

‘It’s been an absolute nightmare’

Family violence in kinship care



This research report has been prepared by Rachel Brehan and Ann MacRae.

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Research Report

*'It's been an absolute
nightmare'*

Family violence in kinship care

September 2017

GLOSSARY OF TERMS AND ACRONYMS

Kinship Care—Kinship care refers to the care provided by relatives or members of the child’s social network when a child is unable to live at home with their parents.

Domestic and family violence—Domestic violence is physical, sexual, psychological or financial violence that takes place within an intimate or family type relationship and that forms a pattern of coercive and controlling behaviour. Domestic violence may involve a range of behaviours that are abusive but not necessarily violent.

Informal kinship care—A placement arrangement that is made between the family without the involvement of statutory intervention.

Statutory kinship care—Statutory kinship placements occur when Child Protection intervention has occurred and a decision has been made to place the child with a relative or significant friend. It may also involve an order made by the Children’s Court.

DHS—DHHS was previously known as DHS (Department of Human Services). The earlier term is frequently used by participants in this research.

DHHS—Victorian Department of Health and Human Services

CP—Child Protection

CSO—Community Service Organisation

ABS—Australian Bureau of Statistics

AIFS—Australian Institute of Family Studies

CAMHS—Child and Adolescent Mental Health Services

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Executive summary

Baptcare is a community organisation in Victoria that provides a range of services to vulnerable adults, families and children, including kinship care. Baptcare has become concerned about staff's observations of family violence and abuse aimed at kinship carers and children in care perpetrated by children's close family members during the placement. Baptcare proposed this research to gain a better understanding of how family violence directed towards the kinship care placements were impacting children and their kinship carers.

Kinship care refers to the care provided by relatives or members of the child's social network when a child is unable to live at home with their parents and is the preferred placement option within the child protection system. Of the 43,399 children in out of home care in Australia, 20,528 are living in formal kinship care (Australian Institute of Health and Welfare (AIHW), 2016). These numbers are continuing to rise.

One Australian study suggests that informal kinship care may be three times more common than statutory care (Smyth & Eardley, 2007).

The aims of this research were to explore the types, frequency and impact of family violence directed towards the kinship care placement (carers and/or children) from a close family member of children in care, or by the children themselves.

One hundred and one kinship carers in formal and informal kinship care in Victoria responded to an online survey. The majority of these carers were women, mainly grandmothers and aunts of children in care. Twenty-two carers participated in a follow-up interview. Recruitment of participants was

specifically targeted towards kinship carers who had direct experience of family violence during their placement.

This study has demonstrated that significant amounts of violence from family members are being experienced by kinship carers in Victoria and the children in their care. Half of the carers experienced physical abuse and violence from a family member of children being cared for.

More than eight in ten carers experienced psychological, emotional and verbal abuse. Half of the carers experienced property damage. Carers reported multiple impacts including stress and anxiety, detrimental effects on their mental and physical health, conflict with other family members, and a sense of powerlessness.

Carers reported that two thirds of the children in their care experienced family violence by their close family member once placed in care. The violence occurred both in front of the carer and when out of their immediate care, thus subjecting them to further abuse and re-traumatisation. Carers reported multiple impacts of the abuse and violence on the children including stress and anxiety, psychological issues, trauma, behavioural problems and difficulties at school.

Just under half the carers reported experiencing family violence caused by the child in care. The majority of violence was caused by boys and younger children of both genders, suggesting trauma and distress emanating from children's experiences of trauma and separation from their parents.

One third of carers were reluctant to report incidents of abuse and violence due to fear of repercussions from protective services including the removal of the child from their care, further violence and intimidation, and further risk to children's safety.

The provision of support to kinship carers is known to be inequitable when compared with foster care, and the results of this study reinforce this fact. In this study, where kinship carers reported receiving support, this had largely come from their own family and friends. A concerning message from carers about support in relation to family violence was that protective services such as police, legal services, and the Courts were found to be difficult to navigate and unhelpful.

In the context of the risks to physical and psychological safety from family violence, these findings must be of concern to authorities and support services charged with responding to children who have experienced abuse or neglect.

A systemic approach is needed to improve the safety of kinship carers and children in care, as well as providing adequate support for carers to sustain placements and to provide children with the best chance to lead a healthy, loving and fulfilling life.

Key recommendations arising from this study include:

- That access visits from family members who pose a threat to children or carers be appropriately restricted, and that Child Protection or community service staff be available to provide external supervision as necessary.
- That all children in kinship care who are affected by family violence have early access to specialised trauma support counselling.
- That training in care for traumatised children is made available to all kinship carers early in the children's placements that includes a focus on the impact of family violence.
- That Child Protection workers are provided with further training in responding to the threat and actuality of family violence in kinship care such that promote reporting of family violence and provide effective support to carers and children as needed. This training should also specifically address the fraught issue of the removal of children, with a focus on strengths based engagement and support in the context of kinship care.
- That the Centrelink Grandparent Advisor program be extended and renamed as the Kinship Carer Advisor program to improve access and equity for all kinship carers, and that grandparent entitlements such as free child care be made available to all kinship carers.
- That a common and equitable assessment process be established for statutory care payments at levels appropriate to children's needs for all children whether in foster care or kinship care.

Finally, carers are lamenting the lack of respect and recognition from government and community of the hard work that being a kinship carer entails. Greater respect, encouragement and validation by staff of child protection and associated services stand to make a huge difference in the lives of kinship carers with flow-on benefits for the children in their care.

Baptcare is keen to collaborate with kinship carers, the government and the sector to provide solutions to the issues identified in this research. By doing so, and by working together, better outcomes for all kinship carers and children in care can be achieved.

Introduction

BACKGROUND

Kinship care in Australia

Kinship care is defined as “family based care within the child’s extended family or with close friends of the family known to the child, whether formal or informal in nature” (United Nations General Assembly, 2010). Kinship care is becoming the fastest growing form of formal and informal out of home care in several first world countries (Berrick, 1997; Boetto, 2010; Kiraly & Humphreys, 2013a, 2013b) and is the preferred option for formal out of home care for children who are unable to live with their parents (Connolly, 2003; Children, Youth and Families Act, 2005).

Kinship care is referred to in the literature as occurring in either a formal or informal setting. There appears to be common agreement that formal kinship care occurs in the instance that children have been placed with kin following some form of statutory intervention or court ordered placement, with the majority of cases referring to the involvement of a child protection agency (Connolly, 2003; Department of Communities; McPherson & MacNamara, 2014). There is little reference to kinship care as a result of family law court proceedings however it is acknowledged that this would also constitute a formal kinship care arrangement regardless of the presence or absence of protective services involvement (Cooper, 2012). Informal kinship care refers to a private agreement in which family members make arrangements for the care of the child outside of the parental home, independent of the legal system and in the absence of state or agency assessment or involvement (Connolly, 2003; Department of Communities; Dunne & Kettler, 2008; McPherson & MacNamara, 2014).

Due to different methods of data collection and inconsistencies in terminology (Downie, Hay, Horner, Wichman & Hislop., 2010; Dunne & Kettler, 2008; Horner, Wichman, Hay & Downie, 2006) as well as a lack of consistent data systems for formal and informal kinship care (Horner et al., 2006; Weston & Maloney, 2014), the number of children living in kinship care is not known and can only be estimated conservatively (Connolly, 2003). In particular, informal kinship arrangements are predicted to far exceed formal kinship care (Kiraly & Humphreys, 2013a; Weston & Maloney, 2014) but given many informal arrangements are made without the involvement of services, estimates can only be made based on Australian Bureau of Statistics data (Australian Bureau of Statistics, 2003) which is statistically problematic (Horner et al., 2006).

Of the 43,399 children in out of home care in Australia, 20,528 are living in formal kinship care (Australian Institute of Health and Welfare (AIHW), 2016). These prevalence rates continue to rise. It is estimated that the numbers of children in informal kinship care is much greater with one Australian study suggesting that informal kinship care may be three times more common than statutory care (Smyth & Eardley, 2007).

A growing body of research has identified the many advantages of kinship care over alternatives, including improvements to child wellbeing and stability of care (Winokur, Holtan, & Valentine, 2009). Kinship care also provides many children with a web of intimate support for life. However, these benefits to children often come at the cost of significant stress for their carers.

In Australia, the vast majority of kinship carers are believed to be grandparents (Department of Communities; Downie et al., 2010; Dunne & Kettler, 2008) however there are a significant number of older siblings, aunts, uncles and other close relatives or friends providing primary care to a child. Kinship carers, particularly grandparents, experience more vulnerability than foster carers, including older age and greater poverty, health issues and greater likelihood of being sole carers (Boetto, 2010). The close relationship between kinship carers and the children's parents - often itself a problematic parent-child relationship - adds another level of complexity, given the impact on family relationships of parental substance abuse, concomitant mental illness, and family violence (Boetto, 2010).

Family violence and kinship care

There has been significant discourse around the use of language in the context of domestic and family violence and inconsistencies in language present in policy, legislation, practice and research. This has resulted in the lack of agreement on a definitive and overarching description of domestic and family violence (Boxall, Rosevear & Payne, 2015; Tinning, 2010). The Australian Government has adopted the United Nations (1993) definition which states that violence against women is gender based and results in or is likely to result in physical or psychological harm. However, this definition is problematic in the context of broader domestic and family violence given its gendered perspective. Bromfield, Lamont, Parker and Horsfall (2010) state that family violence is overwhelmingly a gendered issue as the vast majority of incidents involve a male perpetrator and female victim. However, this view may be less appropriate to family violence outside of an intimate partner relationship. This definition is restrictive in the context of broader family types including multi-generational families and families where children may commit acts of violence toward parents

and carers. Wilcox and Polley (2015) state that child to parent violence is the most hidden and misunderstood form of domestic violence. Given the lack of research about family violence within kinship care, it could also be argued that this is another ignored and under-researched area of family violence.

Definitions of domestic and family violence vary. Laing and Humphreys (2013) offer an inclusive definition of domestic and family violence which considers the context of a range of family types including kinship care families:

Domestic violence is physical, sexual, psychological or financial violence that takes place within an intimate or family type relationship and that forms a pattern of coercive and controlling behaviour. Domestic violence may involve a range of behaviours that are abusive but not necessarily violent.

Due to gaps in data, the rate of children's exposure to family violence is difficult to determine however as Campo (2015) states, a significant number of Australian children are exposed to domestic and family violence in the home. According to the Australian Bureau of Statistics (2015) 54-61% of women had children in their care when violence occurred and 31-48% of children had heard or seen the violence. Gewirtz and Edleson (2007) highlighted that young children were more likely to be exposed to domestic and family violence than older children.

There is an assumption that children placed in kinship care will be exposed to less family violence than in their own homes (Litrownik, Newton, Mitchell & Richardson, 2003). There is little research on family violence in kinship care, specifically the number of kinship carers who are subject to family violence directed at them by a family member of the child in care or by the child themselves. In a study on quality of kinship and foster care, Berrick (1997) found that rates of violence in the home are significantly higher for kin than non-kin carers and that this violence is not exclusive to family violence in its defined form. Family violence directed towards kinship carers has been briefly identified in research as part of a picture of complexity within the out of home care system and is often identified as difficult relationships, conflict, threats, intimidation, or hostility (Brown & Sen, 2014; Dunne & Kettler, 2008; O'Brien, 2012) but little reported violence. By comparison with general population research which identifies the majority of perpetrators of family violence as male, in the out of home care context, the majority of conflict, aggression and violence came from the mother of the child (Briggs & Broadhurst, 2005; Hunt et.al., 2010) and similar findings were reported by Kiraly & Humphreys (2013a) in relation to kinship care.

Kinship care arrangements are often complicated by family dysfunction including violence (Dunne & Kettler, 2008). Dunne and Kettler (2008) cite the circumstances in which the children enter the care of kin as a key contributing factor to

conflict with the birth parents as well as the economic losses to the parent of relinquishing care of the child. Relationship issues between the children's parents and the kinship carers are also cited as a key reason for conflict which can escalate to violence (O'Brien, 2012). Farmer (2009) and Boetto (2010) reported examples of hostility, threats, intimidation, abuse, physical attacks, false allegations and undermining of placements as specific elements of conflict between parents and carers. There is some evidence to suggest that there are greater levels of exposure to family violence in kinship care than foster care (Berrick, 1997; Brown & Sen, 2014). Due to lack of restriction and authorisation around parental contact with children in kinship care, there is a greater likelihood for children to witness the hostility between carers and parents (Brown & Sen, 2014; Connolly, 2003).

There also appears to be little research about violence from children toward carers and in particular kinship carers. One general population study found that child perpetrated violence in the home is at least (if not more) common than other forms of domestic and family violence (Kethineni, 2004). In addition to violence perpetrated by the family of the child in care toward the carer, Briggs & Broadhurst (2005) reported that one third of foster carers are threatened or intimidated by the child in their care. A review by Brown & Sen (2014) suggested that children placed with kin were less physically aggressive or hostile than children in foster care. In grandparent led households, Day and Bazemore (2011) highlighted the risk posed by violence toward two generations.

What else we know from the literature

Despite the significant number of children living in kinship care arrangements in Australia, there is little specific research or evidence on issues impacting on kinship care, particularly in the Australian context as Australian kinship care research is at an early stage (Connolly, 2003; Department of Communities; Horner et al., 2006).

More specifically, there is a lack of data and studies of informal kinship care arrangements (Connolly, 2003) and child safety or maltreatment in informal kinship care (Connolly, 2003) including exposure to family violence with only occasional reference to parent / carer conflict or tenuous relationships (Connolly, 2003).

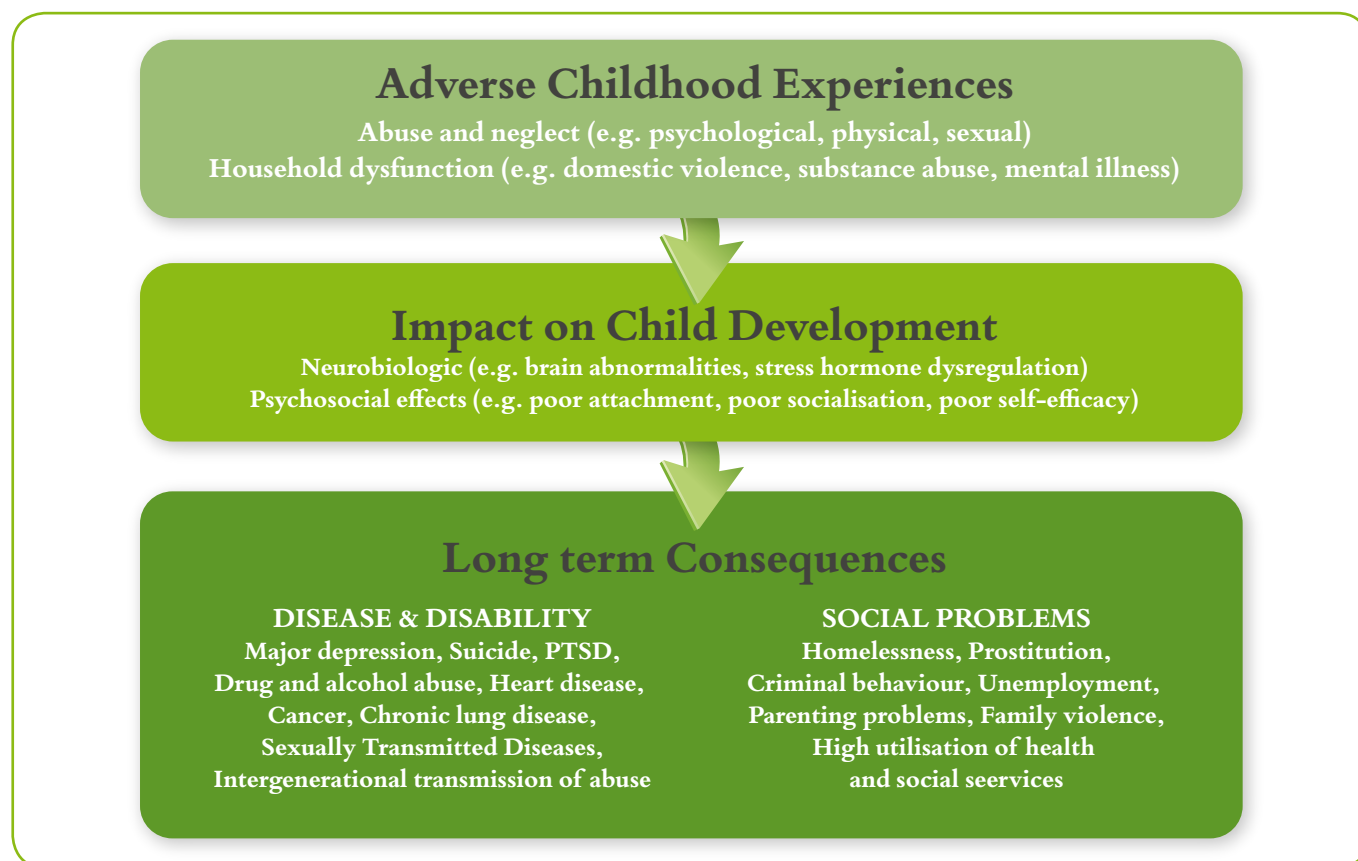


Figure 1: Impacts of trauma on children.

