Strengthening Kinship Families: The role of respite care
Authorship

Juliette Borenstein, Principal Researcher
Andrew Minge, Maureen Campion & Patricia McNamara, Research Support

Acknowledgements

The Kinship Respite Care Scoping Project which was the basis of this report was commissioned and funded by the Respite Care Consortium; a partnership of organisations concerned with out of home care for children. The current membership of the Consortium comprises: Good Shepherd Youth and Family Service, Berry Street Victoria, Anglicare Victoria, MacKillop Family Services, Victorian Aboriginal Child Care Agency (VACCA), Office of the Child Safety Commissioner-Victoria, Post Placement Support Service, OzChild, Foster Care Association of Victoria Inc. (FCAV) and La Trobe University School of Social Work and Social Policy as academic partner.

This research was made possible through the support of the sixteen agencies who participated in the project, and the practitioners who generously gave their time to be interviewed. Particular thanks are due to OzChild for providing their own data to be included in the report. Gratitude is also due to the FCAV, the Mirabel Foundation, Meredith Kiraly, Honorary Research Fellow at the University of Melbourne and Christiane Purcal, Research Associate, Social Policy Research Centre, The University of New South Wales for providing information and data which were used to provide context for the project.
Foreword

*Strengthening kinship families: The role of respite care* is a great title for this scoping report, which adds to the learning of the Respite Care Consortium. The title embraces the spirit of the Consortium’s strategy, which is to build on the strength of parents, grandparents, carers and families to provide safe, secure and loving care for children.

The Respite Care Consortium was formed in 2007. It is extremely satisfying that after five years endeavour the ‘practice wisdom’ and research evidence collected can be used in practical ways to support and sustain families. In this instance this means enriching the experience of family life for thousands of Victorian children and young people living with relatives and non-relatives in kinship care. It also means improved opportunities for grandparents and kinship carers to receive the personal and practical support that is enjoyed by most families through naturally occurring extended family and friendship networks. For professionals it is an invigorating opportunity to work collaboratively with carers to extend the level of support for children. And for the community it is a chance to participate and contribute to the ‘village that raises the child’.

I hope that this report will be read by the caring people who gave it life; by the professionals who contributed enthusiastically to its development, and by researchers and policy makers on whose vision the work is based.

Documenting our work in kinship care aims to reinforce working knowledge and to demonstrate to the broader child and family welfare sector how regular and planned respite can sustain care arrangements and achieve stability for children and young people.

Gratitude is due to all who contributed to this scoping exercise for sharing their valuable knowledge and stories. Thanks to the managers, team leaders and kinship services throughout Victoria who have reflected on the changes they see taking place in their own practice when the child and family’s social support networks improve.

It seems clear that this is only another chapter in the never-ending journey of change and development in the care system. I am looking forward to the day when all Victorian families can readily access the support and assistance they need to raise their children within safe and caring communities.

Manager: Programs for Families, Children and Young People
VICSEG New Futures (Victorian Cooperative on Children’s Services for Ethnic Groups)

*Founding Chair, Respite Care Project Consortium*
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUTHORSHIP &amp; ACKNOWLEDGEMENTS</td>
<td>1</td>
</tr>
<tr>
<td>FOREWORD</td>
<td>2</td>
</tr>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>4</td>
</tr>
<tr>
<td>1. BACKGROUND TO THE PROJECT</td>
<td>8</td>
</tr>
<tr>
<td>1.1 THE RESPITE CARE PROJECT</td>
<td>8</td>
</tr>
<tr>
<td>1.2 THE KINSHIP RESPITE CARE SCOPING PROJECT</td>
<td>8</td>
</tr>
<tr>
<td>1.3 KINSHIP CARE IN VICTORIA</td>
<td>9</td>
</tr>
<tr>
<td>2. THE RESEARCH</td>
<td>11</td>
</tr>
<tr>
<td>2.1 LITERATURE</td>
<td>11</td>
</tr>
<tr>
<td>2.2 AIMS</td>
<td>11</td>
</tr>
<tr>
<td>2.3 METHODOLOGY</td>
<td>13</td>
</tr>
<tr>
<td>2.4 THE FIELD WORK</td>
<td>14</td>
</tr>
<tr>
<td>3. THE FINDINGS</td>
<td>15</td>
</tr>
<tr>
<td>3.1 COMPOSITION OF CARER GROUP</td>
<td>15</td>
</tr>
<tr>
<td>3.2 PRACTICAL DEFINITION OF RESPITE CARE</td>
<td>15</td>
</tr>
<tr>
<td>3.3 THE NEED FOR RESPITE CARE</td>
<td>17</td>
</tr>
<tr>
<td>3.4 MEETING THE NEED FOR RESPITE CARE</td>
<td>19</td>
</tr>
<tr>
<td>3.5 THE EFFECT OF THE PROVISION OF RESPITE CARE</td>
<td>23</td>
</tr>
<tr>
<td>3.6 BARRIERS TO ACCESSING RESPITE CARE</td>
<td>25</td>
</tr>
<tr>
<td>3.7 WHAT IS REQUIRED TO MEET THE NEED FOR RESPITE CARE</td>
<td>26</td>
</tr>
<tr>
<td>3.8 RESPITE CARE FOR FAMILIES RAISING INDIGENOUS CHILDREN</td>
<td>27</td>
</tr>
<tr>
<td>3.9 PREDICTION FOR FUTURE DEMAND FOR RESPITE CARE</td>
<td>28</td>
</tr>
<tr>
<td>3.10 BEST PRACTICE IN THE PROVISION OF RESPITE CARE</td>
<td>29</td>
</tr>
<tr>
<td>4. OTHER LOCAL STUDIES / STAKEHOLDER VIEWS</td>
<td>30</td>
</tr>
<tr>
<td>5. CONCLUSIONS</td>
<td>33</td>
</tr>
<tr>
<td>NOTES</td>
<td>34</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>35</td>
</tr>
<tr>
<td>APPENDIX</td>
<td>37</td>
</tr>
</tbody>
</table>
Executive Summary

The Kinship Respite Care Scoping Project is the third in a series of studies examining the provision and organisation of respite care in Victoria. All three studies have been undertaken by the Respite Care Consortium which currently comprises ten organisations concerned with out-of-home care for children.

The present study involved telephone interviews with key staff from the seventeen (one has since ceased to operate) Department of Human Services (DHS) funded mainstream kinship programs in Victoria, and from the Victorian Aboriginal Child Care Association (VACCA) as an Aboriginal kinship care service provider. A 100% participation rate was achieved; this indicates a strong interest in the issue of respite care for kinship families within the Home Based Care Sector.

The broad goals of the project were to examine the provision and organisation of respite care for kinship families in Victoria, to scope the current and future need for kinship respite care, and to work towards developing a best practice model for the delivery of respite care in the kinship context.

The specific aims have been to:

- understand how respite care is currently being delivered to kinship families: the purpose, how it is accessed, who is providing it, and what form it is taking
- assess the need/unmet need for respite care services by kinship families working with funded kinship care programs, and estimate the future need for respite services
- explore practitioner views of helpful models of respite care service delivery accessed by kinship families
- examine constraints in meeting identified need for respite care by kinship families
- identify and raise awareness of best practice principles, and examples of best practice, relevant to the provision of respite care services to kinship families
- document outcomes of this scoping project and suggest areas for further consideration in a report to be distributed across community service organisations and (DHS)
- be a resource for the community sector and DHS to inform protocols and practice development in the area of kinship care support.

The responses overall clearly demonstrate the commitment of kinship practitioners to the work they do. A comment from one respondent illustrates this:

*A lot of worker time is devoted to sourcing respite care - can be up to 2 hours a day, only to get nothing. Just because we know it is not available, doesn't stop us from looking, and we don't become dismissive of carers, nor steer away from promoting respite as an option. It is a challenge to support this.*
need, and like working through a minefield to get respite happening. Most importantly, we need to keep carers’ rights in mind, and keep pursuing respite options regardless of the prospects for success.

