

Submission to the Inquiry into the Child Protection System in the NT 2010

I have over 20 years experience working in Child Protection in the Northern Territory. This experience has been across all levels in the operational field and in different locations, namely Katherine, Darwin Urban and Darwin Remote Offices.

So the time of my experience ranges from the time when Child Protection was a program under Community Welfare Division in the Dept of Community Development until the present.

Over time the focus has changed from a child welfare perspective to a forensic/investigative approach. Over time this approach appears to have resulted in a change in the nature of the relationships with the families we work with and the relationship with other service providers who also often work with the same children and their families.

As a child protection practitioner, it has been clear for a number of years that our system was not working well.

Some of the growth in the NTFC system has been in response to an immediate crisis, political pressure and the maintenance of an already faltering system. It seems to me that as a Program with the focus increasingly on the investigative process and the collection of the numbers of investigation we have become more and more removed from the local NT context in which we provide a CP service, less grounded in family life and consequently less able to assess how best to use extra resources to best meet the needs of vulnerable children.

In the 1983 Community Welfare Act there was the ideal that aboriginal organisations would take over the running of child protection services in the NT. To my knowledge this ideal was never seriously considered.

Underlying this ideal was the need to support and foster strong aboriginal social welfare organisations in the NT.

This too was never realised. In fact the ACCA's in Central Australia and Darwin were defunded and there was not a commitment to the development of a philosophy and intervention model to engage with and assist aboriginal families in the care of their children.

The 1983 Act was also the first Child Welfare Act in Australia to include the aboriginal child placement principle in the legislation.

Unfortunately the commitment to this principle has been poorly understood. Without trusting relationships with aboriginal families and communities it is difficult to implement. Logically following the ACPD there would be a commitment in terms of preferred practice (namely family/kinship care), resources etc to the identification and support of family carers, and at the same time the development and

maintenance of a strong pool of aboriginal carers. Currently at a rough estimate there are 45% of aboriginal children with non-aboriginal carers.

Development of unique NT child protection practise model

Given the particular demographics of the NT and the projected increase in the ratio of aboriginal to non-aboriginal residents in the NT, the development of a NT model of Child Protection practise seems to be a good idea.

Central to a NT Model is the development of principles (practise knowledge) about ways of working with marginalised aboriginal families in the NT.

The NT is characterised by an "in" and an "out" group. For the "in" group there are relatively good and accessible services and resources for families raising children and an "out" group of families whose level of disadvantage is well-documented by social scientists. This exclusion of the "out" group from services has led to very bad performance indicators in health, education, for the children of this group.

The majority of CP clients are from this marginalised "out" group. A forensic model of Child Protection is very limited when families do not have access to services (both universal and targeted) to assist them in caring for their children. Without development of resources both within NTFC and with other Family support services, the forensic model often merely becomes a model of problem identification, case labelling with very limited capacity to provide a service to the family.

Central to any wide ranging reform is the development of a vision with guiding principles and the identification of "golden bullets" (as described by Noel Pearson) to address the over-representation of aboriginal children in the NT Child protection System.

An NT Model which develops a solid base of NT specific practise (grounded in examples of what works) will lead to the building of specific evidence based practise.

To develop a strong framework there needs to be consistency at all levels of accountability to the style of work that is valued and promoted, this would then provide a platform within the Program for making reasonable, informed, courageous decisions even when there is a crisis in whatever form, eg low staffing, political pressure, media attention etc.

Such a model of CP practice would include the following

- Safety of child is paramount and that usually the family is the best place for a child to grow and development (obviously this involves the management of risk given that due to the pressures on extended families, arrangements are often fragile with the need for a lot of support)
- The development of strong family support services across the NT. Obviously this will be very different in say Emu Point to Palmerston but there will be recognition that access to the services is a right and this may mean consideration may need to be given to including such services in say health centres, schools, CP services
- Engagement with and "working alongside" families, community for local solutions/plans to ensure good enough care of the child in the family/local home
- Family focused (including competence in working with extended family networks)
- Relationship based casework (fundamental when working with aboriginal families)
- Home based casework.
- Knowledge of and respect of diversity in child-rearing styles
- Ethical and transparent use of the authority entrusted in CP workers
- Resources to evaluate effectiveness of interventions

The development and documentation of an NT Model has the potential to

- Develop principles and ways of working (practise knowledge) with families from the very marginalised, disadvantaged families that form the majority of our client group in the NT. The goal would be to strengthen the role of the family in the care of the child(ren) and to work with other service providers to assist families to link in with other services available.
- If there is consistency of approach, there is the potential for building-on and improving the approach both at an individual worker level as well as at the system level.
- With a consistent approach and guiding principles, there is the possibility of recruiting staff who have a personal and professional interest in a way of/or style of working. This may assist in the retention of staff and increase staff morale. It is certainly my experience in NTFC, that a small group of like-minded hard working staff members can maintain a client centred focus and achieve some good (not perfect) outcomes.
- The development of a strong professional workforce who have the capacity to have regular contact with families (ie reasonable work loads and "just enough" recording responsibilities will assist in improving quality issues. The investment needs to be in the front-line staff who interact with children,

families and other services, rather than in investments in resources in how to monitor and ensure compliancy. Just as the development of relationships with families is to work towards assisting them to be the best parents they can be, so too relationships with staff assisting them to be the best caseworker/team leader/manager they can be.

- There needs to be a real commitment to the training and professionalisation of NT aboriginal staff to better reflect the diversity of the population and the client group we service. The future does not bode well for a service that does not make this commitment in the NT. Otherwise we will continue to waste resources on short term contracts with staff who are always in the infancy stage of learning about and appreciating the local context.
- The development of an Intake/Referral system that is local, inclusive of other service providers and has the ability to be flexible depending upon the size and the resources at a local community level.
- Improve the level of dissonance between the rhetoric and the ways of working with families. While the spirit of the Act and the Policy is to work in a
 - Planned and considered manner with families
 - To be respectful of individual differences in the culture of families
 - To be transparent
 - To explore and support family plans to ensure safety of children within the family structure and to see removal from family as a last resort
 - For caseworkers to be accessible and responsive to the client families

The perception of NTFC by clients and other service providers is not consistent with the above. Rather we are sometimes perceived as reactive, not family focussed, not willing to share information in the best interests of the child and unappreciative of the knowledge other services providers.

The development of a child/family centred NT model of Child Protection driven by values and principles has the potential make NTFC an organisation with good morale, have the respect of other service providers , good discipline re the development of good practise and where client families feel they are understood, appreciated for their diversity and where they have a voice.

These are not new ideas, I have included two papers by Garry Scapin (with his permission) and an article about the Alaska Native Medical Centre.

Child Protection Worker

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RATIONALE FOR THE DEVELOPMENT OF ABORIGINAL CHILD PROTECTION POLICY IN DARWIN RURAL DISTRICT

INTRODUCTION

This paper raises issues confronted by Welfare Workers attempting to implement existing child protection policies and guidelines on Aboriginal Communities in Darwin Rural District.

Many of the issues, however, are not confined to the District, and have wider relevance for all staff engaged in child protection.

It is argued that the existing emphasis in child protection policy and practice on the investigation of reports of child maltreatment has meant -

- (i) Other ways of enhancing the care and protection of children such as "empowering families and communities to care for and protect their children themselves" (Child Protection Policy Statement, 1994) are in a poor state of development. Also the preventative services that do exist tend to be circumscribed by the investigative process.
- (ii) Child protection policy has developed in relative isolation. The philosophy and principles of Primary Health Care which are meant to structure the approach of Territory Health Services to issues have yet to be incorporated into child protection policy. Other policy areas with direct relevance to child protection, such as Aboriginal Mental Health are making considerably more progress in this respect.
- (iii) Aboriginal priorities for the care and protection of their children and Aboriginal views on the development of culturally appropriate services have largely been ignored. There has been a general call for the development of an alternative framework of child protection, with an emphasis on prevention and taking into account the special needs of Aboriginal families.

These factors have limited the ability of Welfare Workers to develop collaborative relationships with families, and with workers from other disciplines or agencies.

It is suggested that addressing these issues in the development of an Aboriginal Child Protection Policy would provide a framework useful in not only re-orientating the practice of Welfare Workers, but also in giving substance to the notion that Child Protection is a shared responsibility.

CURRENT POLICY FRAMEWORK

The experience of Workers is that the types of families that come to the notice of statutory agencies are typically those struggling with issues of poverty, unemployment and discrimination. The influence of these pressures is felt through the context of particular relationships, and is recognised by agencies as problems of "family violence", "alcohol abuse", or "child maltreatment".

An effective response to an issue such as "child maltreatment", therefore, requires not only short-term crisis interventions into family relationships, but also the ability to address some of the structural issues confronting family members.

This position is well understood by Workers engaged in front-line child protection in the Northern Territory. However, the ability of Workers to respond in an appropriate manner is severely restricted by a lack of resources, and a policy framework which emphasises the "personal" aspects of the social context of "child maltreatment", at the expense of structural aspects. That is, while the importance of family support and the need to assist communities to care and protect their own children is acknowledged, this is not seriously addressed in the policy framework. Instead there is a highly elaborate system for the investigation of the family circumstances in which "child abuse" is alleged to have occurred, and for the removal of children from families to ensure their protection.

The stated purpose of the Community Welfare Act (1993) is to "provide for the protection and care of children and the promotion of family welfare".

The Act does contain a number of sections which permit Workers to assist families and communities to care and protect their own children.

Section 8(2) states "where, in the opinion of the Minister, a person, family or group is in need of assistance as a result of problems related to social, personal or economic reasons, he may provide such assistance as he thinks fit to promote the welfare of the person, family or group".

Section 68 permits the Minister to "provide such support and assistance to Aboriginal communities and organisations as he thinks fit in order to develop their efforts in respect of the welfare of Aboriginal families and children, including the promotion of the training and employment of Aboriginal Welfare Workers".

The delegations to administer these sections of the Act, however, are held only by office managers, not front-line staff. These provisions also constitute only a very small part of the legislative framework provided through the Act. In contrast, the Act contains many provisions relating to the conduct of investigations into reports of child maltreatment, or admitting children into the Care of the Minister.

The current child protection policy statement which was finalised in 1994, was intended only to outline the goals and objectives of the programs together with some principles of practice. This was meant to promote some consistency in approach throughout the Territory while allowing for some variation in practice between Districts.

The Policy states the program objective is to ensure children are protected from maltreatment by

- Contributing to the prevention of child maltreatment by: promoting an awareness that child protection is a community responsibility; educating the public and professionals working with children about child maltreatment; assisting families to function more effectively; and empowering families and communities to care for and protect their children themselves.
- Effectively responding to notifications of child maltreatment and providing intervention services which are timely and appropriate to the needs of children who have been maltreated, or who are at risk of maltreatment, and their families.

The importance of family support in child protection is recognised together with the need to involve Aboriginal people in the process. However, the focus is clearly on child protection investigation and there is very little detail which might provide the basis for a preventative framework.

The policy does not, for example, refer to Section (8) or Section (68), and offers no guidance on how families might be assisted to function more effectively or how families and communities might be empowered to care for and protect their children themselves.

The Child Protection procedures cover only the conduct of investigations into reports of child maltreatment. Other protocols that exist deal only with different aspects of the investigative process.

The 1994 "Guidelines re: Investigations on Allegations of Neglect in Aboriginal Communities" acknowledge that "many children suffer degrees of intellectual and social impairment as a result of their physical surroundings and social environment". It is suggested that Welfare Workers should endeavour to improve the social circumstances of these children rather than invoke the broad utilisation of statutory powers in the form of child protection investigations. Such interventions are generally to be reserved for those instances where it is alleged a caregiver fails to provide appropriate care or protection to the child. However, in the spirit of the residual nature of the guidelines, no assistance is offered in terms of how to approach the task of improving the physical surroundings and social environment of the children.

It might seem the problem could be solved by extending the current policy to cover the gaps. However, the experience of Workers in Darwin Rural District is that this will not meet the needs of Aboriginal people living in Communities. Evidence from the child protection literature also lends support to the idea that there needs to be a re-think of the current approach in child protection policy.

EXISTING CHILD PROTECTION PARADIGM

The model of Child Protection adopted in the Northern Territory, as reflected in existing legislation, policy, and practice guidelines, has a number of features in common with similar models elsewhere in Australia, North America and England.

These are:

- (i) A conceptualisation of "child protection" as the protection of children from "child abuse". Child abuse or "maltreatment" is defined, in existing policy as "acts of commission or omission which endanger [children's] physical emotional or intellectual development and well-being". This understanding of child protection was derived initially from studies by medical practitioners of unexplained injuries to children. These studies led to the notion of the "battered baby syndrome", the diagnosis of which was supported by a list of "symptoms". The emphasis on services developed within this context was on child rescue. Under the influence of this clinical approach, people were encouraged to view child abuse as an entity which could be studied in isolation of the social context in which it occurred. It also gave the impression it was possible to discuss and talk about child abuse as though there was a degree of consensus about what it was.

The categories of emotional abuse and sexual abuse were later added to the definitions of physical abuse and neglect. Child abuse became a separate area of study distinct from "domestic violence" or "alcohol abuse".

- (ii) Child Protection services have been developed to meet what is essentially viewed as a "private trouble". That is, services are residual in nature, designed to address a phenomenon (viz. child abuse) thought to occur in a statistically small "deviant" sample of the total population.
- (iii) Reporting child abuse or maltreatment to Welfare authorities or Police is the main method of identifying where services are needed. These services to children and families are focused on the "abuse", and occur within the context of an investigation.
- (iv) Although child protection is acknowledged to be a community responsibility, it is concentrated in the hands of Health and Welfare staff, the Police, and to a lesser extent, School staff. In recent years the "discovery" of "sexual abuse", has also led to an increased role of the judicial system in the process. This professionalisation of child abuse has reinforced the existence of a service model in which experts "define and manage the problem" and deliver services to children and families.
- (v) Prevention is conceptualised as a set of activities which prevent child maltreatment (ie. episodes of abuse). In this model, a distinction is often made between primary, secondary and tertiary prevention.

- "Primary prevention refers to programs targeted at the whole community (both children and adults) with the aim of stopping abuse before it starts.
- Secondary prevention also refers to programs designed to prevent abuse, but in this case the programs target specific sections of the child population considered to be more "at risk" of abusing.
- Tertiary prevention refers to intervention to help those that have been abused". Calvert (1993 p. xv).

Such a model is a natural extension of the notion that there is phenomenon which can be separated from the context of family relationships and social and economic factors, and identified as child abuse by reference to the actions of parents or caregivers and the effects these have on their children.

By constructing the "abusive act" in this way, and placing it in the foreground of attention, distinction between the private world of the family and the broader social and economic forces in society is fostered. The latter are relegated to the "background" and are studied principally to determine how they influence the "abusive act".

- (vi) Information produced about child protection reflects the orientation towards child abuse and the emphasis on investigations; for example, information about the administrative efficiency of procedures (eg. time taken to complete an investigation; rate of substantiation) or whether parents "relapsed" and there was another episode of "child abuse" following an investigation. There is relatively little information produced which could be used to analyse child protection interventions in terms of outcomes from the clients perspective.

Working within this dominant paradigm of service delivery it is sometimes difficult to be aware of alternative approaches to ensuring the care and protection of children. Until recent years the focus has been on developing elements of the existing system. However, evidence is gradually emerging which suggests the need for a re-evaluation of the current approach.

NEED FOR REVIEW OF PARADIGM

At least four general areas of concern about child protection policy and practice can be identified in current debate in this area.

- (i) The present system effectively acts as a "service which screens the general population for high risk cases" (Little, 1995 p.19). Trends in child protection data from North America (eg. Besharov, 1992), England (eg. Little, 1995) and from elsewhere in Australia (eg. Budeselik and Bowles, 1995) consistently show an increase in the number of child protection reports. However, this increase is not matched by a rise in the substantiation rate. This same statistical trend is evident in the Northern Territory. Table 1 shows the number of reports received and the rate of substantiation from 1991 - 1994.

Year	1991	1992	1993	1994
Number of reports investigated	488	452	775	726
substantiation rate	56%	54%	49%	48%

Table 1: Rate of substantiation of child protection investigations in the Northern Territory 1991 - 1994.

The obvious question is whether this represents an appropriate use of scarce resources. Concerns have been expressed about whether the needs of many of the families caught up in this process would be better met through a different and less confrontational approach.

