



Kinship Care:

A Literature Review

Introduction

In Australia, “in the last 12 months children... in out-of-home care has increased by 9.3% to 34, 060” (AIHW, 2010, p. viii). Approximately, 45% of these children reside in kinship care (AIHW, 2010). Given the substantial use of kinship care, attention has been directed to the responsible tailoring of policy and programming.

This paper examines national and international research on kinship care with the purpose of informing policy, programming and practice. Kinship care is a viable placement option for many children. However, it does require substantial professional expertise to ensure that the needs of children are being met and that kinship carers have the *commitment, capacity and support* needed to provide a placement. Appropriate service delivery and monitoring of kinship placements is required. Kinship care is a distinctive and unique type of out-of-home care and dedicated program support appears justified.

Prior to examining the research on kinship care, the state of the evidence requires noting, namely:

- there is minimal Australian research on kinship care. Research reported primarily comes from the UK and USA
- the evidence base on kinship care is conflicting and thus definitive conclusions on the effectiveness of kinship care are not possible. There are methodological weaknesses in the research and minimal longitudinal studies on the long-term outcomes of kinship care and
- research does not always distinguish between formal and informal kinship care.

Defining kinship care

Kinship care is generally defined as “the full-time nurturing and protection of children who must be separated from their parents, by relatives, members of their tribes or clans, godparents, stepparents, or other adults who have a kinship bond with a child (CWLA, 1994, p. 2; cited in Winokur, Holtan & Valentine, 2009, p. 8). Kinship care is also referred to as relative, friends, family and kith (“persons from child’s or family’s community”) and kin (relatives) care (Bromfield & Osborn, 2007, p. 1). Kinship placement is one option when children require out-of-home care (Boetto, 2010).

Differentiation is also made between informal and formal kinship care. *Informal kinship care* (also known as private kinship care) is an arrangement that is usually made by the family (and extended family) without statutory or child welfare involvement. These children are usually not under any custody or guardianship arrangements with State or statutory authorities. Conversely, *formal kinship care* is organised by statutory authorities as a result of substantiated child harm and the necessity for a child to be placed out of the home. The child may or may not be in the custody/guardianship of statutory authorities (Strozier & Krisman, 2007; Carpenter & Clyman, 2004; Winokur, Crawford, Longobardi & Valentine, 2008).

For Indigenous Australians, distinguishing between kinship and foster care may not be culturally sensitive or relevant. Indigenous carers may be both kin and kith to children. “Many Aboriginal carers ...[are] caring for multiple children and ...[have the] dual roles of kinship and foster carers” (Higgins, Bromfield and Richardson, 2005 cited in Bromfield & Osborn, 2007, p. 4). Separating

kin and foster care may be an unnecessary distinction (Higgins, Bromfield & Richardson, 2005 cited in Bromfield & Osborn, 2007).

Demographics of kinship carers and impact

Demographics

Kinship care is a rapidly growing form of care in Australia and internationally. Reasons suggested for the increase in kinship care are: changes in legislation and policy regarding placement preference (kin given priority e.g. Aboriginal Child Placement Principle); decreasing number and shortage of available foster care placements; substance abuse by parents so kin are caring for children; changing family structure and conditions; children and families indicating a preference for kinship care; and increase in children requiring out-of-home care (Green & Goodman, 2010; Winokur et al, 2008; Backhouse & Graham, 2009; Bromfield & Osborn, 2007).

Although kinship care is provided by a range of people known to children (e.g. aunts, uncles, sisters, cousins) this form of care is often provided by individuals with the following characteristics: female (regularly grandparents), single, older, unmarried, less educated, living in overcrowded conditions, lower socioeconomic status, unemployed or out of the workforce and, existence of health issues (Shearin, 2007; Yardley, Mason & Watson, 2009; Rubin et al, 2009; Cuddeback, 2004). The motivations of kin for caring for a child are often: family loyalty, commitment and attachment to the child, obligation, not wanting sibling groups to be split up, wanting a child to stay within the family and a desire for the child not to be placed in foster care (Lernihan & Kelly, 2006). The distinctiveness between kinship and non-kin placements is also exemplified by the fact that the placement is often requested in crisis and regularly unplanned. Many kincarers have not had the opportunity to prepare emotionally and materially (e.g. beds, car seats) (Burke & Schmidt, 2009). Many kincarers are approached out of need and thus have not been assessed, trained and equipped (Boetto, 2010).

Impacts

Considerable research has examined the impact of kinship care on carers. Impact means how the caring experience can influence/effect kincarers' wellbeing. A range of impacts both positive and negative have been identified (Table 1). Notably, not all of these issues may be relevant for particular kinship carers. Kinship carers are not a homogenous group (Zinn, 2010). Four main impacts have been identified: personal, financial, child and family-related. *Personal* denote those effects which impact on the kin individually. They encompass emotional and psychological issues and ways in which a kinship carer's personal aspirations may be changed. *Financial* impacts cover the potential economic implications of kinship caring. *Child-related* impacts represent the range of child needs a kincarer may have to respond to or organise assistance for. *Family-related* impacts highlight the potential change in family roles, structure and circumstances for kinship carers. Although these impacts could be classified in other ways, this framework does show the diversity of possible impacts on kinship carers. It is evident that the impact of kincare can be substantial with potentially many adverse implications for carers.

