

***The lottery of systems: Ways forward for children in need –
Kinship or Foster Care?***

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The new Victorian Child, Youth and Families Act (2005) legislation enshrines the practice of prioritising kinship care programs for children entering the child protection system in Victoria. In effect a kinship placement becomes therefore, the default placement for these children. While this position reflects an inherent belief that it is better to 'keep children within the family unit', it is also a response to the increasing difficulty in recruiting appropriate foster carers for traumatised children with high needs and reflects the high costs of providing such care.

Oz Child is in a unique position in Victoria to comment on the differing experiences of children coming into care through Child Protection who are then placed with carers/families either through the Home Based Care or Kinship Care programs. This knowledge has grown from our experience in managing both a large Home Based Care program and since 1998, an outsourced Kinship Care program for statutory clients in Victoria. In the former, Oz Child places approx. 180 children with foster carers each night across five large local government areas in the south east region of Melbourne and in the latter we place children with approx. 70 kinship care families at any one time.

From this unique perspective therefore, we will outline the legislative and policy environments which are having an impact on the delivery of home based care and kinship care We will then discuss the inherent advantages, disadvantages and complexities facing a child or siblings, their families, carers and the staff working with them through a case study of the same children's journey and their potential experiences, depending on whether the placement is through HBC or Kinship Care.

There has been significant reform of Victoria's statutory Child Protection services, including within broader Family Services programs, since the early 2000s, culminating in the passage of two major pieces of legislation in December 2005. The Child Wellbeing and Safety Act "provides a unifying framework for family and placement services delivered by community service organisations, child protection services delivered by the Department of Human Services; and decisions by the Children's Court". The Children, Youth and Families Act "provides the legislative foundations to create a more integrated system of child youth and family services focussing on vulnerable children's safety, health, learning, wellbeing and development"¹

The Child, Youth & Family Act (2006) clearly states in its Best Interest Principles section 10(3)(b), "the need to strengthen, preserve and promote positive relationships between the child and the child's parents, family members and persons significant to the child". Section 10(3)(h) also states that, "consideration is to be given first to the child being placed with an appropriate family member or other appropriate person significant to the child **before** (emphasis added) any other placement option is considered". This principle reinforces an existing trend for an increase in the proportion of kin to foster care placements in Victoria. On June 30 2008 for example,

¹ Briefing Paper to the Victorian Children's Council Task Group on Out of Home Care, May, 2008

there were 1908 children placed in kinship care. Over the past ten years kinship placements have grown from 20% of OOHC placements to 35% and in 2007 for the first time they exceeded those in HBC.² Projections for children being placed through Child Protection are such that by the year 2016 there will be three kinship placements for every foster care placement³. It is of critical importance therefore, that the practice model for kinship care is set up to deal with this projected increase in a way which also ensures, in the first instance, that the safety and interest of the child are best met.

The Victorian Department of Human Services is currently engaged in a review of kinship care provision and is close to defining a new model of service delivery. The recent Victorian budget for the first time identified specific, albeit relatively small, funding to support kinship placements but the manner in which these funds are to be expended has yet to be determined. Currently kinship placements are managed internally by Child Protection staff in all but two DHS regions. The Southern Metropolitan Region has taken the lead in funding Oz Child's program for the past ten years using Child Protection funding. In the remaining regions a small number of kinship placements and assessment are outsourced to a CSO HBC program.

At the same time DHS is also conducting a review of the Out of Home Care system which incorporates kinship care. This review has been instigated in response to a range of issues being experienced in this sector which are not confined to Victoria.⁴ These including the difficulty of recruiting and retaining carers; insufficient placements to meet growing demand; a rise in the need to use contingency placements to accommodate a number of children with very challenging behaviours; the need for increased training and support for carers coping with children whose behaviour complexity stems from multiple and significant trauma and loss; and finally, the growth in the number of kinship carers themselves.⁵ Unlike kinship care, all home based care placements are provided and supported by community organisations in Victoria. The briefing paper for the Review also makes the point that "Kinship and permanent care placements are typically not serviced by a CSO agency and thus receive minimal support and supervision"⁶. Kinship placements through Oz Child's service are one of the exceptions.