Source: Putnam (2008)

In general, domestic and family violence in Australia is under-reported (Campo, 2015; Richards, 2011) and therefore the uncertainty around reporting rates for family violence within the kinship care context may be attributed in part to a lack of reporting (Font, 2015). Reasons for lack of reporting of violence in kinship care include a fear of negative responses to the report such as the child being removed from the placement or judgement and punitive responses from statutory authorities (Briggs & Broadhurst, 2005; Uliando & Mellor, 2012) and the difficulties in taking legal action against family members (Argent, 2009). According to an Australian literature review conducted by the Department of Communities, kin carers tolerate difficulties longer than foster carers and underreport difficulties which can lead to longer unacceptable placements. This may be due to a conflict between keeping children safe versus maintaining family connection with the children's parents (Cooper, 2012). While this may demonstrate both strength and resilience within kinship carers facing adversity without support this may also place kinship carers and the children in their care at greater risk.

There is little research on the impacts of family violence on kinship carers however specific impacts in the literature include fear for their own safety and that of other family members (Briggs & Broadhurst, 2005) and impacts on their capacity to parent (Bromfield et al., 2010). The literature also highlights the

skills of carers in their efforts to protect the children in their care (Kiralý & Humphreys, 2013a). There is significantly more research on the impacts of exposure to violence on children (Campo, 2015; Uliando & Mellor, 2012; Weston & Moloney, 2014). Impacts of violence on children include stress and psychological issues, behaviour and attachment problems, sleep difficulties, strained relationships with the biological parents, academic and learning difficulties and regression in eating and toileting (see Figure1). These impacts are consistent with those outlined in the child trauma guide (DHHS Victoria, 2011) for recognising developmental and behavioural signs of trauma in children.

Within the context of kinship care, family dynamics and hostility that place the child at risk (Weston & Moloney, 2014) provide an explanation for children's challenging behaviours toward grandparents (Dunne & Kettler, 2008).

Kinship carers are provided with little to no support or training around caring for a traumatised child depending on the circumstances in which the child is placed in their care (Berrick, 1997; Boetto, 2010; Briggs & Broadhurst, 2005). Formal kinship carers may receive some support in terms of financial support and support from services however this is reported to be significantly less than formal foster carers and they are not subjected to the assessment and training foster carers receive (Uliando & Mellor, 2012).



Informal kinship carers receive very little or no support financially or from services and are provided with no training or assessment of suitability (Uliando & Mellor, 2012). Kinship carers are relatively physically and financially disadvantaged and funded services focus on practical support, information provision and advocacy (Berry Street Victoria, 2012).

Within the limited literature on kinship care, the needs of carers are articulated, particularly around support with conflict within family relationships. The need for more support around parental contact with the child in care when relationships with family are troubled is strongly identified in the literature (Brown & Sen, 2014; Kiraly & Humphreys, 2013a; O'Brien, 2012). Brown & Sen (2014) identified that kin carers are saying they need more support to deal with parental contact and hostile parents. There is an identified need for access to ongoing training and support (Weston & Moloney, 2014). There is also a need for specific support around dealing with conflict and aggression both from the family of the child in care and the child themselves (Day & Bazemore, 2011). Kiraly and Humphreys (2013b) suggested that the ongoing management of family contact arrangements would be best handled by community service kinship programs that have a mandate to listen to children, parents and caregivers and to provide tailored support. Kinship carers need specific and tailored, ongoing support and training in order to meet their own best interests and those of the child being cared for.

AIMS

Baptcare proposed this research to gain a better understanding of how family violence directed towards kinship care placements were impacting children and families in kinship care in Victoria.

The aims of this research were:

- To explore the types, frequency and impact of family violence perpetrated by a close family member of the child in care, that is directed towards the kinship care placement (i.e. the carers, child in care and/or other members of the carer's household)
- To explore the types and impact of family violence and abuse caused by the child being cared for
- To provide the basis for improvements to practice and service development to better meet the needs of kinship clients and carers in Victoria (and more broadly) and
- To disseminate the research findings to policymakers and practitioners to allow for the development of a practice model and progressive improvements in kinship care and support services.

Methodology

This project used multiple study designs (literature review, survey and interviews) in order to best address the aims of the research. Ethics approval was obtained from the Cabrini Human Research Ethics Committee. Children and young people were not included as research participants.

A literature review was conducted to investigate what is currently known about family violence directed towards kinship care arrangements. This was conducted through a search on online databases (including but not limited to ProQuest, ERIC and PsychInfo) using the key words “out of home care”, “foster care”, “kinship care”, “violence” and “family violence”.

A survey questionnaire was developed in Survey Monkey with a paper-based version available for carers without access to the internet. The development of the questionnaire was reviewed internally and externally with key ‘experts’ from the sector, including Dr Meredith Kiraly, University of Melbourne, Elizabeth McCrea and Ruth Chattey from the Mirabel Foundation, Anne McLeish from Grandparents Victoria, the Centre for Excellence in Child and Family Welfare and Professor Cathy Humphreys from the University of Melbourne. A short pilot was conducted to cognitively test the integrity of the proposed survey by emailing a selection of carers the survey link. A follow-up phone call was conducted post-pilot to discuss any issues with the survey – for example, length, language, comprehension, recall, judgement and response. Post-pilot, relevant edits were made and the online survey link and paper-based version of the survey was finalised for dissemination.

In total, 101 carers responded to the survey. It is unknown how many surveys were sent out due to the online nature of the survey.

Interviews were conducted with carers who wished to share their story in greater detail. Consent for interviews was obtained by the carers willingness to indicate their interest at the end of the survey and to provide their personal contact details for the researchers to make direct contact. Aside from providing consent to be contacted, no identifiable information was collected from the carers. Twenty-three carers provided consent and twenty-two carers were interviewed.

SAMPLE AND RECRUITMENT

The online survey link was emailed to former and current kinship carers in Victoria. The link was distributed to both informal and formal kinship carers. Key stakeholders from the sector who supported the dissemination of the link through their networks included: The Centre for Excellence in Child and Family Welfare, Grandparents Victoria, the Mirabel Foundation and members from the Kinship Care Sector Forum facilitated through the Centre for Excellence in Child and Family Welfare.

Surveys were conducted from November 2016 – May 2017. Interviews were conducted during April and May 2017.

DATA ANALYSIS

Information was entered onto an Excel database that provided the basis for quantitative analysis. Analysis was by simple summation of the incidence of measures as defined and was performed using a statistical package (SPSS). Where appropriate, results are expressed as percentages of the total sample or a sub-sample, or by number of responses where appropriate.

LIMITATIONS

Due to the sample size, analysis was limited to basic frequency counts.

Since the intention of this study was to describe the carers and children’s experience of violence and abuse and the impact this violence has had on them, recruitment of participants was specifically targeted towards kinship carers who had direct experience of family violence since their placement started. No information was obtained about the prevalence of family violence in kinship placements in Victoria. A study of prevalence would be desirable however this would require a randomised sample and a methodology that is independent of carer’s capacity to volunteer information.

Results – Survey of kinship carers

THE CARER'S EXPERIENCE

This section of the report describes the survey findings related to the carers experience of family violence, that was perpetrated by a close family member since the placement began. Data is expressed either as percentages or number of responses (n) as appropriate.

Respondent profile

As shown in Table 1, the majority of carers who participated in the survey were female (96%) and two thirds were aged over 51 years of age (66%). The majority of carers were grandmothers (68%) or aunts (18%). Almost two thirds were in a partnered relationship (63%). These findings are largely consistent with what has previously been presented in the literature: that kinship carers are often older and female.

Just over a third of carers self-reported they received support for their kinship placement from the Victorian Department of Human Services (DHHS) (36%), or a Community Service Organisation (also 36%). Over one-quarter, (28%) of carers believed that they received no support during their placement.

Table 1: Respondent profile (%)

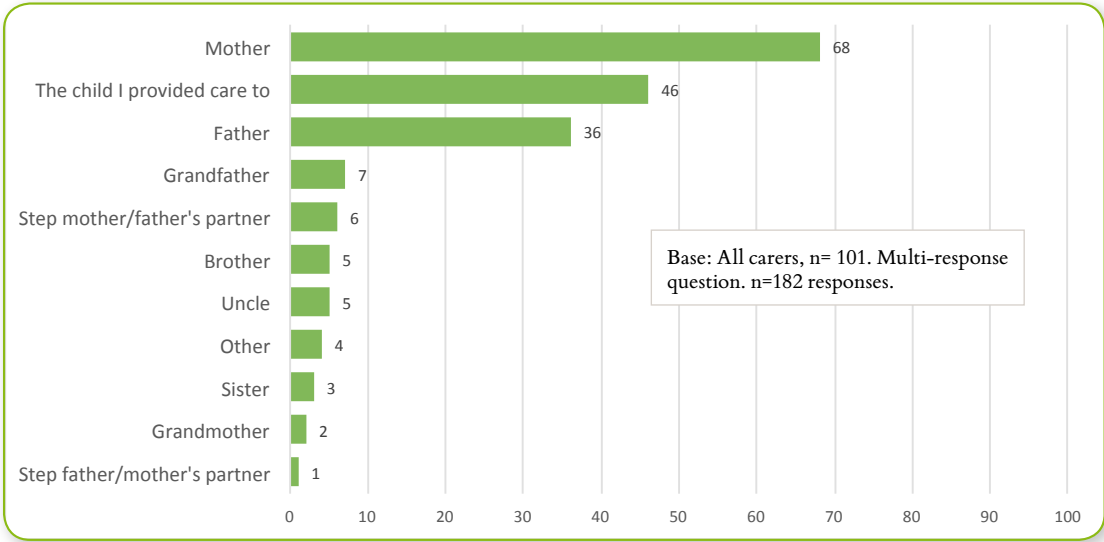
Respondent profile		Respondent profile	
Gender	%	Relationship to child being cared for	%
Male	3	Grandmother	68
Female	96	Grandfather	3
Other	1	Aunt	18
Age group (years)	%	Uncle	0
18-20	0	Brother	0
21-30	1	Sister	1
31-40	12	Family friend	6
41-50	21	Other friend	0
51-60	33	Neighbour or community member	0
61-70	27	I have previously worked with this child/ren	1
71+	6	Other	3
Relationship status	%	Support received	%
Partnered	63	Yes – Department of Human Services	36
Single	37	Yes – Community Service Organisation	36
		None	18
		Other	10

Base: All carers who answered the respondent profile questions, n=78/101.

Perpetrators of family violence

Figure 2 shows the perpetrators of the family violence directed towards the kinship placement was caused by the child's mother (68%), the child being cared for (46%) and the child's father (36%). Smaller numbers of incidents were reported from a variety of other relatives. For some carers, family violence was being perpetrated by more than one family member (182 responses obtained from 101 carers).

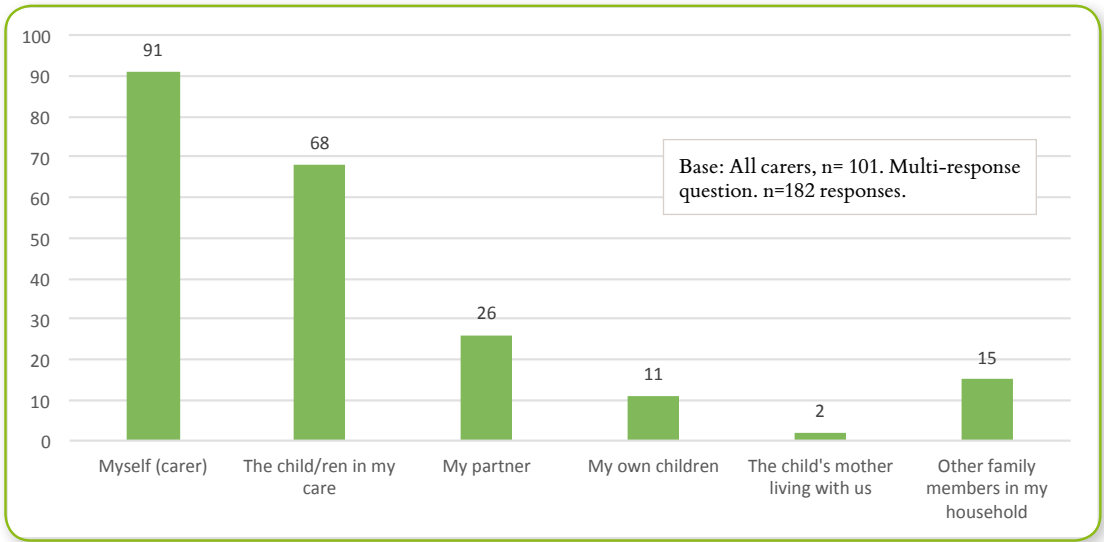
Figure 2: Perpetrators of family violence (%)



Who the violence was directed towards

As shown in Figure 3, the vast majority of the family violence and abuse was directed towards the carer (91%), the children in care (68%) and the partner of the carer (26%). Not surprisingly, violence was directed towards more than one member in the carers household (n=213 responses obtained from 101 carers).

Figure 3: Household members to whom violence was directed (%)





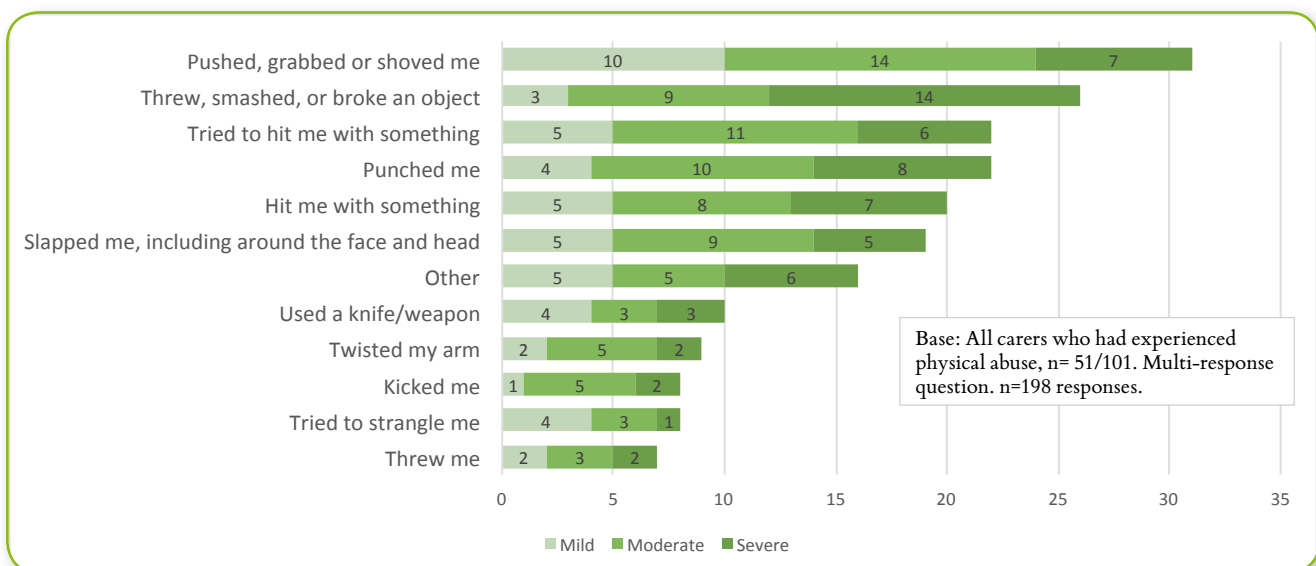
Carers direct experience of physical violence

Carers were asked whether they had direct experience of any type of physical abuse since the placement began, that was caused by a close family member of the child being cared for. Carers were also asked if they considered the acts of abuse to be mild, moderate or severe.

