

THE POOR RELATIONS?

CHILDREN & INFORMAL KINSHIP CARERS SPEAK OUT

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Foreword by Gerri McAndrew

I know, after a career spent in delivering services to children and their carers, that informal kinship care can be a very positive solution, in which children feel cared for and secure. Buttle UK is the largest individual grant giving charity for children and young people. Importantly, these kinship carers make up a significant and growing proportion of applicants to our entire grant giving programmes. We have seen over recent years how kinship carers are under a vast amount of pressure. Despite taking on a huge burden from the state by looking after children who would otherwise end up in the care system, kinship carers and the children they look after are still an overlooked group who experience high levels of poverty and disadvantage with little or no statutory support.

Since kinship care, and in particular, children's experiences of living with kin have been under-researched, developments within policy and practice have been limited, although campaigning groups have begun advocating for change. We therefore sought to gain a more vivid and accurate picture of how informal kinship carers - the group about whom we know least - and the children they look after view their lives. Most importantly, we wanted to know about the experience of these children and how their outcomes compared to children looked after by the state and those in the general population. From this, we hope to identify better practical ways to support informal kinship carers and the children they care for.

In June 2011, we published the first part of this major study. It represented the first ever attempt to use the Census to quantify kinship care in the UK and showed that around 173,200 children were being raised by family members because their parents were unable to care for them. More than 90% of these kinship care arrangements in England, Scotland, Wales and Northern Ireland were agreements outside the child welfare system and the children were not looked after. The study also demonstrated that kinship carers disproportionately lived in poverty. In the second part of the research 80 carers, and the children living with them were interviewed, 19 of whom had received a Buttle UK grant for the children in their care. This is the first time that the views of children living in informal kinship care have been sought on this scale in the UK and the findings are hugely revealing.

We know that kinship children are not the same as children in the general population. Most have been maltreated so they have greater challenges to deal with than others, yet they have better outcomes than those who are looked after. At a time, when rightly there is great concern about the outcomes for children in statutory care, the fact that kinship children do so well despite the pressure they and their carers are under is something to celebrate....But at what personal cost? This in itself demands that all those professionals, who find themselves involved with these families, find solutions that provide better and structured support, and give these children and those who look after them the best possible chance of a happy, secure and successful life.

That is what Buttle UK is committed to doing with the recommendations from this critical piece of research.

Gerri McAndrew,
Chief Executive, Buttle UK
www.buttleuk.org





Acknowledgements

We are very grateful to the Big Lottery for recognizing the importance of finding out more about informal kinship care and for generously funding this research. The study has been conducted at the University of Bristol in partnership with Buttle UK and we are indebted to them for playing such a key role throughout in advising and supporting the research.

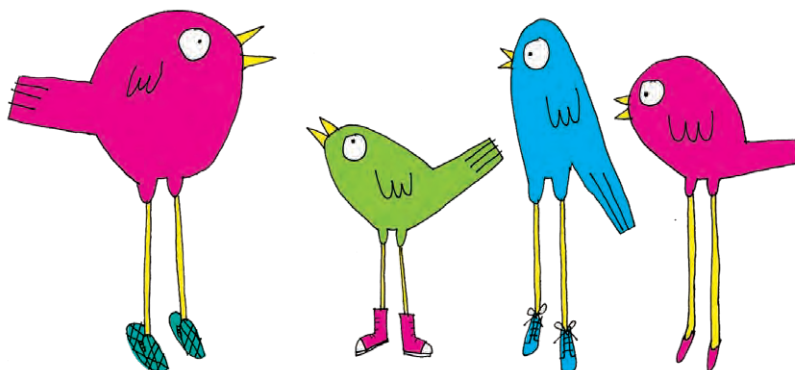
Regular meetings with our Research Advisory Group were invaluable and we would like to thank Helen Jones and Thomasin Miller (Department for Education), Cathy Ashley and David Roth (Family Rights Group), Joan Hunt (University of Oxford), Suzette Waterhouse (Independent Social Work Practitioner), Bob Broad (London South Bank University), David Pitcher (CAFCASS), Lynn Chesterman (Grandparents Association), Sarah Wellard (Grandparents Plus), Tim Carter (Barnardo's South West), John Dicks (London Borough of Greenwich), John Simmonds (BAAF), Nicky Rayner (London Borough of Newham), Kelli Eboji and Harpreet Dhanjal (Brent Council), Danny Negus (Winston's Wish) and Alison Garnham (CPAG) for giving up their time to help us with this work. Particular thanks to Sir Mark Potter who chaired the group so ably.

