How did formal kinship care emerge as a significant form of placement for children in care? A comparative study of the experience in Ireland and Scotland

Highlights

- Formal kinship care (FKC) has emerged as a critical part of many care systems.
- FKC is often 'first option' for children who can no longer live with parents.
- One in four children in care in Ireland and one in three in Scotland lives in FKC.
- Priority for FKC reflects a belief in the value of the child belonging to a wider family.
- FKC emerged as a pragmatic response to families' need identified by social workers.
- Limited availability of residential care and foster care led to the increasing use of FKC.
- Policy and legal measures gradually consolidated FKC in Scotland and Ireland.

Abstract

A notable development in child welfare provision in recent decades has been growth in certain jurisdictions of formal kinship care as a type of placement for children needing 'out of home' care. This trend raises the question of why formal kinship care has emerged in such a marked way in this period in some contexts. This paper sets out to explore this issue by investigating the emergence and development of formal kinship care in two neighboring jurisdictions in Europe where it now accounts for a substantial proportion of all care placements in Scotland and Ireland. The paper sets out a conceptual framework that considers the emergence of formal kinship care against the backdrop of the overall care systems in both jurisdictions and the wider set of societal kinship care practices relating to children. It traces key policy developments in the evolution of formal kinship care in both systems. It reviews policy challenges and influences that may help to account for the emergence and current

relative importance of formal kinship care. This comparative case study aims to contribute to international debates about the development of formal kinship care.

Keywords

Kinship care; relative care; looked-after children; Scotland; Ireland

1. Introduction

For centuries, where families have faced separation and disruption, grandparents, aunts, uncles and older siblings, as well as close friends and neighbors, have stepped in to play an important role in caring for children. In anthropological terms, kinship care is the 'upbringing of a child by kith and kin, non-blood and blood-related relatives, tribes and friends' (Broad, 2007, p. 59). This definition includes both 'informal' kinship care arrangements made by families and 'formal' kinship care where the state is involved in approving and monitoring arrangements and providing financial support. Globally, kinship care is the most common form of alternative care for children not currently living with parents, arguably because of its relatively low cost and popularity among families and across cultures (EveryChild and Help Age International, 2012). Several writers have described the increasing use of formal kinship care by government agencies in different countries, including the UK and Ireland (Aldgate, 2009; McCartan et al., 2018; Munro. & Gilligan, 2013), New Zealand and Australia (Connolly, Kiraly, McCrae, & Mitchell, 2017), and USA (Ching-Hsuan, 2018). Explanations for the growing use of formal kinship care placements include the general preference for family-based care in social work practice (as opposed to residential / institutional care), and the requirement in certain jurisdictions to consider relative placement before non-relative foster care or residential care, often with statutory protection (Brown & Sen, 2014).

This paper examines the origins and development of formal kinship care in Scotland and

Ireland, two countries with different political and societal contexts, but of similar population size, and with some shared history, and many cultural similarities.[1] Both countries mirror the increasing importance, globally, of formal kinship care as part of the State involvement in the care of children. They serve as useful comparative case studies as there are inevitable differences in context and policy responses, with the lens of comparison helping to explore reasons for the growth of formal kinship care in these two jurisdictions in recent decades.

2. Background

Pitcher has identified five characteristics of kinship care: the child is cared for within his or her own family network; care is full-time; the care relationship is long-term; it is a response to family adversity or upheaval; and it can be 'formal' (arranged by the state or its representative) or 'informal' (arranged by the family) (Pitcher, 2014).

There are variations in relevant 'local' terminology and meaning across different countries. For example, the term 'kinship foster care' may be used to distinguish care as a formal placement by State agencies (whether or not there is remuneration in salary or allowances) from private, 'informal' arrangements made within a family and without legal agreements. Such variation in understanding is also reflected in the fact that some studies have examined exclusively care by blood relatives, or 'kin' (Nandy, Selwyn, Farmer, & Vaisey, 2011), while others have included care by both family members and friends (Aziz, Roth, Lindley, & Ashley, 2012). In Ireland, the term 'relative care' typically describes a formal care placement, whereas relative care in Scotland more usually refers to informal kinship care (Selwyn. et al., 2011). While the term kinship care is used widely in professional circles, its use 'is not

[1] Ireland refers to the independent Irish state and does not include Northern Ireland.

common in ordinary language, or indeed among "kinship carers" themselves' (Pitcher, 2014, p. 17).