51% of carers had experienced physical violence and /or abuse. 198 responses were provided from the 51 carers, indicating multiple experiences of physical violence.

As shown in Figure 4, the most common types of physical abuse the carers experienced were carers being pushed, grabbed or shoved (n=31), carers having something thrown at them, or an object smashed or broken (n=26), carers attempted to be hit with something (n=22) and carers being punched (n=22).

Figure 4: Carers experience of physical violence (n)



Carers direct experience of psychological, verbal and emotional abuse

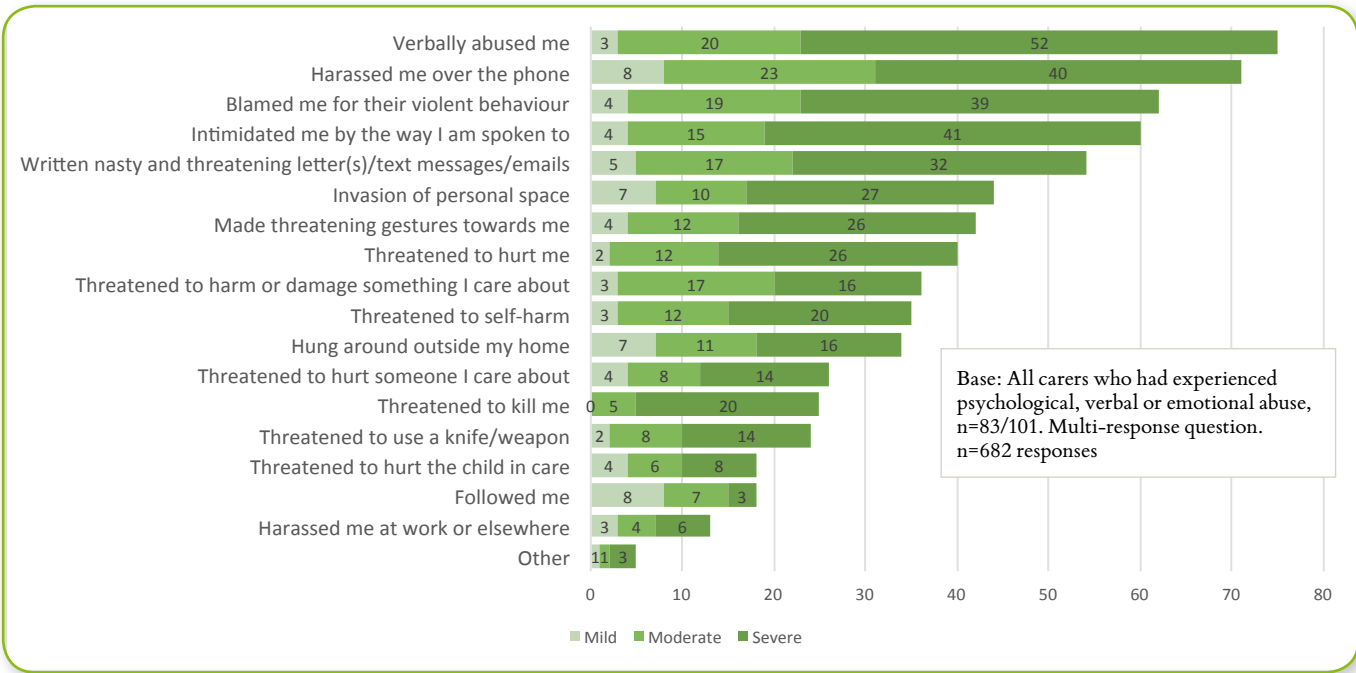
Carers were asked whether they had direct experience of any type of psychological, verbal and emotional abuse since the placement began, that was caused by the close family member of the child being cared for. Carers were also asked if they considered the acts of abuse to be mild, moderate or severe.

82% of carers had experienced psychological, emotional or verbal abuse. 682 responses were provided from the 82 carers, indicating multiple experiences of psychological violence.

As shown in Figure 5, the most common types of psychological, emotional and verbal abuse carers experienced were being verbally abused (n=75), being harassed over the telephone (n=71), being blamed for the perpetrators violent behaviour (n=62), intimidation (n=60) and receiving threatening letters, texts, emails (n=54). The impact of these actions of violence and abuse on the carers ranged in severity.

Of alarming concern is the number of carers who reported various threats being made against them. 40 carers were threatened to be hurt, 25 carers received threats to be killed, 24 carers were threatened by a knife or weapon, and 18 carers received threats to hurt the child being cared for.

Figure 5: Carers experience of psychological, verbal and emotional abuse (n)

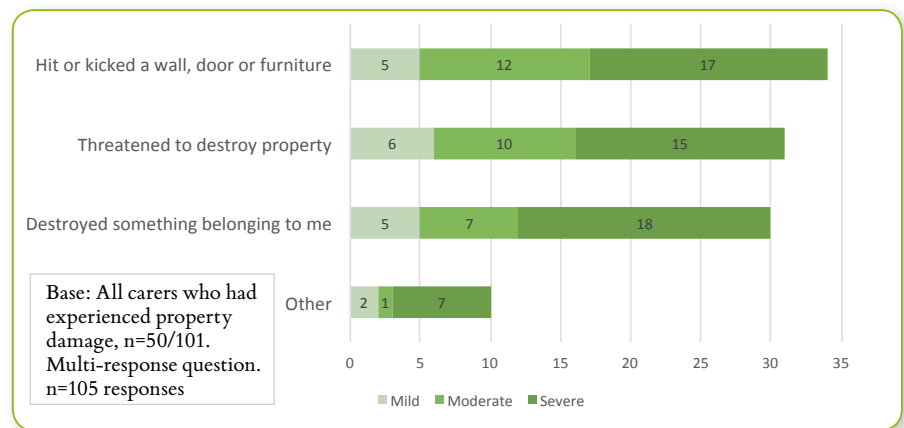


Carers direct experience of property damage

Carers were asked whether they had direct experience of any type of property damage since the placement began, that was caused by the close family member of the child being cared for. Carers were also asked if they considered the acts of damage to be mild, moderate or severe.

50% of carers had experienced property damage caused by a family member of the child being cared for. Again, some carers experienced multiple acts of property damage (105 responses obtained from 50 carers).

Figure 6: Carers experience of property damage (n)



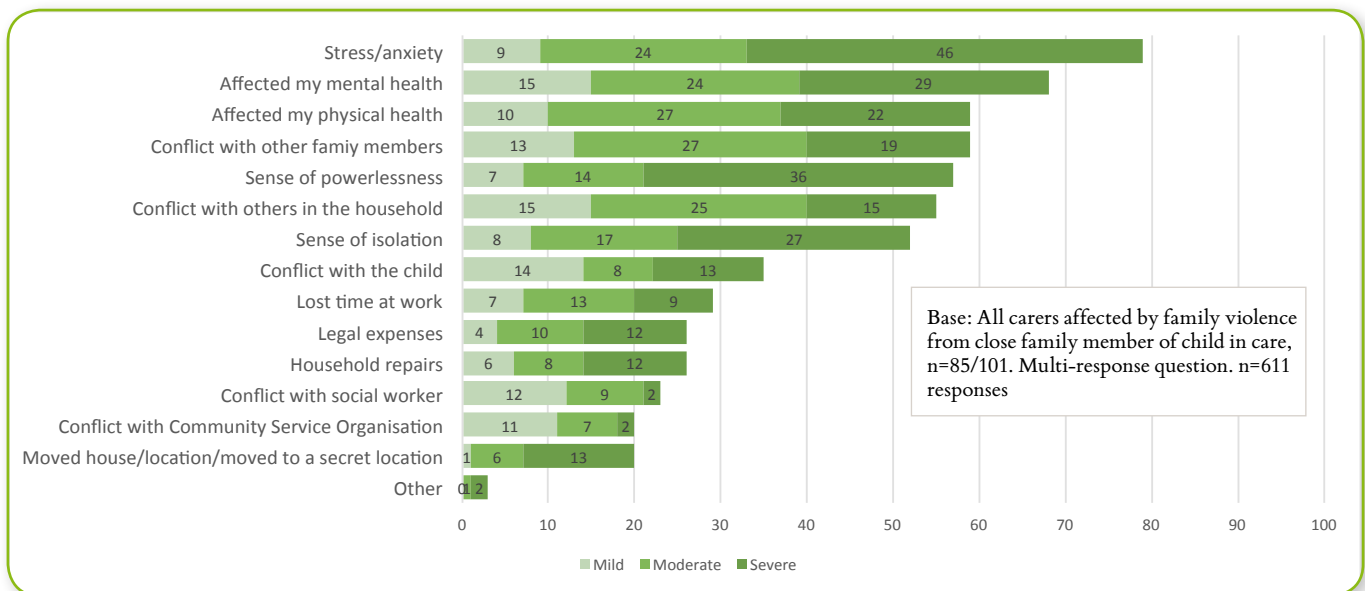
As shown in Figure 6, carers had experienced a wall, door or furniture being kicked (n=34), threats made to destroy property (n=31) and something being destroyed that belonged to the carer (n=30). These incidents were more likely to be reported as severe rather than mild or moderate.

Impact of the family violence on the carer

As shown in Figure 7, carers reported multiple impacts of the family violence (611 responses obtained from 85 carers). The greatest impact the violence and abuse was having on the carer was in regards to stress/anxiety (n=79), detrimental effects on mental health (n=68), and physical health (n=59), conflict with other family members and a sense of powerlessness (n=57 respectively). For the most part, the violence has had a severe impact on the carer.

These reported impacts on the carers are consistent with the literature evidence of the impacts of family violence on adult victims in the general population: physical and psychological harm.

Figure 7: Impact of the family violence on the carer (n)



THE CHILDREN'S EXPERIENCE

This section of the report describes the survey findings related to the children's experience of family violence, perpetrated by their close family member, since the placement began. Data is expressed as percentages and number of responses (n) where appropriate. 68% of carers reported that the child/ren had experienced family violence caused by their close family member since the placement started.

Children's experience of family violence that occurred in front of their carers

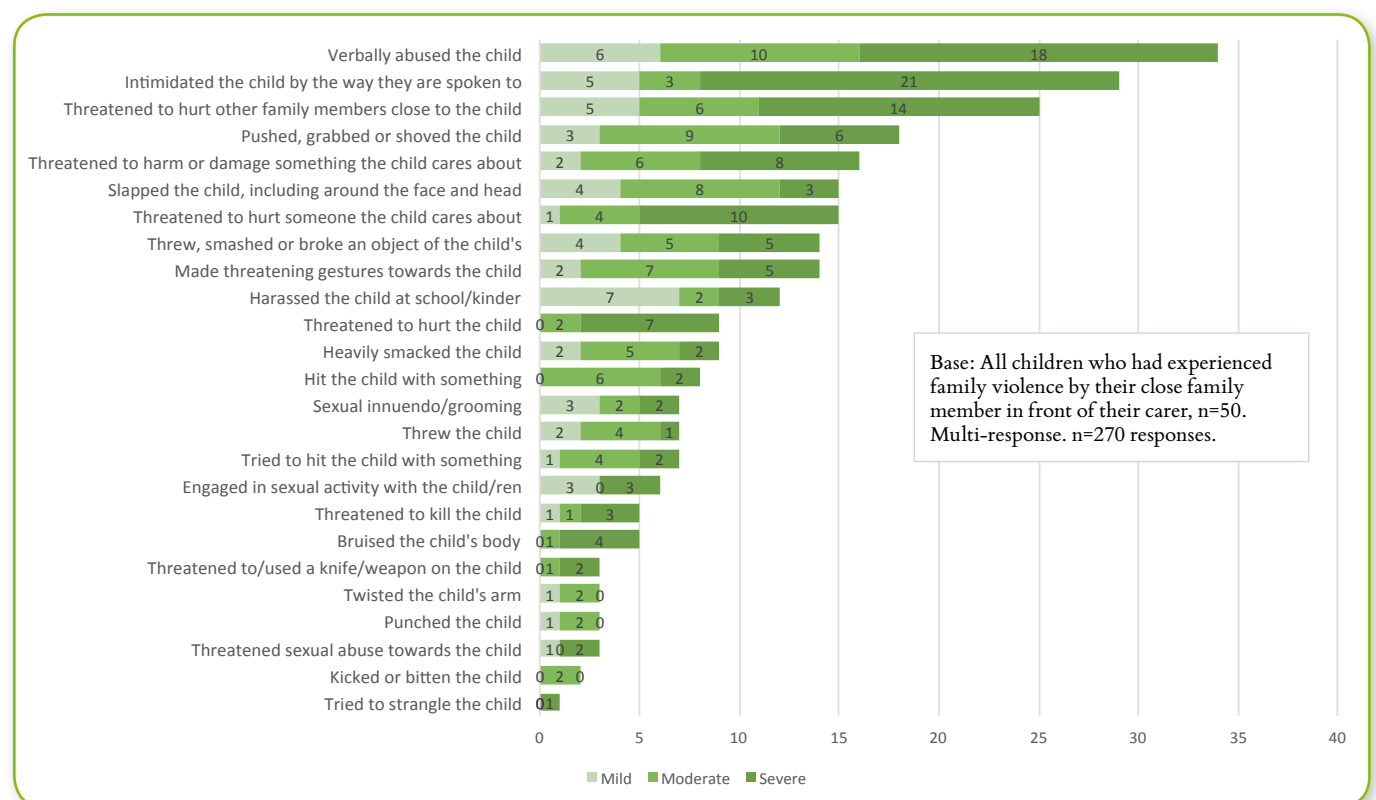
Carers were asked whether the child/ren have experienced any acts of family violence caused by their close family member since the placement began, that happened in front of them. If so, they were asked whether they considered the actions to be mild, moderate or severe.

50% of carers reported children experiencing family violence that occurred in front of them.

As shown in Figure 8, the main types of abuse the children had experienced were verbal abuse (n=34), intimidation (n=29), threats to hurt other family members of the child (n=25) and the child being pushed, grabbed or shoved by their close family member (n=18). Many children had experienced multiple types of abuse from their family member (270 responses obtained from 50 carers). Carers frequently described these experiences as severe for the child.

These results indicate that many of these children who have been placed in kinship care as a result of abuse by their parents are being subject to further abuse and re-traumatisation following placement.

