Report on a research project: an examination of issues around the support and supervision of Kinship Carers with a particular focus on NSW

Kinship Care in NSW
Finding a way forward

By Ainslie Yardley, Jan Mason, Elizabeth Watson

November 2009
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RESEARCH TEAM

Jan Mason Chief Investigator (Dec 2004 – Nov 2009)
Elizabeth Watson Chief Investigator (Dec 2004 – Nov 2009)
Leonie Gibbons PhD student (Dec 2004 - Sept 2007)
Ainslie Yardley Researcher (Jan 2008 – Nov 2009)

Dr Georgina Luscombe
Academic Research and Statistical Consulting
With Lloyd Watson

Social Justice Social Change Research Centre
University of Western Sydney, Bankstown Campus
Locked Bag 1797, Penrith South DC NSW 1797
Australia

ACWA
Nigel Spence (Dec 2004 – Feb 2006)
Eric Scott (Dec 2004 – August 2007)
Andrew McCallum (July 2006 – Nov 2009)
Sylvia Ghaly (Jan 08 – Nov 09)

Association of Children’s Welfare Agencies
Locked Bag 13, Haymarket NSW 1240
Australia

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Biographical Notes

Researchers

Dr Ainslie Yardley
Ainslie Yardley is a performative social scientist and associate member of Social Justice and Social Change Research at the University of Western Sydney. She has a PhD from the University of Western Sydney and a Master of Creative Arts from the University of Wollongong. She is a novelist, theatre artist, and multi-media essayist. Her research, teaching and academic publications incorporate new methodologies and multi-disciplinary approaches including embodied creativity and narrative theory. Her current research is focused on children, creativity, wellbeing and family, and includes collaborative work in diverse communities.

Leonie Gibbons
Leonie Gibbons has qualifications in social work, psychology, information technology and mathematics. She has worked in social research for over 30 years and was a lecturer in research methods (both qualitative and quantitative) at the University of Western Sydney for 16 years. She provided training courses for UWS Research Office and research advice to academic staff and graduate students. Leonie has run her own research consultancy for clients in government, not-for-profit organisations and universities in fields including child welfare, local government, health and education.

Chief Investigators

Professor Jan Mason
Jan Mason is Professor of Social Work and a member of Social Justice and Social Change Research Centre at University of Western Sydney. Her research focuses on linking theory, policy and practice on children’s issues, through collaborative work with major children’s agencies in New South Wales and with Australian and overseas academics. She has researched and published on child welfare and protection, child and family policy, child-adult relations and children's wellbeing. Her particular interest is in facilitating children’s participation in research and in practice and policy development on issues concerning them.

Dr Elizabeth Watson
Elizabeth Watson is an Adjunct Research Fellow in the Social Justice and Social Change Research Centre at the University of Western Sydney. She has a particular interest in the area of women’s work, paid and unpaid, especially the issue of care and care work, and in research methods, methodology, epistemology and ethics, with a particular focus on exploring ways of researching collaboratively with more marginalised groups. Her recent research has been in a number of social policy areas – children’s wellbeing, kinship care, care and caring work, including men’s caring work and women’s human rights.

Statistical Analysts

Dr Georgina Luscombe
Georgina Luscombe is a behavioural scientist and co-director of Academic Research and Statistical Consulting. She has conducted research in the Department of Obstetrics and Gynaecology and the Brain & Mind Research Institute at The University of Sydney, and the Academic Dept of Aged Care Psychiatry at the Prince Henry and Prince of Wales Hospitals. She has consulted extensively on statistical analyses and research methodology in many research fields including general psychiatry, psychogeriatrics, neurology, dentistry, rehabilitation medicine, music therapy, nursing, education, and social work.

Lloyd Watson
Lloyd S. Watson ME (Industrial); Postgraduate study in operations research. He has thirty years experience in the development of stochastic models and data analysis systems for engineers and economists associated with government and commercial policy evaluation.
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On behalf of the Board of the Association of Children’s Welfare Agencies (ACWA) I congratulate our research partners, the University of Western Sydney, on the report “Kinship Care in NSW: Finding a way forward”.

At the time that ACWA initiated this piece of research it was felt that there was a dearth of Australian specific material available on which coherent policy could be based. Since that time there has been growing academic interest in the area.

The number of children deemed to be in Out of Home Care (OOHC) has burgeoned at an alarming rate in NSW. A proportion of this increase can be attributed to some kinship carers now receiving payments from the NSW Government, although not formally constituting a child protection concern. The many developments on the OOHC front in NSW in recent times, and its enmeshment within the broader child protection system, has brought into sharp focus the nature of what gets classified as kinship care.

What then do we know of the kinship carers’ experiences? Where do they see themselves in the scheme of things? Is it realistic to aspire to definitional clarity around the term beyond that which relates to familial ties? Therein lies the primary aim and dilemma of this research: “An examination of issues around support and supervision of kinship carers with a particular focus on NSW.”

As with many research projects it is ACWA’s desire that this report should not only add to the growing body of knowledge in respect to kinship care but also “thicken” the discussion and highlight further research questions that will inform policy and improve the lives of both children and carers.

Of particular interest in respect of the report is the use of a narrative approach that brings very personal and insightful elements to the fore. This provides us with the human story that has brought families to this place, with all the vulnerabilities, frailties, strengths and obligations that make every one a unique experience. Each of these experiences paints a compelling picture that further highlights the complexity of kinship care and the need for understanding and support. It is critical to ensure we do delve behind the terminology and categorisation that can so often cloud our vision.

Although this research is specific to kinship care it will also contribute to the far broader social policy discourse around carers and caring, rapidly becoming a central theme of social policy in general - probably for decades to come. Issues may vary across carer groups but the “unpaid” role, the personal consequences and the hidden economic implications are questions that demand the careful attention of governments at all levels.

My thanks to the research team led by Jan Mason for such a valuable contribution to the collective wisdom on kinship care, particularly in the NSW context and I feel sure it will assist us greatly in finding a way forward.

Andrew McCallum

CEO, ACWA
Narrative one

The First Three Days

The following story is written as a fictional narrative might be written – but it is not a fiction. Although names and places have been altered to preserve privacy, the protagonists are flesh and blood real and the story emerges from their lived experience. In this story a grandfather, grandmother and granddaughter stumble their way through their first few days as a family reforming itself after tragedy.

Michael slipped the key into the ignition and paused, drawing a deep breath to steady himself before bringing the car to life. He couldn’t see Madeline or Emma, but he knew that Emma would be where she had been for the past three days, sitting on the living room floor hugging a cushion with her eyes glued to the TV screen. It hadn’t seemed to matter to her if the sound was on or off so long as there was some kind of action in front of her. She had been so afraid of the dark these last few nights that Madeline had slept with her on the foldout couch with the TV flickering nearby all night long. Madeline would be standing at the front window. She would have pulled the curtain aside a little to watch him drive away. Michael didn’t know why he knew this - he just knew that was where Madeline would be. She would have her hand at her mouth, her head tilted a little to one side as she always did when she looked at him and her eyes were full of tears. She had wanted to come with him, but it just stood to reason that she should stay behind with Emma. No one else could do that. And he was the man in the family. Whatever 21st century convention said, he was the protector, and this was a job that a man should do for his wife and his grandchild. He could protect them from this much at least, if from nothing else.

He slid the car into first gear, indicating and checking the street for traffic. The Wilson’s drove by in their campervan, chequered café curtains in the windows, bicycles lashed to the back. Loraine and Jerry heading off to the Bungle Bungles. He saw Loraine lift her hand and wave madly at him, her broad grin fading as the memory of recent days caught up with her natural friendliness and enthusiasm. In those brief seconds as they passed by he could see the shock and concern return to her gaze, her hand frozen mid wave.

“How long”, Michael wondered before people could look at them again without discomfort, before people would know how to behave towards them, and be with them again. How long before they would know how to be with themselves, before the world returned to something approaching normal. Maybe it never would.
They should have been driving off together today in convoy – he and Madeline with Loraine and Jerry - off on their annual trek. Three days ago they had been packing. Impossible – that was a world away. they were a world away. Loraine and Jerry’s world one that he and Madeline would never inhabit again. Michael pulled out into the quiet suburban street before these thoughts could overtake him and freeze him solid where he sat. He drove the familiar route as if on automatic pilot, hardly registering his surroundings or the passage of time.

The young woman was waiting for him on the porch when he pulled into the driveway. The one who had come to them with her colleague three days earlier, to give them the news about Sarah.

“Mr Graham,” she said, extending her hand, and shaking his with genuine warmth. “I have the key.” She smiled apologetically, “I’m afraid there are a few more things that need wrapping up here. After that I can give it back to you.”

She turned and opened the front door, ducking under the tape stretched across the doorway, turning to hold it high so Michael could step beneath. He crossed the threshold - into his daughter’s home standing in her hallway for the first since that night when they had been taken to the hospital to fetch Emma.

“I know this must be awkward for you,” the young woman said as she moved into the hall, “but it is important that all the formalities are in order.

“At least I can let you in to collect some personal items for your grand daughter. It must have been difficult for her not having any of her own things. Essentially, though, this is still a crime scene – we should confine ourselves to the hall and Emma’s bedroom.” She pulled the first door on her left closed, the living room door, and stood in front of it as he passed, her hands clasped low in front of her, her heels slightly apart.

Standing at ease, Michael thought, to put him at ease – but still guarding that door. She seemed to be studying him, a little concerned perhaps about how he would react.

How quiet it was – more than quiet. He could hear something deeper than quiet. It was as though the walls themselves were absorbing sound, even the sound of his breathing, as though the walls were drawing him in, into the silence of his daughter’s house.

Michael jerked backwards as though he had been struck.

“Sarah!”
His precious – daughter – murdered – Emma’s father – dead too – by his own hand. The thoughts came with a staccato urgency, an invisible force jabbing at him, right above his heart, stressing each terrible word.

How could that be? How could that be?

He was rooted to the spot, listening to the impossible silence that followed the echo of her name. Sarah. Then he heard the soft voice of the young constable call his name, “Mr Graham? Mr Graham? Are you all right?”

He turned to her in confusion, not sure where he really was or what he was supposed to be doing. He looked about him – the hallway took shape again. At the end of the hall he could see sunlight pouring through the doorway from his granddaughters bedroom. Yes, of course, that was where he needed to go. That was why he had come here. He needed to pick up some clothes, Emma’s favourite books – her backpack for school. He needed to find Flat Teddy, and Skelly and Nemo. Everything else would wait awhile. Passing the kitchen on his right something suddenly dawned on him – he turned back to the young constable, his mouth forming a silent question.

“The birds?” she asked, he nodded.

“I took the liberty of feeding them for you,” she said, “I took them to my place.”

Michael felt a sudden rush of gratitude for this small kindness that almost overwhelmed him.

“Don’t worry,” she said, “They’re fine. I’ll bring them to you when you’re ready.”
Section One

The Research Journey
Introduction

The introductory story ‘The first three days’, captures only a very brief moment in time, an hour or so at most, and deals with only one tiny part of the extraordinary story told by a couple who became carers of their granddaughter under very tragic circumstances. Readers of this report might reasonably ask why we would choose to introduce it with a semi-fictionalised narrative like this one, rather than use the carer’s own words to describe his experience? Why would we begin with a narrative at all?

Relating these events even years later remains, for those involved, a traumatic and personally challenging experience. Not one undertaken lightly, or publicly. While the individuals concerned might want others to understand how complex, sudden and devastating the entry into the caring role can be, they do not necessarily choose to be storytellers and they do not choose to have their lives constantly exposed to public view. Both they, and the researcher, are thus left with a dilemma – how to give voice to their reality without compromising the integrity of their experience and without trivialising or sanitising their story?

My choice as a researcher, and as a person with whom the original account was shared, was to step into that very confronting space of the autobiographical account and reconstruct it in a new context, in order to place it at one remove from those who had been and could be further damaged by it. By semi-fictionalising one small aspect of the narrative that had touched me deeply, and imagining how it might have been as those events unfolded, how a man might have felt in those terrible moments, it became possible to pass on the shared experience of the narrative (that occurred between the couple and me) in this more formal context – where we can return to it as our exploration of the experience of kinship caring unfolds.

More stories will follow throughout this text along with commentaries and narrative accounts. These stories are not presented as ‘case studies’ or used simply to illustrate a point. They are included as a form of narrative analysis – a way of drawing deeper insights from the qualitative and quantitative data we have gathered from the carers who have participated in our study. We have looked for where the narratives intersect with those sets of data that are generally seen as objective and verifiable. While this narrative approach is not standard practice in a report of this kind it is integral to our methodology and we will explain more fully why we have chosen to make this departure from convention in the section devoted to methodology.

In the story, The first three days, as I have written it, Michael is touched by the kindness extended to him by the young woman constable – that of personally caring for the family’s pets, while his daughter’s house remained a crime scene. It doesn’t take much effort to imagine how difficult it would be to deal with such a bewildering and painful circumstance, and it is comforting to imagine that concerns for this newly bereaved family would be acted upon very quickly, and with sensitivity. Seeking comforting reassurances that all that could have been done in the circumstances, has indeed been done, is a natural reaction. In reality, no such simple act of kindness happened. No officer of any agency reached out in those first three days after the tragedy. Indeed for the several years that followed ‘Michael’ and his wife and grandchild were left essentially to their own devices, to struggle alone along the path of reconstituting their shattered family and building a healthy, hopeful future for a
shocked and damaged little girl. That the couple have succeeded in large measure to build a comparatively healthy, hopeful future for their grandchild has little, if anything, to do with formal structures of support, and everything to do with their determination and commitment – determination that has had considerable cost, in terms of health, financial stability, loss of treasured pastimes and social interaction. Structures of support do not always fail – it would be wrong to say so, and possible to present evidence of many families who have been supported very well. The evidence emerging from this research, however, points to an inconsistency and unreliability in support service delivery to kinship carers, principally because they are an unknown quantity – a group often on the fringe due to an information deficit in both directions. There are many reasons we can find for these deficits: how carers’ have been defined or not defined by statutory authorities; how they define themselves; what their legal status as a primary carer is; under what circumstances the child came into care; and whether or not the child is already ‘in the system’.

Michael’s story points to how serious the consequences of inconsistency can be. Carers often know nothing of the help they could receive at crucial times in the rebuilding of their families and agencies often have no knowledge that carers are out there struggling on their own in great distress. From the carers’ point of view, their personal narratives are a record of their lived experience and proof positive that they exist – the primary reason why they tell them with such passion. Consequently these stories have great value to carers in their efforts to advocate for themselves and on behalf of others, and great value to us in understanding their concerns.

There are two further reasons why a narrative approach has been centrally located in this study. The first is to acknowledge right up front the central role that all the participating carers’ narratives have played throughout the research process, and the need to anchor the text where it belongs – in their lived experience.

The second is to provide an additional methodological tool. We have included narrative inquiry and analysis as part of our methodology in order to reveal the ‘inner life’ of the research data that is usually obscured from view, packed away in a box and held as evidence of the veracity of the study. This has proved to be a powerful addition to our research toolbox when the data being gathered has included very passionate accounts of complex and painful life experiences. The interpretive character of narrative has taken us beyond case study notes, reporting tools and the simple recording of data. Every element selected to craft each kin carer’s story has been chosen not only to say what happened, but also to show why the story has been told (Josselson et al., 2003, p.62; Yardley, 2008) in the context of the broader task - that of developing deeper understandings of the experience of kinship care that can better inform the development of policy more relevant to carers’ and children’s needs. It becomes possible, through the construction of narrative, to include accounts of events that are too private or too emotionally charged to share directly. This aspect of our research design will be teased out more fully in the section on methodology and research instruments.

The following sections will address: the background to this research project and recurrent themes emerging from it; a discussion of carers life experiences in relation to policy development and service delivery; a statistical analysis and demographic profile of kinship carers; a comparison of kinship and foster carers experiences and views concerning support and supervision; a summary of findings; general conclusions; possibilities for future directions in policy development; and further research that would benefit the field.
Background

The Research Journey: Background and aims

This chapter documents the aims and framework with which we began the project and some of the events and explorations along the way. All research is a journey that inevitably covers difficult terrain, and this project was no exception. Added to the delays and organisational complexities that are part of any project, this project experienced unplanned variations in scope and duration and unexpected personal circumstances that necessitated changes in the research team and extensions to the research program.

The proposal for the research on which this document reports was initiated by Association of Children’s Welfare Agencies (ACWA), the peak child welfare organisation in New South Wales, as a response to the dearth of Australian research available at the time on which to base kinship care policy. An Australian Research Council Linkage grant received in 2004 provided for a post-graduate student to complete the research towards a PhD. The doctoral student contributed to all aspects of the project but, owing to ill health, had to transfer to part time candidature and then in mid 2007 to withdraw from the project. In early 2008, a researcher was employed to follow through on implementation of the project in collaboration with the Chief and Partner Investigators.

The Multi-disciplinary Team

The researchers on this project were a team, some participating in the whole enterprise, others for shorter or longer sections of the journey. This journey was undertaken in the broad context of child welfare, with this continuity ensured by the on-going presence of ACWA team members. Each member of the research team was sought out and brought on board for the various knowledge and skills they possessed and could contribute to the project. This resulted in a truly multi-disciplinary approach to the research questions, as our qualifications ranged across the disciplines of anthropology, creative arts, psychology, sociology, social policy, social ecology, social work and system analysis. Our practice experiences included direct child welfare practice, as foster carer and child welfare practitioners, knowledge and skills gained from practice as research methodology consultants and as novelist and theatre artist. The methodologists had also taught and researched in areas such as caring, new methodologies and the impact of information technology, while some of the team were parents and/or grandparents. The diversity of the knowledge and experiences we brought to this enterprise made our research journey a rich and, at times, challenging experience for us all.
Aims of the Study

**Primary Aims of research:** An examination of issues around support and supervision of kinship carers - with a particular focus on NSW.

**General Aim:**
To contribute to the development of policies on kinship care which will benefit children and their carers particularly in NSW and more generally.

**Specific Aims:**
1. Examine the issues, assumptions and values relevant to policymaking about the support and supervision of kinship carers
2. Compare formal kinship care, informal kinship care and foster care in terms of background, demographics and experiences of caring for children particularly in relation to support and supervision.

Aim One concerned an exploration of the dilemmas associated with questions about what kind of role the state should play in support and supervision of kinship carers – referred to by Hornby et al. as ‘the ultimate question’ posed by this form of care (1996:410). The debate in New South Wales child welfare forums at the time the research was commenced reflected those in the publications from the United States, centring on questions of the government’s role, and responsibility for, support and supervision of children in kinship care (e.g. Bridge and Freeburn, 2001; Cashmore, 2001).

**Research Question**

What are the values and assumptions underlying policy decisions about “best practice” in Kinship Care: what are the issues and assumptions that make support and/or supervision of kinship carers by the State so contentious?

Aim Two of our research project was to provide data on the characteristics of those involved in kinship caring in NSW and to compare this information with data on the characteristics of foster carers. The literature from the US examined at the time the research was commenced, indicated contradictory findings on the characteristics of those caring for their kin children (generally in comparison with foster carers) and the relevance of this to the provision of appropriate care. While many researchers reported that kinship carers were older, had
completed less education, were more likely to be single and had lower levels of income and health than non-kinship carers (e.g. Berrick, 2001; Kelley et al. 2001) other research suggested similarities between kinship and non-kinship carers in all aspects including financial resources, age and support needs (McLean and Thomas, 1996; Woodworth, 1996; Dubowitz et al 1993). The lack of clarity in these findings, combined with the lack of information on kinship carers in New South Wales, emphasised the need for obtaining detailed information about current kinship carers in this state.

<table>
<thead>
<tr>
<th>Research Question</th>
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<tbody>
<tr>
<td>Who are kinship carers? What are their attitudes to the task of caring for their relatives? What do they consider their needs if any for support and/or supervision? In what ways do they differ from foster carers?</td>
</tr>
</tbody>
</table>

Fig 3: Research Q. 2, *Kinship Care in NSW: Finding a way forward*  
(Mason, Watson, Gibbons, 2005)

**The design of the project in the context of its time span**

During the period spanned by the project there have been developments in the area of kinship care practice and policy, and associated theorising, which have impacted on the way we conducted our project within the given constraints of our funded application.

Our project was designed with three separate elements to respond to the two questions. It was initially planned for the elements to proceed sequentially, but ultimately the research processes occurred more simultaneously, than sequentially. These elements of the design included an analysis of relevant literature, the conduct of focus groups, and a survey of kinship and foster carers. The first element, an analysis of literature, was designed to focus on values assumptions and theories about support and supervision. While in the initial proposal to the Australian Research Council, we noted the lack of research on Kinship care and in particular the lack of such research in Australia, the situation changed greatly within the five years spanned by our project. In this time span there has been an exponential increase in research in the area within Australia, as well as internationally.

The second element to the research – the conduct of focus groups – was to include formal kinship carers, foster carers and informal kinship carers. It was intended that the focus groups would provide in-depth information on the carers; their experiences of, and views about, support and supervision; and the ways in which these two concepts are related. Early in the research process the need to tailor our study according to our resource constraints, and the fact that there was already significant existing literature on foster carers experiences and views (e.g. Barber and Delfabro 2003, Sinclair 2005), resulted in a decision to only recruit kinship carers to focus groups. The initial recruiting strategy to recruit focus group participants through member agencies of ACWA proved unsuccessful – agencies being unable to link us with kinship carers, either due to an insufficient base of such carers or commitments and constraints within agencies. In this early stage the doctoral student held one focus group consisting of members of a grandparent group accessed through the NSW Council on the Aging (COTA). The data from this group was used to inform the initial development of the survey as well as the general findings.
During later stages of the research, ease of recruiting kinship carers for focus groups changed dramatically, given impetus by the funding of community based kinship carer support groups and project co-ordinators through which we were able to recruit enthusiastic participants. During the recruitment process a number of groups heard about our research and directly requested participation in it. Again, resource constraints meant we had to limit our project to the earliest of these requests.

The third element of the research, a survey of foster carers and kinship carers was drafted by the doctoral student and then submitted to DoCS and carer groups for input, following which the draft was revised and modified by the researcher and input sought from kinship care project co-ordinators and carer groups. The implementation of the survey was facilitated by DoCS through the selection of a random sample from their database and through the distribution of the survey to potential respondents with a return envelope addressed to the research team at the University of Western Sydney. From that point on, only members of the UWS research team handled survey returns.

The need for a new approach

Exploration of the relationship between Kinship Care and Child Welfare

At the time we commenced this research project we were following a trend in child welfare literature and research that has compared kinship care with foster care (e.g. Dubowitz, 1994; Sykes et al. 2002; Grogan-Kaylor, 2002). This comparison has been based on the way in which kinship care has increasingly been used as an alternative to foster care within the out-of-home care context (Mason et al, 2002). This use of kinship care as an out-of-home care solution for children has resulted in kinship care being considered as a form of child welfare.

Kinship care, if defined as care by relatives or others with whom there is a close relationship, does not self-evidently become part of the child welfare system. Kinship care can and does exist as a fact of life outside the child welfare system, unless and until it is formalised by those with official responsibilities for child welfare. In this way it is very different from foster care, with which it tends to be compared.

It is not surprising that, as a consequence of kinship care policy being considered as a form of out-of-home care, kinship care policy and practice has been influenced by the values and assumptions associated with foster care, which, paradoxically, have included historical assumptions around kinship care as a ‘lesser’ (less professional) form of care. In this process, it often appears to be forgotten that care by kin, as in extended family, in contrast to care within the isolated nuclear family, has been and continues to be the experience of many children in our own and in other societies.

We had recognised in framing the project that we would need to examine assumptions, values and theories around issues of support and supervision of kinship carers. We started the project with an analysis by the post-graduate student, Leonie Gibbons (Gibbons, 2007 notes) in which she challenged the question frequently asked in the literature (and in the early days of
our project) of where kinship care fitted into the child welfare system. She commented that
this was a question constantly asked but never satisfactorily answered. Gibbons put forward
the proposition that we might just be ‘asking the wrong question’. She recognised that kinship
care can be in place as a part of a mix of caring arrangements before, during and after
involvement of the child welfare system, and sometimes exists entirely outside of the welfare
system. This prompted her to propose an entirely differently focussed question: ‘Where does
child welfare fit into the kinship care?’

The following diagram shows that, while foster care is contained within the child welfare
policy area, kinship care interacts not only with child welfare, but also with other policy
areas, such as aging, carers and caring policy. It shows that unlike foster care, kinship care
overlaps with but is not contained by the child welfare system.

As a research team we began to ask the question ‘does conceptualising Kinship care as
child welfare lead us to misunderstand kinship care and ways of researching it?’ We
recognised that it was important not to incorporate this misunderstanding into our survey,
originally designed to compare kinship and foster carers but to move away from past
ambiguities towards greater clarity and precision. In this vein O’Brien (2000) stated the
importance of moving beyond ‘superimposing the traditional foster-care system on relative
care’ and ‘using the energy released’ in this process to bring about ‘the attitudinal and
practice changes’ required ‘to work in a practice of partnership, creativity, openness and
respect’ appropriate to kinship care (p.210-211).

**Background to conceptualisation of Kinship Care and Foster Care**

As part of the process of moving to the clarity required, we sought to understand the
relationship between kinship care (as a policy area) and foster care by, firstly, looking at the
historical conceptualisation of both and, secondly, by looking at the issue of support and
supervision of kinship care and the relevance of discussions occurring during the latter time
period of our project around grandparent care as social care. Much of the contemporary
concern about kinship care as a form of care for children who cannot live with their nuclear
families, appears to be associated with the extent to which Western cultures have
marginalised non-nuclear family forms of care, whether these forms of care within the family are defined as either ‘extended family care’ (Geen, 2003) or ‘grandparent care’ (Cass, 2007).

**Historical factors influencing conceptualization of Kinship Care**

According to Hegar et al, as reported in Geen (2003), ‘(t)he phrase Kinship Care’ was derived from the work of Stack (1974), who described the significance of extended kinship networks in the African-American community. The oral traditions and spiritual teachings of most North American tribes had implied or stated that kin had responsibilities in terms of the care of children of relatives. Similarly, in Australian Aboriginal communities, there has been a strong tradition of extended families looking after children when relative parents have been unable to do so (Bridge, 2001).

It may be that the marginalisation of non-nuclear forms of family care in Western societies is the reason why kinship care (as care by relatives or others with whom there is a close relationship), when formalised for purposes of the provision of support to carers, has been incorporated into the child welfare system. Kinship care can and does exist outside the child welfare system until it is formalised by those with official responsibilities for child welfare. In this way kinship care is very different from foster care, which in contemporary western society typically only exists when established by child welfare systems. In the study (Mason et al, 2002) which preceded the study being reported on here, it was found that the key reason for the introduction of kinship care as a favoured child welfare policy option was that children and carers (and also workers), valued this form of care because it was care of children by those with whom they are familiar. Here it was typically contrasted with foster care, typified by being cared for by strangers, and therefore ‘strangeness’. As one child put it, in kinship care ‘(t)he child is still in the family, their family, it’s not moved to a stranger ... the child knows the person that they’re going to’ (p31).

Applying an historical lens informs understanding on the roles that values and assumptions have played in shaping the way current issues about the relationship between kinship care and child welfare are framed. A focus on kinship care in official Australian policy was the result of attempts by policymakers to address the concerns expressed by Aboriginal communities about the way Aboriginal children had historically been inappropriately placed with (non-Aboriginal) ‘strangers’, i.e. foster carers. The policy response to this was the codification of the Aboriginal Placement Principle in child protection legislation. The accusation by Aboriginal peoples, that placement of their children in stranger care amounted to the ‘stealing’ of their children, is not an accusation limited to indigenous populations. While the cultural impact and collective trauma suffered by indigenous populations through removal into stranger families is incomparable in scale to that of other children in Australia, the deliberate advancement of ‘care by strangers’ as policy has been part of the historical legacy of child welfare, as promoted by leaders of the modern foster care movement in the USA in the mid-nineteenth century (e.g. Brace, 1880). This policy was promoted as a method of saving children of the immigrant poor from the ‘evil influence’ of their ‘unsuitable’ parents. To many poor parents of the time, the ‘child savers’ were viewed as ‘child-stealers’, (Mandell, 2006). The aim of ‘placing’ children out in stranger families was to promote the ‘Americanisation’ and associated values of children of immigrant families, in a similar way to the way assimilation policy promoted child removal from Aboriginal communities to white families. In both instances the aim was about reinforcing the nuclear family and the concept of the ‘good’ mother (Mason, 1993).
Issues of supervision in foster care and Kinship Care

Increasingly in the twentieth century, child welfare policy emphasised that it was important to develop ‘a science of foster-family care and to professionalize practice’, recruitment and assessment practices, in order to match children ‘rescued’ from their own homes and placed with suitable ‘substitute’ families (Kadushin, 1980, p319).

The theme of professionalization of foster care is one that is currently reiterated in child welfare policy. For example, the British Association for Adoption and Fostering (BAAF) refers to the importance of the development of professional foster care schemes, while also recognising the dilemmas posed by this approach as foster caring is also about emotional connections. Supervision of foster carers is typically discussed as part of professional care, and understood to be about practitioners ensuring ‘that the foster carer is aware of, understands, accepts and operates by the standards, policies, procedures and guidance’ of specific child welfare department foster care schemes, such as that operated by the UK Luton Borough Council.

It is in this context, but also in the tradition of policy dating back to English Poor Law times that discussion of supervision of kinship carers is linked in the literature with considerations of support for kinship care. Hornby et al (1996), in their study of kinship care, defined supervision as ‘oversight and monitoring’ of both child and caregiver to ensure the child’s safety’ (p. 410), and referred to an inappropriate confounding needs for financial support with state supervision.

The identification of grandparents as kinship carers provides a link with social care policy

Questions about the appropriateness of confounding support and supervision, in the case of extended family members caring for their relative children, are highlighted by the fact that such care is typically based on concepts of ‘obligation’ (e.g. Mason et al 2002), rather than any concept of professional provision of care. The linkage of support and supervision becomes even more questionable when those doing the care are identified as ‘grandparents’. An elision in the literature between kinship care and grandparent care is understandable given that a large proportion of what is termed kinship care is in fact care by grandparents (Cass, 2007, cites AIHW 2006). In 2004 Australian Bureau of Statistics figures indicated that there were 22,500 grandparent families in Australia with children aged up to 17 years and these represent 1 per cent of families (ABS, 2004).

When the term grandparent carer is used, rather than kinship carer, it tends to move policy issues out of the child welfare arena and into the social care arena. Cass (2007) shows how the application of a ‘social care’ framework to grandparent care enables an exploration of ‘the socio-economic, demographic, familial and public policy settings’ in which grandparent care, as an instance of care-giving/receiving, is located. A social care framework fits well with the policy situation which Gibbons et al identified early in this project for kinship care, whereby kincareers are in actual fact being serviced not just by child welfare policies but by aged care policies and other caring policies, as depicted in the following diagram.
Kinship Care and the voices of children

Importantly in terms of future policy directions, the involvement of grandparent kinship carers (in Australia) with forums within the policy arenas of aging and caring, seems to have contributed to the formation of policies making provision for financial support to carers. The provision of such supports places carers in ‘the general relationships of care’, which can be contrasted with what Cass refers to as, ‘a child welfare and child protection focus in which grandparent care fits into the formal kinship care policies and practices of state welfare authorities’ (p249).

