
Kinship Care

A Selected Literature Review



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by

Marie Connolly PhD

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Section 1:

An Introduction to Kinship Care

The changing nature of statutory care for children

Although known to society for centuries, kinship care is a relatively new phenomenon within systems of child welfare. In the past two decades kinship care – the practice of extended family looking after children in state care – has become an internationally favoured system for children who are unable to be looked after by their parents. Not only has kinship care emerged as a significant contribution to the range of family foster care services, there has been a palpable shift in state preference toward kin as first option when an alternative to parental care is needed (Geen, 2000; Gleeson, 1999a; McFadden, 1998; Colton, & Williams, 1997; Ingram, 1996).

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Shift toward family-centred practices

Overall, child welfare services internationally have moved toward a more family-centred, community-orientated approach to working with children and families at risk (Berrick, 1998). This has included a greater emphasis on strengths-based practice with families, the greater valuing of family as a resource for the child, and the perceived need for the state to maintain and sustain family relationships (Berrick, 1998; Connolly, 1999).

The needs of the child

Discontinuity of placement and a loss of family/cultural identity have been identified as significant difficulties for children experiencing state foster care (Connolly, 1994; Greeff, 1999; Hegar, 1999). A child's need for continuity, familiarity, and a sense of belonging (Department of Health, 1991), foster care drift, cultural imperatives (McFadden, 1998), and the evidence of poor outcomes for children in state care (Hunt, 2003) have been cited as positive reasons to explore the development of kinship care as an alternative option to stranger foster care.

Increases in placement need

Increases in the numbers of reported cases of child abuse and neglect, and the consequential need for safe placements has placed pressure on the state's declining foster care resources (Schwartz, 2002; Scannapieco & Hegar, 1999). According to Crumbley and Little (1997), 30% of US foster parents withdraw from fostering each year, for reasons of inadequate support, more women returning to the workforce, and a negative public image of fostering. They note that the complex needs of children who have experienced serious abuse – emotional, medical, behavioural and developmental – test caregivers and cause them to question their continued involvement as foster parents. The

rising cost of child rearing as a fostering disincentive, and changing family demographics have also been cited as contributors to the shrinking supply of foster homes (Berrick, 1998; Clark, 1995).

Fiscal imperatives

Political philosophies that underpin policies of fiscal retrenchment and a greater withdrawal of the state from costly public services has also been cited as fuelling the interest in kinship care internationally (Hunt, 2003). Foster care is cheaper than institutional care, and kinship care within most jurisdictions is cheaper than foster care (Greeff, 1999). However, the inequitable funding of kinship care has also been source of ongoing debate (Schwartz, 2002; Laws, 2001; Geen, 2000; Gleeson, 1999b; Berrick, 1998; Gleeson, 1996), and recommendations to address the anomalies are beginning to emerge (see for example the Minnesota Department of Human Services, 2002).

As Hunt (2003) quite rightly notes, the influence of these factors and the strength of power they apply will vary across time and between countries.

Definitions of kinship care

Broadly, kinship care has been defined as “any living arrangement in which a relative or someone else emotionally close to a child (e.g., friends, neighbours, godparents) takes primary responsibility for rearing that child” (Leos-Urbel, Bess & Green, 2000:1). There is, however, a great deal of variability with respect to how kinship care is defined. For example, approximately half of the states in the US define kin only as those related by blood, marriage, or adoption, while others go beyond this to include family friends, neighbours and godparents. Some states have no formal definition at all (Leos-Urbel et al, 2000).

Internationally there is considerable variability regarding definitions of kinship care.

Since the introduction of the Children Act 1989, the official term that covers kinship care in the UK is ‘Family and Friends Care’ (Hunt, 2003), a term in itself indicating a broader interpretation of who constitutes kin. Kinship care has also been referred to as ‘relative care’ (Hunt, 2003) or ‘relative foster care’ (Ainsworth & Maluccio, 1998).

Kinship care has been further divided into ‘formal’ or ‘public’ kinship care (where a child welfare agency is involved) and ‘informal’ or ‘private’ kinship care (where the state is not involved). However, these terms have been criticised in the literature as being potentially misleading, inaccurate and/or simplistic since situations of care may have both formal and informal elements.

The term ‘kinship foster care’ has also been used by authors when referring to situations in which the state has legal responsibility through either voluntary agreement or court action. It is important to note that in some jurisdictions ‘kinship foster care’ only refers to the latter – state legal custody following a court order (Hunt, 2003).

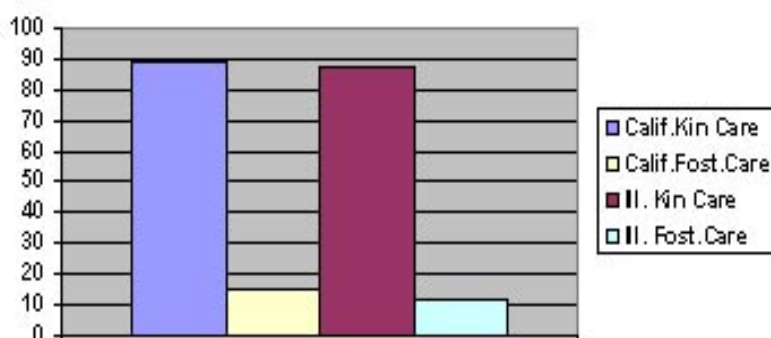
In general the literature makes little distinction between kinship carers that are known to a child, and kinship carers to whom the child is unfamiliar¹. What appears to be an assumption of familiarity may be a consequence of a set of beliefs that have permeated the kinship care literature relating to its perceived benefits:

- That kinship care enables a child to live with a known and trusted caregiver (Tapsfield, 2001; Wilson & Chipungu, 1996; CWLA, 1994)
- That it reduces separation trauma for the child, and preserves attachments (Tapsfield, 2001; McFadden, 1998; Crumbley & Little, 1997; Wilson & Chipungu, 1996; CWLA, 1994)
- That it reinforces identity by providing knowledge about the family (Tapsfield, 2001; CWLA, 1994)
- That it facilitates connections and contact with birth family (Tapsfield, 2001; Geen, 2000; Wilson & Chipungu, 1996; CWLA, 1994)
- That it avoids for the child a loss of everything that is familiar, and is less likely to disrupt schooling and neighbourhood links (Geen, 2000; Greeff, 1999; NFCA, 1993).

