National statistics show that on 31 March 2007 about 7,000 looked after children in England (11% of the total) were placed in kinship care with relatives or friends. There has been no national prevalence study on kinship care in England, so we do not know how many children are living in kinship care arranged informally by family members or friends. However, the Family Rights Group estimates that there are over 200,000 households where kinship carers (usually grandparents) are looking after children who cannot live with their parents. In the London Borough of Greenwich, this hidden population of ‘children in need’ has been targeted for extra support by a Kinship Care Team, which aims to enable children to remain within their family network and to reduce the risk of their becoming ‘looked after’. Hilary Saunders and Julie Selwyn report on their evaluation of this initiative.

**Background**

When children cannot remain with their parents, the Children Act 1989 encourages local authorities to place them with a relative, friend or other suitable person, unless that would not be reasonably practicable or consistent with their welfare (section 23(6)(b)). The Government has expressed a preference for kinship care in such circumstances, claiming that this is ‘much better for most children than entering care’ (Department for Education and Skills, 2006a). This assertion is supported by research which has found that kinship care arrangements are more stable than placements with unrelated foster carers and that kin carers show greater commitment to the children (Rowe et al, 1984; Rowe et al, 1989; Aldgate and McIntosh, 2006; Farmer and Moyers, 2008). Kinship care is particularly helpful in providing secure long-term placements for adolescents (Rowe et al, 1989). Children placed with relatives or friends are likely to do as well as those placed with unrelated foster carers despite facing similar difficulties and often receiving less support (Sinclair et al, 2005; Farmer and Moyers 2008). Moreover, kinship care might enable better matching with regard to culture and ethnicity, and can help to preserve a sense of belonging because usually the young people already know and love their carer (Broad et al, 2001; Farmer and Moyers, 2008). An overview of kinship care studies (Hunt, 2001) emphasised that there are also benefits for society, as kinship care helps to meet the rising demand for out-of-home placements while limiting the cost of public services.

Although most kinship care studies have been undertaken in the US, their findings cannot be generalised to the UK because kinship carers there are predominantly single African-American or Hispanic grandmothers (Berrick and Barth, 1994; Hegar and Scannapieco, 1999), whereas in England they are mostly white couples (Sykes et al, 2002; Farmer and Moyers, 2008). Indeed, Farmer and Moyers’s large-scale study of looked after children (2008) found that significantly more black and minority ethnic children (60%) were placed with unrelated foster carers than were living with family and friends (40%). However, financial hardship, poor health, overcrowding and inadequate support appear to be common experiences for kinship carers in both countries (Dubowitz et al, 1993; Hegar and Scannapieco, 1999; Ehrle et al, 2001; Richards, 2001; Sykes et al, 2002; Farmer and Moyers, 2008).

As grandparents are often kinship carers (Pitcher, 1999; Broad et al, 2001; Hunt, 2001), some of these disadvantages are age related, but they are clearly exacerbated by inadequate local authority support. Farmer and Moyers (2008) detected a general attitude that kin should be able to manage without help. In their study only eight per cent of the kin carers had the benefit of a family placement support worker compared with 92 per cent of local authority foster carers (see also Sykes et al, 2002), and despite tensions and conflict with birth
parents, 43 per cent of kin carers were expected to supervise contact visits themselves.

As the research on kinship care in England has focused mostly on cases where local authorities have placed looked after children with relatives or friends, very little is known about the much larger group who make private kin care arrangements. However, one finding on this group is especially worrying. Farmer and Moyers (2008) found that when relatives or friends cared for a child without initially involving children’s services but later asked for help, local authorities generally said that the child was not their responsibility and refused to provide any financial support.

**Evaluation of the Kinship Care Team**

In 2005 the Hadley Centre at Bristol University was contacted by the London Borough of Greenwich, which asked for an independent evaluation of their Kinship Care Team (KCT). The KCT had been in operation since June 2004 and consisted of two social workers and a support worker. Their work focused on ‘children in need’ who were not looked after but who could not live with their parents. By offering support to kinship carers, children and young people and birth parents, they aimed to enable these children to remain within their extended family. The initial intention was to support each family for a maximum of one year. The range of support services included:

- advice on welfare rights and legal options;
- emotional support and counselling;
- advice on managing difficult behaviour and attachment issues;
- help to access other services such as CAMHS;
- supervised contact;
- payments for bedding, furniture and clothing, and occasionally a small weekly allowance.