Applying a social care framework has relevance for this study, in that such a framework highlights that we are talking about relationships, that there is an ‘other’ who receives care. In kinship care, the ‘other’ is the child or children who are receiving care from their relatives and others close to them. Increasingly in the literature there are examples of adults (such as those with disabilities) receiving care who emphasise that their voices are the important ones to be heard. In the case of children, as the ‘other’ being cared for, it is easy for their voices to be drowned out by the many adult groups with an interest in children’s welfare. Yet, the rights of children to contribute to decision making about their own lives has been recognised in both Australian and International legislation and there is an increasing recognition in the literature of the need to be inclusive of children’s voices in research which affects them. There is currently only a limited amount of research on children’s perspectives of kinship care. That of Messing (2006) is particularly important because it focuses specifically on hearing the voices of children in kinship care, while the research of Aldgate and McIntosh (2006) was inclusive of children’s views, along with those of other stakeholders. In this project we did not include children either as respondents...
to the survey or as participants in focus groups or interviews. In deciding not to include them, we drew on previous experience (Mason et al 2002) where difficulties had been encountered accessing children as participants. We concluded that it would be more appropriate, as a stage beyond this research, to design a study specifically around children in kinship care that included them as research participants. However, we were alert to the fact that in the current project we needed to include in our analytic lens, an awareness of children as active participants in kinship care situations.

**Kinship Care and Aboriginal voices**

Early in the setting of parameters for our research, we had discussions with DoCS and the Aboriginal Child, Family & Community Care State Secretariat (ABSEC) about the most appropriate way in which to be inclusive of Aboriginal voices in our research of foster and kinship carers. At that time, we were advised that ABSEC was conducting its own funded research with Aboriginal kinship carers on the topic of kinship care. In discussion, we agreed that, rather than attempting a specific focus on Aboriginal issues in our research (and respecting ABSEC’s expertise), we would incorporate the findings from the ABSEC research rather than undertaking our own. ABSEC later identified issues in their own research that required clarification and review and the fact that their research findings were not made public at that time prevented inclusion of ABSEC findings in our report. We now understand that the ABSEC report, which has subsequently been reviewed, will be published in December 2009.

**Methodology**

The analysis of values and assumptions influencing conceptualisations of and debates around kinship care in New South Wales, was an important part of our research journey contributing to the design and re-design of aspects of our project and to the analysis of the several different kinds of data produced. This analysis in conjunction with some of the more recent reports on research in the area e.g. Aldgate and McIntosh (2006) and Northern Territory Government (2003), has informed the recommendations in the final sections of our Report, generally in the area of kinship care and, specifically, around support and supervision.

**Qualitative, quantitative, narrative**

We have approached this research, methodologically, from three different angles gathering our primary data using qualitative, quantitative and narrative methods. In this mix, the intersecting analytical techniques and interpretive tools are storytelling and inductive narrative analysis (Denzin and Lincoln, 2003) informed by the notion of the theorists fiction put forward by Dennett (1991, p.82-83). Analysis of the qualitative data informed the quantitative analysis and assisted in developing the ‘right questions’ for statistical review, and vice versa. The narratives create the intersection between the other methodologies allowing the researcher to examine (and interpret) the key features of these diverse materials as a more informed reader. We not only have access to details about the circumstances of carers in diverse caring roles, we have access to information that provides a context for that data and its analysis.
Theoretical orientation: responding to a diversity of needs

Qualitative researchers, as D’Cruz points out, are faced with ‘a proliferation of methodologies and methods that often clash’ with mainstream research conventions (D’Cruz, in Byrne-Armstrong, Higgs, Horsfall, 2001). Mixing quantitative and qualitative methods in sociological research, as we have done here, can sometimes prove problematic (Olsen, 2004), unless other tools can be added to the mix to assist in the cross examination of data, the mediation of analytical processes, differing language styles, and the checking of results. We have chosen to combine narrative inquiry (Clandinin & Connelly, 1999; Richardson, 1997; Lockridge, 1988; Ellis and Bockner, 1996) with other qualitative and quantitative methods in a practical way (see ‘Summary of Open Questions’, Appendix 2), as a mediating tool adding value to the analytical processes and potential for validation (see Appendix 1, ‘Statistical Analysis’), and finally as a theoretical tool, in order to check and recheck the ethical choices we make about how we portray respondents, how we set up the ways in which stories are elicited and gathered, and in delineating how we interpret them, (Charmaz, in Denzin and Lincoln, 2003).

Summary of Quantitative material

Quantitative data was gathered through the primary source of the survey and statistical comparisons made with statistical analysis from secondary sources. Thirty-seven of the survey questions were closed questions designed to create a comprehensive demographic profile of the sample group.

Statistical Analyses

The data we gathered through our survey was in the form of quantitative and qualitative data from foster carers and formal kinship carers (allowing of some comparisons); and qualitative data from group discussions of informal kinship carers (allowing of some comparisons with and extensions of both the qualitative and the quantitative data from the survey).

Quantitative analysis of numerical and categorical data from the survey was undertaken using SPSS. Profiles of formal kinship carers and foster carers in NSW were produced using appropriate descriptive statistics. Comparisons between the two groups of carers were made. (See comprehensive Statistical Analysis and Tables in Appendix 1).

Summary of Qualitative material

Qualitative data was gathered in a number of ways; through eliciting responses to twenty-nine open questions and requests for additional information attached to closed questions included in the survey covering carers’ attitudes, thoughts, feelings and experiences about support, supervision, training, health, financial stability, social interaction and wellbeing; by providing the opportunity for survey respondents to write accounts of their own life experiences as carers (of any length they chose) at the end of the survey form (including additional pages should they wish). Four focus group discussions were held on three sites, the first group held early on in the project to inform the development of the questionnaire. These focus group sessions included sometimes lengthy ‘storytelling sessions’ in which carers described their lives, experiences and views in some detail and depth. The first
session was recorded on tape, subsequent sessions were recorded directly onto computer audio file for later analysis.

**Our Use of Narrative**

Kincarers tell stories all the time, they tell them with passion and they tell them with conviction. The reason, they commonly say, is to flesh things out, to help people understand them and to make their experiences accessible to others — friends and colleagues, the general public, health and legal professionals, politicians and bureaucrats. Carers felt strongly that their stories needed to be told in order to break down the barriers of stigma, remedy what they saw as invalid preconceptions commonly held about them, and correct misunderstandings they felt the general population had about the kincaring role. They wanted to ‘tell it as it is’ and believed that in so doing change would result.

Researchers and theorists tell stories all the time too, to add weight to argument, to tease out complexities, to illustrate a point, and to provide colour. Neuroscientist, Antonio Damasio, explains that narrative has a deeper purpose than simply to illustrate or entertain — to do with the translation of emotion into consciousness and the ‘feeling’ and ‘relational’ state (Damasio, 2000, p.196). Damasio describes extended consciousness, the very core of human relationality and communication, as hinging on the ability to create an autobiographical record in which one's sense of Self, the ‘core you’ is ‘connected to the lived past and the anticipated future’ (Damasio, 2000, Yardley, 2008) and therefore in relational terms to the lived past and anticipated future of others.

For the Kincarer and the researcher the experience of creating an auto/biographical narrative is quite similar to creating a fictional narrative. A story is constructed with a beginning, a middle, and an end dependent on one consistent point of view – that of the storyteller - a very different intention from reportage, collecting data, or recording ‘facts’. For the story to be created the ‘investigation’ of the ‘subject’ must have already occurred — careful observation, reflection on and analysis of the life lived through the medium of the creative self. The intention of story making is to filter detail, to delve into the artifacts of memory, to reconstruct and give shape to events and to create meaning in some depth; meaning that can then be shared with others. The details of the stories recounted through the process of this research were deeply felt and true to individual memory, the kincarer turning him or herself into a ‘character’ in their own story with a set of narrative objectives within the constraints of the unfolding plot – this is what happened, how it happened and why, this is how it felt for me. In the telling and retelling of personal stories, narratives and meanings intersect and overlap. In each new telling, meaning is shared and created anew (Yardley, 2008). It would be seriously neglectful of us, as researchers, not to tap into the wellspring of information and experience held within the stories given to us, particularly when they have been presented to us as carrying such a high value for the participants.

Arthur Frank (1997) describes this process of sharing through narrative as ‘thinking with stories’, a process of great interest to him because of its capacity to alleviate suffering and promote healing. Frank sees the construction of narrative in this context as abounding with moral choices and pointing towards a social ethic grounded in genuinely empathetic understanding of the lived experience of the ‘other’. Carers often reflect on their desire for their circumstances to be, generally, better understood. The three basic narratives structures Frank puts forward — restitution, chaos, and quest are commonly present in carers’ storytelling. Restitution narratives, that anticipate and give prominence to external
interventions (e.g. the police, DoCS, NGOs, family and friends) and that provide answers and resources; chaos narratives, in which the distress caused by seemingly insurmountable challenges, seem to remain in a never-ending loop, without respite or redeeming insights that could alleviate suffering; quest narratives abound, that describe overcoming difficulties despite insurmountable obstacles and a dearth of restorative intervention, where the carer has found insights and solutions that transform experience, allowing the carer to either move on or to at least remain ‘intact’. Lucaites and Condit focus on the form and function of narrative, exploring its role in the formation of social consciousness (1985), an objective dear to the hearts of carers.

The narrative ethic that is developed between the researcher and the research participant in this study is influenced by the intentions we both have towards our audience and towards those whose lives are entangled in the story. The narrative ethic constrains what may be spoken and what one may, or may not write. It is the means by which the boundaries of the story are determined – where the line is drawn between what will be revealed and what will be held back. The young constable (in The first three days) would have a very different story to tell about her experiences than Michael does, or the researchers after the fact, one that remains ‘true’ to her intended audience – her family, her colleagues, her commanding officer.

**Narrative in the research context**

Without narrative, opportunities become more limited for placing what we know from experience on a broader canvas. Josselson, Leiblich and McAdams counsel the ‘narrative’ researcher to do whatever is necessary ‘to capture the lived experience of people in terms of their own meaning-making,’ (Josselson, Lieblich, & McAdams, 2003, p.260, Yardley, 2008.) We have encouraged storytelling in this research (as our participants have encouraged us) and we have used it to assist us to add depth to our analysis across all the data.

Through the shaping of stories we have imposed a framework on our shared experience as researchers, research participants and readers. The stories have similarities – they are all about the experience of being or becoming ‘carers’, but each takes the reader on a different journey towards quite specific understandings. In this research process we have acknowledged the place narrative occupies in the specific domain of social science research, how ideas of ‘truth’ and ‘true stories’ contribute to the structure of text and to the authenticity of the stories we tell as researchers about ourselves, and our collaborative partners in the pursuit of knowledge.

Monk, Winslade, Crocket et al (1997) describe narrative as the ‘archeology of hope’ in the context of narrative as therapy - a tool of family therapy that has gained strength over the past decade in Australia and New Zealand, particularly in cross-cultural therapeutic environments. While there was no intention in this research project of using story making as a therapeutic tool – narrative therapy nevertheless recognizes story making as concerning language and power – the positioning and shaping of ourselves in relation to others - both researcher and participant expected the shaping and sharing of story to be purposeful, to provide clear understandings and practical and authentic outcomes.
Research Design

Our study includes data gathered from 165 primary carers (kinship and foster) and their families who are caring for over 350 children.

The Survey

Our sample population of 800 kin and foster carers, to whom the survey was distributed, was derived by proportional sampling across seven regions so that approximately equivalent proportions of each region contributed to the sample dependent on the number of carers in that region.

Targeted carer population sample 800
Survey response rate 19.5%
Respondents = 2% of the 7,774 formal Kinship Carers and Foster Carers in NSW

The extract was as of the 27th March 2007. The total number of 'Foster and Relative carers' at that time was 11,665. Of these 90% (10,490) were DoCS carers and 10% (1,175) were other carers (NGO carers). The sample was drawn from the DoCS carers. However, there are more carers on the books than are caring for children at any given time and the 26% of DoCS carers who did not currently have children in their care were excluded (based on payments in the past 12 month period). It is from this remainder (n=7774) who were DoCS carers (foster and kin) and receiving a payment, that the proportional sample was drawn stratified across the seven community service regions; Hunter and Central Coast; Metro Central; Northern; Western; Southern; Metro South West; Metro West.

The targeted sample was 10% of the available foster or relative carers who currently had a child in their care stratified by region. We received survey returns from 154 carers, 134 of which had been completed and contained usable data. Kinship carers returned 82 surveys and Foster Carers returned 50 surveys. Information on 255 adults and 295 children, living in the households surveyed, was provided. A small number were both foster and kinship carers. The majority of survey respondents contributed both quantitative data (in closed multiple choice questions) and qualitative data (in answers to open questions). Approximately 50% provided fairly detailed personal stories in the space provided at the end of the questionnaire. Kinship carers’ stories were inclined to be longer and to contain more detail than foster carers stories, although a few foster carers made use of the opportunity to share their experiences at length. These stories and comments have been included in abbreviated form throughout this report where they provide further insights and contribute to the discussion. The qualitative data from these open questions and stories is summarised in Appendix 2.

The survey was a self-completion questionnaire, which was felt to be the most appropriate method for collecting data from a large number of geographically dispersed kinship and foster carers across NSW. The questionnaire was designed to enable comparisons to be made between formal kinship carers and foster carers on a number of factors relating to the caring role. Informal carers were not included in the sample, as they were not part of the NSW Department of Community Services (DoCS) database of clients and informal carers became the targeted group for our focus groups. DoCS research staff drew a probability sample of formal kinship carers and foster carers from the DoCS client database, which was stratified by region to ensure representation from a number of urban, regional and rural areas in NSW.
It was not possible to distinguish formal kinship carers from foster carers on the DoCS database, consequently a single questionnaire was developed with some common sections and some colour-coded sections specific to kinship care and foster care.

Survey packages containing the questionnaire and a reply paid envelope were provided to DoCS, whose staff addressed and sent out to the sample group selected. Participants’ anonymity was maintained through this process, as the researchers had no knowledge of the names or addresses of participants. Participants who chose to complete the survey sent the questionnaire back to the researchers at UWS, using the reply paid envelope, and DoCS staff had no knowledge of who completed questionnaires. 154 questionnaires were returned with 132 of these containing usable data, enabling results from the survey to be generalised to the population of formal kinship carers and foster carers and estimates made of numbers of kinship carers on a range of variables.

The questionnaire covered demographic and background information on the carer; how the carer came to take on this caring role; details of the current caring situation; experiences of, and thoughts on, support and supervision and whether these two concepts are, or should be, linked. The questionnaire contained both closed and open questions with sufficient space for the participants to include as much detail as they would like about their experiences and issues. Participants were encouraged to write their story in the final section of the questionnaire using additional pages if they wished. It was recognized that a ‘story’ could take many forms, from a few paragraphs describing a single event, to a ‘life story’ of heroic proportions that might read like an epic novel.

The Focus Groups

Three focus groups (in addition to the early focus group which informed the survey) were conducted in two regional areas with a total of 31 participants across the three groups caring for approximately 70 children. The majority of these carers were grandparents, with a small number of aunts and uncles included. A series of printed questions were put to each focus group at the beginning of each of the sessions. The questions were not addressed sequentially but were referred to and used as a discursive tool when issues arose as the sessions progressed. The focus group facilitator responded to each group individually and the group determined the focus and flow of each session. Participants in all three groups were keen to introduce themselves, discuss pressing issues of the moment, share their personal stories and provide examples of common experiences. In each session there was a sense of camaraderie and participants were protective of each other’s emotional comfort and personal space. While these sessions became quite emotionally intense at times, they were also noisy, full of good humour and at times hilarious. A few participants became agitated as they described difficult circumstances and ongoing problems, but space was made for these feelings to comfortably subside.

Kinship care support group coordinators were present for the duration of one session, for part of the second and the researcher was with carers by herself for the third. The same researcher acted as facilitator for all three sessions. The presence of the coordinators allowed the researcher to establish a rapport and trust with the group more quickly, and provided additional support for carers during the more stressful discussions. A minor downside was the very occasional leading and prompting of discussion into areas of more general concern – not specific to the participants individual experience - but these diversions were for the most part not significant intrusions.
**Narrative Two**

**Lost in Queensland**

There was rustle of papers and a pause before the voice on the other end of the line continued, “Of course, the best thing for the child would be if you could relocate.”

So far, all that Carmel knew was that her granddaughter was in temporary care having been removed from her parents. “Relocate?” Carmel repeated, unsure what this woman was asking her to do, “You mean relocate her to Sydney?” No it appeared she didn’t mean that. “Then where. Relocate where?”

“Well, to Townsville,” came the reply, as though this was stating the blindingly obvious.

“You mean me?” Carmel sensed rather than heard the woman’s confirmation, “But I live in Sydney,” Carmel responded, “This is my home. Has been all my life. I have no means and no desire to relocate to Townsville.”

“OK. Yes, I see that, but perhaps it’s at least worth a discussion. Don’t you think? It would be of benefit to the child if you could come up at any rate - to help sort something out. Have someone the child knows speaking on her behalf. We would pay your airfare!” She said this brightly as though she was offering a holiday in Bali.

“Her name is Angelique – the child. She is called Angelique.”

“Yes of course - I am aware of that. Her welfare is my primary concern.”

“I haven’t been sitting on my hands down here. I would like to make that quite clear. I’ve talked to DoCS many times about this - there was a temporary custody order. But that all went out the window when my daughter and son-in-law took Angelique up to Queensland. Three years have past since then – we’ve lost three precious years that she could have been protected. The Department said nothing could be done once they crossed the state border, that NSW orders mean nothing in Queensland. Doesn’t it follow then that Queensland orders mean nothing here? That little girl has been abused for years – and I mean abused in the fullest sense of the word. What has suddenly changed that is going to give me any right to have a say in this now?”

“Well, I suppose because we are involved now, and we’d like you to come up.” Simple. Carmel had experienced this kind of simple – it had a way of biting back.

“If I come up, can I bring her back home?” Silence on the other end of the line, “Can I bring her back home?” Carmel asked again, enunciating each word and putting particular emphasis on the last two words.
The silence continued while the woman searched once more for an appropriate response, “Ah! Hm. Well! What say ... what say we just get you up here and we’ll talk about it.” Sooth. Placate. Conciliate.

It was obvious to Carmel that the conversation wasn’t heading anywhere, anytime soon that would benefit Angelique. There was nothing for it but to go – just drop everything and go.

Townsville was much as Carmel had imagined, hot, tropical, unfamiliar and not Sydney. Right now she didn’t want unfamiliar, she didn’t want hot. She wanted the known, the secure, the predictable and the temperate. She had sat in this waiting room for an hour and a half and now the young woman at the desk in front of her was apologising. She didn’t want apologies either. This was a women’s legal service, she was a woman and she wanted legal advice. “I’m sorry,” Carmel heard the woman say, “I really am sorry. I do understand your predicament, and I would like to send you through to see someone right now. You would certainly be entitled to advice if your daughter hadn’t used our service already. It becomes a conflict of interest you see. We can’t advise individuals on opposing sides. It’s for your own protection.”

“For my own protection,” Carmel thought. “Okay, no legal aid, no women’s legal service, no money for a solicitor.” She stepped back out into the midday humidity and looked about her in dismay. She had drawn a blank, money was running out, the hotel she was staying at, modest though it was, exceeded her budget but she needed to be central because she had no transport and everything she needed to attend to was in town.

Impasse.

“Great stuff. Really good idea,” she thought as the tears began to stream down her face, “Here I am, standing on a street corner in a strange town, melting, and bawling my eyes out - because I really need help and I haven’t got a clue where to get it. Angelique would be proud of me.”

In mid-sob, Carmel started to laugh at the irony of it all. “Brilliant. Just bloody brilliant.” Carmel shrugged helplessly as a woman turned to stare back at her as she passed, “Fabulous. Now they just think I’m a complete whacko.”
Section Two

The Kincare Experience
The Kincarer Demographic Profile

Gender, age, education, income, housing, home ownership

The analysis of the characteristics of our kinship/foster carer population sample indicated that kinship carers were predominantly female (see Table 1.), older than the participating foster carers, more likely to have lower incomes and to be in public rental accommodation and less likely than foster carers to be employed, or to have a university qualification. In broad terms these research results are similar to those that have been reported in a recent UK study (Farmer and Moyers, 2008) and to those reported in many US studies which have found that kinship carers are older, have completed less education, are more likely to be single and have lower levels of income and health than non-kinship carers (Berrick, 2001; Kelley et al. 2001; Chipman, Wells and Johnson, 2002; Schwarz, 2002). The findings contrast with other US studies which have suggested similarities between kinship and non-kinship carers in all aspects including financial resources, age and support needs (McLean and Thomas, 1996; Woodworth, 1996; Dubowitz et al 1993).

Data on the number of ‘single parent’ kincarers was sought, but there was insufficient clarity in the data obtained to draw conclusions. Many respondents chose not to disclose their relationship to other adult members of the household or include information as to whether these adults were involved in the care of children. Some respondents included their own adult children in these sections of the questionnaire.

Table 1: Gender distribution among the sole carers (Luscombe, 2009)

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>45</td>
<td>26</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6.7 (3)</td>
<td>3.8 (1)</td>
<td>15.4 (2)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Female</td>
<td>93.3 (42)</td>
<td>96.2 (25)</td>
<td>84.6 (11)</td>
<td>100.0 (6)</td>
</tr>
</tbody>
</table>

The following table shows the level of education reached by formal kinship and foster carers. Only 5.6% of primary kinship carers had a university qualification compared with 35.3% of the foster carers. If we consider all post secondary qualifications, then the difference remains marked – 16.9% of kinship carers compared with 58.8% of foster carers. Furthermore, if we consider those who have not advanced beyond Year 9, the differences are even more marked – 42.3% of kinship carers compared with 7.8% of foster carers.
Table 2: Highest level of education achieved by the survey respondent (Luscombe, 2009)

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>132</td>
<td>71</td>
<td>51</td>
<td>10</td>
</tr>
<tr>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td></td>
</tr>
<tr>
<td>Year 8 or below</td>
<td>15.2</td>
<td>16.9</td>
<td>3.9</td>
<td>60.0</td>
</tr>
<tr>
<td></td>
<td>(20)</td>
<td>(12)</td>
<td>(2)</td>
<td>(6)</td>
</tr>
<tr>
<td>Year 9</td>
<td>15.2</td>
<td>25.4</td>
<td>3.9</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>(20)</td>
<td>(18)</td>
<td>(2)</td>
<td>(0)</td>
</tr>
<tr>
<td>Year 10</td>
<td>28.0</td>
<td>31.0</td>
<td>27.5</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>(37)</td>
<td>(22)</td>
<td>(14)</td>
<td>(1)</td>
</tr>
<tr>
<td>Year 11</td>
<td>4.5</td>
<td>5.6</td>
<td>3.9</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>(6)</td>
<td>(4)</td>
<td>(2)</td>
<td>(0)</td>
</tr>
<tr>
<td>Year 12</td>
<td>2.3</td>
<td>2.8</td>
<td>2.0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>(3)</td>
<td>(2)</td>
<td>(1)</td>
<td>(0)</td>
</tr>
<tr>
<td>TAFE qualification</td>
<td>16.7</td>
<td>11.3</td>
<td>23.5</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>(22)</td>
<td>(8)</td>
<td>(12)</td>
<td>(2)</td>
</tr>
<tr>
<td>University qualification</td>
<td>17.4</td>
<td>5.6</td>
<td>35.3</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>(23)</td>
<td>(4)</td>
<td>(18)</td>
<td>(1)</td>
</tr>
<tr>
<td>Other</td>
<td>0.8</td>
<td>1.4</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>(1)</td>
<td>(1)</td>
<td>(0)</td>
<td>(0)</td>
</tr>
</tbody>
</table>

Home ownership trends (Table 3.), reveal that our sample population differed from other studies with regard to home ownership. Almost 40% of our kinship care survey respondents owned their own homes (as compared to approx. 20% of responding foster carers who were more likely to be paying off a mortgage or living in private rental accommodation). The incomes of the kinship carers (Table 4.) were, on average, substantially lower and those who were in rental accommodation were more likely than foster carers to be in public housing.
### Table 3: Home ownership, type of dwelling and bedroom number by group (Luscombe, 2009)

<table>
<thead>
<tr>
<th></th>
<th>Total % (n)</th>
<th>Kin % (n)</th>
<th>Foster % (n)</th>
<th>Both % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home ownership, N</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own the property</td>
<td>30.8 (40)</td>
<td>38.9 (28)</td>
<td>22.4 (11)</td>
<td>11.1 (1)</td>
</tr>
<tr>
<td>Mortgage</td>
<td>34.6 (45)</td>
<td>19.4 (14)</td>
<td>53.1 (26)</td>
<td>55.6 (5)</td>
</tr>
<tr>
<td>Public rental</td>
<td>19.2 (25)</td>
<td>27.8 (20)</td>
<td>10.2 (5)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Private rental</td>
<td>15.4 (20)</td>
<td>13.9 (10)</td>
<td>14.3 (7)</td>
<td>33.3 (3)</td>
</tr>
<tr>
<td><strong>Dwelling type, N</strong></td>
<td>131</td>
<td>70</td>
<td>51</td>
<td>10</td>
</tr>
<tr>
<td>free standing house</td>
<td>90.8 (119)</td>
<td>87.1 (61)</td>
<td>96.1 (49)</td>
<td>90.0 (9)</td>
</tr>
<tr>
<td>terraced house</td>
<td>1.5 (2)</td>
<td>0.0 (0)</td>
<td>3.9 (2)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>town house</td>
<td>3.1 (4)</td>
<td>5.7 (4)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>flat/unit</td>
<td>3.8 (5)</td>
<td>5.7 (4)</td>
<td>0.0 (0)</td>
<td>10.0 (1)</td>
</tr>
<tr>
<td>other</td>
<td>0.8 (1)</td>
<td>1.4 (1)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td><strong>Bedroom number, N</strong></td>
<td>129</td>
<td>69</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>mean (SD)</td>
<td>3.61 (0.96)</td>
<td>3.39 (0.93)</td>
<td>3.98 (0.92)</td>
<td>3.30 (0.95)</td>
</tr>
</tbody>
</table>

### Table 4: Average gross household weekly income (Luscombe, 2009)

<table>
<thead>
<tr>
<th></th>
<th>Total % (n)</th>
<th>Kin % (n)</th>
<th>Foster % (n)</th>
<th>Both % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>None</strong></td>
<td>6.1 (7)</td>
<td>8.8 (5)</td>
<td>2.0 (1)</td>
<td>12.5 (1)</td>
</tr>
<tr>
<td>$80 to &lt; $500</td>
<td>28.9 (33)</td>
<td>35.1 (20)</td>
<td>18.4 (9)</td>
<td>50.0 (4)</td>
</tr>
<tr>
<td>$500 to &lt; $1,000</td>
<td>32.5 (37)</td>
<td>38.6 (22)</td>
<td>26.5 (13)</td>
<td>25.0 (2)</td>
</tr>
<tr>
<td>$1,000 or more</td>
<td>32.5 (37)</td>
<td>17.5 (10)</td>
<td>53.1 (26)</td>
<td>12.5 (1)</td>
</tr>
</tbody>
</table>
Comparative Quantitative Analysis: Foster Carers and Formal Kinship Carers

Foster Carers

The foster carers tended to be couple carers living in a household with two or more adults. If the carer was a sole carer she was likely to be female. The majority of the relationships with the additional adults were with husband or children. If the adult was Aboriginal or Torres Strait Islander (ATSI) identified, she was slightly less likely to be a foster carer.

Foster carers were significantly likely to be more highly educated than the kin carer group. This was also the case for their family members. They were likely to have a little more than one child or young adult at home, but not so likely to have an adult child at home. The children in foster care were likely to be a lot younger than was the case for kin carers and to have no kin relationship to the carer. A little more than half the foster carers had a legal agreement in place.

Children spent significantly less time in the care of foster carers than was the case with kinship carers, with the majority spending two years or less. There were significantly fewer previous stays than with kinship carers, but the duration of previous stays were similar. Foster carers were much more likely to have cared for other OOHC children in the past. They were unlikely to be providing long term care. DoCS were more likely to have initiated the care placement with the foster carers than was the case with kinship carers.

The foster carers had a similar geographical spread to kin carers. They were far more likely to own or to be paying off their own home, and more likely to have four bedrooms or more. Those who responded tended to be born in Australia and to speak English at home.

Foster carers were much more likely than kinship carers to have an income from a part time or casual job, or from a spouse or partners full time job, with a gross weekly income of more than $500 with most having an income more than $1000.

Foster carers received much more training than kinship carers and felt less prepared than kinship carers for the role. They felt that a lot of the training was held at an inconvenient time but were very happy with the training they received both in terms of quality and relevance.

Most foster carers thought that foster carers should receive supervision and slightly less than half thought that kin carers receiving financial support should receive supervision. About a third thought that all kin carers should receive supervision. About a third of foster carers were currently receiving supervision and a third never had. About a half of those that had received supervision rated it positively.

Most rated their health and financial situation as having remained the same but their contact with friends as having stayed the same or deteriorated. Contact with family hadn’t changed nor their feelings of self-confidence. The amount of time for their own interests had deteriorated. Stress levels had stayed about the same or somewhat deteriorated and wellbeing had stayed much the same. A majority rated their health as good or very good.
Foster Carers tended to see that there had been some difference in how they saw themselves and rated that difference as reasonably significant.

**Formal Kinship Carers**

While there were more kin carer couples, there were a greater number of sole carers than in the foster care group, with a slightly greater proportion living in a household with only one adult, though most were in two or more adult families. If the carer was a sole carer she was extremely likely to be female. The majority of the relationships with the additional adults were with husband or children. If the adult was ATSI identified she was slightly more likely to be a kin carer.

Kinship carers were significantly likely to be less highly educated than the foster carer group. The same applied for their family members. They, like foster carers, were likely to have a little more than one child or young adult at home but not so likely to have an adult child at home. The children in care were likely to be a lot older than was the case with foster carers. The children were far more likely to be a grandchild though some were nephews, nieces or children of friends, and they were very likely to have a legal agreement in place.

Children spent more time in kinship care than children spent in foster care, with the majority staying 2 years or more. There were a significantly greater number of previous stays than with foster carers but the duration of the previous stays were similar. Kinship carers were much less likely to have cared for OOHC children in the past. Kinship carers were extremely likely to provide long term care, with DoCS likely to have initiated the care, but with more of the kin carers having initiated the care than was the case with foster carers. Kinship children had on occasion initiated the care themselves.

Kinship carers had a similar geographical spread to foster carers. They were far less likely to own or to be paying off their own home. If they were not in rental accommodation, they were more likely than foster carers to be mortgage free. Their home was less likely to have a little more than three bedrooms. Those who responded tended to be born in Australia and speak English at home.

Kinship carers were more likely to have an income from a Centrelink pension or benefit with a gross weekly income between $80 and $1000. One third of the kinship carers had a weekly income of less than $500. They received much less training than foster carers and felt more prepared than foster carers for the role, with the majority saying that they hadn’t received any training.

Slightly less than half the kinship carers thought that foster carers should receive supervision and about a third thought that kinship carers receiving financial support should receive supervision. About a third thought that all kinship carers should receive supervision. About a tenth were currently receiving supervision and about two thirds never had. Half of those who had received supervision rated it positively. About a quarter of kinship carers rated their health as improved. Most rated their financial situation as having remained the same or deteriorated, with many more kinship carers than foster carers, rating that their financial situation had deteriorated somewhat or greatly than foster carers. Contact with friends had either stayed the same or deteriorated. Contact with family hadn’t changed nor had self-confidence. The amount of time for their own interests had...
deteriorated. Stress levels tended to have increased and wellbeing had stayed much the same though there was some deterioration noted. Less than 12% rated their health to be very good, the majority rated their health as good or reasonable, with a much greater number of kinship carers than foster carers reporting poor to very poor health. They tended to consider that there had been some difference in how they saw themselves and that tended to be reasonably significant.