We are extremely grateful to the many organisations and people who assisted us by helping to recruit participants. These include the Poverty Truth Commission in Scotland, Clacks Scotland, Barnardo's, Coram, CAFCASS, Winston's Wish, dedicated kinship care teams and of course Buttle UK. We owe our thanks to Debbie Plenty (Age Concern), Angela Jones (Age Concern Grandparents Group, Grandparents Raising Grandchildren Network), Rachel Kelly (Action for Children), Jean Stogdon (Grandparents Plus) and members of both the Cardiff Grandparents Group and the participation group for children, all of whom gave us such useful advice.

Hannah Broadway created the illustrations for the Activity Book that was such a hit with the children; Steve Hunt undertook the recruitment DVDs and Bee McNamara designed our website. Paula Vaisey recruited the sample, developed the children's Activity Book and undertook the majority of the interviews. Later ones were conducted by Emma Ireland and Kate Baxter - we are very grateful indeed for the excellent work they all did, travelling all over the UK. We are also very grateful to Melanie Tomlin, our research secretary, who entered the data so accurately and provided much needed help and support throughout the project.

We would like to thank the many kinship carers and children who made contact with us to express an interest in the study. Most of all, our grateful thanks go to the 80 kinship carers and 80 children and young people who gave so very generously of their time to talk to us and to provide us with such valuable insights into their lives.

We have tried to represent accurately the many different experiences and views of the carers, children and young people in this report and also to convey some of the complexity of the issues. However, if there are any errors they are solely our responsibility.





CHAPTER 1 : INTRODUCTION

'Little is known about informal kinship foster care and how informal kinship families might differ from formal kinship and non-kinship families'

(Cuddeback 2004, p.625)

There is a long history in the UK, as in most countries, of children being cared for by relatives and friends when their parents, for whatever reason, are unable to care for the children themselves. The increasing international research knowledge about kinship care is mostly limited to 'formal' kinship care - commonly meaning placements made by child welfare agencies, where carers have been approved as kinship foster carers. Much less is known about children who live informally with kin, where the arrangements are made outside the ambit of child welfare agencies (Cuddeback 2004). This is of considerable concern since many more children are likely to live in informal kin arrangements than formal ones (Tapsfield and Richards 2003; Annie E. Casey Foundation 2012).

Until recently, very few research studies had investigated informal kinship care in the UK and their findings were limited by small sample size, the inclusion of day care, or an exclusive focus on grandparents (Richards 2001; Selwyn and Saunders 2006). Nonetheless, they suggested that informal carers suffer similar disadvantages to kin caring formally, although their difficulties may be more acute and there are high levels of unmet need. US studies too suggest that informal carers are even more disadvantaged and poorer than those supported formally by welfare agencies (Ehrle and Geen 2002; Goodman *et al.* 2004; Swann and Sylvester 2006; Gleeson *et al.* 2009).