The KCT operated under the legislation on children in need (Children Act 1989, section 17) and as these were not ‘looked after children’, the kinship carers were not bound by the fostering regulations. Assessments, therefore, related technically to the child and to the quality of care provided by the family member or friend. These were undertaken holistically using the Framework for Assessment guidance (Department of Health, 2000) and the Integrated Children’s System procedures. The child received an initial assessment carried out by Greenwich’s Initial Response and Assessment Service, and the initial plan then triggered the referral to the KCT. The KCT then carried out a Core Assessment and drew up a Child in Need plan, determining the support requirements of everyone involved – the child, the carer and the parent(s). That plan was reviewed every six months. This meant that carers were not formally approved or rejected as such. If, however, issues relating to harm or potential harm were identified, this might lead to formal child protection interventions under the Children Act 1989 (section 47), as had happened on a few occasions.

What was particularly interesting about this local authority’s scheme was that it was supporting kinship carers to help ‘children in need’ remain within their family network. This was quite different from the local authorities participating in previous research, where kinship care was primarily used as a placement solution for children who, in most cases, were already being looked after by the local authority.

**Methodology**

The evaluation involved extracting and analysing quantitative data from all of the 58 case files opened by the KCT since the start of the project. This part of the study was designed to ensure that ‘core data’ were available on all the families who had been referred to the KCT, ie both closed and open cases.

Service users were also contacted by their social worker and asked to give
consent to be interviewed by a researcher from the Hadley Centre. This produced a sample of 25 individuals in 12 families, which represented 50 per cent of the families currently receiving services from the team. The sample included 12 kin carers, four birth mothers and nine children and young people. Unfortunately we were unable to interview any birth fathers, a problem that has been encountered by other researchers in this field (Farmer and Moyers, 2008). The interviews were conducted using semi-structured interview schedules. Most interviews were taped where permission was given. We asked the interviewees about the reasons for the kinship care arrangement, the quality of support provided by the KCT, relationships with social workers and how the arrangement was working for them – and we compared responses from the carers, the children and the birth parents. By combining quantitative and qualitative research, we aimed to provide a retrospective view of all the work already undertaken by the KCT, while also looking at the experiences and views of current service users.

Case file data were entered onto an Access database and analysed within Access and SPSS. Interview data were transcribed and entered into a matrix (Dey, 1993) so that answers from carers, children and birth parents could be compared.

**Findings from the case file study**

The KCT only accepted referrals which had come through the children’s services department. This was the route established by the team.

**The children and their birth families**

Two-thirds of the birth families were not receiving services from any children’s services department before the first referral. This is not surprising as only about ten per cent of children in need are known to local authority social workers at any one time (Department of Health, 2001), but it also indicates that the KCT were making contact with

many ‘new’ families where children were vulnerable. Most of the children and young people were teenagers (the average age was 14 but ages ranged from 5 to 18), and this finding reinforced previous research showing that kinship care is frequently used for adolescents (Rowe *et al.*, 1989). Just under a third of the youngsters were of minority ethnicity and ten spoke languages other than English.

The birth parents had experienced a wide range of difficulties, including factors which are known to present a risk to the healthy development of children. More than a third of birth parents had misused drugs or alcohol, a third had mental health problems, and domestic violence, homelessness or imprisonment also featured in many cases. In these circumstances, it was not surprising that almost half of the youngsters (48%) had experienced some rejection by their mother, with half of this being severe or persistent, and nearly three-quarters had been rejected by their father. A quarter of the youngsters had had multiple moves and carers, and 40 per cent had suffered a significant loss or bereavement, such as the death of a parent or not knowing where a parent was. Twenty-two youngsters had been identified as having educational difficulties; other problems mentioned in the case files included self-harm, eating disorders, violent outbursts, promiscuity and ADHD.