Table 1. Impacts of kinship caring

<u>Personal</u>	<u>Financial</u>	<u>Child-related</u>	<u>Family-related</u>
Stress	Housing – may be inadequate and therefore require change with associated costs	Managing behaviour	Managing family dynamics
Health problems	Overcrowding may also be an issue	Managing and responding to scholastic and academic needs	New role in family
Additional possible worries	Income insufficient	Managing a child's particular needs/issues (e.g. disability, grief and loss, abuse effects)	Grief, loss and concern about adult parent
Loss of opportunities	Poverty	Working with a range of services and organizations	Managing family conflict and tensions
Change in perceived plans	Legal costs and implications	Responding to family contact reactions	Managing contact arrangements
Concerns about the future	Costs associated with caring for the child (e.g. medical, set-up, day-to-day, education, psychological and developmental)		
Mental health	Possible sacrifice of employment and income so as to care for the child		
Fatigue and lack of energy			
Depression			
Feeling useful and worthwhile			
Can increase wellbeing			
Positive aging			
Contributing			
Changes in aspirations and lifestyle			
Perceptions of stigma re their own child and kin child			
Insufficient time for recreation and interests			
Isolation			
Anxiety and uncertainty about how to manage particular issues/circumstances			
Grief and guilt			
Limitations to lifestyle			
Loss of independence			

(Yardley, 2009 cited in Yardley et al, 2009, p. 52 & 58; Boetto, 2010; McHugh, 2009; Broad, 2006; Bunch, Eastman & Griffin, 2007; Harden et al, 2004; Vimpani, 2004).

Benefits and risks of kinship care

Research on the effectiveness of kinship care is still emerging with results being mixed and inconclusive. A number of benefits and risks of kinship care have been identified. Some research suggests that kinship care **may afford** the following benefits:

- remove a child from adversity by minimising disruption (Aldgate, 2009, p. 52)
- provide stability (Aldgate, 2009, p. 52)
- preserve continuities (Aldgate, 2009, p. 52)

- reinforce a child's sense of identity and self esteem (Aldgate, 2009, p. 52)
- be less traumatic than going to other forms of out-of-home care (Shearin, 2007, p. 35)
- buffer the effects of family separation
- children continue to enjoy a sense of belonging (Farmer, 2009, p. 340)
- less disruptive than other forms of out-of-home care (Aldgate, 2009, p. 52; Shearin, 2007, p.35)
- children may feel loved by kin (Shearin, 2007, p. 35)
- children and parents may prefer placements with kin (Farmer, 2009)
- children may experience less stigma than other out-of-home living arrangements (Messing, 2006)
- may result in fewer placement changes (Cole,2006)
- children more familiar with extended family (Cole, 2006, p. 498)
- can be an avenue of social capital (Kang, 2007)
- continued connection and contact with birth parents (Cole, 2006; Rubin et al, 2008)
- children are more likely to remain in the same community (Rubin et al, 2008)
- more likely to be placed with siblings (Rubin et al, 2008)
- can create a 'normalising experience' for children (Warren-Adamson, 2009, p. 82)
- can be less restrictive for children (Scannapieco & Hegar, 1999 cited in Winokeur et al, 2008, p. 339; and
- can keep a child connected to their family and culture (Broad, 2006).

However, a number of **risks or concerns** about kinship care have been identified:

- impacts and effects on kinship carers and their own difficulties (see previous section)
- developmental impacts on child (i.e. insufficient stimulation, meeting child needs) due to the capacity of kin carers (Cross et al, 2008; Palacios & Jimenez, 2009)
- safety issues – parents may gain unsafe access and contact to their children (Messing, 2006)
- difficulties for kin to manage new responsibilities and boundaries within the family (Holtan et al, 2005)
- kin may not enforce court orders (Green et al, 2010)
- poorer or different standard of care expected by services providers compared to non-kin placements (Cuddeback, 2004)
- kin having to deal with difficult family dynamics and stress (Argent, 2009)
- kinship carers can be more difficult to work with for professional staff (Cuddeback, 2004) and
- kin families are not sufficiently supported (Warren-Adamson, 2009).

Key messages

Kinship care refers to children residing with family or friends. Kinship care can be formal or informal.

Research on kinship care is inconclusive. Research findings and reported outcomes must be considered cautiously.

Kinship care is often provided by individuals with the following characteristics: female (regularly grandparents), single, older, unmarried, less educated, lower socioeconomic status, unemployed or out of the workforce and, have health issues.

The motivations of kin for caring for a child are often: family loyalty, commitment and attachment to the child, obligation, not wanting sibling groups to be split up, wanting a child to stay within the family and a desire for the child not to be placed in foster care. Kin carers are often not prepared for the placement.

Kinship carers may experience a range of personal, financial, child and family-related impacts (positive and negative). They may be under considerable stress and experience numerous adverse implications.

Kinship care can afford numerous benefits to children such as lessening disruption, continuity, sense of belonging, identity formation, cultural and familial preservation and stability.

Kinship care does have a number of risks which may necessitate monitoring and service support/provision.

Outcomes: foster and kinship care

The research on outcomes of children who reside in kinship care is inconclusive. Research reports on the following outcomes: placement stability, continuity of relationships, behavioural and emotional issues, environmental hardship, reunification, adoption and disruption.

Placement stability is an outcome regularly reported when comparing kin and non-kin foster care (Cuddeback, 2004). Winokur's et al (2008, p. 344-345) research found that "children in kinship care in Colorado experienced as good or better outcomes than did children in foster care.... Specifically, children in *kinship care had significantly fewer placements* and were seven times more likely to be in guardianship" (see also Chang & Liles, 2007).