Locating kinship care on the continuum between out of home care and family preservation has always presented difficulties. The consistent view regardless of whether it is located more towards one or the other end of the continuum, is that kinship care is seen as 'different'. However, it is the delineation of this difference which most influences the direction of policy development and hence practice. When this difference focuses positively on the maintenance of relationships within the extended family and continuity of family identity and culture, issues concerning the quality of care provided, age/capacity of the carer, intergenerational transmission of dysfunction, and child development tend to take second place. When kinship care is defined as sitting more towards the home based care end of the continuum, this difference focuses more on the additional complexities of assessment and support required for the family system, involvement with the court processes and the capacity to manage access. In fact, within kinship care, there is often much less capacity to

² Briefing Paper to the Victorian Children's Council Task Group on Out of Home Care, May, 2008

³ *Victorian families children and their caregivers in 2016*, DHS 2005

⁴ See for example Smyth, A. and Eardley, T (2008) *Out of Home Care for Children in Australia: A Review of Literature and Policy*, SPRC, Sydney : Spence, N. (2004) *Kinship Care in Australia in Child Abuse Review*, Volume 13 (4)

⁵ Briefing Paper to the Victorian Children's Council Task Group on Out of Home Care, May, 2008

⁶ *ibid*

control visits of parents who also remain “family”. Put more bluntly the question arises therefore, -

Is kinship care for statutory clients, a “unique” form of home based care or is it a distinctive approach within family services?

There is a case for example, for arguing that the current DHS model of kinship care is primarily concerned in maximising the family preservation and support aspects of the model however, this then raises the question, according to best practice models, of how this is balanced against potential issues of safety and appropriateness of the placement raised by the additional complexities in kinship care arrangements.

The 2007 Green Paper, *Kinship Care - Care by Relatives and Friends: Policy and Service Design*⁷, identified a number of principles underlying the development of a kinship model for children in statutory care as being:

- The wider family should be encouraged to be involved with the child, to support the carer and where possible the parent.
- Understanding the leadership, decision-making and ways of taking action in the family is critical to supporting the placement. Service systems procedures should be flexible to take account of these factors.
- Use the critical first few months to assist the family to anticipate and plan for challenges ahead.
- Ensure that every approved placement is one where the benefits to the child in maintaining identity and relationships outweigh any difficulties in family history or circumstance⁸.

These principles assume we are dealing with children at the point of entry into the Child Protection system. The reality however, is that many children are initially either placed informally by their own family members with someone other than the birth parent or may be placed for a short term with the first relative identified or who is available. Whether other family members may be a better match for the child or may be further interested is at present not always able to be adequately explored and how long this ‘placement’ may continue can also vary greatly.

Children who are placed with kin through Child Protection come to the notice of the Department for the same reasons as those who are placed in home based care placements i.e. because their parents are unable to care for them through death, imprisonment, intellectual, physical or mental health disabilities and/or because they are not safe in their home environment for a range of reasons including abuse and neglect. They will have experienced similar levels of trauma and loss, with as much consequent social and emotional damage as children in home based care.

The question is raised therefore, as to whether there appears to be a reluctance on the part of departmental policy and planning staff, to recognise the fact that it is currently largely a matter of chance whether a child in need of out of home care placement ends up in a home based care or kinship care placement. In other words, whether or not a willing relative can be located at the time the child comes into care. For the child themselves however, the implications of this decision can have a significant impact on all aspects of the services provided to support the placement and to appropriately meet that child’s needs and future development.

⁷ Kirkegarde, S., (2007) Green Paper *Kinship Care- Care by relatives and Friends: Policy and Service Design*, Child, Youth and Families Division, DHS, Melbourne

⁸ Kirkegarde, S., (2007) Green Paper *Kinship Care- Care by relatives and Friends: Policy and Service Design*, Child, Youth and Families Division, DHS, Melbourne

To best demonstrate these issues, we will now outline the potential impact of the differing services for both children and carers, for two children, aged seven and nine years, who were removed from the care of their mother and her de facto partner on the grounds of substantiated drug abuse, domestic violence and neglect. Neither child at the time was attending school and both showed significant behavioural evidence of harm as a consequence of their parents' chaotic and violent lifestyle with a subsequent failure to prioritise their children's interest over their own.