Practitioners present a picture of how kinship respite care is operating across Victoria, and also provide a clear vision of what they need to provide the necessary support for kinship families.

Based on the data, the group of kinship carers who are working with kinship programs are predominantly, but not only, grandparents, with half of the programs reporting 30 to 59% non-grandparent carers. The non-grandparent carers included aunts, uncles, siblings and family friends. One great-grandparent was also reported.

The number of kinship carers asking for respite care was very variable across programs; that raised questions as to whether the variation was influenced by factors such as the nature of their engagement with the program, the information they have received or a lack of understanding about respite care.

Worker assessed need was also variable, but indicated a medium to high level of need for respite care across programs, with carers of adolescents being over represented in this group. The types of respite care which were sought were regular respite, overnight care, and activity based respite.

Access to respite care varied across programs, with overall low to medium rates of access reported. The programs were predominantly responsible for organising respite care, and success in accessing support seemed to be related to factors such as the approach of the agency to seeking respite care (whether formal care or other options were sought), the location of the program, the availability of funding and respite options, and also whether the program had an organisational connection to a foster care program. The respite options accessed were formal respite care, camps, school holiday and before and after school programs, day care and support within the extended family. Private respite options, such as babysitting and school holiday camps and programs, were noted to be expensive, and sometimes not able to be accessed because of this. Support within the extended family was also noted to be at times problematic.

Respondents from kinship programs are in agreement that respite care is important for carers. There is broad consensus about the effect of respite care and it was considered by some respondents to be ‘imperative‘; they argued that it can make the difference between the placement continuing or not. The effect of respite care on children is acknowledged to be a more complex question. It is believed that respite care could be beneficial for children in reducing stress and encouraging new relationships, networks and different experiences and opportunities. An internal survey conducted by OzChild in October, 2010, showed that 88% of the children were positive about the respite they were receiving. Respondents to the present study suggest, however, careful assessment of each child’s individual needs; assessment should take into account
background, relationships, the situation of the child, whether respite is likely to be a negative or positive experience and whether it would compromise the child’s stability.

Lack of information and understanding of respite care by kinship carers is believed by most respondents to prevent carers from asking for respite. Other factors inhibiting requests for respite include carer concerns, issues relating to the child and ‘system issues’. Carer concerns included: guilt about asking, not wanting to be seen to be non-coping, fear that the child would be removed from their care, or concerns about stranger care. Barriers that constrain access to respite care are believed to be mainly ‘system issues’ such as lack of availability of appropriate carers, intrusive screening requirements and court processes.

In addressing the question as to what is required to ensure adequate access to respite care for kinship carers program respondents identify the need for more formal and private respite options, such as respite foster care, school holiday camps and programs, and family day care, and more resources to ensure access to respite care and to enable workers to undertake the ongoing family work necessary to ensure support for kinship families.

Responses regarding respite care practices for Indigenous children indicate that most programs rely on ‘best practice’ principles for working sensitively and individually with Indigenous children in kinship care. Some programs are liaising with Indigenous agencies. Issues which are raised for consideration include the sensitivity required to address the continuing effect of the practices that gave rise to the ‘Stolen Generation’ and the additional flexibility which may be required to accommodate cultural requirements such as attendance at funerals.

The majority of respondents predict that the future need for respite care will be higher, and the consequences of this, if provision of respite care is not increased, will be more placement breakdowns, and the potential for additional trauma for children in care.

There was broad agreement among the study participants as to what would comprise optimal or ‘best practice’, and the responses addressed aspects of both the process and structural context of kinship practice. The elements of best practice identified include: early comprehensive assessment and planning, balancing the interests of the child and the carer, the importance of engagement with family, the promotion of family connection and support within the family, the necessity for individualised work with families and the importance of access to planned, consistent and flexible respite options.

The provision of respite care is considered by respondents to be potentially vital in preventing the breakdown of care arrangements. At the moment however, as well as there being an overall shortage of accessible respite options and a lack of resources, there is a great variation in the support being received by kinship families across Victoria. Clearly more discussion is required in the field to share and extend knowledge about kinship respite care and to enable the development of a common ‘best practice’ approach to providing respite care to kinship families.

6
It is recommended that the following areas be further explored:

- clarification of the language used to describe respite care, and the services it comprises
- the value and place of different care options as a support for kinship carers
- development of processes to support child-centred, ‘family driven’, individualised, and relationship based practice, using a partnership approach with families; also consideration of what is required to enable ongoing family work to be done to support kinship care arrangements towards self-sufficiency
- improvement of how information about respite care is coordinated and made easily accessible to families and workers
- development of processes to ensure in every case an initial comprehensive assessment of the background, needs and capacity of the kinship family, so that there may be a determination about the viability of the kinship arrangement, and a foundation for determining what respite is appropriate given the needs of the carer and the child. Such an assessment would include an explicit consideration of issues of trauma, attachment and cultural sensitivity
- optimising the potential of carer support groups, for example by running camps as an extension of each support group
- creating processes to ensure planning for respite care at the beginning of engagement, and the identification of an emergency respite care option as soon as possible, with all screening processes completed in a timely manner
- developing an adequate pool of experienced, culturally diverse and appropriately trained respite carers - skilled in the areas of trauma and attachment and cultural competency
- assessing the level of active integration of culturally appropriate respite care as set out within the Cultural Support Plan for each Indigenous child in kinship care
- considering the necessity for additional measures to address issues arising from the greater distances involved in rural areas; larger expenditure of worker time, higher transport expenses and the difficulties because of the need for carers to travel further
- addressing the respite needs of adolescents, and exploring how appropriate respite options could be accessed or developed
- direct provision of brokerage to programs and families to enable access to private respite care when required, and to encourage self-sufficiency
- normalising ‘respite care’, through developing connections within the family network, ensuring access to mainstream services and activities, and exploring other models of support such as *Mirror Families*™ (Brunner & O’Neill 2009).
1. BACKGROUND TO THE PROJECT

1.1 THE RESPITE CARE CONSORTIUM

In 2007, Good Shepherd Youth and Family Services initiated discussions with several other agencies providing respite care for children and families, to create a collaborative approach to increasing understanding and development of respite care in the Home Based Care Sector. This was driven by the view that ‘the availability and support of respite care has been largely underdeveloped, despite its potential to address significant social need and indeed the potential to address the programmatic dilemmas arising from the impact of these needs on an overburdened service system’ (Good Shepherd Youth and Family Service, 2007).

The result of these discussions was that Good Shepherd Youth and Family Service, Berry Street Victoria, Anglicare Victoria and MacKillop Family Services joined together to undertake a project focusing on respite care in the Home Based Care Sector. The broad aims of the Consortium were to examine the provision and organisation of respite care in Victoria, to scope the current and future need for respite care and to work towards developing a best practice model for the delivery of respite care. The four agencies were later joined by the Victorian Aboriginal Child Care Agency (VACCA), Office of the Child Safety Commissioner, Post Placement Support Service (PPSS), Foster Care Association of Victoria (FCAV), OzChild and La Trobe University School of Social Work and Social Policy as academic partner.

To date, the projects undertaken by the Consortium have been a Literature Review covering the national and international literature about respite care (Hartley, 2008), a Respite Care Practice and Research Forum, held in Melbourne in April 2008 and a Respite Care Scoping Project to map, geographically and programmatically, respite care services provided by foster care agencies across Victoria (Ochiltree, McNamara & Halfpenny 2010).