Lives Lived: experiences of carers
Formal Kinship Carers, Informal Kinship Carers, Foster Carers

Formal Kinship Carers

The quotes included in this section are drawn from the answers formal kinship carers gave to the open ended questions in the self-completion survey

The data we have gathered for this research has come from individual carers rather than the family as a whole. Carers’ experience of the caring role has been addressed explicitly, and while the children’s experiences have not been addressed in the same way – by speaking to them directly – their presence has been implicit in much of the data, and their interests and concerns have been constantly present in carers reflections on the caring role and in their descriptions of family life. This does not however, lessen the importance of listening directly to children’s experiences and views about kinship care. These must play a significant role in building knowledge about kinship care and it is crucial for future research to focus on hearing the voices of children about kinship care.

The themes emerging from qualitative sections of the survey data confirm those of other studies undertaken over the past decade both in Australia (e.g. Bromfield, et al, 2005) and internationally (e.g. Dunne and Kettler, 2006).

This chapter ‘Lives Lived’ will deal primarily with the experiences of kinship carers who are the main focus of this study, but will also devote a section to the experiences of foster carers whose participation through completion of the quantitative sections of the survey and the sharing of their written insights and stories in the qualitative sections, have given us a wealth of information. In placing their experiences alongside those of the kinship carers it can be seen that many experiences and concerns are shared and many stand in stark contrast. These shared and contrasting experiences and insights have contributed to the crafting of a clearer and more comprehensive picture of carers lives.

Key Messages

We have encountered kinship carers both close at hand in the focus groups and at one remove, as unidentified respondents to our survey. For carers in either of these circumstances; as participants in the groups, or as respondents to our survey questions, a significant degree of trust was required; on the one hand, trust in revealing themselves to a comparative stranger whose stated intention was to ask questions, delve into complex and personal issues, and find out who they were and what mattered to them most; on the other,
respondents had to trust that the precious time spent recording detailed information and thoughts on an anonymous survey form would be time well spent. All participants needed to trust that the reflections written or recorded in good faith would be respected and allowed their full weight and significance.

Neither the fear of personal exposure involved in talking first hand to a comparative stranger, or the somewhat clinical impersonality of filling in a survey form deterred the carers who chose to participate from wanting to share fully and in detail, what to them is key information and knowledge that needs to be shared and passed on. One of the first questions asked by focus group participants was whether what they had to say would reach those who have the responsibility for and the power to design and make the policy decisions that affect the lives of carers and their families.

We have described previously how passionately kincarers tell the stories of their individual experiences, and how strong their desire is to contribute to ensuring that other carers fare better than they might have in dealing with the complexities that overwhelm when taking on a caring role. Carers have articulated clearly a collective view that the foundations for reviewing and re-modelling kinship care policy lie in the considerable knowledge base of the carers themselves.

**Life has changed for us in ways we never expected:**

Entry into the caring role for most kinship carers generally bears no resemblance to the traditional concepts of child protection, intervention and assessment prior to placement in out of home care. Many carers find themselves in the caring role suddenly, unexpectedly and often in unsettling and traumatic circumstances. There is frequently little or no intervention from child welfare authorities, no ‘pre-placement’ assessment and no caseworker involvement. There are happy exceptions to these negative experiences and some carers report ‘wonderful’ caseworkers who are very helpful to them and prompt in their responses to problems that arise, but these have still proved to be the exception rather than the rule in this research. It may be many years after taking on the primary caring role before kinship carers have any contact with Community Services and many have found that when they have made contact they have still fallen through the gaps.

Carers often have had prior warning that difficulties existed or were emerging in their extended family that might compromise the wellbeing of their relative children, and in many cases have stepped in to provide support. Some carers believed there was a prevailing view that because kinship carers have prior knowledge and experience of the problems existing in families, that they need less support, training and assistance in dealing with them than foster carers do. There may have been years of continuing problems that carers have experienced from the sidelines: mental illness, domestic violence, drug abuse,
physical and emotional violence towards children, sexual abuse and parental incarceration. Relatives may have been periodically – even consistently involved in trying to remedy these situations but they rarely, if ever reported having been prepared for the sudden upheavals and change that the arrival of the child/children in their permanent care brought about.

**Talk to us:** Carers repetitively described to us that the first days, weeks, and months were extremely difficult for them in both practical and emotional terms and that they felt very alone. They found that they had extreme difficulty accessing ‘real people’ (even when they knew where to look) who would listen to their issues and provide them with informed advice, rather than listening to phones ringing out, waiting in endless queues, leaving messages on message banks, trying to get past gate-keeping reception staff, or listening with a sense of helplessness to the ill-informed, time poor support staff so often encountered.

**Treat us with respect:** Kincarers felt that if they did have contact with Community Services and other government agencies, they were treated with suspicion and a lack of trust and respect. The reasons for these attitudes were described in a range of ways – that officers were too busy, that they were simply ignorant of who carers were or how they fitted in; that some workers blamed the carers themselves for the situation that their families were in; that some workers just thought that they were liars or had disloyal or selfish agendas; that workers didn’t stay in their jobs long enough for knowledge to be passed on; that they were poorly trained, or poorly recruited.

**Give us the information we need:** At the very top of the carers’ wish list was access to information from the very first day that they became full-time carers – and often in the time leading up to taking on that role. They felt strongly that the problems that emerged in these early days could have been remedied or at least contained, and prevented from becoming chronic issues that drained their physical, emotional and financial resources sometimes for years to come.

**Be informed yourselves:** Carers often laughingly described attempting to contact Community Services officers and caseworkers only to be told that they were “doing training”. Many felt that this was an excuse to ‘fob them off’ as it didn’t seem to equate with how well informed officers were about many of the issues they were facing or how accessible the referrals and practical solutions that that they were needing became.
Recognise the value of what we do and trust us: There was a deep sense of distress, anger and hurt in the comments made about levels of respect shown to them, and the value – or lack of it – accorded to the contribution carers make to the children they care for. A contribution that they felt was not only of value to their families but to the community as a whole. They felt they were invisible to the world at large as they battled away to give the children they cared for the very best life they could provide, not only so that the children could be happy in the present and have the chance of a better future, but also to make up, in some measure, for the hurts, losses and traumas of the past.

Educate the community about who we are and what we do: Carers continuously encounter a lack of knowledge of what the kinship care role entails, how many children are being cared for permanently by kincarers, how diverse their backgrounds and experiences are, and just how little support they receive. The attitude still prevails in some quarters that people caring for kin children should not even be asking for financial and practical supports because ‘they should be doing it for love’. One carer commented (after hearing that very comment from a person in a relatively powerful position) that ‘love doesn’t come free – they still have to be schooled, and clothed and fed and helped to recover from the terrible things that have happened to them. How can I do all that if I’ve lost my job because I need to look after them?”

Give us the same resources to do our job as other carers get: The most prevalent comment from kincarers about resources was that they wanted parity with foster carers in terms of the supports available to them. They did not necessarily want to be seen as foster carers, have access to identical services, or to be part of the same supervision and assessment systems, but they did want to be seen as having equal status and rights to resources appropriate to their own circumstances and needs and the needs of the children in their care.

Help us to help ourselves: The majority of kinship carers presented as being fairly independent in their attitudes. They wanted to care for their children as they saw fit and in accordance with the children’s and the family’s individual needs and cultural concerns. They were not asking for the government or any other agency to give them ‘handouts’ (their word) simply because they were carers. The main message from them was that they wanted resources available to assist them to assist the children to flourish. The kind of support they wanted included supports that would give the children equal opportunity with other children – in education, physical and mental health, behavioural, developmental and psychological wellbeing and prospects for future employment and healthy relationships.
Prevailing Issues

Getting access to the support and help that is needed

The issues that carers describe with such emotional resonance primarily concern the crucial intersection between the practical assistance available to them and the difficulties and traumas they face on a daily basis. They equate lack of timely practical assistance with problems affecting both the children and themselves becoming chronic issues.

Why is accessing services so complicated?

Carers described being surprised and confused about how difficult accessing services and support proved to be for them. It made no sense to them that they received contradictory answers to their questions, that they were told they were not entitled to supports that others like them were receiving, that they had to struggle to find their way through a maze of bureaucracy to resolve the simplest issues: like how they could get a Medicare card for their child, the right to approve medical treatment in an emergency, access to immediate needs such as clothing and bedding or counselling for a traumatised child. They were perplexed by the inconsistency of service delivery and supports – some got it and some didn’t and there didn’t seem to be any rhyme or reason to them, as to how or why.

Information

Carers felt that agency support workers and officers (particularly DoCS and Centrelink) didn’t have the knowledge at their fingertips, or the training and experience to provide them with accurate answers to their questions concerning what entitlements they might have; where to access support services; where to obtain legal advice, counselling or other specific professional guidance. Many felt they had been misinformed about entitlements which resulted in missing out on support that could have been accessed e.g. establishment grants, Medicare provisions, carers benefits, training. Information often came by way of word of mouth from other carers, or through Kinship Care Project workers rather than through agencies. Carers often felt abandoned in times of crisis and felt that professionals with the negotiating skills to assist them with complex issues, such as domestic violence, children with immediate behaviour problems or educational deficits were not available to assist them when they were needed.

There has been no training but it didn’t occur to me that there might be (we didn’t get training to be parents) but now I am thinking that there should be training to deal with this different and unusual circumstance of a grandchild not living with its parents, and how to explain to the child as she grows, and also to her older siblings and friends, who are already asking questions.

Our Previous caseworker was a loving, careful, observant support. We need consistency

I was left with no direction, no support, a child with multiple problems including an eating disorder and later diagnosed ADHD, etc etc, including substantial financial costs overall.
Training, skills and knowledge

The majority of kin carers reported not having attended training sessions of any kind in preparation for raising kin children full time, to assist in the transition to this new role or to assist with ongoing problems. The reasons they gave for not attending included being told that they were not eligible, training sessions being held at times when they could not attend and training not being available specific to their needs. For example one kin carer related how she had turned up for a workshop only to be told that she didn’t need to do this as she was ‘ONLY’ a kin carer.

The survey data showed that 77% of kinship carers had not received training or professional advice of any kind. This percentage was higher amongst the focus group participants. Some felt that they didn’t need any training because they had already been parents. A significantly greater proportion of the Foster Care group were satisfied or very satisfied with the relevance of training they received.

The kind of training that kinship carers felt would be helpful to them; anger management for children; positive behaviour programmes; coping with babies born drug addicted and developmentally challenged; managing children’s needs and moods. Some carers commented that the skills and knowledge needed to bring up children now, are very different to the skills and knowledge they brought to raising their own children 20 or 30 years ago. Those who had attended training relevant to their particular circumstances valued it highly.

Legal complexities

Kinship carers regularly find themselves parties in highly complex legal proceedings, following failed dispute resolution with a child’s parents. Carers who do not have a voluntary consent order through the Family Court (in NSW), agreed to by the parent (which will often accompany informal care agreements) often want the security, in the first instance, of an interim order to provide security and stability for both the carer and the child prior to obtaining a parenting order. Court proceedings can be extremely time consuming and drawn out - with repeated appearances that are financially and emotionally draining. Kincareers often feel marginalised and disadvantaged by processes that can leave them paying huge legal fees, including fees for adjourned proceedings when parents represented by legal aid have

What training for kinship carers? I wasn’t made aware by Docs or anyone else that it existed

There was a workshop held in my town and when I knew it was on I attended DoCS office on that morning and said I was there to do the training and the DoCS officer said that I was ONLY a kinship carer and didn’t have to do it and I said I wanted to do it and she said there was

As my daughter has bipolar – I have attended carer workshop for mental health. With my granddaughters’ counselling – I did learn heaps from how to deal with some of her worries. With, the three I have, it is the emotional things we all go through at different times.

The legal system should help carers not work against them in cases of abuse. Why do carers who choose to look after children in a safe environment, helping keep these children safe and still have to pay $50,000 and above to prove the parents are not fit parents on top of the expense of raising these children.
failed to appear. It is not uncommon for carers to be operating under a family Court order in NSW, only to find themselves without legal rights or protections of any kind if the order is contravened and a child is moved interstate. There is no mechanism of redress in the Family Court for the carer if the order is breached – although the party contravening the order may be fined. This may also mean having to deal with more than one child protection authority in different jurisdictions. These issues within families can be extremely complicated and fraught, as differing agendas are worked through. These issues are particularly distressing where a child has been, or is in danger of, physical, emotional or sexual abuse.

**Personal and Family Issues**

**Domestic circumstances**

Carers have often already downsized their dwellings and relocated for retirement, thus leaving them with insufficient space for children moving into their homes on a permanent basis. Younger kinship carers (aunts, uncles, cousins, siblings, friends) often already have young families of their own with little space for additions to their families. Carers frequently have to start from scratch setting up, renovating, furnishing and decorating suitable living space for their kin children. The notion of sleepovers, topping and tailing in one bed or sleeping on blow-up mattresses on the floor, as exciting and fun diversions, goes out the window when living arrangements become permanent. This is a loss for both the carer and the child, as the ‘time out’ recreational, back-up relationship becomes the permanent care situation, often with no alternative back up. Frictions can develop in the broader family with carers now unavailable to other members of the family (children, siblings, other grandchildren). Some carers have reported needing to move out of homes they owned because they were too small and upsize into rental accommodation. Some carers who were already renting, reported having to move to cheaper rental areas away from social networks in order to afford houses with more bedrooms.

The law courts! What we went through was absolutely disgusting. The father has got a record as long as your arm, he’s a very violent man – six assault charges against him – and the mother has been on drugs. When they broke up, she took up with another fellow who is a drug dealer. Yet we had to fight for those boys. Both of those parents aren’t fit to have them, but we had to fight for those boys even thought the parents didn’t want them – and the cost of it all.

I love looking after my grandson but lack of help and support made it very hard to cope at times i.e. my house is 130 years old and 2 bedrooms, my grandson doesn’t have his own room and my house is in bad need of repairs. It leaks when it rains, mould growing in different rooms and I am not in a situation to do anything. DoCS know about this and won’t help me.

I would love to move to a bigger house where the children could have a room of their own.
Respite, rest and recreation

The need for respite care was as important to the survey respondents as it was for the focus group participants. Carers reported that the unrelenting task of caring for children with high needs, often in difficult circumstances, had taken its toll on their quality of life – and reduced the quality time they needed to be spending with the children. Carers commented that finding the time even for the day to day tasks of shopping and running a household, was more difficult than it had been prior to becoming primary carers, and was further complicated by the time consuming tasks of trying to access medical reports, find counsellors, deal with behaviour problems, organise new schools, get ‘up to speed’ with what had been happening in the child’s life at home in order to develop strategies for a way forward.

Comments in the survey echoed the feelings of one carer who said in an informal conversation that she felt like was ‘pushing a very big rock up a very steep hill – and then waiting for it to roll back down on me.’ Rest and recreation had become a thing of the past for many respondents and a number of the comments on the survey form were written in capitals or heavily underlined.

Carers felt that regular access to respite would have given them the opportunity to manage challenges more successfully, remain resilient, maintain their health and keep on top of problems emerging with the children.

Health Challenges

Some carers had found that raising kin children on a permanent basis had given them renewed vigour and purpose; that they were getting more exercise and re-introducing more youthful activities into their daily schedules. Others had found that their health had markedly deteriorated, particularly if they had underlying or pre-existing conditions. The quantitative data provided in the survey differed slightly from the qualitative data collected in the open questions, where carers were more likely to describe issues that were troubling them. A comment made in a focus group provided an interesting insight on these slight tensions between the quantitative and qualitative data relating to health, one carer commenting that, ‘if I’m asked to tick a box, I’m more likely to say things are fine because I want them to be fine, I need them to be fine – if you ask me how I feel, I’ll tell you how I feel.’ Factors reported as contributing to deterioration in health included additional stress, lack of sleep, worry, lack of time for attending medical appointments, having no personal time and the difficulties of finding child-care when needed.
Social Isolation

Many carers found themselves more socially isolated than they had been before, with some friends wanting child free time, others drifting away due to the carers changed concerns, time constraints, lack of availability, and differing preoccupations. Some had become more isolated from other family members who disapproved of them taking on the primary care of kin children, or who felt jealous or left out. Normal routines where social contacts occurred; going to yoga, golf, craft classes, sports events, book club, lunches with friends; had been disrupted and spontaneous recreational activities with friends and colleagues were restricted or non-existent. There were quite a few self styled ‘grey nomads’ who greatly missed going off on road trips, and the contacts and friendships they made when travelling with or meeting up with other mobile campers. They found themselves restricted by school timetables, lack of resources and fatigue. For some male carers who had left work due to the need to share the caring load, social isolation was acute due to friendships and social contacts being associated primarily with their work environment. While some older carers reported increased social interaction with younger parents (see Health Challenges) other (grandparent) carers wanted the opportunity to share child centred activities (playgroups etc) with other grandparent carers with whom they felt they would more in common than with young parents.

Concerns about Children

Behaviour and emotional problems:

It is common for carers to be dealing with moderate to extremely severe behavioural and emotional problems when the children come into their care. Problems such as ADD, ADHD, or a child’s mental health problems may have contributed to parents being unable to cope and requesting support from grandparents or siblings, although our evidence suggests that there are likely to be multiple contributing factors to children coming into the care of relatives. A large number of carers (both in the survey and the focus groups) report that children have been living in extremely stressful circumstances, with distressing and dangerous events commonplace in their households; drug and alcohol abuse; openly inappropriate sexual behaviour, domestic violence; emotional and sexual abuse of the children or their siblings; malnourishment; lack of general care and nurturing; seriously ill or dying parents; parents with mental health problems. The list is long and well documented. Carers almost universally reported they did not receive appropriate support with these very complex situations.
and distressing problems – distressing both for themselves and the child – and worried about the consequences this lack of timely support would have for the child’s wellbeing. They felt strongly that they should have access to support and advice when it was needed and specific to their needs and the needs of the child.

**Disabilities**

A child’s disability, as was the case with behavioural and emotional problems, might have been a contributing factor in parental care breaking down. Some carers were looking after more than one disabled child, and on occasions a disabled parent as well. These carers were desperately in need of support, in terms of household modifications, equipment and domestic help (especially where a child had very high maintenance physical disabilities), respite, and a raft of professional services; counselling, allied health services, physiotherapy, occupational therapy, speech therapy and so on. Many found this support very difficult to find and worried about their own health breaking down and what that would mean for the child’s long-term future.

**Education**

Recent research by the CREATE Foundation has shown that children raised in kinship care are likely to have poorer educational outcomes than other Australian children. Carers face many challenges in ensuring optimal educational opportunities for their kin children. The reasons for children coming into kinship care in the first place include many factors that are likely to contribute to educational deficits. Children are more likely to be under stress, to have had interrupted school attendance as a result of disrupted family life, illness, truancy or changes of residence; they are more likely to have changed schools or to have learning difficulties or disabilities. Grandparents in particular are conscious of not having the relevant knowledge or contemporary educational background to assist their grandchildren with homework, or to assess where children are in need of assistance. Kinship carers are more likely to have been educationally disadvantaged themselves as evidenced by only 5.6% of the cohort of kinship carers in this study having gained a university qualification and 16.9% reaching Year 8 or below with the majority leaving before Year 10. They are also more likely to be under resourced in terms of technology in the home. Many carers have reported difficulty in getting professional advice or finding support for children with learning difficulties, or children in need of coaching to catch up to their contemporaries after periods of absence from school.

I think being a kinship carer to a child that has cerebral palsy and partner with mental health problems, is life changing. Life is hard at times but it is what you make of it. Positives and negatives - more positives in life.

My grandson has a rare condition, we were told he wouldn’t reach 3 years, but he will be 10 soon so we appreciate the time we have. It can be hard, it can be frustrating with DoCS.

Working for this special person.

As years passed the children suffered at the hands of school mates as they were always with their grandparents with their mother in jail and father not interested in them.

As they attended high school neither of us could help them with their homework as it was well
Rewards and challenges

The challenges faced by carers have been dealt with in some depth in this section. When asked how the rewards weigh up against these challenges and the complexity of their role, carers are quite explicit. Their primary reward emerges from a deep commitment to raising their kin children and providing them with security and the chance to live a happy and fulfilling life. The majority say that despite the difficulties they wouldn’t have it any other way. They see taking on the role of primary caregiving as a serious obligation towards the children – maintaining the connection with family and the cultural heritage to which the children belong. They do not see taking the children in as a choice they can make one way or the other, but rather as the only possible decision - simply ‘doing the right thing’ by them. When carers talk about the ‘rewards’ and benefits gained from raising kin children, they tend to describe their experience in those terms; the satisfaction of maintaining family continuity, of keeping the children where they belong and with people who love them. They describe the relief of knowing that the children are safe; knowing that they are being cared for well; and knowing that they are loved. These are very much child centred rewards – rewards gained through the knowledge of the benefits accrued to the children. The rewards carers see for themselves, as individuals, mainly concern the inner strength gained from rising to the occasion and challenging adversity, and the benefits of love returned; other benefits are harder to pin down - some carers have reported meeting and making new friends with people they would not otherwise have socialised with, through the cohort of younger parents at pre-school and primary school; or of keeping up with contemporary and popular culture in a way they might not have otherwise had the inclination or opportunity to pursue. A few have said they are healthier because of the extra physical activity and mental stimulation required to look after young children. The most common benefits described are relational – the opportunity to develop a close and loving bond and the affection and love that is reciprocated.

My husband and I took on our grandson so we would know where he was and he would have love and a bed to sleep in every night. Our daughter (his mother) was into drugs. We have no regrets. Sometimes it has been very hard as no one told us about DoCS. In the twelve months since (we found out) it has made it easier. A grandson at high school is very hard on the pocket. But I would do it again. He gives me love and calls me Mum, never goes to school without saying ‘bye Mum love you’. I am very proud.

It has been very hard on both my wife and myself but we wouldn’t have it any other way to see our grandchildren grow up in life to what they are now is all we need to carry on. We love our grandchildren deeply and would have it no other way.
Financial Issues

Financial issues are a constant concern to carers, beginning with the instant increase in household expenditure with the arrival of the child/children into their home; along with other costs (including set up expenses, education, medical and legal costs etc.) can result in extreme hardship. Unlike foster carers kinship carers can be placed into several different categories – or no category at all – depending on the manner in which a child comes into care. If an order has been made placing the child in the care of the Minister, and the child is then placed in the care of grandparents or other relatives by Community Services then it is more likely (though not automatic) that a carer will receive the same care allowances and support services that are available to foster carers, and the child be assigned a caseworker (though this is also not automatic). If a child has come into kinship care by any other means – through an informal agreement, a parental consent order, or order from the family court, without previous DoCS (Community Services) intervention (under the Child Protection Act) then a carers status regarding financial and other assistance is some what blurred. Carers often feel that they are unfairly treated in comparison to foster carers, who they see as receiving benefits, concessions, training, and legal protections that they themselves do not.

In our case a relative died with no will, and these kids were out of control and none of the family wanted them or wanted us to take them in. But to me you can have everything in the world, but the most important thing is family and holding on. We still have lots of problems but they don’t get in trouble with the police anymore and they attend school.

The fact that I can see my own daughter having regular contact and maintaining a loving and meaningful relationship with her 2 children - if they had gone to Foster carers, her contact would have been 3 monthly and not her current weekly contact.

I enjoy looking after my two granddaughters. They have helped me as much as I help them since I lost my daughter. I am not interested in a relationship as I have had my life and only to happy to devote the rest to my two girls.

I’m only just starting to get financial support now, after 18 months, nobody told me I was entitled to anything, I found out from a lady in the support group. KC

I wish I had known about the financial help policies four years ago. I have only recently got a copy and DoCS still won’t help me or return my phone calls. KC

I rang Centrelink and told them – these boys are with us and my daughter is getting the money. They said, “You’ll have to write a letter”, so I did, and they wrote her a letter but she didn’t reply so they just kept paying her and I got nothing. KC

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The lack of parity with foster carers in terms of financial assistance has been further complicated for kinship carers by the lack of definitional clarity – who is a ‘formal’ carer and who is not. Carers describe this complexity as ‘frustrating’ and ‘mystifying’ and ‘completely unfair’. Foster carers also describe frustrations with regard to financial matters such as payments, reimbursements, and inconsistency in interpretation and implementation of policy. Both foster and kinship carers express deep concerns about inconsistencies and lack of equity.

To summarise what we learned from the qualitative and the quantitative information provided by formal carers (in response to the survey) the most important issues for carers included the following:

• Life had changed for them in ways they never expected, on a permanent basis; and they needed support in the following ways:

• To be treated with respect and given useful information in a timely way; to have access to well trained, informed professionals who could give specialist advice and support according to their needs.

• To be trusted; and have their skills and knowledge, and the value of their contribution recognized; to be resourced equitably; to be helped in such a way that they could continue to help themselves.

• They wanted respite, rest and recreation and the opportunity and resources to deal with health issues and social isolation; financial support to offset and prevent financial losses and expenditures; training specific to their needs and the needs of their children.

• They wanted to be supported to help the children in their care to deal with emotional, psychological and physical health issues; behavioural problems; disabilities; and social and educational needs.

• They were caring for their kin children because they loved them and wanted them to be raised in their families of origin – with their own kith and kin.

I have had to reduce my earning capacity by working less hours (casual worker). Because I am over 50 and caring for a 4 year old it can be physically and emotionally a problem. KC

After almost 8 years of taking on this role I found out, through a friend, that I could receive a payment from DoCS, this was December 2007! I have had no other contact from DoCS either before or since, regarding my grandchild.

Even though I have an exemption from work as a carer I do not qualify for any Centrelink allowances for myself as I do not pass the assets test. Even though my husband does as he gets a partial disability pension on the same assets. KC

To summarise what we learned from the qualitative and the quantitative information provided by formal carers (in response to the survey) the most important issues for carers included the following:
Lives Lived:

Experiences of informal kinship carers

_In this section information has been drawn directly from the experiences of informal carers who participated in the focus groups. These are the researchers impressions, reflections and observations of the sessions with informal kinship carers in the focus groups._

The Kincarers who participated in the focus groups were recruited through kinship care support groups coordinated through local neighbourhood centres and the Samaritans and were predominantly, but not exclusively, informal kinship carers. Much of what was discussed in the focus groups echoed what formal kinship carers had written in the surveys about prevailing issues. There was an additional intensity in the way these group discussions were experienced by the researcher, and her presence in the room would have had some impact on the way the carers experienced the discussion.

Participants came from diverse backgrounds and ranged in age from approx 35 to 75. Most were grandparents and a few were aunts and uncles. The ages of the children when they came to the carers households ranged from newborn babies to teenagers.

The reasons for having the children in their care included the child’s parent suffering a mental illness; a serious physical illness, accident or disability, drug and alcohol addiction; domestic violence; murder-suicide; parental incarceration and, in a few families, the child’s disability. Several of the grandparents were sole carers.

Some session were emotionally charged, some more reserved and emotionally contained, depending on what point the carers had reached in their caring journey, or how dramatic and heartbreaking their stories were. The grief and sorrow expressed at times was quite palpable and affecting. The extremity of some carers’ circumstances at times influenced the group aesthetic, damping down any tendencies towards over dramatisation.

In some sessions, most of the available time was spent on the range and complexity of the issues facing the group in their daily lives (past and present). It seemed that people needed to give voice to these issues and put feelings firmly on the table before anything else could be tackled (a quasi initiation rite for the researcher as the newcomer and outsider perhaps). The researcher did not intrude on these narratives by interrupting them or setting strict time limits.

A potent sense of injustice and unfairness emerged at some point in all sessions, regarding treatment by DoCS, Centrelink and a deep distrust of the implementation of law through the courts. Carers felt very strongly that the children’s voices were not heard, for example, some children’s own designated legal representatives having failed to consult with them or find out what they wanted or where they wanted to be. There was the sense that the parents ‘rights’ were given precedence and that children’s lives were regularly disrupted by court orders regarding access. The carers felt that they had to fight every inch of the way to achieve stability for the children and that they were accorded no rights whatsoever. They
felt aggrieved at the way they were treated by authorities at all levels and were often very angry and upset that they were not believed and their concerns fell on deaf ears.

Sometimes the mood in sessions was calm and practical, with measured approaches to problems – a desire to research potential solutions, look for professional advice and find answers rather than rage against fate. How the whole group responded seemed to be influenced by the more outgoing personalities within the group. There were some very positive ‘live wires’, with buoyant personalities who cracked jokes (appropriately) and laughed a lot. Others commented that this very positive attitude towards life raised other peoples’ spirits.

Across all the groups carers talked about financial losses, loss of jobs, of homes and loss of opportunities for ongoing work. Most said their friendships had been negatively affected and their social life had become virtually non-existent. There was also a strong sense in some sessions of a great ‘swag’ of lost dreams – for travel, study or creative pursuits, and for the couples, of having a relaxed and comfortable relationship in retirement. There was great concern about health issues (some had already had serious health events such as strokes and cancer) and the potential for adverse outcomes (disability and death). One woman was concerned and afraid that her incremental loss of sight would eventually mean that her grandson would be taken from her. All were to a greater or lesser extent fearful about the sustainability of their families. They felt threatened by the authorities rather than supported by them.

Despite these very serious problems the majority of carers in these sessions seemed to be intent on finding a way to keep their heads above water rather than locked into the repetition and drama of their stories. The focus was on coping with the circumstances they found themselves in and to the best of their ability doing a good job of parenting. This positive focus, carers said, was supported and encouraged by the kinship care project workers.

These carer’s came from a relatively diverse economic base, all were articulate and willing to share their experiences and knowledge. It was clear that the support and friendship the groups provided was extremely important to the carers and assisted them to develop and maintain a degree of resilience through the cycles of crisis and change that characterise the kinship carers role. The majority of carers (if not all) had received no practical or emotional support prior to finding out about and joining the groups. Only one had received financial assistance. Lack of family support was a problem for most of these carers – having no one available to look after the children while they shopped, went to the doctor, had a haircut, or took personal time out. This was particularly difficult for the sole carers.

Carers said that The Kinship Care Projects provided the groups with support in a number of ways – a place to meet, a source of information, funds for social gatherings and respite (camps etc.) and groups and activities for children. This support seemed to play a significant role in the vitality of the group and was highly valued by the members. The possibility of projects losing funding was something that was mentioned frequently and something the groups indicated they did not want to confront, as it was too overwhelming. The workers expressed concern (in de-briefing outside the groups) about the impact this might have on the carers and of the need to discuss these possibilities with the group and prepare contingency plans. The possibility of loss of funding had become ‘the elephant in the room’.
Carers expressed quite clearly what they wanted: to keep meeting together and to have clear information available to them right from the beginning about what rights they had and how to activate them. They were desperate for respite and wanted publicity about existing support groups and services available in schools, hospitals, doctors surgeries, Centrelink offices, (in short wherever carers go) so that carers didn’t struggle on their own, sometimes for years, before finding support and guidance.

There were countless references to the time spent (hours, days, weeks and even years) trying to get information from agencies about rights and obligations, and about what support services were available. These efforts, it seemed, habitually went nowhere. One carer pointed out that the hours a carer spends in contact with a DoCS or Centrelink officer (or other service provider), represents hours of a workers time and if those contact hours were unproductive, it was a waste of taxpayers money.