When Child Protection received the notification, they conducted an initial investigation which established that the children were no longer safe in their home. They were therefore, removed and an attempt was made to find a relative who could take on their immediate care needs.

In Scenario One, when no-one suitable was able to be located, a referral for an emergency home base care placement was made to Oz Child's Home Based Care program by the allocated Child Protection case worker. At the time the case was referred to Oz Child, DHS was still in the process of developing and finalising a further Assessment and Case Plan and there was still significant statutory involvement of the parties through the court system.

In line with the initial Case Plan, Home Based Care was requested to consider taking on case contracting and the case was assessed for funding at an Intensive level, in recognition of the high needs of the children and the likely difficulties in maintaining the placement due to their behavioural difficulties. The Intake worker was then able to identify a suitable match from among the available carers in the program.

The carers matched with the siblings, had been accredited with Oz Child for over five years. To gain this accreditation, they had had to undergo a thorough family assessment, had their home checked for its suitability and had completed both the basic level of training for carers (including the competency based Shared Stories Shared Lives training) and the more specialist training in the effects of trauma and abuse on children through the therapeutic foster carer advanced training as well.

Prior to accreditation both carers had also been required to have a clear police check and to maintain a current Working With Children Check. They had also subsequently attended a number of training sessions including one which outlined the new Quality of Care Guidelines which mandated the process for dealing with allegations of abuse or other quality of care issues which could arise. The carers already had one child on long term placement but after discussion with the Oz Child caseworker, agreed to take on the two new children for an anticipated three months as the case plan at that stage was still geared towards reunification if appropriate at a later date. As this case was categorised within the program at an Intensive level of care, the carers themselves were entitled to a higher rate of reimbursement and a specified amount of brokerage funding was available on an annual basis for the children's particular needs – for example, specialised counselling.

In Scenario Two, the children's grandmother agreed and was in fact, very keen to take on the fulltime care of the children in the first instance. Since she had been estranged from her daughter for some time however, she had not seen much of the children in recent years and they were not very familiar with her either. The grandmother was in her late sixties, suffered from a number of chronic health problems and was on a pension – characteristics she shares in common with the majority of kinship carers. Research for example, has confirmed that kinship carers

tend to be single women, most often the maternal grandmother or aunt who are older and less financially well-off than general foster carers⁹.

In this scenario, the DHS worker made a visit to the grandmother's home, which she shared with her unmarried son and two dogs, to do a risk assessment prior to placing the children. It was established that once she took on the full time care of the children she was (only) entitled to be reimbursed for their care at the general foster care rate for each child and no brokerage amount was offered as part of this. Obviously, she had been given no specific training in the 'role' of a carer although she was in fact, subject to the same Quality of Care guidelines as foster carers. If in the future it was determined that the children were unable at any stage to return home and she was to agree to a Permanent Care Order, it was not certain whether she would continue to receive her caregiver payments or whether they would in fact stop as this is currently inconsistent across the State. There would therefore, be no guarantee whether full financial responsibility for the children's care would continue at the same level or be changed. (This is a crucial point for review recognised by DHS but at present this reflects the current situation). It would also not necessarily be the case that an allocated worker from DHS would then be assigned to the children although limited support through general services of community agencies could be accessed if she knew where to go.

Given the complexities of many of the family histories and/or dynamics involved in kinship care situations, timely and comprehensive assessment is a critical factor in ensuring the safety and best interests of the children involved. It is highly possible therefore, that without adequate resourcing, risk and safety matters may be overlooked and the quality of assessments conducted may vary. Where further resources have been allocated for a more detailed assessment, it is of significance to note that Oz Child has recommended that 3 of the 28 closed cases referred to us be closed and the child removed from what was found to be an unsafe placement. A further child has also had to be removed subsequently in this period. These cases include one instance where the child was living in a household which included an alleged known paedophile. Clearly the initial assessments in these cases, if in fact they were able to be undertaken before the children were placed (sometimes by their own family members) in a kin placement, may have been inadequate and represent a question as to the duty of care issues arising for these children.