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These beliefs reinforce the notion of kinship caregiver familiarity with the child, and that they are also likely to live in close proximity. In addition, McFadden (1998:13) states “because of the *pre-existing* (my emphasis) emotional bond of the caregivers and the children, the children are often viewed more positively by kin than by non relatives...”. The notion of caregiver familiarity is further reinforced by two studies that indicate that previous knowledge of the child can be found in the majority of kinship placements (Lewis and Fraser, 1987; GAO, 1999). In the GAO study that looked at a range of issues including the child’s familiarity with their caregivers in California and Illinois, a very high degree of familiarity was confirmed within kinship care by comparison with foster care placements:

Figure 1: Children’s familiarity with caregivers in California and Illinois



¹ Whether or not the caregivers are known to the child, of course, if biologically linked they would always meet both narrow and broad definitions of kin.

Given the nature of families it would seem reasonable to suggest that in most situations familiarity with caregiver is more likely to be the case. Inevitably however, this will not apply to all. Indeed, Kornhaber (cited in Hunt, 2003) found that only a minority of grandparents had a close relationship with their grandchild. Greater mobility within society is likely to impact on the connectedness of family, and if family members live geographically distanced then a child is obviously more likely to be placed away from their home, interstate (Chipungu & Everett, 1998), or perhaps even outside the country of origin (Forrest and Rushton, 1999). Obviously this is not the case with foster care since good practice would seek to preserve geographical continuity and links with family. As Hunt (2003:16) astutely notes “(I)n these circumstances the justification for placement with kin must rest on a different set of arguments, which are more to do with cultural and genealogical continuity than environmental stability”. Such placements would also need to be made carefully and according to the best longer-term interests of the child given the likelihood that the child could lose contact with immediate family.

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Essentially it is for each country to decide how to define kinship care, and this is likely to depend on unique cultural experience, beliefs about the nature of kinship, and the way in which kinship care as a system of care has developed over time. The broader definition of kinship care that also accommodates emotionally bonded people within the child’s network provides far greater flexibility and is consistent with the CYPF Act Section 2 definition of family group which includes people to whom the child has a significant psychological attachment. Importantly, also within that section, family group includes the child or young person’s *whanau or other culturally recognised family group* (my emphasis). In the New Zealand context this reflects the commitment to *maatua whangi* care by members of the same *iwi*, and also reflects recognition of the special relationships that *iwi* membership creates. The question of whether the kinship caregivers need to be known to the child is less a matter of definition and more a question of placement management and

good practice that is cognisant of the best interests of the child. In the absence of pre-existing emotional bonds it is essential to ensure that transitions into kinship care are managed well, according to the nature of the kin relationships, and that the child be adjusted psychologically for placement.

Rationale and goals of kinship care and the elements of quality care

According to Gleeson & Craig’s (1994) analysis of kinship care in the US, the purpose and/or goals of kinship care are rarely articulated in state policy. However, clearly understanding the purpose and goals of kinship care is more likely to facilitate the promotion of values and care policies that are consistent with the best interests of the children and families who interface with the welfare system.

The development of kinship care as a knee-jerk response to a resource deficit within the systems of alternative care is only likely to provide short-term service vision and short-term benefits for children and families (Ingram, 1996). If, however, the purpose and goals of kinship care are established with the best interests of the child in mind, then longer-term benefits are more likely to ensue.

Some of the goals and principles underpinning foster care are consistent with kinship care objectives:

- To avoid inflicting further harm or maltreatment (Pecora, 2002)
- Reduce the trauma of separation and provide continuity of care (Ingram, 1996)
- Maintain family, school, and other connections (Pecora, 2002)
- Preserve family ties (Ingram, 1996)
- Work toward positive long term outcomes, such as developing personal and social relationships; good physical and mental health; educational achievement etc. (Carter, 2002)
- Foster positive cultural and personal identification (Pecora, 2002)

Identifying child and family-oriented goals and principles for kinship care are more likely to result in strategic service development.

In general, there has been minimal attention paid to the issue of quality within kinship care placements. The notion of 'better' care has not been advanced, in fact the standards for care are often less rigorously applied than in other areas where the state has care responsibility for the child, for example in foster care or residential care (Hunt 2003; Chipman, Wells & Johnson, 2002). Indeed, Hannah and Pitman (2000) note:

Kin placement is recognised as having many benefits. But placements are made which would not have been approved had the carers been assessed within the foster care system. They may have been deemed unsuitable because of parenting capacity and style; age; physical capacity; accommodation; family configuration or relationships.

Elements of quality care that have been identified by Shlonsky and Berrick (2001) are consistent with many of the kinship care objectives outlined above, and include: child safety (also physical safety within the home and neighbourhood, medical and dental care); educational support and the capacity to promote the child's education; mental health and behavioural support (particularly the capacity to understand the child's mental health needs and the ability to deal with difficult behaviour); developmental factors (the stimulation required for children to achieve their developmental milestones); the furtherance of positive attachments; the characteristics of

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caregivers (both personal and demographic); and the child's quality of life (including the child's level of satisfaction).

In the US a recent government investigation into the quality of kinship care found:

...that overall, the quality of both kinship care and other foster care was good and that in most respects the experiences of children in kinship care and in other foster care settings were comparable.

(GAO, 1999).

In general kinship care has been found to score higher with regard to the quality of relationships, although this is clearly difficult to assess and research is fraught with methodological difficulties. Nevertheless, research generally reports positively with respect to relationship quality (Hunt, 2003; Altshuler, 1999; Stelmaszuk, 1999), Altshuler also reporting greater depths of bonding. By comparison, Gaudin and Sutphen (1993) found no differences in relationship affection with respect to kinship care and foster care. From the research therefore, kinship care has been found to be either equal to or more positive than foster care with respect to the quality of relationships.