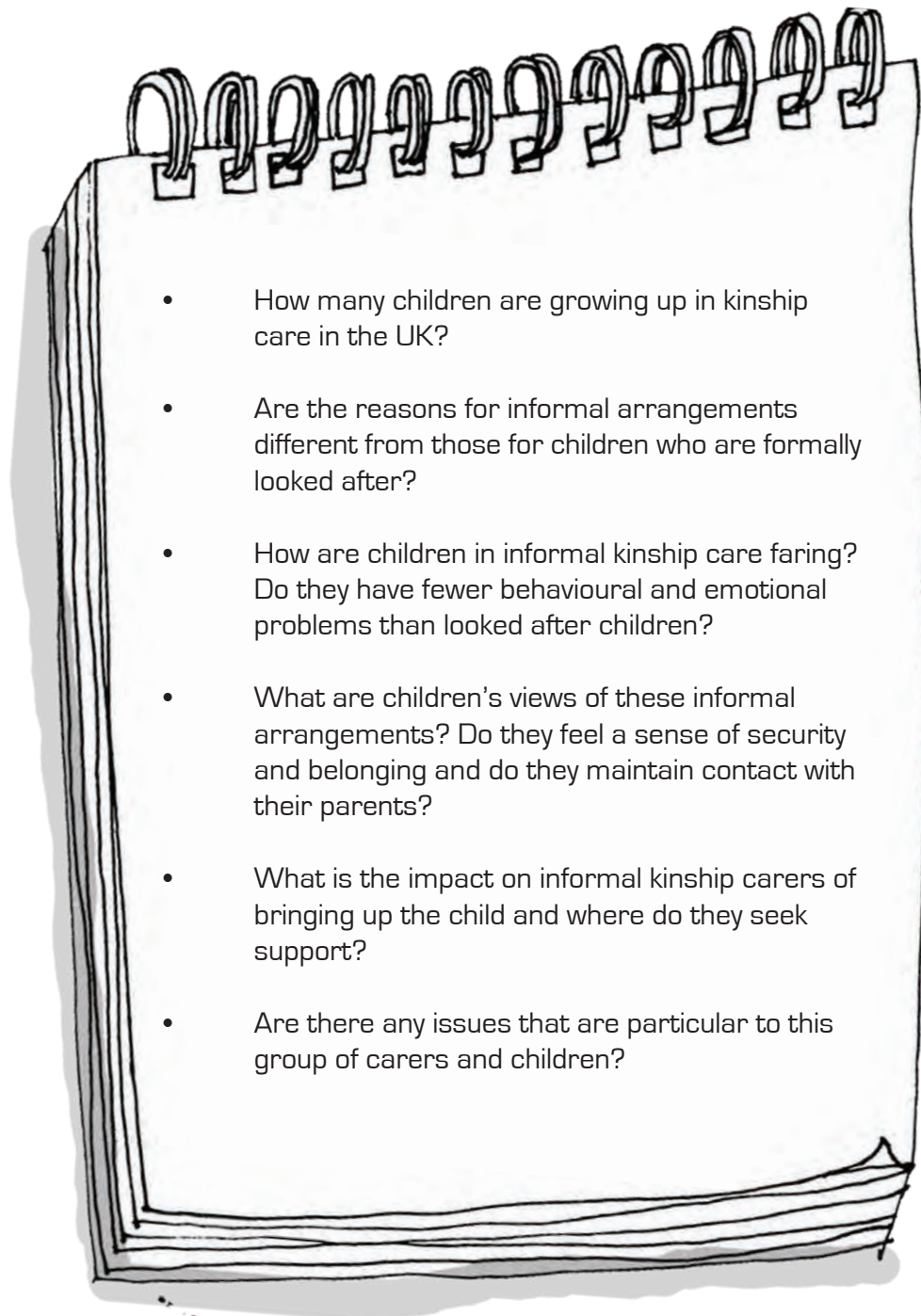
In recent years, the number of children living with relatives or friends has been growing in the UK and other countries, including the US (Winokur *et al.* 2009), Australia (Paxman 2006) and New Zealand (Connolly 2003). Such growth is believed to have been driven by pressures on child welfare agencies and foster placements caused by a number of factors, including increased reporting of child maltreatment, growing problems with HIV infection, parental drug and alcohol misuse (McFadden 1998; Aldgate 2009), and higher levels of family breakdown (DCSF 2010). In addition, a desire to diminish the role of the state and the costs of public services and concerns about removing children from their wider families and communities have encouraged the use of kinship care (Hunt 2003).