These concerns have prompted moves to target the investigative process more effectively by narrowing the definitions of abuse and training workers to screen referrals. Unfortunately, these measures by themselves do not satisfactorily deal with the question of how to meet the needs of families whose children do not fit the new criteria for services.

Ironically, at a time when many other child protection services are seeking to restrict the number of investigations, Workers in Darwin Rural District are under considerable pressure to apply the investigative process to a broader range of the population. In the general absence of broad based family support services and in the context of "moral panic" induced by accounts of the "failure to thrive problem", there is a concerted push to have the circumstances of all children medically defined as malnourished investigated by Welfare Workers. This seems to be motivated by the desire to see "something done about the problem".

This tension suggests to the Writer that the "screening" debate is more than just about the efficiency of child protection investigations, it raises direct questions about the role and function of child protective services in society.

- (ii) Although the focus of the definitions of maltreatment is on the harm done to children, the focus of child protection interventions is very much on the behaviour of parents/caregivers towards children. The existence of structural factors such as poverty and inequitable policy and service arrangements are acknowledged, but the way child protection services are constituted makes it difficult to address these as part of the intervention. Instead, much of the attention is directed at the monitoring and surveillance of parental behaviour. Thorpe's analysis of 633 child maltreatment cases in Western Australia during 1987, led him to the conclusion "investigations, judgements, assessments and interventions appear to fit more into an activity which would be described as the regulation of parenthood, the enforcement of standards and the imposition of norms rather than the protection of children....."(Thorpe, 1994 p.197).

(iii) Child protection investigations do not operate independently of social structures.

Although 'child abuse' occurs at all levels of society, people from 'socially disadvantaged' sectors of society, or people with special needs, are over-represented in the statistics. Their experience of child protection is also different in terms of the type of 'abuse' reported and the outcomes of investigations. In the Northern Territory, 52% of substantiated allegations of child abuse in 1991/92 involved Aboriginal children, yet Aboriginal people constitute only 25% of the population. Forty-three per cent (43%) of investigations into Aboriginal families were for issues relating to neglect (Kerr, 1993). Within the European population of Darwin, the children of single mothers show a similar statistical profile (Maric, 1994).

In other words what was conceived as a measured and fair response to concerns about family and child well-being, is shown to discriminate markedly across cultures or even within groups of people in mainstream society. More importantly, the people most effected by the program are those with the least control over their living circumstances, and the greatest dependence on the State. Thus while they are the most vulnerable to changes in Government policy, their marginalised existence makes it very difficult for them to have much influence on the policy development process.

A re-examination of the social context of reporting and intervention would include an analysis of the visibility of these groups of people to welfare agencies. It would also analyse how judgements are made by Workers about what has occurred and the nature of the response required. That is, while there are examples of horrendous acts against children for which there would be universal agreement such acts constituted child abuse, many situations are not clear-cut. Determining what is abuse or neglect relies on judgements influenced by values, situations and cultural views. Who does the judging in this context is an important question.

In the current paradigm of child protection, the abusive act is taken as the most appalling thing that could happen in many of these families. In fact, except for instances of serious harm to children, ignoring special needs and regulating and controlling behaviour of parents may well constitute a more insidious threat to family well being.

(iv) Increasingly it is being realised child protection policy cannot remain isolated from developments in other areas of social policy. Services for the protection of children cannot only respond as if the problem involved tackling a series of relatively discontinuous 'abusive episodes'. Instead, these 'abusive episodes' towards children need to be placed within a wider context. This would include an examination of the pattern of relationships and behaviour within the family over a longer time frame, and examining the interrelationships between 'child abuse' with other issues such as alcohol abuse (eg. Major, 1995), violence (eg. Tomison, 1995), and mental health (eg. Swan and Raphael, 1995). For example, Maric (1994) examined 100 cases of child maltreatment in Darwin Urban District from 1993/94. Family violence was identified in 22% of the sample as a difficulty within the family. The figure for alcohol or drug abuse was 41%. There is no comparable data for Aboriginal people, but alcohol abuse is consistently cited as a major problem (eg. Bolger, 1991). Similarly, Aboriginal mental health issues have been identified as associated to a large extent with a number of social problems such as alcohol abuse, family violence and child abuse (Swan and Raphael, 1995).

Policy frameworks developed in these other areas also suggest alternative ways of conceptualising child protection policy development.

Conclusion

It is quite clear the current debate over the child protection paradigm is not just about the conduct of child protection investigations, the role and function of child protective services in a society is also under question. That is, what part do investigative processes play in society's efforts to ensure the well-being of children?

Thorpe (1994) and Rayner (1994) point out that behind this issue is the further question of the relationship of the State towards families.

This is not merely a philosophical distinction, for it has very real implications for the way services are structured, delivered and evaluated.

The present paradigm appears to construct parents "not as nurturing and supporting agents whose difficulties and structural disadvantages require compensation, but as potential threats from which children require protection " (Thorpe, 1994; p. 199). The State is thus set up in opposition to parents or caregivers and is prepared to intervene in the private world of the family if necessary.

This paradigm arose out of very real concerns about the serious harm which is sometimes inflicted on children. The system which has developed in response to these concerns does in many instances provide an effective response and "rescue" for such children. The problem is that this view of the task at hand has been allowed to take over the agenda completely and dominate service provision.

The roles available under such a paradigm are limited, concentrating mainly on the task of monitoring and surveillance, investigations, and direct intervention. The centrality of the role of Welfare Workers in this process encourages the view that they "own" the problem. The roles of members of other disciplines are also circumscribed by the paradigm. There has been by comparison, very little development of frameworks for multi-disciplinary action outside the investigative context.

There is another way of constructing the relationship between the State and families, whereby caregivers are encouraged and supported by the State to look after and protect children. In other words, there is an assumption that parents and the State share common goals in relation to the well-being of children and that it is possible to work in a collaborative way to achieve these goals.

Removing barriers to the achievement of these goals becomes the focus of activity under this approach.

Such a framework can more easily deal with structural issues and special needs, and releases family members and Workers from narrow and confining roles.

It also enables the existing contributions of family members and Workers from all disciplines to family and child well-being to be recognised and validated. An emphasis on problem identification and control, often means the strengths of families are overlooked, and it is difficult to relate the activity of other Workers directly to child protection.

This approach to policy development and service provision is consistent with the principles of Primary Health Care, and has been applied with some success in Disability Services (eg. Dempsey, 1994).

Of course, some children will continue to be seriously harmed by caregivers no matter what the policy framework, and there will need to be an effective response to these situations. What is being suggested is not that such services be downgraded or regarded as unimportant, but that they be placed in their proper perspective.

Thorpe (1994) argues there needs to be a re-conceptualisation of child protection which "would begin to distinguish between child welfare (those measures which promote the care and well being of children) from child protection (those measures which act directly as a barrier between children and significant harm or injury (p. 198)". In this context, child protection investigations are only a small part of a wider policy framework which has as its primary aim not the prevention of abusive acts per se, but the promotion and maintenance of child and family well being.

Prevention in this context is not based on residual notions of service delivery. It is inclusive, rather than exclusive. It involves tackling structural issues directly and has as one of its goals, the creation of a more equitable and just society.

Rayner (1994) has proposed a five tier model of prevention based on this approach. These tiers are:

- (i) non-abusive society: addressing structural issues of poverty, unemployment, discrimination, social injustice and homelessness.
- (ii) non-abusive communities: addressing the special needs of communities, such as Aboriginal people.
- (iii) healthy family environments: addressing parental support and education, and family focused policies and services.
- (iv) children at risk: addressing short term assistance to children who are abused or at risk of being abused.
- (v) children who have been harmed: addressing long term services for children who have been harmed by abuse.

In the opinion of the writer there is a need to move in the direction suggested by Thorpe (1995) and Rayner (1994). This type of approach shows for greater potential for meeting the needs of Aboriginal families and children in Darwin Rural District.

ABORIGINAL VIEWS ON CHILD PROTECTION

It has been consistently stated by Aboriginal writers that the promotion and maintenance of their family life and culture is regarded as a fundamental health goal (eg. D'Souza, 1994, Houston, 1993). Members from Communities throughout Darwin Rural District have re-affirmed this position in workshops and meetings with District staff.

Members of the Aboriginal Forum Group in Darwin Rural District requested that future policy development should be family-centred.

In other words, child protection issues are conceptualised as part of much wider problems such as:

"how does my family keep/get healthy, strong, happy?"

"how can culture remain strong?"

Detailed analysis by Aboriginal writers of current approaches to child protection (eg. DeSouza, 1994, SNAICC, 1993, 1995) and the provision of services to Aboriginal families (eg. Crowe and Pohl, 1994) is only just beginning to emerge.

In the broader field of Aboriginal health, however, since the publication of the National Aboriginal Health Strategy in 1989 there has been a progressive development of principles and strategies to address health issues. These have direct relevance for child protection services.

Similarly, there has been considerable development of frameworks and strategies to address Aboriginal Mental Health in recent years. Much of this is summarised in Scapin (1994). Child protection is one of the major areas of activity addressed in reports of consultations with Aboriginal people (eg. Swan and Raphael, 1995).

Drawing from this wide variety of published sources it is possible to distil these general issues and concerns into four basic principles considered essential in the development of culturally appropriate child protection services for Aboriginal people.

- (i) **Historical Grounding:** A recognition of past Aboriginal history and an understanding of how that history continues to inform the present.

A persistent theme in Aboriginal writing and reports based on consultations with Aboriginal people is the destruction of family life and authority structures within the Aboriginal community. This has been brought about in their view by past assimilationist policies and practices, and recovery is made more difficult by what is perceived as continued racism and indifference to the special needs of Aboriginal people. They remain marginalised economically and socially from the rest of Australian society.

It has been argued that it is not possible to fully understand issues such as child protection, family violence or mental health amongst Aboriginal people without reference to their current and past experiences in Australian society, (eg. Choo, 1990; Tippett, 1994; Swan and Raphael, 1995). It is further argued that such an understanding must be incorporated into the design and delivery of services to address these issues.

This is particularly important for a service inheriting an historical legacy of enforced removal of Aboriginal children from their parents.

History has produced for Aboriginal people a legacy of continual oppression, fear and distrust, and an experience of investigative processes by outside agencies as having negative consequences for Aboriginal people.

Any discussion about child protection on Aboriginal Communities cannot therefore be confined to improvements to existing investigative procedures. It has to include consideration of the nature and role of the investigative process in an overall response to children and families in need.

- (ii) **Self-determination**: A recognition of the right of an indigenous people to define social issues and determine appropriate responses.

A comprehensive strategy for self-determination includes the following elements:

(a) Development of Policy Framework.

The development of a overall framework within which problems can be defined and understood from an Aboriginal perspective, is regarded as fundamental (eg. SNAICC, 1993; 1995; Swan and Raphael, 1995; Tippet, 1994). However, the process also needs to extend right down to an understanding and recognition of the particular context in which issues become evident. In child protection this includes determining whether harm has occurred or is likely to occur and what action is required in response according to Aboriginal Terms of Reference.

The right to determine appropriate child rearing practices and have these recognised in family interventions has been a persistent demand from Aboriginal writers, (eg. SNAICC, 1993). Aziz (1989) outlined a list of criteria, developed after consultation with Aboriginal people, for determining instances of "child abuse and neglect" in Aboriginal Communities. The discussion on neglect, in particular, emphasised the importance of understanding the context of the care giver's behaviour from an Aboriginal viewpoint. Similar arguments have been made about violence between Aboriginal men and women, (eg. Bolger, 1991) and alcohol abuse (eg. Moore, 1992).

(b) Changes in organisational relationships.

Community based and community controlled Aboriginal organisations are regarded as essential in a comprehensive service. They provide the infrastructure needed to develop and deliver culturally self-determined services.

Changes are also required in the way staff of Government Departments relate to Aboriginal people. Cultural awareness courses can be useful in re-orientating attitudes to Aboriginal people, but what is also required is a shift to a more equal relationship. This will involve a willingness to incorporate and respect Aboriginal aspirations in the design and administration of public policies and services (Dodson, 1993).

Instead of defining problems within program boundaries, and applying the "expert" technology of that program to those problems as defined, definitions and goals are negotiated, and a collaborative relationship is sought to address the issue.

(c) Employment strategies.

At one level there is need for an increase in the numbers of Aboriginal people employed in community-based organisations and Government Departments. More important, however, there is a need to consider what those people do in those jobs, and the environment in which they work. There have been increased calls within recent years for the Aboriginal people to be employed in policy development and evaluation as well as service delivery (eg. Tregenza and Abbott, 1995). Within service delivery, the need for a range of employment opportunities has been identified, including liaison, direct service delivery and community development. Finally, in terms of job design, there is a need for some flexibility to negotiate tasks and priorities and to recognise the fact that Aboriginal people are accountable to their own community as well as to policies and programs (eg. Josif and Elderton, 1992).

(d) Education.

Education priorities are closely linked to the employment strategy. The existence of Aboriginal knowledge and ways of doing things must be recognised. Education at tertiary institutions is not only a means for learning new information and skills, but also provides an opportunity to reflect on the value of Aboriginal Terms of Reference in understanding social issues and determining an appropriate response.

(e) Research.

Research must be conducted within Aboriginal policy and practice frameworks, reflecting the special needs and priorities of Aboriginal people.

- (iii). **Culture as a Source of Strength**: A recognition of the value of cultural knowledge, values and kinship structures as a resource for Aboriginal people in addressing current issues.

Culture confers meanings to peoples lives and structures knowledge, thoughts, feelings and behaviour. Paradigms of knowledge and service delivery are cultural artefacts. Aboriginal people wish to be recognised as "holders and producers", not merely "consumers" of knowledge. There are other priorities and ways of "knowing" and doing things.

In 1993, Aboriginal Health Workers from Darwin Rural District identified Land, Law and Culture as the appropriate foundation of all strategies in Aboriginal Health. The Strong Women, Strong Babies, Strong Culture Program also identifies these as important sources of strength for Aboriginal families.

Kinship is another fundamental institution of Aboriginal life. It informs an understanding of what is meant by "family" or "community" in an Aboriginal context. It is also an

important organising principle in the design and delivery of culturally appropriate services.

(iv) **Holistic Approach**: An individual cannot be considered independent of his/her family, and social issues cannot be considered independent of each other.

At a social level, "child abuse and neglect cannot be separated from the issues of poverty, family violence, substance abuse, unemployment, over-representation of our people including children in institutions etc. nor is it a separate issue from health, housing, education, employment and the law. Aboriginal child abuse and neglect has its foundations in the historical and social circumstances of the past" (SNAICC, 1995, p.16).

Some insight (albeit at a very simplistic level) into the conceptualisation of an individual's situation can be understood with reference to kinship.

"Membership in Aboriginal society, whether in traditional, rural or urban groups is determined by the value placed on relationships to kin. This bestows identity and defines a person's place in the social structure as well as providing a person with an identity" (Crowe and Pohl, 1994).

Thus on one level, alcohol abuse, petrol sniffing, family violence, and child abuse are labels given to observed behaviour of family members. However, the behaviour of these family members, due to the inter-connectedness of society, has implications for relationships between other family members. The maintenance of good family relationships was identified by Crow and Pohl (1994) as one of the most essential aspects of Aboriginal family life. The destruction of family relationships brought about by assimilationist policies and current social circumstances was identified by Choo (1990) as a major aspect of Aboriginal poverty.

Conclusion

If Aboriginal participation is a goal in child protection, it is more likely to occur when Aboriginal people are able to see the relevance of the program to their aspirations and cultural imperatives.

It is clear that the present paradigm of child protection which places great importance on surveillance and investigation of families to prevent abusive acts is unlikely to generate much support amongst the Aboriginal community. This is particularly the case when the services offered and the institutional framework within which they are provided do not take any account of Aboriginal Terms of Reference.

While the ability to intervene on behalf of individual children and their families is important, the clear message is that this needs to be accomplished within a broader framework of preventative services.

This concept of prevention is not residual. It requires an approach which directly addresses issues of equity and justice in order to foster the re-assertion of cultural knowledge and strengths which will enable Aboriginal people to care and protect their own children.

A framework for prevention in Aboriginal Child Protection has been suggested (SNAICC, 1995). It resembles in many respects the framework developed by Rayner (1994).

