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Relative Care - Issues for Social Care Workers?

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Introduction

This article is drawn from a PhD research study[1] conducted between 1993-1997 (O'Brien 1997) and further developments arising in the field in Ireland since that date (O'Brien & O'Farrell 2000). It is divided into two sections. In section one, the emergence of relative care is traced, together with the regulatory framework that has developed (Dept. of Health 1995a). A snap shot of a cohort of ninety-two children and their families is presented to give an outline of the persons currently using or involved in relative care in Ireland. This data-set is compared with known international trends.

In section two, the key stages in the evolution of the relative care placements are considered. These stages and associated processes are initial decision-making, assessment of relatives, access arrangements and future planning. Key points that need to be considered by the social care worker at each of these stages are identified. The article concludes by identifying a number of principles that need to be considered for the development of relative care in an Irish context.

[1] Reference in this article to the research study will cite it as 'the study'.

Section One

Relative Care in Ireland: Setting the Scene

The development of formal relative care in Ireland is traced in part to the Child Care Act 1991. Relative care was introduced as a viable care option, alongside foster care, residential care and adoption. The increase in the use of relative care as a formal care option is a more recent development in the Irish child welfare system, though the use of extended family and clan care can be traced back to life under the Brehon laws (O'hInnse 1940). These earlier formal practices lost significance in response to historical changes, but the practice of extended family members informally caring for children continued as a tradition in face of adversity, and evidence of its use is still with us today in Irish society.

The increased use of formal relative care is perhaps one of the most interesting and challenging developments to take place in recent years in Ireland. A number of factors have converged to influence this development, including the preference for foster care over residential care, a shortage of traditional foster parents, greater emphasis on family connection as a means to enhance children's identity, the emergence of partnership as a key principle in child care, and positive research outcomes. However, it may be argued that initial development reflected a value system or an ideological preference for family unity among individual workers, combined with a placement crisis which left little choice except to use this care option. Development was not a result of coherently formulated policy and regulation that provided specific guidance for developing relative care practice.

Prior to the publication of the child care regulations in 1995, (Dept of Health 1995a; 1995b) it was not possible to distinguish between children placed in foster care as distinct from relative care, as both groups of children were recorded as being in the foster care system. This lack of separation of information on the use of relative care was a feature of many international child welfare systems, (Gleeson 1996) and made it difficult to track the rate at which change was taking place precisely. Currently, approximately one-quarter of all children entering care are placed in relative care, though variation exists across the regions (Dept of Health 1999).

Legislative Difference between Foster and Relative Care Regulations.

The distinction between relative carer and foster carer in the Child Care Act 1991, and the subsequent publication of the two separate sets of similar regulations, provides an interesting frame within which to understand the place of relative care in current child welfare practices. Section 36 (2) of the Child Care Act, 1991 states:

> *In this Act, "foster parent" means a person other than a relative of a child who is taking care of the child on behalf of a health board in accordance with regulations made under section 39 and "foster care" shall be construed accordingly.*

The reports of the Dail debates in 1990 pertaining to the Child Care Bill, 1988 give an understanding of this inclusion of the distinction between foster parent and relative carer. There was recognition throughout the debate of the contributions that relatives offered as an option for children unable to live with their own parents. The debate occurred at a time when limited research regarding relative care was available.[2] Strongly-held views welcoming it as a care option were expressed, but reservations were raised as to the potential impact on the provision of informal care-giving, and the resultant potential cost for the state. These views were due in part to a long tradition in Irish society of informal care within families, which was shaped by our particular economic, social and cultural history.