At the time of referral to the Oz Child Kinship Care program, the two children in our case example had been living with their grandmother for nine months already. The referral had been prompted specifically by the need to have a comprehensive psycho-social assessment completed in order to support Child Protection's application to the Court for the initial order. It appeared therefore, that while ideally a comprehensive assessment of kinship care placement options within the extended family be conducted as soon as possible after a child has come into care, there had not been time initially for a Family Meeting to identify potential family resources to support the placement and to take advantage of family knowledge about the suitability of any placement within the family with regard to best meeting the children's needs.

In fact, DHS Southern Region has taken a lead in using family meetings having funded two Family Decision Making positions for the past ten years. The original pilot Oz Child Kinship Care program highlighted the value of an early involvement in such meetings. Oz Child found that an early FDM can engage members of the wider family

⁹ Smyth, A. and Eardley, T (2008) *Out of Home Care for Children in Australia: A Review of Literature and Policy*, SPRC, Sydney

network and best empower them to take responsibility together for finding solutions for the child(ren) involved. The process also assisted in identifying unsuitable carers as well as broader potential supports and networks that the family could offer the chosen primary carer. This process therefore, generally complimented the assessment process by valuing family members knowledge of their own history and dynamics¹⁰. Our experience with regard to the positive role a FDM can play in developing 'family owned' solutions has also been more widely recognised¹¹ and it is helpful to note that the proposed new model of kinship care includes an introductory Family Meeting (as opposed to a full FDM) within four weeks of placement.

In our experience to date however, a referral to our Kinship Care program has been more likely to have been made for assessment of *established* placements, meaning that the assessment needs to take account of the existing family situation, including the willingness of the carer to engage in any involvement in court.

As kinship carers see themselves as relatives rather than foster carers there are often issues around the ability of the caseworker to ensure appropriate levels of care are being provided. The recent legislation requires community agencies providing out of home care and/or family services programs to meet specific Registration Standards. In the case of the Home Based Care program this includes compliance with specific standards relating to the care of children however, while the Kinship Care program comes under the scope of these same standards, to date it has been excluded from some compliance requirements as there is no agreement about how the standards relating to the care of children should be applied and what is the acceptable level of care for kinship placements. The reality however, is that most of the carers we deal with may be less competent, and certainly are much less trained than our foster carers. The challenge for caseworkers is therefore, determining the point at which the risk of cumulative harm from less than good-enough 'family care' outweighs the benefits of maintaining family connection and identity. This dilemma remains therefore, a major one to debate and consider further.

Another complication that has arisen has been that kinship carers are subject to the same Quality of Care Guidelines as foster carers however, unlike foster carers who are in the position of being able to carefully consider whether they are prepared, after training and assessment, to take on the responsibilities entailed in caring for a child at the required standards, kinship carers often have the care of a child thrust upon them without any time to think through the issues and the implications – they see themselves as having 'no choice'. As most kinship carers report that the primary drive and motivation for taking on the care of their grandchild or relative is to ensure they are kept out of the out of home care system, mandating their inclusion under the scope of the Quality of Care guidelines creates further difficulties around maintaining the placement. The level of knowledge of carers about this situation can also vary enormously and their motivation to take account of it can also vary.

To return to the case study of the two children, it is also worth noting that within the Home Based Care program, each case worker would expect to have a case load of between eight and twelve children (depending on the assessed range of classifications of complexity of the children involved, either General, Complex or Intensive). By contrast however, at present staff in the Kinship Care program have a

¹⁰ Hannah, L and Pitman, S (2000) Oz Child's Kith and Kin program, Oz Child, Melbourne

¹¹ See eg Algate, J. and McIntosh, M., 2006 *Looking after the family: a study of children looked after in kinship care in Scotland*, Social Work Inspection Agency. Also literature from NZ where FGC have been mandated since 1989 for all decisions about the future care of children where care and protection issues are involved.

case load of fourteen 'family' units. So, while in Home Based Care, each child is counted as a separate unit for funding purposes, within Kinship Care, the unit cost is recognised by "family"- ie the two children count as one unit. The assumption of a caseload of 14 'families' per worker in our experience usually equates to an average of up to 21 children. This therefore, raises issues of equity for staff as well as children in being able to potentially receive similar levels of case worker support which is not dependent on which 'program' they happen to be included in.