FUTURE POLICY FRAMEWORK

There appears to be a convergence of views from within mainstream services and from Aboriginal people about the direction of future policy development in child protection.

It seems that persisting with the present paradigm of child protection and trying to graft preventative services onto the existing framework of child protection investigations will not meet the expressed needs of Aboriginal people. It is also an option with limited usefulness in mainstream society.

Instead what is required is a shift in emphasis in the policy framework from the "personal" to the "structural" aspects of the social context of "child maltreatment".

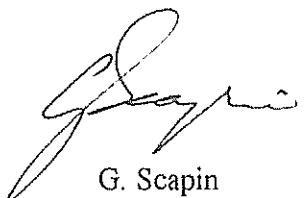
This will entail a significant change in the nature of the current relationship with clients of the service.

It will also mean developing a framework of prevention, not with the limited aim of preventing abusive acts, but in order to work together with families to improve child and family well-being.

Child protection investigations will continue to play an important part in ensuring the care and protect of children. However, in such a policy framework it is likely the investigative process will undergo significant changes, and it will not longer constitute the principle form of response.

There is enough material already published which suggests what such a preventative framework might look like. Such an approach can be supported by existing legislation and is entirely consistent with Primary Health Care principles.

Development of such a policy might finally give substance to the notion that Child Protection is a shared responsibility.



G. Scapin
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Kinship Care

Construction of an Issue

The current international debate about kinship care has its origins in recent trends in foster care. There has been an increase in the number of children entering state care. Associated with this there has been a decrease in the proportion of children placed with foster parents who are unknown to the child or family but registered and approved by state agencies as being able to fulfil this role. Many of these children have instead been placed in the care of grandmothers, aunts and (to a lesser extent) other family members or with people who have an existing close emotional attachment to the children.

The extent of this trend has varied widely both between countries and even within jurisdictions. The shift in the nature of foster care arrangements has been most dramatic in parts of the United States.

Family and friends are of course a traditional source of support to parents in bringing up their children. This includes helping out by caring for children when their parents are unable or unwilling to do so or are experiencing difficulties. At the core of the kinship care debate, however, is not only the increasing interest of the state in accessing the child's existing care networks, but in many cases the increasing **reliance** by the state on these networks to meet the care and protection needs of children.

The evidence suggests that this development is due to a combination of factors.

Various commentators have pointed to a general rise in the level of poverty as increasing the vulnerability of families. They have also suggested that families are now presenting with more complex issues (eg. mental health problems, drug and alcohol abuse). In the United States, "crack" cocaine abuse and AIDS have been identified as significant factors in some areas. This has put pressure on agency resources.

At the same time there has been a growing disillusionment amongst many agency staff over the future of traditional foster care. There has been little progress in improving outcomes for children in care and agencies have found it increasingly difficult to recruit new foster parents to add to the pool of general foster carers. Placement of children in need of care with family members was one strategy that helped meet this shortfall. This strategy was also consistent with recent ideological shifts in the way agencies approach working with families. Over the past ten years there has been an increasing interest in developing policy and practice around working in partnership with families to achieve better outcomes for children.

These developments have also been shaped by the broader political and economic context.

The United Nations Convention on the Rights of the Child has been influential in getting Indigenous Child Placement Principles inserted in welfare legislation. These principles require workers seeking alternative care for an Indigenous child to first consider placing the child within their own extended family or kinship group. This principle is contained in Section 69 of the N.T. Community Welfare Act (1983).

In New Zealand there is an emphasis in the Children, Young Persons and Their Families Act (1989) on the role of kin in making decisions about the care and protection of children. This was due largely to a campaign by Maori leaders to incorporate Indigenous perspectives. However, as Brown (2000) and Worrall (1999) have pointed out, this change in emphasis also occurred at a time when the New Zealand government was busy cutting back services in a range of areas including health and education. A shift from state responsibility to family responsibility and policies around working in partnership with families was both ideologically sound and attractive as a way of reducing dependence (costs) on the state.

It has recently been acknowledged that as well as private care arrangements amongst families and kinship foster placements, there is a third category of kinship care. This category consists of children placed in the care of family and friends informally following state intervention in family life (eg following a child protection investigation). Unlike kinship foster care, there is no Order or legally enforceable agreement supporting the placement. This is a relatively unexamined area of welfare practice. It is difficult to estimate the size of this third group as agencies don't routinely report on this aspect of their work, but it is believed to be significant. Ehrle, Green and Clarke (2001) report that the 1997 National Survey of America's Families estimated there were 1.3 million American children in private care arrangements, 200,000 in kinship foster care, and 300,000 children placed in the care of family and friends following state intervention.

Research into whether kinship care has delivered the benefits to children and families that were anticipated has mainly come from the United States and has focused primarily on kinship foster care. The American Congress directed the Department of Health and Human Services, in the Adoption and Safe Families Act of 1997, to convene a Kinship Advisory Care Panel and commission a Report to Congress on Kinship Foster Care. This provides a useful summary of research to that date (Department of Health and Human Services, 1999). Dorothy Roberts (2001) also summarised research and analysed it from a black perspective. She concluded

"Kinship foster care has many advantages compared to non-kin foster care. It usually preserves family, community and cultural ties. Children are more likely maintain contact with their parents and to remain with siblings if they are living with relatives than if they are placed in non-relative foster care. It is likely that the children are already familiar with the kin caregiver, so the placement avoids that trauma of moving in with strangers. Kinship foster care usually allows children to stay in their communities and to continue the cultural traditions their parents observe. Kinship care is more stable: children

living with relatives are less likely to be moved to multiple placements while in substitute care. There is also evidence that children are better cared for by relatives than by strangers: more children in kinship foster care reported that they felt loved and happy, and fewer are abused while in state custody" (p. 1625).

Over the last three years there has been an increase in the amount of research from England (eg Greeff, 1999; Broad, 2001). Research from New Zealand (eg Worrall, 1999; 2001) and Australia (eg Mason et al, 2002) remains very thin.

Hunt (2001) included an analysis of some of this research as well as the latest research coming from the United States in her scoping paper into "Family and Friends Carers" for the Department of Health in England. Hunt was more conservative in using research results to make claims for the benefits of kinship care. She noted there was relatively little research into assessing whether kinship care produced better outcomes for children in terms of improved well-being and functioning in life. She reported that research results using proxy measures of well-being such as "children's contact with parents" or "abuse in care" were not always consistent.

Hunt attributed a lot of this variation to methodological problems. The diversity within and between groups of children and carers who are the subjects of the research makes it difficult to compare results of different studies. For example, children in kinship foster placements may have come to the kinship foster placement straight from the family home, from a short-term crisis placement, or after spending a long period in general foster care. In research there was often no effort to control for these differences. Fundamental differences in legislation, policy and practice between jurisdictions also made it very difficult to interpret the relevance of research to local conditions.

Another major factor in interpreting results is that it would appear caseworkers and their agencies treat kinship foster placements in a different way to general foster placements. Kinship foster carers are frequently provided with a lower level of financial support. "Agencies tend to devote fewer resources to the reunification of children in kinship foster care with their parents. Caseworkers have less contact with relatives and the children in their care and are less likely to offer them services" (Roberts, 2001, p1633).

Hunt did conclude that research has consistently shown that carers generally have a high level of commitment in caring for children and derive satisfaction from doing so. They tend to be motivated out of a genuine concern for the children, and a desire to keep them within the family and not be "lost" within the welfare system. Children generally report they feel secure and happy in the placement. Placements with family do tend to be much more stable, and the child is likely to remain in contact with siblings.

In these respects, Hunt concluded, children in kinship placements do better than children placed with strangers. With regard to the other measures, although the evidence was less clear-cut, it appeared that children at least did no worse. What was clear, however, was that placement with kin does not guarantee good outcomes

for children. Kinship carers required as much (if not more) support than general foster parents. Carers frequently found they had to make sudden and major adjustments in their lifestyle and in their relationships with family members, and were often unprepared for the demands placed on them by an emotionally deprived child.

The need for support was further highlighted by evidence from research that the greatest impact of kinship foster care initiatives has been on the sectors of the population most heavily disadvantaged economically and socially, and already over-represented in the statutory welfare system (viz the poor, and black/Indigenous people). In America, poor, urban African Americans are the group most heavily engaged with the welfare system. Typically black children enter care because of issues of neglect, mostly associated with parental substance abuse. In New Zealand and Australia there are similar trends amongst Maori and Aboriginal people.

Kinship carers as a group also experience many of the same economic and social disadvantages. As Roberts (2001) succinctly put it "many kinship carers come from poor or low-income families like the grandchildren, nieces, and nephews placed in their homes. They are more likely to be single females and to have less income, more health problems and more children to take care of than non-relative foster parents" (p.1634). They don't, however, necessarily share the other characteristics of the child's parents. In fact, it is likely to be the resourceful members of the family who are approached to provide care. It has been noted, although not generally given much prominence, that even though families may be large and the potential exists for a range of alternative carers, in practice the care responsibilities within families seem to fall to a few. Typically carers are women, often single, mainly from the maternal side of the family, and who have a number of other care responsibilities (other children, or perhaps an aged relative). Shifting the responsibility to families may mean in practice increasing the burden on these carers.

Reviews in the literature of efforts to regulate and support kinship placements providing care and protection for children have revealed a wide variation between states, local authorities, and agencies in policy and procedure and levels of support provided. Quite simply, policy and practice has not kept up with developments. In the United States there are marked differences between States. In England there are marked differences between local authorities within a few miles of each other, both in terms of the priority given to kinship care and in the level of support provided to families. This is sometimes referred to as the "postcode lottery" (Jenkins, 2001).

This confusion is partly due to uncertainties about the proper role of the state in supporting and promoting kinship care.

"There are social workers and social service departments who see kinship care as the responsibility of families and think that there is an expectation on relatives to step in and look after children whose own parents are unable to do this. They think families should take on these responsibilities without seeking any help from the state. Other social workers and social service departments see kinship care as the responsibility of the state and as an alternative to residential or stranger foster care. They think relatives should receive adequate financial and other support to care for children who might otherwise

be looked after in stranger foster care or residential care" (Tapsfield, 2001, p.87).

Other writer's have commented on the contradictions that become apparent by trying to support kinship foster care in a residual welfare system. That is, although it is apparent many families are socially and economically disadvantaged and that this increases their vulnerability, increased assistance is available only at the price of state intervention into family life. "Making kinship care part of the child welfare system has a dramatic impact on the relationships of family members and on their relationship to the state....the extended family exchanges its autonomy over child raising for financial support and services needed to raise its children" (Roberts, 2001, p.1629). Writing in the context of the American social services system, Roberts noted "families involved in kinship care must exchange a degree of autonomy and independence in child rearing that is in proportion to the amount of support they receive from the government. The price of the highest amount of aid – foster care benefits – is relinquishing custody of children to the state and submitting to foster care regulations and supervision by the child welfare system" (p.1628).

Roberts argues that the price the child welfare system exacts for its support stems from its underlying philosophy. Again, writing in the context of the American social services system:

"The child welfare system is built on the presumption that children's basic needs for sustenance and development will and can be met solely by parents. The state intervenes to provide special institutionalised services – primarily placing children in foster care – only when parents fail to fulfil their child rearing obligations. The child protection approach is inextricably tied to our society's refusal to see a collective responsibility for children's welfare" (p 1639-1640).

For Roberts this approach to state responsibility is defective in three ways:

1. All the responsibility for taking care of children is placed on their parents, without taking into account the economic, political, and social constraints that prevent many parents from doing so.
2. The child protection system is only activated when the families are already in crisis. The role of government is limited to rescuing children who have been mistreated by deficient parents, rather than ensuring the health and welfare of all families.
3. Because the system perceives the resulting harm to children as parental rather than societal failures, state intervention to protect children is punitive in nature.

Australia, indeed the Northern Territory, has a range of policies and measures that are much more supportive to families than the American social services system. However, the broad thrust of the criticism still applies and it does highlight that support for kinship care should also involve elements of broader social policy such as income support through benefits or tax concessions, and access to services such as health care, education and child-care. Support services for vulnerable families are needed. Provision also needs to be made for access to appropriate legal remedies

for regularising family care arrangements without the need for statutory welfare involvement.

One final point that needs to be made is that the construction of the kinship care issue has largely been professionally driven. The existence of Indigenous Child Placement Principles in legislation is evidence that Indigenous groups have strong views on the role of kinship care in meeting the needs of children. The Children, Young Persons and Their Families Act (1989) in New Zealand also incorporated Indigenous principles about the importance of kin being involved in decisions about the care and protection of their children. Indigenous groups continue to battle to have their voice heard in policy debates. However, there is very little in the literature about kinship care that is written from an indigenous or even a client perspective. The recent increase in the number of Grandparent support groups in England and the United States is a sign that the agencies' concerns and priorities are not necessarily shared by all groups.

This last point is important, as the way the issue has been constructed has had a major influence in the way people have defined kinship care and on the way people have approached issues in kinship care.

Defining Kinship Care

There is no universally agreed definition of kinship care. This is partly due to the fact that there is no agreement about the precise extent of the issue under study. Different terms are used in the literature depending on the focus of research or on the approach taken by the researcher.

The term "kinship" is sometimes used only to refer to relatives, and other times has included "fictive kin" (ie persons classified as kin but not related by blood), and friends. Because of this confusion, the expression "kith and kin" is used in some contexts to demonstrate that the focus is wider than just family.

"Kinship foster care" or (in England) "family and friends care" are terms used to refer to the placement of children in state care with family or friends.

The Report to Congress on Kinship Foster Care (Department of Health and Human Services, 1999) grouped all care arrangements made with the assistance and/or involvement of child welfare authorities as "public kinship care". This included informal care arrangements following a child protection investigation, and children in state care. Care arrangements made without involving child welfare authorities were categorised as "private kinship care".

The term "kinship care" in this paper refers to the full-time care of children by family or friends in all contexts (private care arrangements, informal care arrangements following a child protection investigation, and state care). "Family" is understood in its broadest sense to include extended family as well as Aboriginal kinship networks.

This is deliberately rather a broad definition. At a fundamental level this is because

“kinship care is not a local authority service. Kinship care is a feature of the ways families operate and it can be supported and encouraged by local authorities, or, it can be unsupported and undermined” (Tapsfield, 2001, p. 85).

As such, “kinship care” does not sit neatly within the foster care program or indeed any particular welfare program. It has elements of family support, child protection and child placement (Mills and Usher, 1996; Gleeson and Craig, 1994).

There are other practical considerations as well. The status of a child’s care arrangements can and does change quite readily, and it makes little sense in this paper to unnecessarily restrict analysis to only one care context. Similarly, people in families define who are members of their family, not professionals. The broad definition of family makes allowance for this.

It is recognised that even this definition may be limited in some contexts. A draft Accreditation Policy Statement from the Office of the Children’s Guardian in New South Wales has argued that as the term “kinship care” has been used in so many different ways, Aboriginal people need to find a new word to adequately express the particular kinship experience for Aboriginal children (NSW Office of the Children’s Guardian, 2002).

Principles for Developing a Service Response

The crisis in general foster care influenced early research priorities with the effect that the focus was initially on comparing kinship foster care with traditional foster care. It quickly became apparent that there were a number of practice issues. These issues centred around the processes of assessment, decision-making and planning, support, and permanency planning. Mixed up with these issues, however, were some fundamental questions about the principles that should underpin policy development. To put it simply, different principles lead to different emphases and goals in practice. Disagreements about principles make it impossible to agree on best practice.

Hunt (2001) identified these fundamental questions as:

- What should be the role of the state in relation to the support and regulation of kinship care?
- Where does kinship care fit in the spectrum of child welfare services?
- Is there a necessary link between finance, support and regulation?

All these questions are linked together and cannot really be considered in isolation. However, it is perhaps helpful to begin with the second question as it goes to the heart of understanding the nature of kinship care arrangements.

Many writers have argued that although kinship foster care is superficially similar to traditional foster care, it should be considered as fundamentally different.

A constant theme in the literature is the extent to which extended families are often already involved in the care of children prior to any contact with the state. There is a lot of evidence that many families (even without assistance from the state) continue to take in children needing help despite barely having enough to provide for their own children. Many kinship studies report that family members approached by agencies to care for children have often been providing care on and off for these children for some time before state involvement. In fact, it is not uncommon for the referral to have come from the carer who is seeking support to be able to make proper arrangements for the children's care and protection. When members of extended family therefore are asked by agencies to provide support to the parents, provide temporary respite care, or to take on the care of children to ensure their protection, this is often an extension of their current role (eg Bonecutter and Gleeson, 1997; Worrall, 1999).