However, writers have expressed concern about other aspects of care quality. Poorer levels of medical care have been identified in kinship care situations including lack of adequate immunization, poor dental care, and greater developmental and mental health problems. It is important to note, however, that comparable rates for dental and health care were found in situations of foster care (Dubowitz et al., 1992). Kinship families are less easy to keep track of, and medical records for children are often incomplete (Gennaro, York & Dunphy, 1998). Questions about physical safety have been raised, and greater levels of exposure to violence, and drug and alcohol use have been found in kinship situations (Berrick, 1997).

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Overall in the area of quality of care, research is limited and findings are mixed. It is also difficult to arrive at appropriate standards for kinship care given its essentially different nature from foster care. However, in the light of the rapid development of kinship care internationally calls for proactive kinship care practice and policy development have been made (Hunt, 2003; Berrick, 1997; Danzy, 1996). Incorporating appropriate standards

and guidelines based the best interests of the child and the needs and goals of kinship care would seem to be a good place to start.

Research into kinship care: What can international research tell us about kinship care?

Most state services provide care statistics that can give an overall sense of how kinship care is evolving internationally. However, because different countries have different ways of defining care, and different methods of collecting data, the danger of trying to compare findings that are essentially not the same is a major problem. Because of this, international comparisons need to be approached with caution. However, in giving a broad picture of the scope and development of kinship care internationally, care statistics can be very useful in illuminating similarities and differences, and help to anticipate emerging

issues within the practice and policy areas.

Despite the widespread use of kinship care, in fact, relatively little research has been undertaken to help us know if it is working as a care practice for children and families. Research findings and conclusions tend to be limited by unrepresentative samples, methodological problems, and of significant importance, a lack of baseline measures from which progress comparisons can be drawn. Hunt (2003) argues that it is impossible to draw reliable conclusions when comparing kinship care with foster care – an essential research area for policy development – when studies are essentially measuring different things. For example, Flynn (1999 cited in Hunt, 2003) identifies social work input as factor associated with better placement outcomes. However, research suggests that kinship carers get less service support, an inequity that makes comparisons with foster carers also problematic. Caregiver and child characteristics can also significantly differ across kinship and foster care systems creating misleading outcome findings – sometimes favouring kinship care, sometimes favouring foster care. What Hunt (2003) identifies as *selective interpretation* of such findings can inappropriately result in pro- or anti-kinship care responses, neither of which is particularly helpful when trying to develop sound care policy.

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In addition, writers have cautioned against the universalising of international research given the difficulties inherent in comparing uniquely different cultural situations. For example, Greeff (1999) warns:

We must take care not to universalise from any one model. Ideas from Poland or New Zealand may be very relevant to social work in Sweden or Britain, but these paradigms may need significant adjustment to the different social patterns in different society.

Nevertheless, these issues and limitations notwithstanding, it is important to note that there is a dearth of research in New Zealand (and Australia) relating to kinship care and it is important that policy is not developed in a research and information vacuum. International research can illuminate the experiences of children and families interfacing with the care system, and is particularly important to the understanding of child safety issues, placement continuity, the measuring of health and wellbeing outcomes for children, and the particular needs of families. In general, these areas of research have been dominated by a relatively recent proliferation of studies from the US. Research contribution from the UK is far less extensive, Australian research is embryonic in stage, and no published or web-based studies could be found reporting on the Canadian experience. This review of research literature will therefore largely focus on US and UK contributions to the field.

Section 2:

Kinship Care Statistics

International patterns of use and prevalence

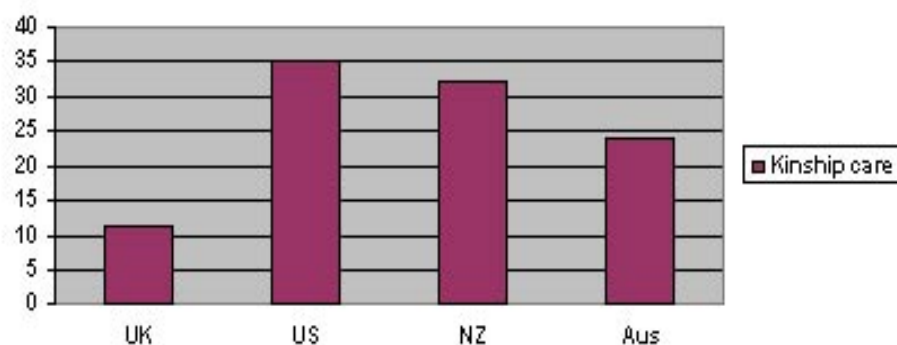
Although writers note exponential increases in kinship care, in fact, its development internationally varies considerably.

Although writers note exponential increases in kinship care, in fact, its development internationally varies considerably. In the UK, Hunt (2003) reports that the incidence of children being looked after by relatives has not changed significantly since the introduction of the Children Act 1989. In 1992, 9% of all children were looked after by relatives, a figure that rose to 11% by 2000.

The Department of Health (2003) statistics indicates that this figure has remained constant. Interestingly, UK local authority placement of children with parents equals that of kinship care at 11% of the total number of children in care. The numbers of children in the UK statistics relate to children in state custody. However, a hidden number of children placed with kin and being supported by the state through allowances, if added to the kinship care statistics, would inevitably impact on the overall figures (Hunt, 2003). Little is know about these children, or how many there may be overall, but local studies indicate that the figures may be significant, possibly equalling the kinship care numbers (Tan, 2000 & Waterhouse, 2001, cited in Hunt, 2003).