Additionally, 'flexipak' funds are provided for all children in foster care and for those assessed at the Complex or Intensive level of care, supplementary funding of \$1200 per year is provided with another \$11,000 p.a brokerage for those at the Complex level of care. This additional support provided to children placed with foster carers assists therefore, in accessing any necessary specialist support services such as counselling, remedial educational resources etc. Each case worker would also have responsibility for developing a LAC plan for each child which involved identifying their needs across the seven identified domains of child development and developing action plans to address these needs. Unfortunately, this situation is not the same for children placed with kinship carers.

As in Home Based Care, the Kinship Care program case worker's role however, involves supporting the carer - in this case the grandmother, as well as the children. However, in addition there is often the expectation that the worker focus at least some of their time on work within the family of origin - i.e the mother - in order to best implement the case plan and manage the access arrangements. In other words, the work done by the Kinship Care program case worker appears to be similar in expectations to that within the Home Base Care program but with the addition of work within a complex family system on less funded hours and resources to support the placement.

The different funding formulae applied to Home Based Care and Kinship Care placements appears therefore, to be at the heart of the inequities experienced by children in each stream. The question can therefore, be raised whether implementing a family preservation model recognises that this is also clearly in the interests of any funding body. As Hornby et al¹² point out, the reality of using a family preservation model to fund kinship care is that the entitlement to support from government is inversely proportional to legal and social responsibilities carers have to the child. In other words government support is least for parents who have both a legal and social responsibility to care for the child, somewhat more for kinship carers who have a social but not legal responsibility (although this can change if they move to Permanent Care) and most for foster carers who ultimately have neither responsibility.

It also appears that children in the Kinship Care program currently do not have a requirement to have a LAC plan, so that there is no systematic way in which the children's development is monitored across all seven LAC domains. Furthermore, when needs are identified, resources for meeting these needs are more limited given the brokerage to help meet a child's needs is at an average of \$77 per annum.

Navigating the system is more difficult for children and their families in kinship care placements where expectations that the family will provide a high level of financial support are present. This expectation can also be made in the face of the reality that many kinship carers do not necessarily have the financial capacities available to

¹² Hornby, H. et al. Kinship care in America: What Outcomes Should Policy Seek? *Child Welfare* Vol. LXXV #5 September/October 1996

support children adequately whereas in foster care, they may not have to face this expectation to the same degree.

This potential inequity in financial support for the needs of children in kinship care as opposed to those in foster care, also needs to be viewed in the broader context of the primary carer's circumstances. Unlike foster carers who can choose the time of life and family circumstances in which they may volunteer to become a carer, kinship carers often feel they have little choice. As the majority of these carers are grandparents who are most likely to be on a pension or benefit,¹³ the impact of taking on the care of a child can have considerable financial and lifestyle implications, particularly as there is no capacity with the present kinship care programs for funding to be at a higher rate of carer reimbursement to reflect the often complex needs of children in such a placement. Carers in the Oz Child Kinship Support Group for example, have prime responsibility for their children through Permanent Care Orders and expressed clearly their concerns about a drop in their living circumstances. They also worried how they would be able to financially support the child in the long term and who would care for the child should they become ill. These financial constraints therefore, appear to limit their capacity to independently fund not only the every day expenses not covered by the reimbursement received as a carer but any additional specialist services that may be needed for the child(ren).

Other concerns expressed by our kinship carers relate to social isolation, not feeling able to call on other family members to assist because of their own busy lifestyles and relationship difficulties with their adult child which can deteriorate when the grandparent becomes the primary carer. Some carers also spoke of feeling conflicted and guilty about having taken on such a caring role. For many, there remain tensions in providing and monitoring information with regard to phone calls and access between the children and their parents. Some also experience fear, both for themselves and the child, about contact with the birth parent when conflict has been very high. They also worry about how to cope with exposure to verbal and sometimes physical abuse or threatening behaviour during access and the difficulty they may have in protecting children from being exposed to this. These concerns are however, lessened within the Home Based Care program however, as usually there is more ability to exercise control over the interface between the carer and the birth family.