The stability of kinship placements is also supported by other research (Farmer, 2009). This improved stability for children in kin placements is at times at the expense of the carers who may be suffering considerable stress (Farmer, 2009). Kin carers often have a strong commitment to persevere with a placement even when it is experienced as highly challenging as compared to non-related foster carers (Farmer, 2009). The *duration of unacceptable placements* (including very poor placements) can be longer for kin as compared to foster placements. This may be due to insufficient professional monitoring and follow-up, that concerns raised from others was not sufficiently considered, or that quality standards were not upheld because practitioners felt "...that they could not intervene readily in kin placements or thinking that, for children, being with family trumped other difficulties" (Farmer 2009, p. 339, also Farmer, 2010, p. 439). Other suggestions

are that there was no good alternative and that the child was older and more difficult to place (Lutman et al, 2009).

Some research has suggested that the outcome of **continued relationships** between child and biological parents may be enhanced by kinship care arrangements particularly through contact arrangements (Holton et al, 2005).

The number and nature of **behavioural and emotional** problems of children in kinship care as compared to non-kin care has also been considered but is inconclusive (Cuddeback, 2004). Some research has reported that children in kinship care do experience less behavioural problems than their non-kin counterparts (Holtan et al, 2005). However, some children in kinship care may have emotional and mental health difficulties but these are not identified due to their placement status. Kin carers may be less inclined to report behavioural difficulties and persist with the placement. "This 'sticking power' is a key contribution of kincarers but also means that many of them continue to care when they are under considerable strain, and in those circumstances placement **quality is poor**" (Farmer, 2009, p. 442 emphasis added).

In Cuddeback's (2004) research synthesis on kinship care it is reported that "there is some evidence that children in kinship care are functioning **less well compared with children in the general population** ...[e.g. more behavioural problems, homework difficulties, lower performance on English, maths, problem solving, listening, comprehension]...(p. 628, emphasis added).

Some research has suggested that kinship placements do not afford children the same level of **safety** as non-kin placements. Traditional foster placements may be safer in terms of potential for violence and other environmental hazards (Berrick, 1997 cited in Chang & Liles, 2007).

Children residing in kinship placements **may be experiencing greater 'environmental' hardship** due to the demographic features of their caregivers (e.g poverty, older, single, illness, less educated) (Ehrle & Geen, 2002, p. 30). This can impact on a child in terms of a kincarers' capacity to offer resources and/or facilitate learning and opportunities (Ehrle & Geen, 2002). Kincarers receive less services, training and support provision than non-kin foster carers (Ehrle & Geen, 2002; Cuddeback, 2004).

Reunification to biological parents has been found to **occur more slowly** for children in kinship care compared to foster placements (Cuddeback, 2004). Some USA research reports that **return rates from kinship** care compared to foster care to natural family are lower (Hayward & DePanfilis, 2007). This may reflect that placement with kin may be used when reunification is less likely and/or that family dynamics/opinions may lessen the likelihood of a child returning home (Farmer, 2009). Research has not sufficiently established the reason for reunification differences between kin and non-kin (Talbot, 2006).

Some research reports that kin are less likely to **adopt** a relative child. The reasons for this are unclear but may be related to: psychological barrier of kin to adopt a relative child; reluctance on the part of professional staff to discuss this permanency option; kin having insufficient information about adoption, kin being concerned about the effects of adoption on the family network; and kin hoping that parents may eventually be able to care for their children (Cuddeback, 2004; Nash, 2010; Ryan et al, 2010).

Overall, outcomes for children in kinship care appear positive. “If the goal of kinship care is to enhance the behavioural development, mental health functioning, and placement stability of children, then the evidence base is supportive” (Winokur, Holtan & Valentine, 2009, p. 37). However, children in kinship care have “worse outcomes than children who have never lived in care¹, but do at least as well, if not better, than children in non-relative foster care” (Bromfield and Osborn, 2007, p. 6).

Hunt et al (2009) further add that successful kinship placements are more likely if:

- the child is **younger** at the time of placement
- the child has **minimal problems**
- the child **has resided** with the kin previously
- the kin **initiated** the placement
- the kin is a **grandparent**
- the kin is a **sole carer**
- there were no other **siblings** living in the household (cited in Hunt, 2009, p. 109; see also Lutman, Hunt & Waterhouse, 2009), although other research has stated the opposite (e.g. Farmer & Moyers, 2008; cited in Hunt, 2009, p. 109).

A strong commitment to a child, good parenting capacity, flexibility, adequate support and resources have also been identified by kin themselves as factors that may contribute to optimal kinship careproviding (Coakley et al, 2007).

Conversely, **disruption** or less favourable outcomes for children in kinship may occur if: a parent has **drug** issues, has **multiple partners** or is involved in prostitution; the **child is older** (ten and above); the carer is **not highly committed** to the child; both child and carer **do not know each other well**; the child has significant **health, behavioural and disability** issues; the child is placed with an **aunt and/or uncle**; and **contact** is not supervised (Farmer & Moyers, 2008 cited in Hunt et al, 2009, p. 109; Chang & Liles, 2007, p. 520; Lutman, Hunt & Waterhouse, 2009). Farmer (2010, p. 440) also report that the following factors may be predictive of poor quality kin placements: carer strain, low kin commitment to a child, and a child who previously truanted from school prior to placement. These factors are important to consider when identifying which kin placements may be at higher risk for disruption and therefore require greater support. Some children who have disrupted kin placements will re-place within their family networks and continue to have a good relationship with a previous kinship carer (Lutman et al, 2009).