Based on the figures of children in state custody, the UK figures represent a very different picture from other western countries. In Australia kinship care accounts for 24% of care placements (Hunt, 2003), more than double the UK figure. In the US figures indicate that kinship care has grown dramatically from 18% of placements in 1986, to 31% in 1990 (Clark, 1995). Data from 39 states in 1998 found that kinship care accounted for 37% of children placed in family foster care (Leos-Urbel, Bess & Green, 2000). Data from 46 states in 1999 found that kinship care accounted for 35% as a weighted national average of all children in state custody (Mayfield, Pennucci & Lyon, 2002)². The following graph provides a broad picture of the kinship care figures as a percentage of children in care internationally:

Figure 2: Kinship care figures as a percentage of children in care



² Establishing true figures with respect to the percentages of children in kinship care is complicated by a number of factors including the difficulty in estimating figures of subpopulations (e.g. formal or informal kinship), and problems with sampling (e.g. the number of states in the sample)

Consistent across all jurisdictions is the variability across national boundaries. In the US the percentage of kinship care placements ranges from under 5% in some states to over 50% in others (Mayfield, Pennucci & Lyon, 2002). Figures from the UK indicate similar variations with percentages of 20% in South Wales, compared to 4% in Hampshire (Hunt, 2003). Even in similar midland authorities there are significant variations (between 21% and 33% in the 1999 Waterhouse study cited in Hunt, 2003). Although, if kinship care placements that are supported by state allowances (as opposed to state custody) in the UK are as high as indicated in the studies, it might impact significantly on national variation (i.e. some local authorities may favour the less intrusive option).

In the US, urban centres have seen the greatest increases in kinship care placements (Scannapieco & Hegar, 1999), New York for example increasing from 151 in 1985 to 14,000 in 1989.

Research suggests that in the US the majority of states give kin preference with respect to placement of the child (Leos-Urbel, Bess & Green, 2000). In addition, the majority of states instruct workers to actively seek a kinship placement when a child is in need of care. Some states prioritise placement among kin, for example Idaho prioritises: 1. immediate family; 2. extended family members; 3. non-relative family members with a significant established relationship with the child; and 4. other licensed foster parent. Louisiana is even more specific prioritising among biological kin: 1. grandparent; 2. aunt or uncle; 3. sibling; 4. cousin. Approaches to the implementation of kinship care will be further discussed under section 4 of this report.

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Given kinship care as a practice is a deeply rooted tradition in some societies, particularly where shared parenting is a feature of the cultural milieu, it is perhaps not surprising that people of colour also feature strongly in the kinship care statistics. Of all ethnic groups, African Americans have the highest rates of kinship care (Szolnoki & Cahn, 2002) and children in kinship care are disproportionately represented by ethnic minority groups in the US (Clark, 1995). According to Hegar (1999:23):

African American children make up 44 percent of those living with grandparents without a parent in the home ... That pattern is about six times more common for African American children and one and a half times more for Hispanic children than for white, non-Hispanic children.

It is not clear whether a similar cultural phenomenon is occurring in the UK. However, it has been suggested that kinship foster carers are more likely to be from ethnic minority groups in some areas of the UK (The Hadley Centre, 2002; Broad, 2001). The difficulty in establishing accurate statistics in kinship care is even more problematic with respect to cultural demographics.

Issues relating to benchmarking

Trying to get a sense of what might be appropriate levels of kinship care within a care system is not necessarily helped by the analysis of international figures. Firstly, as noted earlier, methods of collecting data varies according to

definition and the ways in which the services have developed over time. So figures are not necessarily completely reliable. But perhaps more importantly, apart from the UK figures, kinship placement numbers have been rising rapidly within an unstable environment, and it may be prudent to be cautious with respect to benchmarking under these conditions.

Along with the US, New Zealand has followed a rapid development pattern with respect to kinship care. Kinship care (or in-family as opposed to out-of-family care) in New Zealand accounts for 32% of placements (Statistics New Zealand, 2002), a figure more closely approximating US figures (35%). According to Hunt (2003), in the absence of compelling evidence that it is,

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in fact, harmful to children, the heavy reliance upon kinship care in the US would make it unfeasible to reverse the trend in that country. While Hunt suggests that the same could be said for New Zealand, the small numbers of children in care mediate against this argument. It would be possible to return to a heavier reliance on out-of-home care. However, given the pro-family commitment reflected in the principles of the Children, Young Persons and Their Families Act (1989), the strong practice commitment to developing care partnerships with family/whanau, and the negative consequences of foster care practice for children (Connolly, 1994), it is unlikely that New Zealand would want to return to a greater reliance on foster-care. Inevitably both systems of care have a role to play in child welfare since children need families, but not all children can always be accommodated within their family of origin. Rather than benchmarking numbers on the basis of experiences elsewhere, it may be more desirable for kinship care or foster care numbers to find their own levels based on whether the system of care effectively meets the child's needs, and whether it is relevant to the particular family circumstances.

This raises the important question that can be explored by an examination of the international research: Do kinship care placements promote the wellbeing of children? And how does kinship care compare with other systems of care?

Section 3:

Do kinship placements work well for children?

Whether or not kinship care promotes the well-being of children is a fundamental question. While state intervention clearly responds to the immediate care and safety needs of the child, it is important that it also protect the child's developmental trajectory and promote the enhancement of their life chances. Knowing whether kinship care is working for children is therefore of central importance. However, despite the centrality of this, research into whether kinship placements work well for children and provide for both immediate and long-term needs is limited. Here we will look specifically at what the research suggests about issues of child safety, placement continuity, and the overall well-being of children in kinship care.

While state intervention clearly responds to the immediate care and safety needs of the child, it is important that it also protect the child's developmental trajectory and promote the enhancement of their life chances.

Child safety

When the state intervenes and takes a child into state care, it has a responsibility to ensure ongoing safety and protection. This is the case whether the child is placed in foster care or kinship care. If the child is in the care of the state and further abuse occurs, apart from the consequences for the child, it can be seen as the ultimate insult to the family (Berrick, 1998). It is also, of course, considered untenable by the community. Kinship care has raised concerns about safety, particularly because of the intergenerational implications of child abuse and neglect, the use of substance abuse (Gennaro, York & Dumphy, 1998), and poor parenting practices across generations (Hunt, 2003). In addition, the complexity of family relations and continued access between children and parents has also been raised as issues of concern. In particular, a study by Rodning, Beckwith and Howard (1991) found that over half of the children placed with kin were actually being cared for by their birth mothers. This study used a very small sample and findings cannot be generalised. It is reinforced, however, by the GAO (1999) findings that suggest that kinship caregivers may be less likely to enforce protective restrictions with respect to parental visits than do foster caregivers. This highlights the potential for unmonitored placement access, and the need for greater practice vigilance. Writers have warned that in the interests of keeping families together there may be a danger of children's safety being compromised and risk factors underestimated (Foulds, 1999).