Kinship care is an ancient response to urgent child caring in many cultures, but as a formal State-endorsed arrangement it is a relatively modern phenomenon in western countries like USA and Australia (Winokur, Holtan, & Batchelder, 2015). Several authors have highlighted the growth in the formal engagement of extended family in caring for children unable to stay with parents. For example, it has been suggested that kinship foster care has become 'the fastest growing form of child placement in several countries around the world' (Hong, Algood, Chiu, & Lee, 2011, p. 863), while Connolly et. al. (2017) reported statutory kinship care providing around half of all out-of-home care in Australia and New Zealand.

Various factors appear to contribute to the increasing importance of kinship care in many countries (McCartan et al., 2018; Munro & Gilligan, 2013).

- higher numbers of children entering care;
- the preference for family-based care;
- substance abuse affecting parents' capacity to look after their own children;
- high demands on fostering services and difficulties in recruiting foster carers;
- relatively low cost;
- the decline of residential care;
- the development of legislation and regulations to formalize and regulate kinship caring.

The main advantages of kinship care are seen as relating to emotional permanence where children maintain family ties, have a stronger sense of identity, secure stability and have an increased possibility of the child remaining in the same school and community (Broad 2001, Burgess et al, 2010 & Dill, 2010). In a study for the Joseph Rowntree Foundation, Broad et

al. (2001) found that young people were overwhelmingly positive about kinship care, feeling loved, settled and safe within a family environment they understood. Perry et al. (2012) compared the stability of kinship and foster placements in Ontario, Canada, and found that foster placements were four times more likely to end within the first month. Kin placements were also more stable in subsequent months. In the Farmer and Moyers' English study (2008), the majority (93%) of the children in kin placements were set (according to their care plan) to remain in their placement until they reached adulthood. In contrast only 61% of the unrelated foster placements were planned as long-term, while 21% were planned as short-term. Significantly more of the kin placements were close to the child's family home, with 65% of kin placements near the parental home, compared to 46% for foster care (Farmer & Moyes, 2008). There may also be advantages for the child in respect of mental health and well-being (e.g. Winokur et al., 2015), but some authors point out that research evidence on this point is somewhat inconclusive (e.g.Cuddleback, 2004).

There are many challenges facing kinship carers including providing care at short notice and in times of severe crisis, negotiating tensions with the child's biological parents, establishing relationships with statutory services and seeking to get help for a child (or children) who may have complex health and educational needs (Aldgate, 2009; Black, 2009; McCartan et al., 2018). Analysis of UK census 2001 and 2011 data found children in kinship care families are disproportionately living in the poorest households and compared with parents, carers reported being in poorer health, have lower income, lower grade occupations and live in social rented accommodation (Nandy et al., 2011; Wijedasa, 2017). Studies with caregivers have found disadvantages for the child where grandparents experience psychological distress because of poverty and poor support (Gleeson, 2014; Kelley, Whitley, Sipe, & Crofts Yorker, 2000). Furthermore, there are circumstances where kinship placements may be used too

readily and with less rigorous assessment than would be usual when planning foster care placements (Uliando & Mellor, 2012).

3. Method

The value of the comparative approach lies in the opportunities afforded to the authors (two based in Scotland and one in Ireland) to use the broad cultural similarities of the two countries as a constant backdrop, allowing differences in policy and practice to prompt questions about the functions of formal kinship care. Such questions help in understanding whether formal kinship care as part of child welfare provision has developed in these two contexts more through imaginative innovation or accidental reform. The conceptual framework underpinning this study emerged from questions derived from a series of initial discussions held by the authors as we sought to understand better the 'drivers' behind the growth of formal kinship care in our two countries.

Two key questions emerged from our initial review of the emerging issues.

1. How did formal kinship care emerge in Scotland and Ireland?
2. Why has formal kinship care become an important placement option and why has it developed at a given time in history?

The inter-country dialogue continued, using the framework questions as a guide to further reading. The authors reviewed national policy documents about kinship care in Scotland and Ireland. We used published statistics and, where necessary, contacted government statisticians to clarify definitions and details in statistical reports. In addition, the authors held informal consultations with six key informants (three in each country), all senior social work officials or academics who held knowledge of the history of formal kinship care within child and family welfare provision in Scotland and Ireland. The main reason advanced in national

literature and policy documents for children becoming looked after / placed in kinship settings is because their parents are unable to care for them adequately. Precipitating factors cited include 'substance abuse, mental or physical incapacity; domestic violence; imprisonment; teenage parenthood; parental separation or death' (Hunt, 2018, p. 176).