Views on kinship care

Children's views

Given the increase in the use of kinship care, research has also examined children and young people's views on kin placements. In the main, children and young people do appear to value kinship care and develop quality attachments to their caregivers (Burgess, Rossvoll, Wallace & Daniel, 2010). This section summarises research that reports on how children/young people: experience and perceive kincare, any concerns they may have, and issues pertaining to kinship care that are important to them. The value in considering this research is that it highlights the

¹ See also Smith & Palmieri (2007) for mental health comparison to general population. Children residing in kin arrangements may have higher emotional/behavioral issues compared to the general population.

diversity of experiences/perceptions children and young people may possess. It also assists in emphasising the needs of children residing in these placements.

A number of studies have specifically examined children and young people's perceptions and experience of kinship care. These findings are best conceptualised as insights from *some* children and thus are not generalisable. Children in kinship placements may:

- feel a sense of belonging and not wish to reunify with their parents (Burgess et al, 2010) or
- feel hopeful that they will eventually live with their biological parents (Messing, 2006)
- consider that living with kin is preferable to being in foster care (Burgess et al, 2010)
- not feel different to their peers but rather view their arrangements as just a different family form within a diverse society (Burgess et al, 2010). Alternatively, some children may feel different to their peers (Aldgate, 2009)
- not feel stigmatised by their care arrangements (Messing, 2006)
- perceive their kincarers as supportive and understanding (Burgess et al, 2010)
- feel safe and secure (Burgess et al, 2010; Broad, 2004)
- feel valued and like being cared for by someone who loves them and offers permanency (Messing, 2006; Broad, 2004)
- be fond of their carers and siblings (Messing, 2010)
- view contact with family, familial relationships (including biological parents) as important (Messing, 2010)
- appreciate being out of a difficult situation and value the stability and predictability of their current arrangements (Aldgate, 2009)
- understand and value the importance of caregiving (Messing, 2006)
- be optimistic about their future (Broad, 2004) and
- feel more secure when kincarers have legal rights (Messing, 2006).

Children in kinship care may be concerned or worried about:

- the nature of their relationship with biological parents, particularly if contact was missed or the 'inability to spend time with them' (Messing, 2006, p. 1424)
- the possibility of being moved into foster care (Messing, 2006)
- the health and wellbeing of their relative caregiver (particular if older caregiver) (Burgess et al, 2010, p. 302)
- about their own future (Broad, 2004)
- how to manage the negative experiences they had prior to moving into kinship care (Broad, 2004)
- communicating with their grandparent (generational issues) (Boetto, 2010)
- grandparents' health, energy and financial capacity (if grandparent is the carer) (Boetto, 2010) and
- not being sufficiently listened to or supported by professional staff (Broad, 2004).

Besides the advantages and possible concerns for children, for some, kinship care has its challenges, namely: "adapting to different household, adapting to different styles of parenting and moving to a different area with accompanying loss of friends" (Aldgate, 2009, p. 55). Research

has also highlighted that some children may not fully understand why they require kinship care. For example, one third of the children in Aldgate's (2009) research were not clear about this issue. This research finding highlights the importance of ensuring appropriate explanations are provided to children about the reasons for out-of-home care (Aldgate, 2009).

Parents' views on kinship care and contact

The emotions and impacts of kinship care are not exclusive to children and carers. Birth parents can experience a range of feelings which may impact upon their behavior towards the kincarer and their child. Despair, shame, *intense* feelings of grief and loss are some of the reactions parents may have when their children are removed and placed in out-of-home care (Harries, 2008; Thorpe & Thomson, 2004 cited in Harries, 2008, McHugh 2009). Some parents may require assistance from professional staff to reinstate a positive role with their children and kin² (Gleeson & Seryak, 2010).

Although, relationships between birth parents and kin may be amicable and positive, intense parental emotions can result in difficulties with placement arrangements. For example, some parents may be hostile towards a placement and try to undermine it. This may result in behavior such as: critiquing and complaining about the care of their child, raising allegations against the kin and being verbally and physically aggressive towards kin (Farmers and Moyers, 2008; Farmer, 2009; Farmer, 2010).

Contact can also be experienced as difficult for kin. Some carers feel unsure about how to manage tricky contact situations and therefore assistance may be required. Professionals may need to be skilled in mediation and counseling (McHugh, 2009). Notably, unsupervised, difficult contact arrangements have been identified as a possible factor in kinship placement disruption (Farmer, 2009; Farmer, 2010; Cuddeback, 2004). The relationship and attitude of *both the parent and the kincarer* can influence the success or otherwise of contact arrangements (Ziminski, 2007).

Practitioners are well placed to assist in building and facilitating a positive relationship between kin and birth parents. Birth parents are significant stakeholders in the kinship system and can continue to have a positive influence in their children's lives. Many birth parents do continue to be actively involved via visiting, child care and decision-making (Green et al, 2010, p. 1363).

² Notably, Gleeson & Seryak (2010) are referring to informal kinship placements, however this issue may also be relevant for formal kinship placements.

Key messages

The outcomes on kinship care are inconclusive. Positive outcomes provisionally reported are: placement stability, continuity of relationships and behavioural development.