Nearly three-quarters (72%) of the children and young people were already being cared for by relatives at the time of the first referral, and in these cases the KCT’s intention was to provide support for an arrangement which the family had already made. In about a third of cases social workers played a more proactive role, either asking the birth parent if there was a relative whom the child could stay with or suggesting kinship care to other family members. However, despite such attempts, in almost every case only one person or couple offered to care for the child.
The carers

Grandmothers were caring for almost half of the children, aunts and older siblings cared for about a third, and friends of the family cared for a fifth. Nearly all (93%) of the youngsters were living with a carer who held the same religious beliefs and was of the same ethnicity, and all had a carer who spoke the same language.1

The 58 children were being cared for in 48 different kinship arrangements. Ninety per cent of the carers were living in rented accommodation and this was often overcrowded (51%). Almost half of the youngsters had to share a bedroom and some had to share a bed or sleep on the sofa due to overcrowding. Nineteen (39%) of the carers had other children living with them, often adult children so they ranged in age from six to 36 years, but 13 carers (27%) had never cared for a child before. Very few adults living in the carers’ households were employed, so most were dependent on pensions and benefits. Forty per cent had some problem with debt. Eleven (23%) of the carers were in poor health and six (12%) were disabled.

Despite these difficulties, the quality of care according to social work recording in the case files was considered good or very good in 78 per cent of cases. Most carers were described by social workers as responding to the child's needs sensitively and demonstrating warmth, affection, praise and encouragement. Some carers (13%) were high on warmth but also high on criticism, a style of parenting that is 'good enough' but may provoke conflict with teenagers. However, in eight per cent of cases relationships were very problematic; this seemed to be because the carer had difficulty in setting boundaries, could not help the children to regulate their emotions and behaviours, and did not always model appropriate behaviour.

Contact

Most youngsters saw at least one of their birth parents regularly, and where contact was occurring it was described mostly as positive. However, contact visits were described in case file recording as having an adverse effect on 36 per cent of the children and young people, often because the birth parent did not turn up or due to conflict, drug/alcohol misuse or rejecting behaviour. Over a third of the youngsters had no direct contact with their birth parents, although some of these had indirect contact. When contact was unreliable, the KCT tried to support visits by providing travel expenses and occasionally supervising contact (in four cases they supervised visits). Five youngsters had no contact with their birth family because their parents were dead or their whereabouts unknown.

Length of KCT involvement

A quarter of cases were closed within 16 weeks, but most of the current kinship arrangements were expected to be long term and to require continuing support. Only seven of the 27 youngsters with whom the KCT were currently working were highly likely to return home.

Interview findings

We interviewed 12 carers, nine children and young people and four birth mothers from a total of 12 families (almost half of the KCT’s caseload at the time). The answers provided by the children and young people were generally very brief, the birth parents tended to say more and some kin carers described their situation in great detail.

The experiences of the carers

Most of the kinship carers said that they had willingly agreed to care for the child. Nearly all had previously looked after her or him overnight, at weekends or during school holidays, so they

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1 Following the introduction of the Children (Private Arrangement for Fostering) Regulations 2005, children placed in the care of friends are now considered to be privately fostered and in Greenwich they no longer come within the remit of the KCT.
already had a close relationship with the child and they thought this had contributed to the success of the placement. In two cases involving teenage mothers, grandmothers said they had always looked after both the mother and the child. Only one carer had initially expected to care for the child short term; in fact, the arrangement had lasted several years.

Most kinship carers showed a remarkable level of commitment to the child. We found lots of evidence of carers doing everything they could, often in very difficult circumstances. For example, one carer got up before 6am to accompany the child on a lengthy bus journey to school in order to ensure that he was not bullied, and another tutored the child in all the subjects he would have to learn at school while waiting months for a school place to be provided. We got the impression that, although many of these children and young people had suffered neglect, trauma or abuse, they were now loved, protected and cared for. As one grandmother expressed it:

*He’s my grandson, he’s been through hell and I’m now telling you that I am going to turn the tables round for him.*

Kin carers could also be very sensitive to the needs of birth parents. Some refused to apply for adoption or residence orders because they hoped that eventually one of the birth parents would be able to reclaim the child. One described how she and the birth mother had worked together to address the child’s emotional needs. However, the goodwill of carers was sometimes stretched to breaking point by the behaviour of birth parents. One carer had found it impossible to provide for the child because the birth mother had not handed over the Child Benefit book. She commented:

*This was going on for seven months and I just couldn’t do it... I sat there and I cried, and I said, ‘I tell you what, you take that child and you deal with it,*

*because I can’t deal with it.’ I had £47 myself. I said, ‘I can’t feed this child, buy nappies and everything else.’*

Fortunately this carer was given a small weekly allowance by the KCT, which enabled her to continue caring for the child.