Exploring the issue of child safety in statutory care is complicated by a number of factors. Statistics rely on reported incidents. Reporting bias, and the under-reporting in general of child abuse will inevitably impact on the figures. Further, as with other areas of research, studies may have different methods of collecting data and if so researchers may well be trying to compare findings that are essentially not the same. For example, some studies looking at child safety have used kinship foster families who are licensed caregivers making generalisation problematic (see for example, Zuravin, Benedict & Somerfield, 1993). Writers have noted differing levels of child protection supervision

in foster care by comparison with kinship care. This and the possibility of greater worker tolerance toward reportable transgressions within kinship care situations will produce unequal sample groups (Shlonsky & Berrick, 2001). Further, children in foster placements often have more behavioural problems than those placed in kinship care (Benedict, Zuravin & Stallings, 1996), creating the potential for greater caregiver frustration.

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Given the centrality of the safety issues, there is surprisingly very little research that has looked specifically at child safety within kinship care placements. What research there is tends to be contradictory. Dubowitz, Zuravin, Starr, Feigelman, and Harrington (1993) found that both kin and foster care givers are more likely to be accused of abusing a child in their care than the general population³. In the study by Zuravin, Benedict and Somerfield (1993) the researchers found that non-related caregivers were twice as likely to have a confirmed case of abuse against them as kinship caregivers, although as noted above the study used licensed as opposed to non-licensed kinship carers. However, research by Benedict (1996) found that while non-related caregivers were more likely to be exposed to substantiated reports of abuse than kinship carers, the difference was not significant. By comparison, Terling-Watt (2001, cited in Hunt, 2003:13) found that few kinship placements involved allegations of abuse or neglect noting that “arguments that relatives are as dysfunctional as the children’s families of origin are not borne out”.

Child safety and the need to protect children in state care, while important in a general sense, is of crucial significance when managing a system of kinship care. The particular nature of kinship care and the complex issues relating to state/family responsibility for child care and protection, increases the need for more research into this underdeveloped but critical area.

Continuity and permanency issues

Using three types of continuity measures: the child’s previous familiarity with the caregiver; the child’s contact with parents while in care; and the child’s continued involvement with a known community, the GAO (1999) study found that there was significantly more continuity in the lives of children in kinship care by comparison with children in foster care.

According to Berrick, (2000) children in kinship care experience fewer placement changes. Citing a study examining the experiences of children under the age of six years, Berrick notes that 53% of the children in foster care experienced at least three placement changes, versus 30% of the children in kinship care. Webster, Barth and Needell’s (2000) longitudinal study reports similar findings. After eight years in care they found that almost 30% of children in kinship care experienced three or more placements, versus 50% in non-kinship care. These and other US research studies indicate that children in kinship care had fewer placement changes than children in other types of care.

³ Note the study reported unsubstantiated abuse allegations.

Given what we know about the potentially damaging consequences of separation, reducing the number of placement changes for children in all types of care situations is an important welfare aim.

Hunt (2003) reports that kinship care may also minimise discontinuities by providing alternative care options within the family if the initial family placement discontinues. However, how children in kinship care adjust and cope with placement movement within the family is an important research question. In this regard we do not know whether children who move around within family, experience the same negative effects as those experiencing drift in foster care.

Critics of kinship care have argued that not enough attention is paid to the processes of permanency planning for children within the kinship system. This view is supported by studies that suggest a slower reunification rate of kinship care children to their parents (McLean & Thomas, 1996). Research, however is contradictory. Many studies indicate that children in kinship care are more likely to remain in care longer (Hunt, 2003). However, other more recent studies suggest that there may be no differences in length of stay, in fact the GAO (1999) study found that children in their study spent less time in care.

Although the US offers a range of permanency options for kinship placements: adoption, guardianship, and long-term foster care, Leos-Urbel et al (1999) argue that the unique nature of kinship care can make these options problematic. By its very nature, kinship care is a method of family preservation. It preserves the family by maintaining the child within the family group and by facilitating the maintenance of family connections. Perceiving kinship care in this way rather than as a placement option that disrupts the family, may create more positive ways of examining the strengths of kinship care, and its position within the systems of care.

Given what we know about the potentially damaging consequences of separation, reducing the number of placement changes for children in all types of care situations is an important welfare aim.

Perceiving kinship care as a model of family preservation may create more positive ways of examining the strengths of kinship care, and its position within the systems of care.

Health and wellbeing outcomes

Most children who are taken into the care of the state are likely to have experienced abuse, neglect, or separation from their parent. These traumatic experiences may also place them at greater risk of emotional or behavioural difficulties (Kortenkamp & Ehrle, 2002). It has been suggested that when a child is separated from a parent, living with a relative may ameliorate this trauma by providing a sense of family support (Billing, Ehrle & Kortenkamp, 2002). Nevertheless, research in the US has also found that children placed in kinship care are significantly exposed to levels of poverty (Ehrle, Geen & Clark, 2001) an influence that can also impact negatively on a child's development. According to examination of the research by Billing et al (2002:1), children in kinship care "face significant barriers to well-being compared with children living with their parents", and that this is likely to be associated with living in poverty. Because of this possible association with poverty, Billing et al

compared children in low income relative and parent care households, finding that:

...children living with low-income relatives fare worse on some measures of well-being compared with children living with low-income parents, but on others they are doing just as well (Billing et al, 2001:1).

Identified areas in which low-income relative care children and parent care children are similar include: comparable levels of behavioural and emotional difficulties; activity involvement; and physical health status. The writers speculate that living with a relative may help the child to overcome negative past experiences, provide a familiar environment, and helping the child to retain connections with family.

School engagement is one measure in which children from relative care fare worse than children in low-income parent care. Suspensions and expulsion are more likely for children in relative care. Billing et al suggest that adjustment difficulties may be a reason for this, separation from parent issues, or that they are more likely to have physical, learning, or mental health conditions.

Billing also raise issues with respect to relative caregiver capacity to provide care given the greater likelihood for them to experience poor mental health themselves, higher levels of aggravation, and the extra pressure inherent in child care.