The financial implications of introducing placements with relatives as a care option remained central to the debate. This aspect of the debate reflected an underlying ambivalence surrounding the financial consequences for the state of legitimising relative care as a placement option within the care system. The ambivalence centred on the reluctance of the state to encourage unnecessary dependency, or to finance informal family arrangements made in respect of child rearing, while recognising that some children needed to be cared for by the state (Dail Report, 1990: 662). Further evidence of the ambivalence towards relative care was demonstrated in the attempts made to devise structures outside the foster care system to finance relative placement. The community welfare service[3], administered by the Health Board on behalf of the Dept. of Social Welfare, was examined as an alternative to including relative care as part of child care

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2 Research was limited, and the studies of Thornton (1987); Dubowitz (1991); and Rowe (1984) are generally referenced as the early influential studies in the field. Research is still rather limited, with the majority of studies conducted in USA where this care option has been used for increasing numbers of children since the late 1980's. Two recently published books now add to the knowledge base on relative care (Greeff 1999 and Broad 2001)

2 Up until the early 1990s in Eastern Health Board, the Community Welfare Service was used to finance a number of relatives caring for children. Financial help was generally provided until such time as a formal fostering assessment was completed. The relatives would then be incorporated into the foster care system. The community welfare service was also used to provide financial help to some relatives if the Board considered that the relatives might not satisfy the necessary conditions to be approved as a foster parent. Two major difficulties were seen for relatives, if financed by this service. Firstly, they had to satisfy a standard means test to be eligible for supplementary benefit, and secondly, if eligible, the maximum allowance available under the community welfare scheme was substantially less than the fostering allowance. The community welfare service withdrew from

system within the health boards. This proposal was, however, not incorporated in the final draft of the Child Care Act, 1991 and the decision was made to administer foster care and relative placements within the Dept. of Health / Health Boards. The strong emphasis in the debate on financial considerations was identified by the politicians, though it was stressed by speakers that the reason for the distinction between relative and foster parent was not for "financial reasons .....but for sound practical reasons", and to avoid unworkable and cumbersome regulations, particularly in relation to assessment. (p. 662). While the inclusion of relatives was eventually seen "as an enlightened approach" (p. 655), attempts made to prioritise placement with relatives over other care options failed to get adequate support to be accepted, though this was not pushed forcibly at the time (p. 663). Therefore the separation of "relative" and "foster parent" in the Child Care Act, 1991, and the subsequent making of two sets of regulations can be seen to reflect an ambivalence surrounding the placement of children with relatives. Furthermore, in this research study, it was found that financial considerations and the underlying ambivalence surrounding the financing of family members to look after their own remain a central feature of the current relative care system.

Relative Care Regulations 1995

The 1995 Regulations set out a framework for relative care practice, which includes the promotion of the welfare of the child, pre-placement procedures, monitoring of placements and removal of children from placements. The regulations went some way towards providing a clearer and more concise structure for those involved in the placement of children in alternative care than was available in earlier time. The main significant changes in the placement of children from the 1983 to the 1995 foster and relative care regulations are:

- The **best interest of the child** is identified as priority. (Article 4)
- A **care plan is required** for each child.(Article 11)
- The **duties** of foster parents and relatives are clearly specified. (Article 16)
- The introduction of mandatory **support services**, pre-placement and in-service **training** recognises foster parents and relatives need for services. (Article 15)

financing relatives in the 1990s, as they saw it as the responsibility of the child care service within the health board.

- The re-emphasis on **review** meetings as a forum for making and evaluating care plans with provision for the **active invitation** of all involved in the child's life to attend. (Article 18)

- The extension of **ministerial inspection powers** to monitor the system. (Article 25)

- The overall **partnership ethos** underlying the regulations designed to support "the best interest of the child" and " the inclusion of the child's view".

Comparison of the Two Sets of Regulations

In reviewing the development of relative care in Ireland and its place in the care system, it is instructive to look briefly but specifically at the differences and similarities between relative and foster care regulations. The extent of similarity in the layout; content and language of both relative and foster care regulations is most striking on comparing the two sets of regulations. Only minor differences exist between the two, as set out in **Table 1.**

Differences in Foster Care and Relative Care Regulations.