Children may be slower or less likely to reunify with their biological families when in kinship care. This issue requires critical consideration and monitoring.

Children residing in some kinship placements may be experiencing greater 'environmental' hardship due to the demographic features of their caregivers.

Kincarers may persevere with difficulties longer than non-kin carers which may have adverse implications for the carer, the child and the quality of the placement. This issue needs careful assessment as the duration of unacceptable placements can be longer in kin as compared to foster placements.

Successful kinship care placements are more likely if: the child is younger, the child has minimal problems, the child has previously resided with kin, the kin initiated the placement, the kin is the grandparent, the kin is the sole carer, and no other siblings live in the household.

Disruption or less favourable outcomes for children in kinship may occur if: parent has drug issues, has multiple partners or is involved in prostitution; the child is older (ten and above); the carer is not highly committed to the child; both child and carer do not know each other well; the child has significant health and disability issues; the child is placed with an aunt and/or uncle; and contact is not supervised.

Children's views and experience of kinship care should be sought so as to ascertain perceptions and any concerns.

Some children in kinship care did not have a clear understanding of the reasons for their placement. Checking understandings and appropriate explanations about their histories may be required.

Birth parents' needs and feelings should not be neglected. Placement arrangements and contact can be affected. Kincarers may need assistance with contact.

Assessment

Assessment of potential kinship carers is a critical issue. It is an integral component of working towards positive placement outcomes for children and families. Three main challenges are often cited in relation to kinship care assessments: (1) whether there should be differences in assessment standards between kin and foster care; (2) whether intergenerational transmission has occurred and as such, whether kin carers have the same difficulties/issues as biological parents; and (3) that kinship assessments can be difficult for both families and workers.

Many potential carers acknowledge the necessity of assessment but can feel resentment about the attention given to 'risk' (Doolan et al 2004 cited in Hunt, 2009, p. 112). Balancing information provision to authorities and family privacy can be difficult for families (Argent, 2009, p. 8). Further, calls from practitioners to have a different model/approach to kinship assessments create complexity to the kinship assessment process (Hunt, 2009).

The significance of quality assessment is supported by research (Hunt, 2009). "Farmer and Moyers (2008) found that placements were more stable where carers had been assessed as foster carers while Hunt et al (2008) report better quality placements where there had been a pre-placement assessment (not necessarily a full assessment)" (p. 112).

Although there is no consensus in the literature, nor apparent evidence on the effectiveness of particular assessment tools/approaches, many commentators do consider that kinship assessment does require a unique approach. This does not mean declining standards but rather "widen[ing] our horizons" (Argent, 2009, p. 7). Suggestions pertain to both the *process* and *content* of undertaking kinship assessments. Specialist kinship assessors have also been recommended (Gupta, 2008).

The *process elements of kinship care assessments* could include being: **flexible but rigorous** (Pitcher, 2001 cited in McHugh, 2009), **supportive** (Pitcher, 2001 cited in McHugh, 2009), **empowering, collaborative** or exchanging information (Hunt, 2008; O'Brien, 2001; Waterhouse, 2001 cited in McHugh, 2009, p. 44;), **enabling rather than approving** (Hunt, 2008; O'Brien, 2001; Waterhouse, 2001 cited in McHugh, 2009, p. 44 Breslin, 2009, p. 29); **sensitive, respectful and inclusive** (Doolan & Nixon, 2004 cited in Hunt, 2008, p.4-5 in McHugh, 2009, p. 43); **partnership based** (Gupta, 2008); and **valuing the insights** and knowledge that kin offer (Doolan & Nixon cited in McHugh, 2009). The intent of these processes is to make the assessment process friendlier and more supportive and thus

Figure 1: Assessment topics

Ability of the kincarner to meet the needs of the child

Quality of the relationship between caregiver and child or level of attachment (attention should also be given to kincarner understanding of the child)

Relationship with birth parents – will they support or undermine the placement?

Existing family relationships, dynamics, potential difficulties and issues

Capacity of kincarner to respond to and manage family dynamics

Capacity of the kincarner to ensure the child's safety

Kincarner's parenting capacity

Capacity and perception of role change within kin network

Kincarner health, wellbeing, current lifestyle capacity and commitments

Capacity to manage family contact

Views of the child, birth parents and carers

Ability to identify and acknowledge difficulties

Kincarner's capacity to change and alter his/her behaviour if needed

Identification and discussion of strengths, potential stressors and support needs.

(Ziminski, 2007; Chang & Liles, 2007; Green et al, 2010; Child Welfare League of America, 2000 cited in Cuddeback, 2004; Sheahan & Klaassen, 2010; Pitcher, 2001 cited in McHugh, 2009; McHugh, 2009; Farmer & Moyers, 2008; Calder & Talbot, 2006; Coakley et al, 2007; Green et al 2010).

less stressful for potential kincarers. The ability to accurately ascertain carers' capacity and support needs may then be enhanced (Gupta, 2008). Flexible but thorough approaches still prioritise the safety and wellbeing of children but give greater latitude on domains such as potential caregivers' age, health and physical environment (Flynn, 2001; O'Brien, 2001; Hunt, Waterhouse & Lutman, 2008; Wheal, 2001 cited in McHugh, 2009, p. 43).