4. Formal kinship care in Scotland

The population of Scotland is the highest it has ever been at 5.42 million people, of which just over one million (19%) are aged under 18 (Registrar General for Scotland, 2018). Constitutionally, Scotland is one of the four 'nations' which form the United Kingdom (UK), the others being England, Wales and Northern Ireland. Scotland is also one of three legal jurisdictions in the UK (England and Wales constituting a single jurisdiction); the applicable 'Scots law' governing social care and family life in Scotland has developed independently, having its origins in an ancient, pre-Union (i.e. pre-1707) legal system. Since 1999, there has been devolution of government within the UK, with significant powers ceded by the UK Parliament in London to the Scottish Parliament in Edinburgh and to assemblies in Cardiff (Wales) and Belfast (Northern Ireland). The Scottish Parliament has powers to legislate in 'devolved' matters, including education, housing, law and order, health, social services, and some aspects of income tax and social security.

The Children (Scotland) Act 1995 is the primary legislation for the care and protection of children in Scotland. The Act introduced the term 'looked after children' to refer to children provided with both out-of-home care and supervision while living in the family home. There was no reference to kinship care as a formal placement for looked after children in the associated Regulations and Guidance for the operation of the 1995 Act.

Being looked after in Scotland means that there is formal intervention in the child's care, either 'compulsory supervision' by social services while the child remains in the family, or

the provision of out-of-home accommodation with a care agency. At 31 July 2017, there were 14,897 children looked after by local authorities in Scotland (Scottish Government, 2018). In numerical terms, family foster care was the most significant placement type at 36%. Formal kinship care accounted for 28%, while 25% were supported in compulsory supervision while living with one or both parents, and 10% were living in residential (group care) placements. The remaining 2% includes children awaiting adoption.

There has been a steady growth in the use of kinship care as a placement choice for children in care in Scotland. Formal kinship care placements accounted for less than 10% of all looked after children in the years between 1984 and 1999 (personal communication with Scottish Government statistician), followed by a steady rise to 28% in 2017 (Scottish Executive, 2003; Scottish Government, 2018). If the Scottish category of compulsory 'home supervision' (looked after at home) is removed from the figures, to leave only children in out-of-home care, these proportions would be higher – approximately 22% in 1984, rising to 37% of all out-of-home placements in 2017. That is, more than one in three children in Scotland living in out-of-home care are now in formal kinship care placements.

The total number of children living with relatives or family friends in a formal kinship care placements in Scotland was 4,138 at 31 July 2017 (Scottish Government, 2018). There is considerable variation among Scotland's 32 local government areas (counties) in the use of formal kinship care. West Dunbartonshire (a mainly rural county geographically to the west of Glasgow) had the highest proportion of children in formal kinship care at 61% of children in out-of-home care. At the other end of the scale, Falkirk (a town in central Scotland) had 19% of children in out-of-home care, while the smaller northern island communities of Orkney and Shetland had fewer than five children in a formal kinship care placements in 2017. Furthermore, there was also considerable variation in rates of children in out-of-home care placed in formal kinship care among Scotland's largest cities: Glasgow (49%),

Edinburgh (30%), Dundee (27%), and Aberdeen (23%) (calculated by authors from Scottish Government, 2018).

In Scotland, throughout the 1980s there was an increased prevalence of illegal drug use in inner cities, most notably in the largest city, Glasgow, and the capital, Edinburgh. This predominantly involved a younger population who subsequently had children, and this in turn typically led to child welfare concerns. Gradually, a pattern emerged of areas of high problematic drug use having higher rates of children looked after by relatives, a critical issue continuing to influence kinship care rates in the 2000s (The Fostering Network and BAAF Reference Group, 2009).