Article	Regulations	Subject	Difference
3	Relative	Definition of relative	Omitted in foster care regulations
6	Relative	Emergency placement and assessment	Omitted in foster care regulations
5. 5	Foster care	People with training and expertise to be included on committee, generally accepted to mean foster parent.	Omitted in relative regulations
7	Foster care	meet needs of child/ matching	Omitted in relative regulations
27	Foster care	Placement of child with person on panel of other Health Boards.	Omitted in relative regulations
14	Foster care Relative	Foster and financial allowance	Same allowance, different name

The main difference refers to the definition of both sets of carers. A relative carer cannot be referred to as a foster carer. Relatives are defined widely and 'relative' includes the spouses of a relative of the child and a person who has acted in loco parentis. This is intended to enable a health board to place a child with a person who has an existing

relationship with the child; for example through marriage, co-habitation, adoption or friendship (Dept of Health 1995a). A second difference is the inclusion of a provision through which a health board can make an emergency placement with a relative prior to the full assessment of the carer. This provision does not extend to a prospective foster carer. The specified composition of the approval panel for relative and foster carers raises another difference. In the foster care regulations health boards are to consider including people (generally accepted to mean foster parent) with training and expertise in foster care (other than professionals) on the approval committee. No reference to the inclusion of a relative is made in the relative care regulations. This may have longer-term implications, as relatives' voice may be absent from committees that are involved in making key policy decisions and devising quality practice guidelines in health boards. A fourth difference is found in the terms used to describe the financial supports. Although the definitions are the same, the foster carer receives a 'fostering allowance' while the relative carer receives a 'financial allowance'. This difference raised some reservations initially, as it was feared that this would facilitate differential payment systems to be introduced later. However, this has not happened, and there are no indications that this is a policy direction that the government is likely to take. The fifth difference relates to the foster carer's scope to extend services to children who are living in other health board areas. This facility is omitted from the relative regulations. It is interesting to postulate on why this distinction was made. Did the legislators think that it was unlikely that children from a family may be in different geographical areas or health board jurisdictions at the same time? The last difference refers to the process by which the foster carer and the child are matched. This process is stipulated for the foster carer, but no reference is made to it in the relative care regulations.

To conclude this comparison it can be seen that there are only minor differences between the two sets of regulations, although these extend to twenty-five sections each. As they deal with what many consider to be the same subject matter, the question may be posed as to what the objective or purpose was in having separate regulations for relatives and foster parents? Furthermore, in what way, if any, does this separation assist in determining the type of system which relative care needs to develop? The type of services and case management structures required for relative care remains a central issue, and this is particularly relevant when the profile of children and the relatives are considered.

Profile of Children and their Families

The biographical information on the birth families in the study reflects a population that is characterised by poverty, as indicated by high dependency rates on social welfare, housing status and lives blighted by addiction and inability to cope. These findings

show many characteristics similar to children in the general care population in Ireland (Richardson, 1988; O'Higgins 1996). The children's age, reason for care, and high number of siblings placed together, reflect international trends (Rowe et al 1984; Dubowitz et al 1991, Thornton 1987, Berrick Barth & Needell 1994; Iglehart 1994).

Care Careers of the Children

The childrens' care careers show that, for over half the children in relative care, the current placement was their first experience with the care system (57.6%). Of the remaining children who had previous care experience, the majority were moved from within the care system to the relatives. The high number of children (63%) in relative care on the basis of court orders reflects national trends (Dept of Health 1992) and known international trends (Rowe et al 1984; Dubowitz et al 1990, Thornton 1987, Berrick Barth & Needell 1994; Iglehart 1994). The longer period of time which children stay in relative care is identified in the literature as a key issue with policy and practice implications. The study showed that four out of every ten children (39%) were in relative care for longer than three years. This information would be more meaningful if it had been possible to compare the length of time in the placement with the initial care plan, and placement decision-making.