1.2 THE KINSHIP RESPITE CARE SCOPING PROJECT

To extend the work already done (McNamara, 2010; McNamara et al, 2010a, 2010b, 2010c; Elefsiniotis and McNamara, 2009; McNamara, 2009; Cash et al 2009; Lewis et al, 2009) a second scoping project focusing on respite care in a kinship context was proposed. In July/August 2010 an informal email survey was sent to program managers of DHS-funded kinship care services in order to gauge interest in participating in the proposed scoping project. Written responses were received from 10 programs. A consultation with a focus group of kinship carers, program managers, social policy researchers and relevant stakeholders was then facilitated by the Consortium. The result of this consultation was strong support for a scoping exercise to explore best practice models of respite within the Victorian kinship context. The feedback also was consistent with current research in identifying a need for respite care to support isolated and under-resourced kinship families and a lack of available respite options for kinship carers (especially grandparents).
1.3 KINSHIP CARE IN VICTORIA

The commonly accepted definition of ‘kinship care’ in Victoria, as set out in the Department of Human Services (DHS) Kinship Program Model, is: ‘the care provided by relatives or a member of a child’s social network when a child cannot live with their parents’. There is a further distinction between ‘statutory kinship care’, where there is child protection intervention, and sometimes a court order, and ‘private kinship care’ (sometimes called ‘informal’ or ‘non-statutory’ kinship care) where children are cared for by relatives without any child protection intervention (DHS Kinship Program Model 2010, p 2). Utilising the Aboriginal Child Placement Principle (DHS Aboriginal Child Placement Principle Manual 2002), ‘Aboriginal kinship care’ has been defined as ‘[care] provided by relatives or friends to an Aboriginal child who cannot live with their parents, where Aboriginal family and community and Aboriginal culture are valued as central to the child’s safety, stability and development’ (DHS, 2011).

Over the last decade there has been a steady increase in the number of kinship care arrangements. For example, the number of children placed in statutory kinship care in Victoria has grown from 1616 in 2005/06 to 2383 in 2010/11 (Australian Institute Health and Welfare, 2012, p 68). These figures do not include private care arrangements and DHS estimates that in 2010 in Victoria there were around 10,000 children under 18 years growing up in kinship care (DHS, 2011). It is now acknowledged that kinship care is a more frequently used option than placement of children with non-relative carers (DHS Kinship Program Model, 2010; O’Neill 2011).

With the increase in kinship care, there has been more consideration of the situation of kith and kin carers, focusing particularly on their support needs. In outlining the foundation of the current Victorian Kinship Program Model, the following points were made about carer need, drawing on the results of extensive consultation with stakeholders in Victoria and a review of the current national and international literature:

Most children in kinship care have suffered considerable upheaval and adversity. Currently most kinship carers depend solely on their own resources, informal support from family and friends and their capacity to access mainstream services in order to manage the unexpected and ongoing demands of kinship care.

Even those kinship arrangements that are potentially extremely stable and secure over the long term could be jeopardised if responsive, timely, extra supports cannot be accessed. It is also quite difficult for kinship carers to understand, negotiate and access relevant community services when they need them, even when there may be potentially helpful services available.

Despite receiving the same basic carer payments as unrelated foster carers, most statutory kinship carers still need considerable personal and other resources in order to manage the unexpected and ongoing demands of kinship care. The nature and extent of the trauma,
grief and loss experienced prior to placement by children placed in statutory kinship care are very similar to children placed in foster care or residential care. (DHS Kinship Program Model 2010, p 4-5)

By March 2010, seventeen Kinship Programs across Victoria, auspiced by fifteen agencies, had begun implementing the Victorian Kinship Model. About twelve months later, VACCA commenced the operation of a specialized Indigenous kinship program, and a further ten Aboriginal kinship programs have now been established.

The services provided under the Victorian Kinship Model are: kinship information and advice, kinship family services (accessible to private kinship arrangements) and kinship placement support (for statutory kinship care only). The kinship placement support has two components: placement establishment services for up to six months and case contracted ongoing placement support for a small proportion of families to ensure placement viability. The programs do not have any brokerage, and additional funding is restricted to ‘some extraordinary client expenses, and some extraordinary placement establishment and/or maintenance expenses’ (DHS Kinship Program Model 2009, p 15).

There is no direct reference to ‘respite care’ in the Kinship Program Model, other than as an example of support that can be provided by the ‘extended family network’ (DHS Kinship Program Model 2009, p 8). The Model, however provides the principles which should guide the development of kinship respite care in Victoria. Some of the relevant articulated goals are:

- to more effectively harness the capacity of extended family networks to provide the best possible kinship care arrangements for children unable to live with their own parents.

- to assist more kinship carers to provide ongoing normative age appropriate life experiences for the child with the minimum level of professional intervention from the formal service system, building on their informal supports and other available community resources (p 5).

The Aboriginal Child Placement Principle also informs practice development in the kinship area. The principle establishes the right of the child to grow up within their own Indigenous culture, with a sense of connection to their kinship network and community (DHS Aboriginal Child Placement Principle Manual, 2002).
2. THE RESEARCH

2.1 LITERATURE

A manifest difficulty in this project is the lack of common understanding of the term ‘respite care’. In presenting the Consortium’s comprehensive Literature Review, Hartley notes that:

\[
\text{the business of ‘naming’ respite services needs further discussion, especially around finding a balance between the need for uniformity and shared conceptual approaches in the sector and the diverse ways in which primary carers and community members may recognise, understand and accept ‘respite care’. (Hartley, 2008, p 4)}
\]

She reports that participants in the Respite Care Practice and Research Forum, held in Melbourne in June 2008, expressed reservations about using the term ‘respite care’ for various reasons. One view expressed was that ‘respite care’ is neither a commonly used term nor one which potential users immediately and clearly understand. Others avoided the use of ‘respite care’ because of the association with child protection and the removal of children (p 4).

Hartley also notes a shift in understanding of the term ‘respite care’ relating to who benefits, and also as to the timing of the intervention. She suggested that:

\[
\text{the focus has shifted from a predominant emphasis on ‘respite’—a break for carers—to a much broader focus on a wide range of potential benefits for children, primary carers, other family members and the communities in which they live…A second and related shift is a strong emphasis on the potential of respite care to be an effective early intervention and preventive service (p 5).}
\]

Drawing from the literature, the broad definition of respite care that Hartley arrived at is:

\[
\text{a period of relief from regular caregiving for the primary caregiver and assistance which is temporary or time-limited and would not normally go beyond perhaps a week at a time (p 3).}
\]

Additionally, she concluded (p 3) that the primary purposes of respite care are to:

- prevent escalation of stress and other problems in families and hence to avoid the possibility of children entering the statutory system or the possibility of neglect and abuse of children (Fry 2005; FRIENDS National Resource Center for Community Based Child Abuse Prevention, 2007)

- benefit children by giving them opportunities to extend their support networks, to have positive experiences of family life they may not otherwise have and to have some time out from often stressful family situations (Share Care 2000).
She also notes that respite care is focused on the whole family and has potential benefits for both children and caregivers (Fry 2005).

Looking at the context of kinship care, it is apparent that the consumers of services are not a homogeneous group. Kinship carers may either have assumed the role of carer because of child protection intervention, or else through a private arrangement. Kinship carers may also have family relationships of different degrees, or be biologically unrelated to the child in their care, that is, are connected as ‘kith’, not ‘kin’.

O’Neill (2011) notes that:

There appear to be significant differences between kin and kith carers in terms of motivation as well as the visibility and acceptance by others of the role.......The experience of kinship care appeared to be far more complex for grandparent carers (particularly grandmothers) than for any other group (p 96).

A particular focus on grandparents, who constitute the largest proportion of kinship carers, is noticeable in the literature, often without a consideration of the issues for non-grandparent and for ‘kith’ carers.

Hartley (2008) concludes that;

(the) heterogeneity of kinship carer families cannot be assumed and their specific support needs for respite and children’s activities are likely to be quite diverse (p 30).

Notwithstanding the diversity of kinship families, the need for support in this group is well established. In the DHS Green Paper on Kinship Care (2007), kinship carers are reported to have identified respite and childcare as two of the practical supports that were either non-existent or difficult to access where they lived (p 8). The Council on the Ageing (COTA) National Seniors Report (2003) relating to grandparent carers revealed concerns about the general lack of support (particularly for non-statutory carers), and specifically a lack of respite.