Portengen and van der Neut (1999) point out that the caseworker has in consequence a very different role in the planning and decision-making process in kinship care compared with traditional foster care. They represented this using the following diagram.

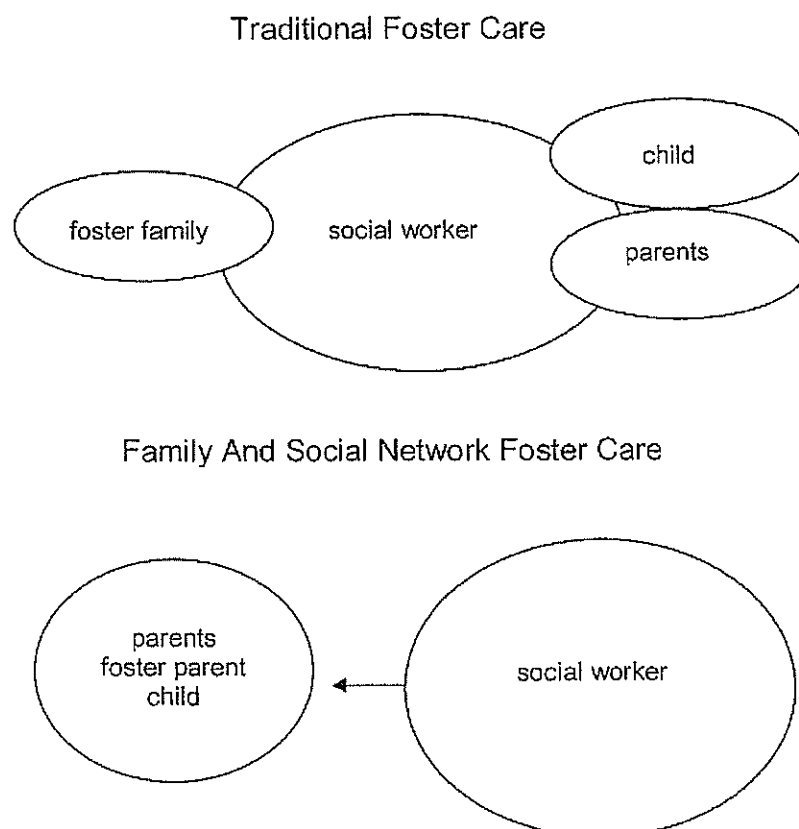


Figure1 The social worker's position in traditional and network foster care

"In traditional foster care, the social workers link and filter the information: they decide what information should be told to the parent about the foster parents and what information should be told to the foster parents about the child and her parents. All parties are dependent on that information and this puts the social worker in a powerful position. They are like the spider in the centre of the web: all parties need them for information about and contact with each other. In kinship care, the parents, child and foster parents know each other; they know many things about family lifestyle, the history of the family, the way they raise children, family secrets and so on. They do not need the social worker for information: the social worker needs them to get information. She has to prove that she is worth trusting with this information before they will give it" (p.53).

This is an **exchange** model of casework practice (Smale et al, 2000). What is exchanged is not only information, but also resources and expertise. Not many social workers are familiar with the social realities of their clients and nor are they the experts in how to manage in that environment. This is particularly true in working with Indigenous clients. Workers therefore seek to tap into the resources of the extended family. This includes asking for assistance to identify appropriate carers and for help in negotiating a role for the parents in the care plan. Workers also seek to draw on expertise within the family in understanding and providing for the needs of children, and in protecting children from harm in the environment in which the family actually lives (as opposed to the carefully controlled and tightly managed environment aspired to in traditional foster care). To do so they will need to negotiate. From the point of view of the family, they may seek resources, support in managing their relationship with the parents, and access to particular expertise in negotiating bureaucracy or in managing the behaviour of the children placed in their care.

Mason et al (2002) argue that the differences between kinship care and traditional foster care also extend much deeper than the role of the caseworker. In their view the origins of "traditional" foster care stem from a paradigm in child welfare that emphasises "good" care and advocates that children who are maltreated should be placed with "good" substitute carers.

"The determination of "good" parents relies also on assumptions about the best kind of family being the nuclear family and on professional assessments in determining this. The practice of formalising kinship care, challenges the role of child protection agencies as being about redistributing children from dysfunctional or deviant families to more socially acceptable families....When children are removed from "at risk" situations, but relocated elsewhere in the same family, the state's role in defining appropriate care for these children becomes ambiguous in terms of past practices. The ambiguity increases when children placed in care are from cultural backgrounds which differ from those dominant in child welfare authorities, usually white, middle class, professional" (p. 46).

Of course few workers would subscribe entirely to this paradigm, but its influence on people's thinking is surprisingly strong. The angst expressed in the literature about whether the standards for kinship foster carers should be "less strict", and the accompanying assumption that this would lead to a "lower" standard of care, is due to this legacy of trying to apply principles developed for the care of children by strangers.

These difficulties are multiplied the further one moves away from kinship foster care. Applying these principles to other types of kinship care would lead to the state becoming involved in intensive regulation and monitoring of family life.

An alternative suggested by many writers is to see kinship foster care not only as a substitute care service but also in a sense as an extension of the work done to preserve, support and strengthen families in family support and child protection casework (eg Ingram, 1996; Jackson, 1996; Sultmann and Testro, 2001). The existence of a Court Order or legal care agreement (it is argued) does not require a worker to apply a different set of principles or assumptions about families.

Workers already support some private kinship placements through family support casework, and negotiate placements of children with extended family following some child protection investigations. The exchange model of casework practice is as appropriate in these situations as it is in kinship foster care. Issues of assessment, decision-making and planning, support, and permanency planning are just as relevant in placements outside the context of kinship foster care. A Court Order or a legal care agreement in one sense introduces a new complexity, but in another sense it clarifies the often implied authority of the caseworker in child protection and family support casework. Placement of the child with extended family can be viewed as preserving the child's links with family and in that sense is an extension of family preservation principles.

This approach brings together the different types of kinship care and provides some insights into how the various practice issues in kinship foster care might be resolved. It is also consistent with the reasoning behind the insertion of the Indigenous Child Placement Principle in legislation. The earlier focus on "kinship foster care" reflects the preoccupation of child welfare professionals. From the point of view of families, the broader issue is how they can receive the support they need to care for and protect their children.

Agencies have to "move away from the traditional paternalistic system of welfare in which the child is rescued by the bureaucracy, to one where the family is seen as the priority carer and protector and is supported to undertake this role" (Connolly as cited in Nixon, 2001, p.93).

The FACS Policy and Practice Manual accepts that the state has an important role in supporting families and acknowledges the family as the unit in society primarily responsible for the care and protection of children. The role of government is firstly to support parents and families so that they are better able to fulfil their responsibilities and secondly to intervene directly on behalf of children when they are at risk of maltreatment. If a child needs to be placed in alternative care, Workers must first look towards care within the extended family, and then to care outside the family. The

Manual states that in any work with children and families the primary consideration of FACS must be the welfare and the best interests of the child, although these interests are usually served by maintaining the child within the family wherever possible.

In carrying out this role, a "collaborative working partnership" with families is promoted in the Manual as an appropriate framework for casework practice. In this context "family" refers to not only the "immediate family" but also to "extended family".

This statement of position is consistent with the suggested direction for policy development, and provides a partial answer to the question of the role of the state in supporting and regulating kinship care. However, if families and the state are to work together, they need to work out the nature of the partnership. What is the context of the "exchange"?

The state is obviously in a very powerful position relative to families, particularly families from marginalised groups in society. At a most basic level the state controls the distribution of resources needed by families to function effectively. The state also possesses statutory powers and how these powers are used can have a major impact on families. The families who are most vulnerable to this power are typically the families most heavily involved in state sponsored kinship care arrangements. Appropriation of kinship care as a preferred placement option has the potential to further increase the intrusion of the state into family life. Successful work with these families will require some strategic thinking about roles and responsibilities (ie power sharing).

Morrison, as reported in Brown (2000), and writing about child protection services, wrote:

"One of the greatest challenges for professionally-orientated child protection systems is how to engage in meaningful dialogue with local communities, often in neighbourhoods suffering acute deprivation whose accumulated experiences of welfare and other institutional systems may often have been very negative. If a more holistic approach to child protection is to be achieved, it will require the ability of agencies to work collaboratively at this developmental level, to have the confidence to relinquish some of their power and to learn how to identify, work with and strengthen informal caring networks that in any event carry out the bulk of social and child care work within communities" (p.92).

Another way of looking at the issue is to think of the family and the state as two separate systems. The issue is where to draw the boundary between the state and the family (eg Greeff, 1999). From the point of view of the state, there are decisions to be made about what to become involved in, how (and how far) to become involved, and when to take control of a situation. From the point of view of the family, there are decisions about when to approach the state for assistance, and how far they are prepared to cooperate with the state. This is a contested area of social policy and there are no hard and fast rules about where the line should be drawn.

For Aboriginal people there is a history of state involvement in family life with often disastrous consequences. Policies were frequently based on ignorance about Aboriginal family life, and at times have been aggressively interventionist. It is not that long ago that Aboriginal adults were themselves Wards of the state, effectively denied the respect of being recognised as being able to make decisions for themselves. The Stolen Generation is a product of a time when it might be said that the state recognised no boundaries in terms of intervening into Aboriginal family life. These effects are still being felt today. Aboriginal people also remain the group most dependent on the state for assistance, and consequently are vulnerable to shifts in state policy about family life, including kinship care. For example, the rate of Aboriginal children in out of home care in the Northern Territory is amongst the lowest in the country, but it is still over twice the rate of other children. Forty per cent of these children are in kinship foster care (AIHW, 2002).

For these reasons the political agenda for Aboriginal people has long been to focus first on economic and social development with a view reducing dependence on the state and consequently the vulnerability of Aboriginal families. Secondly, to seek recognition of the value of culture and family in shaping identity and providing a foundation for life. Thirdly, to seek support from the state for resources to preserve, support and strengthen Aboriginal family life, while at the same time limiting the extent of direct state intervention into family life.

"Indigenous people often see welfare departments as unable to assist them and their communities. They perceive the departments as bureaucracies which require a lot of paperwork, judge indigenous people's lives and ultimately remove their children " (Bringing Them Home, 1997, p.456).

This view of welfare departments inhibits some Aboriginal kinship carers from seeking the assistance they need " for fear they will be perceived as not coping" (Bridge, 2000, p. 9).

In this context Aboriginal organisations have an essential role to play in providing direct services to families, mediating the effect of state policies affecting family life, and acting as a power base to effect changes in the wider community. There is a wariness, however, within the Aboriginal community about the sort of "partnerships" between Indigenous organisations and the state typically on offer.

"Partnerships' between Indigenous children's agencies and government departments, where they exist, are unequal partnerships. Departments retain full executive decision making power and the power to allocate resources affecting Indigenous children's welfare. Judicial decision making occurs within non-Indigenous Courts. In no jurisdiction are Indigenous child care agencies permitted to be involved in the investigation of an allegation of neglect or abuse. The difference between being allowed to participate and having the right to make decisions is evident in Indigenous communities' experiences of child welfare systems" (Bringing Them Home, 1997, p. 449).

Section 68 of the NT Community Welfare Act (1983) enables support to be provided to Aboriginal communities and organisations to "develop their efforts in respect of the welfare of Aboriginal families and children". Section 70 permits the delegation of powers and functions under the Act to a community government council or to a committee of an incorporated association. The mechanisms are therefore in place to enable Aboriginal organisations to take a greater role in providing services to families.

The lack of progress to date suggests that for Aboriginal people (and the rest of the population as a whole) the contents of the FACS Policy and Procedure Manual and special provisions in the Act can only make a limited impact on changing the role of the state in family life. If principles about sharing state power with kin are to have any significant impact on the activities of workers and the Courts, it may be necessary to follow New Zealand's lead by incorporating those principles into legislation in such a way that they influence every action taken under the authority of the Act.

All of these issues come to a head in the current debate about payments to kinship carers.

A consistent finding in the literature noted earlier is that kinship carers are motivated to provide care out of concern for the child. Yet an equally consistent finding is that financial assistance is the most frequent request for support from kinship carers (eg Dubowitz et al, 1993; Bringing Them Home, 1997).

Foster parents are paid a fortnightly allowance that is intended to meet most of the costs of caring for children placed in their care. There is some agreement that children placed with family under a Court Order should expect some assistance with costs from the state. However, typically the regular allowance paid is less than the foster rate and there is a reluctance to extend this support to other categories of kinship care. When the Order expires so too (usually) does the assistance.

Hornby et al (1996) identified this reluctance as stemming partly from uncertainty over whether to regard any particular placement with family as inside or outside the welfare system. Debate centres around the respective obligations of family and state.

Many families manage without the need for state assistance. Worrall (1999) suggested that to understand what might cause a family to request assistance, it was important to make a distinction between "caring about" and the ability to "care for" a child. That is, while a grandmother may care deeply about the well-being of her grandson and is prepared to act on that concern, she may lack the means to do so.

In Worrall's view, many people underestimate the potential impact the placement of a child can have on a carer's financial and emotional resources. Anecdotal evidence from the research suggests that an inability to make ends meet is what prompts many kinship carers to approach the state for assistance (eg Waldman and Wheal, 1999; Wheal, 2001). Without assistance, some private placements may break down, the child return to parental care and perhaps later become the subject of a child protection investigation. Tapsfield (2001) gives examples of people giving up full-time work in order to care for a child. Agencies may need to provide ongoing financial

support before some carers feel they are able to commit to caring for a child long-term.

The rhetoric of "partnership" and "collaboration" implies some obligation on the part of the state to assist families. However, the goal of "strong independent families" cannot be achieved in a system where the resources a family needs are all tied up in statutory welfare agencies, and families can only get help in exchange for some autonomy or by coming under the gaze of the agency. Similarly, for carers looking after children who are clients of an agency, an arrangement where assistance can be terminated at the discretion of the agency without regard to the ongoing viability of the placement (often under pressure to get the family "off the books") is no basis for a "partnership".

From the point of view of the statutory welfare agency, extending the reach of the agency and retaining clients indefinitely in order to provide them with support also leads to unacceptable consequences. The agency loses its focus on meeting the protective needs of children, its effectiveness in meeting the needs of clients declines, and its efforts contribute to increasing the social costs to children and families they are trying to help.

Ideally, there should be a system of support, including financial assistance, existing outside the statutory welfare system. This would reduce the need for families to access the statutory welfare system for support, and would enable the statutory welfare system to discharge clients when there was no further protective concerns.

This support could perhaps be provided "at arm's length" through a non-government organisation, or could be built into the income maintenance system provided through national governments.

Most of the research on kinship care has come from the United States, where the system of state support to families is very fragmented and income maintenance support is much less generous than in other countries such as Australia. This has created a strong pressure from families to access the comparatively better allowances available through statutory welfare programs (McGowan and Walsh, 2000).

In England, there is a provision in their legislation for a Residence Order. This allows a child to remain with a nominated carer (equivalent in many ways to the orders relating to residence obtainable through the Family Law Court in Australia). It is not an Order supervised by local authorities, but there is provision for local authorities to make regular payments to support the placement. These payments are made at the discretion of the local authority and cease when the child turns sixteen. Jenkins (2001) has been critical of the way local authorities have used this discretion. Often acting without adequate guidelines, the assistance provided by different local authorities is highly variable.

In Australia the Federal Government has accepted the principle that assisting families with the costs of raising children and supporting the informal care system is an important part of "supporting and strengthening" families. Using a combination of tax concessions and benefits, assistance is provided in the form of supplementary

income to help with general costs in raising children for people on low income, assistance with child care costs, and assistance in meeting the extra costs of caring for a child with a disability. There is also a carer allowance for a family member taking responsibility for the full-time care of a child with a severe disability.

The Child Support Agency enforces orders for support from the Family Law Court to a parent caring for a child after separation from their former partner.

Families taking on the care of children would be eligible to claim for most of these forms of assistance. There is no special category of assistance for kinship carers except in the circumstance where the child's parents are both dead or are incapacitated in some way (thus effectively leaving the child without any parents).