One of the cited advantages of relative care is the greater opportunity it provides to keep siblings together (Johnson 1995). The study showed that two-thirds of the children had siblings placed with them, or within the extended family network. Only four children were placed with relatives who also fostered non-related children, and this gives a picture of relative carers as principally fostering children from their own families. While relatives are an important resource to the agency in facilitating sibling unity, the study also points to the resource implications required to support multiple placements.

Over half the children (58.7%) were living in relatives' homes where the assessment process had been completed. The length of time to approval was generally between seven and twelve months. The failure to achieve the approval in the twelve-week period specified in the Regulations has implications for the agencies, and also seriously impacts on the relative's access to support structures.

Characteristics of Relatives

The profile of the relatives in the study was similar to international studies in terms of having low-income levels. While slight variation existed in the age structure of relatives compared to international trends (Rowe et al 1984; Berrick et al 1994; Iglehart 1994), the relatives were on average older than the traditional foster carers approved by the agency. The children were predominantly cared for by relatives on maternal side of the

family, with maternal aunts providing care in the greatest number of instances. While maternal aunts featured also in international studies (Task Force 1990; Dubowitz 1993; Thornton 1987), grandparents provided a greater proportion of the relative carers in the US studies. This difference may be partly explained by the different family structures in the two countries, with larger family size being a feature of Irish society. The study showed that the relatives are predominantly married, which again is at variance with the international trends outlined in the above studies. However, when compared to a profile of the foster parents approved in the agency (Conway 1991), the number of children placed in families headed by single parents was higher in relative care. This reflects a departure in policy in the agency in which the study took place.

Section Two

Phases in relative care placements, and key questions for the social care worker

Key research findings based on the identified phases of (a) initial decision-making to place the child in the relative home, (b) assessment of the relative home, (c) contact and (d) future planning are now considered (O'Brien 2001). Under each of these four headings a number of particular practice issues which may concern or which may have relevance for the social care worker are identified.

In this exploration, the differences and similarities between relative and foster care practice are highlighted. The difference in the way in which both sets of carers connect to agency is of particular importance, as is the existence of previous family connections, the motivations to care and the profile of the groups. The similarities between the foster and relative carers are that both care for a group of children who have special needs. Also, compared to the agency, both occupy a less powerful place in the system, and both lose autonomy over their own lives by virtue of becoming involved in a structured and regulated care relationship.

Decision-Making

The means by which relative carer parents become involved generally arises out of a crisis for a member of their extended family. The relatives respond to a set of pressing circumstances involving a dependent child. The situation is brought to the attention of the child welfare agency. As part of the initial situation assessment the availability of informal help is examined, and preventing the reception of children into care is the first priority. If care is required, the feasibility of relatives providing a placement for the child is discussed between the child welfare agency and the family. In the main, it is the agency that approaches the family, asking them to consider formally fostering the child. If the decision is made by the child welfare agency to place the child with relatives and the relatives are in

agreement, the placement is made following an initial risk assessment involving checking references, police check etc. The detailed formal assessment process generally then takes place while the child is in situ.

On the other hand, prospective foster parents approach the agency for information regarding the task of fostering. If interested, they are provided with training on what is involved. Their suitability and readiness for the task is discussed and following completion of a formal assessment process, a child is placed with the foster family when the need arises. The preparation/ assessment process culminates with the placement after the agency and prospective foster carers enter a contractual arrangement.

In the study, it was found that the families who become relative carers are motivated to care for the children by a wish to either rescue the child in the event of the child being in the care system already, or to keep the child from entering an anonymous care system. This finding is similar to Thornton (1987, 1991) & Berrick et al (1994). The level of caution among relatives, already informally caring for children, to agreeing to become foster parents for the agency, was seen. Many had no alternative in seeking to secure adequate financial help, or were trying to protect the child in the event of a deteriorating relationship between the relatives and the birth parents.