In the UK, there has been increasing legislative direction that the first placement option to be sought should be with kin. This has been backed up for the first time in England by statutory guidance for family and friends care, as kinship placements are known (Department for Education 2011). These changes were spurred on by research that showed positive outcomes for children in formal kinship care and suggested that there was scope for making more such placements (Broad 2001; Broad *et al.* 2001; Sinclair 2005; Aldgate and McIntosh 2006; Farmer and Moyers 2008; Hunt *et al.* 2008). However, most of the resulting increase in the use of kinship care in England has been made not in the formal child welfare system (where children are 'looked after' and cared for by kinship foster carers who receive a regular allowance), but through private law court orders (Residence and Special Guardianship Orders) in which financial support is discretionary and social work support rare.

This is shown in the statistics: between 2006 and 2012 the number of Residence Orders increased from 880 to 1,290, whilst Special Guardianship Orders increased from 60 to 2,130 (Department for Education 2012; Ministry of Justice 2012) - and most of these orders were made to kinship carers (Wade *et al.* 2010). In contrast, the proportion of looked after children placed with formal kinship foster carers has stayed relatively stable at 11% for at least the last eight years. It is therefore of pressing public interest to discover the true extent of informal kinship care in the UK and to find out more about the

circumstances and needs of the children and carers living in these arrangements.

In addition, children and young people's perspectives about living in kinship care (or other placements) are often lacking in research (Berrick *et al.* 1998; Talbot 2006), although children's views have been included as part of wider investigations of kinship care in the UK (see e.g. Broad *et al.* 2001; Aldgate and McIntosh 2006; Hunt *et al.* 2008; Ince 2009). The few studies which have concentrated entirely on children's views of kinship are mainly from the US, sometimes have small samples and focus predominantly on children in formal kinship care (see e.g. Altshuler 1999; Wilson and Conroy 1999; Hislop *et al.* 2004; Fox *et al.* 2008; and in the UK Burgess *et al.* 2010). One exception is Messing's US study (2006) which used focus groups to explore children's views of informal kinship care. It is therefore very important to hear from children themselves about their experiences of living informally with family and friends.



Reviews of the research on kinship care (Cuddeback 2004; Hunt 2003) have highlighted large gaps in our knowledge about informal kinship care and raise questions such as:

Phase 1: Analysis of the 2001 Census



This study, planned over two phases, set out to answer these questions.

The first part of the study analysed the UK 2001 Population Census to provide a reliable estimate of the extent and characteristics of kinship carers and children living in these arrangements. The full report from phase one has been published elsewhere (Nandy *et al.* 2011).

Key findings to emerge from analysis of the 2001 census:

- In 2001 about 173,200 children were growing up with a relative in the UK. The prevalence of children in kinship care had more than doubled since the census in 1991.
- Only 5% of the children were living with a formal kinship foster carer. This means that 95% of children lived in informal kin care arrangements.
- About 30% of the children were of minority ethnicity: more than twice their representation in the general population.
- Teenagers were more likely to be in kinship care than younger children.
- The majority of the kinship children were living with a grandparent but surprisingly, more than a third were being brought up by a sibling. Most kinship care was provided by a single female carer.
- The rates of long-term illness or disability amongst kin carers were much higher than in the general population.
- Most kin families were living in poverty. In addition, most kinship children (71%) experienced multiple deprivations, in comparison with 29% of children in the general population.

Phase 2: The views of children and their informal kinship carers



This summary report focuses on the second phase of the study, which used a multi-method approach to consider from children's perspectives, what it was like to be brought up by relatives or friends. The views and experiences of their informal kinship carers were also considered.

Definitions of formal kinship care vary and can include arrangements in which a private law legal order (such as a Residence or Special Guardianship Order) has been secured. However, we chose to classify those with such orders as informal carers, given that they have no automatic entitlement to support, they are not formally supervised by social workers, the children have no care plans, nor are they eligible for leaving care support. It is important to note that although some children on Special Guardianship Orders do now appear to receive sustained support and their carers get the equivalent of foster care allowances, very few carers in our sample were on these orders and hardly any were supported by statutory services in this way. Some of the few carers with Special Guardianship Orders in our sample had in fact been refused help by Children's Services.

Contacting kinship carers and children

By definition, informal kinship carers are not generally in contact with Children's Services and therefore there was no easy way of identifying this population.