Assessing the suitability of these payments in meeting the needs of kinship carers is beyond the scope of this paper, but it will be an essential part of any efforts to develop an appropriate system of financial support.

The New Zealand government has the most generous system of support for kinship carers. The commitment of the government to involving kin in decisions about the care and protection of children, and the fact that the same government is responsible for statutory welfare services as well as income maintenance policies are undoubtedly some of the reasons behind this policy direction.

The Unsupported Child's Benefit is intended to "help support the child when their parent's can't support them because of a family breakdown". It is a fortnightly payment. The amount depends on the child's age and whether the child has any income from another source (eg from the estate of a deceased parent; if the child is working or is receiving another allowance from the state). It is not regarded as income and so is not taxed and will not affect any other income the carer receives. To receive the allowance carers must intend providing care for at least the next twelve months and the care arrangement must be ratified at a family meeting.

The benefit is designed to complement care arrangements made through the statutory welfare system. It is only available to private carers (ie not foster parents) and cannot be claimed while the child is in the care of Child, Youth and Family. A Family Group Conference undertaken in the course of a statutory welfare intervention that recommends the new care arrangement can substitute for the requirement for a family meeting. If a person provides care to a child discharged from the care of Child, Youth and Family, they may be eligible for up to an extra \$26 a week.

Worrall (1999) has criticised the amount of the allowance, claiming that the allowance still does not cover all of the extra costs of looking after a child. In her view, payment of the Unsupported Child's Benefit "only ensures family income is not totally compromised by the arrival of another dependent" (p. 197). One potential barrier to access is that the carer must apply for child support from the child's parents (although the money is paid to the government not to the carer). The fact that a family meeting has ratified the change in care arrangements might go some way to reducing this potential source of conflict.

Whatever arrangements are put in place to provide financial support to carers, they will not cover all contingencies and will not be able to avoid all the contradictions that become evident when trying to balance responsibilities and obligations. It may be as Greeff (1999) suggests, "we are actually talking about a pattern of negotiation where there is no one rule or pattern of relationship that applies to all cases and where the relationship between a particular care network and the state is in the process of being negotiated. It is an individual matter depending upon the particular elements of the situation" (p.203). What is clear, however, is that the focus should be on the needs of the child rather than on the status of the carer. In a comprehensive system supportive of kinship care, there should be provision for carers to get financial assistance without requiring ongoing regulation of family life. For that to happen, statutory welfare agencies can't be the main sources of assistance except in specific circumstances. Community organisations and the income maintenance system also have important roles to play.

Service Response Consistent With Principles

The introduction of the New Zealand Children, Young Persons and Their Families Act (1989) has re-defined the nature of the relationship between the state and the family for statutory welfare work in that country. Families are supported by the state to develop their own solutions to problems. Children are to be placed out of the family only as an interim measure until suitable family members are found or as a "last resort" permanent placement. The Family Group Conference is enshrined in law as the forum in which social workers and families work together to reach agreement on how to keep a child safely within the family group

Family Group Conferences are confined mainly to serious care and protection issues (a more informal process leading to a family/whanau agreement is used in less serious cases). The Conferences are facilitated by Care and Protection Coordinators. The Coordinators are appointed under the Act and, although part of the Department, are managed separately to the caseworkers involved with the family. They consult with family members and with professionals involved with the matter and then convene a meeting. They have the right to veto the participation of a family member but must provide the meeting with an explanation and must ensure this person's views are put before the meeting. There is provision to assist some family members to attend the meeting. At the Conference, the Coordinator first lets everyone know why the conference is being held, what the issues are, and what help is available to sort out the problem. The family then consult in private about the matter. Finally the Coordinator assists the combined group to make decisions, recommendations and plans. If the family is unable to provide care and protection, or if agreement cannot be reached, the matter is referred to the Family Court.

The Coordinators therefore play a key role in the process and much depends on their skill in preparing participants for the meeting and in mediating between the various viewpoints.

An advocate of this approach has described the Family Group Conference as "an outward sign of a commitment to inclusive, empowering, partnership practice by professionals who work with families. It is the partnership mechanism that enables

the formal state and professional systems to interact in an equal and respectful way with informal family and community systems. The model shifts professional activity from assessment and intervention planning based on a professional view of the best interests of the child, to exchange and action as partnership activities. It recognises that informal systems have knowledge and strengths that are unavailable to the state and professional systems" (Doolan, 2002, p.1).

In other words, practice is structured around the requirement to hold a Family Group Conference, or to develop the family/whanau agreement.

A "collaborative working partnership" with families is also promoted in the FACS Policy and Practice Manual as an appropriate framework for casework practice.

The Manual outlines a number of principles and beliefs underpinning such a framework. These include:

- Most families have the potential to be competent and self-sufficient
- Family members have the capability to make decisions for themselves
- Casework should emphasise and build on existing strengths of families and respect cultural and ethnic differences

Family Meetings are promoted as the primary "decision making forums".

Family Meetings are meetings between caseworkers, members of the child's immediate and extended family, and where appropriate, the child.

The main reason for convening a Family Meeting is to:

- *provide the family with clear reasons for FACS involvement with them and their child*
- *seek and record the views of the child and family in relation to decisions being made*
- *provide family members with maximum opportunities to participate in planning to meet their child's needs*

The Family Meeting formalises the family's decision making, although work done with the family before and after the meetings is equally crucial to effective involvement. (Section 6.4.1.)

These meetings are meant to be held on a regular basis in all child protection and substitute care cases. Although the regularity of these meetings will be defined by the case, the Practice Standard is that they will be held at least three monthly during the first twelve months of a case, and occur at least every six months after.

It is acknowledged in the Manual that the nature of statutory welfare work imposes some constraints on this process. FACS reserves the right to insist on certain conditions being met in negotiations with the family. It is suggested that it is still possible to work collaboratively within the constraints as long as FACS outlines their position clearly at the start of the negotiations (ie. the "bottom line").

Taking children into care is described as an option of "last resort" which should only be contemplated after careful consideration of other options and alternatives such as providing assistance to the family. When identifying the most suitable placement for a child

Research indicates that the placement option which offers children the greatest stability and chance of achieving positive and improved outcomes, is one within their own family kinship system. Therefore kinship care options should be considered in all cases, before the consideration of other non-relative placement options. (Section 14.3.2)

Superficially, therefore, the two frameworks of casework practice are similar. They both incorporate many of the ideas and principles discussed so far in this paper. The NT framework, however, is much less developed and there has not been any training or any changes in organisational arrangements to support this framework. The two frameworks also differ in another crucial aspect. The New Zealand Family Group Conference is a legal requirement in certain situations. The Family Meeting referred to in the FACS Manual exists only as a policy requirement for best practice. Doolan, writing about a similar state of affairs in England, sees this as a weakness if the intention is to use the Family Group Conference model as a way of re-structuring relationships between state and family in statutory welfare work.

"The problem with this is that social workers control the gateway to the process. If they are sceptical about the value of the Family Group Conference; if they cannot commit the time for the referral process; if they believe that child protection decisions should be taken only by trained professionals; then a Family Group Conference will not happen" (Doolan, 2002, p.5).

The FACS Policy and Practice manual makes a distinction between "General Foster Care" and "Specific Foster or Specific Kinship Care".

Specific carers are those who have been specifically selected to provide care for a particular child or sibling group. They may already know or have a relationship with the child or they may be recruited and assessed as having the specific skills and talents required to care for a specific child. (Section 15.3)

The Manual later makes it clear that the term "kinship care" is used quite narrowly and only refers to the placement of children with relatives or with members of their kinship group. It does not include those children placed with a carer who is unrelated but has an existing (prior) relationship (eg. is a friend of the child's family, is a parent

of the child's school friend, or knows the child through a sporting or other group activity etc).

All foster carers must be registered in accordance with Section 63 of the Community Welfare Act (1983) before children can be placed in their care and before they can receive foster allowance and other supportive measures from the Department. It is acknowledged in the Manual that the registration of specific and kinship carers is somewhat different to general foster carers.

The assessment of specific foster carers involves completing the same range of checks and undertaking a similar process of home and individual interviews as general foster carers. However the content of the assessment interviews will be more specific, focussing on the circumstances and needs of the child being considered for placement. (Section 15.4.1)

Assessment of specific kinship carers is seen as a special case, but

further development of assessment criteria, sample assessment reports and practice standards in relation to the assessment and approval of kinship carers will be undertaken at a later date. (Section 15.4.2)

Research would indicate that the assessment of carers is not the only area of casework practice that needs development if it is to be consistent with the principles outlined earlier. Kinship carers have a need for a range of supports (including financial support). A "collaborative working partnership" with families requires caseworkers to be skilled in this way of working. Issues around permanency planning also take on a different meaning when the objective is no longer long-term placement outside the family. These issues are discussed below.

Assessment

In a "collaborative working partnership" between the state and families, children, family members and welfare professionals work together to assess placement options. The "bottom line" for welfare professionals in reaching agreement about the proposed placement is whether the placement meets minimum standards for the care and protection of children. These standards are the same ones welfare professionals apply in child protection practice. That is, whether the strengths of the family and the protective factors outweigh the risk factors. This does not mean, of course, that a placement that just meets the minimum standard is an ideal situation for a child. This is recognised in child protection practice. It is the reason assistance designed to improve the circumstances of children is offered to families. Similarly, it does not mean that the welfare professional cannot advocate on behalf of the child in discussions with family. The point to grasp is that the process is first about negotiating an agreement and then about providing assistance as necessary.

When forming a view about placement options in a family, Scannapieco and Hegar (1996) suggest that traditional frameworks for assessment of foster carers do not

take into account the potential strengths of a kinship placement and are therefore inappropriate as a guide. They suggest that as well as looking at the family situation and the safety and protection considerations, workers should also explore the prospects of preserving existing attachments, maintaining the child's identity, and the opportunities for permanency planning. This shifts attention away from a narrow focus on the child and carers, to considering the family as a whole as well as the broader social context.

This shift in focus also allows another potential strength of a kinship placement to be taken into consideration. Responsibility for the care and protection of a child is often shared by other members of the family as well as the people entrusted with the child's day to day care. In forming a view about the suitability of a placement, a worker must also consider the role other family members can play in supporting the goals of the placement. The combined efforts of several family members may be sufficient to ensure adequate care and protection for the child.

Working with families in this way will require caseworkers to develop their skills in working with social networks. Family networks, like other social networks, have a dynamic of their own which must be taken into account by the worker. Marchand and Meulenbergs' (1999) concepts of "family scripts" and "family accounts" provide one example of how dynamics operate within families. "Family scripts" are the interpretations various family members place on events and their experiences within the family. Views that "the mother is hopeless" or "the children take after their father" can have powerful influences on transactions between family members. The decision to care for a child may result from a sense of obligation or guilt about past events and be a way of "settling the account". These dynamics can work powerfully to support a placement or can ultimately be very destructive.

In traditional foster care, assessment of carers is often portrayed as a separate process to casework with the family. In larger teams it may be possible to have workers specialised in "assessment" of kinship carers, but in smaller teams and in remote area practice, the "assessment" process frequently runs concurrently with the casework during consultations with the family. This is consistent with the exchange model of casework practice.

In other words, as well as getting to know the family history, family constellation and social network, and exchanging information about the agency, caseworkers are simultaneously

- Activating and mobilising support and resources.
- Obtaining approval and support.
- Constructing a framework for agency support.(Portengen and van der Neut,1999)

Completing a genogram is often a good way of both identifying members of extended family and structuring discussions about all these goals.

Taken together, these features of kinship assessment suggest a very different approach from the traditional "procedural" approach to assessment and approval of strangers as foster parents. Waterhouse (2001) characterised this shift in focus as a

change in emphasis "from 'approving' towards 'enabling' relatives to care for children" (p.45).

Decision-making and Planning

If "Family Group Conferences" or "Family Meetings" are the forums in which social workers and families work together to reach agreement on how to keep a child safely within the family group, there is general agreement the first meeting should take place sooner rather than later. The actual timing will depend on what stage the case is at. There is also agreement there should be meetings to review progress.

O'Brien (2001) suggests that the initial meeting provides a platform to:

- Address the issues that led to the need for care.
- Share concerns and to consider the protection agenda.
- Examine options.
- Reach a solution that is based on the care and protection needs of the child.
- Identify the resource availability and requirement needed to support the placement.
- Organise the access arrangements and outlining the mutual expectations of each participant.

The outcome from this meeting is a Care Plan that details how the various issues are to be dealt with.

It is evident from the previous discussion about assessment that much of the agenda for the meeting has already been canvassed in discussions between the worker and the family and possibly amongst the family prior to the meeting. Indeed this phase prior to the meeting is in many ways the most crucial. It is important that all relevant family members are identified and invited, they must understand the purpose of the meeting, and have been provided with some details about the involvement of the agency. Family members hearing the allegations of abuse for the first time at the meeting may be in "shock" and in no position to give a considered response. It will also be embarrassing for all concerned to sit through the lurid details of abuse in a public forum like that, and may provoke a situation where the family feel forced to defend the parents. Providing basic information prior to the meeting respects the privacy of the family and allows family members to talk amongst themselves about the issues and come to the meeting better prepared.

Worrall (1999) points out that the power dynamics within the family can have a major effect on the ability of family members to have their say at the meeting. The prospective carers may be particularly vulnerable in this respect as they may feel under considerable pressure to agree to provide care. In some extreme cases the abusive parent may pose a threat to other members of the family to such an extent that their presence will inhibit discussion. The worker will need to plan carefully to ensure the goals of the meeting are achieved.

The Family Group Conferences only provide the basic framework for decision-making and planning and the actual meetings represent only a small part of the

interaction between the agency and the family. Most of the routine decision-making and planning happens during the implementation of the Care Plan. Caseworkers will need to develop their skills in this area as well.

O'Brien (1999;2001) has researched the complexities of the relationships that develop in kinship care between the child, the birth parents, family carers and the agency. A care plan that meets everybody's interests and operates with the cooperation of all parties is the ideal, but in practice this ideal is hard to achieve. Even care plans that have been successfully negotiated can run into trouble later. Alliances can form between some of the parties and with the effect of excluding others (eg an alliance between the carers, the child and the agency, excluding the parents; or an alliance between the parents, family carers and the child, excluding the agency). Sometimes these alliances aren't stable and the system becomes chaotic.

O'Brien concluded that the relationship the parents' had with each of the other parties was the best predictor about how relationships might develop. She also found that confusion over care plans, expressed in conflicts over access arrangements, could ultimately undermine cooperation and lead to an escalation of conflict. This would have repercussions for all relationships. The pressure on the carers might become so great that they withdraw from providing care for the child. The parents could find themselves excluded and/or denigrated as simply causing too much trouble. The children become caught up in the conflict and torn by loyalties, and agencies could become increasingly anxious about their role and authority in the system.

Some of this conflict may have existed prior to agency involvement. However, the intervention of the agency and the management of their relationships with the other parties can have a powerful influence on outcomes.

Support

Evidence from research is that kinship carers, like foster parents, need a range of practical and emotional support as well as financial assistance in order to look after the children placed in their care. They are often called upon to provide care unexpectedly, and frequently do not have the resources to manage the extra demands adequately. Their role in decision-making and case planning also introduces additional support needs.

No two families are the same and this diversity is reflected in the wide variety of kinship care arrangements. The circumstances in which children have entered kinship care and the needs of these children differ widely. In some families a carer may be able to draw upon a strong and supportive kin network, while in others the carer will need to rely on outside help. Past experience may influence attitudes of carers and extended family towards the involvement of other services. Evidence suggests also that the needs of carers change over time.

Services will therefore need to be flexible and not necessarily provided by, or requiring contact with, statutory welfare agencies. For carers to be able to access that support there will need to be information about the services available. Kinship

carers consistently complain that agencies they deal with do not have a clearly stated policy about how kinship care is supported by that agency. As a consequence they are unsure as to what assistance they can request for themselves or for the child in their care. They also find it difficult to find out what other services might be available elsewhere (eg Broad et al, 2001).

Effective support begins with a care plan that has been negotiated properly and which sets out clearly the different responsibilities of carers, the agency and the birth parents.