Tensions were evident at the decision-making stage which need to be considered. These include the difficulties for the relatives in approaching the agency, the hesitancy among social workers about the risk assessment model used, and the birth parents annoyance at the relatives for contacting the agency. Birth parents annoyance was heightened if the relatives had previously been involved in caring for the children as part of a private arrangement. Certain factors were seen also as contributing to difficulties not being identified or articulated. These included the speed of placement, the lack of opportunity or commitment to network with other relatives or to address the concerns and make plans with the family as a group. Also noted were the lack of specific skills among front-line workers to conduct network and family meetings and to manage conflictual relationships. These factors in the early stage are all identified as contributing to the difficulties that may unfold later in the management of the relative placement.

Issues for the Social Care Worker:

A number of key questions arise at the initial decision-making stage (when either moving a child into the care system or moving the child within the care system) for the social care worker to address. These are set out below, and should be seen in addition to the processes identified above:

- What are your views on relative care placements, and how might these impact on how you consider relative care?

- Do you see relative care as essentially a positive idea, or have you seen cases that have not worked, and therefore you are a hesitant to pursue it?

- Does the research evidence substantiate your position?

- In your line management and among your multi-disciplinary colleagues who would you have to work on to persuade to consider relative care as an option?
- Who are your allies for this care option?

- In your work experience, are placement options chosen/ selected primarily out of expediency. As a result, are the child's social and family network fully/ adequately explored or utilised?

- If so, what can you do at an agency or individual level to create change in this practice?

When faced with responsibility for having an input into care-planning for an individual child:

- Do you know the child's family and social network?

- What are their connections in the community including school, friends & interests?

- What is the history of the child's connections with their network?

- Who has a special interest in the child now/ past?

- Are there other people not related, but who could be of assistance?

- If you do not know, whom do you need to consult to assist in this information gathering process?

- Do you have ways in which you can include the child helping you recognise their family and social network?

- What is the child's willingness to commit to living with a relative family in general, and does the child have a particular choice?

Assessment:

The vast majority of children entering relative care do so in an emergency. In so far as the child's care needs are examined, an initial assessment is made, the child is placed and the full assessment of the relative carers is completed after the placement is made. The regulations provide for this emergency placement, but stipulate that this assessment process should be completed in a 12-week period after the placement. The study showed that few of the assessments were made within this stipulated time frame. This was a finding which had major implications for all the parties involved.

The study showed that the protracted nature of the assessment process, and the co-existence of multiple roles and tasks for the social worker during the assessment stage is a particular characteristic of relative placements. This was found to compound the difficulties for both the social workers and relatives. It was evident that the model used to assess relatives is a replica of the assessment approach and model used with traditional foster parents. Super-imposing this model of assessment in relative care was seen to be inappropriate. The process by which the relatives become connected with the agency, the different demographic profile of the relatives, the fact that the child is already in place, and the family connection between relatives, birth parents and children are not provided for in the traditional foster care model. The traditional framework was developed to prepare stranger foster parents for a hypothetical child at an imagined future date, which is very different from the characteristics of the relative placement.

Issues for the Social Care Worker:

The social care worker is unlikely to be involved in completing the assessment of the relative home, but they may be involved in working with the child and/ or their birth family. One of the main issues to be considered at this stage is the possibility that the child may feel insecure, especially if the assessment process is protracted. Likewise, the relatives may feel restricted in requesting assistance either for themselves or for the child, as they may be afraid that requests for help could be interpreted as them not coping. Ways have to be found to normalise the process of seeking assistance.

Other central issues which needs to be addressed are

- What frameworks are needed to assess the relative home, and what decision-making tools are required?
- What support structures need to be in place?

- Should the assessment take more account of approach of the needs of all involved i.e. child, birth parents and the relatives, rather then focusing primarily on the relative home in isolation?
- How do current case management systems, which operate primarily in the foster care system, need to change to incorporate co–working, family meetings and a general move from a role-based definition of work towards tasks that need to be completed?