Where respite is able to be accessed by carers, Hartley (2008, p 17) found that it was an effective intervention. The outcomes included: reduced levels of stress for primary caregivers, general primary caregiver satisfaction with the provision of respite and a reduced level of use of alternative placements while receiving respite. An evaluation by the Share Care Program (2000) in Melbourne established that respite care could also: help avoid the breakdown of relationships between carer and child, establish new relationships and connections for the child, provide children with experiences of families different from their own, support children through age related changes and transitions, and extend children’s networks in the local community.
Hartley notes that whilst there is a higher proportion of *Indigenous children in kinship care* than non-Indigenous children, there is a dearth of research as to outcomes and support needs for these kinship families (p 31-32). One study which has explored the needs of carers of Indigenous children, found that both kith and kin carers wanted respite care (Higgins et al, 2007, p 4). Both carers and service providers noted that a more flexible model of care is required to allow regular respite care when it is needed (ibid). Bromfield and Osborn (2007) also identify other general issues to be considered, including the degree of family contact, culturally appropriate training for non-Indigenous carers and appropriate approaches to recruitment, training and support for Indigenous carers.

### 2.2 AIMS

The broad goals of the current project are to examine the provision and organisation of kinship respite care in Victoria, to scope the current and future need for respite by kinship carers, and to work towards developing a best practice model for the delivery of respite care in the kinship context.

The specific aims are to:

- understand how respite care is currently being delivered to kinship families: its purpose, how it is accessed, who is providing it and what form it is taking
- assess the need/unmet need for respite care services by kinship families working with funded kinship care services and estimate the future need for respite services
- explore practitioner views of helpful models of respite care service delivery accessed by kinship families
- examine constraints in meeting identified need for respite care by kinship families
- identify and raise awareness of best practice principles, and examples of best practice, relevant to the provision of respite care services to kinship families
- document outcomes and suggest areas for further consideration in a report to be distributed across community service organisations and the Department of Human Services in Victoria (DHS)
- be a resource for the community sector and DHS to inform protocols and practice development in the area of kinship care support.
2.3 METHODOLOGY

This scoping project targeted the seventeen funded mainstream kinship programs in Victoria, and VACCA as a provider of Aboriginal kinship services. The ten other Aboriginal kinship service providers were not included in the study in part due to resource constraints, and also because they were more recently established and had low case numbers.

The research aimed to elicit the experiences of program managers and team leaders working in the kinship programs in regard to the provision of respite care. This is a qualitative descriptive study of the manager/team leaders’ views on and experience of respite care provision to kinship families. The research team has analysed respondents’ ‘lived experience’ through phenomenological interpretive analysis (Osborn & Smith 2008). Curtin and Fossey’s (2007) principles for ensuring the validity of qualitative research have been followed. Triangulation of data sources and cross-checking of thematic coding from interview transcripts have been employed. To this end, descriptive statistics regarding respite provision have also been collected from the programs.

Ethics approval for the project was obtained from Anglicare Victoria’s Research Ethics Committee, (2011-02), and this approval was endorsed by the Consortium partner organisations at the time.

2.4 THE FIELD WORK

At the commencement of this project, there were seventeen DHS-funded mainstream kinship programs (one has since ceased operation), auspiced by fifteen agencies. VACCA had a recently established specialised Aboriginal kinship program. An invitation was sent to the sixteen agencies (representing eighteen programs) to invite their participation in the project. All agencies agreed to telephone interviews being conducted by the researcher with an appropriate staff member (100% response rate) and these interviews were completed using a semi structured interview schedule (Appendix), and recorded. The organisations approached to participate in the scoping exercise were given information about the project and all provided written consent to participate. The nominated interviewees were also provided with written information about the project, and gave written consent to participation.

Interviews were conducted by telephone, and the interview schedule was provided in advance to the interviewees. Interviews ranged from half to one and a half hours in length. A written record was taken of the interview. Both qualitative and quantitative data were collected and the responses were analysed using Excel and thematic analysis (Liamputtong 2009). No individual or organisation is identified in the resulting report except with their consent.
3. FINDINGS

3.1 COMPOSITION OF CARER GROUP

To provide context for the study, the respondents were asked what approximate proportion of the carers with their program were grandparents. The proportions of grandparent and non-grandparent carers are shown in Figure 1. Fourteen of the programs provided a response.

While it is usually assumed that grandparents make up the majority of kinship carers, one program reported a majority (57%) of non-grandparent carers with their program. Overall half of the respondents reported between 30 to 59% non-grandparent carers and half of the programs reported between 0 to 29% non-grandparent carers. The non-grandparent carers included aunts, uncles, siblings and family friends. One great-grandparent was also reported.

3.2 PRACTICAL DEFINITION OF RESPITE CARE

The respondents were asked:

**What do you understand by the term ‘respite care’ (including the purpose), and what would you consider to be examples of respite care?**

The accepted *purposes* of respite care fell into the categories represented in Figure 2, with indication of the number of respondents nominating each purpose. Not all respondents directly addressed this question.
It is notable that respite care is seen more commonly to provide a break for carers, rather than as a mutual break for carers and children. There were, however, separate benefits (different social and recreational experiences and an expanded network) which were identified for children.

**Examples** of respite care identified fell into the categories represented in Figure 3, with indication of the number of respondents nominating each type of respite care.
that don't involve overnight care. One respondent made the point that contact arrangements (access) with parents should be considered as respite care, especially as some carers characterise it in this way.

3.3 THE NEED FOR RESPITE CARE

Respondents were asked:

- What proportion of kinship carers referred to your program express a need for respite care?

- In what proportion of the kinship families in your program have workers assessed a need for respite care?

- What types of respite care are requested /required by carers?

The proportions of kinship carers requesting respite care as reported by respondents is represented in Figure 4. Not all of the respondents answered this question and one (P7) provided a separate figure for statutory and non statutory kinship carers.

![Figure 4: Proportion of Kinship Carers Requesting Respite Care](image)

FIGURE 4 PROPORTION OF KINSHIP CARERS REQUESTING RESPITE CARE

There was an extreme variation in the figures reported in response to this question: from one report of “never” (at referral) to 100%. Comments made suggest that a number of factors may have impacted on the response variability.

The question of the timing of requests for respite care was raised by a number of respondents. Several indicated that initially, kinship carers may be less likely for different reasons to request respite care. One respondent noted that it was usually not until the kinship worker had had a ‘one to one’ meeting with the carers, that a request would be made. The importance of assessment work based on an established relationship was emphasised. One respondent also distinguished
between the proportion of requests for respite care from *statutory clients and non-statutory clients* (80% and 20% respectively), indicating that this may be a factor of relevance. It is also reasonable to believe, given the variation in practices between programs, that issues such as how, when and *what information is given to carers* and what questions are asked, may influence whether kinship carers request respite care. Several respondents discussed the dilemma of informing carers of the option of respite care, when in reality they may not be able to access it. There is also an issue with the *lack of common understanding* of what constitutes respite care, and what language can be used to describe it.

**Worker assessed need for respite care** was also variable, as shown in Figure 5. Not all programs provided a response to this question.

![FIGURE 5 WORKER ASSESSED NEED FOR RESPITE CARE](image)

Five respondents expressed the view that 100% of kinship carers need respite care and the majority indicated a medium to high (60-100%) level of assessed need for respite care. For the programs reporting a lower level (under 40%) of assessed need, there appeared to be a number of additional factors. One program applied an initial criterion for situations where respite was considered to be appropriate where there were children under ten years in a sibling group. Another respondent noted that some of the kinship families referred to their program had established arrangements in place, where respite care had already been organised within the family. A respondent in a rural area cited distance as a factor in limiting worker time for direct contact with families. Two respondents also noted a lack of available carers, which may influence consideration of respite as a possible option. One also stated that children’s behavioural issues had influenced decisions about respite care as an appropriate support option.