The issue of financial support has already been discussed elsewhere in this paper. A high level of practical assistance (eg accommodation, dealing with bureaucracy, gaining access to legal aid, transport etc) will also be required. A balance will need to be struck between meeting the needs of the child and the needs of the carer's family. One of the strengths of a family placement is that the child has the opportunity to lose the "foster child" label and develop an identity as a family member. Assistance should be provided in a way that improves the quality of life for the child without singling out the child as different from other children in the home.

Taking on the care of other children, particularly in circumstances where the children have been removed from the care of their parents, changes relationships within families. A grandmother, for example, moves beyond a supportive role to her daughter and assumes some or all of the responsibilities of a parent. This can lead to difficulties in the relationship between the two women and other family members may be drawn into the argument. For many families the difficulties start when the grandmother applies for the child payment from Centrelink. In many informal arrangements, grandmothers do not at first claim this allowance. They do this to avoid "trouble" or because they fear the child might be removed from their care to enable the mother to reassert her claim to the payment. If statutory welfare services intervene to protect the children, the grandmother may then be subject to accusations from the parents that she has gone "against" her own family and "sided" with welfare.

Caseworkers expect kinship carers to take on a lot of the responsibility for facilitating access and maintaining the relationship between the birth parents and the child (Breeman and Boisen, 1999). Research suggests that kinship carers tend to accept this responsibility to a greater degree than foster parents (Le Prohn, 1994).

Access between the birth parents and the child has been described as

"among the most anxiety provoking and sensitive issues in kinship placements. Relationships between the child and their birth parents may be complicated by events that have occurred previously. Equally, the relationship between the kinship carers and birth parents may be complicated by both parties' feelings about what has happened. Kinship carers may also have strong feelings about the abuse that the children have experienced, making the carer ambivalent about promoting contact in a positive way" (Brudenell and Savage, 2000, p.9).

Worrall (2001) conducted in depth qualitative research into the experiences of five New Zealand-born European families in caring for a total of 14 kin children who had suffered abuse and neglect. She noted that all 14 children had high levels of physical, emotional, educational, and behavioural difficulties as a consequence of their neglect and abuse. "Severe soiling and wetting problems, smearing of faeces, public masturbation, extreme aggression, destructiveness, self-harm, sexual promiscuity, hyperactivity, and withdrawing were among the behaviours described. Several children were frequently suspended or expelled from school. One caregiver described explaining to teachers the reasons for difficult behaviour when the perpetrator was an extended family member: 'We feel we are seen as part of the problem'" (p.506).

The behaviours of this group of children may be extreme but the point is that children with these behaviours are placed with family members. Many foster parents would also recognise and appreciate the difficulties faced by these kinship carers. Kinship carers seem to face the added dimension of implied moral responsibility for the behaviour.

An often overlooked aspect of kinship care, as with foster care, is the impact of an additional child on the other children belonging to the carer. They may resent the attention given to the child. They may pick up bad habits from the child or even be at risk themselves from the child's behaviour. Evidence suggests that the issue of discipline within the home can often be a point of disagreement between the agency and the kinship carer. The carer may need to re-evaluate their methods of discipline within the home for all of the children.

For all of these reasons, regular contact with a caseworker and the opportunity this provides to talk things over is consistently rated by carers as one of their main sources of emotional support (eg Broad et al, 2001).

Brudenall and Savage (2000) argue that the standard training for foster parents does not prepare kinship carers well for their role in case management and the issues they must deal with as a consequence of this role. They suggest additional training must be provided to meet this need.

In the traditional foster care system, training of carers is closely tied to regulating care and maintaining standards. Using this approach with kinship carers is likely to be perceived not as support but as another form of authority and interference. Waldman and Wheal (1999) conducted a survey of training needs for kinship carers on behalf of the National Foster Care Association of Britain. They found that "carers indicated that there were particular issues with which they struggled but the prominent conclusion was that carers were managing well with a life-changing situation which they had often not anticipated. Thus the orientation of any training should be one that validates a carer's changing experience, promotes strengths and leads people to identify their own learning needs without telling them what they should know"(p.147).

Waldman and Wheal suggested establishing support groups for carers and packaging information in ways that visiting workers could make available (and

discuss with the carer) as appropriate. Formal didactic methods of training should not be the primary means of delivery.

Permanency Planning

The FACS Policy and Practice Manual defines permanency planning for a child in the care of the Minister as

aggressively clarifying and deciding upon the purpose of a given placement and actively seeking and implementing a plan for permanence. (Section 13.4)

In other words, at some point a decision has to be made as to whether casework will continue to be directed at returning the child to parental care or instead at supporting an alternative permanent placement. Either way, the goal of the statutory welfare agency is (as far as possible) a placement outside the state system. To achieve this goal every worker must consider the implications of their actions and decisions at each stage of their work with the family. Permanency planning is therefore as much a process as it is about achieving an outcome.

Kinship care seems to pose particular challenges for both process and outcome in permanency planning.

Research evidence suggests that once a child is placed with a family carer, the worker's contact with extended family falls away, and contact with the parents is not maintained. Contact is mainly with the carer and the child (Gleeson, O'Donnell and Bonecutter, 1997). Even that contact, however, tends to be less than the level of contact with the child and carer in traditional foster care (eg Hunt, 2001). The children tend to stay longer in state care. In the United States many families resist pressure to adopt the child in their care, despite the incentive of financial support. These trends have led to expressions of concern about whether the state is discharging its responsibilities effectively in meeting the needs of children in kinship care placements.

A closer examination of the trends suggests that these "problems" are the result of the way the state and family systems are interacting.

There appears to be some confusion in the mind of the caseworker as to what to do next now that a placement within family has been achieved. In traditional foster care, placement of a child within extended family is considered to be way of achieving permanence. Parents have a much better chance of maintaining contact with their child in a kinship placement. There is therefore not the same pressure on the caseworker to resolve the child's status as there is when the child is placed with strangers. Amongst the competing priorities of a busy caseworker, casework with the family is likely to slip down the list of things to do. Contact between the caseworker and the parents may also be problematic. This acts as a further disincentive to work to include all family members in planning for the child's future. Alliances form and the birth parents run the risk of being excluded.

The other factor behind the trends is that caseworkers and family members **share** the decision-making. A caseworker must negotiate with family members to achieve permanency for the child. The attitudes and opinions of family members therefore influence both the process and the outcome.

Workers often fear that family members acting out of sympathy for the abusive parent may not provide adequate protection for the child. In fact, family members are just as likely to be harder on the parents than workers are prepared to be. This can put constraints on casework activity.

Many family members are also reluctant to terminate the rights of a parent in order to provide care. This is partly because of the major change this brings about in family relationships, but also because many grandparents (for example) continue to hold out hope that the child's parents will be able to resume care at some future date. They tend to only seek changes to the legal status of the child if they can see some advantage in doing so.

In the United States a family member who is also the guardian of a child seems to be able to resolve some legal difficulties when acting on behalf of the child in their care to gain access to services such as health and education. Evidence also suggests that some carers (eg elderly carers in poor health) seek to become a legal guardian as this enables them to appoint an alternative guardian of their choice in their will in case they die suddenly. However, it would seem that the main reason many family members seek changes to the legal status of the child is because they fear that the child's parents will try to remove the child from their care.

Bonecutter and Gleeson (1997) point out that the same research that highlights what appear to be "problems" for permanency planning in kinship care, also shows that children are happier in the care of family. The children often maintain contact with their parents, and if they do return to parental care, tend not to be re-admitted into state care. They suggest that the way to build on these strengths and to achieve good outcomes for children in kinship care is for the state to shift the focus in permanency planning to the goals of the family rather than the goals of the agency. This shift in focus highlights the importance of the process rather than a specific outcome.

Bonecutter and Gleeson provide an extensive discussion on the casework principles that best promote the long-term protection and wellbeing of children in kinship care. They summed up their approach in terms of four principles for best practice. The National Resource Centre for Foster Care and Permanency Planning in the United States incorporated this work and added a fifth principle. These principles are:

- **A broad view of family:** a perspective that goes beyond the child, parent, caregiver triad to identify the persons in the kinship network who can contribute to an understanding of the complexity of caregiving demands, identify the families need to ensure permanency for the child, and make a commitment to participate in rearing the child to adulthood.
- **Ongoing striving for cultural competence:** Caseworkers to continually strive to become aware of their personal biases, to prevent these biases from influencing their view of families, and

discover the strengths in families, including their patterns of shared caregiving across generations and kinship care.

- **Collaboration in decision-making:** means that families need to be involved in designing the best safety and permanency plan for the child and family.
- **A long-term view of child rearing:** means that permanency planning must look far beyond the change in case status that represents the exit of the child welfare system from the child's life. It needs to look several years past the child welfare system's involvement in order to assist the family in developing truly permanent plans that help them care for the child as changes occur in the child and their family.
- **Including children and youth in the planning and decision-making process:** family meetings called to engage family members, should involve young people in determining potential relatives as resources for placement and permanency planning at all levels (pp.7-8).

The fourth principle suggests an answer to the confusion in the mind of a worker about how to manage the transition from state involvement in kinship care. Discussing the future needs of the child and role of the child's parents in meeting those needs, identifying family relationships that will become more significant as the child becomes older, identifying contingency plans should something happen to the carer, and clarifying the future role of the agency in supporting the placement will provide a concrete focus for planning.

Kinship Care in the Northern Territory

The main legislation in the Northern Territory dealing with family relationships and the care and protection of children consists of the NT Guardianship of Infants Act, the NT Adoption Act, the NT Community Welfare Act, and the federal Family Law Act.

The Guardianship of Infants Act deals with only a very narrow range of issues around the meaning and definition of guardianship, and the appointment of alternative guardians following death.

Recent changes to the Adoption Act have meant that the adoption of a child no longer severs completely the connection between a child and their birth parent. An "open" adoption is encouraged which maintains some contact between birth parents and their child. However, it is an option rarely (if ever) used and nor is it a very appropriate way to ensure permanent care for most kinship care arrangements.

The Law Commission in New Zealand issued a discussion paper in 1999 entitled "Adoptions: Options for Reform" which canvassed the idea of abolishing the legal concept of adoption and replacing it with the concept of "legal parenthood". Legal parenthood was described as a modified version of guardianship, conferring the status of parenthood and encompassing issues of custody and access. Unlike guardianship, the legal relationship would not terminate upon the child reaching maturity. It was proposed to incorporate the New Zealand equivalent of the

Guardianship of Infants Act and the new concept of legal parenthood in one "Care of Children Act". In conjunction with the Children, Young Persons and Their Families Act this would provide a range permanency options for children and young people.

It is not clear whether this approach will find favour with families in regulating aspects of kinship care.

The Family Law Act is currently the main recourse for families seeking to confirm the legal status of changes to care arrangements without the involvement of statutory welfare agencies.

Aboriginal people have been slow to make use of the Act to resolve issues about care arrangements. Part of the problem seems to be that the concepts embodied in the Act do not take into account Aboriginal Terms of Reference. Maori in New Zealand have expressed the same concern about legislation in their country.

New Zealand are currently reviewing their equivalent of the Family Law Act. As part of that process Pitama et al (2002) reviewed Maori perspectives of guardianship, custody and access. They pointed out that from a Maori perspective a child does not belong exclusively to parents but to the whole extended family. Rights and responsibilities of different family members also change over time. One suggestion was to replace the concept of "access" with the concept of "availability". It was argued that the wellbeing of a child depended on the availability of his parents, his family, his tribe, his language, his culture and his land.

Reforms to the Australian Family Law Act in 1995 attempted to shift from the notion in law that parents have rights over children towards the idea that parents have responsibilities to children. These responsibilities were not dissolved along with the marriage. Concepts of guardianship, custody and access were replaced by concepts of shared parenting, residence and contact.

A review of the Family Law Act reforms (Rhoades et al, 2000) did not consider the impact of the reforms on efforts by extended family to resolve kinship care arrangements in the Family Law Court. However, it was noted that recent decisions by governments to restrict eligibility for legal aid had led to an increasing problem in the administration of justice. Many applicants are now representing themselves in Court and there are increasing delays in the progress of hearings. These are all factors which could be expected to inhibit family members from attempting to resolve matters in this way.

The Review also indicated that there was some confusion in the minds of many applicants about the reforms. The confusion centred around the principle that children have a right of access with both parents and the concept of shared parenting. In many instances aggrieved parties living alone interpreted these ideas to mean they had a right to access with their child and to be involved in a detailed way with the day to day decisions of parenting (even down to the level of what their child had for lunch). An indirect consequence of the reforms therefore has been to provide an opportunity for these individuals to further harass their ex-partners. This is a serious problem as the core business of the Family Law Court today is mediating between parties where there has been a past history of conflict and abuse.

Kinship carers making applications to the Family Law Court may face similar problems. A desire to protect a child from further abuse, or concern over parental threats to remove the child, are typically reasons kinship carers seek to resolve the legal status of care arrangements.

The principles and ideas in the Family Law Act are borrowed from the (English) Children Act (1989). Under this Act, kinship carers are able to obtain a Residence Order which grants them a level of parental responsibility equal to the parents and places a child permanently in their care. This Order does not terminate the parental responsibilities of the birth parents. Evidence suggests that family members sometimes have difficulty negotiating with the birth parents over how responsibilities are to be shared.

The Adoption and Children Bill currently before the British Parliament aims to address some of these concerns. This Bill makes provision for a new special guardianship order under the Children Act. This order will give the special guardian "clear responsibility for all the day to day decisions about caring for the child or young person and for taking any other decisions about their upbringing, for example their education. The provisions therefore make it clear that (subject to any other Children Act order in force) a special guardian may exercise parental authority to the exclusion of others with parental responsibility, such as the birth parents.....Unlike adoption, under a special guardianship order the birth parents remain the child's parents and retain parental responsibility, though their ability to exercise that responsibility is limited" (Department of Health Discussion Paper, 2002, pp.15-16). The court is able to make an Order in relation to contact between the child and the birth parents.

There are additional features of the Bill that also address some of the other issues of kinship carers. For example, the special guardian is able to appoint another guardian for the child in their Will in the event of their death. Unlike adoption, the order can be revoked if circumstances change.

The other significant feature of the Bill is that there are also provisions that place a duty on local authorities to make arrangements for providing support services to special guardians.

The NT Community Welfare Act regulates the involvement of the state in issues around the care and protection of children in two ways.

Firstly it structures the relationship between the state and families. The Act outlines how assistance might be provided and provides a framework for intervening on behalf of a child if maltreatment has occurred or if the child is judged to be at risk of maltreatment. It has been argued in this paper that the way the relationship is structured can have a major influence on the ability of the state to engage with families appropriately around issues of kinship care. The current Act embodies some of the principles supportive of kinship care, but does not make them as explicit or as binding as equivalent legislation in New Zealand.

The Act also creates the Family Matters Court to consider appropriate care arrangements for children found to be in need of care.

The dispositions currently available to the Court are:

- Direction to parents, guardians or persons having custody of the child to take necessary steps to secure the proper care and welfare of the child.
- Direction that the child reside with a person it considers suitable.
- Direction that the child be under the joint guardianship of the Minister and the parents, guardians or persons having custody of the child, including directions related to the custody of and access to the child while under that guardianship.
- Direction to transfer the sole rights in relation to the guardianship of the child to the Minister or such other person, including a direction relating to access of the parents, and such other persons as the court thinks fit, to the child.

Making a direction for a child to reside with a suitable person, and transferring guardianship to a third party might be regarded as opportunities to support kinship care as an alternative to state care. Joint Guardianship is typically between the Minister and the parents, or between the Minister and a family member. This option permits a more formalised arrangement with a kinship carer. The terms of the partnership are negotiated between the Department and the family. Such an arrangement enables the worker to use their delegated authority to support the placement and ensure the child's care and protection.

FACS workers are able to use the Policy and Practice manual for additional guidance in how to work with families. It has been argued in this paper that the existing policy contains many of the principles supportive of kinship care, but little has been done in an organisational sense to ensure FACS staff are able to work in that way.

Analysing the policy and legislative framework is, however, only half the story. Workers must use their judgement in deciding how to apply policy and legislation in a particular situation. An evaluation of the role of kinship care in statutory welfare services must therefore also consider what workers are actually doing.

Unfortunately there is no reliable information available about the extent to which welfare workers support informal care arrangements in family support cases. Similarly, there is no reliable evidence about the extent to which they rely on informal kinship placements to ensure the care and protection of children following a child protection investigation. Yet evidence from research in other countries suggests that more children are living with family as a result of these practices than are on care and protection orders.