A number of suggestions are offered on the *content of kinship care assessment*. Black (2009) reports via the Scottish experience that "the starting point for assessment should be the child's plan, where the needs of the child are identified and proposals about how those needs might be best met are developed. The assessment of the carers should focus on the child's needs and full consideration of how the kinship carers could meet those needs and what kind of supports and services they would require to achieve successfully the goals of the plan for the child" (p. 44). Gupta (2008) suggests a two-stage process which involves an initial viability assessment prior to placement followed by a more in-depth appraisal which examines parenting capacity and any vulnerabilities/difficulties in offering the placement. Discussion on how these issues might be best managed is also an important feature (Gupta, 2008).

Many issues that should be considered when undertaking traditional foster carer assessments are relevant for kinship assessment (e.g. family history, motivation to care for the child, child's history, understanding of harm, discipline and behavior management approach, capacity to work with statutory services, risk and safety factors etc). Factors that are particularly pertinent for kinship assessments are detailed in Figure 1.

Recognition of the necessity for culturally-sensitive assessment approaches for Indigenous careproviders has also been emphasised³ (Bromfield et al, 2007 (c)). Key principles suggested are:

- "using a flexible approach to assessment criteria
 - adapting assessment tools to reflect an Indigenous communication style
 - harnessing community knowledge in the assessment process and
 - collaboration between organisations and the department in the assessment process"
- (p.3).

A number of practice principles are suggested on how the assessment process can be culturally-sensitive: ensuring that plenty of time is dedicated to **establishing rapport**, using a **yarning** or conversation style of communication; not asking for **information that has been provided** in other forums (e.g training); canvassing **community knowledge** about the capacity of the individual to provide care; assessing domains that would normally be examined with non-Indigenous careproviders; examining Indigenous issues such as **participation in Indigenous** community, understanding of **Indigenous kinship systems**, knowledge of **supports and services**, awareness and understanding of **historical welfare Indigenous** issues (Higgins & Butler, 2007, p. 7).

Finally, it is vital that any type of kinship care assessment involves ensuring that **both** the carer and the child are assessed so as to determine whether the placement is "mutually supportive". "**Being related is not enough to ensure quality caregiving**" (Crewe & Wilson, 2007, p. 234 emphasis added).

³ These recommendations pertain to recruiting Indigenous careproviders and are not differentiated between kin and foster carers.

Support for kinship placements

Contemporary literature on kinship care emphasises the importance of quality support and assistance to kinship carers. Quality support may strengthen both the stability and effectiveness of kinship placements. The benefits of kinship care can be easily **eroded** if carers do not have sufficient support (Palacios & Jiménez, 2009). It has been recommended by several commentators that this form of care requires well-developed policy, frameworks and resourcing (Yardley et al, 2009; Backhouse & Graham, 2009; Warren-Adamson, 2009; Hunt, 2005 in Sinclair, 2005; Boetto, 2010). Kinship care could be recognised as a specialist area of practice.

Argent (2009, pgs.8-10) argues that if organisations wish to support kinship care, a number of issues require consideration:

- Does the organisation support and encourage practitioners to explore kinship care as a placement option?
- Are there specialist teams or a dedicated, specialist kinship care practitioner within a service?
- Are family group conferences or meetings seen as an integral part of kinship work? “Family meetings should not be used merely as one-off events to identify possible carers, but to establish ways of working together to support the family’s children. Decisions have to be reviewed, progress should be acknowledged and sticking points must be identified” (p. 8).
- Does a service have a specialised assessment process and courses which aim to effectively prepare kincarers?
- Are there appropriate financial and other forms of support available to kincarers (formal or informal) which is comparable to non-kin foster carers?
- Are the support processes and packages for kincarers accessible, culturally-sensitive and respectfully incorporating kincare traditions?
- Are information resources available for kinship carers in their local communities in various languages? Are local practitioners also aware of provisions, support available etc?

Figure 2: SUPPORT AREAS

Adequate financial support for a range of expenses (e.g. schooling, uniforms, transport, extracurricular, respite care)

Housing

Information provision on a variety of matters (e.g. parenting, behavioural management, legal standing; financial entitlements)

Identification and linkage to relevant services (e.g. mental health, family support)

Respite care, childcare services

Caseworker availability, engagement, expertise and continuity. Workers who are knowledgeable about a range of issues: e.g. behavioural management, health, their family and the child

Relationship development with child – assistance to further strengthen attachment with the child

Educational support to redress any difficulties with assisting the child academically

Support groups for carers to reduce social isolation (not all carers desire to be part of support groups). Also mechanisms that combine education and support (e.g. computer training course – see Strozier et al 2004)

Preparation and training to deal with the challenges of kinship careproviding

Help with contact when problems are being experienced

Counselling for kinship provider (e.g. grief and guilt) and child (grief, harm issues etc) e.g. see Vimpani, 2004) and

Increased social work/practitioner support.

(Yardley et al, 2009; Shearin, 2007; Cross et al, 2008; Cole, 2006; Gaska & Crewe, 2007; Backhouse & Graham, 2009; Argent, 2009; Strozier et al, 2004; Farmer & Moyers, 2008; McHugh, 2009; Scannapieco & Hegar, 2002; Miller-Cribbs & Farber, 2008; Burke & Schmidt, 2009).

- Are kinship carers fully briefed and prepared for kinship care: i.e. options available, some of the potential issues, benefits and risks?
- Is legal advice readily available and accessible to kinship carers?
- Are there strategies and resources (e.g. financial assistance with housing, transport) in place to assist kincarers who take sibling groups?