Figure 8: Children's experience of family violence that occurred in front of their carers (n)



Children's experience of family violence when away from their kinship carers

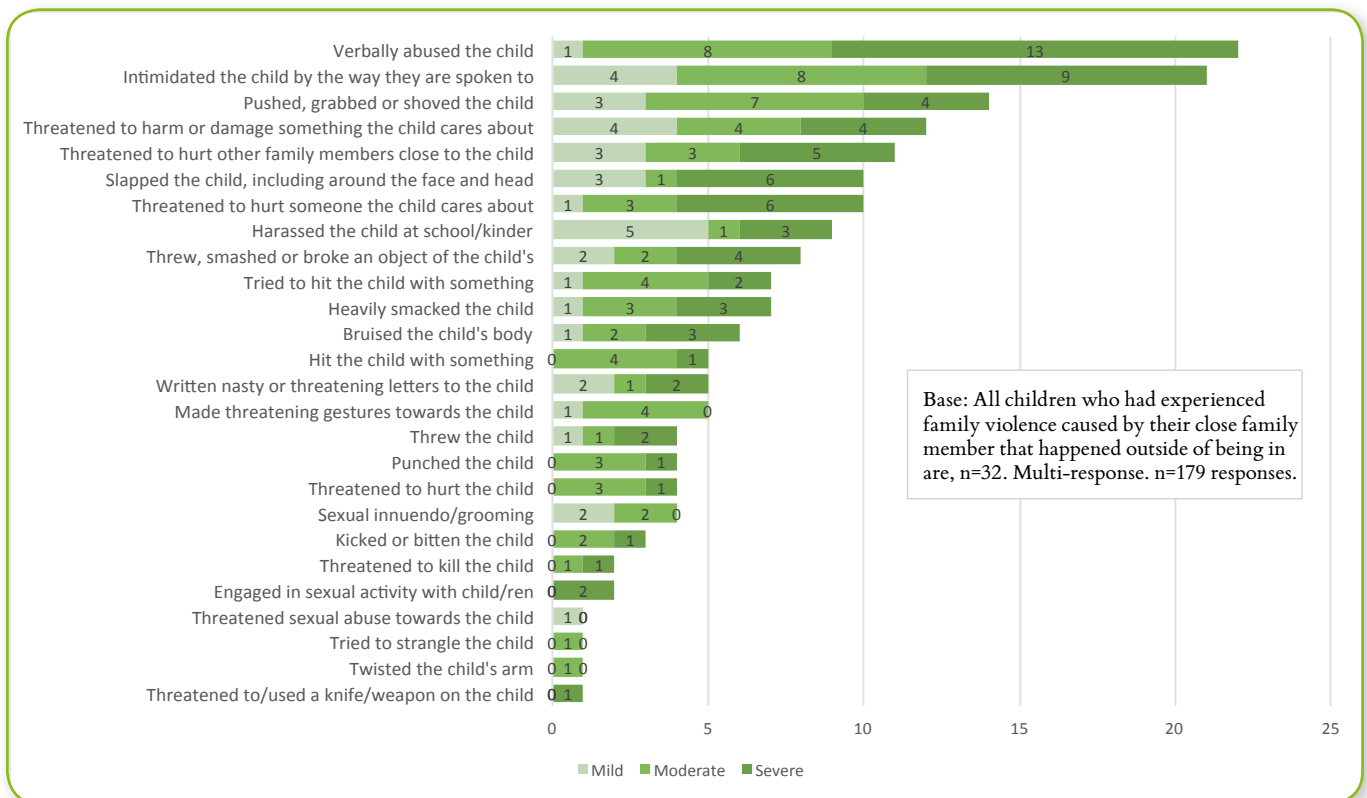
Carers were also asked whether the child/ren have experienced any acts of family violence caused by their close family member since the placement began, that happened when not in the immediate care of their carers. If so, they were asked whether they considered the actions to be mild, moderate or severe.

32% of carers reported the children experiencing violence and abuse while outside of their immediate care.

As shown in Figure 9, the main types of abuse the children had experienced were verbal abuse (n=22), intimidation (n=21), the child being pushed, grabbed or shoved by their close family member (n=14) and threats to harm or damage something the child cares about (n=12). Clearly, many children had experienced multiple types of abuse from their family member (179 responses obtained from 32 carers). Carers have frequently considered these experiences to be severe for the child.

It may be speculated that some children do not disclose abuse caused by their family members during contact with their parent(s). It is therefore possible these figures underestimate the incidence of family violence during unsupervised parental contact visits.

Figure 9: Children's experience of family violence that happened away from their carers (n)



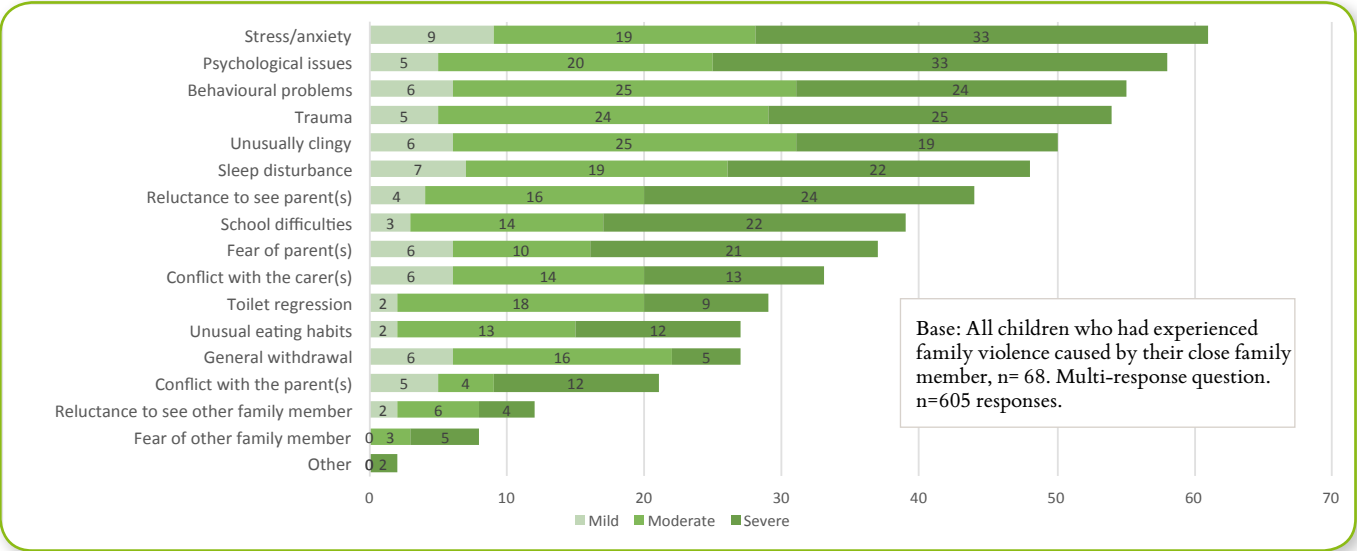


Impact of family violence on the children

As shown in Figure 10, the main impacts of the violence on the children as reported by carers were stress/anxiety (n=61), psychological issues (n=58), behavioural problems (n=55), trauma (n=54), the child being unusually clingy (n=50), sleeping difficulties (n=48), reluctance to see parents (n=44), problems at school (n=39) and fear of parents (n=37). Not surprisingly carers have frequently reported the impact of this violence on the children to be severe.

Many of these children experienced multiple impacts of the abuse (605 responses obtained from 68 carers).

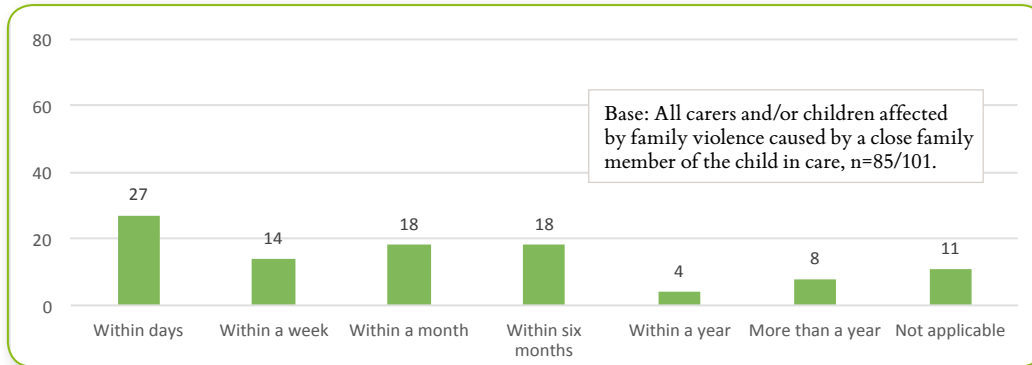
Figure 10: Impact of the family violence on the children (n)



When the violence started

As shown in Figure 11, for 27% of households, violent incidents started within days, and for 14% these started within a week. 36% of households experienced violence within a month to six months. Only a small proportion (12%) of households first experienced acts of violence more than six months after the child was placed with the carers. The early onset of violent incidents from family members (usually children's parents) may suggest an association with the distress and anger parents frequently experience upon separation from their children.

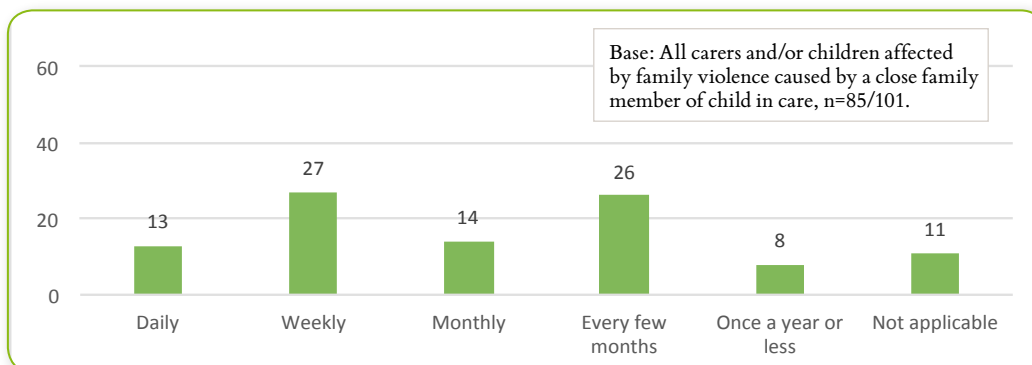
Figure 11: Length of time since the placement started that the first incident of family violence occurred (%)



Frequency of violent incidents

Carers were asked how many times (on average) they and/or children in their care had experienced acts of family violence since the placement began. As shown in Figure 12, 40% of carers and/or children had experienced family violence daily, if not weekly. 14% of households experienced family violence on a monthly basis, with a further 26% every few months. Very few carers and/or children (8%) had experienced family violence infrequently (once a year or less).

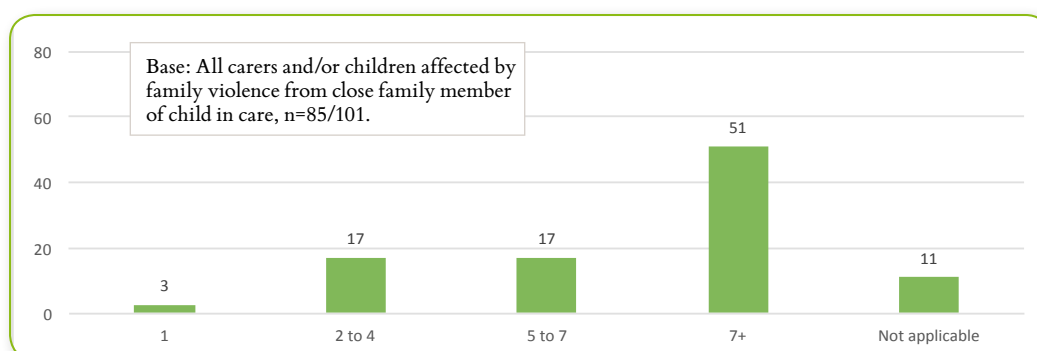
Figure 12: Average amount of times the carers or children experienced acts of family violence (%)



Number of family violence incidents

Carers were asked about the number of incidents of family violence and abuse they and/or the children had experienced since the placement started. Figure 13 shows that many of the carers and children experienced a lot of incidents of violence. Half of carers and/or children (51%) had experienced more than 7 incidents of family violence. An additional 34% had experienced between 2-7 incidents.

Figure 13: Number of family violence incidents the carer or children have experienced (%)



VIOLENT INCIDENTS PERPETRATED BY CHILDREN IN CARE

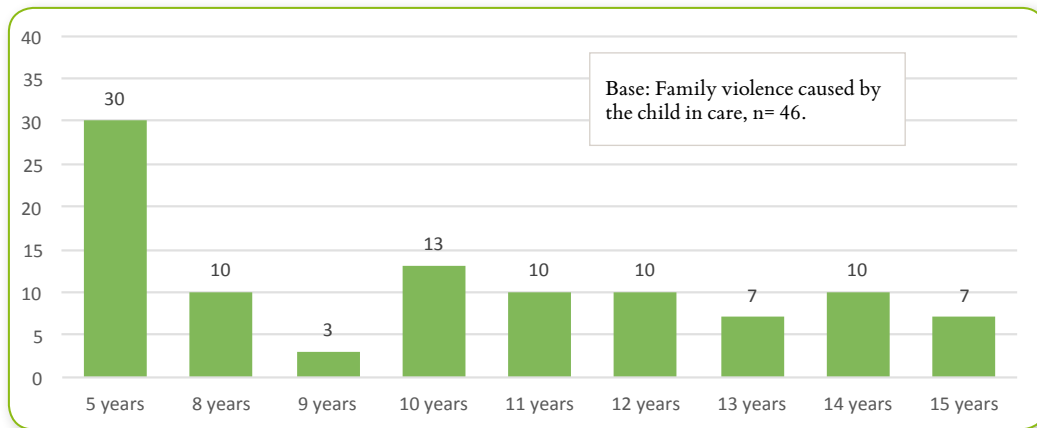
This section of the report describes the survey findings related to acts of family violence caused by the child in care. Data is expressed as percentages and number of responses (n) where appropriate.

Nearly half (46%) of carers reported experiencing family violence from the child being cared for.

Gender and age of children committing acts of violence while in care

Two thirds (66%) of the acts of violence from children were perpetrated by boys. Children aged from 5 to 10 years committed just over half (56%) of the acts of violence. In 30% of cases, it was the five year-old children who were reported to have been violent. These behaviours may indicate trauma and distress emanating from children's experiences of trauma and separation from their parents.

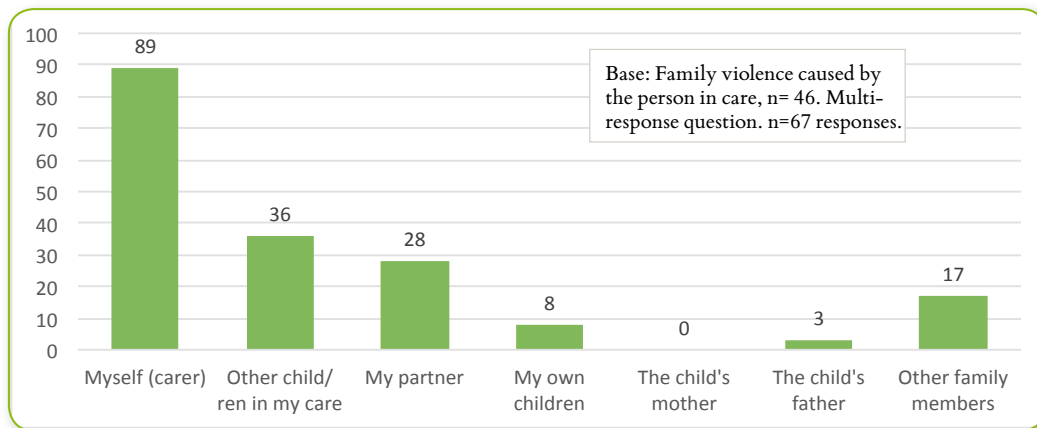
Figure 14: Age of the child when they began causing acts of family violence while in care (%)



Who children's violent behaviour was directed towards

Figure 15 shows that overwhelmingly, the violence and abuse caused by the children was aimed at the carer (89%), followed by other child/ren (36%) and the partner of the carer (28%).

