family placements would have not been acceptable in a foster care setting'. One respondent noted that:

A lack of support, particularly lack of financial support to meet the needs of their child in relation to therapeutic and other services due to the special needs of the child, is commonly cited as a reason for moving children from kinship placements into foster care.

The sixth respondent had some concern that kinship carers would take on the care of children due to feeling guilty, or not having a choice about whether they take them or not. In her experience, placements that had not worked out were those were:

Carers who haven't engaged with the agency, and are not happy in seeking agency support and management, this has often led to placement instability and breakdown.

Four respondents disagreed with the premise that kinship placements were more stable. Two had experience of stable foster care programs. Two others did not think that all kinship placements were in the best interests of the child due to the inability of kinship carers to seek support/assistance when issues arose.

3.12 Best practice to ensure stability in kinship and foster care

Respondents were asked provide comments/suggestions on 'best practice' in ensuring placement stability in foster and/or kinship care. Some respondents (**n**=12) focussed on kinship care and others on foster care (**n**=12). Most respondents provided multi-faceted responses covering a variety of different aspects of both types of care (**n**=60) and a smaller number of respondents focused on best practice principles in relation to the child in care (**n**=20). Provided below is a summary of comments/suggestions for 'best practice' in the following areas:

- A. Kinship care;
- B. Foster care;
- C. Either type of care: and
- D. Practice principles relating to the child.

A. Kinship care: The main focus on best practice in this area related to the role of agencies/caseworkers.

- Ensure all kinship carers are assessed and checks are completed.
- Kinship carers need agency support and a level of trust needs to be developed to support carers with complex issues like guilt and shame.
- Provide initial training (including parenting skills) for kinship carers and ensure a training calendar in all areas for kinship (and foster) carers.
- Kinship carers (statutory and non-statutory) to be eligible for the same financial support as foster carers.
- Tailor support and interventions around the assessed needs and wishes of family members.
- Put structures in around contact.
- Provide more support for children in kinship care.

- Be available to answer a kinship carer's enquiries.
- Connect kinship carers to a support group.
- Reassure a [potential] carer that it is okay to say 'no' if they feel they are not able to provide care.
- Child protection concerns need to be addressed with kinship carers.
- Kinship carers need to demonstrate an adequate level of insight and have safety plans in place for child protection concerns.

B. Foster care: Carer/worker training, relationship development and the assessment process were the focus for best practice in foster care with respondents recommending that:

- Recruitment to screen people's 'motivation to care' and to ascertain levels of resilience (i.e. carers able to form sound and strong bonds regardless of the behaviour of a young person).
- Carers to be accredited by an independent 3rd party/Ombudsman's office.
- Workers to ensure a good "fit" or 'match" (carer/child) in the first instance by considering children's needs (including cultural needs) and carer experience.
- Initial carer training needs to be longer and more informative, and accredited carers attend at least four training sessions a year.
- Enhanced training for foster carers to be provided and certificates issued on completion of a training program that eventually leads to a professional qualification (similar to the New Zealand model)¹⁹.
- Provide appropriate carer supervision.
- Include carers in worker training.
- Build trusting relationships between caseworkers and foster carers.
- Address issues when they first arise as worker/carer contact should not occur only when there are complaints/allegations/issues.
- Make carers feel that they are 'heard' and are treat them as part of a team.
- Provide carers with information regarding placement decisions and provide realistic information about children coming into their care.
- Encourage carers of long-term placements to integrate children into secure foster family relationships.

C. Kinship and foster care: In best practice for both kinship and foster care the predominant focus, provided by 25 separate comments/suggestions was on

¹⁹ In New Zealand the *National Caregivers Training Programme* has a range of training courses available for caregivers to attend. On completion carers can enrol in the *National Certificate in Family/Whanau Foster Care* (Level 4) followed by the *National Diploma in Whānau/Family and Foster Care* (Level 6) (Lawrence, 2012)

providing support for carers and for children. A summary of types of support for carers/children included:

- Provide carers with adequate financial assistance for the costs of care.
- Provide regular on-going support including weekly emails/telephone calls and monthly home visits.
- Respond to carer calls in a timely manner and provide after-hours support.
- Encourage carers to attend ongoing training and support groups.
- Provide casework to carers and answer questions openly and honestly.
- Treat carers with the respect and courtesy that they deserve and acknowledge their commitment and dedication.
- Create support networks (professional and volunteer) around carers.
- Provide respite as requested and arranging appropriate and timely services for carers and children.

Many of the suggestions/comments on best practice focussed on the importance of developing positive relationships between workers, carers, children and parents, including:

- Good communication and shared decision making is possible where workers have the ability to engage with, and listen to, children, parents and carers.
- Not allowing 'rules' to get in the way of good communication; maintain confidentiality but do not allow 'rules' and 'systems' as an excuse to keep people uninformed.

A number of responses for best practice concerned OOHC policy and programs and included the following key points:

- A strong case management system is essential.
- Professional, i.e. minimum degree/qualification for all agency staff.
- Adequate level of worker time and supervision is critical.
- Formalised carer contracts (i.e. where expectations of high quality care are articulated) are important.
- Clear permanency plans for children are critical.
- Adoption needs to be actively pursued for children in long-term care and/or move children in foster care out of the system via PR orders.
- Abuse allegations to be conducted by an 'Independent 3rd party' as opposed to the OOHC provider.
- Legislate to compel contact and/or policies requiring agencies/carers to deliver meaningful contact, wherever safe to do so.

- Provide ongoing staff training and encourage commitment to professionalise the OOHC workforce, including foster carers.
- Provide external support for carers, such as mediation or appropriate follow up, if a placement ends.

D. The child in care A number of respondents focussed on what can be considered ‘best practices principles’ in relation to the child in care. They begin with a quote from one respondent followed by a summary of the principles:

Best practice is always putting the needs of the child first; developing a relationship with the child and encouraging open communication and a sense of permanence for both children and carers. [Best practice is also] minimal placement changes, offering support throughout their education, helping young people to develop the necessary skills and values and ensuring a strong sense of identity.