Contact:

The third juncture which is explored is contact between the child and the birth parents. It is likely that the social care worker will be centrally involved in this process, through their role in devising contact plans, and/ or facilitating and supervising the arrangements. In the study, it was shown that contact is seen as the barometer by which the level of tensions in the network of relationships is evident [4]. The themes of competence and incompetence, loyalty and disloyalty, affection and anger, control and loss of control are played out in the arena of contact in the network. If cordial/ harmonious relationships exist between the family members, and the agency is satisfied that the child protection needs are safeguarded, the family members are usually given a clear mandate and encouraged to organise contact themselves, with the agency providing an overseeing role.

In the networks where contact was problematic, the difficulties were seen to evolve over time, but were not in existence when the placements commenced. The difficulties reflected disagreements over the care plan and conditions imposed on contact, and were connected with the fundamental questions of "who owns the child" and "who is in control". The stories surrounding contact in the networks highlighted many difficulties that hindered trouble-free contact. The principal difficulties for the birth parents were associated with not fully understanding or agreeing with the plan/ system in place. The birth parents showed limited appreciation/ insight about the way their addictions and mental health problems impacted on the negotiations. They felt increasingly marginalised, shut out and distanced from their children as problems arose. Where contact was difficult, the relatives found that their patience was seriously tested, and many felt their tolerance of the birth parents had reached breaking point. The relatives expected the agency to invoke controls to safeguard the placement and to exert control when this point was reached. The children generally felt that the relatives were supportive of their wishes. Frequently the agency intervened with more rigorous contact

4 In the study the views of the birth parents, relative carers, children and social workers were obtained and the analysis of the data led to the development of a typology of different relative care placements (Grief 2000). Reference to the network of relationship draws on this data.

conditions in an attempt to ameliorate growing conflict. These restrictions sometimes further compounded the difficulties, leading to a system fraught with distance, conflict, exclusion and unhappiness.

Practice Issues for the Social care Worker

While case management practices in relative care should aim at avoiding the emergence of the types of conflict which may surround contact arrangements, it also needs to consider the potential for the exclusion of any member of the network. The challenge is the development of services and practices which facilitate the meeting of different perspectives, and within which the different accounts, aspirations and fears can be shared.

- If difficulties arise, for whom is this a problem?

- What are the different participants' views of what is needed to resolve the difficulties?

- Are agendas that belong to different domains impacting on the contact arrangement? If so, can they be separated out?

- Are the criteria on which contact plans are based relevant? (It is not uncommon to find contact arrangements continuing to build on old plans long after the plans changed – eg, the need for the drug-addicted parent to give evidence of clean urine prior to allowing contact to go ahead. In this instance, this criteria was relevant when it was fundamental to the reunification plans in place. However, long after the reunification plans were abandoned, this remained as a condition for contact). What do you think the impact of this criterion would be on the frequency of contact?

- How appropriate are the contact premises, and do facilities minimise or escalate the tensions during the contact?

- Are there sufficient materials to assist the children and the parents to communicate in a way that is helpful to both i.e. what are their favourite activities together?

- If there are tensions in the contact arrangements, are there tensions in the multi-disciplinary team that need to be first sorted out?

Future Plans

The final juncture of the relative care placement now considered is the place of the future planning. In comparing the literature of relative care with traditional foster care, the major issues which emerge are that placements last longer, and reunification rates are lower (Dubowitz et al 1993; Link 1996; Ingram 1996). The majority of relatives also show an unwillingness to adopt (Thornton 1991; CWLA 1994). The study did not specifically examine reunification rates, but focused on future plans with the participants to obtain an understanding of the evolving networks. In summary, relatives were resigned to rearing the children in their care to adulthood, as they were committed to the children. In the relatives' discussion of the future, they knew that the children had a preference for growing up with their own parents, but they were realistic that this was not a possibility in many of the networks. Sometimes this was at a huge cost to the relatives themselves, but they were prepared nonetheless to keep going. This motivation, which is undoubtedly connected with a sense of obligation and loyalty associated with being "family", is one of the great strengths of relative care, and perhaps accounts for the greater stability of relative care compared to other care options.