Like the research into kinship safety, child well-being outcome research is underdeveloped, sometimes contradictory, and not fully reliable. Nevertheless on the basis of what research there is, Hunt (2003:14) concludes:

“... findings are broadly positive and while it cannot be said for certain that children in kinship care do better than those in non-related care it seems at least that, on balance, they do no worse. And while there may be little enough positive evidence..., the absence of recent negative evidence is also not without significance.”

... findings are broadly positive and while it cannot be said for certain that children in kinship care do better than those in non-related care it seems at least that, on balance, they do no worse. And while there may be little enough positive evidence..., the absence of recent negative evidence is also not without significance.

Clearly creating or developing child well-being measures is a challenge for researchers. Nevertheless, it is critical that we begin to more clearly conceptualise, research, and evaluate the essential dimensions of childhood well-being, and investigate them from a variety of perspectives including the child's (Altshuler & Gleeson, 1999). For example, using length of placement as a measure of stability may in fact tell us little about the child's sense of stability and belonging. Exploring the dimensions of well-being from a child's perspective is likely to provide richer understandings of the ways in which kinship care is meeting the needs of children.

Who does kinship care work best for?

The research provides no certain advice with regard to whether or not kinship care is the best option for children who are unable to live with their parents. Kinship placements are likely to both help and harm in some situations. Research into success factor analysis – what factors influence the success or

failure of kinship care – is significantly underdeveloped, and what findings there are tend to be less than helpful when faced with complex practice decisions.

Kinship placements are likely to both help and harm in some situations.

Hunt (2003) summarises research findings as follows:

- Few factors were identified as being predictive of child well-being. No significant relationship was found between ratings of child well-being and either child's history or level of input into decision-making. Higher levels of well-being were associated with the child's mother having been married, and not having housing problems (Althshuler, 1998).
- In a study that looked at drug-exposed and non drug-exposed children in kinship and foster care, non drug-exposed children placed with relatives did better than all groups, drug exposed children did worse (Brooks & Barth, 1998). As Hunt notes this is particularly interesting given the heavy use of kinship care in American situations of maternal drug use. The complex needs of children in these situations is likely to create placement vulnerability and require high levels of service and support.
- Gender may be significant, boys in kinship care exhibiting more difficulties than girls (Starr, et al 1999; Solomon & Marx, 1995), and experiencing a higher level of placement breakdown (Hunt & Macleod, 1999).
- Placement disruption has been found to be more likely for the older child (Harwin et al, forthcoming; Altshuler, 1998; Terling-Watt, 2001; Webster, 2000).
- In one study placements involving ethnic minority children or dual heritage children were found to be less likely to experience breakdown (Harwin et al, forthcoming). However, Hunt and Macleod (1999) have found little differences in ethnicity as predictive factors.
- Placements with aunts may be more vulnerable to breakdown than placements with grandparents (Hunt & Macleod, 1999; Harwin et al, forthcoming).
- Little difference in success outcome was found in the only study that explored success rates of placements that were made following a full welfare agency assessment versus placements in which the child was already in kinship care (Rowe et al, 1984).

There is little empirical evidence looking into what does not work in kinship care. However, Berrick, Needell and Barth (1999) do identify some characteristics of kinship care situations that would raise practitioner concern. These include:

- caregiver history of child protection services involvement; criminal history; knowledge of poor parenting skills; poor home conditions; too many people in the household,
- uncooperative history with protection services

- caregiver agenda to assume child custody; vendetta responses; lack of willingness/capacity to get on with parents of the child; too lenient attitude toward parent that may risk child safety.

Sound professional judgement, high quality assessments, capacity to work with family to find solutions, and a system that provides guidelines, training and support for people involved in the triangle of care is perhaps more likely to result in good placement outcomes.

Overall the lack of research in this area provides little assistance to a practitioner who needs to consider what type of care may be more appropriate for a child, and in what circumstances. Sound professional judgement, high quality assessments, capacity to work with family to find solutions, and a system that provides guidelines, training and support for people involved in the triangle of care is perhaps more likely to result in good placement outcomes.

Section 4 now looks at the issues relating to the implementation of kinship care, and some of the issues relating to the approval and management of kinship placements.

Section 4:

Issues of Kinship Care Implementation

According to the research, children in kinship care are more likely to experience personal health challenges, exhibit higher levels of behavioural or emotional problems, and face their own personal challenges following a history of child abuse and/or neglect. At the same time they are more likely to live with caregivers who may themselves experience health and mental health challenges, and live in situations of low-income and/or poverty (Ehrle & Geen, 2002). This raises important issues relating to the service needs of children in kinship care, and the assessment, monitoring, and support needs of the kinship care system as a whole.

Approval and management of kinship placements

In general, children move into care placements because their parents are unable to meet their care and safety needs. When taken into the care of the state, it is not unreasonable to assume that the state will then provide safe care and the nurturing that is required for them to thrive and grow. It has been argued that at least the same investigative scrutiny that is applied to parental care should be applied to alternative care giving situations, whether the care is provided by family or by people unknown to the child (Shlonsky & Berrick, 2001). However, approaches to the assessment and monitoring of kinship care can be seen to vary considerably.

In the US kinship care policies have evolved in ways that have multiple options for assessing kin (Leos-Urbel, Bess & Geen, 1999). In an in depth study of kinship care practices in the US, Jantz et al (2002:10) investigated how states approach approval for kinship care by devising the following three categories of assessment and putting these questions to states across the US:

- Full licensure – where the same standards are required of kinship carers as foster carers.
- Waived or modified standard – where assessment is on the same basis as licensure but standards may be waived or modified in kinship situations.
- Separate approval process – where kinship carers are assessed on different standards than foster carers.

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Their findings suggest that many states offer kinship placements leeway with respect to the traditional licensing processes, while at the same time maintaining safety standard requirements. They found, however, that this is not easy to achieve. States struggle to decide when it is appropriate to maintain the same standards for kinship care as foster care, and when to make exceptions in the light of the benefits kinship care provides. Areas of the licensing standards are often waived, or are specifically designed for kin, and the study indicates that

this is increasing overtime. The study also highlights the challenge of aligning policy with practice when decision-making varies between workers.