Respondents provided further comments about the need for respite care. One observed that there was a higher rate of need for respite care for carers of adolescents. Another raised the issue of *level of need* and noted that while 100% of their kinship carers “need a break”, in 50% of cases respite care is required to avoid breakdown of the care arrangement. A point was also raised about addressing both immediate and longer term need for respite care. It was asserted that regardless
of current need, every kinship carer requires a contingency plan for emergency respite for when
the need arises. Several programs have incorporated in their processes an initial inquiry about
emergency contingencies.

The types of respite care which are requested/required by kinship carers, as reported by
the respondents, are represented in Figure 6, with indication of the number nominating each type
of respite care.

FIGURE 6 TYPES OF RESPITE CARE REQUESTED/REQUIRED BY KINSHIP CARERS

The majority of respondents reported that carers requested a “regular break”. One respondent
cited carers saying: ‘I want a weekend off a month’ is a common way for them to express need.
Another respondent stated the requirements as: ‘a break - something regular and in school
holidays - to go out for dinner, sleep in, catch up with friends, chance to have other
grandchildren’. A third said that ‘most want regular respite to have a break, also activity based
[respite so they can] catch up on tasks, or overnight to relieve stress of care’. One program had a
request from a carer for “someone ‘able bodied’ to do the things they can’t do”.

3.4 MEETING THE NEED FOR RESPITE CARE

The respondents were asked:

For kinship families who have been assessed as needing respite care, what proportion
have been able to access respite care?

What types of respite care have been accessed by kinship carers in your program? Who
has arranged it, and who provides it?

What in your view have been effective (in terms of meeting purpose) forms of respite
care accessed by kinship carers with your program?
The proportion of kinship carers who have been assessed as needing respite care, and who have been able to access it, is represented in Figure 7. Not all respondents directly answered this question.

Again there is great variability in access to respite care where kinship families have been assessed as being in need of care. The majority of respondents reported low to medium (0-59%) access to respite care options. Whether a program is in a rural or metropolitan setting is not necessarily a good predictor of access to respite care, as the average access rates for both settings were almost identical (metro-48%, rural-49%). The question of barriers to access for carers is considered separately.

Some of the responses highlighted additional factors to be considered. OzChild was able to provide additional data which they have collected from their program\(^1\), and the organisation was able to differentiate a group of carers who were receiving respite, but were not positive about the care received, or who wanted more (28%). This raises the question of the adequacy and perhaps the appropriateness of respite care which is received.

One respondent made the point that her program’s carers had a high rate of access to respite care because of the strong advocacy of their workers. It was noted by several respondents that a significant amount of time is spent by workers (one respondent estimated up to 2 hours a day) on identifying and accessing respite care for kinship carers in their program.

As an additional comment to highlight the desperation of carers unable to access respite care, one respondent noted that carers were getting involved as foster carers, to provide care but also to be able to access respite care when they needed it.
The types of ‘respite care’ accessed by kinship carers engaged with the programs is represented in Figure 8. The chart indicates just the range of options accessed, rather than the proportions used.

![Types of respite care accessed by kinship carers](image)

**FIGURE 8** TYPES OF RESPITE CARE ACCESSED BY KINSHIP CARERS

There are marked differences between programs in the range of respite care options accessed by kinship carers. One of the factors influencing this is the approach of the program. Several respondents expressed a preference for formal care options because of the training that must be provided to carers, the structured nature of the care, and also because it avoids problematic issues within the family which may impact on the care of the child. Other programs, however, intentionally avoid formal care options, as they view them as not ‘normal’ experiences for children in kinship arrangements and as inconsistent with the goal of kinship programs to encourage self-management.

Another factor is the availability of respite care options, which is impacted by the location of the program. Responses reveal differences in funding arrangements in different regions. For example, in one region a program receives no funding for camps and school holiday programs, whereas in another region it was reported that DHS funded camps were the most accessible respite option. There is also an identifiable “rural factor” with some respondents from country Victoria noting that distance can make some respite care options problematic, as well as using up worker time for travel.

Also relevant to availability of respite options is the relationship or protocols which exist between the kinship programs and local foster care programs. Some respondents noted the benefit of having a foster care program at the same agency.
In relation to the **arrangement of respite care**, several respondents indicated that the vast majority of carers have not had a comprehensive assessment of need done when referred to the program and do not have any respite care in place. Four respondents reported that kinship carers had formal respite care arranged by the Department of Human Services (that is, they arrived with this arrangement in place). All respondents indicated that they had the major role in arranging for respite care. Twelve of the eighteen respondents also reported family involvement in arranging respite.

**The providers of respite care** reported to be used by programs are represented in Figure 9, with indication of the number of programs nominating each type of provider.

![Diagram of Providers of Respite Care Used](image)

**FIGURE 9 PROVIDERS OF RESPITE CARE USED**

It was apparent from responses that formal foster care was used by nearly all the programs. Family and social networks were also widely used, as were other informal respite options such as camps, school holiday programs, before and after school care and family day care.

Broadly, most forms of respite care accessed by kinship carers were considered to be **effective** in meeting the purpose of respite. **Regular respite** was considered to be the most helpful and important form of respite care because of “predictability, developed relationship” and allowing “rest and re-charge”. It was also considered important as a means to “keep the placement going”, to allow children new experiences, and to develop in children the ability to form new relationships.

**Family day care** was also singled out as being a useful form of respite, as it was delivered by trained carers, and as a relationship could develop between the child and carer. **Childcare** was also considered to be ‘vital for working carers’ and positive in terms of the child’s developmental needs.
While *family and social networks* were the first option considered by programs in identifying respite opportunities, the potential issues were also identified. One respondent noted that respite within the family can be helpful, but ‘sometimes causes complications eg. transfer of carer payments and behaviour issues’. Others noted that pressure can be brought to bear on carers by family members and it was commented that ‘it can be disempowering for carers who find themselves in complex family relationships’, especially in the context of court ordered access arrangements.

### 3.5 THE EFFECT OF THE PROVISION OF RESPITE CARE

Respondents were asked:

**How do you consider that the provision of respite care effects:**

(a) the safety, stability, development and wellbeing of the child/ren in the family?

(b) the functioning and wellbeing of the kinship carers?

The overall response about the **effect of respite care on the functioning and wellbeing of carers** was unequivocal. All respondents considered that carers benefitted from respite. This was especially seen to be the case because of the older demographic of kinship carers. One respondent noted that the value of respite care for kinship carers could not be overstated. Another remarked that the provision of respite care was ‘imperative’ and made the difference between the placement continuing or not. A further respondent noted that three out of six placement breakdowns for kinship families with their program were attributable to lack of respite.

An example provided by one respondent was a long term care arrangement for an adolescent where regular respite, occasional overnight stays and holiday camps were described by the worker concerned as ‘wrap around respite’. It was the view of the worker that this respite care enabled the arrangement to continue.

The benefits of respite care for kinship carers were seen to include the following:

- providing a break (‘a calm clear space to breathe, and to think about what is going on’)
- allowing time for themselves
- reducing stress
- ‘re-charging batteries’ - replenishing emotional and physical energy
- increasing opportunities for self-care
- having time out to be normal and to do things for themselves
- allowing kinship carers to engage in the activities of their life stage
- maintaining their contacts and connections
- spending time with their partner and other family members
- reducing isolation and allowing for experiences to be shared
- allowing carers the time to deal with any feelings of grief and loss associated with their role transition.
Many respondents also noted the link between improved functioning and wellbeing for carers through provision of respite care and improved outcomes for children. As one stated: 'If we can look after the emotional wellbeing of carers through respite, the quality of care will improve and this will assist with the emotional stability and [developing a] sense of belonging for the child.' In practical terms the respondent felt that without respite care the quality of care for the child may not be different from the situation from which they were removed.

It was apparent from responses that the question of the effect of the provision of respite care on the safety, stability, development and wellbeing of children in kinship families is more complex. All respondents agreed that respite care could be of benefit to children. A strongly expressed concern, however, was that this would only be the case if the individual circumstances were carefully considered, the views of the child were sought and respite was well managed and (preferably) planned.