The original (and increasing) use of formal kinship care in Scotland is thus arguably strongly linked to child welfare concerns about children in households in crisis. This relates principally to the context of substance misuse (Black, 2009), as well as to childhoods characterized by chaos and volatile relationships with parents, such that children 'contrasted their lives at home with the sanctuary of the kinship household' (Aldgate, 2009, p. 56). These concerns also arose at a time when the numbers of foster carers and residential care placements were proving insufficient to meet the level of need, factors discussed more fully below. Two reasons for formalizing such formal kinship care arrangements (i.e. as opposed to more informal arrangements) also emerged: first, the benefits of remaining in touch with birth families rather than being placed with strangers (Hunt, Waterhouse, & Lutman, 2010); and, second, that many children in kinship care would otherwise be looked after in more costly non-relative foster or group care setting and so the lower costs (only relevant in Scotland) may have been attractive to state agencies (McGhee et al., 2017). This second point led our Scottish informants to express concerns that financial considerations could conflict with the best interests of the child. A further complicating factor relates to the rights of kinship carers to social and emotional support, and financial allowances in parity with foster carers. In

Scotland, this has been problematic because of the complex interface with the state benefits system reserved to the UK government and because of variations in local policy and interpretation of statute among Scotland's 32 local authorities (Equality and Human Rights Commission, 2016).

During the 2000s there was consolidation of care by relatives as a significant part of the Scottish care system, and as we have seen, now accounting for over one in three children in out-of-home care placements. There has also emerged a strong policy emphasis promoting kinship care in Scotland following a national consultation on foster care and kinship care, *Getting it Right for Every Child in Kinship and Foster Care* (Scottish Government, 2007). There were two policy imperatives identified in the report: providing a child-centered approach to kinship and foster care; and supporting high quality kinship and foster care, based on the guiding principle of preferring family-based care:

> Unless there are clear reasons why placement within the family would not be in the child's best interests, care within the wider family and community circle will be the first option for the child (Scottish Government, 2007, p. 3).

To progress this ambition, the British Association for Adoption and Fostering (BAAF) and The Fostering Network supported the program *Moving Forward in Kinship and Foster Care*, with a task group focused on the assessment and training needs of kinship carers (The Fostering Network and BAAF Reference Group, 2009). The work included addressing the training needs of kinship carers, developing assessment guidelines for the kinship carers of looked after children, and considering existing models of good practice for kinship carers.

Another trend in recent years has been an increase in the political attention given to formal kinship carers by emulating foster carers in becoming organized via local and national

support groups. Leading child welfare social worker, Anne Black, noted some years ago that: 'kinship carers in Scotland have become more visible; their numbers are rising and several strong support groups have been formed that are vocal in the political landscape' (Black, 2009, p. 42). The work of these grassroots support groups for kinship carers has highlighted the level of unmet need for children and carers in formal (and informal) kinship care. Critically, these groups have campaigned on the issue of wide local variation in financial allowances paid for children in formal kinship care depending on the local authority area (county) in which the child lives (Gillies, 2015). Scottish Government (2010) statutory guidance makes explicit the expectation that care provided to looked after children and young people should be of optimum quality, and reflect the standards of care children would receive from a concerned parent. Thus, allowances are financial payments made to carers, by local authorities or independent fostering agencies, to recognise and meet the costs of caring for a looked after child. This specifically includes

- a healthy diet and good physical care;
- opportunities for stimulation and exercise;
- development of social skills and participation in activities in the community;
- building self-esteem, including good presentation and acceptability by peers;
- a safe and comfortable environment;
- full inclusion in special celebrations such as birthdays, Christmas or other cultural or religious events and promoting and developing educational opportunities (Scottish Government, 2010, p.41).

There is no national set minimum rate of kinship care allowance in Scotland (compared to other parts of the UK and Ireland) (Child Poverty Action Group in Scotland, 2019). In Scotland, the calculation of kinship care allowance is further complicated due to the legal order under which a child is formally looked after impacts on the interaction with the wider

benefit system (in particular entitlement to Child Tax Credit and Child Benefit). Taking this into account, there is further differentiation based on the age of the child; for example, the kinship care payment for a child age between 5 and 10 ranged from £96 in Highland to £200 in North Ayrshire (Kidner, 2016, p.23). In sum, this has led to considerable variation across Scotland in the level of financial allowances received by kinship carers.

5. Formal kinship care in Ireland

Ireland has a population of 4.86 million people (Central Statistics Office, 2018). It is among the countries with the highest use globally of family placement for children in care, with a rate of 92% of the 6,072 children in care at September 2018 (Department of Children and Youth Affairs, 2019). These family placements comprise two forms: placements with strangers, i.e. traditional foster care, providing for approximately 65% of all children placed; and formal relative care providing for approximately 27% of children placed (Tusla (Child and Family Agency), 2018b). The emergence of formal relative (kinship) care as a placement option is a notable new trend in the Irish children in care system in recent decades. There is regional variation in the use of formal relative care. The area with highest percentage use of formal relative care (September 2018) is Dublin South West, Wicklow and Kildare (38%), followed by counties on the West coast – Mayo (37%) and Kerry (35%) - and then the high social need area of Dublin City North (32%). Areas with the lowest percentage use of formal kinship care are Donegal (15%) and Cavan-Monaghan (15%) (Tusla (Child and Family Agency), 2018b).