- Foster carers need to be child focused and not fulfilling their own needs (whatever they may be).
- Workers/carers to provide clarity for children (at age appropriate level) around why they have been placed, the length of time of the placement, and the services and support (including contact visits with family) to be provided.
- Workers/carers to ensure children’s rights are met and advocate for the child as necessary.
- Workers/carers to ensure continuity of relationships for children and keep other placement aspects as constant as possible.
- Workers to follow-up and liaise with services providers the child is receiving.
- Workers to inform school teachers of significant changes in the child's life.
- Workers to hold regular reviews and assist in planning for children regardless of care type.
- Workers to ensure regular home visits with children (know them and what is happening to them); provide them with birth family information and ensure family connections. Assist and manage children's feelings in relation to birth family and contact.
- Workers to provide early intervention and professional support in all domains (e.g. education, medical, psychosocial etc) to address children’s past trauma.
- Workers/carers to ensure children’s cultural needs are being met.

3.13 Summary

For aspects on stability that could be compared between carer interviews and survey respondents, there was no particular dissonance between foster carers’ lived experiences with fostered children (in Section 1) and the opinions from survey respondents on the attitudes, skills and insights needed by foster carers in providing stable placements.

In several areas, respondents with kinship care experience, acknowledged the many constraints and vulnerabilities that kinship carers faced in providing stable care and the need to develop carer skills and insight by providing specific training, education/support and respite. Respondents' recognition of what kinship carers require, while a positive sign, denies the reality of programs that do not always meet their needs and therefore those of children. The statement by one respondent that once children are placed, child protection workers often reduce their involvement and support, which undermines a family's ability to trust and work cooperatively, was evident in this study. Some tension was evident with survey respondents who indicated a number of negative attitudes towards kinship placements. These tensions were mirrored in carer stories of not wanting to be involved with agency workers. Specific training for workers and carers involved in kinship placements may go some way in ameliorating these tensions.

Respondent's comments on fostered children's actions and reactions, in relation to contact/access visits, and birth parent behaviour around contact was informative as the views of children in care and birth parents were not included in the study. The concerns expressed by respondents, around foster carer's negative attitudes to contact with birth parents, were not supported in the carer interviews. There was some evidence from kinship carer interviews, that not all children were having contact with parents and wider family members, though it was unclear why this was happening.

Awareness of identity issues for kinship carers, their emotional responses to their circumstances and the need to encourage kinship carers to attend support groups was identified by many respondents.

Respondents, in general, were keen to debunk the myth that kinship carers do not need support and noted that adequate resources (financial and non-financial) need to be made available for this group of carers, because of their additional vulnerabilities and the challenges of family relationships. Respondents noted the need for workers to provide, a less directive and more collaborative approach, in meeting the needs of kinship families.

Respondents provided a mixed response as to why restoration/reunification was less likely to occur for children in kinship care. The significance of long-term court orders for children in kinship care and limited caseworker involvement in placements, evident from the carer interviews and supported by respondents' comments, appears to indicate that restoration is not a high policy consideration for children in kinship care.

The survey responses concluded with comments/suggestions on 'best practice' in ensuring placement stability in foster and/or kinship care' and reflected many of the responses to various aspects discussed throughout the survey.

Concluding remarks

As noted in the introduction the percentage of children being placed in kinship care (47 per cent in Australia is significant and is now higher than the use of foster care (44%). Despite the paradoxical finding in this study of highly stable, long-standing kinship placements, there did appear to be greater risks to stability for kinship than for

foster care placements. While the study was not able to isolate a particular dominant risk to stability, any number of aspects, separately or linked together, give reason for concern.

Common themes suggested by all carers for keeping placements stable were providing children with routines and boundaries; developing/maintaining strong relationships (with workers, family and birth family); receiving respite; and being supported by workers.

Survey respondents noted that adequate resources need to be made available for kinship carers and suggested a different approach be taken by workers in meeting the unique needs of kinship families.

State jurisdictions, through legislation, policy and programs aim to protect children in care, provide placement stability, ensure their well-being and safety and meet their needs. Legislation and policy provides the framework for using kinship care as the preferred option to maximise these outcomes. If this is the case, why is this option less supported than other options? The disjuncture between policy and practice in this area can have grave consequences. Kinship carers, predominantly older grandparents, provide care. Why are they expected to do this under circumstances (i.e. lack of support/services) that put their wellbeing and the children's at greater risk, than say that of foster carers and fostered children?

It is difficult to find words that convey the incredible tenacity, resilience, determination and commitment of foster and kinship carers interviewed in this study. While there were many issues that the carers, particularly the kinship carers, wanted to discuss they were not complaining about what had happened to their lives.

Overwhelming evidence from this study and many others find that many kinship carers appear to require more information and support, not less. It may be time to consider whether, in the proposed 2012 NSW reforms to child protection, more attention is given to ways that acknowledge (with financial and non-financial support) the significant contribution to society, being provided by kinship carers, rather than suggesting that after two years they can 'self-regulate', however this is to be interpreted. Kinship care is not a static phenomenon; rather it is a changing, challenging and complex experience, occurring over long periods of time for many kinship families. Circumstances and situations will change, sometimes for the better sometimes for the worse, over the lifecycle of these families. To suggest that after 'two years' kinship carers can go it alone with the parenting responsibilities they face is somewhat facile, and needs to be seriously questioned.

The unresolved debate on the appropriate roles and responsibilities for state and family, in relation to the care of children in kinship care, is one that is not going to go away. It requires the input of others to move the debate along.