The benefits of respite care for children in kinship families which were identified by respondents can be grouped as either those arising from addressing problematic issues or in a more positive sense, from opportunities which are presented through respite care. Issues which respite care was seen to address are:

- stress
- relationship difficulties (especially for adolescents)
- lack of contact with other children
- safety ("providing another lens on the child").

It was also considered that respite care can create opportunities for children by:

- increasing access to activities and new experiences
- increasing social contacts and relationship possibilities
- allowing the development of resilience, self esteem and other skills
- creating opportunities to have fun.

The questions which need to be considered in assessing whether respite care would benefit a particular child, were identified as:

- how long the child had been with the kinship family
- whether the circumstances of the child would render the experience traumatic, with consideration to attachments and past trauma
- what the 'message' to the child might be in arranging respite care ("shouldn't be seen as punishment")
- whether there is sufficient consistency such that stability is promoted.

One respondent noted that respite care should be "a break and not a disruption" and that it should be 'normal and not special'. Another comment was: '[it is] attachment which makes a placement last and not respite'. In the context of the care of Indigenous children, another respondent expressed the concern that respite can 'separate the child out from family', depriving the child of cultural experiences which they might have. This respondent also raised the concern that children
might also question why they are separated from the family and others remain, creating resentments against other family members. It is interesting to note that data collected by OzChild\(^1\) established that 88% of children with their program were positive about the respite care they are receiving.

### 3.6 BARRIERS TO ACCESSING RESPITE CARE

The respondents were asked:

**Where kinship carers have not expressed a need for respite care, do you believe that lack of information or understanding about respite care is a factor?**

**Do you believe that there are other barriers to kinship carers requesting respite care?**

**For those kinship families not able to access respite care, what has prevented such access?**

Eleven out of seventeen respondents (one not directly answering this question) indicated that they believe that **lack of information or understanding** is a factor in kinship carers not expressing a need for respite care. One respondent identified issues with carer literacy as compounding this problem. It was further pointed out by several that there is also a language issue, in that ‘respite care’ is a formal or jargon term, which does not have a commonly understood meaning.

Other barriers to carers **requesting respite care** were identified. About 70% of the issues raised related to **carer concerns and issues**. The largest identified issue was carer reluctance to ask for respite care, due to factors such as:

- guilt at letting the child down
- difficulty in admitting that support is needed
- concern about how they will be viewed by family and workers
- reluctance to be a burden
- fear that the child will be taken away from them.

Other carer related barriers were concerns about the child being looked after by others and about how the child would cope with this. Some carers also were apparently indicating that they did not want to be part of ‘the welfare system’. Respondents reported that some carers also could not see the possibilities of respite care arrangements for the children in their care. Several respondents also noted that cultural factors were instrumental in carers not expressing a need for respite care. These include the ongoing effects of the placement practices that produced the ‘Stolen Generation’ of Indigenous peoples and culturally influenced assumptions, such as that a grandparent should assume sole responsibility for the care of their grandchild.
Some ‘system’ related barriers (20% of identified issues) identified were the lack of support and responsiveness of the system, the lack of options for respite care, financial factors, the complexity and intrusiveness of screening processes, transport issues and eligibility for services.

Child related factors (5% of identified concerns) which respondents believed impact on whether a carer expresses a need for respite care, are the anxiety of the children and adolescents making their own choices about what they want to do.

Respondents also identified that family issues or family conflict could also influence whether a carer expressed a need for respite care (5% of identified issues).

On the question of what has prevented carers from accessing respite care, factors identified are:

- ‘system’ issues (50% of programs), such as lack of formal and informal care options, screening processes, lack of information and legal processes (as for example where an order needs to be varied)
- financial issues (16% of programs), such as loss of reimbursement, and lack of brokerage
- family related problems (16% of programs), including conflict and incapacity
- carer attitudes and beliefs (16% of programs)
- other external factors (2% of programs), such as distance.

3.7 WHAT IS REQUIRED TO MEET THE NEED FOR RESpite CARE

The respondents were asked:

What would enable you to arrange respite care in all cases in which there is assessed to be a need for respite care?

What would be required to ensure that kinship families continue to receive respite care for as long as they require this form of support?

The factor which was most clearly identified (46% of responses) as being required in order to meet the assessed need for respite care was availability of both formal and private care options. There was a strong view that there should be a focus on the recruitment of respite carers (of different cultural groups), with some prioritisation and dedicated funding. As well as an inadequate supply of formal respite carers, some respondents noted that respite care for kinship carers was not prioritized, and there was an example of a regular respite arrangement for a kinship carer being cancelled because respite was required for a child in foster care. It was also noted that there should be more access to school holiday camps and day programs.

Respondents also identified a need for different respite options to suit the range of needs in a diverse group. The needs of adolescents were singled out, as there was reported to be a high need and a lack of respite options for this group. Several respondents emphasised the need for
flexibility in matching respite options to the individual circumstances of kinship families. There was also a point made about ensuring access to mainstream options for kinship families (such as school holiday programs and camps), so that respite could be normalised and the same opportunities provided to all children. Brokerage monies and adequate up front funding were seen as important in ensuring this (21% of responses). Several respondents also saw the need for resourcing more family work, so that the capacity of the family network could be identified and developed.

Some respondents also noted the need for the development of relationships and protocols between kinship programs and respite care providers (5% of responses) to ensure a more flexible and responsive service to kinship families. There was also a proposal for a centralised information point to make information about respite care options readily accessible to workers and families. Education of kinship carers about respite options was seen to be important in overcoming reluctance to access support.

The question as to how to ensure the continuity of respite care for kinship families who require it, resulted in the identification of similar desired measures. Respondents cited as important: the availability of more formal and private respite care options (43%), more brokerage and dedicated funding to support respite care (35%), more worker time to identify and develop the family network and identify individualized respite options for the family (8%), better understanding between kinship programs and respite care providers (5%), better information provision (3%) and initiatives (such as volunteer driver schemes) to compensate for distances in rural regions (3%).

An interesting point was made by several respondents about the importance of early assessment of the need for support and family work to determine an emergency contingency for the kinship carer to avoid future stress. One program noted that: ‘if the child is in fostercare and something happens, it is assumed that the child would go to their (respite) fostercare placement again; however there is no natural progression for a child placed in kinship care.’

3.8 RESPITE CARE FOR FAMILIES RAISING INDIGENOUS CHILDREN

What is the approximate representation of Indigenous children and families in your program?

What do you take into consideration when arranging respite care for these families?

Thirteen of the eighteen programs were working with Indigenous children. The proportions of Indigenous children in the program client groups varied, ranging from one to ten children.

Of the respondents from programs currently working with Indigenous children, most took the approach that their standard case work practices would be used, with consideration of best practice principles. One respondent made reference to the Aboriginal Child Placement Principle,
and about half of the respondents indicated consideration of cultural factors and a focus on maintaining links with a child’s own network. Four respondents noted that there would be consultation with an Indigenous agency. This study did not explore whether Cultural Support Plans were in place for the children in care. One respondent highlighted the sensitivity required because of the continuing impact of practices that gave rise to the ‘Stolen Generation’ and noted also the particular flexibility required in respect to respite, to meet needs such as attendance at funerals. Another emphasised the importance of using Indigenous carers where possible and cultural awareness training for all foster carers.

3.9 PREDICTION OF FUTURE DEMAND FOR RESpite CARE

Fifteen of the eighteen respondents (83%) expressed the view that the demand for respite care would increase in the future; three predicted that it would stay the same. The reasons given for an expected increase in demand were:

- the effect of kinship programs ‘finding their feet’ and becoming better known
- the increase in kinship care
- the demographic of carers, with an ageing population
- increase in complexity of the behaviour of children in care
- carers are more educated and will request support
- will be more demand for post permanent care support.