### Preventing children from entering the care system

Most of the 12 kinship carers said that if they had not provided care, the child would have ‘gone into care’ or they could not imagine what would have happened. Only two thought that another family member would have taken the child. One asked rhetorically: ‘Who else could have done this?’ Another insisted that there was nobody else because the birth mother had ‘fallen out’ with everyone else in the family. In three cases the carer’s willingness to provide care had not only benefited the child but had also enabled the birth mother to recover from mental illness or addiction, as described in the following comment:

*I think he would have gone into care. Or [his mother] wouldn’t have tried to detox – she might have just kept him and stayed as she was. You see, I was the only person she could trust.*

All the kin carers believed that the children had benefited from living with them. They often talked about providing encouragement, security, boundaries or proper meals for the child, and some described how the child had changed:

*[She’s] a different child now... happy, outgoing, outspoken, dancing around, singing, going to school on time, everything a child normally should do... It’s like she put everything behind her.*

*He’s slowly becoming a more confident child, whereas before he could not do anything. He actually couldn’t even tie his shoelaces when he arrived. His confidence grows because we keep making him take little steps at a time.*
The carers also reported that although several of the children and young people had previously missed a lot of school, most were now attending regularly (at their carer’s insistence) and their results were improving.

**The carers’ views of the KCT**

The carers’ first impressions of the KCT were generally very positive, with social workers being described as ‘easy to talk to’, ‘lovely, lovely, nice people’, ‘quite enthusiastic’ and ‘a bit of a guardian angel’. None of the carers complained about the assessment process and some expressed appreciation that this task had been carried out sensitively by the social workers. In particular, they appreciated the fact that the KCT was supporting them in keeping the child within the family network:

*I like the way they are straight down the line . . . more normal, more family centred than the social services department, who always want to know whether you’re abusing the child.*

The service provided was generally rated highly, although carers often said that particular kinds of help were not needed. Several carers stated that they really appreciated being listened to, having emotional support or reassurance, being valued and knowing that there was someone they could turn to. Some were very grateful for financial assistance and practical support, particularly with filling in forms. Three-quarters of the carers (9) were satisfied with the service but two said they were dissatisfied.

The dissatisfied carers had both been hoping that the KCT would help them to obtain assistance from another council department, specifically transport to school for a child with special needs and rehousing for a family living in extremely overcrowded conditions due to the kinship care arrangement. The inequitable funding of different types of foster care was also raised by another kinship carer, who was receiving a regular allowance of £30 per week from the KCT. She commented:

*It was just an awful struggle obviously, having to give up work, so initially it was a relief to have that [£30]. I suppose what I’m comparing it to is children who are fostered . . . I know that had she been fostered through the system, that the foster carer would have had enough income to have met all of [the child’s] social needs.*

It is possible that some of the other kinship carers may have shared these views, if they had been aware of the allowances paid to local authority foster carers. However, mostly they appeared to be grateful that the KCT was helping them to do what they wanted to do – to protect and care for the child.

**The views of the children and young people**

The children and young people mostly chose to say very little about the circumstances in which they had come to live with their kinship carers, but their comments usually confirmed information provided by the carers. One child, for example, spoke about feeling scared when the police took him to the carer’s house because he didn’t know why, and the carer also complained that the situation had not been explained to her. However, in another case where the carer tried to protect the child’s feelings by concealing the reason for the kinship care arrangement, the child clearly knew the reason but felt unable to talk about it for fear of upsetting the carer.

Five children and young people confirmed that their social worker had asked them how they felt about coming to live with their relatives and had taken their views into consideration. In other cases social services became involved later, but one child was too young to be consulted and two youngsters said they ‘had no choice’ and were not happy with the decision.