Figure 15: Who the violence was directed towards, perpetrated by children in care (%)

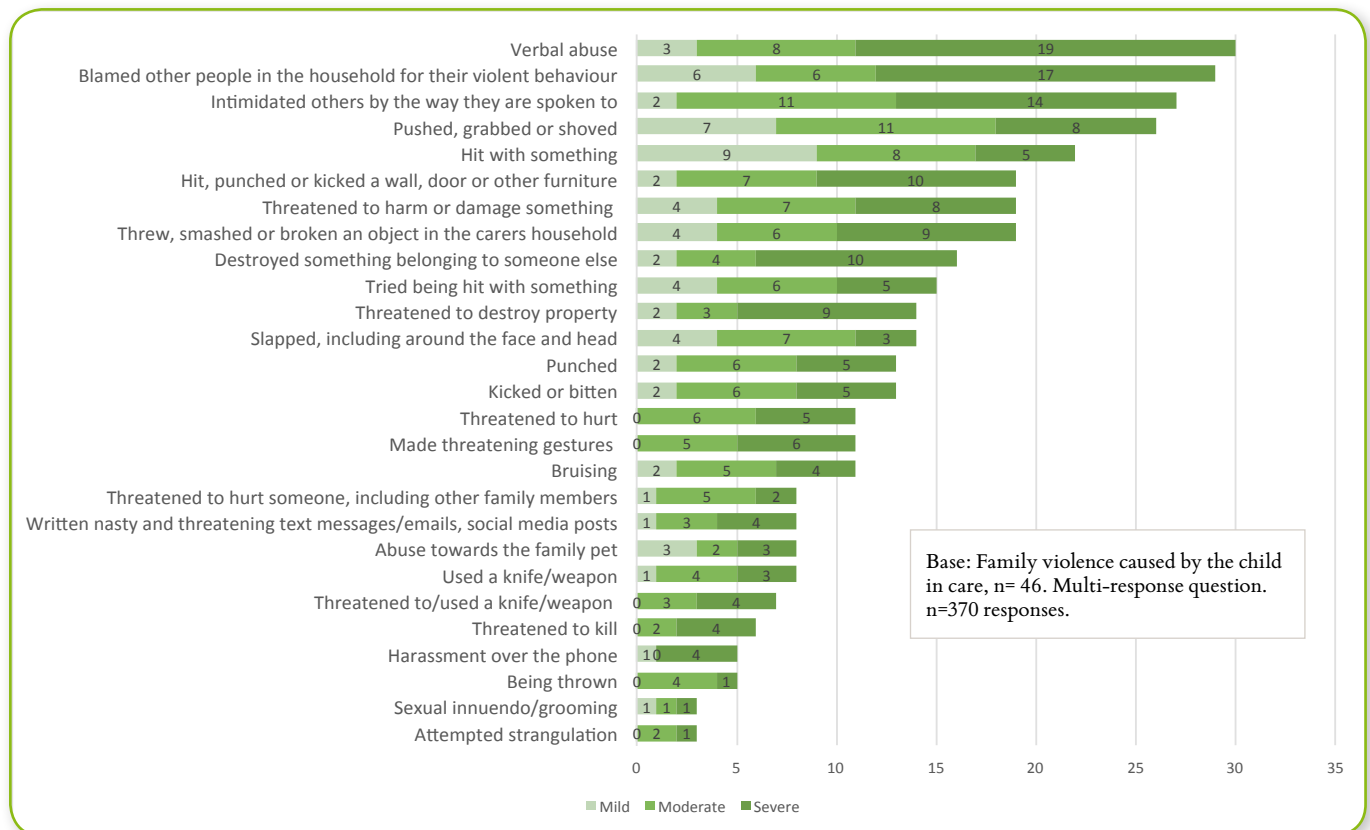


Types of violent incidents from children in care

Carers who had experienced family violence caused by the child in care were asked to report on the types of violence and abuse they had experienced. Carers were also asked if they considered the acts of violence and abuse to be mild, moderate or severe. The number of responses (370 responses provided from 46 carers) show that many carers were experiencing multiple types of violent incidents from the children they provided care to.

As shown in Figure 16, the main types of violent incidents by the child in care relate to verbal abuse (n=30), blaming others for their violent behaviour (n=29), intimidation (n=27), being pushed, grabbed or shoved (n=26) and carers being hit with something (n=22). A further 22 acts of violence were identified. However, the incidents reported most often as severe were types of verbal abuse rather than physical aggression.

Figure 16: Types of family violence caused by the child in care against the carers and their household (n)



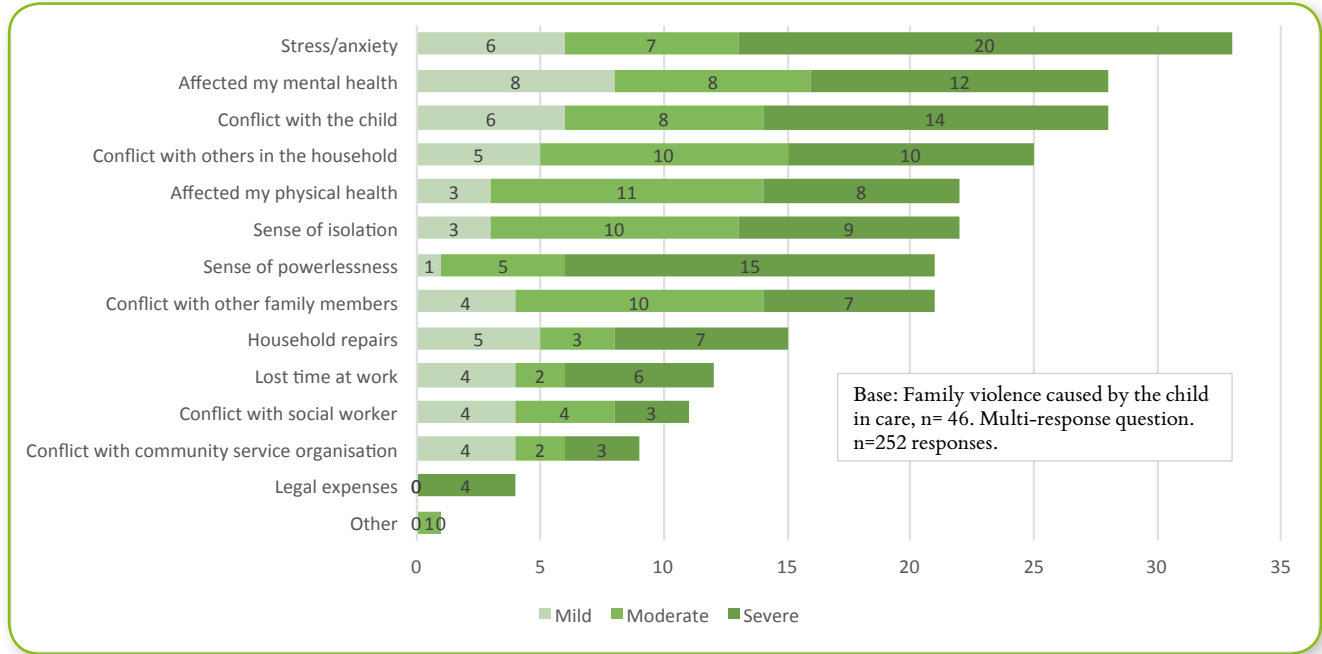


Impact of children’s violent behaviours on the carers

Carers who had experienced family violence caused by the child being cared for were asked about the impact the violence and abuse has had on them and their household and whether they considered the impact to be mild, moderate or severe.

As shown in Figure 17, carers reported multiple impacts of the family violence (252 responses obtained from 46 carers). The greatest impact the violence and abuse was having on the carer was in regards to stress/anxiety (n=33), detrimental effects on mental health (n=28), conflict with the child (n=28) and conflict with others in the household (n=25). The impact of these behaviours was frequently described as severe.

Figure 17: Impact of family violence caused by the child in care against the carers and their household (n)



When the child's first violent incident occurred

As shown in Figure 18, for almost four in ten cases (39%), the children's first violent incident occurred within the first week of the placement starting, with a further 24% occurring within six months. There is an increase in occurrences after 12 months since the placement started. This may be due to incidents occurring over a longer time period but it may also coincide with the development of secure attachment with the caregiver. Previous literature has found that for children in out of home care, attachment is disrupted with the parent and as a child becomes more securely attached to a new caregiver, this can present in negative behaviours which serve to push the caregiver away, thus reinforcing previous messages of rejection (Hughes, 2004).

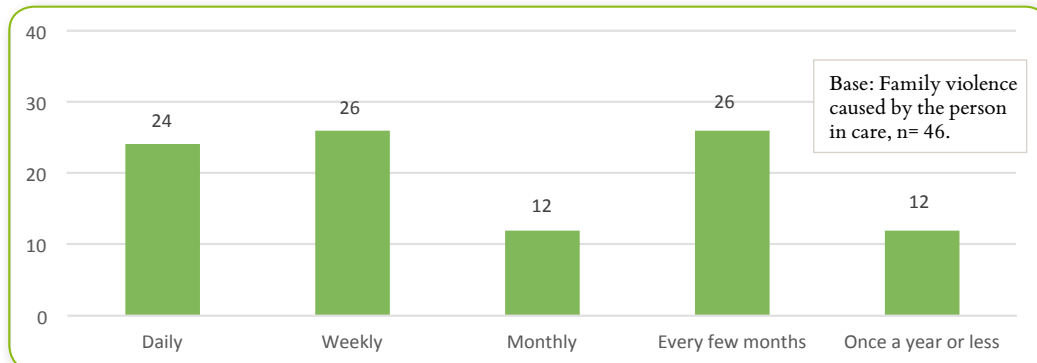
Figure 18: Length of time since the placement started that the first incident of family violence occurred that was caused by the child being cared for (%)



Frequency of children's violent behaviours

As shown in Figure 19, half the carers (50%) had on average, experienced violent incidents daily or weekly. Just over one in ten of these carers (12%) experienced family violence on a monthly basis, with a further 26% every few months. Very few of these carers (12%) experienced family violence infrequently (once a year or less).

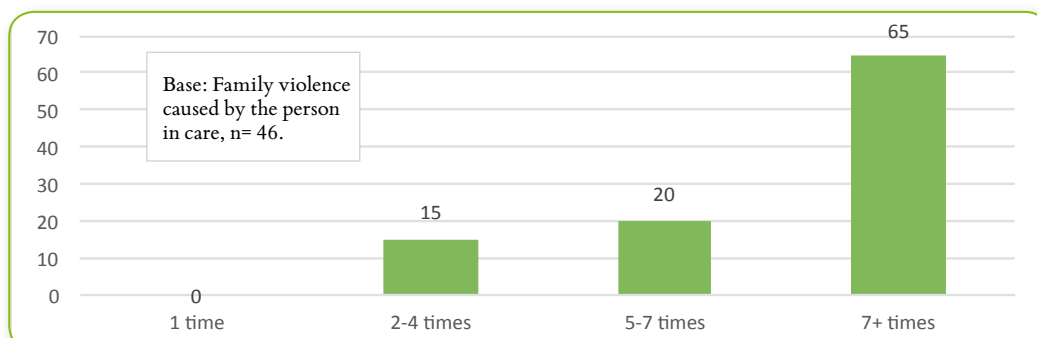
Figure 19: Frequency of children's violent behaviours (%)



Number of children's violent incidents experienced by carers

Carers who had experienced violence and abuse from the child they provided care to were asked about the number of incidents of family violence and abuse they had experienced since the placement started. Figure 20 shows that the majority of these carers (65%) had experienced more than 7 violent incidents. One-fifth of the carers (20%) had experienced between 2-7 incidents. There were no reports of single incidents of violence.

Figure 20: Number of children's violent incidents experienced by carers (%)



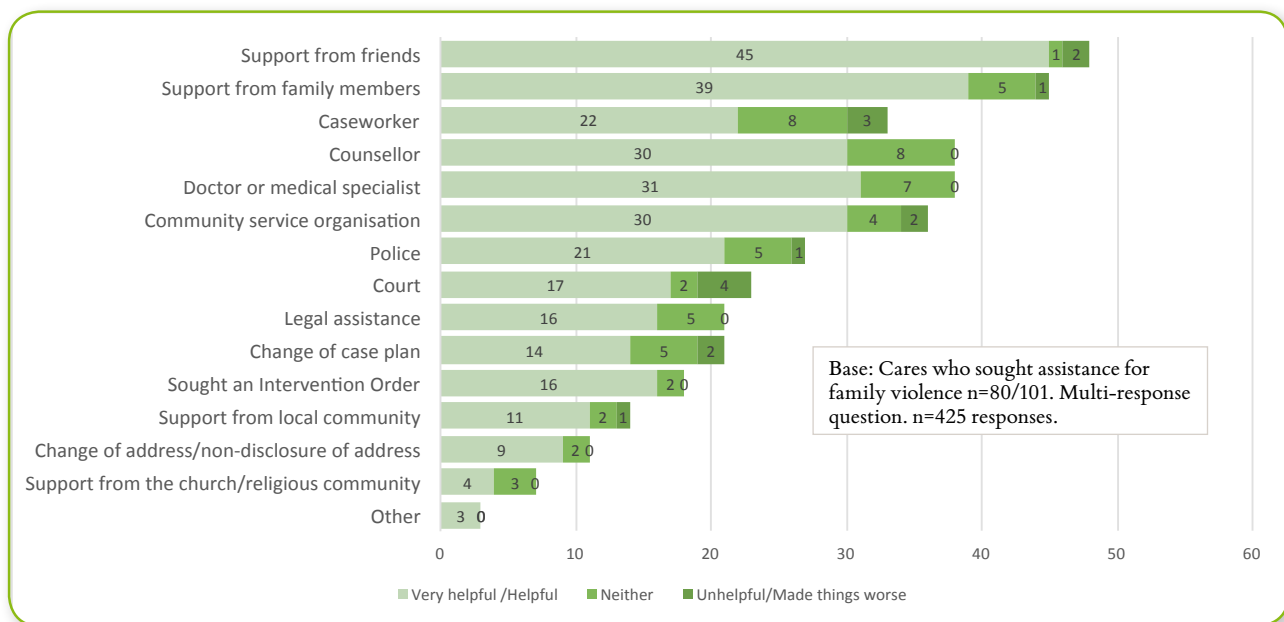
SUPPORT IN RELATION TO FAMILY VIOLENCE

This section of the report describes the survey findings related to the types of supports accessed by carers in relation to their experience of family violence, as well as their reluctance to report family violence to others. Data is expressed as percentages and number of responses (n) where appropriate.

Kinds of support received

Most of the carers (79%) had sought support and assistance to help deal with their experience of family violence. Figure 21 outlines the types of supports received and the extent to which carers thought they were helpful. As demonstrated by the number of responses (425 responses obtained from 80 carers), clearly carers had sought multiple types of assistance. The main kinds of assistance carers reported as being helpful included: support from friends (n=45), support from family members (n=39), assistance from a doctor or medical specialist (n=31), help from a counsellor and community service organisation (n=30 responses respectively). Seeking assistance that was unhelpful or made things worse was only apparent for a handful of carers.

Figure 21: Support and assistance received for family violence (n)

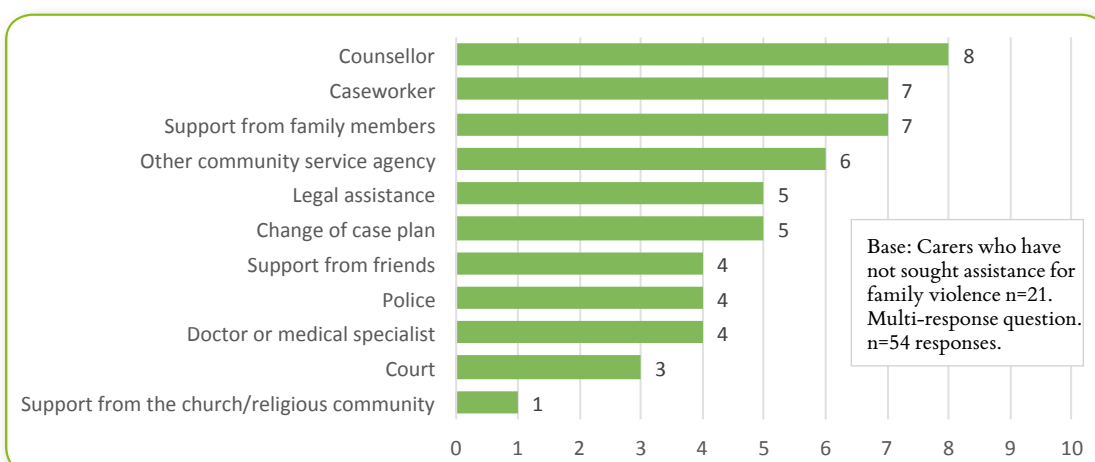


Unmet needs for support

The carers who had not sought assistance and support to deal with family violence (21%), were asked about the types of supports they thought may have been helpful. Again, multiple responses were provided (54 responses from 21 carers).

As shown in Figure 22, support from a counsellor (n=8), a caseworker (n=7) and support from family members (n=7) were reported as being of likely help. Support obtained from formal and statutory authorities were deemed less helpful. However, these results should be treated with caution due to the low sample base.

Figure 22: Supports that may be helpful if carers sought assistance (n)



REPORTING FAMILY VIOLENCE

This section of the report describes the survey findings related to reporting family violence.