Kinship care should be supported. Many children who require kinship placements have similar needs to children residing in other out-of-home care arrangements. Well-supported and quality caregivers are essential to heightening the likelihood of positive outcomes for children (Lernihan & Kelly, 2006). The research shows that kincarers can have diverse and high-level requirements. They may be under considerable strain and potentially experiencing numerous adverse effects in terms of their emotional, psychological and familial wellbeing. They may be silently dealing with these issues because of their strong commitment and dedication to a child in their care. Their support needs are clearly evident, but as a group kinship carers are less likely to receive assistance, support and monitoring than non-kin foster carers (Hunt, 2009; Cuddeback, 2004). Kinship carers have reported wanting to be valued, respected, trusted and treated as experts (Murphy, 2008). Educating the wider community on their role is also seen as valuable (see Yardley et al, 2009).

So what types of supports are optimal? Support may be required at any point during the placement but may be particularly needed in the early stages (Farmer & Moyers, 2008). “Although sudden placements often are unavoidable, support, training, and services can be **“front-loaded”** to help stabilize these imminent kinship placements” (Coakley et al, 2007, p. 107 emphasis added). A number of themes regarding appropriate support have been identified in the literature, which are detailed in Figure 2. Any of these support areas may to a greater or lesser extent be relevant to particular kinship carers. It has been suggested that a framework for identifying different levels of support may be required (Hunt, Waterhouse and Lutman; O’Brien, 2001 cited in McHugh, 2009). Not all kinship carers will **require or desire** formalised support and assistance. But provision does need to be available. Consultation with a range of kinship carers from a variety of communities and cultural/ethnic backgrounds is required to ascertain differing needs and potential service responses (Hunt, 2005 in Sinclair, 2005).

Support can also come from within the family system and personal links (e.g. friends, community groups, church) as there may be considerable resources and strengths within the informal support network (Burke & Schmidt, 2009).

Yardley et al (2009) also make an important point in relation to supervision and kinship care. From their research they found that for some kincarers the term ‘supervision’ was not viewed positively but associated with negative connotations such as “surveillance and spying” (Yardley

Figure 3: POSSIBLE SPECIFIC TRAINING ISSUES:

Managing familial relationships and dynamics

Building, facilitating and maintaining positive familial relationships

Conflict resolution

Boundary setting

Working effectively with child welfare services

Child and anger management and permanency planning

Responding to child’s needs

Drug issues – babies with drug addiction

Positive communication

Life skilling.

(Coakley et al, 2007, p. 106; Burke & Schmidt, 2009; Yardley et al, 2009; Sheahan & Klaassen, 2010, p.14).

et al, 2009, p. 69). A 'professional' supervision approach (i.e partnership, sharing ideas, assistance, and empowerment to make the decisions) may be more positively viewed by kincarers (Yardley et al, 2009, p. 70).

Increasing kinship placements

Kinship care offers promise as a good out-of-home care option for many children but is not suitable for all. Some children may not have kin with the capacity and capability to care for them (Hunt et al 2008 cited in Hunt, 2009). The goal to potentially increase the use of kinship care must be tempered with this aforementioned proviso.

Increasing kinship carers is not a simple matter because they cannot be recruited in advance. However, a number of processes (suggestions) can be employed to ensure that kinship placement possibilities are maximised:

- kinship care be considered in the early stages of a child's placement (Farmer & Moyers, 2008)
- requesting child and family members to diagrammatically represent (e.g. genogram, ecomap, family tree, network mapping) all members of the child's family and strength of these relationships. This should include both sides of the child's family (i.e. sometimes one side of the family is neglected in discussions) (Argent, 2009, p. 12; Hunt, 2009)
- use of family group conferencing to assist in the identification of possible kin and collective planning for a child (Breslin, 2009). Family group conferencing can enhance placement stability (Breslin, 2009)
- legislation that requires notification of kin when a child is likely to need a out-of-home placement (Rubin et al, 2008, p. 555)
- if caregivers receive quality support, training and assistance this can facilitate other potential carers stepping forward. This may be particularly so for recruiting Indigenous carers (Higgins & Butler, 2007)
- given that kincarers are often motivated to care for a child due to commitment and love, it has been suggested that recruitment efforts "might appeal to kin's strong convictions about family values to attract them to fostering" (Coakley et al, 2007, p. 106). Reassurance of kin about the stabilising and positive effects of quality kincare, plus support, information provision and resources available may also impact on any concerns held and thus improve recruitment (Coakley et al, 2007) and
- that practitioners be encouraged to be more diligent and active in examining kinship options. Some research suggests that social workers may not be sufficiently initiating kin placements (Farmer & Moyers, 2008; cited in Hunt, 2009) or may be haphazard in their approach (Nash, 2010).

Given that kinship carers have reported wanting to feel valued, respected and seen as 'experts', community education and awareness strategies may also assist in boosting interest if the profile of kincare was increased. This could be achieved by strategies such as: kinship care day, accessible information provision on supports available, kin carers mentoring others, dedicated focus for example during child protection week. Although the aforementioned suggestions have not been empirically tested, strategies which have the dual purpose of raising awareness and validating/supporting existing kin must in part assist in recruitment efforts.

Indigenous and cross-cultural issues

Aboriginal and Torres Strait Islander children are overrepresented in the child protection system (Higgins, 2010). Issues such as stolen generation, past government practices, intergenerational impacts, economic, material and social disadvantage can make Indigenous communities particularly vulnerable and wary of government involvement. Past issues can act as both a barrier and incentive for Indigenous people to be careproviders (Bromfield, Higgins, Higgins & Richardson, 2007 (b)). These issues add complexity to how to best support Indigenous children requiring out-of-home care in a culturally-sensitive manner (Bromfield, Higgins, Higgins & Richardson, 2007 (a)).