4 Appendix 1

Placement Stability in Foster and Kinship Care Study 2012 - Carer Form

<p>We would like you to provide us with some personal information about yourself, your family and the children for whom you are caring. The first set of questions relates to you and your own birth children. The next sets of questions are about your experience as a carer/grandparent. The last two questions are about payment to assist with the costs of caring.</p>					
<p>PLEASE TICK BOXES AS REQUESTED</p>					
Q1. Marital status	<i>Married</i> <input type="checkbox"/>	<i>Single parent (divorced or separated)</i> <input type="checkbox"/>	<i>Single</i> <input type="checkbox"/>		
Q2. Relationship to children (if Grandparent go to Q.3 others go to Q4)				
Q3. Maternal grandparent/s	<i>Yes</i> <input type="checkbox"/>	<i>No</i> <input type="checkbox"/>	Paternal grandparent/s	<i>Yes</i> <input type="checkbox"/>	<i>No</i> <input type="checkbox"/>
Q4. Age	Q5. Sex		<i>Male</i> <input type="checkbox"/>	<i>Female</i> <input type="checkbox"/>	
Q6. Do you identify as an Aboriginal or Torres Strait Islander? <i>Yes</i> <input type="checkbox"/> <i>No</i> <input type="checkbox"/>					
Q7. Labour force participation	<i>Full-time work</i> <input type="checkbox"/>	<i>Part-time work</i> <input type="checkbox"/>	<i>Unemployed (or looking for work)</i> <input type="checkbox"/>	<i>Not in paid work or retired</i> <input type="checkbox"/>	
Q8. What is your main source of household income	<i>Salary/Wage</i> <input type="checkbox"/>	<i>Income support</i> <input type="checkbox"/>	<i>Retirement income</i> <input type="checkbox"/>	<i>Other</i> <input type="checkbox"/>	
Q9. Do you have children of your own?	<i>Yes</i> <input type="checkbox"/>	<i>No</i> <input type="checkbox"/>	<i>(if yes go Q 10, if no go to Q12)</i>		
Q10. Ages of children	Child 1years	Child 2 years	Child 3years	Child4years	Any other children?
Q11. How many of your children are living at home?Number <i>None</i> <input type="checkbox"/>					
<p><i>The next questions are about your experience as a carer (or grandparent) and the children in your care.</i></p>					
Q12. How long have you been <u>currently</u> caring (for foster or grandchildren)? <i>(if <u>not</u> continuous, note years/months of the current period)</i> Years/Months					
Q13. In total how long have you been a foster carer (or grandparent caring for grandchildren)? Years/Months					
Q14. How many children are currently in your care? Number					

Q15. Please note sex and age of children in care. (e.g. 'boy 4 years')	Child 1	Child 2	Child 3	Child 4
Q16. How long have the children currently in your care lived with you.	Child 1.....(years/months)	Child 2.....(years/months)	Child 3.....(years/months)	Child 4.....(years/months)
Q. 17 Total number of birth/foster/kinship children in your care number.			
Q18 Do you receive an allowance from the department (DoCS) (now FACS)				
a) Care Allowance (CA)?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/> (go to Q 19)
b) Supported Care Allowance (SCA)?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/> (go to Q 20)
Q19. For how many children do you receive a CA (number)			
Q20. For how many children do you receive a SCA (number)			
Q21. Do you receive any payments from the Federal Government to support the child/ren in your care?				
a)Family Tax Benefit (Part A)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
b)Family Tax Benefit (Part B)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Other payments? (please describe)			
Q. 22 Do you have a court order to care for the child/ren?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/> .
Please describe the order			
(e.g. Children's Court? Family Court? Other arrangement?)				

5 Appendix 2

Foster Carers Questionnaire: Placement Stability in Foster & Kinship Care

Family relationships & contact /access arrangements

Q1. Can you tell me about the child/ren you are fostering and how they came to live with you? (*Refer to the completed carer sheet for appropriate prompts*).

Q2. When the foster children came to live with you what were the practical consequences for your household? (**Prompt** *housing space; beds/bedrooms/furniture, moving house, school arrangements, other financial costs*).

Q3. After making the decision, to foster, how did this affect your family relationships? (**Prompt:** *with husband/partner, children, siblings*).

Q4. ‘Some people find becoming foster carers puts stress and strain on family relationship and for others it brings them closer together’. Can you tell me whether any of your relationships have changed since you became a foster carer? (**Prompt:** *positives, negatives, any difficulty or stress?*).

Q5. How is the child/ren’s relationship with their birth parents and other family members? (**Prompt:** *frequency of contact with birth parents and others; satisfaction with contact/access arrangements*)

Identity and roles issues around being a carer

Q6. What has been the impact for you on being a foster carer? (**Prompt:** *change of identity, different role; mixed feelings, loss of lifestyle, social life, and employment*)

(*Check on carer form whether in work or not – if not in work go to Q8*)

Q7. Has the fostering role meant a change for you in paid work arrangements? (**Prompt:** *full to part time; part to full time; from retirement to part time; from retirement to full time; took early retirement; cite other arrangements*).

Support and services (non-financial) – child and carer

Q8. Who supports you in your role as carer of these children? (**Prompt:** *family other relatives, friends, caseworker, agency, other*)?

Q9. When foster child/ren come to live with you there is an involvement with a government or non-government agency, or the court; what has been your experience of this involvement? (**Prompt:** *workers, court officials, other agency or service providers; positive & negative aspects*).

Q10. How is the current relationship with the agency working for you and the child/ren? (**Prompt:** *caseworker, supervision, case plan, reunification/restoration plan*).

Q11. How would you describe the foster child/ren's health? (**Prompt:** *good, average, poor*).

Q12. Do you think their current physical and emotional health is different to what it was when they came to live with you? (**Prompt:** *in what way?*)

Q13. Do your foster child/ren have any special needs, difficulties or disabilities? (*if yes - Prompt: what are they and how do you manage them?*)

(For age appropriate children – if pre-schoolers go to Q16)

Q14. How is the foster child/ren going at school? (**Prompt:** *any concerns re progress; attendance (e.g. suspension, truancy, behaviour overall)*).