In the 1990s, there were changes in law, policy and practice that saw the gradual growth in reliance on relative care. This period might be considered as the 'emergence' phase. In Ireland, formal relative care gained legal recognition and the principle of the same level of

allowance payable in foster ('traditional' non-relative) and formal relative placements was established.

Formal relative care received legal recognition for the first time in the provision of the Child Care Act 1991. Section 36 of the Act includes reference to relative care as one of the placement options open to the authorities when making a placement in care for a child. The regulations linked to this provision define a 'relative' as including 'the spouse of a relative of that child and a person who has acted *in loco parentis' ("Child Care (Placement of Children in Foster Care) Regulations," 1995).* Formal relative care in Ireland differs from informal relative care, in that the latter occurs on the initiative of relatives acting independently, whereas *formal* relative care placements are made on the initiative of social workers from the Child and Family Agency (Tusla)[2] when they are seeking a suitable placement for a child needing a full-time care placement. In the case of formal relative care, carers receive the same allowance as do non-relative carers and can expect access to the support of fostering social workers. Informal relative carers may apply for a Guardian payment (see below) but otherwise have no dedicated source of support. A new advocacy group for the cause of informal relative carers is beginning to emerge to highlight anomalies and injustices experienced by informal relative carers.

In the parliamentary debates discussing this legislation in draft form with the Special Committee on Child Care Bill, 1988, the Minister gave some insight into the reasons behind the policy shift in giving recognition to formal relative care as a placement option. Part of its attraction was its potential flexibility.

> Situations can arise where the best person to look after a child who has been in care is a relative, for example a grandparent, or a friend of the

[2] http://www.tusla.ie/

> family. In such cases, it might not be appropriate to foster the child with such persons as this would require that all the conditions of the foster care regulations be satisfied. Rather it may be desirable that other more flexible arrangements be made … I might add that this is the first time that placement with relatives has been given specific statutory recognition.[3]

Some years prior to the passage of this legislation, there had been a major review of policy on children's services (Task Force on Child Care Services, 1980). Significantly, this review had *not* mentioned relative care as a possible type of formal care, so relative care had emerged as an option in the intervening period - that is between 1981 and 1990 - when the debate discussed here occurred. What was happening in the 1980s that may have influenced inclusion of relative care as a placement option in the legislation? One prime suspect must be the emergence of a drug problem especially in central Dublin in the very late 1970s and early 1980s (Dean, O'Hare, O'Connor, Kelly, & Kelly, 1985; Gilligan, 2011), of which more later.

Regulations relating to the placement of children in care (three sets covering foster care, relative care and residential care) were enacted at the end of October 1995. The Child Care Act 1991 regulations provided for an allowance to be paid to relative carers. In a written answer to a question from Deputy Tony Gregory in Dail Eireann (Irish parliament) relevant to the issue, the Minister for State for Children confirmed that the same allowance would be payable to foster carers and relative carers (Parliamentary Debates Dail Eireann, November 7th 1995). In retrospect, this seems a very significant additional step in the establishment of formal relative care as a core part of the children in care placement system. Deputy Gregory was representing a Dublin inner city constituency where, as mentioned above, a major drug problem emerged in the 1980s. (For further detail, see Gilligan, 2011, Chapter 6). This drug

[3] Parliamentary Debates Dail Eireann, 4th April 1990, Column 653

problem eventually influenced the child welfare system when the welfare of children born to drug users became a concern to extended families and the child protection system.

Reflecting its new status as a recognized form of placement, formal relative care began to appear as a category in Irish children in care statistics in 1998. The growing importance of formal relative care was further underlined by the Working Group on Foster Care (2001) which set out a very clear guiding principle giving pre-eminence to relative care as a form of placement in care planning. In a period of ten years or so, this new form of placement had arguably moved centre-stage in policy thinking in relation to children in care.

> Subject to the principles of good practice, placement with a relative should be the first option explored by a health board when placing a child in care (Department of Health and Children, 2001, p. 76).

