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Maine Parenting Relatives Mental Health and Substance Abuse Project

A Generations United-Funded Project

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INTRODUCTION

Kinship care has been a long-standing tradition that transcends cultures and time. Today it takes on a new meaning as families face increasing pressures from substance abuse, domestic violence, divorce, unemployment, poverty, and health issues. Some families are able to address the safety and well-being of their children through their own resources and these children may never come to the attention of the child welfare system. This is commonly referred to in the professional community as “Informal Kinship Care.” Other children may be identified by the child welfare system and enter foster care. Often there is an assumption that there are no family resources to call upon. There is a powerful movement spreading across the USA to challenge these assumptions and develop better ways to help families utilize their resources to protect their children and keep the children placed within their families. This is commonly referred to as “Formal Kinship Care.” As the foster care system becomes more taxed, kinship care is becoming an increasingly important resource for our children. These families present with unique challenges and needs that can be easily overlooked. It is critical that as service providers we review these challenges and needs so we are better prepared to support this growing population.

WORKING WITH KINSHIP FAMILIES: REFLECTIONS OF A CLINICIAN

Bonny Dodson, LCSW

Clinical work is a dynamic process. We touch our clients' lives and their lives touch ours. At the core of good clinical work the clinician has the challenging journey of asking him or herself difficult questions while honestly soul searching and self-reflecting. This is what separates mediocre clinicians from the master clinicians. This is what keeps the profession humble, forthright and revitalized.

As colleagues and I have ventured further into working with kinship families, we have found ourselves deeply moved and affected. It has triggered a re-learning of the “leave work at work” concept we mastered early in our careers. After discovering (with great relief) this common experience, we developed some theories about this occurrence. Why can we work with severely traumatized clients and put it aside but the kinship families linger with us? I believe these

families hit closer to home. We are all vulnerable. At anytime a relative could die, take ill or become incapacitated leaving nieces, nephews or grandchildren needing care. Protective issues can arise for multiple reasons. In the back of our minds, we know it could be us. How would we want to be treated and what would we want to happen for our child or family member? We all know that there is a lot at stake for the child and for the family we are working with. Kinship care is a natural phenomenon and if we all looked in our family histories, we would find examples of kinship care. Transference and counter-transference issues are likely to arise and it is critical for the clinicians working with kinship families to be aware of this and be prepared to do their work in order to avoid projecting their issues onto the client/family.

Effective work with kinship families requires a true collaborative effort. Whether we are providing an assessment process (fulfilling placement, foster parent licensing or adoption study requirements) or mental health intervention, this collaboration is at the foundation of a solid plan that will meet the needs of the child and the family. Family-centered, strengths-based models have been around for decades yet we are still guided in practice and policy by deficit-based and professionally driven treatment /practice models. Models such as Family Team Meetings, Integrated Case Management and Family Group Conferencing challenge professionals to give up some of the power and control and enter into a higher level of collaboration with families. This can feel very disconcerting to traditionally trained professionals who are used to diagnosing and prescribing a course of treatment with clients. In treatment foster care, we are accustomed to working as a team in which many decisions are made by consensus and some decisions are decided by one member: Department of Human Services (DHS) guardian, the foster parent etc. Foster parents are licensed, trained and monitored. Most treatment team members are accountable to a supervisor, agency or licensing board. When children are with kinship families there are far fewer controls, checks, and balances. We often underestimate the natural checks and balances within the kinship system and miss opportunities to work with the family to build on these.

A few years ago Community Health and Counseling Services (CHCS) did a survey on Kinship Care with a cross section of people involved with Kinship: two mental health agencies (represented 13/16 counties), foster parents, DHS workers in two regions, CASA volunteers and kinship families. The overwhelming theme across all these groups was “the apple doesn’t fall far from the tree” and skepticism about families’ abilities to plan for the safety and permanency of their children. As I reflect on the kinship families I have homestudied and families for which we have provided mental health services, I continue to be challenged in this area. It is true that in some families the impact of substance abuse and various forms of domestic violence and mental illness has resulted in a multigenerational legacy. The idea of keeping children in some of these family systems instills legitimate fear in professionals and the community. While in no means would it ever be recommended to risk safety in

consideration of kinship placement, our fears and biases can overshadow the family's strengths and resources. Our unchecked assumptions based on our training, past cases, intuition or incomplete information can blind us to the possibilities. When joining with a family in a mutual assessment process the family is allowed to tell their story freely and explore the meaning of their story, lessons learned and vision for the future. When discussing concerns with families I continue to be amazed by the metamorphous of case "facts", into assumptions, into clearer truths, into better plans for children.