Some of the children and young people were relieved to find that their social worker was nicer than expected, particularly if their expectations were based on Elaine the Pain in the Tracy Beaker stories! However, two teenagers
‘couldn’t see the point of a social worker’ or thought there wasn’t ‘a problem to fix’. Most of the children and young people said that they could talk to their social worker, but none had a phone number to enable them to contact him or her directly.

Some of the children were clearly struggling to deal with very difficult emotions. Two expressed agonising fears that their elderly carer might die and both said they couldn’t talk to anyone about this. One child said that he felt as though his ‘heart had been punched and ripped out’ when his father refused to visit him.

Permanency arrangements

The remit of the KCT is to support informal kinship care arrangements (ie where there is no legal order) and to work towards permanence for the children and young people. However, they found that when they raised the issue of legal orders, many kinship carers were very reluctant to consider this due to the potential effect on family relationships. Such concerns were sometimes expressed in the interviews. For example, one carer said that she had refused to apply for a residence order because she ‘couldn’t possibly do that’ to her own (adult) child, especially as she still hoped that the birth parents might be more involved with the child in future.

In three out of the 12 families who took part in the interviews, it was clear that the birth mothers would not be able to care for the child in the future due to serious health problems. These three cases all involved younger children and the KCT wanted to ensure that they had permanent placements. In two of these cases they were helping carers to apply for special guardianship orders (covering the legal costs in one case), and in the third case they advised the carers to obtain a residence order at their own expense, but the carers decided they could not afford this.

In a further three cases birth mothers had recovered from mental illness or addiction and, following assessments by the KCT, were about to reclaim their children. In other cases there may have been some possibility of reunification with birth parents, but in two cases where birth parents were in prison, it was not clear what the care arrangements would be following their release. One carer who was looking after a young person over the age of 16 was very relieved to be told that there was no need to apply for a residence order.

The experiences and views of the birth mothers

We were only able to interview four birth mothers. However, their experiences illustrated the extremely difficult circumstances that often prompted referrals to the KCT and the scheme’s potential to provide security for the child while sometimes also enabling reunification with a parent in the long term.

The four birth mothers had all experienced severe problems in terms of physical or mental illness, drug or alcohol misuse, or domestic violence. In two cases the support provided by the KCT enabled relatives to continue looking after the child for a very long time (five years in one case) and this respite made it possible for the birth mothers to obtain treatment and to regain their health. Both of these mothers were happily anticipating the imminent return of their children. In the two other cases reunification was impossible as the mothers had a progressive debilitating illness. However, one mother accepted the kinship care arrangement as the best solution in the circumstances:

_I suppose that my health will deteriorate, so that’s a kinda bad thing, but I know that mum and dad will always be supportive . . . because they always have been, no matter what . . . It’s good because I can talk to my mum and dad about anything._

The other seriously ill birth mother resented the KCT’s role in arranging for the child to live with a relative because
she thought that support should have been provided to enable the child to remain in her care. While it was doubtful that this would have been possible, it was worrying that this birth mother appeared to have hardly any contact with social services and only very limited medical assistance. In this case the carer and the child were also very distressed by the lack of medical care provided for the birth mother. Interestingly, in one of the reunification cases both the birth mother and the carer also claimed that if adequate medical support had been provided when the birth mother first became ill, the kinship care arrangement would not have been necessary.

The birth mothers appreciated being able to keep the child within the family and having frequent contact. With one exception, handing over the child was not seen as an irrevocable act, as it might have been if local authority fostering had been the only alternative. However, their views on the KCT tended to be less positive, apart from one mother who was extremely grateful for the support she had received. One appreciated attending parenting classes, which the KCT arranged for her. Another stated that, given that the kinship care arrangement was voluntary, it was ‘a bit intrusive’ for the KCT to require a police check and medical check before the child could stay with her overnight. Two mothers said that they felt uninformed and excluded from the work of the KCT and were uncertain about the process for reclaiming their children.

**Suggested improvements to the service**

Although the KCT was generally working well, our evaluation identified areas where improvements could be made.

**Multi-agency working**

Many families assisted by the KCT had acute needs that could only be met by working in partnership with other departments and agencies. For this reason we recommended that the KCT should meet with key service providers to discuss how procedures could be improved to meet the needs of children living in kinship care. The following problems needed to be addressed on a multi-agency basis:

**Education**

Paying more attention to the educational needs of children and young people, eg by fast-tracking the provision of school places for children in kinship care and ensuring that coursework was transferred promptly to the new school.