This 'first option' principle seems to have been accepted by the Irish government and used to guide its policy in this area. This can be evidenced in reference to the principle in parliamentary debates: for example, in a written answer (Parliamentary Debates, Dail Eireann, 30th June 2004) by the then Minister of State for Children Brian Lenihan to Deputy Aengus O'Snodaigh, also representing a Dublin constituency affected by drugs.

The Working Party also made a recommendation for an increase in the value of the fostering allowance payable to foster carers and its implementation was announced by the Minister for Children in 2001 (Department of Health, 2001). The parity in allowances payable to foster and relative carers first decided in 1995, was continued in this increase, thus further consolidating the status of formal relative (kinship) care as a central part of the mainstream children in care system. The rates of care allowance (at time of writing) payable in respect of children in foster or formal relative care are €325 per week per child under 12 and €352 per week per child aged twelve and over (Department of Children and Youth Affairs, 2019).

In addition to children placed by social workers with relatives under the Child Care Act 1991, there are also children who find themselves placed informally with relatives because of decisions made within the extended family and independently of any involvement by social workers. In relevant cases, family members have responded to their own concerns about the quality of care received by the children in question – with grandparents often stepping into the breach (O'Leary & Butler, 2015). In such cases, a child who is an 'orphan' may be entitled to have a Guardian's Payment made to their guardian until they reach age 18, or age 22 if the young person remains in full time education. The term 'orphan' here applies 'where both parents are dead, or where one parent is dead or unknown or has abandoned the child, and the other parent is unknown or has abandoned the child.' From March 2018, the maximum rate payable under this scheme is Euro 181 per week per eligible child (considerably less than the Euro 325/ 352 payable to children in formal relative / kinship care as discussed above). In 2016, children recognized as 'orphans' and eligible for this payment actually slightly exceeded the number of children in relative care under the Child Care Act 1991: 1,971 children (and young people) as opposed to 1,715 (Tusla (Child and Family Agency), 2018a, p. 60, Table 24).

There is evidence of controversy about the differential treatment of relative carers providing care under informal or formal relative care arrangements (O'Leary & Butler, 2015).

In terms of the influence of drug use on the rise of formal kinship care, there are clear parallels with the Scottish experience. There was a similar picture in Ireland (from 1979) where increasing drug use in Dublin gradually worked through to a greater burden on child protection services, as young drug users eventually became parents. For example, there is a high rate of placement in high drug use areas such as Dublin City North which had a rate of placement in care in 2016: 136 per 10,000 children under 18 or 2.6 times the Irish average rate of 53 per 10,000 (Tusla (Child and Family Agency), 2018b). In the period after parental

drug use gave rise to child welfare concerns, social workers were addressing these issues at a local community level and often seeking placements for children primarily with grandparents and wider kin. It should also be noted that the emergence of formal relative care as form of provision in the care system may have been due not only to immediate policy triggers but also to its compatibility in terms of issues of family ties and culture in Ireland – an issue explored in Munro and Gilligan, (2013). There has been an increase in the past 20 years in the ratio of children in care to the general population under 18 years of age: from 3.2 per 1,000 under 18 in 1996 to 5.4 per 1,000 at the end of 2016 – a 51.2% increase (Tusla (Child and Family Agency), 2018b). Also relevant is a dramatic fall in the percentage share of care placements held by residential care of all children in care in the period close to when formal kinship care and serious drug misuse emerged (Gilligan, 2009; O'Sullivan & Breen, 2008). (For a fuller discussion of features and trends in developments concerning foster and relative care in Ireland, see Gilligan, 2019).

6. Discussion

There were two big developments in child welfare globally in the latter part of the 20th Century: de-institutionalization (the movement to close large-scale institutions); and the emergence of *formal* kinship care. Informal kinship care, organized within and by extended families, is clearly a universal phenomenon, but this formal type of kinship care emerged, one might say, somewhat by stealth. This paper has sought to explore how formal kinship care emerged in two separate jurisdictions with sufficient similarities and differences (including population, culture and politics) to make them relevant comparators. It has sought to identify points of convergence and divergence in the emergence of formal kinship care in both jurisdictions, which may be of relevance to illuminating or understanding developments in

relation to formal kinship care in other jurisdictions. The following three themes have emerged from our paper.