All the stories had elements of sadness and degrees of difficulty, some stories were horrendous and the levels of ongoing stress and anguish unsustainable when measured against what might be considered societal norms or typical expectations in life. By the same token, there seemed to be a highly sustainable degree of love and commitment to the children. This commitment was a predominant theme through all the sessions.

To summarise what we learned from the information provided by informal carers in the focus group sessions, the most important issues for carers included the following:

- Clear communication about rights, obligations and support services
- Access to information about all support services from day one
- Access to appropriate supports from day one
- Being treated with respect and dignity – as having valid concerns and needs
- Simple systems that facilitate access to information and services rather than obstruct access
- Well trained specialist officers and allied professionals in support agencies and health and legal services: people who know what kin-caring is about and know what is available to support that role
- Recognition that kin-carers are playing an important role in the community
- Recognition, support and funding for community kin-care agencies, support groups and projects
- Community education
- Centralised advocacy

Informal carers felt they had received substantial benefit from the following:

- Locally run kinship care support networks and projects (staffed)
- Respite Care of an appropriate kind (as judged by carers)
- Camps for carers and kids, entertainment for kinship carers’ children
- Opportunities for peer support
- Supervision that was part of a support provision approach centred on the wellbeing of the child and the kinship care family
- Support specific to their needs from agencies, other carers, support groups and kinship care support networks
- Financial and other practical assistance when necessary
## Issues affecting formal and informal kinship carers

### Services: deficits and accessibility

- Lack of access to and shortfall in provision of practical assistance
- Unnecessarily complex processes
- Workers lacking specialist training

### Difficulties with own children/parents of children in care

- Addictive behaviours; drug problems
- Mental health problems
- Interference in child’s care
- Problems surrounding access visits
- Custody disputes
- Appropriation of money
- Debts and irresponsible spending
- Incarceration
- Pregnancies/bringing more ‘uncared for’ children into the world
- Violent or aggressive behaviour towards Kincarer and children

### Losses

- Loss of homes through added financial burdens
- Loss of jobs by one or both partners because of complexity of children’s care
- Loss of friendships due to lack of time for external relationships and lack of understanding by others of changed circumstances
- Loss of opportunities for relaxation and recreation
- Losses with family relationships – less time for other children and grandchildren, jealousies, relatives disapproving of carers role or actions
- Loss of “who I used to be”.

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*Fig. 6: Issues affecting formal and informal carers (Yardley, 2009)*
Lives Lived:

Experiences of foster carers
A composite view

In this composite dialogue drawn from comments made by foster carers in the open questions of the survey, foster carers introduce themselves and open up a general discussion about their experiences at a group session:

MAGGIE: Welcome everybody. I’m Maggie, and I’ll be facilitating the session tonight. Hope you’re all comfy on those lovely metal chairs! Nothing like luxury is there! At least we’ve got a heater! What I would like to do first is just to go around the circle, introduce ourselves, give everybody an idea of who we are and why we’re here. Everyone OK with that? Great. And you’re happy to go first, Louise? Fantastic, lets get started then - off you go!

LOUISE: My name is Louise, my husband and I have five children of our own - two 25 year old boys, one 23 year-old girl and two teenage girls that still live at home. It has always been my wish to foster children and when most of my children grew up and moved out my husband and I discussed it with our remaining children and then began fostering. We have ended up having two little girls placed with us that are long-term. My birth daughters love them and they have really fitted well within our family unit. It has been a challenging road but very satisfying and rewarding especially with all the love these children have and the smiles they give.

MAGGIE: Wonderful, sounds like a very happy outcome. I’m sure you’ll have lots of words of wisdom for us along the way, thanks Louise.

SHARON: I’m Sharon, I’m here because I think that ALL carers should receive an A to Z printout covering all the help we can get for the foster children, and who and where to get it from in PLAIN ENGLISH – easy to understand. I’m hoping I’m going to get something like that here. So that’s why I came.

MAGGIE: O.K.! Sharon’s a straight talker. Good on you. I’m certainly intending to cover from A through to Z as far as we possibly can in the time we have together. Thank-you Sharon, that’s all very important stuff – and we will have some material for you to take home later on. So we’ll get back to that. Thank-you. Who’s next?

DONNA: Hi, I’m Donna, I do fostering (well my husband and I do of course) taking kids for short care – so we have a lot coming through, mostly only for a few days or weeks at a time so far, but we haven’t been carers for that long yet – we’re newbies, but I’m getting the hang of it.

MAGGIE: Thanks Donna.

SALLY: We’re a couple so might go together shall we Frank?
FRANK: OK. We’re Frank and Sally – we have twin boys with us at the moment. They’ve been with us for 18 months and we hope they might be staying. They’re doing pretty well now – after a bit of a rocky start, mainly because of complications with the mother. But that’s all sorted now and things are going pretty well. They’re great kids and we’re getting on like a house on fire now. I take them to footy and they’re turning out pretty good little runners as well – no trouble at school any more or anything like that. We had a bit of a trust issue with one of them for a while, but that seems to be in the past. Anything else Sal?

SALLY: No, don’t think so, that’ll do for now. They’re good boys – well we think so.

ANNA: I’m Anna, I’ve been fostering for a while as a single person. I grew up in a very busy household with foster children coming and going at all times. Short-term/long term/crisis/adoption. I found it a very positive experience, and enjoyed all care giving roles. So I guess that’s what drew me into the role. Not having my own children yet, but with a house, job, and a love of children, I thought it was the right time. It’s all going well.

MAGGIE: Great, thanks.

JANINE: My name is Janine, I haven’t got any kids yet - I’ve just been through all the assessment processes and I wanted to come along to see how other people are feeling about being foster parents and what kind of things might crop up for me when I’m really on the job, so to speak. I’m excited about it all, but I’m also pretty nervous, so I wanted to get the story from the pros I guess.

FRANK: Don’t know about pros!

SALLY: Yes, we’ve all made a few mistakes along the way that’s for sure.

SHARON: I think the main thing is to make sure you’ve got the right support from the get-go, all the stuff you need, health checks – everything. One of the hard things is not getting enough information so you’re left a bit in the dark. Not to mention MIS-information. If it is financial DoCS tell us different things. Even clothing is hard to get for the kids. I do short care too, like Donna, which can be for one night through to three years or more. Most children, 99%, come with no clothes. But DoCS don’t want to help financially with this. Some caseworkers take the kids to the shop and get them PJs and a dressing gown, NO slippers or NO underwear and silly hair brushes that are NOT suitable and silly little junkie toys before they bring them to the house. I have no room at home to store clothing so I keep the bare minimum. OF COURSE I keep PJs for all sizes and dressing gowns, new hairbrushes new toothbrushes etc. But I don’t keep slippers, school uniforms, underwear or everyday clothes. I just don’t have the space. If they take them shopping I should be asked first WHAT TO GET.

LOUISE: I imagine short-term care is much more difficult. I think I would find it difficult – but we certainly haven’t had any of that sort of problem with DoCS. We’ve had really good support from our caseworker. She’s fantastic.

MAGGIE: Janine is sitting there looking even more nervous now! Maybe we need to focus on some of the positives before we put her off altogether.
SHARON: She might as well go in with her eyes open. No point going in thinking that love is all you need. DoCS need to be honest with carers right from the word go to reduce stress and make it a happy placement for all. When they ring us to ask us to take children they should be truthful about their ages. They often tell us ages that are within the ages we carers have stipulated but when they arrive they are usually younger or older and we feel that we’ve been tricked. They should be more honest about the kids’ problems. We are usually told after they arrive, just a little oversight by DoCS and again we feel we have been tricked.

MAGGIE: What’s your experience been, Donna?

DONNA: Yes I guess, underwear, socks, that kind of thing – I’ve had that problem too. A change of clothes would be far better and then reimburse us for what we buy – so that it’s suitable.

SHARON: If the kids come with NO clothes DoCS do reimburse me – but usually months later. The kids need clothing IMMEDIATELY. They usually just come in the clothes they have on and MOST PARENTS do not like giving the carer the kids’ clothes – if they do, they give us the old raggy things. Most of the time it’s a school uniform they have on. DoCS supply us with one uniform each so if they came in uniform they usually come in a summer one even though it is winter so it is not much use either. We need that written A to Z of who pays for what - and a different one for short term respite, and long term. The regulations are different for them all.

FRANK: I suppose they’re desperate to find someone – they get a call out about a child in need and there just aren’t enough of us out there to pick and choose.

JANINE: I hope that doesn’t happen to me first up - I’m not sure I could handle teenagers – I really don’t know what I’d do. I was really hoping that I might be able to look after younger ones – and I was hoping it would be for long enough to get to know them. How do you deal with a stranger’s child if you only have them for five minutes?

SHARON: Well, I wouldn’t panic before you have to, the caseworker is supposed to contact you before bringing the kids - to tell you more about them and answer any questions but usually they just arrive and you haven’t had the phone call to definitely say YES or NO. The children rarely come with placement letters, medical numbers or profiles and it takes weeks to get them off the caseworker.

SALLY: We said we wouldn’t do respite or short term for that reason. But we did in the end and that was how we got the boys. So it worked out for us. But carers should all be given case plans whether they are short or long term.

SHARON: I have never seen a case plan since I became a carer, even though children have stayed with us thirteen months, twelve months - six months. I never really know what is happening, I am told the bare minimum, which really makes it hard to plan my life, or have holidays.

ANNA: As I said my experience has been good. I think it helps what kind of networks you have. I have many friends with children and live an active lifestyle so a few extra children
is never really a problem. I have always had access to support networks. All the things you need to do - scheduling work commitments and access, appointments (doctors/psychiatrist/counsellors etc) can often be a nightmare but not so different from having biological children. I’m still enjoying the little ones - tough times with others sometimes, as each child is in need of TLC. But if I can offer nothing else I can give that.

FRANK: We’ve been pretty lucky I think – everything has worked out really well for us, but we do have a friend with a disabled boy, and she has a tough time.

SALLY: That’s right. I think sometimes foster parents get taken for granted – and that’s not right – she never gets any support. I think that if a child has high support needs the carer should be put in contact with at least two other support carers, so they can get information about equipment and disability agencies and things like that. Her main concern with the system is the constant changing of caseworkers who don’t follow up. Which has been really difficult for her. Her child needs a wheelchair, for example, and it took six months to come from overseas – and in the meantime the boy is growing out of it and he hasn’t even got it yet! She really thinks there needs to be specialist people in DoCS who are trained to deal with disability issues.

SHARON: Another thing is family access. Caseworkers should organise parent and sibling contact as soon as possible and give the carer a written agenda. Most of the time I don’t know when visits are to be when a child comes to stay. I have been going out the door to go to the shops or out on an excursion and a driver arrives to take them to a parental visit that I knew nothing about, or the children aren’t driven home from school and when I ring the office to find out why I have been informed that they are there visiting their parents. Again I had not been told. It’s not me I’m worried about with all this to-ing and fro-ing by the way – it’s the kids

I will be told on Thursday that they are going to the Grandparents on the Friday for the weekend. Sometimes it is the kids that tell me and I have to ring the office to ask if it is true and for the times etc. Caseworkers are hard to contact – they are either out of the office, on sick leave or the constantly used one – ‘at training’. How much training do they need?

LOUISE: I don’t think caseworkers and other officers need LESS training by any means. They need professional development like anybody else. It’s what kind of training they have and when that matters. I think the problem everybody has is that things need to be more consistent.

MAGGIE: Yes, it seems people are feeling that things need to be a bit more predictable.

SHARON: And EQUAL. We need that A to Z!
Overarching Themes

Several overarching themes have emerged throughout this research, from the qualitative and quantitative material, across all participants. Distrust and dissatisfaction with the policies and practices of statutory authorities have been constant themes, as have information and knowledge deficits stemming from poor communication and lack of practitioner training. Along with these, deficits in practical supports due to the way policy is developed and implemented have been common themes in carers’ contributions to the survey and focus groups. These themes fall into two broad categories; the quality of communication to carers; and the ways in which their concerns are drawn (or not) into policy development.

<table>
<thead>
<tr>
<th>Distrust and dissatisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional response to communication and knowledge deficits</strong></td>
</tr>
<tr>
<td>• Distrust of DoCS and other agencies and authorities by many kinship carers</td>
</tr>
<tr>
<td>• Lack of confidence in and dissatisfaction with DoCS, Centrelink, legal and other authorities and services expressed by many carers</td>
</tr>
<tr>
<td>• General feeling of lack of support</td>
</tr>
<tr>
<td>• General sense of few services being available</td>
</tr>
</tbody>
</table>

Fig. 7: Overarching themes: Distrust and Dissatisfaction; emotional responses (Yardley, 2009)

<table>
<thead>
<tr>
<th>Poor Communication/Deficits in knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practical and Policy Issues</strong></td>
</tr>
<tr>
<td>• Difficulties in finding out what services and supports are available. DoCS, Centrelink and other providers are insufficiently informed about services available and kinship rights.</td>
</tr>
<tr>
<td>• Poor communication and lack of knowledge/DoCS, Centrelink officers</td>
</tr>
<tr>
<td>• Own lack of knowledge of current trends/education/technology</td>
</tr>
<tr>
<td>• Inability to get information and help when it’s needed.</td>
</tr>
</tbody>
</table>

Fig. 8: Overarching themes: Poor communication; Deficits in knowledge (Yardley, 2009)

Issues that have been frequently highlighted by kinship carers (as a whole) as ongoing problems for them are outlined in the following summary, *Issues affecting Wellbeing*. They fall within these overarching ‘policy and communication’ themes and are affected by them. These themes provide a background to the interpretive sections and to our findings and recommendations.
### Issues affecting the wellbeing of kinship carers and children

<table>
<thead>
<tr>
<th>Health issues</th>
<th>Social issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Extreme stress</td>
<td>• Social stigmas</td>
</tr>
<tr>
<td>• Exhaustion</td>
<td>• Lack of understanding in the general community about kin-caring experience</td>
</tr>
<tr>
<td>• Auto-immune disorders (anecdotal)</td>
<td>• Restrictions on participation</td>
</tr>
<tr>
<td>• Lack of time for health care regime fitness program</td>
<td>• Unrealistic attitudes and expectations</td>
</tr>
<tr>
<td>• Normal issues of aging intensified</td>
<td>• Disrupted generational links contribute to isolation and familial support</td>
</tr>
<tr>
<td>• Anxiety and depression</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal issues</th>
<th>Fear (emotional components)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of legal protections for both themselves and the children in their care</td>
<td>• Actual and perceived fears</td>
</tr>
<tr>
<td>• Complexity of legal systems and processes particularly across State boundaries</td>
<td>• Fear of death by violence from domestic abusers (sons-in-law and other family members)</td>
</tr>
<tr>
<td>• Exclusion of children’s voices and concerns</td>
<td>• Fear of dying and leaving the children alone</td>
</tr>
<tr>
<td>• High legal fees and court costs</td>
<td>• Fear of ill-health</td>
</tr>
<tr>
<td></td>
<td>• Fear of having the children taken from them</td>
</tr>
<tr>
<td></td>
<td>• ‘Interference’ from authorities – without support (casework distanced from reality of carers and children’s lives)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problems with the children</th>
<th>Worries about children</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Behaviour problems</td>
<td>• How it will affect them living with “old” people</td>
</tr>
<tr>
<td>• Illnesses</td>
<td>• Worries children will become socially isolated</td>
</tr>
<tr>
<td>• Educational deficits</td>
<td>• Worries they have problems down the track</td>
</tr>
<tr>
<td>• Learning difficulties</td>
<td>• Concern about the quality of education they are able to provide</td>
</tr>
<tr>
<td>• Disabilities</td>
<td>• Worries about how to maintain parental contact (or control the excesses in these relationships.)</td>
</tr>
<tr>
<td>• Developing and maintaining friendships</td>
<td>• Worries about keeping the children safe</td>
</tr>
<tr>
<td>• Emerging sexuality</td>
<td>• Worries that their parenting skills are rusty</td>
</tr>
<tr>
<td>• Previous Sexual abuse</td>
<td>• Concern that the children don’t have enough opportunities for “being children” and “having fun”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial issues</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduced income</td>
<td></td>
</tr>
<tr>
<td>• Lack of access to benefits</td>
<td></td>
</tr>
<tr>
<td>• Increased costs</td>
<td></td>
</tr>
<tr>
<td>• Financial insecurity</td>
<td></td>
</tr>
</tbody>
</table>

Fig. 9: Issues affecting the wellbeing of kinship carers and children (Yardley, 2009)

The following sections *Looking at Kincare Experience* and *Support and Supervision*, elaborate on these themes in the context of the trajectory of the kinship care ‘career path’, and the ways in which carers experience support and supervision.
Section Three

Looking at

the Kincare Experience
Narrative

Coffee in Katoomba

It is a beautiful spring day in the mountains and two women in their early sixties in an open-air café in relaxed conversation, a colourful array of shopping bags at their feet. They are well dressed and seem to be at ease with their surroundings and with each other’s company.

LILY: Have you heard from Jenny lately? I’ve been wondering about her. Haven’t seen her in years.

MAREE: No, haven’t heard from her in a while (Maree’s reply is diffident, she looks out towards the street to avoid Lily’s gaze).

LILY: No? What’s up? You two have a scrap? You’ve always been best mates haven’t you?

MAREE: Yeah, we are, well we were, but she doesn’t have time for girl talk or socialising these days. Doesn’t have time for anything much since she got her granddaughter.

LILY: Oh, really, (Lily looks startled) when did that happen?

MAREE: About six months ago.

LILY: How come?

MAREE: Her daughter did a runner, (she puts her hand over her coffee cup so it doesn’t spill, leans across the table and speaks conspiratorially). You know - that dreadful druggy boyfriend. Followed him up north. Hasn’t seen her since.

LILY: Lord – that’s rough.

MAREE: Mmm. Makes it difficult. Changed her life, especially now she hasn’t got Harry to fall back on.

LILY: Oh God yes! I forgot about that! That was so sad! Didn’t hear about it ‘til ages afterward. Not what you would have expected is it. How does she cope with all that I wonder?

MAREE: Haven’t got a clue. It’s all a bit relentless. You know, I’d really like to have kept in touch – help her out a bit. I did try. She’s a real live wire Jenny - always good for a laugh, really good company. Well she was. But I’m past it with little ones. Don’t want to know about it if the truth be told. Been there done that!
LILY: Tell me about it! It’s enough minding them for an entire afternoon!

MAREE: I’m too old for all that palaver now. It’s just too exhausting. Like I said, I did try for a while, used to ask her out, go over there, but you can’t have a proper conversation. She’s running here or she’s running there, and she can’t go out because she can’t get child care – can’t afford it and even if she could the baby’s got allergies so they won’t take her in day care until she’s old enough for an Epipen. So you can only see her at home and all she wants to talk about is whether the baby’s putting on weight, or how hard shopping is because she has to read every label with a magnifying glass to check all the ingredients with a crying baby on her hip – and then there’s the endless hassles she’s having with custody. Drive you nuts.

LILY: Wow, she was always such a laid back capable Mum! Everything seemed to just happen without effort for her. I was so jealous.

MAREE: I know – kind of a ‘professional’ compared to me. Hard to believe isn’t it. Can’t understand what happened to that daughter of hers either.

Lily: I heard she went off the rails a bit when Harry passed away.

MAREE: True. Idolised her father. Real shame that was. Real shame. Their lives just went to hell in a hand basket.

LILY: Still surprises me you know – she really was so capable. Always thought she was a bit of saint actually. You could always rely on her to be there. Took on more than I ever would.

MAREE: Well, she does pretty well considering, better than I could ever hope to. I suppose it helps having a natural aptitude! You know she was a foster carer too before she got her granddaughter?

LILY: I didn’t know that.

MAREE: Yeah, she got the little boy when Sally was in high school. He would have been about seven when she got him. He’d be 19 now, went off last year and joined the Air Force. Good kid. After he went she was going to head off to visit her sister in England, travel a bit. Now she’s got the daughters’ baby girl instead. Eternal motherhood.

LILY: (Lily raises her eyebrows, shakes her head with an exaggeratedly concerned and sorrowful expression.)

MAREE: Both through DoCS as it happens.

LILY: DoCS for the baby too?
MAREE: Went through all the business to get the boy. Then DoCS were involved with the daughter and brought the baby to her when the mother up and vanished. But, oh boy, has it been different. What she got for the foster boy compared with what she gets for the baby.

LILY: How do you mean?

MAREE: She got all sorts for the foster care boy that she doesn’t get for baby - clothes, furniture, health care card, counsellors, you name it, care allowance - but for the baby girl, absolutely nothing.

LILY: Why would that be, she was better off then than she is now? Are there two different systems?

MAREE: I don’t know if there are two different systems – you’d have to wonder if there is a system at all according to Jenny (she laughs). They assume that if the kids are related to you, you should just do it for love. Well of course you’d do it for love wouldn’t you? Partly. I suppose if it came to the crunch I’d do it too – if there wasn’t any other choice - because you do love them and want them to have a good life. But love doesn’t always cut it when they need things and you haven’t got the money to pay for them, does it?

LILY: Is Jenny in trouble financially? Harry left her in good shape didn’t he?

MAREE: Well, yes and no. They had a lot tied up in shares and most of that is gone.

LILY: Really?

MAREE: And she spent a fortune when George was sick. She made sure he had absolutely everything he needed. Got that job to keep things ticking over. Had to give up work, though, when the baby arrived on her doorstep. She really loved that job. It kept her in the thick of things – gave her satisfaction, not to mention proper money. Helped her get over missing Harry.

_The women fall silent for a few minutes, toying with the remains of milk froth and moving cake crumbs around their plates._

LILY: Still, there’s not much you can do is there? It’s just bad luck. You just have to deal with what life throws up, don’t you? What else can you do? Somebody should do something about the daughter, though, surely. She’s an adult and she’s supposed to be the mother.

MAREE: Well, exactly, but whose going to take that on?
The waiters brings the bill and they each put a twenty dollar note into the folder, gathering their purchases as they finish their conversation and say their farewells.

LILY: I suppose. Well I guess I should maybe ring her sometime, or something. See how she’s going, although, we were never that close. I wouldn’t really know what to say to be honest.

MAREE: Mmm. I know, it’s hard - but I should. I really should. I keep meaning too.

LILY: (Lily pauses, hooks her shoulder bag over her shoulder, then breaks from her short reverie). Well, I better get a move on, hadn’t I, got to pick Martin up from the station – he’s early today.

MAREE: Oh, is he? That makes a nice change. Be able to have dinner together tonight then?

LILY: Yes, we will, doesn’t happen often. It’s been great seeing you, though, it really has. Loved the shopping – haven’t had any retail therapy in months. Good for the soul.

MAREE: Yes it is, some light relief. Great to see you too, we’ll catch up at the growers market? (Lily nods) See you then, take care.

LILY: You too!

The two women head in opposite directions towards their cars, both parked nearby in the street – they turn, grin at each other and laugh at the awkwardness of trying to wave loaded down with parcels.
Reflections on significant themes

Career path of Kincaring

Career paths of Kinship Carers follow different trajectories depending on a number of factors:

Which institutions are involved (or not involved), Initially, in the placement of children and become involved in the longer term e.g. Police, Community Services, NGOs or none of these.

Enduring quality relationships with wider family, friends and community support contributes to outcomes.

Fig. 10: Career path of kincaring (Yardley, 2009)

It has been noted earlier in this report that the ‘career paths’ of kinship carers follow different trajectories from those of foster carers. The most marked difference between them being the enduring quality of kinship carers’ relationship with the kin child’s wider family - and the emotional and organisational complexities that this relationship brings about. Associated with this difference is the finding that indicates that there is no comparable difference between formal and informal kinship carers. Policy currently draws a distinction between ‘formal and ‘informal’ carers – between those carers who have entered the statutory system and are eligible for various kinds of financial and other types of assistance, and those who have not entered the system and therefore remain substantially unsupported. Our findings indicate that this distinction is inappropriate. Instead we found that generally, informal carers are engaged in the same kind of care, with the same degree of commitment as formal carers and that the children in their care are suffering from similar degrees of disadvantage and trauma in their lives. Further, we found that kinship carers, formal or informal, have diverse experiences in interactions with government and non-government agencies, in terms of the supports they receive. We were unable to identify consistency between the two distinctly labelled groups, in terms of for example, the benefits they received.
Our overall finding about the distinction between formal and informal kinship carers was that the difference exists only in terms of statutory definition - formal carers caring for children already officially determined as being ‘at risk’. These findings resemble some of the findings from the collaborative work of Chapin Hall and University of Chicago researchers comparisons of formal kinship care (supported by the state) and informal kinship care (without formal public support). The federal agency, Health and Human Services, which initiated the research, considered that in order to understand the growth in the formal kinship care population in the United States, they needed ‘more insight into the nature of all kinship care giving’. http://aspe.hhs.gov/hsp/cyp/kincare/sect5.htm

The researchers found when comparing formal and informal kinship care groups that they got a ‘vague’ picture, with the clearest observation being that, ‘while informal kinship arrangements appear to operate in a similar fashion in each of the four states examined, the utilization of formal kinship foster care varies widely’. They concluded from their results that while ‘informal kinship is an adaptive response to general social conditions, formal kinship is far more a creation of local policy, agency practice, and conditions that affect the administrative operation of governments’ (Harden et al, 1997).

Leonie Gibbons identified in earlier work for this study concerning formal and informal care arrangements that:

1) There are a great variety of arrangements in relation to the State, and a variety of combinations of these:
   a) Some have a court order, some do not
   b) Some receive payment, some do not
   c) If payment is received, it may come from the state or commonwealth or both
   d) Payment may be regular or one off
   e) Some have a caseworker, some do not
   f) Carers may or may not be officially designated by the statutory authority as a kinship carer (and it is unclear what this definition is)
   g) There may be variation in frequency of contact – some have ongoing contact, some have a one off or irregular contact

2) Some kinship carers have more than one child in kinship care and each child may have a different arrangements in relation to formal/informal care

There are important implications for policy if, as our results indicate, the fundamental difference between formal and informal kinship care in NSW is DoCS and other statutory bodies’ involvement with the families of children who are in formal kinship care. If, as our findings suggest should happen, we remove the definitional distinction between formal and informal kinship care we are left with the problem of how to provide for the needs of many more kinship families who have so far remained unsupported. An unsustainable tension then results from kinship care remaining in the child protection framework along with foster care. If we attend to that problem by removing kinship care service provision from the child protection area, as our research indicates should happen, we are left with the problem of ensuring that all kinship care families are not left out in the cold with regard to the supports that statutory recognition provide.

The following section on supervision and support will tease out further issues that need to be confronted in order to adequately provide for the needs of all kinship carers and their children.
Section Four
Support and Supervision
Supervision and Support

This section will look at the information provided by all carers about support and supervision and how that comparative information informs ways of resourcing kinship care into the future.

Supervision

Hesitancy about the term on the part of kinship carers suggests that the term supervision as it is used in policy terms is not understood and when carers hear it used their natural response is to equate it with surveillance – they may also have experienced negative supervision. Supervision in the context of professional social work practice – valuing what ‘the other’ is saying – does not equate with the concept predominantly presented by carers in their responses.

In policy, and in ideas about appropriate intervention in the general fields of child welfare and child protection (and in some other policy areas as well), the concepts of support and supervision are often linked. The assumption has frequently been that if the one, support, is offered it follows that the other, supervision, will be put in place as well. Just what supervision means, however, has not been clear. While policy documents in the relevant government departments have attempted to spell out what supervision entails, this has not necessarily clarified either its status or content; nor has it enabled outsiders and researchers to actually find out just what it implies. What it might mean in the context of kinship care has been especially unclear. On the other hand, the concept of support has, in general, been considered to be much more straightforward and yet this is a ‘grab bag’ of a concept, the contents of which may also be far from self-evident. The question of what support kin carers are entitled to remains contentious. For these reasons, we designed our research with a specific focus on these two contentious concepts and sought to discover:

- who carers thought should receive supervision
- which carers were receiving support and/or supervision now
- what kind of supports and supervision they were receiving now
- how they felt about what was on offer
- what they wanted to receive or receive more of.
Tables 5. and 6. show details of carers responses to two of these research concerns: which carers are receiving supervision; and how satisfied carers are with the supervision they are getting.

**Table 5: Who was receiving supervision?** *(Luscombe, 2009)*

<table>
<thead>
<tr>
<th>This table relates to foster carers and formal kinship carers</th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td></td>
</tr>
<tr>
<td>I am currently receiving supervision for a foster child</td>
<td>14.3 (19)</td>
<td>0.0 (0)</td>
<td>31.4 (16)</td>
<td>30.0 (3)</td>
</tr>
<tr>
<td>I am currently receiving supervision for a relative/kin child</td>
<td>7.5 (10)</td>
<td>9.7 (7)</td>
<td>0.0 (0)</td>
<td>30.0 (3)</td>
</tr>
<tr>
<td>I have received supervision for a foster child who was previously in my care</td>
<td>8.3 (11)</td>
<td>1.4 (1)</td>
<td>15.7 (8)</td>
<td>20.0 (2)</td>
</tr>
<tr>
<td>I have received supervision for a kin/relative child who was previously in my care</td>
<td>4.5 (6)</td>
<td>6.9 (5)</td>
<td>0.0 (0)</td>
<td>10.0 (1)</td>
</tr>
<tr>
<td>I have never received supervision</td>
<td>50.4 (67)</td>
<td>62.5 (45)</td>
<td>37.3 (19)</td>
<td>30.0 (3)</td>
</tr>
<tr>
<td>I cannot remember</td>
<td>8.3 (11)</td>
<td>11.1 (8)</td>
<td>5.9 (3)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Other</td>
<td>4.5 (6)</td>
<td>2.8 (2)</td>
<td>5.9 (3)</td>
<td>10.0 (1)</td>
</tr>
</tbody>
</table>

**Satisfaction concerning supervision received** *(Survey Question 36)*

Respondents were asked, if they had received supervision, how they found the experience. Approximately half of those who had received supervision rated it as positive or extremely positive (51.0%), and the ratings did not differ significantly between the foster care group and the kinship groups.

**Table 6: Rates of satisfaction of supervision** *(Luscombe, 2009)*

<table>
<thead>
<tr>
<th>This table relates to foster carers and formal kinship carers</th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td></td>
</tr>
<tr>
<td>Extremely positive</td>
<td>14.3 (7)</td>
<td>20.0 (4)</td>
<td>8.7 (2)</td>
<td>16.7 (1)</td>
</tr>
<tr>
<td>Positive</td>
<td>36.7 (18)</td>
<td>35.0 (7)</td>
<td>39.1 (9)</td>
<td>33.3 (2)</td>
</tr>
<tr>
<td>Neutral</td>
<td>24.5 (12)</td>
<td>15.0 (3)</td>
<td>30.4 (7)</td>
<td>33.3 (2)</td>
</tr>
<tr>
<td>Negative</td>
<td>8.2 (4)</td>
<td>5.0 (1)</td>
<td>13.0 (3)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Extremely negative</td>
<td>6.1 (3)</td>
<td>10.0 (2)</td>
<td>4.3 (1)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Not sure</td>
<td>10.2 (5)</td>
<td>15.0 (3)</td>
<td>4.3 (1)</td>
<td>16.7 (1)</td>
</tr>
</tbody>
</table>

As the research progressed it became apparent that, regardless of any official definitions of the nature of support and supervision (and their lack of clarity), kin carers themselves have very particular understandings of both these notions and very strong feelings about supervision and support as well. In the focus groups, kinship carers wanted to talk at length
about the kinds of supports they needed but they steered away from all discussion of supervision and for the most part rejected any idea that this had a place in their lives and the way they raised their families. Indeed, some carers saw the idea of being supervised by others as insulting.