The criteria for inclusion in the study were:

- The carer had not been approved as a foster carer
- The parents were not involved in the day to day care of the child
- The child was not a looked after child and was aged between 8-18 years
- The child had been living with the carer/s for at least six months
- Both the carer and the child gave consent to take part in the study

An extensive recruitment campaign was undertaken in which the study title 'Your Family, Your Voice: Growing Up with Relatives or Friends' was intended to reach out to children and their carers. Our bird logo was used in all the recruitment material. DVDs were made and sent out with an information pack to families who expressed an interest in the study and were posted on You Tube and the project web site. A Facebook page was also created. Posters, appeals for volunteers and information about the study were sent to charities, voluntary agencies, and parents' advice centres for distribution and posted on their web sites. Information about the study was also posted on Ezines, Mumsnet and sent to organisations such as The Confederation of Community Groups (Northern Ireland), the Poverty Truth Commission (Scotland), the Kinship Care Alliance, Family Rights Group, Grandparents Plus and the Grandparents Association. Support groups for kinship carers were contacted across the UK and information sent about the study with an appeal for people to participate. Posters asking for volunteers were also displayed in contact centres in the UK, some prison visiting centres and in family projects run by Coram and Barnardo's. The study was also publicised in 'Primary Times'. This magazine is the most widely read of all parenting magazines and is freely distributed to every child in primary school. Our partner organisation, the children's charity Buttle UK also forwarded on information about the study to all the carers on their database who met the study criteria.

We knew that it would be particularly difficult to recruit minority ethnic groups and therefore we used additional strategies to boost the sample of minority ethnic children and carers. A double page spread appeared in 'Voice' - a publication that reaches 200,000 African Caribbean people in London. The Child and Family Court Advisory and Support Service (CAFCASS) forwarded a letter about the study on to minority ethnic clients

who had obtained a legal order in the previous year, as did Brent Kinship Care team. Posters were put up in Chinese supplementary schools and places of worship were contacted. In spite of these efforts, Chinese and Asian children and sibling carers proved especially difficult to recruit.

As a result of this recruitment activity, 200 carers expressed an interest in the study and from these the sample was drawn. Where kin were caring for a sibling group, one child per family was selected to ensure that there were sufficient numbers of boys and girls and younger and older children in the sample.

Interviewing children and carers

Eighty children and their carers were interviewed in the four UK countries: England (78%), Scotland (11%), Wales (6%), and Northern Ireland (5%). In each family the carer and child were interviewed separately at home. The children's semi-structured interview contained four main themes: 1) moving to live with a relative; 2) belonging; 3) relationships with family and friends and 4) wellbeing. During the interview, the children completed an Activity Book called 'A Book about Me'. This contained colourful pictures and drawings, activities and three standardised measures to assess depression (Birleson 1981), psychological security (IPPA-R Armsden and Greenberg 1987; Gullone and Robinson 2005), and self-concept (Piers and Herzberg 2002). An illustrator was employed to work with the research team on developing this book. It proved a very successful tool and was enjoyed by many of the children and young people.

The carers were asked about their decision to become a kinship carer; the difficulties of parenting; and their own health using a standardised measure, the Health Status Questionnaire (SF-12-v2™ QualityMetric 2010); the pressures they faced and the support they needed and received. They also completed a mental health screening questionnaire in relation to the children, the Strengths and Difficulties Questionnaire or SDQ (Goodman 1997). Our analysis of the census data had shown that many kinship children were growing up in low income households. Since we know that children who grow up in poverty tend to have poorer outcomes across a range of dimensions (Brooks-Gunn and Duncan 1997; Bradshaw 2001), we were particularly interested to find out how they were getting on and how their carers were coping.

Analysis

Numerical data were analysed within SPSS using bivariate, Chi-square, biserial correlations, Kendall's Tau and Mann Whitney U tests as distribution was skewed. A detailed summary of the family's circumstances was written up immediately after the interviews and this together with the interview data were coded and analysed thematically within NVivo.