Reluctance to report family violence

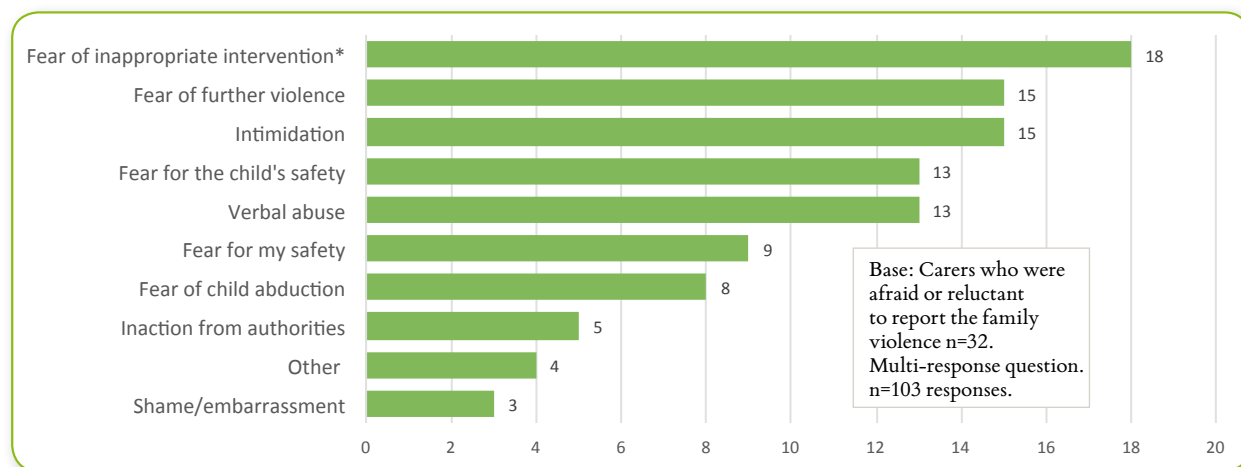
Carers were asked whether they felt afraid or reluctant to report the family violence directed at their kinship care placement. Just under one third of respondents (32%) indicated they had felt reluctant or afraid to make a report, with a further 4% unsure.

Barriers to reporting family violence

Carers who reported feeling afraid or reluctant to report their experience of family violence were asked about their barriers to doing so. As shown in Figure 23, carers provided multiple reasons for their reluctance to make a report (103 responses obtained from 32 carers).

The main barriers were the fear of inappropriate intervention from authorities (including the removal of the children from their care, n=18), fear of further violence from the family perpetrator (n=15) and intimidation (n=15), fear for the child's safety and further verbal abuse (n=13 respectively).

Figure 23: Barriers to reporting family violence (n)



* Fear of inappropriate intervention from authorities (e.g. removal of child/ren)

Results – Interviews with kinship carers

This section of the report details the findings of 22 qualitative interviews from carers who requested a follow-up interview at the end of the survey. Interviews were conducted by telephone and occurred during April and May, 2017.

Six questions were asked of carers including:

1. What strengths do you have that support your ongoing care for the child?
2. What strategies do you use to keep yourself and your family safe?
3. What training or support have you received for caring for a traumatised child?
4. What support has the child received around their trauma experiences?
5. What supports and services would help you to continue to care for the child?
6. What advice would you give to new kinship carers about supports for themselves and the child they will be caring for?

Personal strengths of carers

Most participants had difficulty articulating personal strengths that support their ongoing care for the children. However, comments about the barriers that they have had to overcome in order to provide care suggested significant inner strength and determination to give children the best possible chance in life. Words such as resilience, determination, patience, perseverance, stubbornness, tenacity, bravery and commitment were commonly used. Statements such as “you just have to keep going” and “you do what you have to do” indicate strong dedication and commitment to these children.

“Oh that’s a very easy question for me to answer. When I took over the care of these children at the request of my daughter, I made one promise to myself and to them. That promise was I wanted them, I just wanted them to have a chance in life. I just wanted them to have a chance. I wanted them to be able to make choices for themselves and I wanted to be able to give them that. And that’s what’s got me through all these years.”

“Just perseverance, I keep going no matter what.”

Some carers reported that they draw on the strength they have developed as a result of their own trauma histories. Others drew from professional experience of working with traumatised children with backgrounds such as teachers, early childhood educators, disability, mental health and community service workers and even a child protection worker. Some illustrated their conviction and commitment through promises made to themselves and the children to be their protector,

advocate and enabler. Others drew on strong family values, cultural and community ties. Some had strong family support, others were caring alone either without the support from family or with family who were outright unsupportive. A few carers focused on the strengths gained from caring for the children such as a chance to feel young again, wisdom and the chance to be a parent.

“I have learnt one of my strengths is that I am very tenacious and there’s no way that anyone’s going to hurt these children because I’ve been through it [too].”

Protective strategies to keep the family safe

Carers demonstrated a tailored variety of protective strategies to ensure the safety of the children in their care and their own families. Many carers were faced with the threat and reality of violence from the children’s parents, the parent’s associates or the children themselves. Many also experienced significant barriers to their caring tasks by the systems they interacted with such as child protection, police and the legal system. Where difficulties with these systems were encountered on several occasions, it resulted in increased harm to the children and resourceful strategies by carers to protect the children were often employed.

“My family has its own bubble in this world and we are very happy to stay inside it and if you want to challenge that bubble, you do so, it’s almost like backing a lioness into a corner with her children.”

“One of the best strategies I guess I used was the fact that I always put the kids first. No matter what. Whatever the situation is, in my head I just said to myself “What’s the best interest for these children? What are they going to get out of this?”

Great personal and financial costs burdened these families, making the job of keeping the children safe even more difficult to achieve. Some carers reported paying between \$25,000 to \$100,000 in court costs to stabilise the placement of children. These carers reported that the biological parents received legal aid which resulted in financial and systems abuse for some carers by the parents.

Some carers accessed their superannuation early, others delayed retirement or increased their mortgage in order to cover the legal cost of gaining secure care of the children, placing their future financial security at risk.

Others have been unable to access income support payments or are paying living expenses beyond their means to support the children.

"Most of the people I know in our group, we've all accessed our superannuation early just to be able to put these support services in place for them because it's really important that we get them nice and young."

Some carers reported that court orders have included addresses and phone numbers, made available to the parents and the public leaving frightened families with nowhere to hide. Three carers who have had the ability to gain permanent care have moved states, leaving family and friends behind in order to ensure the safety of the children. Others reported enforcing strict access conditions with the children's parents to ensure children's safety during contact visits. Several carers have had to relinquish a relationship with their own son or daughter in order to protect their grandchildren. Some carers reported having to go to extraordinary lengths to protect the children from the child's own behaviours with little or no support. But overwhelmingly clear through the carer's stories told was a fierce protective instinct, a strength and willingness to do whatever it takes to protect the children in their care.

"I would take my last breath to protect these two."

"I would run in front of a bullet in heartbeat to protect those kids."

Training and support in caring for traumatised children

In contrast to the training and preparation that foster carers receive around caring for traumatised children, kinship carers often have no warning and little time to prepare for the arrival of the child into their care and therefore do not receive any specialised training prior to the child's placement. However, it was also clear from the interviews that regardless of whether DHHS was involved in the placement of the children, none of the carers interviewed were offered or provided training about parenting a traumatised child following the child's placement. No information was provided around available training and support and those who did access training did so through their own resourcefulness and research into what was available.

"We all share that sort of information. If we find something out, yeah, we're all onto it straight away."

"So because he came to me voluntarily and not through child protection I've had to like try and find lots of support systems myself and a lot of the support systems um as soon as you mention the child didn't come through DHHS they're like 'we can't help you.'"

The majority of carers could identify the stark differences between caring for a biological child and caring for a child with sometimes extensive and horrific trauma histories. However, some carers felt there was also a lack of understanding from statutory workers around the impacts that trauma had on the children and their carer and failed to understand issues of attachment. A number of carers suggested that child protection workers did not see a need for any additional support or training around caring for these children despite their backgrounds which included significant trauma.

"Absolutely not a skerrick of [training / support], and even to get the department saying to us you know he needs the counselling or he's lashing out at us or whatever, they're just like yeah nup, can't help you sorry, well look into it. You never hear back from them."

"DHHS have said to me 'oh you know, what can we do to support you?' but nothing's actually happened. So when they've said to me 'how can we support you?' I'm like I don't know, you need to tell me what's available, they don't. It's like here's the kids, deal with it."

In addition to a lack of information, referral and access to specialised training, most carers who were able to source this kind of support reported doing so at their own financial cost. Many of these carers did so on very limited income and sacrificing their own needs to enable this. Many carers identified that whilst foster carers and the children in their care were entitled to some financial benefit such as flexible funding (even if it was simply the ability to access a service due to the statutory status of the child), kinship carers reported being expected to bear the cost and are often denied access to supports simply due to the method in which the child came into their care and their permanent care status.

Training courses that some carers identified as beneficial included the "Mad, Bad, Sad" training provided by the Australian Child Trauma Group, "Tuning into Kids" through Berry Street and training programs offered through support groups such as the Council on the Ageing (COTA), the Children's Protection Society, Kinship Carers Victoria, the Mirabel Foundation, Bethany and Baptcare. Many interviewed carers stated that they have conducted their own research and learning through online communities and google searches.

Carer support

Many of the carers interviewed had children in their care due to the substance use or mental health issues of the children's biological parents. As such, these carers were eligible for support through the Mirabel Foundation. The majority of carers identified some affiliation with Mirabel and all who did so were highly impressed by the service and support they had received. They described Mirabel services including information and advice, support groups, respite and camps for carers and children, all of which were identified as very beneficial to the carers. Several carers identified the inability to access the service due to geographic location however had accessed information and advice by phone.

Another invaluable resource to the grandparent carer cohort was the Centrelink Grandparent Advisor. Most grandparent carers reported regular contact with the Advisor and the sharing of information both to and from the service to support new grandparent carers as they became known. However, many kinship carers are also not entitled to access this service due to not being a grandparent, with no equivalent support provided to aunts, uncles, sibling and kith carers. Some carers reported other aspects of dealing with Centrelink as unsupportive, difficult to navigate and in some instances "absolutely appalling". Two grandparent carers reported separate incidents of being told by a Centrelink worker that if they wanted increased financial support they should have another baby! A common complaint about Centrelink was the unwillingness of staff to disclose helpful information about entitlements and supports, with carers often discovering their entitlements through the grandparent's Advisor or other kinship carers.

"Don't expect DHHS or Centrelink to tell you what you're entitled to. You need to find out and then you need to demand it from them, they won't be offered to you."

Several of the carers interviewed had been in contact with Bethany's support services due to exposure to family violence. Some carers have been able to access additional family support services from agencies such as Anglicare, Wesley Mission and Baptcare. Although the support received from these agencies was reported as being helpful, it was identified that these were often time limited supports and not all carers had been able to access general family support services. Some carers were able to access specialist support through Berry Street programs however this was limited to children on Child Protection orders and was subject to a long waiting list.

It was strongly noted throughout the interviews that many instances of children being placed with kinship carers were a result of or following DHHS intervention. However, upon

placement, no statutory orders were made no follow up support provided and therefore the children and carers were not eligible for access to support services which are available to foster carers and formal kinship carers.

"If they're going to be putting placing kids with family members they need to be able to access [services]... I can't access a lot of the things that people that have taken on kids through child protection can access. You know I've saved them from like putting a kid in foster care and I'm taking on that role as his parent but I can't access anything because he didn't come through child protection."

Several carers reported seeking additional support from their General Practitioner to access a Mental Health Care Plan for psychological and counselling support related to the impact of caring for the children. However other carers reported having to pay the full cost of accessing mental health support and counselling services in order to gain this support.

Many kinship carers also reported receiving support from the children's schools. Whilst some carers sang high praise for the over and above levels of support provided by the schools, this was not the experience of all carers, with some fighting constantly to access supports and safety measures from the schools involved.

Peer support, both through online groups, formal groups, family, friends and other kinship carer connections were identified as the most common and most beneficial supports for kinship carers. One carer identified the value to her of the Children's Protection Society fortnightly support group however commented that this group has since discontinued. Anglicare (South Eastern) and the Baptcare kinship carers support group were also mentioned as helpful. Many carers identified as being part of an online 'closed' group on Facebook for kinship carers. This Facebook group was cited by many carers as being a vital support just through being able to vent to other carers in similar situations, sharing of information and lessons learned along the way, and giving and receiving of advice between others in the same situation. This group was the most commonly cited and most valuable resource identified by kinship carers in the interviews.

"Join a support group. If you don't like the one you've found, find another one, keep looking until you find one that's right for you."

Overall, the kinship carers interviewed demonstrated exceptional resourcefulness in accessing varied supports through their own research, networks and reading. Despite the lack of forthcoming information from services about supports available to them, the majority of interviewed carers identified that they have been able to access at least one support system whether it be in person or online.



Trauma supports

As part of an introduction prior to interview, kinship carers were asked to provide a brief background as to their situation as kinship carers and their experience of family violence. Some carers gave brief but informative backgrounds to provide context for the interview however other carers took the opportunity to disclose comprehensive details of the children's trauma history. In addition to exposure to family violence, for some children resulting in the death of a parent, the children of the carers interviewed have been subjected to varying degrees of abuse including sexual abuse, physical abuse and chronic neglect. Stories included reports of babies who had been beaten and bones broken at just weeks of age, toddlers who were chronically neglected and sexually abused, and children in their primary school years who had been subjected to years of violence, drug abuse, neglect, rape and physical abuse prior to leaving the care of their parents.

"We're here to protect this little boy and give him a childhood that he hasn't had and we believe we're over the worst of it and he came to us young enough that we can alter his life."

Listening to some of these stories it was not difficult to imagine that many of these children who are now in kinship care, and have been for many years, continue to bear the physical and emotional scars of their past. Carers reported physical and psychological impacts on the children including anger and aggressive behaviours, physical scars, developmental delays, cutting, self-harm and suicide attempts, somatic illness and dissociation, post-traumatic stress disorder, anxiety, depression. These stories illustrate the impacts of trauma and the need for specialist support.

Access to specialist support for these children has not been easy or possible for many. Lengthy waiting lists, ineligibility for access to specialist services due to the lack of a statutory order, high treatment costs, inadequate facilities and resources, and overburdened support service systems are significant barriers identified by kinship carers. In addition, a generalised lack of awareness and understanding of the specialist trauma support required by these children has been identified from the source from which this should have been expected: Child Protection. Many carers identified having contacted DHHS requesting support around the children's trauma experiences, to be told that they were not entitled to flexible funding or the children did not need it.

Carers have been left to try and access supports themselves, often at a high financial cost and significant travel for carers outside metropolitan areas. Psychologists and school related supports were the most commonly identified supports. Others have attempted to access supports but due to the cost and limited income have not been able to do so and try to manage the trauma symptoms on their own. Many carers illustrated cases of having to fight hard to get a basic level of service for the child in their care and if not for their strong will and determination this would not have been successful. For those who were able to access services, several carers reported concern about the high turnover of staff which resulted in an inconsistency of care for children who had already experienced significant turmoil in their lives.

Many identified the difficulties in accessing support through the Child and Adolescent Mental Health Service (CAMHS) due to wait lists and the lack of “crisis” at the time of referral. A further barrier to accessing support has also been the child themselves not wishing to attend, particular teenagers who simply desire to be “normal” and fit in with their peers which is already challenging given their situation of living with a grandparent or other kin carer. Specific services that were notably beneficial were the Australian Childhood Foundation counselling service, CASA, the Australian Child Trauma Group, the Mirabel Foundation, Baptcare, Berry Street Take Two, St Luke’s Anglicare, local GP’s and medical centres and maternal child health services. From the carers themselves, the children receive love, support and understanding of their backgrounds and a listening ear and for some, this is all they can offer.

Gaps in service

Overwhelmingly the most common response to the question of what kinds of supports are needed to continue to care for the child was additional financial support including funding to support access to services, at least at the level that foster carers are entitled to. It was commonly identified that there needs to be a recognition of the significant financial cost of raising a child in kinship care as opposed to a one’s own child and that this cost extends beyond the age of 18 years. Particularly for older carers, reduction of earning capacity and the additional costs of supports and services for children who have experienced significant trauma have a significant impact on kinship carer’s financial stability and security.

Many kinship carers had a number of small children placed in their care at little notice and at a time in their lives where their own children had grown up or left the home. The provisions needed to care for small children were reported to require significant outlay at short notice. Many carers reported having to quit their jobs to take care of the children and identified that the children are often placed in their care with the clothes on their back and little else. Due to a reluctance for DHHS to continue to support to children placed in kinship care, the financial entitlements offered to foster and formal kinship carers are not on offer to kinship carers where there is no statutory order in place. In the instance of permanent care orders or parental responsibility, the kinship carer is treated as an ordinary parent with no flexibility in the consideration of their special needs resulting in the same or less entitlements from Centrelink in terms of income support.