Fig. 12 Support – Carer’s views (Yardley, 2009)

When we asked kinship carers themselves what they were receiving now, what they were looking for and what they might need, provision of services and supports of all kinds were very high on their list of priorities. Two general provisions in particular stood out. The first is access to good quality information, especially about the health conditions and troubling behaviours of the children in their care, and workshops and training that would provide information and advice about how best to deal with these demanding problems. The second was the ongoing support of a case worker, someone dedicated to their family, known and trusted, who would be available for consultation and advice when it was needed; who has detailed knowledge of the family and especially of the children and their needs; who would work with the family to address problems and put them in touch with other providers and services (and not just during office hours). They wanted workers with sound training and extensive knowledge in their field and they wanted continuity and a degree of certainty.

On the other hand, for many of the carers in our study, both in the survey and focus groups, the idea of supervision was anathema. For many it smacked of surveillance, of spying and checking up on, with an eye to correction and interference. Those who were prepared to consider the concept confined its application to very specific circumstances. Those smaller numbers of carers who felt comfortable with the concept of supervision had usually experienced very positive relationships with caseworkers.

Yet, it was clear to us as researchers that, encompassed in, even inherent in, the role of case worker, as these kin carers described it, was provision for the kind of supervision that kin carers would accept and even welcome. This kind of supervision is much closer to
professional supervision now regarded as essential for those engaged in particular kinds of work, those who work with people in troubled or testing circumstances – for counsellors, doctors, clergy. This kind of supervision is more in the nature of a ‘working-with’ relationship in which there is mutual respect, a great deal of listening and where the aim is to help those who have sought supervision to make their own decisions as to how to proceed in their professional life and relationships. Applied to the kin carer sphere, this kind of supervision would be based on detailed understanding of family circumstances, of the people involved and of their very particular needs, especially the needs of the children. It is a very different model from that of surveillance and checking up. There are many benefits that flow from this kind of supervision, not the least being that there is someone outside the immediate family who has a detailed understanding of that family and its needs and whose role is to help family members find solutions to problems and hopefully avoid some before they develop.

The following tables compare the rankings formal kinship and foster carers gave to the supports they were receiving, in order of their importance to them.

<table>
<thead>
<tr>
<th>The most important kind of support already received for the children currently in care – formal kinship carers</th>
<th>The most important kind of support already received for the children currently in care – foster carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from your family 43%</td>
<td>Caseworker support from DoCS 69%</td>
</tr>
<tr>
<td>Caseworker support from DoCS 40%</td>
<td>Support from your friends 55%</td>
</tr>
<tr>
<td>Support from your friends 33%</td>
<td>Support from your family 51%</td>
</tr>
<tr>
<td>Support groups (eg foster care or grandparent support group) 17%</td>
<td>Support groups (eg foster care or grandparent support group) 33%</td>
</tr>
<tr>
<td>Information on dealing with behavioural problems 16%</td>
<td>Information on dealing with behavioural problems 31%</td>
</tr>
<tr>
<td>Child care 15%</td>
<td>Child care 27%</td>
</tr>
<tr>
<td>Assistance in dealing with the child’s/children’s parents 15%</td>
<td>Respite care 22%</td>
</tr>
<tr>
<td>Respite care 10%</td>
<td>Assistance in dealing with the child’s/children’s parents 16%</td>
</tr>
<tr>
<td>Information on parenting 7%</td>
<td>Information on parenting 6%</td>
</tr>
<tr>
<td>Caseworker support from another organisation 4%</td>
<td>Caseworker support from another organisation 4%</td>
</tr>
<tr>
<td>Legal assistance 4%</td>
<td>Legal assistance 2%</td>
</tr>
<tr>
<td>Caseworker support from Centrelink 0%</td>
<td>Caseworker support from Centrelink 2%</td>
</tr>
</tbody>
</table>

Table 7: Important supports (from L. Watson tables, 2009)
The following background on non-government funded Kinship Care Support Projects provides a context for formal kinship carers’ rankings of the value to them of support groups (Tables 7 and 8), and of other non-governments supports accessed by kinship carers. It also contextualises the findings emerging from our research that underpin recommendations relating to community based supports.

Table 8: Additional supports wanted (from L. Watson tables, 2009)
Support from non-government sources

Support Groups and Funded Projects

Regional Kinship Care Projects have been developed over the past several years to provide support for carers who have full-time care of kin children (grandchildren, nieces and nephews, other relatives and friends). These projects have emerged due to a growing need and demand for a coordinated approach to provision of information, services and support. These projects are highly valued by carers as they help to fill the gap in policy that informal carers have been disappearing into in increasing numbers in recent years.

Funded regional projects, such as the Kinship Care Regional Project based in Springwood, that provides support to carers in the Blue Mountains, Hawkesbury and Penrith areas, and the Samaritans Kinship Care Group which facilitates support groups in the Lake Macquarie and Wyong area and at Cessnock, Raymond Terrace, Toronto, Harrington, Morisset, Charlestown and Gorokan, are examples of well run, effective and cost effective coordinated services to kinship carers. An evaluative review of the Springwood project (Thomas, 2008) found that:

- Both relative carers and project workers reported the support groups had reduced the carers’ sense of isolation and had increased their experience of being supported.

- Young people, relative carers and project workers confirmed the KAOS group helped reduce the sense of isolation in the lives of participants.

- In addition to this, their support base had been increased through their involvement in project activities which provided contact with project workers and connection to other young people living in care.

- Relative carers and young people reported the recreational/social activities offered through the project reduced their sense of isolation and supported their connection with other people in shared circumstances.

- Project participants reported improvements to self-esteem and confidence since participating in the project. Young people described positive changes in themselves and in their relationships with other people; a view supported by Relative Carers and KAOS workers.

- Project participants advised activities offered through the project would have been beyond their financial, and physical resources.

In addition to the support group and other activities that focused on the increased quality of life and wellbeing of both carers and children, the review noted that the practical information gathered and disseminated by the project coordinator had:

- Increased knowledge regarding participant’s rights, resources and supports.

- Facilitated collaboration between different service providers including Centrelink, the Sydney West Area Health Service (SWAHS) through two significant project activities, ‘The Resource Booklet for Relative Carers’ (Centrelink); and the KAOS Group (SWAHS).
Section Five

A way forward
CONCLUSION

This final section brings us to the end of the research journey we have shared with kinship and foster carers throughout New South Wales. We began this journey with a general aim as researchers, to contribute to the development of policies on kinship care in order to benefit children and their carers; an aim explicitly shared by those kinship and foster carers who joined us and gave so generously of their time, their knowledge and their life stories. We are very conscious, as this research narrative reaches its conclusion, that new stories are only just beginning for many children and carers embarking on their own real life experience of kinship care.

In this section, we summarise the six main findings of the research and interpret the meaning these findings have for moving forward in kinship care policy and practice. In translating these findings into recommendations, we identify similarities with the recommendations of some other relevant reports on kinship care.

This process contextualises our recommendations, so that they can be seen not only to be drawing on the contributions of the kinship carers in NSW who have participated in our study, but more broadly on the contributions of other kinship carers and their children. In this section we are stepping into the larger landscape referred to as ‘kinship care’ where our knowledge of the way the lives of carers and their families are lived can be expanded and enriched; and our understandings of the various ways in which those outside the life of kinship caring construct their views and develop policy on kinship care. It is our intention, through firmly anchoring the reporting of our research in the lived experience of carers, to make a meaningful contribution to changing constructs that will shape kinship care policy into the future.

Summary of findings

Finding 1: Kinship care differs from foster care at functional and emotional levels.

In our study kinship carers typically differed from foster carers in several important ways. The first difference between the two forms of care, according to our qualitative data, related to the motivations or incentives carers had for taking on full time care of children of whom they were not parents. Kinship carers differed from foster carers in that they typically took on the task of caring for their relative children for reasons associated with feelings of familial obligation. Foster carers typically took on the task of caring for the children of others with a vocational-like motivation.

Secondly, kinship carers were generally, intensely emotionally involved with their relative children prior to taking on their full time care, whereas foster carers were more likely to be in a ‘stranger’ relationship with the children brought into their care. While our qualitative
data indicated that intense emotional involvements with the children they cared for characterised the feelings of many foster carers, this involvement was typically built during the period of care, and not before it. Foster carers, according to our data typically identified their roles as socially responsible and quasi-professionals.

Thirdly, it was often the kinship carers (and sometimes the children) who decided that specific kinship care relationships were needed. Recruitment and assessment did not occur as part of a professional practice of matching children and carers, as was likely to have been the case with foster carers. Child welfare case management procedures or legal custody determinations at times confirmed or modified familial arrangements. Typically, although not always, kinship carers who became formal carers, did so after a period of informal, part-time or full time care.

Fourthly, the kinship carer was most frequently in a relationship with one or other of the parents of the child who came into care, and family dynamics in existence prior to full-time kinship care across three or more generations frequently continued, albeit on a different basis, once the carers had full time care of their grand or relative children. This generally differed from foster care where, even when there was ‘inclusive’ practice towards the family of the children, it was typically seen as a more or less valuable ‘professional’ responsibility, motivated by concern for the child’s wellbeing rather than family obligation and associated emotional ties.

Fifthly, in terms of qualitative data, the kinship care and foster care groups were distinct from one another according to a number of key characteristics. The majority of kinship carers had suffered financial losses and lacked financial stability. They were more likely to be receiving income from a Centrelink pension or benefit and to have a lower gross weekly income; the majority of carers had received little or no training; had received a lack of practical supports and services, a factor that had contributed to unresolved problems with the children, deteriorations in health, and reduced social interactions. The kinship carers were more likely than the foster carers to be sole carers.

**Finding 2: It was not possible to distinguish between formal and informal kinship carers in terms of characteristics and experiences.**

In our research findings the only characteristic that consistently differentiated formal and informal carers was the definition of some kinship carers (by one or more statutory organisation) as formal kinship carers, and the inclusion of these kinship carers on the organisation’s database. In terms of other characteristics and the lives they lived, the similarities were such that the two groups (as officially defined) could not even be said to fit onto a visible continuum.

Early in the research when we attempted to distinguish between formal and informal carers for purposes of structuring our research interventions, we identified that a great variety of arrangements exist between kinship carers and the State. For example, there may be no contact with any statutory agency, there may be ongoing contact, one-off or irregular contact with one or more agency; there may be a court order, and there may not; some carers receive payment, some do not; if payment is received, it may come from the State or Commonwealth or both, payment may be regular or one-off; and carers may have a caseworker, or they may not.
Finding 3: Kinship carers have need for supports and services.

The kinship carers participating in the study were predominantly female, older than the participating foster carers and on average had lower incomes than foster carers. They were more likely to be in public rental accommodation and less likely than foster carers to be employed. Kinship carers considered they lacked the range of supports that would help them to tackle the initial difficulties characteristic of the settling-in phase, and the ongoing supports needed to ensure opportunities for the children in their care, equal to opportunities available to their peers – the best possible chance for healthy, happy futures, general wellbeing and future success. The issue of support had great significance not only in terms of the material conditions of the kinship families, but also in terms of the emotional and behavioural problems the children in their care experienced due to the stressful and often traumatic circumstances from which they had been removed. Carers clearly defined their need for staffed, locally run support networks, respite care, camps for children with other carers and kin children, information about services, rights and obligations and specialist officers in relevant agencies, including health and legal services.

Finding 4: Kinship carers want a partnership approach with professionals based on respect for them and the caring they are doing

Strong evidence emerged in both the survey data and from focus groups that kinship carers want a collaborative approach that respects their own knowledge and, for many, the views of their children. They felt that the family, including the children, needed to be at the centre of all discussions, decision-making and interventions; and that these partnerships needed to be established in a timely way.

Finding 5: The current system that connects support and supervision is not working to further the wellbeing of carers or children

There is overwhelming evidence from both the focus groups and the survey data that existing systems and access to supervision and support have failed to meet the needs of carers and children as they live their lives in kinship care. Comments from both survey respondents and focus group participants indicated that carers found accessing support services difficult and were suspicious of regulatory supervision, feeling that in some way being ‘observed’, ‘supervised’, ‘assessed’ by statutory authorities was insulting to them as primary caregivers, created a culture of blame, and felt to them like being under surveillance.

Seventy per-cent of formal kinship carers reported that they had not been assessed or received any supervision. Carers reported that assessment processes were either non-existent or untimely, and inappropriate to the existing circumstances of the family and the specific needs of the child in relation to the family as a whole. While more than half of all foster carers received supervision, about three quarters of all formal kinship carers had either never received or could not remember receiving supervision. Of those kinship carers who have received supervision, 55% rated it either positively or extremely positively; 15% were neutral; 15% rated supervision as a negative or extremely negative experience; and 15% were not sure.
Kinship carers felt that it was more in the interests of their children to sit down and talk through problems and find practical solutions within a supportive environment that had their interests as a family at heart. Carers felt that it was counter-intuitive to provide supervision and support to families only if and when a child had already been physically or emotionally damaged.

Finding 6: Kinship carers value the support, information, social interaction and other initiatives provided by local community organisations and groups

Carers (particularly the informal carers) consistently reported that locally based Kinship Care Projects have been their primary source of information, referrals, practical support and advocacy. Carers emphasized that the opportunity to discuss problems and issues, and to share knowledge and support with their peers had been very valuable to them. They also emphasized that the input of well trained, knowledgeable, and well-informed coordinators had been crucial to the gathering and dissemination of information, and the accessing of supports and services available to carers. Carers involved with carer support groups felt that the benefits they gained from the support of their peers, and from the supports and services offered by Kinship Care Projects, had been marred by the short-term nature of project funding and the constant threat of these projects being defunded. Carers felt a level of anxiety and stress concerning their ability to maintain community engagement, appropriate child-centred activities and access to information, without the support of these projects that link them with a range of agencies and activities that they could not financially sustain on their own; community legal, financial and health services; occasional respite and after school care. Carers believed that the knowledge base already existing at community level amongst kinship support agencies, support projects and carers groups had not been effectively accessed or consulted to feed into policy development. They reported that funding agencies had expressed the view that these groups should work towards becoming self-sufficient and then be encouraged to ‘fly solo’. They felt that there was a lack of knowledge concerning the complexity of their circumstances and that they needed much more than the opportunity to talk and share experiences in peer support groups. Carers have expressed a degree of anger and frustration at what they see as a lack of understanding on the part of policy makers about what is happening on the ground.

A New Way Forward – Initial Steps

Our findings confirmed the suggestion made early in this project that, asking where kinship fits in the child welfare system, is a misleading question when it results in applying out-of-home care models, such as that applied to foster care, to kinship care. Our findings on the characteristics and needs of kinship carers suggest that a new way forward will instead be found by applying a social care framework to policy to promote the wellbeing of children (and their carers) in kinship care. A focus on the provision of the kinds of financial and other supports required by kinship carers places them in what Cass, (2007), refers to as ‘the general relationships of care’, which can be contrasted with ‘a child welfare and child protection focus’, in which grandparent care (and we would argue kinship care more
Generally), ‘fits into the formal (our emphasis) kinship care policies and practices of state welfare authorities’, (p249).

Attempts to develop policy for kinship carers based on a dichotomy created by the statutory organization is invalid, according to our findings, because it ignores the similarities between formal and informal kinship carers in terms of characteristics and needs, and camouflages the ways in which kinship carers differ, in these terms, from foster carers. It is important to move away from attempts to place kinship care in categories that only serve to befuddle current policy discussions and research on kinship care, and therefore fail to adequately promote the welfare of children and their families.

Within the broad area of social work that informs child welfare practice, social care is defined as working on the basis of partnerships with vulnerable individuals and families, to provide them with social services to meet their needs and strengthen their quality of life. The practitioner working within this framework seeks to understand the person/family within the totality of issues confronting them, (e.g., Higham, 2005). Child welfare research has shown the value to the wellbeing of children and families, when practitioners build bridges between themselves and the adults caring for children, working with them to create a common agenda for the welfare of the children. These interactions focus on building resources for families through, for example, ‘Wraparound’ processes for delivering services, by mobilizing community networks and group interactions to provide support, information, and sharing of expertise and resources (Callahan et al. 2000). These resources have often included support groups such as those valued by kinship carers in our focus groups. Research which set out to assess the value of a specifically designed intervention in the United States, with grandparent carers, has demonstrated the effectiveness of a multi-modal home based intervention in reducing emotional stress and increasing benefits and social support including help with legal aspects of kinship care. The multi-modal intervention included nursing, social work and legal services, as well as monthly support group meetings (Kelley et al, 2001).

**Recommendations**

The following recommendations are based on the conceptualisation of a way forward prompted by our findings. There is a strong resonance between our recommendations, and those in a 2005 report, ‘Looking after the family: a study of children looked after in kinship care in Scotland’, by Aldgate and McIntosh. Like our study, the Scottish study employed both quantitative methods, in the form of a survey, and qualitative methods including interviews with carers. Aldgate and McIntosh went beyond the scope of our study, interviewing children and surveying policies and practices across Scotland.

The recommendations from the Aldgate and McIntosh Report and other documents (both Australian and British) have been drawn upon, where they parallel our recommendations. Drawing out these parallel recommendations indicates that, while our findings may have a direct relevance to kinship care in NSW, they reflect and contribute to a growing evidential basis for moving ahead in certain directions on kinship care policy.
1. **Kinship Care be regarded as separate from Foster Care and resourced and supported by a distinct framework of equal status to foster care.**

**Similar recommendations from other research:**
Aldgate and McIntosh (2006) considered kinship care unique and different from foster care because of the way that kinship carers take on the task of caring for their relative children, not like foster carers, as ‘quasi professionals’ in stranger relationships with the children - but because of familial relationships and obligations. On the basis of this uniqueness, Aldgate and McIntosh specified that kinship carers need a different model of support, ‘which recognises the child, parent and kinship carers as part of a family system with its own strengths, networks and needs’ (p145). They suggested redefining kinship care as a separate category of ‘looked after children’, where children would be included irrespective of their routes into kinship care.

Bromfield et al, (2006), in their discussion about a culturally appropriate framework for Australian indigenous kinship carers, found that an implication of their analysis was that a model, separate from current placement, recruitment and assessment practices, was needed for kinship care.

2. **Partnership approaches be established that place families centrally and includes the voices of children, repositioning practitioners in relation to families and children; building collaborative relationship with equal exchanges of information and insights.**

The Northern Territory discussion document, drawing on the work of others, (e.g. Portengen and van der Neut, 1999), pointed out that an exchange or collaborative approach is more appropriate to kinship care practice than the traditional foster care practice where the case worker is central.


3. **Supervision and assessment be redefined as working with family members and children towards safeguarding and promoting the wellbeing of children.**

Aldgate and Macintosh, (2006), suggested that, 'Kinship care needs a model of assessment and support which builds on the strengths of the kinship system and empowers individual family members to share the responsibility for safeguarding and promoting the welfare of children' (p153).

Farmer and Moyers, (2008), noted that there was variation throughout the UK on assessment and supervision, and concluded that this was an aspect of policy and practice which needed strengthening in relation to building on the strengths of kinship care arrangements to make supervision and assessment work in this context.
4. Support services be separated from risk-based regulatory supervision.

Broad, Hayes and Rushforth, (2001), drew attention to the tensions between risk based regulatory supervision and statutory protection responsibilities and the provisions of appropriate support to kinship carers. They recommended that the voluntary sector should take the lead in providing appropriate kinship care services that are 'sensitive and responsive to users an carers needs', funded by central government and delivered in partnership or separately from social service departments and other child protection agencies.

Aldgate and McIntosh, (2006), recommended an exploration of the merits of paying kinship carers an allowance through the Scottish tax and benefits scheme, which would have the effect of separating the links between financial support and supervision.

5. Financial and other support services be provided through a whole-of-family multi-modal specialist intervention from the time that kinship care comes into consideration and:

6. Services in the whole-of-family model should be connected with families at any point when asked for by the carers or the child.

Recommendation 10.4, of the Wood Report, (2008), was that 'integrated, multi-disciplinary and co-located’ services be provided to children and families, including nurse home visiting, child care, primary health care, school readiness programs, routine screening for domestic violence, preschool services, school counsellors, breakfast programs and early learning programs.

7. Integrated support team of trained professionals be coordinated by locally based agencies

Aldgate and McIntosh, (2006), considered that a social work support framework for kinship carers should provide ‘a transparent, coherent and consistent model of support in partnership with families, and which is responsive to their needs at any one time’ (p160).

The Northern Territory (2003) discussion document noted the need for services to kinship carers to be flexible, to take account of the fact that needs of carers change over time, that no families are the same and that the circumstances and needs of children differ.

8. Funded support for community based kinship care support agencies and groups, grandparent support groups and agencies be provided; with ongoing support for interaction, information sharing and engagement between these agencies and groups.

This recommendation is drawn from our own findings that have shown, quite explicitly, the value of stable, well-informed and well-resourced community networks and supports that provide practical back up to peer support groups and individual carers; and socially integrating activities for their children.
1. Kinship Care be regarded as separate from Foster Care and resourced and supported by a distinct framework of equal status to foster care.

2. Partnership approaches be established that place families centrally and include the voices of children, repositioning practitioners in relation to families and children; building collaborative relationship with equal exchanges of information and insights.

3. Supervision and assessment be re-defined as working with family members and children towards safeguarding children.

4. Support services should be separated from risk-based regulatory supervision.

5. Financial and other support services be provided through a whole-of-family multi-modal specialist intervention from the time that kinship care comes into consideration.

6. Services in the whole-of-family model should be connected with families at any point when asked for by the carers or the child.

7. Integrated support team of trained professionals be coordinated by locally based agencies.

8. Funded support for community based kinship care support agencies and groups, grandparent support groups and agencies be provided; with ongoing support for interaction, information sharing and engagement between these agencies and groups.

Fig.13: Recommendations, Kinship Care in NSW – finding a way forward (Yardley, 2009)
Afterword  

by Leonie Gibbons

I was very pleased to be invited to write this Afterword. Having worked on the predecessor to this project (Mason et al, 2002) and the development of and initial stages of this study, it was disappointing to have to withdraw in September 2007 due to ill health. The concern is always that the project may not be able to continue and be completed when a central member of the team must withdraw. As is evident from the report, this was very fortunately not the case for this study.

I am delighted the research has been able to build on the early work I undertook and take it in new and exciting directions. The voices I heard in the focus group I conducted two years ago have come through strongly in the report and been reinforced and complemented by data from both the survey and the subsequent focus groups conducted by Ainslie Yardley. The inclusion of the narrative approach adds depth to the findings. It captures the lived experiences of the kinship carers in a way that vividly evokes the kin carers’ voices, almost as if they are in the room with you.

In inviting me to write this Afterword, Ainslie, Jan and Liz have provided the opportunity for my own voice to be included in the report. This inclusiveness is reflected in the way the kinship carers stories have been told.

Kinship care is a key area for the development of policy. The findings of this report are important and timely. It is now time for them to be put into practice.
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Slides for inclusion in Powerpoint training packages may be obtained by contacting ACWA and SJSC.
Appendix One
Kinship/Foster Care Study
 Statistical Analysis

Overview

The primary intention of this survey is to compare the experiences of foster and kinship carers in a range of areas:

- Household/Family structures and relationships
- Demographics: race/cultural affiliation, age, income, educational attainment, home ownership, employment status, and location
- Legal protections
- Financial security
- Health and wellbeing
- Uptake of support services
- Levels of institutional intervention
- Levels of satisfaction/dissatisfaction with the caring role

Survey Respondents

Of n = 133 returned surveys, 54.1% (n = 72) identified as kin carers, 38.3% (51) identified as foster carers, and the remaining 7.5% (10) as both kin and foster carers. It is important to note that n = 7 were not currently active carers (n = 4 of the kin carers or 5.6%, and n = 3 of the foster carers or 5.9%).

The sample was divided into three groups based on the year the respondent commenced caring role:

- short care experience (commenced caring between 2004 to 2008)
- medium care experience (commenced caring between 1999 to 2003)
- long term care experience (commenced prior to 1999)

Of the 72 kin carers, 44% (n = 32) had only short term experience with care (commenced 2004 to 2008), 35% (25) medium term experience (commenced 1999 to 2003) and 18% (13) were long term carers (commenced prior to 1999), with 3% (2) unknown (not reported).

Of the 51 foster carers, 35% (n = 18) had short term experienced, 37% (19) had medium experience and 20% (10) had long-term experience, with 8% (4) not recorded.
For those n = 10 who were both kin carers and foster carers, 60% (n = 6) commenced their caring role prior to 1999, 30% (3) had medium experience and only one (10%) had commenced recently (2004 to 2008).

**Part One: Household/Family structures and relationships; Demographics**

**The Adults**

*Number of sole or primary carers in each group (Survey Question 2)*

The proportion of sole or primary carers was compared between the Foster Care group and the Kin Care and Both groups combined (numbers were too small for valid analysis of the original three groups). After excluding the three with missing data from the Kin carers group, there was a weak trend towards more couple carers in the Foster Care group compared with the combined Kin Care/Both groups ($\chi^2 = 3.09$, df = 1, p = 0.079; see Table 1).

**Table 1:** Proportion of sole or primary carers by care group

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>133</td>
<td>72</td>
<td>51</td>
<td>10</td>
</tr>
<tr>
<td>Sole or primary carer</td>
<td>33.8 (45)</td>
<td>36.1 (26)</td>
<td>25.5 (13)</td>
<td>60.0 (6)</td>
</tr>
<tr>
<td>Couple carers*</td>
<td>63.9 (85)</td>
<td>59.7 (43)</td>
<td>74.5 (38)</td>
<td>40.0 (4)</td>
</tr>
<tr>
<td>Missing</td>
<td>2.3 (3)</td>
<td>4.2 (3)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

* Couples are defined as husband/wife or primary respondent + spouse/partner, regardless of whether the second adult was nominated as having a caring role or not.

*Number of households with more than two adults (defined as 18 years or older) (Survey Question 2)*

This information was missing for one Kin Carer. Over three-quarters (77.3% or n = 102/132) of households had two or more adults. There was a significant difference in the proportion with more than two adults between the Foster Care and the other households: $\chi^2 = 5.69$, df = 1, p = 0.017 (see Table 2).

**Table 2:** Proportion of households with two or more adults by care group

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>132</td>
<td>71</td>
<td>51</td>
<td>10</td>
</tr>
<tr>
<td>One adult only</td>
<td>22.7 (30)</td>
<td>28.2 (20)</td>
<td>11.8 (6)</td>
<td>40.0 (4)</td>
</tr>
<tr>
<td>Two or more adults</td>
<td>77.3 (102)</td>
<td>71.8 (51)</td>
<td>88.2 (45)</td>
<td>60.0 (6)</td>
</tr>
</tbody>
</table>
The average number of adults per household was 1.9 (Standard Deviation 1.0, range 1 to 7) for the Kin Carers, 2.2 (SD 0.7, range 1 to 4) for the Foster Carers, and 1.6 (SD 0.5, range 1 to 2) for the Both group. The Foster Care households had significantly more adults than the other household groups (Mann-Whitney U z = -2.93, p = 0.003).

Gender of primary carers (Survey Question 2)

N.B. because the primary carer could not always be identified (and it could not be assumed that the respondent was necessarily the primary carer) gender distribution is presented for the n = 45 single carer (or non-couple) households.

The sample of single carers was predominantly female (93.3%, see Table 3), and this did not vary significantly between the care groups (Fisher’s Exact Test p = 0.196).

Table 3: Gender distribution among the sole carers

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>45</td>
<td>26</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>% (n)</td>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Male</td>
<td>6.7 (3)</td>
<td>3.8 (1)</td>
<td>15.4 (2)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Female</td>
<td>93.3 (42)</td>
<td>96.2 (25)</td>
<td>84.6 (11)</td>
<td>100.0 (6)</td>
</tr>
</tbody>
</table>

Relationships among the household: proportion of grandparents; aunts/uncles; siblings; extended family/community carers (Survey Question 2)

N.B. of the 45 households with a single or primary carer, n = 30 households comprised only a single adult and so are not considered here (the question is n/a).

Of the remaining 103 households:

n = 1 survey was missing all information on number of adults and all other information including relationships;

n = 1 had seven adults in the household, but all information on relationships is missing.

This leaves information on 101 households with 124 adults (other than the respondent). The majority of other adults were husbands (56% or n = 69) and children (20% or n = 25). Details of the other adults are presented in Table 4.
Table 4: Relationship of other adult members of the household to the carer

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>124</td>
<td>59</td>
<td>59</td>
<td>6</td>
</tr>
<tr>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td>55.6 (69)</td>
<td>54.2 (32)</td>
<td>57.6 (34)</td>
<td>50.0 (3)</td>
</tr>
<tr>
<td>Wife</td>
<td>3.2 (4)</td>
<td>6.8 (4)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Partner/spouse</td>
<td>9.7 (12)</td>
<td>11.9 (7)</td>
<td>6.8 (4)</td>
<td>16.7 (1)</td>
</tr>
<tr>
<td>Daughter</td>
<td>4.8 (6)</td>
<td>3.4 (2)</td>
<td>6.8 (4)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Son</td>
<td>15.3 (19)</td>
<td>11.9 (7)</td>
<td>18.6 (11)</td>
<td>16.7 (1)</td>
</tr>
<tr>
<td>Mother</td>
<td>3.2 (4)</td>
<td>3.4 (2)</td>
<td>3.4 (2)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Sister</td>
<td>2.4 (3)</td>
<td>5.1 (3)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Grandchild</td>
<td>3.2 (4)</td>
<td>1.7 (1)</td>
<td>3.4 (2)</td>
<td>16.7 (1)</td>
</tr>
<tr>
<td>Boarder</td>
<td>0.8 (1)</td>
<td>0.0 (0)</td>
<td>1.7 (1)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Foster child</td>
<td>0.8 (1)</td>
<td>0.0 (0)</td>
<td>1.7 (1)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Not reported</td>
<td>0.8 (1)</td>
<td>1.7 (1)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

Number of adults in the household of aboriginal or Torres Strait Island origin (Survey Question 2)
n = 1 survey was missing all information on adults in the household.
n = 1 had seven adults in the household, but information on ATSI status was missing.

The total number of known adults in the survey households was 255 [131 respondents + 124 other adults]. Of these, ATSI origin status was missing for 21% (n = 54; see Table 5), and so statistical analysis was not performed. Considering only adults where data on ATSI origin were known, 10.3% (n = 10/97) of Kin carer household adults, 6.5% (6/92) of Foster Carer household adults and 8.3% (1/12) of Both household adults were of ATSI origin.

Table 5: Adults of Aboriginal or Torres Strait Island origin

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>255</td>
<td>129</td>
<td>110</td>
<td>16</td>
</tr>
<tr>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6.7 (17)</td>
<td>7.8 (10)</td>
<td>5.5 (6)</td>
<td>6.3 (1)</td>
</tr>
<tr>
<td>No</td>
<td>72.2 (184)</td>
<td>67.4 (87)</td>
<td>78.2 (86)</td>
<td>68.8 (11)</td>
</tr>
<tr>
<td>Missing</td>
<td>21.2 (54)</td>
<td>24.8 (32)</td>
<td>16.4 (18)</td>
<td>25.0 (4)</td>
</tr>
</tbody>
</table>
**Education levels of Foster and Kin Carers and their household (Survey Questions 3 and 4)**

The highest level of education achieved for all carers is presented in the Table 6. Approximately a third of the sample had reached Year 9 or lower and a third had a TAFE or University qualification.