Planning and Practice

- Is the long-term plan in place in the child's interest? On what basis are you making this decision?

- Is there a need to divert very stable relative care placements that are in existence for a long time into a separate system where financial and other supports are available, and yet the child can live as normal a life as possible? (Many children in relative care do not see themselves as in public care).

- Have the birth parents received adequate services to assist them towards the goal of reunification?

- Are services still available to them, even if the future plan is for the child to remain in the care of the relative?

- Are sufficient services directed towards working with the different participants in dyad and triad groups, as well as individually? (Frequently within the care system, individual professionals work alongside individual players, and the only forum for larger group interaction is in the very structured context of reviews, which have a very particular focus).

- Are you aware that the network of relationships is an evolving, dynamic system in which you are a player, and as a player you are centrally involved and not merely a discreet observer of unfolding processes?

Conclusion

In this article the emergence and evolution of relative care was explored in section one. In section two, key findings from the study related to decision-making, assessment, contact and future planning were highlighted. Questions that may be relevant for the social care worker were raised.

In considering the place of relative care in the child welfare system and the place of the social care worker within it, it is important to re-iterate that, as relative care has expanded, it has been developing within the existing foster care system. This system is itself characterised by multiple challenges in terms of meeting children's needs, recruitment and retention of foster carers, role confusion, and placement breakdown (IFCA 2000). This is a situation portrayed similarly in Berridge's review of international foster care literature (1997).

There are a number of frequently expressed concerns surrounding relative care, such as protection needs, service provision, reunification rates, financial equity and applicability of the traditional foster care system (O'Brien 1997b; 2000c) which will need to be addressed into the future. In addressing these particular issues, a central question remains. This is should relative care continue to develop within the current foster care system? Another possibility is to develop a separate system to take account of the many differences that exist between these two care arrangements. This debate has taken place principally in the USA, where formal relative care first developed, but there is now a need for it to occur here in Ireland. It was regrettable that in the recent review of foster care (Dept of Health and Children, 2001), greater prominence was not given to this question.

The system chosen for managing relative care into the future will need to take account of many of the issues raised in this chapter. It will also need good coordination and communication structures, as well as skills development in place to address the challenges. In the meantime, it is important to emphasise the principles upon which relative care programmes should be built upon. Many of the principles identified are already incorporated in programmes in child welfare agencies. If applied specifically to the relative care services, the ability to meet the needs of the different participants involved in relative care should be enhanced. The important principles are:

- Families have the **capacity to protect** children who cannot live with their birth

parents, and they have the capacity to make workable plans. The emergence of family group conferencing as a practice approach reflects this development (O'Brien 2000b)

- Children who are unable to live with their own parents should be given an opportunity to live a life style similar to their peers, **(Normalisation)** which means minimum disruption to their lives, and being placed with people with whom they have connections.

- Children should be consulted, when making care plans, and ultimate decisions should be made **'in the best interests of the child'**

- Professional/ agency workers have a wealth of **knowledge and practice experience** to be tapped to benefit families and children in need of alternative care. However, they also have an ethical responsibility to examine the ways in which their knowledge is professionally enclosed, and how this influences them when presenting 'expert' opinions, particularly as it relates to assessment.

- The stigma of statutory intervention, particularly where state care is seen as negative and dis-empowering for families and children, must be removed by developing systems based on **respect, collaboration, and accountability.**

- **Partnership** should underpin relative care. Unless strenuous effort is put into examining the contradictory discourses surrounding relative care, the inherent difficulties of partnership in terms of power differentials may be masked.

- Systems for managing relative care networks must have as a primary aim the **amelioration and diffusion of the strains** in the relationship between family members. This will mean less marginalisation and humiliation for the birth parents.

In the meantime, a wider debate is needed as to which case management system best serves the needs of the different participants. Social care workers undoubtedly will have a major input into the outcome.

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