Some grandparent carers reported being unable to access even basic income support from Centrelink due to assets and superannuation entitlements, with two just \$1000 over the income threshold for a pension.

One carer suggested the enhancement of support by including provision of a pack of information and practical items upon placement. Such a pack would include things like nappies, formula, service information, support contacts and information resources on caring for a traumatised child. Services such as the Alannah and Madeline Foundation and the Pyjama Foundation were cited as providing support packs which were beneficial however very few carers received these and they were not provided as a matter of course.

The second most commonly reported need for support was respite care and outside school hours’ activities for children. Carers reported barriers to respite care such as lack of availability, cost and being unable to place sibling groups together. It was identified that some grandparent carers are entitled to 50 hours’ respite support from Centrelink however this is not available to all kinship carers.

One carer reported a quote for respite for the 4 children in her care comes at \$800 for a weekend. Such outlays would certainly be out of reach for most kinship carers, particularly those who are struggling to survive on a basic income. Carers indicated that they were desperate for a break, if only a couple of times a year, just to get a good night’s sleep or do something to take care of themselves.

“I had to quit my job on the day and go back to being a single mum on a pension and that really hurt my freedom, I lost all my support network and friends. When he’d go down for a sleep I’d collapse on the floor face first you know in a puddle of dried Weet-bix and things like that. It’s just there is no respite for us either and even to this day if someone offered me respite I wouldn’t take it because I can’t put him with another stranger and think that that’s normal because I wouldn’t have done that for my own children so why would I do that for a traumatised child? But having like an angel or a nanny, a pretend nanny who is there on a slow basis to build up that rapport with the child to maybe one day having him overnight for you, you know, it wouldn’t even be to go out but to have a full night’s sleep.”

Carers also identified that the children in their care were often disadvantaged around access to social and sporting activities due to financial cost and logistical reasons. Suggestions for enhanced supports included support groups for children of the same age group, funding for access to social and sporting activities, funded respite care hours and in home support to enable tasks like housework and shopping.



Several carers also identified the need for specialist advocacy services particularly in regard to Child Protection services. Many carers identified the struggles of negotiating the service system around child protection and legal support. It was suggested that a specialist service to advocate for kinship carers during the process of child placement would be an invaluable resource.

There was great frustration expressed at the lack of service system knowledge within Child Protection, the legal system and Centrelink with many carers finding out about relevant supports and services through word of mouth. It was also suggested that a referral and advice service for kinship carers that is effectively promoted through DHHS, courts and Centrelink would provide much needed access to supports sooner.

Kinship carers directly and indirectly highlighted a need for higher level system changes. Kinship carers who are not grandparents identified a struggle to access supports and services which are promoted as kinship care supports but which are only available to grandparent carers. These carers asked for recognition from all levels of government that kinship carers are not the same as foster carers or biological parents and that grandparent carers and other kinship carers should not be treated the same. Carers also asked for more flexibility from the legal system and Centrelink in terms of the application of blanket rules which do not take into consideration their specific circumstances. Three carers also queried the differences between states. One carer received kinship payments which were then stopped when she moved to Victoria due to differences in entitlements.

Lengthy court processes were reported with one case spanning over 9 years and another cost the grandparents \$100,000 in legal fees whilst the parents received legal aid. It was identified that in some cases, the children's parents used the legal system in financial abuse of the carer in retaliation for gaining care of the child. One carer reported that the child's mother did not want the child to return to her care but would continue to fight in court with the intention to financially ruin the grandparent.

Some carers reported that Child Protection processes oriented toward reunification of the child to their parents spanned several years before determining the child is unsafe and resulted in cumulative harm to children through a lack of security about their care and repeated exposure to abuse whilst with their parents. It is noted that changes to child protection laws in Victoria in 2016 are intended to limit the time children spend in out-of-home care before permanent arrangements are in place for their care.

Carers recognised that the Child Protection system is overburdened and that in their experience, this resulted in children being placed in direct harm through inadequate assessments, investigations and poor decision making.

"We had nine years before we got permanent care and in that nine years she was expected to be on the list for reunification despite each time she had an overnight there was some kind of, the police would come and remove her or another time there was a stabbing there and I got a phone call from the police to come and get her and each time DHHS would come in on their white horses and put all these services in place for mum and a couple of weeks later they would try another overnight and something else would happen."

Finally, carers asked to be supported to learn about children in their care, to access appropriate supports without excessive costs and for ongoing support throughout the child's developmental stages through to independence. Carers reported feeling criticised, disrespected, undervalued and exceptionally scrutinised. Some saw this as particularly unjust in that they had placed their own lives and plans on hold for up to 18 years to provide care for children who were not their direct responsibility.

"And yet I was treated like I was so lacking in value. I was very tired of hearing the phrase of "you're only the grandmother". Well you know what? This only the grandmother has raised these children now for 14 years, has educated them and has enabled them to grow into strong women so don't you call me only the grandmother ever again. Treat me with respect, treat me as an intelligent person that I am, and treat me knowing full well that I am only there for the care of my grandchildren."

"You're being told by women in their mid-twenties who have never had children how to raise a child ... I will protect him but don't tell me that I have to take him to his drug affected parents one more time and a guy's got a gun at his head saying, 'you know, you want to pay me back the hundred bucks you owe me or the kids going to cop it in the head.' Don't you tell me how to raise a child you know it's just ridiculous."

"It doesn't matter what you do someone is going to tell you how wrong you're doing it."

Advice for new carers

In general, carers found it difficult to articulate advice that they would give to a new carer about supports for themselves and the child they would be caring for. An honest impression of how difficult the job is being a kinship carer was provided by several carers whose advice was to 'run away and not do it'.

Although these carers stated that they would do it all again to provide safety and protection to the children, their hindsight glimpses of the enormous burden of taking on the care of a traumatised child and all the complexities and difficulties that come with this provided an insight into the darkest places that this experience has taken them. Nevertheless, they had a wealth of advice to help other carers avoid some of the heartache that they have endured.

Examples of carer verbatim is provided below.

"Ask for help and know that its ok. The squeaky wheel gets the oil. And if you are given things you don't need, pass them on to someone who does. Never knock anything back."

"Don't take it personally (from DHHS caseworkers) and be respectful but don't give up. Be assertive about what you need."

"Get informed. Know what you need to know about your situation. Research."

"Link in with support services. Become computer literate. Look at websites. Go on any grandparents, kinship and foster care sites."

"Get as much support from family and friends as you can. These children need to know the importance of family in their lives and you will need the support."

"Be aware you may have to choose between the relationship with your child and the relationship with your grandchild. The blurring of roles between mother and nanna are hard. Be prepared for that."

"Look after yourself. You can't take care of the children if you don't take care of yourself."

"Get your own therapy".

"Be aware that the children's behaviours come from a place of trauma and will not respond to the way you would normally respond to poor behaviour. Put consequences in place but never tell them they are bad because of their behaviour."

"Ask for trauma informed training right from the beginning."

"Be a good listener. Keep the lines of communication open. Tell the child the truth, not horror stories but don't lie to them about why they live with you."

"It's been an absolute nightmare."

"Take it one day at a time."

"It's hard, be prepared for how hard it's going to be. Be prepared to give up the life you are living."

Discussion

This study has demonstrated that significant amounts of violence from family members are being experienced by kinship carers in Victoria and the children in their care. In addition to the 101 kinship carers who reported experiences of family violence by responding to the survey, there are likely to be many others who either did not receive the survey questionnaire or whose circumstances meant that a survey response was not possible or a priority. In the context of what is known about the risks to physical and psychological safety as a result of family violence, these findings must be of concern to authorities and support services charged with responding to children who have experienced abuse or neglect.

The participants in this study were mostly grandmothers with a number of aunts and various other relative or kith carer types. Most (87%) were over 40 years of age and one third (33%) were in the "older" category of over 60 years. Two thirds of carers were partnered and one third of carers were single. Many carers were reliant on income support with some on an aged pension. A few carers had resigned from work and some had accessed superannuation early in order to take on care of the children. Some carers were accessing parenting support payments or family tax benefit but no carers were identified as accessing disability payments (most of this information came from qualitative interviews which did not specifically ask about income and represented only a small number of carers). This is consistent with what has previously been presented in the literature: that kinship carers are often older, female and socio-economically disadvantaged. Numbers of sole carers who responded were similar to respondents to other surveys of kinship carers (Kiraly, 2015). Therefore, we can assume that many of these findings may have some similarities with the experiences of other kinship carers who have experienced family violence.

Unlike studies of the general population that present family violence as a gendered issue with the majority of perpetrators being male, in this study the majority of perpetrators were the children's mother (68%). Nearly half were the children themselves (46%) and only one-third (36%) were the father of the child and 7% were the male grandparent. Another large survey of kinship carers in Victoria also found more safety threats from mothers than fathers (Kiraly and Humphreys, 2013), although it may be relevant to note that a number of studies have found that children in kinship care typically have more contact with their mothers than their fathers (Kiraly and Humphreys, 2013a). In many situations, carers reported more than one perpetrator of violence such as a child's parent and the child themselves.

In this study, nearly half of children were reported to have committed violent acts. This figure seems very high particularly given that many of the children were very young. It may reflect both the distress children experience when subject to trauma and separation from their parents or learned aggression and may also reflect an absence of impulse and aggression regulation in these children. Therefore, family violence represented in this study comes from two main perpetrator types: the child themselves and the child's parents and has been directed towards two main victim types: carers and the children in their care.

Most respondents (91%) indicated that the violence was directed at themselves and one quarter (26%) stated it was directed at their partner. However, of great concern was that two-thirds (68%) of reported violence was also directed at children. Qualitative interviews of participants also reflected the concern around child safety with several reports of extreme violence, threats and intimidation toward children in their care.

The results of this study indicate that many kinship carers are subject to serious physical violence, emotional abuse and property damage. Most commonly reported acts of violence in this study include attempted and actual physical assaults, verbal abuse, harassment, blaming (for the child being in care), intimidation, threats of harm and invasion of space. In addition, half of carers report damage to property which has had detrimental psychological and financial impacts. The number of kinship carers reporting these types of violence is concerning, however also very concerning were reports of the use of a knife or weapon, attempted strangulation, carers being thrown, perpetrators threatening self-harm or to kill or maim the carer or child in care and stalking. These examples of violence are criminal behaviours and are clearly a threat to the physical and psychological safety of carers and the children.

Also of great concern is that carers are reporting violence both toward themselves and to the child in care, both when the carer is present and absent. This suggests that many of these children who have been placed in kinship care as a result of abuse by their parents are being subject to further abuse and re-traumatisation in their home with the carer and during contact visits with their parents. Carers reported witnessing children being verbally abused, intimidated, threatened with harm to someone or something they care about, physically abused and subject to property damage, often by their own parents. Carers also report similar occurrences being disclosed to them by the child following unsupervised contact with their parents.

It is clear that the dual perpetration of violence toward carers and children would undermine the protective capacity of carers however unsupervised parental contact is also clearly providing the opportunity in some cases for significant further harm to the children. Acts of violence including hitting or throwing the child causing injury, sexual assault and grooming of the child and threats to kill or physically harm the child or carer were reported by children to their carers in small but concerning numbers.

Analysis of the frequency and onset rates of the abuse and violence indicate some interesting patterns. The first incident of violence usually occurred within the first six months of placement which might suggest a relationship between parental distress upon separation and an increase in conflict during this period. Of most concern is the frequency in which carers are subject to violence: weekly (27%) or every few months (26%) and in 13% of cases, on a daily basis. Half of carers (51%) reported 7 or more incidents over time indicating that the exposure to family violence in kinship care was a regular and ongoing concern.

Reported impacts of the violence and abuse on the carers are consistent with the literature evidence of the impacts of family violence on adult victims: physical and psychological harm. Carers report increased stress and anxiety, decline in mental and physical health, conflict, disempowerment and isolation. Interviews also highlighted the impact of the violence on relationships: both with the children's parent (often the son or daughter of the carer) and within their own family unit with some carers indicating a direct link between the violence and relationship breakdown with partners. Additionally, the advice from carers provided in the qualitative interviews resonated with the impacts of trauma with many carers describing the stress, anxiety and hard work involved in continuing the role of kinship carer.

Some carers also indicated in the interviews that their help in seeking support with services including protective services (Child Protection, police and the legal system) were frequently met with responses which were not appropriate for the difficulties encountered and in some instances, responses that could be considered punitive or made matters worse. Many carers cited a lack of responsiveness from police to threats, stating that threats could not be acted on, resulting in fear, anxiety and in some instances relocation to escape the danger. Some situations were reported where the child's parent had come to the home uninvited and instigated instances of violence and when reported to Child Protection, carers were told that if they could not protect the child then the child would be removed from their care. They were not, however, offered any support or strategies to ensure the child's safety

from these situations that were primarily outside of their control. This punitive approach to reporting incidents has led some carers to be hesitant in reporting the violence following subsequent occurrences. The results of the survey mirror these anecdotal glimpses with many carers reporting conflict with agencies and child protection as a direct impact of their experiences of violence. An additional impact of exposure to this violence was conflict with the child in care, hence further destabilising children who have already experienced trauma prior to placement.

There is an assumption that a child will be safe once placed in out of home care. However, as Tilbury, Osmond, Wilson & Clark (2007) state, placement is not always sufficient to ensure safety. It would be naïve to believe that removing a child from their environment and placing them in a new one is sufficient to mitigate the risks that are inherent in the complexity of child trauma. Scaffolding of support services and specialised treatment of the child as well as a focus on key aspects of relationship building and psychosocial development are essential to work towards safety. However, many children are placed in care without any follow up support or support that is unhelpful or detrimental to the child's placement and recovery. Particularly in kinship care, where there are no formal protective orders, access to services, support and care is particularly difficult. Many carers in this study reported barriers to access through funding, eligibility criteria, availability of services, wait lists and recognition of the need for support to be the main difficulties in interactions with child protection and other agencies.

In regards to child perpetrated violence, the reported increased occurrences at the 12-month point may coincide with the development of secure attachment with the caregiver. Hughes (2004) states that for children in out of home care, attachment is disrupted with the biological parent (and may have been insecure to start with) and as a child becomes more securely attached to a new caregiver, this can present in negative behaviours which serve to push the caregiver away, thus reinforcing previous messages of rejection. Although this behaviour is seen to be a positive in that it indicates that the child is forming an attachment, it is also often a crisis point as caregivers struggle to understand the sudden onset of violence toward them and this often leads to placement breakdown at this point (ironically then reinforcing the behaviour). In the context of kinship care, there is an assumed relationship between the carer and child however as the literature indicates this may be a tenuous link and even if there is a close

relationship this does not mitigate the impacts of a change in the relationship from relative to relative carer.

There is a strong evidence base on the impacts of family violence on children. Herrenkohl, Sousa, Tajima, Herrenkohl & Moylan (2008) reviewed over 500 studies and concluded that child abuse compounds the effects of family violence and increases the likelihood of psychological problems in youth and adulthood. Price-Robertson, Higgins & Vassallo (2013) found that long-term exposure to multiple forms of maltreatment results in 'cumulative harm', which has similar effects to trauma, but with more specific outcomes for children's development and behaviour. These include aggression towards self and others, self-hatred, lack of awareness of danger, and disturbed attachment behaviours. Flood and Fergus (2008) asserted that family violence and its impact on children, have a significant and long-term economic cost to the Australian community as a result of reduced productivity, welfare receipt, medical costs, unemployment and a range of other factors. However, a meta-analysis of 118 studies in childhood exposure to domestic violence by Kitzmann et al. (2003) (cited by Humphreys 2007) found that over one-third of children exposed to domestic violence demonstrated wellbeing comparable with, or better than, children from non-violent homes. Richards (2011) suggested that children from violent homes are a heterogeneous group, who live in 'different contexts of both severity and protection', while Bedi and Goddard (2007) and Clements, Oxtoby and Ogle (2008) argue that a range of 'mediating factors' such as children's age, gender, coping ability and social support, may influence the extent of the trauma suffered by children exposed to domestic violence.