Analyses compared excluded the n = 1 “other” and collapsed years 10, 11 and 12 (numbers were too small to conduct a valid analysis using the original categories). There was a statistically significant association between group (Kin Carer/Both vs Foster Carer) and highest level of education achieved: $\chi^2 = 31.38$, df = 4, $p < 0.001$, Foster Carers having received much higher levels of education.

<table>
<thead>
<tr>
<th>Table 6: Highest level of education achieved by the survey respondent</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>132</td>
</tr>
</tbody>
</table>

Year 8 or below 15.2 (20) 16.9 (12) 3.9 (2) 60.0 (6)
Year 9 15.2 (20) 25.4 (18) 3.9 (2) 0.0 (0)
Year 10 28.0 (37) 31.0 (22) 27.5 (14) 10.0 (1)
Year 11 4.5 (6) 5.6 (4) 3.9 (2) 0.0 (0)
Year 12 2.3 (3) 2.8 (2) 2.0 (1) 0.0 (0)
TAFE qualification 16.7 (22) 11.3 (8) 23.5 (12) 20.0 (2)
University qualification 17.4 (23) 5.6 (4) 35.3 (18) 10.0 (1)
Other 0.8 (1) 1.4 (1) 0.0 (0) 0.0 (0)

Data on the highest level of education in the household followed a similar pattern (see Table 7). Analyses excluded the n = 1 other and collapsed Year 8 and below with Year 9; and collapsed Year 11 with Year 12 (numbers were too small initially). The Foster Carer and the combined Kin Carer/Both groups differed significantly in terms of highest level of education achieved in the household: $X^2 = 33.11$, df = 4, $p < 0.001$. 
Table 7: Highest level of education achieved in the household

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>131</td>
<td>71</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Year 8 or below</td>
<td>7.6 (10)</td>
<td>8.5 (6)</td>
<td>0.0 (0)</td>
<td>40.0 (4)</td>
</tr>
<tr>
<td>Year 9</td>
<td>7.6 (10)</td>
<td>12.7 (9)</td>
<td>2.0 (1)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Year 10</td>
<td>19.1 (25)</td>
<td>26.8 (19)</td>
<td>12.0 (6)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Year 11</td>
<td>6.9 (9)</td>
<td>9.9 (7)</td>
<td>0.0 (0)</td>
<td>20.0 (2)</td>
</tr>
<tr>
<td>Year 12</td>
<td>8.4 (11)</td>
<td>11.3 (8)</td>
<td>6.0 (3)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>TAFE qualification</td>
<td>21.4 (28)</td>
<td>18.3 (13)</td>
<td>26.0 (13)</td>
<td>20.0 (2)</td>
</tr>
<tr>
<td>University qualification</td>
<td>28.2 (37)</td>
<td>12.7 (9)</td>
<td>52.0 (26)</td>
<td>20.0 (2)</td>
</tr>
<tr>
<td>Other</td>
<td>0.8 (1)</td>
<td>0.0 (0)</td>
<td>2.0 (1)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

The Children

Proportion of households with children or young adults (< 18 years) at home (Survey Question 5)

The proportion of households with children or young adults still at home was similar between the Foster Care households and the combined Kin Care and Both households (p = 0.955). On average, Kin Care households had 1.2 children or young adults still at home (SD 1.5, range 0 to 6), the Foster Care households had 1.1 (SD 1.4, 0 to 5) and the ‘Both’ households had 1.2 (SD 2.0, 0 to 6), a difference which was not significant (p = 0.907).

Table 8: Proportion of households with at least one child or young adult at home

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>133</td>
<td>72</td>
<td>51</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>No children/young adults</td>
<td>47.4 (63)</td>
<td>45.8 (33)</td>
<td>47.1 (24)</td>
<td>60.0 (6)</td>
</tr>
<tr>
<td>At least one child/young adult</td>
<td>52.6 (70)</td>
<td>54.2 (39)</td>
<td>52.9 (27)</td>
<td>40.0 (4)</td>
</tr>
</tbody>
</table>
**Proportion of households with adult children (18 years+) at home (Survey Question 5)**

The proportion of households with adult children still at home was similar between the Foster Care households and the combined Kin Care and Both households (p = 0.714; see Table 9). On average, Kin Care households had 0.1 adult children still at home (SD 0.4, range 0 to 2), the Foster Care households had 0.2 (SD 0.5, 0 to 2) and the ‘Both’ households had 0.1 (SD 0.3, 0 to 1), a difference which was not significant (p = 0.920).

**Table 9:** Proportion of households with at least one adult child at home

<table>
<thead>
<tr>
<th>N</th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td></td>
</tr>
<tr>
<td>No adult children</td>
<td>89.5 (119)</td>
<td>90.3 (65)</td>
<td>88.2 (45)</td>
<td>90.0 (9)</td>
</tr>
<tr>
<td>At least one adult child</td>
<td>10.5 (14)</td>
<td>9.7 (7)</td>
<td>11.8 (6)</td>
<td>10.0 (1)</td>
</tr>
</tbody>
</table>

**Foster Carers who also have birth kids (under 18) at home (Survey Question 5)**

A third (33.3%, n = 17/51) of the Foster Carers also had birth children (under 18 years) at home: 15.7% (n = 8) had one birth child, 11.8% (6) had two children and 5.9% (3) had three birth children at home.

**Age ranges of children cared for in each group e.g. are babies more likely to be in the care of kin or foster carers? (Survey Question 6)**

Information on 295 children was provided in survey Question 6, and n = 274 of these children were aged under 18 years, including three birth sons. Consequently, there were 271 children (under 18 years) who were either non-birth kin (friends, friends children and step children) or foster children, considered in this section (see Table 10 regarding the relationships of these children to the carers).

The Kin Care children (n = 120) had a mean age of 9.2 years (SD 4.4; range less than 1 to 17 years). The Foster Care children (n = 118) had a mean age of 7.9 years (SD 4.3; range less than 1 to 16 years). The ‘Both’ children (n = 33) had a mean age of 11.2 years (SD 3.4; range 5 to 17 years). The children in Foster Care group were significantly younger than the other groups: Mann-Whitney $U_z = -3.26$, $p < 0.001$.

Just under a third of the Foster Care group had in the past or were currently caring for a child 4 years or younger (n = 32/118; 27.1%), compared with 15.8% of the Kin Carers (19/120) and none of the Both group, a difference which was statistically significant: $X^2 = 9.42$, df = 1, $p = 0.002$ (comparing the Foster Care vs combined Kin Carers/Both).
Table 10: Relationship of (current and past) non-birth kin and foster children (aged under 18) with the respondent

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>271</td>
<td>120</td>
<td>118</td>
<td>33</td>
</tr>
<tr>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td></td>
</tr>
<tr>
<td>Foster child</td>
<td>49.8 (135)</td>
<td>0.0 (0)</td>
<td>97.5 (115)</td>
<td>60.6 (20)</td>
</tr>
<tr>
<td>Grandchild</td>
<td>37.3 (101)</td>
<td>78.3 (94)</td>
<td>0.0 (0)</td>
<td>21.2 (7)</td>
</tr>
<tr>
<td>Nephew/Niece</td>
<td>8.1 (22)</td>
<td>15.8 (19)</td>
<td>0.0 (0)</td>
<td>9.1 (3)</td>
</tr>
<tr>
<td>Friend’s child</td>
<td>2.2 (6)</td>
<td>2.5 (3)</td>
<td>0.8 (1)</td>
<td>6.1 (2)</td>
</tr>
<tr>
<td>Adopted child</td>
<td>0.7 (2)</td>
<td>0.0 (0)</td>
<td>1.7 (2)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Great grandchild</td>
<td>0.7 (2)</td>
<td>1.7 (2)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Step grandchild</td>
<td>0.4 (1)</td>
<td>0.8 (1)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Step nephew</td>
<td>0.4 (1)</td>
<td>0.8 (1)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Sister-in-law</td>
<td>0.4 (1)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
<td>3.0 (1)</td>
</tr>
</tbody>
</table>

Are grandparent carers more likely to be caring for their son’s or their daughter’s children? (Survey Question 6)

There were 105 grandchildren amongst the 295 children described in Question 6, 98 from the Kin Care group and 7 from the ‘Both’ group. Of these 105, 68 (64.8%) were their daughter’s children, 36 (34.3%) their son’s and one was not recorded.

How many Carers have legal agreements? How many have no legal agreements? (Survey Question 6)

Legal agreements were in place for three-quarters of children cared for by Kin Carers (n = 99/132), over half of children cared for by Foster Carers (57.4%, 74/129) and two-thirds of those children in the ‘Both’ group (64.7%, 22/34). The Foster Care group had a significantly lower proportion of legal agreements: \( X^2 = 7.81, \) df = 1, p = 0.005.
Average length of time children spend in Foster Care (Survey Question 6)

Considering all 129 children in the Foster Care group (including 10 adult children) and those 20 foster children from the ‘Both’ group:

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current length (months)</td>
<td>149</td>
<td>0</td>
<td>180</td>
<td>27.6</td>
<td>33.7</td>
</tr>
<tr>
<td>Total time in past (months)</td>
<td>148</td>
<td>0</td>
<td>96</td>
<td>3.7</td>
<td>12.7</td>
</tr>
</tbody>
</table>

and excluding the adult children (and one for whom age was missing):

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current length (months)</td>
<td>138</td>
<td>0</td>
<td>132</td>
<td>27.4</td>
<td>31.8</td>
</tr>
<tr>
<td>Total time in past (months)</td>
<td>137</td>
<td>0</td>
<td>60</td>
<td>2.4</td>
<td>7.8</td>
</tr>
</tbody>
</table>

Average length of time children spend in Kinship Care (Survey Questions 6)

Considering all 132 children in the Kinship Care group (including 9 adult children):

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current length (months)</td>
<td>132</td>
<td>0</td>
<td>204</td>
<td>61.3</td>
<td>52.8</td>
</tr>
<tr>
<td>Total time in past (months)</td>
<td>132</td>
<td>0</td>
<td>144</td>
<td>4.3</td>
<td>16.6</td>
</tr>
</tbody>
</table>

and excluding the adult children:

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current length (months)</td>
<td>123</td>
<td>0</td>
<td>204</td>
<td>59.6</td>
<td>49.0</td>
</tr>
<tr>
<td>Total time in past (months)</td>
<td>123</td>
<td>0</td>
<td>144</td>
<td>3.8</td>
<td>16.8</td>
</tr>
</tbody>
</table>

In summary, children spend longer in Kinship Care than in Foster Care.
The longest and shortest stays for children in each group (Survey Question 6)

Stays were significantly shorter in the Foster Care group: $X^2 = 25.05$, df = 3, $p < 0.001$ (see Table 11).

### Table 11: Length of current stay (months) by group

<table>
<thead>
<tr>
<th>Current stay</th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>295</td>
<td>132</td>
<td>129</td>
<td>34</td>
</tr>
<tr>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>20.3  (60)</td>
<td>14.4 (19)</td>
<td>27.9 (36)</td>
<td>14.7 (5)</td>
</tr>
<tr>
<td>6 months to &lt; 2 yrs</td>
<td>26.1  (77)</td>
<td>16.7 (22)</td>
<td>34.1 (44)</td>
<td>32.4 (11)</td>
</tr>
<tr>
<td>2 yrs to &lt; 5 yrs</td>
<td>24.1  (71)</td>
<td>27.3 (36)</td>
<td>20.9 (27)</td>
<td>23.5 (8)</td>
</tr>
<tr>
<td>5 years or more</td>
<td>29.5  (87)</td>
<td>41.7 (55)</td>
<td>17.1 (22)</td>
<td>29.4 (10)</td>
</tr>
</tbody>
</table>

In contrast, the total length of previous visits did not differ significantly between the Foster Care group and the other combined groups: $X^2 = 0.83$, df = 2, $p = 0.662$ (see Table 12).

### Table 12: Total length of previous stays (months) by group

<table>
<thead>
<tr>
<th>Previous stays</th>
<th>Total</th>
<th>Kin carer</th>
<th>Foster carer</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>295</td>
<td>132</td>
<td>129</td>
<td>34</td>
</tr>
<tr>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Less than a month</td>
<td>82.4  (243)</td>
<td>84.1 (111)</td>
<td>83.7 (108)</td>
<td>70.6 (24)</td>
</tr>
<tr>
<td>1 month to &lt; 1 year</td>
<td>8.1   (24)</td>
<td>6.8 (9)</td>
<td>8.5 (11)</td>
<td>11.8 (4)</td>
</tr>
<tr>
<td>1 year or more</td>
<td>9.5   (28)</td>
<td>9.1 (12)</td>
<td>7.8 (10)</td>
<td>17.6 (6)</td>
</tr>
</tbody>
</table>

Average number (and range) of repeat stays in each group (Survey Question 6)

Of the N = 295 children, 81.7% ($n = 241$) had not stayed previously. Of the remainder, one child had 372 previous visits (they stayed on weekends over a period of many years). Of the remaining 53 children:

In the Kin care group ($n = 21/132$), the mean number of times children had stayed previously was 2.3 (SD 1.2); median 2.0; range 1 to 4 times. In the Foster care group ($n = 22/129$), the average number of previous stays was 1.6 (SD 1.3); median 1.0; range 1 to 6 times. In the ‘Both’ group ($n = 10/34$) the average number of previous stays was 2.7 (SD 2.4); median 2.0; range 1 to 8 times. The average number of previous stays was significantly lower in the Foster care group: Mann-Whitney $U = -2.59$, $p = 0.010$. 

Kinship Care in NSW – finding a way forward
The number of children cared for currently and in the past in each group, and the maximum number at any point (Survey Questions 7, 8 and 9) see Table 13:

Table 13: Number of children cared for currently or in the past and the maximum number at any point by group

<table>
<thead>
<tr>
<th>Group</th>
<th>Current (Q7)</th>
<th>Past (Q8)</th>
<th>Maximum (Q9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Carers (n = 51) mean (SD)</td>
<td>1.8 (1.2)</td>
<td>19.1 (34.4)</td>
<td>2.8 (1.9)</td>
</tr>
<tr>
<td>range</td>
<td>0 - 6</td>
<td>0 - 150</td>
<td>1 - 10</td>
</tr>
<tr>
<td>Kin Carers (n = 72) mean (SD)</td>
<td>1.7 (1.2)</td>
<td>0.9 (1.4)</td>
<td>1.9 (1.5)</td>
</tr>
<tr>
<td>range</td>
<td>0 - 8</td>
<td>0 - 6</td>
<td>0 - 8</td>
</tr>
<tr>
<td>Both (n = 10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Children mean (SD)</td>
<td>1.3 (0.8)</td>
<td>10.8 (15.1)</td>
<td>3.2 (2.0)</td>
</tr>
<tr>
<td>range</td>
<td>0 - 3</td>
<td>0 - 50</td>
<td>1 - 8</td>
</tr>
<tr>
<td>Kin Children mean (SD)</td>
<td>1.1 (1.5)</td>
<td>0.2 (0.4)</td>
<td>1.4 (1.8)</td>
</tr>
<tr>
<td>range</td>
<td>0 - 5</td>
<td>0 - 1</td>
<td>0 - 6</td>
</tr>
</tbody>
</table>

Types of care provided by carers in each group (Survey Question 10)

This is restricted to the n = 126 households currently providing care (Q10 asks about the children ‘currently in your care’).

The proportion of Foster Carers providing long-term care (77.1%) was significantly lower than the other combined groups (94.9%): $\chi^2 = 8.97$, df = 1, p = 0.003 (see Table 14). There was no significant difference between the Foster Care and the other groups combined in terms of providing high support care: $\chi^2 = 0.004$, df = 1, p = 0.947.
Table 14: Type of care currently provided by group

<table>
<thead>
<tr>
<th>Type of care provided</th>
<th>Total 126</th>
<th>Kin 68</th>
<th>Foster 48</th>
<th>Both 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Long term</td>
<td>88.1 (111)</td>
<td>95.6 (65)</td>
<td>77.1 (37)</td>
<td>90.0 (9)</td>
</tr>
<tr>
<td>High support</td>
<td>19.0 (24)</td>
<td>16.2 (11)</td>
<td>18.8 (9)</td>
<td>40.0 (4)</td>
</tr>
<tr>
<td>Crisis/emergency</td>
<td>11.1 (14)</td>
<td>7.4 (5)</td>
<td>12.5 (6)</td>
<td>30.0 (3)</td>
</tr>
<tr>
<td>Medium (3 - 12 months)</td>
<td>10.3 (13)</td>
<td>2.9 (2)</td>
<td>18.8 (9)</td>
<td>20.0 (2)</td>
</tr>
<tr>
<td>Short term / temporary</td>
<td>9.5 (12)</td>
<td>1.5 (1)</td>
<td>16.7 (8)</td>
<td>30.0 (3)</td>
</tr>
<tr>
<td>Respite</td>
<td>7.9 (10)</td>
<td>4.4 (3)</td>
<td>10.4 (5)</td>
<td>20.0 (2)</td>
</tr>
<tr>
<td>Teenagers only</td>
<td>3.2 (4)</td>
<td>4.4 (3)</td>
<td>0.0 (0)</td>
<td>10.0 (1)</td>
</tr>
<tr>
<td>Pre adoption babies</td>
<td>2.4 (3)</td>
<td>1.5 (1)</td>
<td>4.2 (2)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Unsure</td>
<td>4.8 (6)</td>
<td>5.9 (4)</td>
<td>4.2 (2)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Other</td>
<td>4.0 (5)</td>
<td>4.4 (3)</td>
<td>4.2 (2)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

Initiation of placement (Survey Question 11)

Again, this is restricted to the n = 126 households currently providing care. There was a trend towards a difference in the proportion of placements initiated by DOCS between the Foster Carers (81.3%) and the other groups combined (66.7%): $X^2 = 3.15$, df = 1, p = 0.076.

Table 15: Initiation of placement for children currently in care, by group

<table>
<thead>
<tr>
<th>Initiation of placement</th>
<th>Total 126</th>
<th>Kin 68</th>
<th>Foster 48</th>
<th>Both 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>DoCs</td>
<td>72.2 (91)</td>
<td>64.7 (44)</td>
<td>81.3 (39)</td>
<td>80.0 (8)</td>
</tr>
<tr>
<td>You</td>
<td>27.0 (34)</td>
<td>30.9 (21)</td>
<td>22.9 (11)</td>
<td>20.0 (2)</td>
</tr>
<tr>
<td>The child’s parent/s</td>
<td>17.5 (22)</td>
<td>29.4 (20)</td>
<td>0.0 (0)</td>
<td>20.0 (2)</td>
</tr>
<tr>
<td>Another family member</td>
<td>4.8 (6)</td>
<td>2.9 (2)</td>
<td>4.2 (2)</td>
<td>20.0 (2)</td>
</tr>
<tr>
<td>The child</td>
<td>1.6 (2)</td>
<td>2.9 (2)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>The child’s brother or sister</td>
<td>0.8 (1)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
<td>10.0 (1)</td>
</tr>
<tr>
<td>A neighbour</td>
<td>0.8 (1)</td>
<td>1.5 (1)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Unsure</td>
<td>1.6 (2)</td>
<td>1.5 (1)</td>
<td>2.1 (1)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Other</td>
<td>3.2 (4)</td>
<td>4.4 (3)</td>
<td>2.1 (1)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

Geographical locations: Where are people located and are there any patterns for either group (Survey Question 12)

Geographic location did not differ significantly by group (small rural, regional, rural and remote combined; large and small coastal combined; Foster vs Kinship/both; see Table 16):

$X^2 = 5.77$, df = 3, p = 0.123.
Table 16: Geographic location by group

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>City</td>
<td>33.3 (44)</td>
<td>33.8 (24)</td>
<td>39.2 (20)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Regional centre</td>
<td>18.2 (24)</td>
<td>15.5 (11)</td>
<td>21.6 (11)</td>
<td>20.0 (2)</td>
</tr>
<tr>
<td>Small rural/regional town</td>
<td>25.0 (33)</td>
<td>22.5 (16)</td>
<td>23.5 (12)</td>
<td>50.0 (5)</td>
</tr>
<tr>
<td>Rural/remote area</td>
<td>6.1 (8)</td>
<td>5.6 (4)</td>
<td>7.8 (4)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Large coastal town</td>
<td>13.6 (18)</td>
<td>16.9 (12)</td>
<td>7.8 (4)</td>
<td>20.0 (2)</td>
</tr>
<tr>
<td>Small coastal town</td>
<td>3.8 (5)</td>
<td>5.6 (4)</td>
<td>0.0 (0)</td>
<td>10.0 (1)</td>
</tr>
</tbody>
</table>

Home ownership, type of dwelling and number of bedrooms (Survey Question 14)

There was a significant difference between the Foster Care group and the others in home ownership status (see Table 17): $X^2 = 12.89, df = 3, p = 0.005$; a greater proportion of foster carers owned their property or were paying off a mortgage. There was also a significant difference in the size of dwellings, the homes of Foster Carers having four bedrooms on average compared with 3.4 in the combined other groups (Mann-Whitney $U z = -3.77, p < 0.001$).

Table 17: Home ownership, type of dwelling and bedroom number by group

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Home ownership, N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own the property</td>
<td>30.8 (40)</td>
<td>38.9 (28)</td>
<td>22.4 (11)</td>
<td>11.1 (1)</td>
</tr>
<tr>
<td>Mortgage</td>
<td>34.6 (45)</td>
<td>19.4 (14)</td>
<td>53.1 (26)</td>
<td>55.6 (5)</td>
</tr>
<tr>
<td>Public rental</td>
<td>19.2 (25)</td>
<td>27.8 (20)</td>
<td>10.2 (5)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Private rental</td>
<td>15.4 (20)</td>
<td>13.9 (10)</td>
<td>14.3 (7)</td>
<td>33.3 (3)</td>
</tr>
<tr>
<td>Dwelling type, N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free standing house</td>
<td>90.8 (119)</td>
<td>87.1 (61)</td>
<td>96.1 (49)</td>
<td>90.0 (9)</td>
</tr>
<tr>
<td>Terraced house</td>
<td>1.5 (2)</td>
<td>0.0 (0)</td>
<td>3.9 (2)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Town house</td>
<td>3.1 (4)</td>
<td>5.7 (4)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Flat/unit</td>
<td>3.8 (5)</td>
<td>5.7 (4)</td>
<td>0.0 (0)</td>
<td>10.0 (1)</td>
</tr>
<tr>
<td>Other</td>
<td>0.8 (1)</td>
<td>1.4 (1)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Bedroom number, N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>3.61 (0.96)</td>
<td>3.39 (0.93)</td>
<td>3.98 (0.92)</td>
<td>3.30 (0.95)</td>
</tr>
</tbody>
</table>
Nationality and language spoken at home (Survey Questions 17, 18, 19 and 20)

Only 17.3% (n = 23/133) respondents were born overseas and this did not differ significantly between the groups (Kin carers 13.9%, Foster carers 21.6% and ‘Both’ 20.0%; $\chi^2 = 1.06$, df = 1, p = 0.304). When considering the other members of the family, a similar pattern occurred (Kin carers 8.5%, Foster carers 10.2% and ‘Both’ 20.0%; FET p = 1.000). Only two respondents (1.5%) did not speak English at home, one each from the Kin care and the Foster care groups. Approximately 10% (12/133) of respondents and/or their family spoke a language other than English at home, and this did not differ significantly between the groups (FET p = 0.767).

Part Two: Financial Security

Employment rates of foster and kinship carers (Survey Question 21)

Respondents were asked about the sources of income for the household during the four weeks prior to survey (see Table 19). A significantly greater proportion of the Foster Care group reported having an income from a part-time or casual job ($\chi^2 = 5.12$, df = 1, p = 0.024) or from a spouse or partner’s full-time job ($\chi^2 = 10.09$, df = 1, p = 0.001), and a significantly greater proportion of the Kin Care or ‘Both’ group reported having income from a Centrelink pension or benefit paid to the respondent ($\chi^2 = 6.11$, df = 1, p = 0.013).

Table 19: Sources of household income during the four weeks prior to survey

<table>
<thead>
<tr>
<th>Sources of income</th>
<th>Total 133</th>
<th>Kin 72</th>
<th>Foster 51</th>
<th>Both 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Full-time income from your job</td>
<td>12.8 (17)</td>
<td>11.1 (8)</td>
<td>17.6 (9)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Part-time or casual income from your job*</td>
<td>19.5 (26)</td>
<td>12.5 (9)</td>
<td>29.4 (15)</td>
<td>2 (20.0)</td>
</tr>
<tr>
<td>Full-time income from your spouse/partner’s job **</td>
<td>21.1 (28)</td>
<td>12.5 (9)</td>
<td>35.3 (18)</td>
<td>1 (10.0)</td>
</tr>
<tr>
<td>Part-time or casual income from your spouse/partner’s job</td>
<td>9.8 (13)</td>
<td>6.9 (5)</td>
<td>15.7 (8)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Full-time income from other adult/s in your household</td>
<td>0.8 (1)</td>
<td>0.0 (0)</td>
<td>2.0 (1)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Part-time or casual income from other adult/s in your household</td>
<td>1.5 (2)</td>
<td>0.0 (0)</td>
<td>2.0 (1)</td>
<td>1 (10.0)</td>
</tr>
<tr>
<td>Financial assistance from DoCS for the child/ren</td>
<td>78.9 (105)</td>
<td>79.2 (57)</td>
<td>76.5 (39)</td>
<td>9 (90.0)</td>
</tr>
<tr>
<td>Financial assistance from Centrelink for the child/ren</td>
<td>54.1 (72)</td>
<td>58.3 (42)</td>
<td>45.1 (23)</td>
<td>7 (70.0)</td>
</tr>
</tbody>
</table>
Respondents were asked about household gross weekly income (income prior to taxation) averaged over the previous four weeks (including: wages, salary, pensions, allowances and Family Tax Benefit/Family Allowance; excluding: carer allowances/subsidy payments or other money received from DoCS or Centrelink for the children in their care). There were significant differences in income between Foster Carers and the other groups ($X^2 = 17.45$, $df = 2$, $p < 0.001$; see Table 18).

**Table 18: Average gross household weekly income**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Minimum</td>
<td>Maximum</td>
<td>Mean</td>
</tr>
<tr>
<td>None</td>
<td>114</td>
<td>6.1 (7)</td>
<td>8.8 (5)</td>
<td>2.0 (1)</td>
</tr>
<tr>
<td>$80 to &lt; $500</td>
<td>28.9 (33)</td>
<td>35.1 (20)</td>
<td>18.4 (9)</td>
<td>50.0 (4)</td>
</tr>
<tr>
<td>$500 to &lt; $1,000</td>
<td>32.5 (37)</td>
<td>38.6 (22)</td>
<td>26.5 (13)</td>
<td>25.0 (2)</td>
</tr>
<tr>
<td>$1,000 or more</td>
<td>32.5 (37)</td>
<td>17.5 (10)</td>
<td>53.1 (26)</td>
<td>12.5 (1)</td>
</tr>
</tbody>
</table>

**Part Three: Preparation and training**

*Average number of hours of formal training or other preparation prior to becoming a carer (Survey Question 23)*

The Foster Carers received significantly more hours of formal training or other preparation than the other groups combined (Mann-Whitney $U = -8.01$, $p < 0.001$).
Comparative levels of preparedness in each group (Survey Question 24)

Respondents were asked how well prepared they felt to have their first kin or foster child (see Table 19). The proportion of Kin Carers reporting being prepared or very prepared was higher than Foster carers (with unprepared and very unprepared combined: \( X^2 = 12.06, \text{df} = 3, p = 0.007 \)).

Table 19: Perceived preparedness for caring role: kin and foster carers

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Very prepared</td>
<td>30.8 (37)</td>
<td>40.0 (28)</td>
<td>18.0 (9)</td>
</tr>
<tr>
<td>Prepared</td>
<td>29.2 (35)</td>
<td>22.9 (16)</td>
<td>38.0 (19)</td>
</tr>
<tr>
<td>50/50</td>
<td>28.3 (34)</td>
<td>21.4 (15)</td>
<td>38.0 (19)</td>
</tr>
<tr>
<td>Unprepared</td>
<td>5.8 (7)</td>
<td>8.6 (6)</td>
<td>2.0 (1)</td>
</tr>
<tr>
<td>Very unprepared</td>
<td>5.8 (7)</td>
<td>7.1 (5)</td>
<td>4.0 (2)</td>
</tr>
</tbody>
</table>

N.B. preparedness for the “both” group is presented separately as they answered in regards both Kin and Foster children.

Table 20: Perceived preparedness for caring role: ‘Both’ group

<table>
<thead>
<tr>
<th></th>
<th>Kin children</th>
<th>Foster children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Very prepared</td>
<td>33.3 (2)</td>
<td>40.0 (4)</td>
</tr>
<tr>
<td>Prepared</td>
<td>33.3 (2)</td>
<td>40.0 (4)</td>
</tr>
<tr>
<td>50/50</td>
<td>33.3 (2)</td>
<td>20.0 (2)</td>
</tr>
<tr>
<td>Unprepared</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Very unprepared</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

Factors that prevent training opportunities (Survey Question 26)

Respondents were asked if they had been offered training which they did not want or could not take up (see Table 21). The majority of the Kin carers and ‘Both’ group had not been offered any training (72.0%), a significantly larger proportion than among the Foster carers (\( X^2 = 48.65, \text{df} = 1, p < 0.001 \)). The proportion of Foster carers experiencing childcare difficulties and finding the training was held at an inconvenient time was significantly greater that in the other groups (\( X^2 = 5.41, \text{df} = 1, p = 0.020 \) and \( X^2 = 4.95, \text{df} = 1, p = 0.026 \) respectively).
Table 21: Factors preventing training opportunities

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>133</td>
<td>72</td>
<td>51</td>
<td>10</td>
</tr>
<tr>
<td>No, I have not been offered training*</td>
<td>48.1 (64)</td>
<td>77.8 (56)</td>
<td>9.8 (5)</td>
<td>30.0 (3)</td>
</tr>
</tbody>
</table>

Of those who had been offered training:

- it was not training wanted: n = 69
  - wanted: 34.8 (24)
  - not wanted: 65.2 (45)

- had childcare difficulties**: n = 16
  - 26.1 (18)
  - 73.9 (48)

- it clashed with work: n = 46
  - 26.1 (18)
  - 73.9 (48)

- it was a inconvenient time**: n = 7
  - 44.9 (31)
  - 55.1 (37)

- had transport difficulties: n = 10
  - 14.5 (10)
  - 85.5 (60)

- had other difficulties: n = 9
  - 17.4 (12)
  - 82.6 (57)

* KC/both vs FC p < 0.001; ** KC/both vs FC p < 0.05.

Satisfaction concerning amount, quality and relevance of training (Survey Question 28)

A significantly greater proportion of the Foster Care group were satisfied or very satisfied with the amount of training they received compared with the other groups (linear by linear association $X^2 = 4.71$, df = 1, p = 0.030; see Table 22).