Terminology

Relatives and friends are referred to as 'kin' in this report for the sake of simplicity - 'kin care' or 'kinship care' therefore refer to arrangements with either family or friends. 'Unrelated', 'non-kin', or 'stranger' foster carers are the terms used for foster carers who are not related to the child. Relatives include any family member other than the birth parents, such as grandparents, aunts, uncles, cousins or older siblings. Friends include the friends of the child or of the parents, god-parents, step-parents, teachers or any other unrelated adult who provided the child with a home.

For some time now, the terms 'Children's Services' or 'Children's Social Care' have been used in place of 'Social Services' to refer to statutory children's services and this is the terminology we use. However, during the interviews, the kin carers usually still referred to 'Social Services'.

The names and some of the details of the children and carers have been changed in order to preserve confidentiality.

This chapter has set out why the study was undertaken and the ways in which children and kinship carers were recruited. We turn now to describe the kinship families who took part in the study.





CHAPTER 2 : THE CHILDREN, CARERS AND KINSHIP FAMILIES

Eighty children living in informal kinship care were interviewed, 18 (22%) of whom were of minority ethnicity. The average age of the children was 13 years and 59% were female (Table 2.1).

Table 2.1: The gender and ages of the kinship children

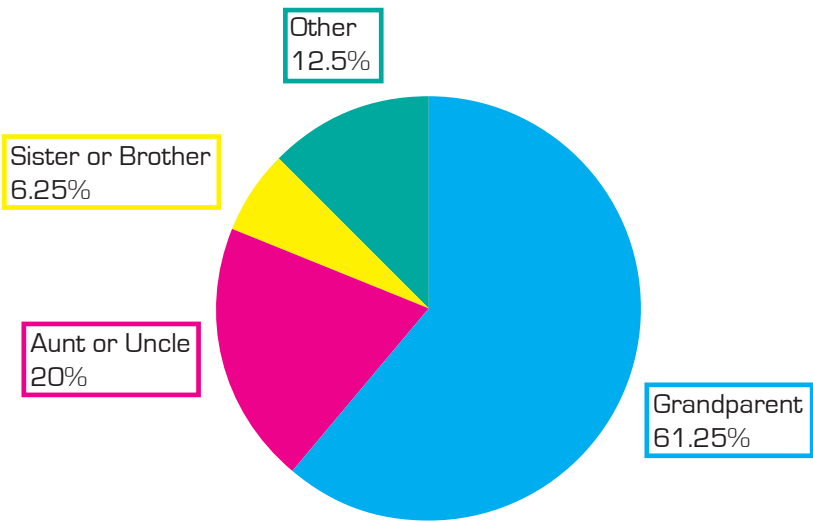
	8 - 11 years	12 - 15 years	16 - 18 years	Total
Boys	14	10	9	33
Girls	15	23	9	47
Total	29	33	18	80

The 80 kinship carers interviewed were mainly of white British ethnicity (90%) and female (96%). The youngest, a sibling was 22 years old and the oldest was a 79 year old grandmother.

CARER’S RELATIONSHIP TO THE CHILD

The children were mainly being cared for by grandparents, although one in five lived with aunts and uncles and 6% with a sibling. Just over 12% of the children were living with an adult connected to the family (the ‘other’ category in the chart below). These were often ex-partners of the children’s parents, great aunts and in one case each, a parent’s cousin and a parent’s previous foster carer (see Figure 2.1).