There is also no reliable data on the extent to which use is made of the dispositions in the Family Matters Court to divert children from state care to kinship care.

The only data available concerns the children in state care. Unfortunately this only provides indirect evidence of casework practices, and much of the data is incomplete. Without other qualitative research, it is impossible to draw any firm conclusions.

At the end of June in 2002, there were 190 children in care, down from 200 children the previous year. Between 1987 and 1996 the numbers of children in care on the 30th June each year fluctuated between 109 and 140. The current figures therefore

represent an increase since then of approximately 40%. The reason for this increase is not clear, although it is consistent with the national trend.

If caseworkers were actively supporting kinship care as a placement alternative, the data should show a significant number of children placed with extended family and extensive use of joint guardianship. This trend should be greater for Aboriginal children, as it is a legal requirement to consider placing Aboriginal children with extended family as the first option. The data broadly speaking are consistent with these expectations, although data quality issues prevent a detailed analysis.

Approximately 12% of all children on care and protection orders at the end of June 2002 have remained with their parents. Of the rest, about a quarter are with family members. This figure is likely to be a significant underestimate. A scan of some of the data for 2002 suggests that some family placements have been coded as "foster" placements. It might be expected that this issue impacts to a greater extent on the coding of placements for Aboriginal children (as there are more children on family placements) but without exhaustive analysis of individual records it is impossible to say precisely what biases have been introduced into the data. For this reason a comparison between placements of Aboriginal and non-Aboriginal children has not been undertaken.

Seven children at the end of June 2002 were in care under a Temporary Custody Agreement. A total of 169 children were in care under authorities finalised in the Family Matters Court. Of these, 40% were children in care under joint guardianship arrangements. Separate figures for Aboriginal children are not available at present, and current figures do not identify whether the joint guardian is a parent, family member, or another person.

Aboriginal children constitute approximately 40% of the Northern Territory population aged between 0-17 years. At 30th June 2002 they made up approximately two thirds of the number of children on care and protection orders. Forty per cent of these children were in kinship care arrangements. A further 5% were with their parents. The rest were in general foster care. Half of these (approximately a quarter of all Aboriginal children) were with non-Aboriginal carers.

Information from other sources suggests that there are a number of both specific and general factors contributing to the trends for Aboriginal children on care and protection orders. For example, the over-representation of Indigenous children is partly due to the "visibility" of many Indigenous families due to their involvement with public services, and partly also reflects the relative disadvantage in circumstances of many Indigenous families. Many of the Aboriginal children living with non-Aboriginal carers have high support needs (most due to severe disability). Children with high support needs are often unable to be maintained in remote communities. Children with severe forms of disability are often faced with the prospect of competing for limited places in institutions in the major centres. In the past such children were placed in hospitals until accommodation became available. Foster care can at least provide a family environment for these children. It is difficult, however, to find Indigenous carers able to meet the high support needs of these children (particularly Indigenous carers living in close geographical proximity to the child's family).

There are no doubt other constraints on casework practice contributing to these trends that have yet to be identified.

These issues again highlight the fundamental problem with the current level of information about patterns of kinship care. That is, there is no reliable data on the interaction between the state and family systems. What is needed is information about the contemporary circumstances of families and patterns of care. This would be complemented by research into the "careers" of children who come to the notice of statutory welfare authorities. For children in state care this would involve exploring the pathways of children within the state system. Research is needed on the circumstances of children coming into care, the approach taken by caseworkers to determine placement options (including the factors that influence their decision), the type of support offered to children in care and to their families, the child's progress in care, and the circumstances under which children are finally discharged from care.

There are some immediate issues of data quality to address. It may also be possible to adjust parts of the client information system to produce additional data. However, until some basic research is completed, it will be impossible to identify what additional information would be useful or to interpret data in any meaningful way.

Organisational Constraints

The focus of this paper has been on trying to understand some of the implications of state support of kinship care arrangements for policy development and for casework practice by staff in a statutory welfare agency. These issues cannot, however, be considered in isolation from questions about the capacity of the agency to engage with families in this way.

Capacity is understood here to refer to the human and financial resources of an agency and the way these resources are distributed and managed. This includes having enough staff who are appropriately trained, adequate funding for programs, and appropriate models of service delivery. It also includes the existence of effective leadership in being able to deal with uncertainty and balance opportunities and risks in such a way that staff are able to work in creative ways with families.

Kinship care can sometimes look like a cheap alternative to general foster care. It has been argued in this paper, however, that kinship carers require at least as much support as general foster carers. They also have some different support needs that will require the development of new training and resources. Caseworkers will need to develop new skills. Establishing community-based organisations as service providers will cost more in the short-term. The agency will also need to develop different organisational arrangements to work with kinship carers and to work collaboratively with community-based organisations. All this will have to be done within an environment of fiscal restraint.

It is beyond the scope of this paper to review the capacity of the NT Department of Health and Community Services to support kinship care. The experience of New Zealand, however, gives some indications of the challenges ahead.

New Zealand has perhaps the most fully developed framework for state support of kinship care. The Children, Young Persons and Their Families Act (1989) re-defined the nature of the relationship between the state and the family. It established new ways for engaging with families over care and protection issues and new roles for staff. It provided for the creation of social services provided and managed by Maori (Iwi Social Services). Unfortunately it appears that the resources need to support this vision have not been forthcoming.

The Ministerial Review of the Department of Child, Youth and Family Services (Brown Report, 2000) noted that the introduction of the Act was followed by a series of significant funding cuts, accompanied by a series of organisational re-structures. This occurred as part of a broader governmental process of economic re-structuring (including strategies for reducing government expenditure).

These changes took place at a time when demand for services in the form of child protection notifications continued to increase annually.

This has led to a situation where staffing levels are inadequate, there are insufficient resources to support families at risk, and services to families and kinship carers have reduced. Staff morale in many areas is low, and recruitment and retention of staff is a major issue. The energy of remaining staff is spent on primarily on crisis management rather than on sustained and planned intervention. Iwi Social Services have been established, but they are typically funded at lower levels than other established agencies doing equivalent work.

The original intention was that Iwi Social Services would be independent and the government would purchase statutory services from them. This has not occurred. Part of the reason is that the government has yet to commit to the practical steps necessary for devolution. The Department, however, is also faced with a dilemma in supporting such a change. It is concerned that "a sizeable proportion of our current resources will need to be transferred to iwi and Maori providers" (Department of Child, Youth and Family Services Submission to Ministerial Review, 2000, p13). The Department will need to continue to provide a "safety-net" service for all citizens, including clients of Iwi Social Services who have needs too "complex, challenging or dangerous to manage in community settings". The concern is whether government will provide the necessary funds to the Department to cover any shortfalls.

The submission by the Department to the Ministerial Review also commented on the pressure on staff of constant public and media scrutiny. The focus of attention tended to be on the mistakes of the Department, particularly on child deaths. Doolan (2002) identified this as a crisis for leadership.

"The phenomenon of child death by abuse has come into full public awareness during recent times and appears to many to be a new and rapidly increasing problem that requires concerted state intervention. Much political and media pressure is applied to statutory agencies to "fix" the problem, and social workers bear the brunt of criticism from a perplexed and naïve public. Such events create a crisis for social work as living with uncertainty and balancing risks, constitute the daily activity of effective social work. There is inevitably an

intensification of agency prescription of social work activity, and social workers are encouraged in many subtle and not so subtle ways to become risk averse. The continued use of stranger care, and the difficulty of achieving family reunification in a conservative legal system, may all point to the development of a defensive practice, which begins to eat away at professional commitment to work collaboratively. Further, managerial annexation of the social work process weakens the very core of social work endeavour. Social workers who do work that requires flair, inventiveness and a large degree of self-management, are forced into procedural strait-jackets. Many statutory agencies fail today as environments conducive to best professional performance, but rather environments that feature high levels of anxiety and the fear of making a mistake" (p.5).

Engaging with families and working with kinship carers is ultimately about sharing the responsibility and the risks with family. Confident workers are able to negotiate and share responsibility for the care and protection of children. Adequate resources and support ensures kinship carers are not left with all the responsibility.

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APPENDIX ONE

**Summary of policy statements relevant to
kinship care taken from the FACS Policy and
Practice Manual.**

Kinship Care in the Northern Territory

The FACS Policy and Procedures Manual makes it clear that in working with children and families the first priority is strengthening and preserving families. If a child needs to be placed in alternative care, Workers must first look towards care within the extended family, and then to care outside the family. In both situations, every effort must be made towards family reconciliation unless this is not in the best interests of the child.

The difficulty for Workers seeking guidance in relation to Kinship Care is that relevant policy is neither gathered into one place nor given the prominence it requires. Instead relevant policy is scattered throughout the Manual and incorporated in other topics. In some cases, relevant policy has also yet to be developed.

Strengthening and Preserving Families

The FACS Policy and Practice Manual acknowledges the family as the unit in society primarily responsible for the care and protection of children. The role of government is firstly to support parents and families so that they are better able to fulfil their responsibilities and secondly to intervene directly on behalf of children when they are at risk of maltreatment. The Manual states that in any work with children and families the primary consideration of FACS must be the welfare and the best interests of the child, although these interests are usually served by maintaining the child within the family wherever possible.

In carrying out this role, a "collaborative working partnership" with families is promoted in the Manual as an appropriate framework for casework practice. In this context "family" refers to not only the "immediate family" but also to "extended family".

This framework rests on a number of principles and beliefs. These include:

- Most families have the potential to be competent and self-sufficient
- Family members have the capability to make decisions for themselves
- Casework should emphasise and build on existing strengths of families and respect cultural and ethnic differences

In this framework of casework practice Family Meetings are promoted as the primary "decision making forums".

Family Meetings are meetings between caseworkers, members of the child's immediate and extended family, and where appropriate, the child.

The main reason for convening a Family Meeting is to:

- *provide the family with clear reasons for FACS involvement with them and their child*
- *seek and record the views of the child and family in relation to decisions being made*
- *provide family members with maximum opportunities to participate in planning to meet their child's needs*

The Family Meeting formalises the family's decision making, although work done with the family before and after the meetings is equally crucial to effective involvement. (Section 6.4.1.)

These meetings are meant to be held on a regular basis in all child protection and substitute care cases. Although the regularity of these meetings will be defined by the case, the Practice Standard is that they will be held at least three monthly during the first twelve months of a case, and occur at least every six months after.

It is acknowledged in the Manual that the nature of statutory welfare work imposes some constraints on this process. FACS reserves the right to insist on certain conditions being met in negotiations with the family. It is suggested that it is still possible to work collaboratively within the constraints as long as FACS outlines their position clearly at the start of the negotiations (ie. the "bottom line").

The ability of extended family or social network to support the parents to care for and protect the child, is one of the factors to be taken into account when deciding whether to remove a child from the family home.

Entry to care must always be considered a last resort option, and one which should only be contemplated after careful consideration of other options and alternatives, such as family support, placement with relatives and friends, assistance through preventative family care payments, child care, Family day care, counselling etc. (Section 14.2)

Preventative Family Care payments can be used to provide assistance to parents to prevent the need to remove a child from the family home. They can also be provided to extended family or other members of the parent's social network to either enable them to assist in caring for the child or to provide alternative care.

The aim of preventative family care payments is to reduce the risk of harm to a child and consequential likelihood of a child coming into the care of the minister.

This aim might be achieved by providing financial payments to parents or other adults caring for the child, or, on rare occasions, directly to a young person who is living independently. (Section 17.8)

The type of situations that might be addressed by use of PFC payments include:

- payment for the provision of respite care for a child where the parent/s need some relief from the stress of caring for their child
- payment to assist a child and family to be re-united or reconnected
- payment to assist people who are caring for children other than their own where the carers are experiencing financial strain because of the care they are providing or the family is not reasonably able to assist with financial support for the child.
- payment for goods and services which will enhance a family's capacity to undertake its child rearing role and where there is a real likelihood of the child being removed from the family.

Payments may be "one-off", or made on a continuing time-limited basis as defined by the case plan.

There are restrictions on the use of these payments.

Firstly, assistance is not available as a long-term source of support. Ongoing payments may not be authorised for a period exceeding six months. Secondly, as the children supported by the payments are not in the care of the Minister, the obligation to support them is less clear. One consequence is that the funds are subject to greater fiscal restraint within the Department. The Manager may not approve expenditure that will aggregate to more than the Manager's financial delegation (\$5,000). This translates to an upper limit of approximately \$200 per week for six months. In cases where there is a perceived need for a higher level of payment the approval of the District Manager must be sought. There is also a stronger expectation (compared with payments to children in care) that the expenditure for the year will be contained within budget.

Children in the Care of the Minister

It is possible for children in the care of the Minister to be living at home with their parents. The FACS Policy and Procedure Manual does not deal with this situation directly, although the implication is that other policy relating to strengthening and preserving families is relevant in this situation.

The section of the Manual referring to "Substitute Care Practice" deals with children in the Care of the Minister who have been removed from their family home. In terms of family-based placement options, the Manual makes a distinction between "General Foster Care" and "Specific Foster or Specific Kinship Care".

Specific carers are those who have been specifically selected to provide care for a particular child or sibling group. They may already know or have a relationship with the child or they may be

recruited and assessed as having the specific skills and talents required to care for a specific child. (Section 15.3)

The Manual later makes it clear that the term "Kinship Care" is used quite narrowly and only refers to the placement of children with relatives or with members of their kinship group. It does not include those children placed with a carer who is unrelated but has an existing (prior) relationship (eg. is a friend of the child's family, is a parent of the child's school friend, or knows the child through a sporting or other group activity etc).

When identifying the most suitable placement for a child

Research indicates that the placement option which offers children the greatest stability and chance of achieving positive and improved outcomes, is one within their own family kinship system. Therefore kinship care options should be considered in all cases, before the consideration of other non-relative placement options. (Section 14.3.2)

For Aboriginal children in the care of the Minister, Section 69 of the Community Welfare Act (1983) requires that "every effort is made to arrange appropriate custody within the child's extended family", or at least with "Aboriginal people who have the correct relationship with the child in accordance with Aboriginal customary law".

All foster carers must be registered in accordance with Section 63 of the Community Welfare Act (1983) before children can be placed in their care and before they can receive foster allowance and other supportive measures from the Department. It is acknowledged in the Manual that the registration of specific and kinship carers is somewhat different to general foster carers.

The assessment of specific foster carers involves completing the same range of checks and undertaking a similar process of home and individual interviews as general foster carers. However the content of the assessment interviews will be more specific, focussing on the circumstances and needs of the child being considered for placement. (Section 15.4.1)

Assessment of specific kinship carers is seen as a special case, but

further development of assessment criteria, sample assessment reports and practice standards in relation to the assessment and approval of kinship carers will be undertaken at a later date. (Section 15.4.2)

Child Maintenance payments can be made to support placements and to provide other services to children in the care of the Minister.

At a basic level, the standard foster payment to carers is an ongoing age-related payment that is meant to cover most of the day to day costs of caring for a child. Higher rates are available, although these are nominally tied to the level of care a

particular child requires and the costs this incurs, rather than the financial circumstances of the foster family or the higher cost of living in remote area.

Discretionary payments are for goods or services that are not covered by the foster payments.

Decisions about the appropriate level of foster payment or the approval of discretionary payments can be made at the level of the local FACS Office.



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Building Healthy Relationships at Alaska Native Medical Center

After helping Southcentral Foundation perfect the art and science of advanced access scheduling in the 45,000-patient clinic where he works, Douglas Eby, MD, MPH, somewhat unexpectedly, says this: "We want to tell the world: *It's not about access*. Access is only a tool that helps create relationships because it breaks down barriers. Relationships are really what it's all about." It is only through solid relationships, says Eby, that you can begin to get at insidious underlying health issues such as depression, domestic violence, and obesity.

Eby is vice president of medical services for Southcentral Foundation (SCF) at the Alaska Native Medical Center (ANMC) in Anchorage, Alaska, USA, a Native owned and managed 150-bed hospital and large medical center with more than 375,000 outpatient visits annually. The clinic serves the urban sprawl of Anchorage, as well as more than 50 remote villages in a 100,000-square mile catchment area that is so large it would be America's seventh largest state.