(For age appropriate children – otherwise go to Q16)

Q15. Do you have any concerns with the foster children about substance (*i.e. alcohol or drugs*) misuse?

Q16. How satisfied are you with the support and service provided by the agency? (**Prompt:** *In meeting children's needs, in meeting carer needs*).

Q17. In relation to information/training/education what type of program do you think would best help you in your role?

Q18. Do you belong to a carer support group? (*If yes ask next Qs*) (*If 'no' go to Q 21*)

Q19. What type of activities does the group provide? (**Prompt:** *Information, training, social, etc*)

Q20. How satisfied are you with what happens at the group meetings?

Support (financial) (TO BE ASKED OF CARERS RECEIVING PAYMENTS)

Q21. You noted on the carer form that you receive a payment from the department. How important is it for you to have this financial support?

Q22. (*If also receiving financial support from Federal government ask*) How important is it for you to have this financial support?

Q23. Were there any issues or concerns in accessing the payments you are receiving?

Q24. How have you managed financially since the children came to live with you?

Q25. Do you have any concerns about the future regarding your finances?

Carer health and well-being

Q26. How is your health? (**Prompt:** *good, average, poor*).

Q27. Do you have a health or medical conditions? (**Prompt:** *if 'yes' ask 'what they are'*)

Q28. Do you think your health as stayed the same, improved, or got worse since you became a foster carer?

Q29. How do you look after your own health needs?

Q. Tell me the activities you participate in? (**Prompt:** *Church, gym, swimming, walking, fishing, social outings, theatre activities, education or university courses, professional development, etc*).

Q30. Have you had to change or give up your physical or social activities since the foster children came to live with you? (**Prompt:** *if 'yes' ask 'what they were and why the change'?*)

Q31. Are you satisfied with the balance between the time spent with foster children and time spent on your own interests and activities? (**Prompt:** *if 'no' ask why*)

Partner's health (for those with partners)

Q32. Is your partner/spouse's health the same or different since the foster children came to live with you? (**Prompt:** *If 'different' ask in what way*)

Q33. Does your partner/spouse have a medical or health condition?

Q34. Besides the foster child/ren living with you do you have other caring responsibilities? (**Prompt:** *partner/spouse, other family members - elderly parents, friends?*)

Stability & positive and negative aspects

Q35. How have you been able to keep the placement safe and stable for the foster child/ren? (**Prompt:** *Easier aspects, difficult aspects, factors that might lead to placement breakdown*)

Q36. If there was a comment, suggestion or idea you would like to make about keeping foster care placements stable, what would it be?

Q37. What, for you, are the rewards and satisfaction of being a foster carer?

Specific cultural and community issues for Aboriginal foster carers.

Q38. How do you maintain the child/ren's links to their cultural and their community?

Q39. Are there any difficulties in maintaining these links?

Q40 What would assist you in maintaining the children's links to their cultural and community.

6 Appendix 3

Survey on Stability in Foster & Kinship Care

1. Briefly describe your background in OOHC, your current role and time in this position, whether you are non-Aboriginal, Aboriginal or from another cultural background and whether you are with a government or non-government agency (Aboriginal/ non-Aboriginal).
2. Thinking about placement stability in FOSTER CARE, what in your experience are the most important aspects in ensuring stability (e.g. carer support, services for children, carer education/training, carer support groups). Add any missing aspects you regard as important.
3. Thinking about placement stability in KINSHIP CARE, what in your experience are the main aspects (e.g. carer support, services for children, carer education/training, carer support groups) affecting stability? Add any missing aspects you regard as important.
4. In relation to achieving placement stability what do you see as the main difference between foster and kinship care?
5. Children and young people's contact and access with birth family members is important for placement stability; what are the common issues around contact and access for foster and kinship carers; how are they resolved and by whom?
6. The quality of family relationships is particularly important in kinship care placements. What factors (positive & negative) in relationships between various family members in kinship care impact on placement stability?
7. Issues of identity for children in kinship placements can be significant. How are these issues best addressed?
8. Kinship carers, often grandmothers, struggle with their changed role and identity issues of 'who' they are. How are these issues best addressed?
9. Kinship carers have been noted in studies as 'missing out' on formal and informal supports and services including caseworker support; how do you see the caseworker role in relation to supporting kinship placements compared to foster care placements?
10. In ensuring stability connections between culture, family and community are seen as particularly significant for Aboriginal families; how does your agency support maintaining these connections with children placed with kinship and foster carers.
11. Research studies indicate that, compared to foster placements, children in kinship placements are less likely to be reunified/restored with their birth parents. What has been your experience in this regard and why would this be happening?
12. Some studies indicate that, in general, kinship placements are more stable than

foster care placements; what has been your experience in this regard and why do you think this happens?

13. Based on your experience, please provide comments or suggestions on 'best practice' in ensuring stability in foster and/or kinship care.