Table 22: Satisfaction concerning amount of training

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>74</td>
<td>17</td>
<td>48</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>24.3 (18)</td>
<td>17.6 (3)</td>
<td>25.0 (12)</td>
<td>33.3 (3)</td>
</tr>
<tr>
<td>Satisfied</td>
<td>33.8 (25)</td>
<td>11.8 (2)</td>
<td>39.6 (19)</td>
<td>44.4 (4)</td>
</tr>
<tr>
<td>50/50</td>
<td>24.3 (18)</td>
<td>23.5 (4)</td>
<td>25.0 (12)</td>
<td>22.2 (2)</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>6.8 (5)</td>
<td>5.9 (1)</td>
<td>8.3 (4)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>10.8 (8)</td>
<td>41.2 (7)</td>
<td>2.1 (1)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

A significantly greater proportion of the Foster Care group were satisfied or very satisfied with the quality of training they received compared with the other groups (linear by linear association $X^2 = 4.24$, df = 1, p = 0.040; see Table 23).
Table 23: Satisfaction concerning *quality* of training

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>% (n)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very satisfied</td>
<td>29.0</td>
<td>26.7</td>
<td>28.3</td>
<td>37.5</td>
</tr>
<tr>
<td>Satisfied</td>
<td>43.5</td>
<td>13.3</td>
<td>52.2</td>
<td>50.0</td>
</tr>
<tr>
<td>50/50</td>
<td>13.0</td>
<td>20.0</td>
<td>10.9</td>
<td>12.5</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>7.2</td>
<td>6.7</td>
<td>8.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>7.2</td>
<td>33.3</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

A significantly greater proportion of the Foster Care group were satisfied or very satisfied with the *relevance* of training they received compared with the other groups (linear by linear association $X^2 = 5.98, df = 1, p = 0.015; see Table 24).

Table 24: Satisfaction concerning *relevance* of training

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>% (n)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very satisfied</td>
<td>27.7</td>
<td>23.1</td>
<td>28.9</td>
<td>28.6</td>
</tr>
<tr>
<td>Satisfied</td>
<td>29.2</td>
<td>7.7</td>
<td>35.6</td>
<td>28.6</td>
</tr>
<tr>
<td>50/50</td>
<td>26.2</td>
<td>15.4</td>
<td>26.7</td>
<td>42.9</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>9.2</td>
<td>15.4</td>
<td>8.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>7.7</td>
<td>38.5</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Part Four: Uptake of Support Services

Who is getting benefits (Survey Question 30)
N.B. even though Q30 stated “for the children currently in your care”, some of the n = 7 not current carers did answer this item.

Rank the kinds of support people want in each group (Survey Question 31)

Table 25: Financial assistance from Centrelink

<table>
<thead>
<tr>
<th>Centrelink</th>
<th>Kin (n = 72)</th>
<th>Foster (n = 51)</th>
<th>Both (n = 10)</th>
<th>Total (n = 133)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Tax Benefit A</td>
<td>54 (75%)</td>
<td>34 (67%)</td>
<td>9 (90%)</td>
<td>97 (73%)</td>
</tr>
<tr>
<td>Family Tax Benefit B</td>
<td>51 (71%)</td>
<td>30 (59%)</td>
<td>8 (80%)</td>
<td>89 (67%)</td>
</tr>
<tr>
<td>Medicare card benefits for the child</td>
<td>39 (54%)</td>
<td>28 (55%)</td>
<td>6 (60%)</td>
<td>73 (55%)</td>
</tr>
<tr>
<td>Health Care card</td>
<td>35 (49%)</td>
<td>27 (53%)</td>
<td>7 (70%)</td>
<td>69 (52%)</td>
</tr>
<tr>
<td>Child Care Benefit</td>
<td>18 (25%)</td>
<td>19 (37%)</td>
<td>6 (60%)</td>
<td>43 (32%)</td>
</tr>
<tr>
<td>Carer Allowance</td>
<td>22 (31%)</td>
<td>16 (31%)</td>
<td>4 (40%)</td>
<td>42 (32%)</td>
</tr>
<tr>
<td>Foster Child Health Care Card</td>
<td>4 (6%)</td>
<td>16 (31%)</td>
<td>6 (60%)</td>
<td>26 (20%)</td>
</tr>
<tr>
<td>Carer Payment</td>
<td>13 (18%)</td>
<td>8 (16%)</td>
<td>3 (30%)</td>
<td>24 (18%)</td>
</tr>
<tr>
<td>Parenting Payment</td>
<td>12 (17%)</td>
<td>5 (10%)</td>
<td>5 (50%)</td>
<td>22 (17%)</td>
</tr>
<tr>
<td>Other Financial Assistance</td>
<td>3 (4%)</td>
<td>4 (8%)</td>
<td>2 (20%)</td>
<td>9 (7%)</td>
</tr>
<tr>
<td>Maternity Immunisation Allowance</td>
<td>3 (4%)</td>
<td>2 (4%)</td>
<td>0 (0%)</td>
<td>5 (4%)</td>
</tr>
<tr>
<td>Double Orphan Pension</td>
<td>3 (4%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>Maternity Payment</td>
<td>1 (1%)</td>
<td>1 (2%)</td>
<td>0 (0%)</td>
<td>2 (2%)</td>
</tr>
</tbody>
</table>
### Table 25: Financial assistance from DoCS

<table>
<thead>
<tr>
<th>Financial Assistance: From Docs for:</th>
<th>Kin (n = 72)</th>
<th>Foster (n = 51)</th>
<th>Both (n = 10)</th>
<th>Total (n = 133)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Care allowance</td>
<td>31 (43%)</td>
<td>26 (51%)</td>
<td>4 (40%)</td>
<td>61 (46%)</td>
</tr>
<tr>
<td>Statutory Care Allowance +1</td>
<td>5 (7%)</td>
<td>9 (18%)</td>
<td>2 (20%)</td>
<td>16 (12%)</td>
</tr>
<tr>
<td>Supported Care Allowance</td>
<td>8 (11%)</td>
<td>4 (8%)</td>
<td>0 (0%)</td>
<td>12 (9%)</td>
</tr>
<tr>
<td>Statutory Care Allowance +2</td>
<td>4 (6%)</td>
<td>7 (14%)</td>
<td>0 (0%)</td>
<td>11 (8%)</td>
</tr>
<tr>
<td>Extra Financial support</td>
<td>3 (4%)</td>
<td>7 (14%)</td>
<td>1 (10%)</td>
<td>11 (8%)</td>
</tr>
<tr>
<td>Supported Care Allowance</td>
<td>3 (4%)</td>
<td>2 (4%)</td>
<td>2 (20%)</td>
<td>7 (5%)</td>
</tr>
<tr>
<td>Supported Care Allowance</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Pre Adoption Allowance</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

### Table 25: Other supports

<table>
<thead>
<tr>
<th>Other supports from DOCS</th>
<th>Kin (n = 72)</th>
<th>Foster (n = 51)</th>
<th>Both (n = 10)</th>
<th>Total (n = 133)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caseworker support from DoCS</td>
<td>29 (40%)</td>
<td>35 (69%)</td>
<td>7 (70%)</td>
<td>71 (53%)</td>
</tr>
<tr>
<td>Support from your family</td>
<td>31 (43%)</td>
<td>26 (51%)</td>
<td>3 (30%)</td>
<td>60 (45%)</td>
</tr>
<tr>
<td>Support from your friends</td>
<td>24 (33%)</td>
<td>28 (55%)</td>
<td>4 (40%)</td>
<td>56 (42%)</td>
</tr>
<tr>
<td>Information on dealing with behavioural problems</td>
<td>19 (26%)</td>
<td>16 (31%)</td>
<td>5 (50%)</td>
<td>40 (30%)</td>
</tr>
<tr>
<td>Support groups (eg foster care or grandparent support group)</td>
<td>12 (17%)</td>
<td>17 (33%)</td>
<td>4 (40%)</td>
<td>33 (25%)</td>
</tr>
<tr>
<td>Child care</td>
<td>11 (15%)</td>
<td>14 (27%)</td>
<td>2 (20%)</td>
<td>27 (20%)</td>
</tr>
<tr>
<td>Respite care</td>
<td>7 (10%)</td>
<td>11 (22%)</td>
<td>4 (40%)</td>
<td>22 (17%)</td>
</tr>
<tr>
<td>Assistance in dealing with the child’s/children’s parents</td>
<td>11 (15%)</td>
<td>8 (16%)</td>
<td>3 (30%)</td>
<td>22 (17%)</td>
</tr>
<tr>
<td>Caseworker support from another organisation</td>
<td>3 (4%)</td>
<td>2 (4%)</td>
<td>3 (30%)</td>
<td>8 (6%)</td>
</tr>
<tr>
<td>Information on parenting</td>
<td>5 (7%)</td>
<td>3 (6%)</td>
<td>0 (0%)</td>
<td>8 (6%)</td>
</tr>
<tr>
<td>Legal assistance</td>
<td>3 (4%)</td>
<td>1 (2%)</td>
<td>3 (30%)</td>
<td>7 (5%)</td>
</tr>
<tr>
<td>Caseworker support from Centrelink</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
<td>2 (20%)</td>
<td>3 (2%)</td>
</tr>
</tbody>
</table>
Rank the kinds of financial assistance people want in each group (Q31).

**Table 26: DoCS ranking**

<table>
<thead>
<tr>
<th>From DoCS:</th>
<th>Kin (n = 72)</th>
<th>Foster (n = 51)</th>
<th>Both (n = 10)</th>
<th>Total (n = 133)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra Financial support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(one-off contingencies)</td>
<td>17 (24%)</td>
<td>12 (24%)</td>
<td>2 (20%)</td>
<td>31 (23%)</td>
</tr>
<tr>
<td>Statutory Care Allowance +1</td>
<td>9 (13%)</td>
<td>5 (10%)</td>
<td>1 (10%)</td>
<td>15 (11%)</td>
</tr>
<tr>
<td>Statutory Care Allowance +2</td>
<td>4 (6%)</td>
<td>1 (2%)</td>
<td>1 (10%)</td>
<td>6 (5%)</td>
</tr>
<tr>
<td>Supported Care Allowance</td>
<td>3 (4%)</td>
<td>3 (6%)</td>
<td>0 (0%)</td>
<td>6 (5%)</td>
</tr>
<tr>
<td>Supported Care Allowance +1</td>
<td>2 (3%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Supported Care Allowance +2</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
<td>1 (10%)</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Pre Adoption Allowance</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
<td>0 (0%)</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

**Table 27: Centrelink ranking**

<table>
<thead>
<tr>
<th>From Centrelink:</th>
<th>Kin (n = 72)</th>
<th>Foster (n = 51)</th>
<th>Both (n = 10)</th>
<th>Total (n = 133)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Tax Benefit A</td>
<td>11 (15%)</td>
<td>6 (12%)</td>
<td>1 (10%)</td>
<td>18 (14%)</td>
</tr>
<tr>
<td>Family Tax Benefit B</td>
<td>11 (15%)</td>
<td>5 (10%)</td>
<td>1 (10%)</td>
<td>17 (13%)</td>
</tr>
<tr>
<td>Medicare card benefits for child</td>
<td>7 (10%)</td>
<td>7 (14%)</td>
<td>1 (10%)</td>
<td>15 (11%)</td>
</tr>
<tr>
<td>Foster Child Health Care Card</td>
<td>2 (3%)</td>
<td>11 (22%)</td>
<td>1 (10%)</td>
<td>14 (11%)</td>
</tr>
<tr>
<td>Health Care Card</td>
<td>6 (8%)</td>
<td>5 (10%)</td>
<td>1 (10%)</td>
<td>12 (9%)</td>
</tr>
<tr>
<td>Carer Allowance</td>
<td>8 (11%)</td>
<td>3 (6%)</td>
<td>0 (0%)</td>
<td>11 (8%)</td>
</tr>
<tr>
<td>Parenting Payment</td>
<td>10 (14%)</td>
<td>1 (2%)</td>
<td>0 (0%)</td>
<td>11 (8%)</td>
</tr>
<tr>
<td>Child Care Benefit</td>
<td>5 (7%)</td>
<td>3 (6%)</td>
<td>2 (20%)</td>
<td>10 (8%)</td>
</tr>
<tr>
<td>Maternity Immunisation Allowance</td>
<td>2 (3%)</td>
<td>2 (4%)</td>
<td>0 (0%)</td>
<td>4 (3%)</td>
</tr>
<tr>
<td>Maternity Payment</td>
<td>2 (3%)</td>
<td>1 (2%)</td>
<td>0 (0%)</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>Carer Payment</td>
<td>3 (4%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>Double Orphan Pension</td>
<td>2 (3%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>2 (2%)</td>
</tr>
</tbody>
</table>
Rank the kinds of support people want in each group (Q31).

**Table 27: Ranking of other supports**

<table>
<thead>
<tr>
<th>Other support:</th>
<th>Kin (n = 72)</th>
<th>Foster (n = 51)</th>
<th>Both (n = 10)</th>
<th>Total (n = 133)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caseworker support from DoCS</td>
<td>20 (28%)</td>
<td>20 (39%)</td>
<td>1 (10%)</td>
<td>41 (31%)</td>
</tr>
<tr>
<td>Information on dealing with behavioural problems</td>
<td>23 (32%)</td>
<td>14 (27%)</td>
<td>4 (40%)</td>
<td>41 (31%)</td>
</tr>
<tr>
<td>Respite care</td>
<td>13 (18%)</td>
<td>10 (20%)</td>
<td>1 (10%)</td>
<td>24 (18%)</td>
</tr>
<tr>
<td>Support groups(eg foster care or grandparent support group)</td>
<td>15 (21%)</td>
<td>7 (14%)</td>
<td>2 (20%)</td>
<td>24 (18%)</td>
</tr>
<tr>
<td>Support from your family</td>
<td>11 (15%)</td>
<td>7 (14%)</td>
<td>1 (10%)</td>
<td>19 (14%)</td>
</tr>
<tr>
<td>Assistance in dealing with the child's/children’s parents</td>
<td>6 (8%)</td>
<td>9 (18%)</td>
<td>2 (20%)</td>
<td>17 (13%)</td>
</tr>
<tr>
<td>Legal assistance</td>
<td>14 (19%)</td>
<td>2 (4%)</td>
<td>0 (0%)</td>
<td>16 (12%)</td>
</tr>
<tr>
<td>Support from your friends</td>
<td>6 (8%)</td>
<td>7 (14%)</td>
<td>2 (20%)</td>
<td>15 (11%)</td>
</tr>
<tr>
<td>Information on parenting</td>
<td>5 (7%)</td>
<td>4 (8%)</td>
<td>1 (10%)</td>
<td>10 (8%)</td>
</tr>
<tr>
<td>Child care</td>
<td>2 (3%)</td>
<td>6 (12%)</td>
<td>1 (10%)</td>
<td>9 (7%)</td>
</tr>
<tr>
<td>Caseworker support from Centrelink</td>
<td>7 (10%)</td>
<td>1 (2%)</td>
<td>0 (0%)</td>
<td>8 (6%)</td>
</tr>
<tr>
<td>Caseworker support from another organisation</td>
<td>3 (4%)</td>
<td>3 (6%)</td>
<td>1 (10%)</td>
<td>7 (5%)</td>
</tr>
</tbody>
</table>
Part Five: Supervision

Views on who should receive supervision (Survey Question 34)

Respondents were asked to indicate whether they felt it was important for different carers to receive supervision (see Table 25). There were no statistically significant differences between the Foster care and the other groups in the proportion believing certain carers should receive supervision.

Table 25: Views regarding which type of carers should receive supervision

<table>
<thead>
<tr>
<th></th>
<th>Total 133</th>
<th>Kin 72</th>
<th>Foster 51</th>
<th>Both 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Foster carers</td>
<td>52.6 (70)</td>
<td>47.2 (34)</td>
<td>56.9 (29)</td>
<td>70.0 (7)</td>
</tr>
<tr>
<td>Kinship/relative carers receiving government financial support</td>
<td>41.4 (55)</td>
<td>34.7 (25)</td>
<td>43.1 (22)</td>
<td>80.0 (8)</td>
</tr>
<tr>
<td>Kinship/relative carers not receiving government financial support</td>
<td>28.6 (38)</td>
<td>23.6 (17)</td>
<td>27.5 (14)</td>
<td>70.0 (7)</td>
</tr>
<tr>
<td>Kinship carers with legal custody of the child</td>
<td>29.3 (39)</td>
<td>25.0 (18)</td>
<td>27.5 (14)</td>
<td>70.0 (7)</td>
</tr>
<tr>
<td>All kinship carers</td>
<td>33.1 (44)</td>
<td>30.6 (22)</td>
<td>29.4 (15)</td>
<td>70.0 (7)</td>
</tr>
<tr>
<td>No kinship carers</td>
<td>6.0 (8)</td>
<td>4.2 (3)</td>
<td>7.8 (4)</td>
<td>10.0 (1)</td>
</tr>
<tr>
<td>Other</td>
<td>8.3 (11)</td>
<td>9.7 (7)</td>
<td>7.8 (4)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

Carers experience of receiving supervision (Survey Question 35)

Approximately half of the sample (50.4%) reported never receiving supervision (see Table 26). The Foster Care group were significantly less likely to report never receiving supervision than the other combined groups ($X^2 = 5.70$, df = 1, $p = 0.017$).

Table 26: Experience of receiving supervision

<table>
<thead>
<tr>
<th></th>
<th>Total 133</th>
<th>Kin 72</th>
<th>Foster 51</th>
<th>Both 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>I am currently receiving supervision for a foster child</td>
<td>14.3 (19)</td>
<td>0.0 (0)</td>
<td>31.4 (16)</td>
<td>30.0 (3)</td>
</tr>
<tr>
<td>I am currently receiving supervision for a relative/kin child</td>
<td>7.5 (10)</td>
<td>9.7 (7)</td>
<td>0.0 (0)</td>
<td>30.0 (3)</td>
</tr>
</tbody>
</table>
I have received supervision for a foster child who was previously in my care

<table>
<thead>
<tr>
<th>Experience</th>
<th>Total 49</th>
<th>Kin 20</th>
<th>Foster 23</th>
<th>Both 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely positive</td>
<td>14.3 (7)</td>
<td>20.0 (4)</td>
<td>8.7 (2)</td>
<td>16.7 (1)</td>
</tr>
<tr>
<td>Positive</td>
<td>36.7 (18)</td>
<td>35.0 (7)</td>
<td>39.1 (9)</td>
<td>33.3 (2)</td>
</tr>
<tr>
<td>Neutral</td>
<td>24.5 (12)</td>
<td>15.0 (3)</td>
<td>30.4 (7)</td>
<td>33.3 (2)</td>
</tr>
<tr>
<td>Negative</td>
<td>8.2 (4)</td>
<td>5.0 (1)</td>
<td>13.0 (3)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Extremely negative</td>
<td>6.1 (3)</td>
<td>10.0 (2)</td>
<td>4.3 (1)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Not sure</td>
<td>10.2 (5)</td>
<td>15.0 (3)</td>
<td>4.3 (1)</td>
<td>16.7 (1)</td>
</tr>
</tbody>
</table>

Satisfaction concerning supervision received (Survey Question 36)

Respondents were asked, if they had received supervision, how they found the experience. Approximately half of those who had received supervision rated it as positive or extremely positive (51.0%), and the ratings did not differ significantly between the Foster care group and the other groups.

Table 27: Satisfaction with supervision

Part Six: Health and Wellbeing

Improvements and deterioration in wellbeing (Survey Question 38)

Respondents were asked about whether their health and general wellbeing had improved, deteriorated or stayed the same since becoming a carer. The only statistically significant difference between the care groups was in terms of self-rated health, with about a quarter of the Kin/Both carers reporting an improvement (24.4%), compared with only 6.1% of the Foster Care group (linear by linear association $X^2 = 5.70$, df = 1, $p = 0.017$; see Table 28).
### Table 28: Changes in health since becoming a carer

<table>
<thead>
<tr>
<th>Your health</th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>% (n)</td>
<td>%</td>
</tr>
<tr>
<td>Greatly improved</td>
<td>123</td>
<td>7.3</td>
<td>13.8 (9)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>123</td>
<td>9.8</td>
<td>9.2 (6)</td>
<td>6.1 (3)</td>
</tr>
<tr>
<td>Stayed about the same</td>
<td>123</td>
<td>53.7</td>
<td>49.2 (32)</td>
<td>61.2 (30)</td>
</tr>
<tr>
<td>Somewhat deteriorated</td>
<td>123</td>
<td>25.2</td>
<td>24.6 (16)</td>
<td>26.5 (13)</td>
</tr>
<tr>
<td>Greatly deteriorated</td>
<td>123</td>
<td>4.1</td>
<td>3.1 (2)</td>
<td>6.1 (3)</td>
</tr>
</tbody>
</table>

### Table 29: Changes in financial situation since becoming a carer

<table>
<thead>
<tr>
<th>Your financial situation</th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>% (n)</td>
<td>%</td>
</tr>
<tr>
<td>Greatly improved</td>
<td>127</td>
<td>4.7</td>
<td>7.2 (5)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>127</td>
<td>11.8</td>
<td>11.6 (8)</td>
<td>8.0 (4)</td>
</tr>
<tr>
<td>Stayed about the same</td>
<td>127</td>
<td>47.2</td>
<td>36.2 (25)</td>
<td>62.0 (31)</td>
</tr>
<tr>
<td>Somewhat deteriorated</td>
<td>127</td>
<td>23.6</td>
<td>29.0 (20)</td>
<td>20.0 (10)</td>
</tr>
<tr>
<td>Greatly deteriorated</td>
<td>127</td>
<td>12.6</td>
<td>15.9 (11)</td>
<td>10.0 (5)</td>
</tr>
</tbody>
</table>

### Table 30: Changes in contact with friends since becoming a carer

<table>
<thead>
<tr>
<th>Contact with friends</th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>% (n)</td>
<td>%</td>
</tr>
<tr>
<td>Greatly improved</td>
<td>126</td>
<td>3.2</td>
<td>6.0 (4)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>126</td>
<td>5.6</td>
<td>6.0 (4)</td>
<td>4.0 (2)</td>
</tr>
<tr>
<td>Stayed about the same</td>
<td>126</td>
<td>41.3</td>
<td>43.3 (29)</td>
<td>38.0 (19)</td>
</tr>
<tr>
<td>Somewhat deteriorated</td>
<td>126</td>
<td>38.9</td>
<td>34.3 (23)</td>
<td>44.0 (22)</td>
</tr>
<tr>
<td>Greatly deteriorated</td>
<td>126</td>
<td>11.1</td>
<td>10.4 (7)</td>
<td>14.0 (7)</td>
</tr>
<tr>
<td>Contact with family</td>
<td>Total</td>
<td>Kin</td>
<td>Foster</td>
<td>Both</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------</td>
<td>-----</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>N</td>
<td>128</td>
<td>69</td>
<td>50</td>
<td>9</td>
</tr>
<tr>
<td>Greatly improved</td>
<td>3.9 (5)</td>
<td>7.2 (5)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>9.4 (12)</td>
<td>11.6 (8)</td>
<td>6.0 (3)</td>
<td>11.1 (1)</td>
</tr>
<tr>
<td>Stayed about the same</td>
<td>62.5 (80)</td>
<td>58.0 (40)</td>
<td>68.0 (34)</td>
<td>66.7 (6)</td>
</tr>
<tr>
<td>Somewhat deteriorated</td>
<td>17.2 (22)</td>
<td>13.0 (9)</td>
<td>22.0 (11)</td>
<td>22.2 (2)</td>
</tr>
<tr>
<td>Greatly deteriorated</td>
<td>7.0 (9)</td>
<td>10.1 (7)</td>
<td>4.0 (2)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feelings of self confidence</th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>129</td>
<td>70</td>
<td>50</td>
<td>9</td>
</tr>
<tr>
<td>Greatly improved</td>
<td>10.1 (13)</td>
<td>11.4 (8)</td>
<td>8.0 (4)</td>
<td>11.1 (1)</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>17.8 (23)</td>
<td>14.3 (10)</td>
<td>20.0 (10)</td>
<td>33.3 (3)</td>
</tr>
<tr>
<td>Stayed about the same</td>
<td>55.0 (71)</td>
<td>52.9 (37)</td>
<td>60.0 (30)</td>
<td>44.4 (4)</td>
</tr>
<tr>
<td>Somewhat deteriorated</td>
<td>12.4 (16)</td>
<td>15.7 (11)</td>
<td>8.0 (4)</td>
<td>11.1 (1)</td>
</tr>
<tr>
<td>Greatly deteriorated</td>
<td>4.7 (6)</td>
<td>5.7 (4)</td>
<td>4.0 (2)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time for own interests</th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>127</td>
<td>68</td>
<td>50</td>
<td>9</td>
</tr>
<tr>
<td>Greatly improved</td>
<td>1.6 (2)</td>
<td>2.9 (2)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>3.9 (5)</td>
<td>4.4 (3)</td>
<td>2.0 (1)</td>
<td>11.1 (1)</td>
</tr>
<tr>
<td>Stayed about the same</td>
<td>28.3 (36)</td>
<td>32.4 (22)</td>
<td>22.0 (11)</td>
<td>33.3 (3)</td>
</tr>
<tr>
<td>Somewhat deteriorated</td>
<td>40.2 (51)</td>
<td>35.3 (24)</td>
<td>46.0 (23)</td>
<td>44.4 (4)</td>
</tr>
<tr>
<td>Greatly deteriorated</td>
<td>26.0 (33)</td>
<td>25.0 (17)</td>
<td>30.0 (15)</td>
<td>11.1 (1)</td>
</tr>
</tbody>
</table>
Table 34: Changes in stress levels since becoming a carer

<table>
<thead>
<tr>
<th>Stress levels</th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>128</td>
<td>70</td>
<td>49</td>
<td>9</td>
</tr>
<tr>
<td>N</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Greatly improved</td>
<td>2.3 (3)</td>
<td>4.3 (3)</td>
<td>0.0 (0)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>2.3 (3)</td>
<td>2.9 (2)</td>
<td>0.0 (0)</td>
<td>11.1 (1)</td>
</tr>
<tr>
<td>Stayed about the same</td>
<td>40.6 (52)</td>
<td>37.1 (26)</td>
<td>49.0 (24)</td>
<td>22.2 (2)</td>
</tr>
<tr>
<td>Somewhat deteriorated</td>
<td>35.9 (46)</td>
<td>34.3 (24)</td>
<td>32.7 (16)</td>
<td>66.7 (6)</td>
</tr>
<tr>
<td>Greatly deteriorated</td>
<td>18.8 (24)</td>
<td>21.4 (15)</td>
<td>18.4 (9)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

Table 35: Changes in wellbeing since becoming a carer

<table>
<thead>
<tr>
<th>Wellbeing</th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>127</td>
<td>68</td>
<td>50</td>
<td>9</td>
</tr>
<tr>
<td>N</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Greatly improved</td>
<td>3.1 (4)</td>
<td>4.4 (3)</td>
<td>0.0 (0)</td>
<td>11.1 (1)</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>9.4 (12)</td>
<td>5.9 (4)</td>
<td>14.0 (7)</td>
<td>11.1 (1)</td>
</tr>
<tr>
<td>Stayed about the same</td>
<td>56.7 (72)</td>
<td>54.4 (37)</td>
<td>62.0 (31)</td>
<td>44.4 (4)</td>
</tr>
<tr>
<td>Somewhat deteriorated</td>
<td>22.8 (29)</td>
<td>25.0 (17)</td>
<td>20.0 (10)</td>
<td>22.2 (2)</td>
</tr>
<tr>
<td>Greatly deteriorated</td>
<td>7.9 (10)</td>
<td>10.3 (7)</td>
<td>4.0 (2)</td>
<td>11.1 (1)</td>
</tr>
</tbody>
</table>

Self-rated current health status (Survey Question 43)

Approximately two-thirds of the sample rated their current health as good or very good (65.6%). However, health status differed significantly between the Foster Care group and the other groups (linear by linear association $\chi^2 = 6.34$, df = 1, $p = 0.012$), fewer of the Foster Care group reporting poor or very poor health.

Table 36: Self-rated current health status

<table>
<thead>
<tr>
<th>N</th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>131</td>
<td>71</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Very good</td>
<td>16.8 (22)</td>
<td>11.3 (8)</td>
<td>26.0 (13)</td>
<td>10.0 (1)</td>
</tr>
<tr>
<td>Good</td>
<td>48.9 (64)</td>
<td>46.5 (33)</td>
<td>52.0 (26)</td>
<td>50.0 (5)</td>
</tr>
<tr>
<td>Reasonable</td>
<td>27.5 (36)</td>
<td>33.8 (24)</td>
<td>18.0 (9)</td>
<td>30.0 (3)</td>
</tr>
<tr>
<td>Poor</td>
<td>5.3 (7)</td>
<td>7.0 (5)</td>
<td>2.0 (1)</td>
<td>10.0 (1)</td>
</tr>
<tr>
<td>Very poor</td>
<td>1.5 (2)</td>
<td>1.4 (1)</td>
<td>2.0 (1)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>
Changes in self-image (Survey Question 46)

Respondents were asked about how they saw themselves and their role in life since becoming a foster or kinship carer (see Table 37). There was no significant difference in self-perception between the Foster Care group and the other groups.

Table 37: Changes in how the carer sees themselves and their role in life

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Very differently</td>
<td>26.0 (34)</td>
<td>22.2 (16)</td>
<td>30.6 (15)</td>
<td>30.0 (3)</td>
</tr>
<tr>
<td>Differently</td>
<td>26.7 (35)</td>
<td>33.3 (24)</td>
<td>22.4 (11)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>A little differently</td>
<td>23.7 (31)</td>
<td>22.2 (16)</td>
<td>22.4 (11)</td>
<td>40.0 (4)</td>
</tr>
<tr>
<td>The same</td>
<td>23.7 (31)</td>
<td>22.2 (16)</td>
<td>24.5 (12)</td>
<td>30.0 (3)</td>
</tr>
</tbody>
</table>

Significance of change in role in life (Survey Question 47)

Respondents were asked if their role in life had significantly or fundamentally changed, or had it stayed the same since becoming a foster or kinship carer (see Table 38). There was no significant difference in self-perception of change of role in life between the Foster Care group and the other groups.

Table 38: Changes in how the carer sees themselves and their role in life

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Kin</th>
<th>Foster</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Very significant changes</td>
<td>16.3 (20)</td>
<td>22.1 (15)</td>
<td>10.9 (5)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Significant change</td>
<td>38.2 (47)</td>
<td>36.8 (25)</td>
<td>39.1 (18)</td>
<td>44.4 (4)</td>
</tr>
<tr>
<td>Slight change</td>
<td>26.8 (33)</td>
<td>25.0 (17)</td>
<td>28.3 (13)</td>
<td>33.3 (3)</td>
</tr>
<tr>
<td>No change</td>
<td>18.7 (23)</td>
<td>16.2 (11)</td>
<td>21.7 (10)</td>
<td>22.2 (2)</td>
</tr>
</tbody>
</table>
Appendix Two
Kinship Care Survey - Open Questions

Q.27: What topics have been covered in any training you have already received, and what training would you like to receive now or in the future?

Differences between kin and foster carers.

Some significant differences between foster and kinship carers to be noted. No foster carers indicated that they have not been offered or, indeed, that they have not received any training. On the other hand, a number of kinship carers noted that they had not been offered or received any training.

What training for kinship carers? I wasn’t made aware by DoCS or anyone else that it existed. (KC)

One noted that it was now really too late and that the needed training should have been there in the early years of taking on the care of her grandson. Some kinship carers did not see training as necessary; raising one’s own children successfully was training enough for the present task of caring for grandchildren.

Quality of the training provided.