6.1 Three layers of kinship care: informal; semi–formal; formal

Formal kinship care as part of the public child welfare system represents what might be conceptualized as one of three layers of kinship care in both Scotland and Ireland. *Informal* kinship care occurs under the radar of the State system, with decisions and plans made inside family systems. Given its more informal nature, there tends to be less formal evidence and data about the realities of informal kinship / relative care. What might be described as *semi-formal* kinship care is also evident in both jurisdictions, as in carers receiving a payment from the State system in recognition of the care being provided to a child (not formally in care) under a privately agreed arrangement within an extended family. *Formal* kinship care concerns children received into public care, and then placed by social services with a relative carer under a formal arrangement. Under formal kinship care, carers receive a payment and, in principle, can access support from social workers as necessary.

6.2 Kinship care as the new 'flexible friend' of the children in care system

Formal kinship care benefits individual children in need of placement in care in both Scotland and Ireland. It is a placement option that can provide the children with a timely placement and keeps them within extended family. Formal kinship care is also advantageous for the wider child welfare system in both countries. Arguably, kinship carers have come to serve almost as a 'reserve army' of carers who can be 'called up' as the occasion demands. In effect, formal kinship care fits the bill for the children in care placement systems on the grounds of both principle and pragmatism. In principle, it is good for children to be placed within their wider family. Demand for care placements may fluctuate, but the potential availability of kinship care placements for any child needing placement allows the child

welfare system to adapt to changing circumstances. For example, changes in demand as in the impact of significant new community drug problems in our two cases, or changes in supply, as in the impact of the reduction of residential care places also evident in both our cases. Formal kinship care is the system's 'flexible friend' judging from the experience in both Scotland and Ireland. Formal kinship care has within it the potential to serve *this child* as long as this child needs the service of a placement. This formal kinship care has the remarkable capacity to match precisely placement capacity to placement need. It can be flexible in terms of offering placements at the right time in the right place. In providing this flexibility, it seems that formal kinship care occupies a liminal space between the polarities of *principle* (following the good practice of placement in the extended family) and *pragmatism* (enabling the care system to adapt to fluctuations in the demand for or supply of placements).

6.3 From practice pragmatism to policy principle

In both countries, it seems that formal kinship care as a wider policy has gradually caught up with 'grass root' local practices where local decision makers had initially sought to ensure that they could offer placements urgently required by children needing placement on a piecemeal basis. From this perspective, initial pragmatism led on to a more considered articulation of a policy principle that helped make formal kinship care a major option in the children in care placement system. In both countries, the pressure of community drug problems seems to have led to the first traces of reliance on formal kinship placement operated pragmatically on a case-by-case basis. Gradually this 'pre-emergence' pattern of local ad hoc decision making became more formalized as reflected in the emergence of a more recognized form of policy, first tentatively and then in a more consolidated and embedded way. This perspective reminds us that new developments are not always the result of centrally planned 'top down' approaches. Formal kinship care represents a fascinating

example of how patterns of 'street level' decision-making may also help shape policy from the 'bottom up' (Lipsky, 2010).

7. Conclusion

Arguably, there have been three separate phases in the emergence of formal relative (kinship) care in Scotland and Ireland. In the 1980s, there was increasing pressure on the care system to provide placements for children, in part due to increasing drug use and the impact on families, and a reduction of residential care places previously traditionally available. This period might be regarded as the 'pre-emergence' phase for kinship care. In the 1990s, there were changes in law, policy and practice which saw the gradual growth in reliance on formal kinship care and this period might be considered as the 'emergence' phase. The consolidation phase, the 2000s, saw formal kinship care established as a core part of the two care systems, accounting fairly consistently for more than one in four of all placements in each of the two countries, and one in three in the case of Scotland. In our two cases, our study shows that formal kinship care seems to have emerged initially in response to demand factors (the impact of increasing parental drug use in certain areas) and supply factors (the concurrent reduction of available placements in traditional residential settings). In both cases, national policy caught up with local practice solutions, and eventually embedded the new formal kinship care placement option as mainstream care in response to wider emerging policy principles supporting children to be cared for in extended family systems. This is a notable achievement in both jurisdictions. Looking to the future, there seem to be two key policy challenges to be addressed. The first is fine-tuning provision of practical and financial support for formal kinship carers (for example achieving parity of allowance for formal kinship care and foster care in Scotland). While strictly beyond the realm of formal kinship

care, there also remains the challenge of developing a stronger policy response in Scotland and Ireland to the needs of carers providing kinship care outside the children in care system.

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