7 References

- Allen, M. & Bissell, M. (2004). Safety and Stability for Foster Children: The Policy Context. *The Future of Children*. No. 14(1):48-73. Retrieved from: <http://www.jstor.org/stable/160275>.
- Argent, H. (2009) 'What's the problem with kinship care?' *Adoption & Fostering*. Vol. 33(3): 6-14.
- Association of Children's Welfare Agencies (ACWA). (2011). *Caring for those who care about our children: Findings from the Carers Training & Support Needs Survey* developed by The Association of Children's Welfare Agencies (ACWA) in partnership with The Australian Foster Care Association of Australia (AFCA). Retrieved from: <http://www.acwa.asn.au/>
- Australian Foster Care Association (AFCA). (2001). *Supporting Strong Parenting in the Australian Foster Care Sector*. Report for the Commonwealth Department, of Family and Community Services, (Principal researcher: Dr Ross Gurney, Better Enterprises), Canberra: AFCA.
- Australian Government, Australian Institute of Health and Welfare, (AIHW), 2013, *Child Protection Australia*, Child Welfare Series No. 55. Retrieved from <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129542752>.
- Australian Government, Australian Institute of Health and Welfare, (AIHW), 2003, *Child Protection Australia*, Child Welfare Series No. 34. Retrieved from <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442455278>.
- Australian Government, Productivity Commission, (2012) *Report on Government Services 2012*, Retrieved from: <http://www.pc.gov.au/gsp/rogs/2012>.
- Aziz, R., Roth, D. & Lindley, B. (2012) *Understanding Family and Friends Care: The Largest UK Survey*, Family Rights Group, London.
- Barnardos (2012) *Promoting Stability in Foster Care*, Permanency Planning Practice Paper – Step 5, Barnardos, Sydney.
- Backhouse, J. (2008). *Grandparents Raising Their Grandchildren: Impact of the Transition from a Traditional Grandparent Role to a Grandparent-as-Parent Role*. Southern Cross University.
- Backhouse, J. & Graham, A. (2010). Grandparents raising their grandchildren: An uneasy position. *Elder Law Review*, retrieved from http://uws.edu.au/law/sol/areas_of_expertise/elder_law/elder_law_review_vol6.
- Berrick, D. J. (1997). Assessing quality of care in kinship and foster family care. *Family Relations*. 46(3): 273-280.
- Blakely, M. (2012) 'The best of both worlds: How kinship care impacts reunification', *Families in Society*, 93(2): 103-110.
- Boetto, H. (2010) Kinship care: A review of issues, *Family Matters*, 85:60-67.
- Borenstein, J. (2012) *Strengthening Kinship Families: The Role of Respite Care*, Respite Care Consortium, Report No.3. Melbourne.
- Borenstein, J. & McNamara, P. (2012) 'Strengthening kinship families: scoping the provision of respite care in Australia', *Child & Family Social Work*.
- Brandon, P. D. (2004), 'Identifying the Diversity in Australian Children's Living Arrangements'. *Journal of Sociology*, 40(2): 179-192.
- Brennan, D., Cass, B., Flaxman, S., Hill, T., Jenkins, B., McHugh, M., Purcal, C. and valentine, k. (2013) *Grandparents Raising Grandchildren: Towards Recognition, Respect and Reward*. Social Policy Research Centre, SPRC Report 14/13.

- Broad, B. (2001). Kinship care: Supporting children in placements with extended family and friends. *Adoption & Fostering*. Vol. 25(2):33-41.
- Bromfield, L. M., Higgins, J.R., Higgins, D.J. & Richardson, N. (1997). *Why is there a shortage of Aboriginal and Torres Strait Islander carers? Perspectives of professionals from Aboriginal and Torres Strait Islander agencies, non-government agencies and government departments*. Paper 1. Retrieved from: www.aifs.gov.au/nch/pubs/reports/promisingpractices/.../paper1.doc.
- Brouwer, G. (2009), *Own Motion Investigation into Child Protection – Out-of-Home Care*, Victorian Government Printer, Melbourne . retrieved from: http://www.ombudsman.vic.gov.au/resources/documents/Probity_of_the_Kew_Residential_Services_and_St_Kilda_Triangle_developments.pdf.pdf.
- Brown, S., Cohon, D. & Wheeler, R. (2002). African American extended families and kinship care: How relevant is the foster care model for kinship care? *Children and Youth Services Review*. Vol. 24(1/2): 53-77
- Bullock, K. (2004) The changing role of grandparents in rural families: The results of an exploratory study in Southeastern North Carolina. *Families in Society*. Vol.85(1): 45-55.
- Campbell, J. & Handy, J. (2011), Bound to care: Custodial grandmothers' Experiences of Double Bind Family Relationships, *Feminism and Psychology*, 21(3): 431-439.
- Carpenter, S. and Clyman, R. (2004) The long-term emotional and physical well-being of women who have lived in kinship care. *Children and Youth Services Review*. Vol. 26:673-686.
- Casey Family Programs (2008). *Kinship Care*. White Paper. Retrieved from http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/kinship-relative-care.html.
- Cashmore, J. (2000). What the research tells us permanency planning, adoption and foster care. *Children Australia*, 25(4): 17-22.
- Cawthon, D. (2008) *Training Kin to be Foster Parents: Best Practices from the Field*. Retrieved from http://www.childfocuspartners.com/images/Training_Kinship_Caregivers_0708.pdf.
- Chipman, R., Wells, S., & Johnson, M. (2002). The meaning of quality in kinship foster care: caregiver, child and worker perspectives. *Families in Society: The Journal of Contemporary Human Services*, 508-520.
- Christiansen, O. Havik, T. & Anderssen, N. (2010). Arranging stability for children in long-term out-of-home care. *Children & Youth Services Review*. Vol. 32(7): 913-921.
- Climo, J., Terry, P. & Lay, K. (2002). "Using the Double Bind to Interpret the Experience of Custodial Grandparents." *Journal of Aging Studies* 16 (February): 19–35.
- COTA (Council of the Ageing) National Seniors. (2003). *Grandparents Raising Grandchildren*. A report of the project commissioned by the Hon. Larry Anthony, Minister for Children and Youth Affairs. Retrieved from http://www.fahcsia.gov.au/sa/families/pubs/parenting-grandparents_raising_grandchildren/Pages/default.aspx.
- Courtney, M. A. & Needell, B. (1997). Outcomes of kinship care: Lessons from California. In J. Berrick, R. Barth, & N. Gilbert (Eds.) *Child Welfare Research Review*. Vol 2. New York: Columbia University.