There were no negative comments about the training on offer and some carers had attended numerous courses over the years. (However, note some minor criticisms made in answer to other questions and some suggested improvements in how training might be offered.)

DoCS have regular training meetings which I attend throughout the year. (FC)

Topics and subject matter.

Given some prominence by both kin and foster carers were topics such as challenging behaviours, anger management on the part of children, the behaviour of children who have been sexually abused, recognising and reporting abuse, caring for children who display sexualised behaviour.

Mental health issues, autism, and dealing with complex family relationships (in particular with birth parents and explaining these relationships to the children in their care) also featured on both lists, as did the area of legal issues.

Stress management is an issue for kin carers.

Suggested topics included workshops on how the DoCS system works, the various policies of particular relevance to kin and foster carers, help with making use of computerised systems and accessing the website, information on how to become a foster carer (from kin carers).
One difficulty with the wording of Q.28 was that it was doubled barrelled and some kin carers did not make clear whether they were listing what training had already been accessed or whether the topics they listed were what they saw themselves needing but had not received.

Q.29: Please add any other comments you have about training.

Some criticisms and suggestions for improvements:
One kin carer relates how she had turned up for a workshop only to told that she didn’t need to do this as she was ONLY a kin carer.

From one respondent (FC) the comment that courses are too short and there is too much time taken up with answering individual questions.

Suggestion that handouts be sent out before the training session enabling there to be time to read and reflect before training session:
Handouts should be sent to all foster carers not just those attending the training session. Carers should be able to get the information in DVD form - on all subjects. This could be kept by the carer for future reference. (FC)

Some night courses for working parents (FC).

Interesting comment from FC who had experience of NZ foster care training:
Comments that the NZ training looked at ‘worse case scenarios’ whereas the Australian was more ‘hearts and flowers’ and about ‘how rewarding’ fostering is. NZ training was judged more useful.

A kin carer reflected on they lack of preparedness for all the red tape involved, the DoCS legal requirements, the Centrelink requirements, the medical issues. Another simply noted that there is ‘always so much to learn’. A third wrote of the need to learn more about dealing with the ‘the unusual circumstance of a grandchild not living with its parents’ and all the implications of that.

The need for computer access and the fact that not all carers will have a computer is also noted and the suggestion made that this might be seen as the responsibility of government (KC).

One respondent suggests that there be ‘some joint training for DoCS workers and carers to strengthen the working relationship between them’ (KC)
Q.32: Please add anything else you would like to tell us about additional support you would like to receive. (If there is not enough room, please add a page or write on the back of the questionnaire.)

Lack of information about the children coming into foster care and the difficulty of obtaining such information:

Too late now but if DoCS workers had scrutinised foster son’s files, it would have been informative to me. It has taken me five years to see that the abuse he went through has “stunted” him. Now DoCS don’t want to know.

Be given more information about child coming into your care. This would help dealing with some issues, you would have with child.

Lack of support such as counselling for the children who need it:

(Make it) EASIER to get counselling for foster children. Caseworkers want to wait till the child moves on to full time care or returns to family before they will do this – meanwhile the child has been in your care for up to twelve months with NO HELP. I had a male eight year old who had been sexually penetrated on five proven occasions and although DoCS knew about this when he came here he was not given counselling although I repeatedly asked for it. He was here for twelve months and had behaviour problems both at home and school. Counselling was arranged for him when he went to live with his father.

(Would seem that there might also be an additional issue here, one of not taking the requests of carers seriously, as though they are not in a position to make such judgements about the children in their care.)

Turnover rate of caseworkers and simply not being able to get hold of them when you need them:

My main concern is the turnover rate of case workers – and the absence of them in their constant training time.

Need for respite on the part of kin carers:

I would like to see trained carers available to come to my own home and provide respite for the carer/s to have a weekend away say 4 times a year.

I would have liked respite time away from Peter when he was younger. At nearly 15, he is happy with his friends, sports and hobbies, and it is not an issue now.

Maybe some respite for a few hours on the weekends.
The lack of financial assistance to kin carers:
As I am retiring soon extra finance would be a great help.

Need for additional financial support for foster carers:
Families are under greater financial difficulties at Christmas time so a bonus per child at this time would make it a more stress free holiday time.
I have built a playroom and bedroom for children in my care. Some financial assistance for committed caregivers would be huge.
We received no financial assistance for over a decade. When the children turn 18 we would like to receive reimbursement for our lost finances.

The need for emotional support and someone to talk to on the part of kin carers:
I would have liked (and still do feel the need for) help in procedures to put in place, when the need arises, also, emotional support by phone or email as time is most precious, it’s not easy to seek that type of support at say 10pm when children are in bed and you get to stop and think about the day.

Q.33: In an ideal world, what kinds of support do you think should be available?
Some kin carers are happy with support received:
I am happy with what I receive.
Our previous caseworker, …, was a loving, careful, observant support. We need consistency; we may be a huge family but we are settled and together.
DoCS have supported us in every way when needed and we don’t need any special services.

Support and advice when it is needed regardless of the hour:
24 hours, 7 days a week support and a person other than a hot line. (FC)

Counselling support provided as quickly as possible:
Counselling arranged quickly if needed to discuss what is needed for the kids and to fill the carer in about the kid’s past. Foster carer told about DoCS future plans for the kids. (FC)

Detailed information about the children coming into care:
Support in the form of information about children’s history to help deal with problems. Pre-school, specialists etc yet all this information while the caregivers are told nothing. (FC)
**Individual caseworker for each child:**

Caseworker for each child, a person employed to make sure that the carers get help and support - liaison between DoCS and carers. (KC)

**Playgroups for children being cared for by grandparents:**

For young children, grandparents, playgroups – No other children around grandparents for the child to play and associate with but a grandparent doesn’t want to be with groups of 20 yrs old that there is little in common with. Also would allow grandparents themselves to talk to each other.

**Need for more financial support:**

More support for education e.g. fees, uniforms, school excursions, sport gear. (KC)

A family holiday once every few years would be fine. (FC)

**Financial support inequities:**

Even though I have an exemption from work as a foster carer I do not qualify for any Centrelink allowances for myself as I do not pass the assets test. Even though my husband does as he gets a partial disability pension on the same assets. (KC)

**Respite for kin carers:**

DoCS should not see providing respite care as something extra added to their workloads. Respite care should be offered, rather than carers having to approach the Department because they are doing so as a last measure to keep the placement or because they are burnt out. (KC)

**Support for older siblings:**

Support for older siblings. Financial. They are not able to live with their parents or us but I feel they are older 18 and 19 the struggle. (FC)

Q.37 Please add any comments you would like to make about supervision.

**Suspicion of the concept:**

I don’t think I would like someone with me 24 hours a day. (FC)

It’s a bad word to use. (FC)

Supervision indicates a negative connotation to me. DoCS has support workers for Fosters Carers. (KC)
**Lack of clarity – meaning?**

If you mean does the caseworker comes to my home regularly and talks to me and the children to see if everything is ok, then NO. I see the caseworker when she drops the kids off from school or parental visits but this is NOT good as they are usually in a hurry. I can’t talk about what I want to as the kids are listening or it is at an inconvenient time for me due to visitors, cooking etc.

**Playgroups for children being cared for by grandparents:**

For young children, grandparents, playgroups – No other children around grandparents for the child to play and associate with but a grandparent doesn’t want to be with groups of 20 yrs old that there is little in common with. Also would allow grandparents themselves to talk to each other.

**Need for more financial support:**

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**Bad or poor experiences:**

I have had supervision on access visits but found the worker to make the situation very stiff and uncomfortable. This was when only sibling were at the access. (FC)

I should have been assigned another caseworker straight away and at least fortnightly visitor phone call even if all seems well.(KC)

**Sense of insult associated with the concept of supervision:**

Court order required six, twelve and twenty four month checks on child’s progress. That was a visit by DoCS and then a phone call. I assume if there was cause for concern more would be done. I personally would be insulted if DoCS wanted to supervise me in any more extensive way. (KC)
Support for the idea of supervision:
All placements should be supervised until proven satisfactory. (KC)

I feel it is important to make sure the children are comfortable within their relationships with their carers and other members of the family. (FC)

Sometimes it feels intrusive however there is a need to make sure that children are being cared for properly. Unfortunately it often seems inconsistent and people doing the right thing are treated badly while others providing inadequate care are not picked up on it. (FC)

Positive or neutral experiences:
We are not watched specifically but our children meet weekly under supervision – we keep an eye out for one another and provide respite when needed.
Sorry – that’s not about supervision. (KC)

What is needed if its to happen effectively:
It is very helpful if the person supervising has had experience themselves as a carers, otherwise it is very difficult for them to really understand the issues and problems. If Docs could employ ex-carers to supervise and support them. (KC)

Q.39: For you, what have been the main benefits of being a foster carer or kinship carer?
Both foster and kin carers express the same sense of doing something worthwhile and something that is helping the children experience a safe, stable and loving family environment

The joy of children and of family life

The fact that having the children cared for by family means that the birth mother can see them much more regularly and develop and maintain a loving relationship with her children.

A sense of purpose in life
Q.40: For you, what are the main problems, of being a foster carer or kinship carer?

Similarities between kin and foster carers:

1. Some kin and foster carers said they had no problems.

2. Both kin and foster carers reported the restrictions caring imposes - lack of free time, of time to self, time for personal interests, being tied down to doing things in school hours etc

3. Impact on the couple’s relationship, lack of time together just on their own.

4. The stressfulness of dealing with serious emotional problems of some children and with teenagers and the different kinds of problems that teenagers now face

5. Difficulties of dealing with DoCS. – Lack of support uninterested workers who take a dislike to you because you persist, not returning calls when you’re in a crisis.

6. Financial difficulties. While these are there for both groups they are particularly acute for kin carers. Some kin carers have had to drop out of paid work to take on the care – lack of choice.

Differences:

1. The particular difficulties created for foster carers in not being given adequate information about the child being placed in their care. General lack of information as well.

2. For kin carers, the particular and distressing difficulties of dealing with the birth parents and the wider family.

Q.41: Has becoming a foster or kinship carer affected or changed your relationships? Please describe.

No real change in relationships:

MY relationship with my husband and children is still the same. (FC)

Not with my family. Actually there is nothing to compare as we have been fostering since our teenagers were little kids. (FC)

No – although you do have added pressure when the child is disobedient etc. (KC)

Numbers of both kin and foster carers simply wrote an emphatic ‘No’.
Good/improved relationships:

It has improved some relationships with my family members in that we all come together once a week and see much more of each other. (KC)

Improved relationships. (KC)

Better. (KC)

I live alone. Children’s company is good. (KC)

My biological children adore their special sibling – the feeling is mutual. (F&K)

We all work together as a family better. Some people/friendship we don’t have as much time for. Less judgemental with other people. (FC)

The difficulty of finding/having a partner when you are a single person caring for a group of children:

No one seems to want a ready made family. Have no spare time for a relationship. (Single male foster carer)

Yes I would not have a relationship while I have the children because the children would miss out on my time. (FC)

NB the comment below from a woman (KC) about how she was dating someone but is now caught up with the 24 care of young children.

Having grandchildren can create difficulties in relationship with the birth parent(s):

Yes to some degree. Mother of child is resentful and voiced claim she was raped by her father. But mother refuses to tell police this, so we can settle the matter one way or another. I have signed an undertaking not to leave child alone with her grandfather.

Somewhat with my son.

Yes, greatly. My relationship with my other two children and grandchildren. The relationship with my daughter – “Because I took her children”. I did have a male friend and we used to date. My whole life is now consumed as I’m a 24/7 carer, protector of these three precious children.

Less time to spend with other grandchildren:

Has reduced my time I can spend with other grandchildren and families. Some disagreements between husband and self about decisions regarding children.

(See quote above for a similar comment)
Changes in relationships with friends:

It has decreased my ability to have regular contact with all my friends because of my carer commitments. (KC)

Relationship with friends has changed slightly due to us having young children our friends children are grown up and left home. (KC)

Have found some friends have found it difficult to deal with child as his disability is severe and they are not sure how to handle him although they are supportive of what we are doing. (FC)

Marital relationships (and wider family) – difficulties:

Only with my husband. We had retired and had other plans. He finds it hard to adjust. (KC)

Yes, my children are distant, my husband goes out a lot now never did before. (KC)

Stress on relationship with husband. Instantly back to 20 yrs before with me running around doing everything while he did nothing. Come very close to divorce, had some marriage counselling that produced some improvement. (KC)

Yes. No relationship with my sister child’s mother she refused to accept her placement. My other sister was no help. I no longer trust her. (KC)

Demands on time – little time to self or time with partner:

Not much free time together. (FC)

In some ways because I couldn’t enjoy my life. It used to make me depressed because I didn’t have time for me. (FC)

When children have major behaviour issues it makes for difficulties in interacting with other children including children of friends:

Only if the children have very bad behaviours as people and other parents do not like having them around their own children. If it is sexual behaviour they do not want to put their children at risk. If it is bad behaviour they do not want their children copying it or getting hurt. (FC)

One complaint about DoCS:

When you tell DoCS, they will not listen. ((KC)

Difficult dealing with the health problems of children:

Yes it has been very hard sometimes with their health problems. (KC)
The response of other children – difficulties:

My natural children had trouble accepting these children would be a permanent part of our family. They harboured feelings of resentment when our foster child became a permanent placement. (F&K)

Note the comment above about children becoming distant.

Q. 42 What do you know now, that you wish you had known when you first became a foster or kinship carer?

Nothing of any great significance or that would have made any difference. Had made provision or prepared well and so less impact or fewer difficulties:

Nothing. Before fostering I ensured my own children understood what was to be involved and that they had a say in who and when we let into our lives. Giving them that control allowed for smoother transitions. (FC)

Think that we were very aware of the difficulties we would face before we became foster carers as we had researched for many years before putting our names down. (FC)

Nothing that would have made any difference. (KC)

Several respondents just wrote nothing. (KCs)

Better understanding of the psychological issues and behavioural problems and how to handle them. The particular stress associated with these issues:

More about the psychology problems these children have e.g. reactive attachment disorder and how difficult it makes life them and us. (KC)

There is a lack of respect from the children and they have a lot of emotional problems that affect them, not that it is their fault. (KC)

The stress that comes with him (nephew) and his behaviour. (KC)

Having to be very understanding and very patient which is hard sometimes because they don’t always listen. (KC)

Had an understanding of the legal and related issues:

The legal side of keeping children safe. I was not able to wait until DoCS removed the children. They had already been through too much. I have enough to do without doing paperwork for Courts, visiting solicitors, attending court. (KC)
Had an understanding of the legal and related issues (cont):

My rights as a grandparent. (F&KC)

Like I said; being a foster carer and knowing my rights about what is right for the child’s welfare and safety and letting them know you welcome them with open arms and you can show them love like you show your own kids. (FC)

The financial costs associated with foster care:

1 comment

How children can turn on their parents:

1 comment

DoCS issues. Lack of help/ support. Knowing how to get the help one needs. Only learning about available support (long) after it was needed:

How to get help for the children and what they are entitled to. After five years I have found out some of the things but I still do not know enough as DoCS tell different carers different things and seem to not want carers to know if it is a financial cost. (FC)

Not enough help from some of the case workers. (FC)

Say ‘no’ to DoCS. I cannot save every child. (FC)

How completely disjointed DoCS. (FC)

Lack of support from DoCS. (KC)

I wish I had known about the financial help policies four years ago. I have only recently got a copy and DoCS still won’t help me or return my phone calls. (KC)

Can’t think of anything - Except I would have liked to know that local Family Support existed. (KC)

The things I learned later, once she was in my care. (KC)

Positive aspects of fostering and caring for a grandchild:

I only wish I had done something like I am doing with children many years ago. (FC)

That it is fulfilling. (FC)

How wonderful caring for a young child is, at my age. (KC)

It only gets better. (KC)

I should have started sooner!! (F&KC)
Difficulties:
How hard it would be for us when our nephew called us mum and dad in front of his natural mother and the pain it causes her. It’s not easy for us either. (KC)

“Wish I had known about drugs.” (KC)

How hard it would be caring for a baby in my 60s. (KC)

Q.44: What aspects of being a foster or kinship carer have had the most significant impact on your health (either positive or negative)? Please describe.

Lack of and broken sleep, being constantly tired:
Health has gone from many stresses when we first got the boys one seven days old and the other 18 months. The 18 months one didn’t sleep for 2-3 weeks. Took about one year before he settled with help from counsellors and Tresillian centre. (FC)

Untold numbers of nights of broken sleep. (KC)

Feeling tired. (KC)

Early on – Extreme tiredness - but you get used to being busy all the time again. (KC)

General stress and lack of exercise:
Impact on both physical and mental health. (KC)

Disturbing levels of stress. (KC)
Constant stress from the children’s behaviour and disabilities. (KC)

Stress, anger at children’s parents, dealing with them etc. Isolation, difficult children. (KC)

Stress (KC)
Extra stress at times. (KC)

My mental health. I am snappy and a little bitter and I lost a lot of my self-confidence. (KC)

It can be stressful sometimes but you wouldn’t want it any other way.

No impact:
None. (KC)

Nothing about being a kinship carer has affected my health. (KC)
Positive impact – becoming more active, experiencing love and joy from the children:

Actually no ill effects. I think I am healthier because of fostering and subsequent adoptions. (FC)

Has kept me active as you are with a young child in household again. (KC)

I am much more active, need to be to keep up with the children. I eat better now as I have to prepare meals for children. I lack sleep, when I do have children in bed I then prepare for children’s next day, when my head hits the pillow. I worry about my daughter. (KC)

I am forced to go out early on Saturday mornings for soccer. We ride bikes and walk more. (KC)

I’m fitter than I was from running around after the child. (KC)

I have enjoyed caring and educating my grandchildren but my mobility has deteriorated and it’s hard to do some of the active things with them. (KC)

No time for dwelling on loneliness or stress. Time with children fills your life with being “useful” and needed.
Being a kinship carer has turned my life around for the better. (KC)

Positive as having the kids around they make feel you young again. (KC)

Positive (KC)

The love and joy this young man has brought into my life. (KC)

I never sleep during the day. (FC)

Keeping me busy. (FC)

Keeps me going. (FC)

Aggravating existing conditions and age-related issues:

Constantly lifting young babies and children has weakened my back and shoulders. (KC)

Aggravated existing conditions - arthritis in my hip. (KC)

I think my health has deteriorated because of age, not Peter. He can be stressful at times, but he gets over it, and it doesn’t worry me. (KC)

My age – general health problems which come with age. (KC)
Children’s aliments coming back into the home:

Lice, scabies, staph infections, foster kids come in contact with so many people that you get every flu and cold out here. (FC)

Dealing with DoCS:

Heavy handed attitudes by older DoCS workers to the point they lie. You must keep all records. (FC)

Fun and laughter from the kids – good health:
Stress from DoCS – bad health.
DoCS workers to be more open and HONEST with carers. I am told more from the kids then what I am told by DoCS. (FC)

Stress - dealing with DoCS, chasing up things for the child.
Lack of time for regular exercise. (FC)

Emotional and financial issues:

The financial and emotional (costs). Very Tiring. Time consuming regard education. General transportation to sport events etc. (KC)

Detachment issues with children, especially foster child. He is not bonded to us, sometimes he treats us like we are a boarding house. That’s hard when you try to love, but its not reciprocated. (F&KC)

Q.45: Is there anything you would like to change or improve? Please describe.

Issues concerning DoCS and the rules and procedures:

More support sometimes with DoCS they are always busy. (FC)

The attitude that the DoCS workers dictate what the child needs when they don’t even know the child’s name!!! (FC)

Caseworkers for DoCS staying in their jobs longer. The turnover of staff is ridiculous. (FC)

When a little kid is sick you are often forced to send them on access visits anyway. I would like to be allowed to keep them home until better like other parents. (FC)

LOTS – DoCS need to have more staff so as they can look into problems before children are affected emotionally. THAT more be done about the emotional impact on all. (KC)
Issues concerning DoCS and the rules and procedures (cont):

More support DoCS. (KC)

I’d like to know that my caseworker is available. He goes to training constantly and his position is “temporary”. This is not okay. (KC)

The way DoCS approaches things. (KC)

Disciplinary techniques - DoCS have too many restrictions on what you can and what you cannot do. We should be able to raise these children as our own. (KC)

Financial support for kin and foster carers:

I would like to see all foster and kinship carers receive more money for the jobs they are doing - who else in the world works 24/7 and gets $400 fortnight per child. (KC)

Personal wishes - that things be restored within the family; that the young person grow up to be the person they hope for:

My only desire is to see this young man grow up, be educated, drugs and alcohol free and a worthwhile contributing Australian. (KC)

I can’t change anything. My wish is for Peter to be re-united with his father. The financial assistance has been wonderful, and I am happy to have Peter till he is allowed to go to his dad. (KC)

No changes. A good thing to be doing:

It is a choice you make. There are sacrifices, sometimes some situations work well and others don’t. I think we are better people because of it but the stress/lack of time does impact. (FC)

I would do it all again for any of my grandchildren. (KC)

No would not change for the world. (KC)

Six simple ‘no’ or ‘nothing’ comments from kin carers and 1 simple ‘no’ from a foster carers.

Wish they were younger:

Wish I was 10 years younger. (KC)

Regrets:

I would have dealt with her differently when she refused to come home. (KC)
Q.46: How do you see yourself and your role in life since you became a foster or kinship carer?

DoCS issues:

Sometimes I feel discriminated against by DoCS. The more I complain about DoCS, the harder DoCs make it for me, i.e. not returning phone calls. Even management won’t. (KC)

Financial costs of caring:

If I had remained in the work force I would be far better off financially. But life is far more interesting and full as a foster carer and Dad. (FC)

Transformation of life but also a return to bring a mother again; Just more difficult because of being older; Restrictions:

Going from no children in the house to a toddler again, doing the child rearing over again, had left restrictions on personal time. Now my life is on hold again until child reaches eighteen years. (KC)

I’m a mother again. (KC)

“Like starting all over again.” (KC)

I had my family, children, separated and was starting to do and see things, loved (being) Grandma. NOW I have three dependants and I will be 70. Before that will happen again I know this is for a long time and I try to prepare myself for what’s ahead. At the same time do the best I can for the children. (KC)

I gave up a good job. I played sports and went out socially. My children were becoming independent, so I had ‘free’ time. Now I am a full time mother again, and have very little freedom. (KC)

Being retired we have not been able to travel and enjoy an easy lifestyle in our retirement. (KC)

I was looking forward to retirement, but that’s not possible now, but I am more alert and active because of the change. (KC)

People our age are generally grandparents not parents. (KC)

We don’t have the holidays or dine out as much. But would not change anything as love having our granddaughter safe and sound with us. (KC)
Making a difference:

I feel proud of the job I am doing and the challenge has been trying but also rewarding giving the children a stable life and a secure future. (KC)

Having an altruistic view on life makes one happier with self. The focus is on others and we are really making a difference in the world for the next generation. These kids have dreams where once they didn’t. (KC)

Doing something which is consistent with the kind of person I have always been:

Always been a carer. (KC)

I’ve always been the home kids feel safe in – the faces change over time but the door still revolves – we have a lot of joy. (KC)

I always babysat for everyone I knew. (FC)

Caring for children provides purpose in life and it is worthwhile:

Just to know what some of these children have had to contend with. (FC)

I have something to fill my days. I feel I have a purpose in life. I feel good about making kids happy. (FC)

Not much change rather adjustment and letting on with the task:

As I have the primary care since the age of three months when my youngest child was only 11 years old, my role hasn’t changed that much. (KC)

Nothing has changed as they were born in here and lived with me all their lives. The only thing that has changed is my grandson is ADHD and ODD, so I try to keep on top of things. We have a good day but we also have our bad ones but that’s part and parcel of being a parent or grandparent. (KC)

Our family took everything in their stride. (FC)

Positive implications for the family as a whole; an important learning:

Foster caring has overall been very beneficial for our own birth children. There has been negative times and experiences for them but overall many more positive ones and it has made them see the other side of life. They are now much more caring adults than if they had not had these experiences in the past. (KC)

Positive for the carer:

I am still the same person, perhaps a little more understanding and tolerant of young people. I spend more time with the elderly, helping at nursing home etc. so being involved with more young people now has probably been good for me. (KC)
Positive experiences and growth and also regrets:

I thought I was doing a good job. A lot of positive things had started to happen. I lost my temper with her and slapped her. I felt I let myself down. I thought I was better than that. (KC)

Much more confidence and self assurance. (FC)

Q.47: Has your role in life significantly or fundamentally changed, or has it stayed the same since you became a foster or kinship carer?

Fundamental transformations of carers’ lives:

I was about to enter into early retirement when my children came into my care, so it significantly altered my life. (KC)

My last child was in year 12 and ready to leave home in twelve months then along comes granddaughter into our care. (KC)

Just when you think your time has come, that you have time and yourself, you have to start all over again taking care of little children who need you to love and support them. (KC)

Because we had no children in the household before this child come into the house. I was working 70 hours a fortnight now only fortnightly approximately ten hours casually. Have had to look for childcare and respite plus lots of medical appointments etc. (FC)

For the better. (KC)

Life revolving around the child or children:

I have become a mother again which means ½ -1 hr preparation before you can even walk out the door. Need to feed and dress a child as well as yourself. And at times she is not cooperative about getting dressed etc. (KC)

Bigger meals
More cleaning
Ton of laundry
Constantly watching every child. (FC)

Ongoing parenting roles - continuity:

I was born to hang with kids – I seem to ‘get them’ more than others. (KC)

I have always had a parenting role throughout my adult life. Now that my own children have grown up and left home or are teenagers. I am enjoying being able to continue my role with other children. (FC)
Making a contribution - the importance of that:

Knowing that the smallest of care offered can help. (FC)

The stress of dealing with DoCS:

My life is now more stressful due to not being able to get help for foster children quickly. I can cope with the kids having problems ok but it is the extra stress when dealing with DoCS that makes it hard. Having the kids is fun and enjoyable dealing with DoCS IS NOT. (FC)

Concern for the future and the children’s welfare:

As for question 46 PLUS I’d like to mention it will have a large impact later in life, for example, if something happens to me, these three will be legally my three dependants and not just grandchildren. (KC)

As we now don’t have to worry about our grandchild being taken away from us by their mother. (KC)

Full lives and greater community involvement because of the children in one’s care:

Samuel knows I am always available to drive him and his mates, and I will always pick them up. So my life does revolve around Samuel more. But I am still able to maintain my own social activities. (KC)

Getting our granddaughter to school, after day care and 24/7 care. (KC)

Involved in committees running the Day Care and Preschool the child attends. (KC)

- Linking with school and sport
- More activities. (KC)

I’m a mother again and my old age won’t be so boring. (KC)

Restrictions and costs:

I spend a lot of time at home and feel I have no other significant role, only a carer. (KC)

Personal changes in the kind of person one is or has become:

I am much more focused on the family than I was in the past. I am less selfish. (KC)

I am more conscious of what happens and I find people approach me with issue in their life that are the ‘norm’ with fostering. (FC)

Made me more assertive in the role of advocate for my kids. (FC)
Q.48: Please add any comments or details you would like to give us about the impact of fostering/kinship caring on you and your family. Please add pages if needed.

**Wider family issues:**

Unfortunately my three girls live away, so Samuel does not have a lot of contact with extended family. It would have been easier for me if they were closer. They relate very well when they come to visit. (KC)

Small adjustment by son and daughter who originally felt their children would miss out on the amount of time I would spend with their respective families. Matter resolved. (KC)

It made a big impact on all our lives especially when your youngest child is only five there is a lot of jealousy between your children and the children you have to look after even though they are your grandchildren. It can be very tough as the older ones have to take a back seat because your time is needed by the babies. (KC)

**Concerns about protecting the children and about the future:**

As I have five other grandchildren, the legal issue of leaving children equal shares etc. changes the day, we do take on the role of caring for our grandchildren. Implications are never ending in legal issues which also involved more solicitor’s fees etc. The amount of money that goes to the solicitors and barristers to help protect children would be better spent on making birth parents care for their children and if that’s not happening, remove them, before emotional harm is done to the future children of our world. (KC)

**Positive comments about the experience of caring:**

Fostering has allowed for personal growth within myself and my family. My children have learnt to open up and allow strangers to become part of our family. They can empathise and can understand better now why these young people act and behave and how to approach and work with them to make them feel better about themselves. (FC)

**Positive comments about the experience of caring (cont):**

Overall I love it and so does my family. My children have a real expectation of how life is for some children and I am extremely proud of my children and the way they have pitched in with feeding etc. Good luck we need some changes in the attitude to carers. We need MORE carers!!! (FC)

In ways my mum butts in too much about me being a carer. She thinks she should be one but she is very sick. (FC)

I think that my biological children and foster and kinship kids will continue the pattern and open doors to other kids in need. We are enriched.

When I was married, I was discouraged from this – he was afraid that we’d be robbed somehow. This has been an ideal trade. (F&KC)
The children are becoming responsible adults. One child is apprenticed. Other still at school will progress to year 12. So we are happy with the job we are doing. (KC)

Love having our granddaughter and knowing that she is loved and safe is very important. (KC)

Yes, there are many times when foster kids restrict your life style but so much more “fullness” is received from them, their company, jokes, looks on their faces when they realize your kindness to them it is such a joy when you are able to get their confidence : of course there are always the ‘problem child’ too, but then in life you have to take good with the bad!! (FC)

Financially a disaster but that is because of our choices. We buy the children ‘nice’ clothes and toys as we think it helps their self-esteem. We have never had a holiday but again its our feeling that there are too many people in these kids lives and of course respite care adds even more. (FC)

**Restrictions and costs:**

My husband and I were enjoying life then our daughter died and now we have a teenager who doesn’t like to be left alone so we are stopped from going anywhere, we take her but with the age gap it is difficult. (KC)

At our age and with our lifestyle there isn’t a lot that our grandchild stops us doing on an everyday basis. We go out for lunches more than dinners. We’re happy to be home for bedtime. We don’t drink or party really.

The biggest impact was to do with the amount of work involved that wasn’t being shared by my husband. He doesn’t mind babysitting so I can ocean swim each morning and before he was on long service I had to rely on my other daughter or friends to enable me to continue swimming which is important to me. (KC)

My husband has had bad health in recent years, sometimes the extra stress of a ten year old with some emotional problems can be problematic. (KC)

**Comments about the survey and issues it raises – general comments about caring:**

I am very pleased to see this survey taking place. I see it as an ongoing problem and carers will need all the help they can get. (KC)

I feel so sorry for all the children in these situations. (KC)

Important for children to live with family. (KC)
Comments about DoCS:

More support DoCS (Re-parents).
Always being pressured by parents. (KC)

Comments about policies and inflexibility:

We now have a wonderful case worker BUT she has recently told us we couldn’t get passports for the children because the mother wouldn’t sign. The government should look towards us as doing the community a good service and at least consider each case on its own merits. I promised my children a holiday in New Zealand four years ago, but just before we planned to go, we were given my niece to care for. (KC)

Need for support and recognition:

I love looking after my grandson but lack of help and support made it very hard to cope at times i.e. my house is 130 years old and 2 bedrooms, my grandson doesn’t have his own room and my house is in bad need of repairs. It leaks when it rains, mould growing in different rooms and I am not in a situation to do anything. DoCS know about this and won’t help me. (KC)

Children of parents who choose to foster also need support and training. They are an integral part of the equation and need to be included in the process. (F&KC)

Miscellaneous:

Much more confidence and self-assurance. (FC)