One respondent analysed the demand for respite care in the future succinctly:

_It will remain high on the agenda. The need will remain high and the supply will continue to fall short. Families will continue to get on with it - but placements will continue to break down without it._

Another added to this analysis:

_There is no capacity to meet current need, let alone predicted increased need in the future. The potential for placement breakdown is shocking. Prior to breakdown, the child goes through emotional turmoil, and is probably subjected to further harm, before the caregiver says ‘enough is enough’._

A further comment, in the context of a prediction of an increase in demand for respite care, was that clear focus was required to not ‘encourage a need’ or create dependency but instead to develop supports in the family networks.

It was also predicted by another respondent that an increase in the breakdown rate for kinship care arrangements, consequent on an increasing unmet need for respite care, would ultimately mean that a child’s kith and kin would be less willing to take on their care.
3.10 BEST PRACTICE IN THE PROVISION OF RESPITE CARE

Respondents were asked to consider the question:

**What would you consider to be optimal or best practice in providing respite care for kinship families?**

After two years of operation for nearly all of the Kinship Programs, a very clear view was provided of what would be considered to be optimal or ‘best practice’ in the provision of respite care for kinship families. The responses related to both the process and the structural context of kinship practice and may be summarised as follows:

**PROCESS**

**Assessment and Planning**

- an initial comprehensive assessment scoping the viability of the placement and the background, capacity and needs of the child and carer, with particular attention to issues of attachment, trauma, and cultural needs and sensitivities
- early introduction of the idea of respite support, so that it is both normalised and integrated into the ongoing planning for the family and provision of other relevant information
- early engagement with the extended family to build connections and to ascertain potential support options, using family meetings and elements of Family Decision Making and Family Group Conference processes
- looking for support options first from within the extended family
- seeking and factoring in the views of the child and balancing the interests of the child (including the need to maintain connection with siblings) and the carer, focusing on potential issues of attachment and trauma
- establishing an emergency contingency for respite care at the outset, to avoid crisis driven interventions
- an individualised relationship based partnership approach and family driven practice
- service coordination and collaboration between service providers, as for example between respite providers and kinship workers.

**Ongoing Work**

- timely screening of prospective respite carers
- continuing flexible, responsive and individualised family work
- individual matching to respite options
- provision of safe, regular, planned, consistent, flexible, integrated and ‘normal’ types of respite care.
STRUCTURAL CONTEXT

- accessible and coordinated information about respite care
- availability of safe, regular, planned, consistent, flexible, integrated and ‘normal’ types of respite care, including emergency care and daytime and school holiday care (with additional options targeting adolescents)
- coordination between kinship programs and respite care providers
- access to local respite care options, formal and private-with necessary funding/brokerage/prioritisation to ensure this
- access to an adequate pool of experienced, culturally diverse and appropriately trained respite carers, with training focusing on both the areas of trauma and attachment, and cultural sensitivity
- in rural areas, additional resources to address and compensate for the effects of distance on the accessibility and suitability of respite options, and on the amount of worker time consumed with travel.

4. OTHER LOCAL STUDIES/STAKEHOLDER VIEWS

Other recent local studies confirm the findings of this project, particularly in regard to the need and demand for respite care and add other perspectives of what constitutes ‘best practice’ in the provision of respite care. A number of key stakeholders have also generously offered their views to the researcher regarding respite care access for kinship families.

The Foster Care Association of Victoria (FCAV) and the Post Placement Support Service (PPSS) collaborate in providing the Carer Information and Support Service (CISS) which is available to all carers of children and young people living in home based care in Victoria. Records of the telephone inquiries made to this service in the period from July 2008 to June 2011 (as shown in raw survey data) show a small number of kinship care inquiries, all of which related to a need for respite care.

It is also interesting to note that in the recent FCAV report ‘Strengthening Carers 2011’ (albeit focusing more specifically on foster carers), the necessity for respite care to support placements is acknowledged and a specific recommendation is made for the provision of ‘targeted, effective and individualised formal respite and informal respite options’ (p 32). The report also adopted a more expansive definition of informal respite care to include in-home nanny support, house cleaning, gardening, baby sitting, family and friends support.
Further relevant data was produced by a 2011 research project: *Family Links: Kinship Care and Family Contact* conducted by Meredith Kiraly, Honorary Research Fellow at the University of Melbourne. Although respite care was not the central focus of the study, it was a repeated and noticeable theme in the analysis of survey responses (Kiraly, personal communication 2012). In survey results from the project (as yet unpublished), 31% of the 66 respondents were non-grandparent carers, and 69% were grandparent carers. Responses indicated that 22% of the respondents have respite care, and 51% want it. The comments made by respondents give a clear picture of the demands of their role and their need.

One interviewee, in answering a question about what support they require, answered:

*Respite - big time - (provincial centre named) respite is virtually non-existent. I need to have some normality in my life without girls' appointment/sporting/schooling/my work 7 days 24 hours. It gets really hard.*

Another interviewee, in answer to the same question about what support they need, answered:

*RESPITE - due to our age we find it very difficult, at times, to stay focused and we need a break from the constant pressure of protecting the child.*

In a published report based on part of the same research project *Kiraly & Humphreys* (2011) addressed the longer term support needs of kinship care arrangements for Indigenous children. Two elements of good practice identified in this part of the study were increased financial and non-financial support to caregivers of Aboriginal children and developing cultural awareness in non-Australian workers and caregivers. The need for support was premised on the recognition that; “Aboriginal caregivers are more likely to be older, single, in poorer health, and caring for more children than non-Aboriginal caregivers of Aboriginal children.” (P 4-5)

A large national study (335 participants) of grandparent kinship carers currently being completed by Christiane Purcal at the Social Policy Research Centre at the University of New South Wales, has produced some data relating to the use of, and unmet need for, kinship respite care. The results show that the supports most widely used by the grandparent carers are support groups, childcare, and other respite such as camps. Of the total number of participants, 63.2% are using, and 23.7% would like to be using, *support groups*, 38.5% are using, and 17.6% would like to be using, *childcare and out of school hours care* and 29.7% are using, and 44.1% would like to be using, respite such as *camps*. As context for this, the study established that three quarters of the participants receive incomes below the national average.

A survey conducted by *Kinship Carers Victoria (KCV)* in 2011 asked participants for ‘suggestions for improvement in the lives of carers and children’. The respondents to the survey were 87 kinship carers who had contacted Kinship Carers Victoria and who had agreed to complete the survey. For this group, respite care (including childcare and peer group support) was the second most common response (20%) after ‘improvement to education provision’ (24.3%). It was
noted in the survey report that some participants made only one suggestion, instead of taking up the option of making multiple suggestions. This may have resulted in a lower response rate for the 'suggestion' of respite care. Anne McLeish from KCV adds (McLeish, personal communication 2012) that from her extensive consultations with kinship carers she would endorse the need for kinship respite care. She notes that access to respite has been identified as an issue by kinship carers and that the behaviour of the child can contribute to this. She also reports that carers are identifying a need for supported groups and camps.

The **Mirabel Foundation** provides a variety of support programs for kinship families where children have been orphaned or abandoned due to their parent’s drug use. Respite is provided in various forms such as camps and day activities for children, weekend respite for younger children, and family camps for the carers and children. Elizabeth McCrea, Manager of Advocacy and Family Support at Mirabel in reflecting on their practice, identified elements found to be important for the support of kinship carers (McCrea, personal communication 2012). She said that kinship carers value connection, and that especially given a context of family estrangements, carers and children say that they feel like they have found a new family in Mirabel. She also said that in working with families, it was important to acknowledge that they just want ‘to chat’; to tell their story. She also felt that respite options needed to be ‘normalising’, as for example with camps. An effective initiative has been family camps developed as an extension of carer support groups. She also noted that families needed sufficient financial means to be able to organize the care they require for themselves. Another point made was that support needed to be practical, echoing the more expansive definition of ‘informal respite care’ adopted by the FCAV.