In foster care there are familiar standards. Although occasionally bad things can happen to children in a foster home, it is the exception and there are mechanisms to address these issues. Kinship placements are not new to child welfare but they are increasing in number. We do not have clear guidelines to go by in determining what the "good enough" kinship home is. How do we weigh the benefits of family attachments with the impact of poverty? How do our values come into play?

CASE EXAMPLE

I am so grateful to a special grandmother whom I shall name, Grace (All the names have been changed). Grace had two granddaughters that came into DHS custody. She walked a tight rope caring for these two challenging little girls, setting boundaries with her angry and often uncooperative son and meeting all the requests of DHS and the treatment team and family. She became a licensed foster home as well. The biggest hurt came when it was discovered one of her granddaughters, Trudy, wasn't the daughter of her son. The biological father quickly pursued custody. This made no difference to Grace. This child was her granddaughter in her heart. Trudy was placed with her father and her relationship with her grandmother was severed despite the strong bond between the two and the extended family. Her sister eventually was placed in a non-relative home as well. The loss and emotional devastation for the children and family was likely as damaging as or even more damaging than the original abuse. Grace followed her grandchildren to the best of her ability and remained as much of a resource as the system allowed. Trudy eventually was able to reconnect with her grandmother after placement with her father failed.

What were my lessons learned? Kin goes far beyond blood. The system had total disregard for this child's sense of family, whom she felt safe with and who nurtured her heart. Grace needed more support as she negotiated incredibly complex changes in her family. She had to be the primary decision-maker, not her son. She had to grieve the loss of just being Grammy. Grace and her husband were alone: all the children had left the home. They had to adjust to their new role as parents and partners. She walked a tightrope as she worked with DHS and service providers meeting the needs of her granddaughters and maintaining some semblance of privacy for the family. This was sometimes mislabeled as secrecy, defensiveness, or denial.

The team was focused on the children vs. the family system. When concerns arose about Grace and her home more services were added. In retrospect, it begs a question. What did Grace want/need for support? All our good intentions probably missed the mark. The child welfare and mental health system can't superimpose what we know works for foster homes onto kinship providers. Grace had become a licensed foster parent for her grandchildren but she was a grandmother first and foremost. The team wasn't clear on this at the time, and this led the team to have unreasonable expectations for Grace and her family. She likely could have used more support in negotiating the conflicting roles of foster parent, grandparent, parent, etc.

My mantra in family work has always been to challenge our assumptions and this has particularly held true in my work with kinship families. What initially appears like a contradiction is often two perspectives on the same reality. Grandparents love their adult child. Grandparents are angry with their child for the way they treated their grandchildren. It is possible for them to have both feelings and keep their grandchildren safe. Grandparents can be in a state of disbelief and grief about the actions of their children and believe the disclosures of their grandchildren. Supporting the grief process and the evolution of family responding to a crisis requires a lot of empathy and expanding the context of our cases. The effectiveness of our work is profoundly limited if we are only working with the child. While there are many reimbursement challenges that make it difficult to meet with parents and extended family members, this work is key to effective practice with kinship families.

CONCLUSION

The concept of "use of self" has been a core of many models of clinical work. The nature of kinship work tends to trigger transference and counter-transference issues. It is critical the clinician maintains a high level of self-awareness as he/she works with the family and the system to sort through the many needs, concerns. The process must include a careful distillation of complex case information and family dynamics. The clearest, most accurate picture is created from a mutual/collaborative process with the family so "case facts" are in proper context that naturally flow to case plans that are cohesive and congruent with the child and family.

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