SUMMARY

Kinship care can occur through either an informal or formal basis with the latter most likely when there is statutory intervention for the child. The research suggests that in Australia the ratio of informal to formal kinship care is around three to one¹⁴. It is not therefore, surprising that it is our impression that discussion on the potential new models of kinship care has been more influenced by the understandable advocacy of those representing the more informal carers groups. The question arises however, whether the specific needs and rights of statutory clients – children – have been adequately represented or in fact potentially minimised as an unintended result of this process.

As a consequence, the tendency may have developed to focus on the development of a model which prioritises family preservation with the subsequent reliance on wider family resources being available to support the placement and on the capacity for kinship carers to be able to maintain links with the parent and/or to support

¹³ Smyth, A. and Eardley, T (2008) *Out of Home Care for Children in Australia: A Review of Literature and Policy*, SPRC, Sydney

¹⁴ *ibid*

reunification. This focus however, may potentially lead to the minimisation to some extent of the complexity of families often with serious issues that have crossed a number of generations, whose children come into care through Child Protection. Early intervention and the growth of family support programs in Victoria has in fact, meant that children who do come into care are now more likely to have come from families which have experienced intergenerational cycles of abuse, neglect, family violence and/or trauma. A review of the range of cases in which Oz Child has been involved gives some indication of the reality of family situations that workers are expected to assess and/or then support. These include carer reluctance or refusal to be assessed; limited protection for kinship carers from birth parents; cultural or disability issues that require more time and effort to work through; extreme access requirements; and multi generational issues such as the occurrence of sexual abuse.

This paper has attempted to highlight some of the core differences experienced by children and carers depending on whether the child may be placed in either foster care or kinship care within the Victorian Out of Home Care system. While we recognise the potential benefits of placing children within their family network in terms of maintaining their biological, emotional and cultural connection with, hopefully, a corresponding reduction in the trauma involved in the move from parental to kinship care, we believe that the evidence on whether overall the outcomes for each child are better than for any other form of out of home care is still a question for debate.¹⁵

However, in terms of the services and support 'wrapped around' a child coming through the statutory system and his/her kinship carer, we wish to question what appears to be considerable inequities arising when these placements in each system are more directly compared as we have outlined in this paper. There appears to remain an inherent tension between risk management and the ability to access adequate resources for supporting children who are in need of an out of home care placement. It is sometimes difficult not to escape the conclusion that one of the attractions of kinship care beyond the family preservation rationale is that it costs a great deal less than a placement through home based care. In our ten years of experience working with children in the statutory system however, we remain very conscious of the risk management imperative arising when we view the Kinship Care program through the lens of the Home Based Care program.

In other words, in our Kinship Care program,

- the need to ensure the children are safe in their placement and carers meet the needs of the child is the same as with HBC;
- there are the same requirements to see the child as with HBC when cases are contracted to the Kinship Care program;
- the same case management requirements appear to be required for HBC as for Kinship Care including court/report requirements;
- the same Quality of Care guidelines apply;
- the same need to make sure each of the individual needs of the children are met apply; and
- the same need to arrange care teams, counselling, and assessments etc, given the children have the same sorts of backgrounds in terms of trauma & abuse also apply.

Currently, all of these programmatic requirements are expected to be fulfilled with funding and sometimes minimal recognition that workers are also supporting and monitoring carers who are most likely to be less competent and less trained; more

¹⁵ ibid

enmeshed in their own families; have experienced intergenerational abuse, neglect and trauma; are older; and are entitled to a limited range of financial support. Workers are also required to undertake work with the birth family as appropriate. Placement stability and assessment in these circumstances can therefore, be complex. Furthermore, given the finding that 90% of children in kinship care in Victoria are expected to remain in that placement, the importance of ensuring that the placement is in the best interests of the child is critical.¹⁶

The sense of obligation felt by most families to look after their own in the face of significant difficulties or at a time of crisis is a powerful motivator to offer a child a home. Oz Child believes however, that no one would wish for this to be exploited as a means of reducing the cost of providing a placement which is in the best interests of the child. For many children it is a matter of chance as to whether a relative can be located at the time the child is taken into care. However, we do believe that chance should not dictate the level of support given to that child to hopefully redress the legacy of a disrupted and traumatic childhood and to potentially build his or her resilience to go forward to achieve their full potential.

¹⁶ Stability in Care Audit (2008) DHS, Melbourne