**Health**

Ensuring that medical support services were provided for birth parents and providing easier access to CAMHS provision for children and young people in kinship care. (Only one child in the interview sample had been offered counselling, but loss, rejection and bereavement were prevalent in the sample.)

**Housing**

Giving more priority to rehousing kinship carers in acute housing need. (In one case the kinship care arrangement had led to severe overcrowding, but a flat previously occupied by the child and birth parent had remained empty for two years while the family waited for an offer of suitable housing.)

**Police**

Improving liaison between the police and the KCT, so that social workers could provide support quickly for children placed in emergency kinship care arrangements by the police. Also enabling children to reclaim their possessions after premises had been searched, if possible.

**Transport**

Ensuring that transport could be provided flexibly, if it was needed to sustain a kinship care arrangement, particularly if a child was disabled or had special needs.
Children with more complex needs
The case file analysis identified a small sub-group of children with early instability in their lives, multiple carers and challenging behaviour. These children and young people would not be easy to care for and had kin carers who seemed unable to meet their complex needs. There were also a few carers who lacked warmth and were very ambivalent about the children living with them. In these situations, children and young people needed more intensive support to be provided on a multi-agency basis.

Contact details and information about the KCT
None of the children and young people had been given a phone number to contact their kinship care social worker. This was a serious problem because they were generally aware of all that was going on, and some were struggling to deal with difficult emotions which they felt unable to share with their carers. Several said they had no one to share their worries with. For this reason we suggested that every child and young person should be given contact details for their KCT social worker, perhaps on a card also containing the number for ChildLine.

We also suggested that the KCT should review how they worked with birth parents and should introduce themselves, explain their involvement and be clear about what parents needed to change to be able to care for their child. However, we also acknowledged that as a small team the KCT would have to decide where to concentrate their resources, especially when there were child protection concerns.

Conclusions and implications for practice
The evaluation found that the work of the KCT in Greenwich fitted the Every Child Matters framework for service provision well and reflected the emphasis in the Children Act 2004 on children being brought up within their own families whenever possible. While it was impossible to state categorically that without the work of the KCT the children would have become ‘looked after’, two pieces of evidence suggested that this was highly likely. First, the case file evaluation found that although 34 per cent of children had other relatives who were spoken to about a potential kinship care placement, the reality was that in almost every case there was only one relative or friend who offered to care for the child. Second, when carers were asked in the interviews what would have happened to the children if they had not stepped in, most thought that the child would have ‘gone into care’.

The evaluation concluded that the KCT was effective in promoting stability for children and young people and reducing the need for them to be looked after by the local authority.

Most significantly, the Greenwich KCT was working with ‘children in need’ and providing support for kinship care arrangements that in 72 per cent of cases had already been agreed informally by family members. This was very different from the approach of the local authorities described by Farmer and Moyers (2008), who in such circumstances generally took the view that the children were not their responsibility and refused payment if the carers later requested help.

While the financial help provided by the KCT was mostly restricted to one-off payments for furniture and clothing, and in some cases a small weekly allowance, it was often what was needed to prevent a kinship care arrangement from breaking down. Indeed, it could be argued that the KCT’s willingness to engage with these families and to provide practical and financial help or advice was instrumental in reducing the risk of the children needing to be looked after by the local authority. This, in itself, represented a substantial saving to the local authority. Figures compiled by the Department for Education and Skills show that in 2006 the unit cost of providing an in-house foster placement was estimated at £633 per week (Department for Education and Skills,
In comparison, the cost per child of having a kinship care service was around £140 per week. Indeed, as most of the sample were teenagers, children’s services might have had difficulty providing an in-house placement and therefore an independent agency placement might have been needed, incurring higher costs.