- Cuddeback, G. S. (2004). *Kinship family foster care: A methodological and substantive synthesis of research* in *Children and Youth Services Review*, 26, 623-639.
- Del Valle, J, Lazaro-Visa, S., Lopez, M. and Bravo, A. (2011). 'Leaving family care: Transitions to adulthood from kinship care', *Children & Youth Services Review*, 33: 2475-2481.
- Downs, A C. & James, S. E. (2006). 'Gay, Lesbian, and Bisexual Foster Parents: Strengths and Challenges for the Child Welfare System', *Child Welfare*, 85.2: 281-98.
- Dunne, E. & Kettler L. (2006). 'Social and emotional issues of children in kinship foster care and stressors on kinship carers: a review of the Australian and international literature', *Children Australia*, 31(2): 22-29.
- Ehrle, J. & Geen, R. (2002). Kin and non-kin foster care – Findings from a national survey. *Children and Youth Services*. Vol.24 (1/2): 15-35.
- Falconnier, L., Tomasello, N., Doueck, H., Wells, S., Luckey, H. & Agathen, J. (2010). 'Indicators of Quality in Kinship Foster Care'. *Families in Society*. Vol. 91(4): 415-420.
- Farmer, E. (2009). 'How do placements in kinship care compare with those in non-kin foster care: placement patterns, progress and outcomes?' *Child & Family Social Work*. Vol.14 (3): 331–342.
- Farmer, E., Selwyn, J. & Meakings, S. (2013) 'Other children say you're not normal because you don't live with your parents. Children's views of living with informal kinship carers: social networks, stigma and attachment to carers'. *Child & Family Social Work*, 18: 25-34.
- Farmer E. & Moyers S. (2008). *Kinship Care: Fostering Effective Family and Friends Placements*. Jessica Kingsley Publishers. London.
- Fernandez, E. (1996). 'Pathways in substitute care; representation of placement careers of children using event history analysis'. *Children & Youth Services Review*. Vol. 21(3): 177-216.
- Frederico, M., Jackson, A. & Black, C. (2010). *More than Words – The Language of Relationships*. Take Two – Third Evaluation Report. Victoria: Allardice Group Blackburn.
- Gallard, A. (2010) *NSW Out-of-Home Care Reform Forum: An overview of the approach to implementing the review*, NSW Community Services, Sydney.
- Gautier, A. & Wellard, S. (2012). *Giving up the Day Job: Kinship Carers and Employment*, Grandparents Plus, London.
- Geen, R. (2004). 'The evolution of kinship care policy and practice', *Future of Children*, 14 (1): 131-149.
- Generations United. (2004). *Grandparents and Other Relatives Raising their Children: Caregiver Support Groups*, Fact Sheet, Washington, D.C.
- Gerard, J. M., Landry-Meyer, L. & Roe J. G. (2006). 'Grandparents raising grandchildren: the role of social support in coping with caregiving challenges' *Int. Journal of Ageing and Human Development*. 64(4): 359-83
- Glass J. C. & Honeycutt, T. L. (2010). Grandparents raising grandchildren: The courts, custody and educational implications'. *Educational Gerontology*, 28: 3, 237-251.
- Gleeson, J., O'Donnell, J. & Bonecutter, F.J. (1997). 'Understanding the complexity of practice in kinship foster care'. *Child Welfare*, 76(6): 801-826.

- Goodman C., Potts, E. Pasztor, M. & Scorzo, D. (2004). 'Grandmothers as kinship carers: private arrangements compared to public child welfare oversight', *Youth and Family Services Review*, 26: 287-305.
- Grandparents Association, (2013) *Support Groups*, Retrieved from <http://www.grandparents-association.org.uk/general/support-groups.html>.
- Harden, B. J. (2004). 'Safety and stability for foster children: A developmental Perspective'. *The Future of Children*. Vol.14(1) 30-47.
- Harden, B. J., Meisch, A. D., Vick, J. E. & Pandohie-Johnson, L. (2008), Measuring Parenting among Foster Families: The Development of the Foster Parent Attitudes Questionnaire (FPAQ), *Children and Youth Services Review*, Vol. 30(8): 879-892.
- Harnett, P., Dawe, S. & Russell, M. (2012) 'An investigation of the needs of grandparents who are raising children'. *Child & Family Social Work*, 1-10.
- Hayslip, B. & Goldberg-Glen, R. (Eds). (2000). *Grandparents Raising Grandchildren*. Springer Publishing Company. New York.
- Horner, B. Downie, J. Hay, D. & Wichman, H. (2007). 'Grandparent-headed families in Australia'. *Family Matters*, No. 76: 77-84.
- Howard, J. & Berzin, S. (2011) *Never Too Old: Achieving Permanency and Sustaining Connections for Older Youth in Foster Care*, The Evan B. Donaldson Adoption Institute, US.
- Hunt, J. (2008). *Family and Friends Care*. Research and Practice Briefings: Children and Families, Research in Practice, Dartington (www.rip.org.uk/publications/researchbriefings.asp).
- Hunt, J. Waterhouse, S. & Lutman E. (2008). *Keeping them in the Family: Outcomes for Abused and Neglected Children Placed with Family or Friends Carers Through Care Proceedings*, Research Brief, Department for Children, Schools and Family, London.
- Humphries, C., Kiraly, M., & Connolly, M. (2012). *Protecting Victoria's Vulnerable Children Inquiry-Submission, Issue: Aboriginal children in kinship care*, The Alfred Felton Research Program, University of Melbourne, Victoria.
- James S. (2004). Why do foster care placements disrupt? An investigation of reasons for placement change in foster care. *Social Service Review* Vol. 78(4): 601-627.
- Jerve, J. (2008), *Taking a Break: Creating Foster, Adoptive and Kinship Respite in Your Community*, North American Council on Adoptable Children, National Foster Parent Association and the Collaboration to AdoptUsKids. Retrieved from http://www.adoptuskids.org/_assets/files/NRCRRFAP/resources/taking-a-break-respite-guide.pdf.
- Jones, A. S. (2010). 'Promoting Placement Stability in Foster Care: A Roadmap through the Literature', LaLiberte, T. & Snyder, E. (eds), *Promoting Placement Stability*, CW360, Centre for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota, pp 4-5.
- Keller, T., Wetherbee, K., le Prohn, N., Payne, V., Sim, K. & Lamont, E. (2001). 'Competencies and problem behaviours of children in family foster care: variations by kinship placement status and race'. *Children & Youth Services Review*. 23(12): 915-940.
- Kiraly, M. (2011). 'It is the story of all of us': *Learning from Aboriginal Communities about Supporting Family Connection*, Report #2. Family Links: Kinship Care and Family Contact Research Series. Victoria.