The story of ANMC is the story of remarkable vision, persistence, progress and change. It is the story of how this once federally-owned clinic — "a big, impersonal, 'crank-'em-through' type place," says Eby, where most primary care was delivered in urgent care or emergency room settings — transformed itself into a customer-owned and directed system that provides same-day access to holistic, integrated, family-centered primary care.

Indeed, the transition can be seen in the many run charts produced regularly to help ANMC leaders track their progress.

Moving From Staff-Centered to Patient-Centered

When Eby tells the ANMC story — and he tells it a lot these days — he doesn't need to dramatize the extent of the changes he has seen in his twelve years there. The facts speak for themselves.

In 1994, he says, there was no real primary care system at the clinics. Most area residents got their primary care at the emergency room, when they got it at all. "The clinics were in the hallways; there were no receptionists or waiting rooms. The services were centered on the staff's needs, not the patients'. There was no budget tracking or accountability by department, and every department was an island."

But in 1999, a significant change took place. "The Medical Center came under Native ownership," says Eby. The Southcentral Foundation, an Alaska Native-owned non-profit healthcare corporation, in partnership with the Alaska Native Tribal Health Consortium, assumed ownership and management of ANMC. The new owners brought with them a new value system, and a determination to transform the clinic into a customer-centered system.

They had their work cut out for them. The average delay to schedule a routine appointment was four weeks to several months. The "no-show" rate was about 25 percent. Phone wait times were in excess of two minutes, and waiting time to see the provider in the primary care

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clinics averaged 30 minutes. Moreover, even after starting a limited primary care system in 1996, only 35 percent of the total local population had a designated primary care provider. Of those, 43 percent did not even know who that provider was.

Where to begin? "You have to make decisions based on what works best for your customers, period," says Eby. "Most health care organizations don't really do that."

So they began an extensive process of talking with their customers. Having worked with the Institute for Healthcare Improvement (IHI) since the early 1990s, primarily through participation in the Quality Management Network (QMN), they applied many of the improvement tools and ideas they had learned, and began to design a system around their patients' desires. The plan itself took four months to create, and included principles, a detailed description of the care model, expected outcomes, and a timeline. It took two years to implement.

Today, the picture is quite different.

For the past three years, patients have been guaranteed same-day access to their own primary care provider if they call by 4:00 PM. Use of the Urgent Care Center for primary care is down by 50 percent; the use of specialists is down by 30 percent. The patient-provider match is between 75 percent and 80 percent. Wait times have decreased significantly across the system.

Clinically, the entire system has been re-organized to provide integrated primary care. "We abolished disease-specific teams," says Eby, "and put all those people in the primary care system. Those nurses are now comprehensive primary care case managers working with the doctors. We can't afford to have a different team for every disease. And what about people with multiple conditions? Which team do they get? So we put all our eggs in the holistic basket. And our evidence shows we have the same or better rates of diabetes control, mammograms, pap tests, colorectal screening, immunizations."

Social services, nutrition and health education are all integrated into the primary care system. In fact, a new and inviting patient education and resource center has been located in the lobby of the Primary Care Center, says Eby, as well as community gathering spaces, a Native healing center, and an Internet café.

A comprehensive screening program for depression has been put into place, as well as a chronic pain management program. Clinical pathways have been created and are measured and modified by a cross-disciplinary team. Interdepartmental agreements are written and signed annually, laying out exactly how everyone will work together, support each other, and focus on the patient.

A Culture of Pride and Self-Determination

The importance of Native clinic leadership for the population the clinic serves cannot be overstated, says Eby, who, as a non-Alaska Native is in the distinct minority among ANMC staff. "The whole system harnesses the power of Native traditions. Native culture and values are at its core," he says, citing the Native emphasis on wholeness, relationship, family, and community. "Our success helps in the journey toward wellness because it generates pride," he says. Southcentral Foundation also has a comprehensive program of workforce development and training for career advancement for Alaska Natives, and they've joined IHI's IMPACT Network to bring focus to their work in this area.

The steps that SCF took to get from where they were to where they are

today are too numerous to list here. Their advice and guidance, born from experience, is widely sought, particularly among other public health provider groups.

Here are a few selected "reinvention must-do's" on SCF's list:

- Define the mission (built around the customer) and make it real.
- Drive customer-based change from the top down, use a systems approach, and make sure the "drumbeat" comes from all levels.
- Involve staff in planning and development of the new system.
- Define a single operational paradigm (in ANMC's case, it was to centralize care around patients not diseases).
- Align all support and specialty systems.
- Align incentives ("extremely important," says Eby).
- Celebrate successes (while ANMC staff put in extra hours to work off the appointment backlog in preparation for advanced access scheduling, they were provided with carts of food and beverages and professional chair massages).

The central SCF structures include use of care teams and intensive case management; chronic illness management; use of clinical pathways; and advanced access scheduling. But, cautions Eby, "Advanced access is the first step of a long journey. It's not the first 20 steps, it's the first step."

Eby and the SCF system seem energized by the progress the clinic has made during these years of intensive work, and he heaps much of the credit on his colleagues and the vision of Native leadership. He does not pretend it has been easy. "This is a huge amount of hard work to do and to maintain," he says. "You have to be committed to doing something beyond the ordinary. But that's really the only way to provide health care. Anything less, and you're just treading water."

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Alaska Native Medical Center: Values-Driven System Design

Sweeping change, especially in a large and complex health care system, is never as breezy as the phrase implies. Rather, it is the painstaking result of years' worth of small steps and bite-sized improvement efforts that, when well managed, grow and spread and take hold throughout the organization. But without one fundamental ingredient underpinning it all, says Douglas Eby, MD, MPH, all the work could amount to shoveling sand against the tide.

Eby is vice president of medical services for Southcentral Foundation (SCF) at the Alaska Native Medical Center (ANMC) in Anchorage, Alaska, USA, a large Native owned and managed medical center with more than 425,000 outpatient visits annually, as well as a 150-bed hospital. The primary care system serves the urban sprawl of Anchorage as well as more than 50 remote villages in a 100,000-square mile catchment area that is so large it would be this country's seventh largest state.

As a change leader who has helped make a reality of the vision of Native owners and leaders, Eby can enthusiastically tick off a dizzying list of process and structure changes that the organization has successfully implemented in continual pursuit of improved care and service. These include innovations such as [advanced access scheduling](#); [chronic disease management](#); sweeping workforce development; full integration of complementary practices; telemedicine; and even telepharmacy dispensing, enabling patients in remote villages to receive prescription medications through a sort of vending machine controlled remotely by pharmacists in Anchorage, complete with web-cam counseling between pharmacists and patients.

SCF/ANMC has plenty of data that demonstrate the potency of these innovations. Patient and employee survey data show that both groups rank ANMC's performance above national averages in a majority of categories. Clinical data show a 50 percent increase during the past several years in the number of [diabetic patients whose HbA1c is at or under 7](#), as well as immunization rates for children approaching 90 percent, well above the national average.

But amid all the Center's successes — and there are many — what SCF leaders are most passionate about is the foundation that supports their success: what they term values-driven system design.

Values-Driven Design

"You have to spend a lot of time on the front end of change to figure out both the values that drive the priorities and the structures on which health care is currently based, and the values that drive the priorities of your customers," says Katherine Gottlieb, MBA, SCF's chief executive officer. An Alaska Native herself, Gottlieb says, "Health care must be based on the values of the people you serve. Otherwise, there will be a constant clash between providers and customers."

At SCF/ANMC, the concept of alignment is key. "So many people in health care feel beleaguered because they are stuck between what they view as insatiable patient demands, unreasonable insurer demands, and standards of care that they either want or need to meet. The

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dissonance among those misaligned priorities is driving a lot of people nuts," says Eby. "When you align the priorities, that dissonance disappears."

At SCF/ANMC, aligning provider, patient and payer priorities rests on an unwavering commitment to being truly patient-centered. "We talk about patients as compliant and non-compliant," says Eby. "Those words should be eradicated from our vocabulary. Rather than trying to get patients to be more compliant, we should figure out if we are being compliant with the wants and needs of our patients."

This philosophy is especially central at SCF, not only because it serves a predominately Native Alaskan population, but also because it is owned by Alaska Natives. In 1999, in partnership with the Alaska Native Tribal Health Consortium, the Southcentral Foundation, an Alaska Native-owned non-profit healthcare corporation, assumed ownership of ANMC from the federal government. This launched a turning point in the medical center's approach to delivering care.

"Native cultures have never fully embraced 20th century values," observes Gottlieb. "In the Native community, there is more emphasis on family, more respect for elders, more reliance on common sense and age-old wisdom, and a more team-oriented approach to problem-solving. Native people also tend to be more spiritual, and view the four dimensions of wellness — physical, emotional, mental and spiritual — as inseparable. To be well means being well in all four dimensions."

This is in contrast to the way American medicine has developed. Says Eby, "In the mid-20th century, the values of the industrial revolution influenced medicine, and the body began to be viewed as a combination of parts, like machines. If you view the body as parts, it drives you toward an approach that relies on specialists to fix specific parts of the machine — particularly through procedures and biomedical manipulation, or medications. In usual modern medicine, physical and mental health are often treated separately, and emotional and spiritual health often not addressed at all. The whole person is not central to the system design."

With the transition to Native ownership and management, SCF leaders set about defining the changes they wanted to make in the system. "Katherine and the Board led the way, and continue to lead the way, to clearly defining the system's values, priorities, and goals — and overseeing its evolution," says Eby. "Their strong vision and leadership made it much easier at an operational level to create passion and alignment. They have empowered us to adapt best practices that are in alignment with our goals and systematically put them in place over time."

Conflicting Values

Gottlieb, Eby and others from SCF are in demand as speakers these days, and they offer audiences a step-by-step outline of how to think about aligning a health care system with patient values. The SCF presentation is long and detailed, and reflects the remarkable focus, persistence and commitment that the organization has demonstrated on its own journey of change.

SCF leaders contend that the strong influence of western values on American health care has resulted in a system that respects:

- Separation of body and mind, disregard of spirit and emotion
- Compartmentalization of body into organs
- Organ specific specialists
- Illness understood as infection by outside agent, biochemical imbalance, or breakdown of 'machine' needing surgical intervention
- Illness as an individual experience

- One-on-one visits
- Treatment through medicine and surgery
- Knowledge from books
- Publications as the source of new knowledge
- Centralized institutionalization of 'ill'
- Patients who are 'compliant'
- Patients who are passive

SCF/ANMC leadership asks itself continually what a system built on Native values should look like. They envision — and continually work to create — a system that:

- Emphasizes the extended family and the group, drawing on their strengths
- Develops a system of experienced mentors
- Places counselors, case managers, care coordinators in central roles
- Treats the family rather than the individual
- Creates healing physical environments
- Emphasizes sharing, mutual support, partnering
- Integrates spiritual, mental, physical, emotional health – really!
- Involves more touch
- Respects home prepared remedies
- Avoids institutionalizing people to minimal levels

But what does this mean in practical terms?

For SCF/ANMC leaders, it means embracing a single overarching paradigm that drives every part of the system. "The cornerstone of our entire system is the support of long-term, trusting, continual relationships," says Eby. "The extended family or household is the unit around which our system is designed, and our focus is to support their relationships with one another as well as with us."

To support this paradigm, the organization developed 13 operational principles — the laws of the system — that guide the development and operation of all programs and systems. The principles are carefully written so that the first letters of each one, taken in order, spell out RELATIONSHIPS. They are:

Relationships between the customer/owner, the family, and provider must be fostered and supported

Emphasis on wellness of the whole person, family and community including: physical, mental, emotional and spiritual wellness

Locations that are convenient for the customer/owner and create minimal stops for the customer/owner to get all of their needs addressed

Access is optimized and waiting times are limited

Together with the customer/owner as an active partner

Integration of services throughout all of SCF. No more islands

One seamless system

No duplication of services or roles and responsibilities

Simple and easy to use systems and services

Hub of the system is the family

Interests of the customer/owner are placed first and the system is created around what works best for the customer/owner

Population-based systems and services

Services and systems are culturally appropriate and build on the strengths of Alaska Native cultures

The relationship at the center of this paradigm is that of the patient and

his or her primary care team. With the patient as the hub, the team includes the patient's family, the primary care physician, a nurse case manager, certified medical assistants, case management support, a social worker, and a behavioral health specialist. Additional "virtual" team members include health educators, midwives, nutritionists, and pharmacists. Many specialists (including chiropractors, massage, acupuncture and "usual" medical specialists) are "layered" in.

Integrated Care Without Duplication

Advanced access scheduling, put in place with IHI's help nearly five years ago, makes it easy for patients to see their team members when they want to. "Any barrier to access decreases the relationship," says Eby. When same-day visits with a chosen primary care physician became a routine option, use of the Urgent Care Center and ER for primary care fell by 50 percent. Indeed, more than 80 percent of patients see their designated primary care physician when connecting with the system, compared with just 35 percent eight years ago.

Because the primary care team is the central point of contact for patients, use of specialty care is down by 65 percent. Integrated care is a key principle at ANMC, and that includes integration of complementary medicine, such as chiropractic, massage therapy, healing touch, and tribal doctors who are Native Traditional Healers. "These are not alternative options, they are fully integrated into our system," says Eby.

Fully integrated care at SCF/ANMC means that every part of the system is intentionally planned to avoid duplication and maximize unique capabilities. "When we look at a service or an individual, we ask, 'What are you uniquely qualified to do in our system?'" says Eby.

For instance, in freestanding chiropractic clinics, the range of problems treated can be quite wide. At SCF/ANMC, chiropractors are limited to the treatment of acute pain in the neck, shoulder, and upper and lower back. Similar role definitions are in place for massage and acupuncture practitioners, and for all staff.

SCF/ANMC's use of hospitalists is another example, keeping primary care physicians more available in the office. Ob/Gyns, too, are almost like subspecialists. "Our family doctors and midwives are fully competent to care for routine Ob/Gyn needs," says Eby. "The Ob/Gyns serve as high-end consultants on the more complex cases. At first they were upset that we were limiting their practice, but now they are among the happiest in our system because they focus on the more challenging cases."

Having created disease-specific primary care teams in the mid-90s when the concept was gaining popularity, SCF/ANMC has since dismantled them. "Everything we do, we stack up against our list of operational principles," says Eby. "We looked at our immunization team, our HIV team, and asked, 'Does this treat the whole patient? Is it family-oriented? Does it avoid duplication?' The answer in each case was no. It is our strong contention that it is much better to deal with the whole person in their medical home. We do have diabetes specialists, but their job is to make sure that all the primary care providers are optimizing treatment for their diabetic patients." The same is true for all disease-specific specialists.

Supporting the Workforce Through Continual Change

Creating and sustaining this continual commitment to change can take its toll on staff. So as members of IHI's IMPACT network, SCF/ANMC joined a Breakthrough Series Collaborative on workforce development. "Like everything we do, we set about putting in place whole system optimization of all known best practices," says Eby. "As one example, we have created job progressions for nearly every position we have -

including nurses and doctors – structural ways to drive increased competencies and maturity.”

Under the leadership of Michelle Tierney, Director of Organizational Development, and Sandy Bohling, Human Resources Director, a myriad of system elements have been intentionally redesigned and built into better alignment and integration with everything else at SCF/ANMC. “We have far exceeded our goal of decreasing turnover by 50 percent in nursing and administrative support and front desk staff,” says Tierney.

Helping new staff understand the organization’s commitment to its operating principles is key to their ability to fit into the culture, says Tierney, “so we redesigned our orientation process. At the corporate level new employees get a three- to five-day orientation. At the department level they get another orientation that includes lunch out with a mentor who will continue to work with them over time. We use behavioral-based interviewing, which helps us determine the ‘fit’ better and we have implemented same day hire, meaning the time from application to hire is now measured in hours rather than weeks for many of our positions.” And while most organizations throw parties for departing employees, at ANMC the opposite is the case. “We are working on celebrations when people arrive,” says Tierney. “We want them to know they are part of something big.”

Indeed, what could be bigger than, as Gottlieb puts it, changing the very DNA of the system? “It is the only way to create and sustain lasting change,” she says. “Everything you do, your incentives, rewards, how you train and orient staff, it all becomes aligned because you are running a system where the rules are clear, and the intention is clear, and they are all based on our principles. And if people ask why something is done here a certain way, we say it’s because we found out the values of the community we serve, and we committed ourselves to building a system based on those values, a system that’s truly patient and family-centered.”

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