Results from this study indicate that the impacts of violence on children include stress and psychological issues, behaviour and attachment problems, sleep difficulties, strained relationships with the parents, academic and learning difficulties and regression in eating and toileting. These behaviours are consistent with those outlined in the child trauma guide (DHHS Victoria, 2011) for recognising developmental and behavioural signs of trauma in children. The literature states that younger children are more likely to be exposed to family violence than older children (Gewirtz and Edleson, 2007) and the results from this study are consistent with this finding. The literature also indicates that there is an increased risk for children in kinship care (as opposed to foster care) experiencing family violence after placement due to greater ongoing contact with the children's parents (Font, 2015). While much unsupervised parental contact is positive or takes place without undue problems, without the presence of formal access or protective orders, children's contact with parents at times presents real threats to safety.

However, despite the barriers to accessing formal support to keep children safe, the interviewed carers appeared to have developed skills, strategies and supports to place the best interests and safety of the child as priority.

It is possible that disruptions in development alongside exposure to and impacts of trauma coincide with the onset of violent behaviours and aggression. It is also noted that these behaviours were more frequently reported in relation to boys in both survey and interviews. Although the most commonly reported types of violent incidents by children were verbal abuse, blaming, intimidation and property damage, more concerning behaviours including physical assaults, attempted strangulation, harm to animals and threats to kill or use a weapon were also reported. Violent incidents from children were frequent and often repeated.

As indicated in the introduction, support provision to kinship carers is known to be inequitable and the results of this study reinforce this fact. Bureaucracy, eligibility criteria, guidelines and policy dictate the access to formal support to carers and our results demonstrate a lack of flexibility in such bodies and a disconnect with the reality of kinship carer's situations. The majority of kinship carers who reported receiving some support had done so through social connections such as family and friends. Some carers had utilised mainstream services such as GP's, private counsellors or psychologists, sometimes involving costs they could ill-afford.

Perhaps the most concerning message from kinship carers in terms of accessing support around family violence was the clear message that formal protective services including police, legal services and the courts were found to be unhelpful. Many carers felt that their denial of access to legal support to ensure the safety of the children was unfair considering that the children's parents were usually eligible. Particularly galling was the experience of a number of carers who paid tens of thousands of dollars to access legal representation to obtain orders for children while the parents accessed legal aid (repeatedly).

Family violence is often cited as being under-reported in the general population. This study demonstrated that one third of carers were also reluctant to report incidents of violence. However, the reasons given for failure to report violence in this group were specific to their circumstances. Studies of family violence in the general population reporting indicates failure to report family violence often has a link with stigma, shame, embarrassment and a fear of not being believed. On the other hand, kinship carers reported very little shame or embarrassment with some statements indicating the opposite.

Carer's decisions not to report violence were directly linked with repeated experiences of negative repercussions from protective services (including the fear of the child being removed), the fear of further violence and intimidation and fear that the child's safety might be put at further risk. These results suggest a profound failure to protect from the services whose mandate is to do so and speak to the level of injustice, fear and harm these kinship carers have had to face.

Key themes which have arisen from this study provide opportunity for improvements in service responses to kinship carers where possible.

A systemic approach is needed to improve the safety of kinship carers and children in care, as well as providing adequate support for carers to sustain placements and to provide children with the best chance to lead a healthy, loving and fulfilling life.

Evident inequity in support reported by carers (foster vs kinship, formal vs informal, grandparent vs other kin or kith carer) provide further reason to advocate for policy change at a state and federal level to allow for inclusion of all kinship carers in equal access to financial and service level support as foster carers. Advocacy is also needed with the Federal government to provide all kinship carers with equal access to Centrelink entitlements received by grandparent carers and carers of family members with disabilities, including means-tested child care rebates and respite care.

These kinship carer experiences of child protection workers and other legal and administrative service systems indicate that there is a lack of scaffolding support for kinship carers and the children in their care.

More holistic case planning and post-placement support are two key areas in which existing services can improve the quality of care for children and their carers. This study also suggests there is an impact on child safety of over-burdened and under-trained child protection staff. The lack of access to and availability of specialised trauma supports for children and their carers is also resulting in elongated trauma responses and impacts.

The literature reports the serious impacts of parental substance abuse and mental issues on the parenting of children (Kroll, 2007) however carers frequently reported a lack of support to parents to manage these issues and improve their capacity to continue a positive relationship with their children either through reunification or contact visits.

Carers sang loud praise for kinship support groups however in regional areas and within the non-grandparent cohorts there is a lack of availability. More support groups are needed.

Lack of information provision to carers is also an easily remedied gap in support. Development of referral services or information packs provided to carers upon placement of the child as well as ensuring that service staff are aware of and willing to provide information to carers would go a long way to meet this need.

Finally, carers are lamenting the lack of respect and recognition from government and community of the hard work that being a kinship carer entails. Respect, encouragement and validation are no-cost resources that could make a huge difference in the life of a kinship carer with flow on benefits for the children in their care.

Recommendations

Specific to family violence:

1. That access visits from family members who pose a threat to children or carers be appropriately restricted, and that child protection or community service staff be available to provide external supervision as necessary.
2. That all children in kinship care who are affected by family violence have early access to specialised trauma support counselling.
3. That children displaying violent behaviours are provided with specialised counselling early in their placements with the aim of understanding their concerns, addressing their experience of trauma and reducing violent behaviour.
4. That training in care for traumatised children is made available to all kinship carers early in the children's placements that includes the impact of family violence.
5. That Child Protection workers are provided with further training in responding to the threat and actuality of family violence in kinship care such that promote reporting of family violence and provide effective support to carers and children as needed. This training should also specifically address the fraught issue of the removal of children, with a focus on strengths based engagement and support in the context of kinship care
6. That Child Protection promote the involvement of kinship carers in case planning and care team meetings such that children's and carers' needs are better understood and responded to, and concerns about potential violence are addressed quickly.
7. That Victoria Police work to improve the supports offered to the carers and children to ensure their safety immediately upon request and during times of crisis.

Supports required to enhance the capacity of kinship carers and children

1. That more training and support is provided to Child Protection staff in relation to specialised attachment and trauma support for children that includes a focus on the impact of family violence.
2. That scaffolding support services and specialised treatment of the child, focussing on key aspects of relationship building and psychosocial development are provided as they are essential to work towards child safety.
3. That Child Protection continue to improve their compliance with legislative requirements for timely decision-making regarding children's living arrangements to reduce stress on children.
4. That a common and equitable assessment process be established for statutory care payments at levels appropriate to children's needs for all children whether in foster care or kinship care.
5. That the Centrelink Grandparent Advisor program be extended and renamed as the Kinship Carer Advisor program to improve access and equity for all kinship carers, and that grandparent entitlements such as free child care be made available to all kinship carers.
6. That further training be provided to Centrelink staff to improve their capacity to advise kinship carers of their entitlements and available supports.
7. That respite care be made available to all kinship carers through Centrelink, including both in-home care and alternative care options.
8. That greater access to support groups be made available to kinship carers, and support groups be made available specifically for families affected by family violence.
9. That Legal Aid be extended to kinship carers as well as the parents of children in kinship care.
10. That education is provided to the biological parents of the child in relation to the short and long-term impacts of their perpetration of family violence on the carers and the child in care.
11. That all kinship carers, receive the recognition and respect they deserve from government and the community for putting their lives on hold and doing their best to care for traumatised children, often at a significant risk and financial burden to themselves and their family.
12. That future research is directed towards the impact of trans-generational family violence and abuse on children in care.

STATEMENT FROM THE CENTRE FOR EXCELLENCE IN CHILD AND FAMILY WELFARE

As the peak body for child and family services in Victoria, the Centre for Excellence in Child and Family Welfare has been supporting children and families and the organisations that work with them for over 100 years. We are pleased to be launching this report on behalf of Bapcare and The University of Melbourne, and welcome all new research into the challenges and needs of kinship carers and young people in Victoria. This report is particularly timely given the ongoing Royal Commission into Family Violence, and will assist the sector in assessing the unique needs and support requirements of kinship families. It is crucial for the sector to ensure that carers, young people and families are given a voice to share their lived experiences. We look forward to reading the report in full. The Centre will work closely with organisations across the sector to provide greater support to kinship families and young people in Victoria.

Deb Tsorbaris, CEO the Centre for Excellence in Child and Family Welfare

Bapcare's Response

BAPTCARE EVIDENCE INFORMED AND BASED PRACTICE

Bapcare provides support to kinship carers and is committed to evidence informed practice. This research will result in the following practice improvements at Bapcare:

1. Workforce professional development

- Continue to provide trauma informed training to staff.
- With kinship carers co-create, develop, implement and evaluate a targeted staff training program on the specific support needs of kinship carers, including the impacts of family violence in kinship care (this could be expanded to be delivered as a fee for service model in other organisations, Centrelink, Community Services Organisations, Schools, as part of University training etc.). This training would lead to improved professional understanding and knowledge of support needs for kinship carers.

2. Pilot a 'Kinship Carer Training Package'.

Co-create, develop, implement and evaluate this training with/for kinship carers with the aim of:

- Trauma informed and strength based parenting
- To deliver information on the impact of family violence on the child/young person and carer
- Reducing stigma and isolation
- Provide trauma informed strategies and practical approaches to supporting the child/young person and kinship carer
- Capacity building and peer support.

It would be provided in all programs where kinship carers are receiving a service from Bapcare and would also be informed by other best practice.

3. Explore potential to develop options for supervised visits or family conferences service for kinship carers (informal and formal).

4. Raise awareness of the issues experienced by kinship carers at a state, national and international level through advocacy and submissions to relevant policy reviews.

COMMITMENT TO CONTINUED EVIDENCE INFORMED AND BASED RESEARCH - KINSHIP CARERS

Bapcare recognises that to develop a long term sustainable systemic service response that it is important to look at the situation from a fresh perspective. To support this Bapcare will undertake the following:

1. Co-creation: Undertake consumer engagement to further improve practice and look at the creation of new services and supports

- **Activity:** Focus Groups, interviews and surveys with children and young people; and Kinship carers

2. Further research in relation to international best practice and sustainable responses.

- **Activity:** Conference Workshops

3. Co-creation with innovators, deep thinkers, universities, non professionals and professionals to identify innovative sustainable responses

- **Activity:** Forum with: State Government (DHHS, DEaT); and innovators, thinkers, providers and universities to improve practice and look to create sustainable outcome focused services.

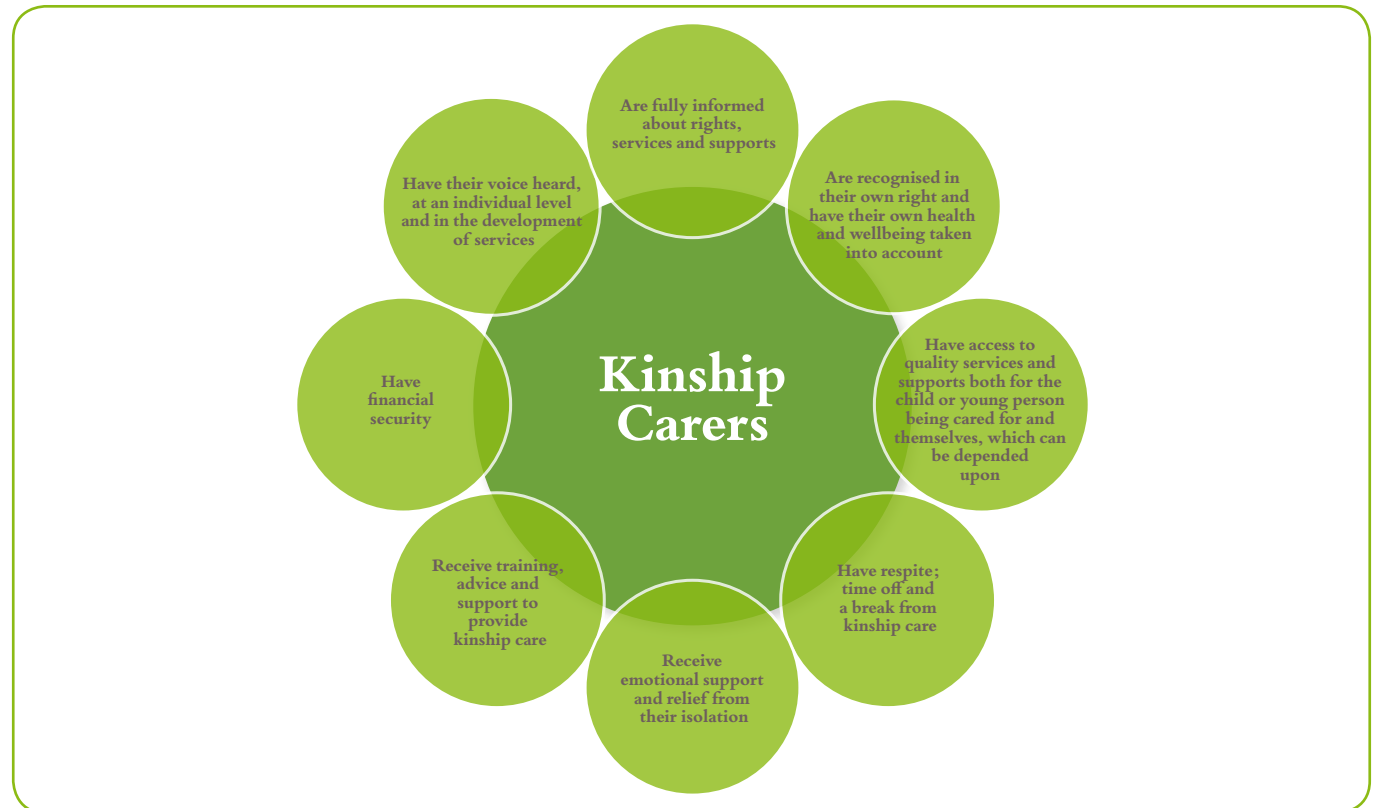
4. Partnerships

- **Activity:** Identification through this process of partnerships and collaborations that will support the outcomes for kinship carers, children and young people.

These will be Bapcare funded.

A SYSTEMIC OUTCOME FOCUSED SERVICE RESPONSE FOR KINSHIP CARERS

Informed and adapted from Kinds Fund, 'Taking Action to Support Carers:
A Carer Impact Guide for Commissioners and Managers (1999)



BAPTCARE PILOT: MOCKINGBIRD FAMILY SUPPORT MODEL

Informed and adapted from Kinds Fund, 'Taking Action to Support Carers:
A Carer Impact Guide for Commissioners and Managers (1999)

NEW WAYS OF IMPACTING – Mockingbird Family Hub Model (US) Capacity Building for Kinship Carers (Informal and Formal)				
SERVICES	Information & Linkages	Peer Support	Training & Education for kinship carers, children and professionals	Respite Care
Low	Level of risk and complexity of need			High
DESCRIPTION	Mockingbird is a kinship care and fostering model. It trains kinship carers around a hub foster carer. The hub carer doesn't foster a child themselves but provides respite beds for other carers in their network. The hub can provide: Information, linkages and referrals; supervision and training; peer support; access to shared activities; respite; professional targeted trauma informed family support delivered by professionals with mental health and family violence professional experience.			
OUTCOMES	Recognition and respect, emotional support, respite, builds capacity, self-esteem, creates peer support, improved information and education on caring, creates stable placements and improves relationships, Specific focus could be developed on support with trauma, grief loss and behavioural issues.			
APPROACH	Baptcare could pilot this model with kinship carers in the Western District across a period of one year working with x children and x kinship carers creating x hubs. Baptcare would seek to collaborate with Mockingbird Family Society in the US to set up a formal partnership, access training and operate Mockingbird in Australia. The research would also be used to inform the model to ensure there is a specific focus on support with trauma, grief/loss, family violence, mental health and behavioural strategies. Through partnerships Baptcare could seek to ensure food, other basic resources and school equipment and supports are supplied within the hubs.			
FUNDING SOURCE NEEDED	Seed funding, Community Grants, Social ventures, fundraising, donations, corporate sponsorships		Business to Government +	

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Baptcare is a customer focused, faith centred and purpose driven organisation working across Victoria and Tasmania, providing residential and community care for older people and support to children, families, and people with disability, financially disadvantaged people and people seeking asylum.

MISSION

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