The Department of Health and Human Services, however, has recently stated “there is no reasonable argument for the state to have different standards of protection simply based on whether a caregiver is a relative or not” (DHSS, 2000, cited in Hunt, 2003:68), and it will be interesting to see how this influences future state practices.

In general, most state policy in the US provides equal opportunities for supervision of placements with respect to kinship care and foster care. However, what actually occurs in practice may be different from what policy promotes. The literature suggests that kin often receive less support and supervision than foster carers. This may be influenced by worker and/or agency attitude. Geen (2000) suggests the level of supervision provided by the state should reflect the particular needs of the child within the kinship placement rather than being based on the type of care per se.

Briefly, the main question emerging from the international literature with respect to kinship care assessment and monitoring policy: is kinship care fundamentally different from foster care requiring different processes of assessment and monitoring, or should the processes be the same for both care types but with flexibility to accommodate the particular issues relating to kinship care?

In the UK kinship carers are subjected to the same regulations as foster carers (Berridge, 1997; Hunt, 2003). While this seems straightforward, the practice realities are not quite so clear. There is evidence of a two-tier system operating with differing standards of assessment, or emergency placements compromising full assessments which sometimes results in illegal placements of children (Hunt, 2003). However, currently not enough is known about this problem, or is the extent of it fully researched.

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Caregiver issues

In a review of the research, Scannapieco (1999) found that women are the most frequent kinship caregivers, grandmothers providing more than 50% of the care. Aunts provide a further 30% of the kinship placements. More recent research reports similar findings (Broad, Hayes, & Rushforth, 2001). Most research suggests that kinship carers are more likely to be older than foster caregivers, and more likely to be single parents. Foster parents tend to complete higher educational qualifications than kinship carers, but nevertheless the majority of carers complete high school. Up to 48% of the kinship carers work outside the

home but have lower levels of income than foster carers. More than 50% of the kinship carers own their own home, but a greater percentage of foster parents do. Between 6% and 20% of caregivers assess their own health as poor. In general kinship carers tend to express greater feelings of responsibility toward

the child, particularly with regard to facilitating other kinship relationships, strengthening the child's social/emotional development, parenting, and being in partnership with the agency.

Unlike foster caregivers, kinship carers are likely to be entering the care giving role when the family is in crisis, family relationships are conflicted, and caregivers unprepared for the task. They may not have adequate space, or the necessary child-related resources (Geen, 2000). They may not have been in a parenting role for some time, and may feel apprehensive about the new role. This may be particularly significant for grandparents taking on the care of grandchildren. The carer's existing relationships may be subjected to strain and risk breakdown (Hunt, 2003; Cimmarusti, 1999), and relationships with the child's parent may also be strained and negatively affected by the placement. The behaviour of the child who may have been traumatised by previous experience may also test the coping skills of the kinship parent. Hence the burdens of care can be considerable and risk overwhelming the capacity of the carer to respond. Strained finances further exacerbate the situation.

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Nevertheless, workers believe that kinship carers are motivated to provide care, not because of money, but because of familial obligation and an interest in family preservation (Beeman & Boisen, 1999). Workers have been found to be generally positive about their experiences in working with kinship caregivers, and have noted that they are more likely to be active in the management of familial negotiations – negotiating access with parents, talking to the parent more about the child's transitional issues, and helping the child to deal with family relationships and dynamics. Notwithstanding this, the workers also identified the relationship between the kinship carer and the parent as being the most difficult to work with. Overall, the majority of workers found kinship carers to be competent in parenting, and saw the placements as being beneficial to the children.

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Kinship carers have been found to be strongly in favour of kinship care, citing their deep affection for the child and support for the parent, the belief that the best place for a child is with family, and a strong interest in preventing the child from entering stranger care. With regard to those carers from ethnic minority backgrounds, their interest in kinship care was also associated with the desire to maintain cultural continuity and religious and cultural heritage. Significantly, kinship carers have also described feelings of isolation and a need for increased financial and social work support (Broad, Hayes & Rushforth, 2001). Having to contend with high caseworker turnover and inadequate information about their entitlements increases their need for support in accessing services, negotiating welfare systems, and providing training for the complex role they undertake (Cimmarusti, 1999).

Hunt's (2003) summary of the research relating to the identification of the service's need of kinship care includes: greater access to social work services; assistance with costs; the guarantee of initial start-up funding; respite care;

housing needs assistance; transport assistance; improved information, advice and advocacy; networking opportunities (e.g. grandparent groups); mentoring; child care training; children's support group; assistance for birth parents and help with birth parent/kinship carer relationship; 'wrap-around service backing; and enabling responses from services underpinned by a family strengths perspective and an overall valuing of the family.

Support of kinship care

As noted earlier, most kinship families live in situations of financial hardship. Many are likely to be retired and living on fixed income, and the additional care of another person (or persons) can place increased strain on an already low income (Ehrle and Geen, 2002). Kinship carers have been found to live with incomes below 200 percent of the federal poverty level (FPL), and 31% live in "poor" families, incomes being below 100 of FPL (Ehrle & Geen, 2002, citing Hardin, Clark & Maguire, 1997). Dire financial circumstances that kinship carers find themselves in, are further complicated by a significant disparity in the reimbursement rates for foster carers and kinship carers. A lack of definite federal policy relating to the financial support of kinship carers in the US has resulted in states deciding for themselves how and when to support kin, resulting overall in the adoption of wide ranging levels of support (Geen, 2000). All kinship caregivers are entitled to receive the Temporary Assistance for Needy Families (TANF), a benefit that is not means-tested. However payments of TANF can range from \$68 to \$514 per month depending on which state you happen to live in (Ehrle & Geen, 2002). Kin caring for children who are involved with the state and who meet licensing requirements are entitled to foster care payments, ranging from \$250 - \$657 per month depending on the age of the child. The average foster care benefit across the country is \$403 and typically foster parents receive additional payments for expenses and supplements in recognition of special need. Unfortunately many of the carers do not meet foster care licensing standards and do not qualify for the foster care rates. According to Scannapieco and Hegar (1999:7):

(T)he conclusion is clear that the caregivers who are most in need are least likely to receive adequate financial support when they open their homes to the children of kin.