The **Centre for Excellence in Child and Family Welfare** in an Issues Paper submitted to the Protecting Victoria’s Vulnerable Children Inquiry (2011) stated:

> Availability of respite care for kinship carers and long-term foster carers, in particular, is becoming a major problem... if adequate, regular respite continues to be out of reach of the majority of full-time carers, particularly those who work with more complex children and young people, rates of placement breakdown and carer retention will continue to suffer accordingly (p 15)

Dr. Peter Lewis the Manager of Policy, Research & Communication at the **Victorian Aboriginal Child Care Agency** (VACCA) noted (Lewis, personal communication 2012) that the provision of respite care for kinship families with the care of Indigenous children should be consistent with the child’s Cultural Support Plan. It was his view that where a child is with non-Indigenous carers, appropriate responsive respite care could potentially address a child’s cultural needs. He also noted the need for Aboriginal cultural competency training for workers and non-Indigenous carers, to encourage cultural sensitivity. In the submission from VACCA to the Protecting Victoria’s Vulnerable Children Inquiry, it is also asserted that an investment in respite care would prevent some placement breakdowns. (VACCA, 2011, p 51)
5. CONCLUSIONS

The results of this scoping exercise show that respite care for kinship carers is considered to potentially make the difference between the care continuing or not. There was unequivocal agreement that respite care is beneficial for kinship carers and if properly managed, also of benefit to the children in their care. The study further established that there is a currently unmet need for respite care for kinship carers and that the demand for respite care is predicted by most programs to increase.

The research has also demonstrated that there is broad consensus among the interviewed program representatives as to best practice principles in the provision of support to kinship families. However, there is also great variation in the respite care being received by kinship families across Victoria. The reasons for this appear to be differences in contextual factors, such as locally available respite options and different funding arrangements but also disparities in how principles are applied in practice.

Clearly, more discussion is required in the field to share and extend knowledge about kinship respite care, and to enable the development of a common ‘best practice’ approach to providing respite care to kinship families.

It is recommended that the following areas be further explored:

- clarification of the language used to describe respite care, and the services it comprises, and also discussion about the value and place of different care options as a support for kinship carers

- development of processes to support child centred, ‘family driven’, individualised, and relationship based practice, using a partnership approach with families; also consideration of what is required to enable ongoing family work to be done to support kinship care arrangements towards self-sufficiency

- improvement of how information about respite care is coordinated and made easily accessible to families and workers

- development of processes to ensure in every case an initial comprehensive assessment of the background, needs and capacity of the kinship family, so that there may be a determination about the viability of the kinship arrangement, and as a foundation for determining what respite is appropriate given the needs of the carer and the child. Such an assessment would include an explicit consideration of issues of trauma, attachment and cultural sensitivity
• further developing the potential of carer support groups, for example in running camps as an extension of each support group

• development of processes to ensure planning for respite care at the beginning of engagement and the identification of an emergency respite care option as soon as possible, with all screening processes completed in a timely manner

• developing an adequate pool of experienced, culturally diverse and appropriately trained respite carers skilled in the areas of trauma and attachment and cultural sensitivity

• assessing the level of active integration of culturally appropriate respite care as set out within the Cultural Support Plan for each Indigenous child in kinship care

• compensating for the issues arising from distance in rural areas

• addressing the respite needs of adolescents and exploring how appropriate respite options could be accessed or developed

• provision of brokerage provided to programs and families directly to enable access to private respite care when required and to encourage self sufficiency

• ‘normalising ‘respite care’, through developing connections within the family network, ensuring access to mainstream services and activities and exploring other models of support such as Mirror Families™ (Brunner & O’Neill 2009).

NOTES

1. In October 2011 OzChild undertook an internal survey specifically for the purposes of the current scoping project. Each kinship worker in the program was requested to complete the survey in relation to their cases. The responses were based on the views of the workers. The results of the survey have not been published.

2. Mirror Families™ is a model created by Claire Brunner and documented by Claire Brunner and Cas O’Neill (Brunner & O’Neill 2009). The aim of Mirror Families is to construct a supportive network for a child or young person, to sustain them throughout the different stages of their life. This is achieved by facilitating the development of relationships for the child or young person based on an existing ‘heart connection’. This process is lead by the child and their parent or carer. The overall goal is for each Mirror Family to become self-managing and to function like a natural extended family.
REFERENCES


Brunner, C. & O’Neill, C. (2009), 'Mirror Families ... creating extended families for life', Children Australia, Vol. 34, No. 4, 6-12


Centre for Excellence in Child and Family Welfare (2011), Issue Paper 2: Their needs: appropriate service models for vulnerable children, young people and families, Submission to the Protecting Victoria’s Vulnerable Children Inquiry

COTA National Seniors. (2003). Grandparents raising grandchildren, Canberra, Australia: Dept of Family and Community Services


Department of Human Services (2007) Kinship care: Care by relatives and family friends (Green Paper. Policy and service design). Melbourne, Australia

Department of Human Services (2007) A new kinship care program model for Victoria Melbourne, Australia


Good Shepherd Youth and Family Service (2007), Research proposal for respite care, August.


Kiraly, M. & Humphreys, C. (2011), It is the Story of all of us. Learning from Aboriginal communities about supporting family connection, Report # 2 Family Links: Kinship Care and Family Contact Research Series, Child Safety Commissioner, Melbourne, Australia


McNamara P (2009) Respite care: Its role in family preservation International Association for Outcome Based Research in Family and Children’s Services Seminar St Catherine’s College, University of Oxford, United Kingdom July 10-12


Share Care (2000), Sharing the care: The role of regular planned respite foster care, Share Care Best Practice Project, 2000.

Victorian Aboriginal Child Care Agency (VACCA) Submission to the Protecting Victoria’s Vulnerable Children Inquiry May 2011
The time period covered by this interview is since the commencement of operation of the new model of kinship care in Victoria in March 2010.

Thank you for agreeing to participate in this interview. Your agency details were passed on by DHS. I understand that you are funded to provide a kinship care program, and I want to ask you about the provision of respite care to kinship families referred to your program.

1. Describe the current operation of your kinship program, in terms of the role allocation for workers, the services provided, and the targets for each service component.

2. What do you understand by the term “respite care” (including the purpose), and what would you consider to be examples of respite care.

3. (a) What proportion of kinship carers referred to your program express a need for respite care?
   (b) Where kinship carers have not expressed a need for respite care, do you believe that lack of information or understanding about respite care is a factor?
   (c) Do you believe that there are other barriers to kinship carers requesting respite care?

4. What types of respite care are requested/required?

5. (a) What types of respite care have been accessed by kinship carers in your program? (providing proportions if possible)
   (b) Who has arranged it, and
   (c) Who provides it?

6. What in your view have been effective (in terms of meeting purpose) forms of respite care accessed by kinship carers with your program?
7. In approximately what proportion of the kinship families in your program have workers assessed a need for respite care?

8. For kinship families who have been assessed as needing respite care, what proportion have been able to access respite care?

9. For those kinship families not able to access respite care, what has prevented such access?

10. What would enable you to arrange respite care in all cases in which there is assessed to be a need for respite care?

11. (a) What is the approximate representation of indigenous children and families in your program?
   (b) What do you take into consideration when arranging respite care for these families?

12. How do you consider that the provision of respite care affects;
   (a) the safety, stability, development and wellbeing of the child/ren in the family?
   (b) the functioning and wellbeing of the kinship carers?

13. What would you consider to be optimal or best practice in providing respite care for kinship families? (for example; in the timing of an assessment of need, the way respite is sought, the available options for respite care, who provides the respite care, or frequency of respite care)

14. What would be required (in terms of resources, respite options, service provision) to ensure that kinship families continue to receive respite care for as long as they require this form of support?

15. What would you predict will happen with demand for respite care for kinship families in the future?

16. Are you aware of the Mirror Families model of support for vulnerable children?

17. Is there anything else you would like to tell us about respite care for kinship carers?