Kinship care for many cultural groups is natural or more in line with existing ways and traditions of caring for children. It has been suggested that kinship care for Indigenous children may be preferable particularly because of the cultural, familial and spiritual connections (McHugh, 2003, cited in Valentine & Gray, 2006). "Thus kinship care helps Aboriginal children maintain their cultural identity and connections, and this lessens the stigma of out-of-home care" (Valentine & Gray, 2006, p. 541).

Although the benefits of Indigenous kinship care are clearly evident, benefits are inextricably linked to the *availability of quality* Indigenous kin placements (McHugh, 2003 cited in Valentine & Gray, 2006). A number of Indigenous carers may already be *overstretched, not sufficiently resourced/trained and not have opportunity to access services* (Valentine & Gray, 2006). This adds complexity to identifying and ensuring secure and robust placements (McHugh & Valentine, 2010). This underscores the importance of examining how best to identify, recruit and support Indigenous careproviders /communities so they can provide quality placements for Indigenous children.

Although Australia does recognise the importance of Indigenous children being with Indigenous careproviders via the Child Placement Principle, it has been suggested that compared to other jurisdictions more could be done (Valentine & Gray, 2006). Valentine and Gray (2006) cite the examples of Canadian First Nations and New Zealand Maori children where there appears to be more support, financial assistance, information provision and more diligent and concerted efforts to identify kin.

Given the different kin structures and conceptualisations of family within different cultural groups, dedicated consultation and active involvement of individuals/communities in decision-making is necessitated. Breslin (2009, p. 30) makes the comment that "...there is currently a lack of guidance around what constitutes effective consultation and the approach from caseworkers is inconsistent, or a 'tick box' approach (NSW Ombudsman, 2008)". This highlights the importance of clearly understanding and ensuring that quality consultation with cultural representatives, leaders and elders occurs.

Given that there is a lack of Indigenous careproviders which means insufficient culturally-sensitive placements, this raises the question of how best to identify and recruit potential Indigenous careproviders⁴. Recruitment of Indigenous careproviders has proved difficult (Bromfield et al, 2007 (a)). However, recruitment difficulty is not always due to willingness on the part of potential carers but rather their "capacity or ability – such as financial capacity or ability to meet eligibility criteria" (Bromfield et al, 2007 (a), p. 5). Insufficient Indigenous careproviders can also be

⁴ Information provided is derived from material that discusses Indigenous careproviders - both foster and kin.

attributed to caregivers retiring, concerns about managing children with high level needs and the stress/strain on existing carers who are often overburdened (Bromfield et al, 2007 (a) and (c)). Recruitment of Indigenous careproviders may be more successful if “using Indigenous people to recruit Indigenous carers and community based recruitment strategies...” (Bromfield et al, 2007 (c)).

Insufficient Indigenous careproviders have also been experienced by Canada’s Aboriginal peoples. Ivanova and Brown (2010, p. 1798- 1801) explored the needs of Canadian Aboriginal careproviders and found that the following support needs were valued: (1) **foster system care support** (e.g. support worker, assessment, school support, respite, funding to keep siblings together in the family); (2) **specialist services** (e.g. tutoring, medical, psychological, training for themselves to manage the specialised issues the children may have); (3) **education** to develop their capacities (i.e. a variety of mechanisms to educate them e.g. mentoring from others; seminars, learning units, support groups, community resources); (4) **cultural and community supports** (e.g. Aboriginal and cultural activities, access to traditional teachings and language, cultural support from Indigenous services and assistance to repair relationships/connections with the child’s biological parents and kinship network); (5) **recreational support** – financial assistance so recreational activities can be accessed and enjoyed; and (6) **housing** assistance. Similarly, carers in Higgins, Bromfield, Higgins & Richardson’s (2007) research reported needing: financial, practical, emotional and peer support, quality, respectful relationships between caseworker, statutory organisation and carer; more collaborative, partnership style approach, involvement in careplans, more detailed information about the child, greater contact with caseworker, having an Indigenous caseworker, contact assistance and more highly skilled practitioners who are experienced and do not impose ethnocentric attitudes.

Key Messages:

Assessment is vital in kinship care. A different approach to assessment is suggested but effectiveness is yet to be empirically established.

Suggestions for assessment pertain to both the process and content of assessment.

The process of kinship assessment could be more collaborative, supportive and partnership based. Safety and thoroughness are still essential.

A number of kincare specific content areas as distinct to foster care assessment have been recommended.

There is substantial justification for developing quality support provision for kinship carers. Not all kincarers will have the same support requirements or the desire to receive support.

Kinship care placements can be increased by implementing more proactive measures for identifying kin. However, kinship care is not suitable for all children. Not all kin have the capacity and ability to offer care.

Cultural awareness of how kin are understood and their role in Indigenous and other cultures is important. Likewise, assessment and support provision require consultation with Indigenous communities, leaders and elders so as to ensure cultural compatibility and social inclusion.

Kinship care does require professional staff who are well trained, skilled and aware of the particularities of kinship care. Specialised training may be required.

Kinship care is different to foster care. Policy, programming and practice need to be tailored to the unique benefits, risks and requirements.

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