- Koob, J. & Love, S. (2010). 'The implementation of solution-focused therapy to increase foster care placement stability'. *Children & Youth Services Review*. 32: 1346-1350.
- KPMG (2010). *National Standards for Out of Home Care: Consultation Summary Report*. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs.
- Lamont, A. (2011). *Children in Care*. Resource Sheet. National Child Protection Clearing House. Melbourne: Australian Institute of Family Studies.
- Lavner, J. A., Waterman, J. & Peplau, L. A. (in press). Can gay and lesbian parents promote healthy development in high-risk children adopted from foster care? *American Journal of Orthopsychiatry*.
- Leathers, S. J. (2006). Placement disruption and negative placement outcomes among adolescents in long-term foster care: The role of behaviour problems. *Child Abuse & Neglect* 3: 307-324.
- Leos-Urbel, J., Bess, R. & Geen, R. (2002). 'The evolution of federal and state policies for assessing and supporting kinship caregivers'. *Children and Youth Services Review*. Vol. 24(1/2): 37-52.
- Mackiewicz, P. (2009), *To examine and compare program elements that achieve positive outcomes for children placed with relatives or kin as a result of child protection intervention*, 2007 Churchill Fellowship Report, The Winston Churchill Memorial Trust of Australia.
- McCrae L. (2011). *Kinship Placement Breakdown- Causes and Prevention*, paper presented at the International Foster Care Conference (IFCO). Victoria, Vancouver Island.
- McConaghy, J. (2008). *Evaluation of the Berry Street (Hume) Kinship Care Program*, Monograph Series 4, Policy & Service Development, Berry Street, Victoria.
- McHugh M., McNab, J. Smyth. C. Chalmers, J. Siminski P. & Saunders P. (2004). *The Availability of Foster Carers*. Report prepared for the NSW Department of Community Services. Sydney: Social Policy Research Centre, University of New South Wales.
- McHugh M. (2002). *The Costs of Caring: Study of Appropriate Foster Care Payments for Stable and Adequate Substitute Care in Australia*. Final Report. Sydney: Association of Childrens Welfare Agencies & Child and Family Welfare Association of Australia.
- McHugh, M. (2009). *A Framework of Practice for Implementing a Kinship Care Program*, a Report prepared for the Benevolent Society. Social Policy Research Centre, University of New South Wales, Sydney.
- McHugh M. & valentine, k. (2010). *Financial and Non-Financial Support to Formal and Informal Carers*. Final Report for the Department of Families, Housing, Community Services and Indigenous Affairs. Social Policy Research Centre, University of New South Wales, Sydney.
- Minkler, M. & Fuller-Thompson, E. (1999). 'The health of grandparents raising grandchildren: results of a national study'. *American Journal of Public Health*. 99: 1384-1390.
- Mission Australia, (2007), *Grandparents raising their grandchildren: Snapshot 2007*, Mission Australia & Macquarie Bank. Sydney.
- Palacios, J. & Jiménez, J. M. (2009). 'Kinship foster care: Protection or risk?' *Adoption & Fostering Journal*, 33(3): 64-75.

- Pecora, P. (2010) 'Why Should Child Welfare Focus on Promoting Placement Stability?' in LaLiberte, T. & Snyder, E. (eds), *Promoting Placement Stability*, CW360, Centre for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota, pp 4-5.
- Nathanson, D. And Tzioumi, D. (2007). 'Health needs of Australian children living in out-of-home care.' *Journal of Paediatrics and Child Health*. 43: 695–699.
- New South Wales. Department of Community Services, (DoCS). (2007). *Permanency Planning and Placement Stability*. Research to Practice Notes. Retrieved from: http://www.community.nsw.gov.au/docswr/_assets/main/documents/researchnotes_permanency_planning.pdf.
- National Survey of Child & Adolescent Well-Being. (NSCAW) (2009). *No. 15: Kinship Caregivers in the Child Welfare System*. Research Brief. Retrieved from: http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/reports/kinship_caregivers/rb_15_2col.pdf.
- New South Wales. Department of Family and Community Services, (FACS). (2012). *Discussion Paper, Child Protection: Legislative Reform Legislative Proposals*. Retrieved from http://www.community.nsw.gov.au/docswr/assets/main/lib100047/cp_reforms_discussion_paper.pdf.
- New South Wales. Department of Family and Community Services, (FACS). (2012) *Foster Care Allowances*. Retrieved from http://www.community.nsw.gov.au/docswr/_assets/main/documents/fostercare_allowances_fact.pdf.
- Newton, R., Litrownik, A. & Landsverk, J. (2000). 'Children and youth in foster care: Disentangling the relationships between problem behaviours and number of placements'. *Child Abuse and Neglect* 24(10):1363-74.
- Nixon, P. (2007) *Relatively Speaking: Developments in Research and Practice in Kinship Care, Research in Practice* (www.rip.org.uk).
- Oburu, P.O, & Palmerus, K. (2003). 'Parenting stress and self reported discipline strategies of Kenyan grandmothers taking care of their orphaned grand children', *International Journal of Behavioral Development*, 27(6), 505-512.
- O'Neill, C., Forbes, C., Tregeagle, S., Cox, E. & Humphreys, C. (2010). *The Cost of Support for Stable Foster Care Placements*. Retrieved from: http://www.fcav.org.au/files/Articles_Publications/Cost_of_Support_4_Aug_2010_Page_Numbered_1__2_.pdf.
- O'Neill, C. (2012). 'Support in kith and kin care: The experience of carers', *Children Australia*, 36(2): 88-99.
- Palmer, S. E. (1996). 'Placement stability and inclusive practice in foster care; An empirical study'. *Children & Youth Services Review*. Vol. 18(7): 589-601.
- Pecora, P. (2010) 'Why Should Child Welfare Focus on Promoting Placement Stability?' in LaLiberte, T. and Snyder, E. (eds), *Promoting Placement Stability*, CW360 Centre for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota, pp 4-5.
- Raman, S. Reynolds, S. & Khan. R. (2011). 'Addressing the well-being of Aboriginal children in out-of-home care: Are we there yet?' *Journal of Paediatrics and Child Health*, March.
- Richardson, R. & Gleeson, J. (2012). 'Family functioning, parenting style and child behaviour in kin foster care', *Families in Society*, 93(2): 111-122.
- Social Care Institute for Excellence (SCIE). (2011). *SCIE Guide 7: Fostering*, Retrieved from <http://www.scie.org.uk/publications/guides/guide07/placement/placement/index.asp>.