Another advantage of the Greenwich project was that it aimed to ensure that children and young people did not undergo the experience of being removed from their parents and placed in the care of strangers. The importance of avoiding local authority care is highlighted in an earlier study (Broad et al., 2001), which described the experiences of 50 young people who were looked after by the local authority before being placed in kinship care. This report stated (pp 17 and 18):

Most of the young people had spent time in local authority care and for most this was a traumatic experience. They described frequent moves, feelings of rejection, and an increasing sense of isolation . . . Almost all those who had experience of local authority care described how desperate they were to leave residential or foster care . . . The young people we interviewed did not want to live with strangers . . . For some, the behaviour of adults they had previously lived with – birth parents, foster carers or residential care workers – made them feel unsafe and vulnerable.

The young people interviewed by Broad and his colleagues were very positive about being placed with relatives or friends, and they said that kinship care was about being cared for, belonging somewhere and feeling safe. Our evaluation of the KCT revealed similar benefits. Most of the children and young people had the security and stability of living with a carer who belonged to their family network, knew them well and was committed to caring for them. In most cases they were loved, protected and cared for, and the kin carers showed a high level of commitment to the child, echoing a key finding of Farmer and Moyers’s research (2008). Nearly all the youngsters were living with a carer who shared the same ethnicity, culture, religion and language, and most of them had continuity with regard to their school, their friendships and their surroundings. The outcomes for the children and young people generally appeared to be positive, and despite their previous experiences some were doing very well, particularly at school.

Research shows that looked after children who are rejected by their parents tend to have very poor outcomes (Quinton et al., 1998; Rushton et al., 2001) and a similar finding might have been expected here, given the very high levels of parental rejection. We were not able to quantify the effect of parental rejection on outcomes. However, the interviews with 12 families revealed that at least six of the children and young people felt secure in their placements and loved and accepted by their carers, and were making very good progress with regard to their education. Obviously we cannot generalise from the findings of such a small study, but this would be an interesting area for further research.

Another notable feature of the Greenwich scheme was the good relationship which the KCT appeared to have with many of their clients. Several kin carers said they would be delighted to speak to us because they were fed up with the bad press that social workers usually receive and wanted to give a different view. In other studies (e.g Quinton, 2004) social services clients often report that their first contact with the service was not positive, but in our evaluation carers commented not only on their positive first impressions of their social worker but also on the openness and

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2 Developed from Personal Social Services Research Unit, Unit Costs of Health and Social Care, Canterbury: University of Kent, 2004. This figure does not include management services or buildings, but these elements would not increase the amount significantly.
warmth of administrative staff who answered the phone. Social work assessments were described as relaxed and non-intrusive but professionally and sensitively conducted. Unlike findings from other kinship care research (Pitcher, 1999), there were no complaints about this area of practice and the carers understood why assessments had to be done. Most carers said that they felt respected, valued and well supported, and several children and young people also praised their social workers.

However, issues (Farmer and Moyers, 2008) about kinship arrangements continuing despite concerns about whether the standard of kin care was ‘good enough’ were also apparent in a few cases. Social workers were concerned about these young people and were faced with complex decisions about whether to remove the child when the family wanted the arrangement to continue, and/or when reunification was being planned.

The issue of financial support for kinship carers raised by Farmer and Moyers (2008), Richards (2001) and Broad and Skinner (2005) was also problematic in our study. While carers generally appreciated the limited financial help provided by the KCT, 40 per cent had debt problems and having to provide for an extra child was often a real struggle. Two of the carers whom we interviewed indicated that they could not have continued caring for the child if the KCT had not given them a small weekly allowance.

While our evaluation of the KCT was very positive, we emphasised that their aim of limiting support to a maximum of one year for each family was unrealistic. In many cases long-term support, including financial support, would be required to meet the acute needs of the kinship carers and the children and young people in their care. This issue needs to be urgently addressed by the government because the substantial welfare and financial advantages of enabling youngsters to remain within their extended family cannot be sustained in the long term without adequate financial support for kinship carers.

We would like to make one final comment with regard to this research. At a time when local authorities appear increasingly reluctant to participate in research involving children, we found it very refreshing to be invited by the London Borough of Greenwich to evaluate practice in this scheme. Since the completion of the evaluation, we have been informed that almost all of our recommendations have been implemented, including ensuring children know how to contact their social workers. In a recent email, John Dicks, manager of the KCT, commented: ‘Our aim to achieve permanence for children is coming to fruition in a small but satisfying way.’

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