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Overwhelmingly the literature talks of kinship carers being disadvantaged financially, many children being described as living in "state-sanctioned poverty" (Hegar & Scannapieco, 1995, cited in Hunt, 2003). Further exacerbating the situation is the fact that despite the increased needs of kinship caregivers and their children, families frequently do not receive the services and financial benefits they are entitled to (Ehrle and Geen, 2002).

While licensing creates some of the difficulties inherent in developing a fair and equitable funding system for kinship care, the situation is further complicated by contested debate relating to the perceived responsibilities of state and family with respect to the care and of children. Emerging from this debate is a fundamental question – does a familial connection mean that a kinship

caregiver, because of their connection to the child, require less financial support than a foster parent undertaking the same role? In fact it could be argued that kinship carers need additional support given the carer may be entirely unprepared for the placement and without the resources to undertake the role.

Writers have also suggested that good kinship placements may be lost because carers may be unwilling to assume care of a child for financial reasons (Clark, 1995).

Addressing the financial hardship incurred by kinship caring has become one of the most pressing issues confronting welfare systems internationally, and it is clearly evident that there is a need to provide an adequate and fair system of financial support for kinship caregivers (Hunt, 2003).

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Section 5:

Implications for kinship care development in NZ

In many ways the rapid growth of kinship care in the US has created a situation in which research and policy development is quickly trying to catch up with practice in the field. A slower pace of development in the UK is providing an opportunity for a more strategic response to policy development, although this is hindered significantly by a lack of research in that country. However, strong themes have emerged from the literature that may be helpful to the development of kinship care in New Zealand. These are summarised here.

The question of definition

In the Children Young Persons and their Families Act (1989), New Zealand has already established an understanding of kin that harness the strengths of the child's biological kin, cultural and social context. This inclusive definition avoids unnecessary restriction of important people within the child's network. Such people will not always be in the same neighbourhood, and sometimes they will not be known to the child. What is of importance is that they be engaged as kinship carers because they provide the best option for the child and are more likely to meet the child's best interests. This is a matter of assessment and careful consideration of where the child's best interests can be met. If the kinship caregiver is not known to the child at the time of placement, or if the placement is distanced from the child's known environment, it is important that effort is made to ease the child into the new environment while at the same time retain the child's established links.

The question of responsibility

Kinship care reflects a partnership relationship between the family and the state. The kinship carer is providing a placement for a child who would otherwise require a foster placement. The state is reliant on kinship carers to support the state's systems of care for children at risk.

In NZ, in addition to the child protection mandate, the state has assumed a responsibility to also promote the maintenance of the family. This is because, inevitably, these two imperatives are related. A strong and well connected family is more likely to be able to support, nurture and provide continuity for a child. Family preservation, therefore, is an important feature of New Zealand's child and family welfare system. Unlike foster care, kinship care is also essentially a model of family preservation, and its appropriate use enables the state to meet both its child protection and family strengthening roles. Hence, a partnership model between the state and the kinship carers is more likely to recognise the contribution of kinship care and the shared responsibility for the child's welfare.

State involvement in a child's life means that it also has special and ongoing responsibilities for the child's care and safety. In a sense, this is what it brings to the partnership.

The question of kinship care standards

Like many other countries, until relatively recently New Zealand has relied on foster care as the traditional system of care for children at risk. The policies and processes of assessment, monitoring, maintenance and support of out-of-home care for children has been modelled on the foster care system. However, kinship care is essentially different from foster care, and it simply may not be appropriate to try and fit kinship care into a foster care paradigm. Internationally, considerable effort has gone into trying to apply foster care processes and standards to kinship care. Often it seems like trying to fit a square peg into a round hole and has resulted in inequitable resourcing, unclear guidelines, and uncertain practices. The challenge for New Zealand will be to work toward the development of appropriate processes that are more relevant to the realities of kinship care. Foster care assessments are designed to investigate the strengths of people who are unknown to the child. Often children are already in kinship care when decisions about child care are being made. This in itself indicates a need to provide kin-specific processes for the assessment and monitoring and management of kinship care placements. It is not a question of whether kinships care situations need to be assessed – the state's responsibility to ensure a child's ongoing care and safety require it. A more relevant question is how they might be assessed. Because kinship care is essentially different from foster care kin-specific processes of assessment, monitoring and management to reflect that difference are necessary.

The question of children's wellbeing

In general, children are removed from their parents because of concerns relating to a child's ongoing safety and well-being. Logically it is incumbent on the state to then place the child in a care environment that promotes the child's care and safety needs. However, little research has been undertaken to evaluate kinship care and to better understand whether the systems of care are meeting children's needs. It is important that this be urgently addressed so that policy is not developed in an information vacuum.

The question of kinship care support

The literature strongly indicates that despite their level of need, kinship caregivers receive fewer services and supports than do non-related caregivers. Currently there is insufficient information to know whether this is inhibiting the potential utilization of kinship care as a valuable system of care for children at risk, although some research indicates that this may, indeed, be the case. What we do know is that overall kinship carers differ socio-economically from traditional foster carers, are more likely to be marginally employed, and face very real economic challenges. The placement of an additional child may be sufficient to destabilise an already fragile system. The family preservation and family strengthening role reinforces the need for the state to appropriately resource kinship care so it is able to support the state in the care and protection of vulnerable children. In many ways, this involves the crafting a fair and equitable system of care that recognises the contributions of stakeholders in the system and also the responsibility of the state to work in partnership with families.

Crafting a fair and equitable policy for kinship care that creates a context of support, protection, stability, and cultural and familial continuity for children is a challenge for child welfare internationally. Experience has shown that child welfare systems are unable to meet the challenges of child care and safety alone. State systems need to harness the strengths of safety support networks that surround the child. While our knowledge about kinship care is underdeveloped – indeed there are massive knowledge gaps – its potential contribution, when appropriately supported and implemented, is already indicated to be considerable. As a system of care it is also most sympathetic to the ideal of family preservation.

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