- Secretariat of National Aboriginal and Islander Child Care (2011). *Growing Up Our Way: Aboriginal and Torres Strait Islander Child Rearing Practices Matrix*, SNAICC, Melbourne.
- Selwyn, J. (2010). 'The challenges in planning for permanency'. *Adoption & Fostering* Vol. 34(3): 32-37.
- Smith, G.C., & Palmieri, P.A. (2007). 'Risk of psychological difficulties among children raised by custodial grandparents'. *Psychiatric Services*, 58: 1303-1310.
- Smyth, C. & T. Eardley (2008). *Out of Home Care for Children in Australia: A Review of Literature and Policy*, SPRC Report No. 3/08, prepared for the Department of Families, Housing, Community Services and Indigenous Affairs, Social Policy Research Centre, University of New South Wales, Sydney.
- Sinclair, I. & Wilson, K. (2003). 'Match and mismatches: The contribution of carers and children to the success of foster placements'. *British Journal of Social Work*. Vol. 33: 871-884.
- Spence, N. (2004). 'Kinship care in Australia'. *Child Abuse Review*, Vol. 13(4): 263-276.
- Staub, D., Emerson, J., Roller White, C. & O'Brien, K. (2010). 'Placement Stability for Youth in Foster Care: A Key to Achieving Permanence and Educational Success' in LaLiberte, T. & Snyder, E. (eds), *Promoting Placement Stability*, CW360 Centre for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota, p14.
- Sykes, J., Sinclair, I., Gibbs, I. & Wilson, K. (2002). 'Kinship and foster carers: How do they compare'. *Adoption & Fostering*. Vol. 26(2): 38-48.
- Tarren-Sweeney M. & Hazell P. (2006). 'Mental health of children in foster and kinship care in New South Wales, Australia'. *J. Paediatr. Child Health*; 42: 89-97.
- Taussig, H. & Clyman, R. (2011). 'The Relationship Between Time Spent Living with Kin and Adolescent Functioning in Youth with a History of Out-of-Home Placement', *Child Abuse and Neglect*, Vol. 34(1): 78-86.
- Thompson, H. & McPherson, S. (2011). 'The experience of living with a foster sibling, as described by the birth children of foster carers'. *Adoption & Fostering*. 35(2): 49-60.
- Unrau, Y. Seita & Putney, K. (2008). 'Former foster youth remember multiple placement moves: A journey of loss and hope'. *Children & Youth Services Review*. 30: 1256-1266.
- valentine, k., Jenkins, B., Brennan, D. & Cass, B. (2013). 'Information Provision to Grandparent Kinship Carers: Responding to Their Unique Needs', *Australian Social Work*, Retrieved from <http://dx.doi.org/10.1080/0312407X.2012.754914>
- Vimpani, A. (2004). 'Challenges for professionals working with children placed in kinship care and their families: a clinical study and literature review'. *Developing Practice*. Vol. 10.: 24-35.
- Ward, H. (2009). 'Patterns of instability: Moves within the care system, their reasons, contexts and consequences'. *Children and Youth Services Review*, 31: 1113-1118.
- Warren-Adamson, C. (2009). 'Exploring kinship care through practitioner collaborative enquiry'. *Adoption & Fostering*. 33(3): 76-84

- Waterhouse, S. (2001). 'Keeping children in kinship placements within court proceedings'. In: *Kinship Care: The Placement Choice for Children and Young People* (ed. B. Broad). Russell House Publishing, London.
- White, J. V. (2009). 'Custodial Grandparents: Defining New Roles', *CSA Journal*, 43: 16-19.
- Winocur, M., Holton, A. & Valentine, D. (2009). *Kinship Care for the Safety, Permanency, and Well-being of Children Removed from the Home for Maltreatment*, Campbell Systematic Reviews 2009:1, Campbell Collaboration.
- Worrall, J. (2006). 'Challenges of grandparent custody of children at risk in New Zealand'. *Families in Society*. 87: 546-554.
- Wulczyn, F., Kogan, J. & Harden, B. (2003). 'Placement stability and movement trajectories'. *Social Services Review*, 6: 212-236.
- Wulczyn, F. (2010). 'Placement Stability in the Context of Federal Policy' in LaLiberte, T. and Snyder, E. (eds). *Promoting Placement Stability*, CW360 Centre for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota, pp 6-8.
- Yardley, A., Mason, J. & Watson, E. (2009). *Kinship Care in NSW: Finding a Way Forward*, Social Justice Social Change Research Centre, University of Western Sydney & Association of Children's Welfare Agencies, Sydney.
- Zinn, A., DeCoursey, J., Goerge, R. & Courtney, M. (2006). *A Study of Placement Stability in Illinois*. Chapin Hall Working Paper. Retrieved from: <http://www.chapinhall.org/research/report/study-placement-stability-illinois>.