Figure 2.1: Relationship of the kinship carer to the child



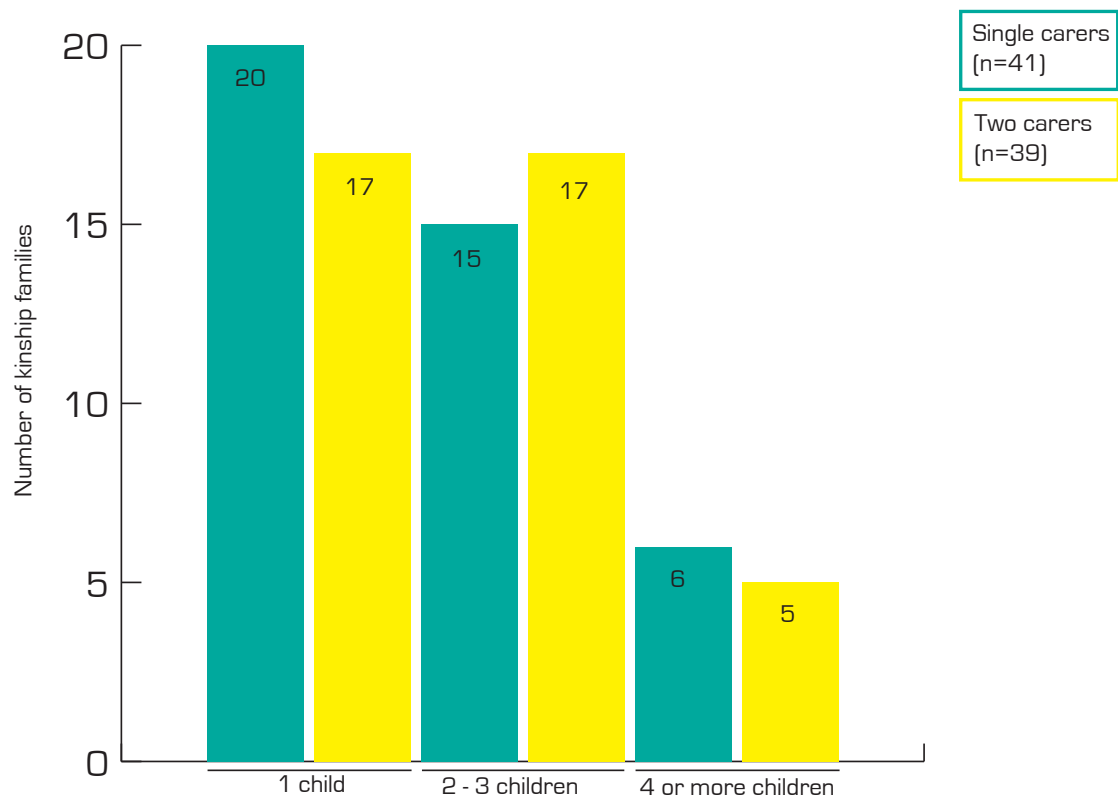
LONE CARERS

Half (51%) were lone carers with no other adult present in the household. This included six single carers who were parenting four or more children.

SIZE OF THE KINSHIP FAMILIES

Just over half (54%) of the kinship families contained more than one child and 22% of the kinship carers were parenting three or more children (Figure 2.2). Often these were the siblings of the kinship child, but there were other children too, such as the carers’ own children and those of other relatives. Grandparents were statistically less likely than other types of kinship carers to be parenting more than one child.

Figure 2.2: Family type and size of households in which the kinship children lived



Households were larger than typically found in the general population. It was not surprising therefore, to find that some carers had problems with overcrowding and this was particularly an issue for sibling (40%) and aunt (25%) headed households.

OTHER CARING RESPONSIBILITIES

Forty-five percent of kinship carers had other caring responsibilities too - 40% of the carers had responsibilities outside the home for another adult (often the parent of the kinship child or a sick or elderly parent) and 5% were caring for their spouse or partner at home.

CURRENT EMPLOYMENT AND FAMILY INCOME

At the time of the interview only 30% of the carers were working, 24% were unemployed, 21% had retired, 16% were permanently sick or disabled, and 9% stayed at home to look after the family. The majority (55%) of households had no adults in paid work and many carers reported that they struggled financially, especially those who were caring for more than one child. Some kin carers were relying on their pensions to cover the cost of bringing up children or were dependent on benefits. Just over a third (34%) of kinship families had incomes, before housing costs, of less than £200 per week (£9,600 a year) and three single grandmothers were trying to manage on less than £100 per week. Figure 2.3 below illustrates the limited income of many families.

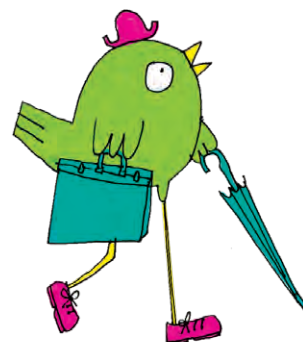
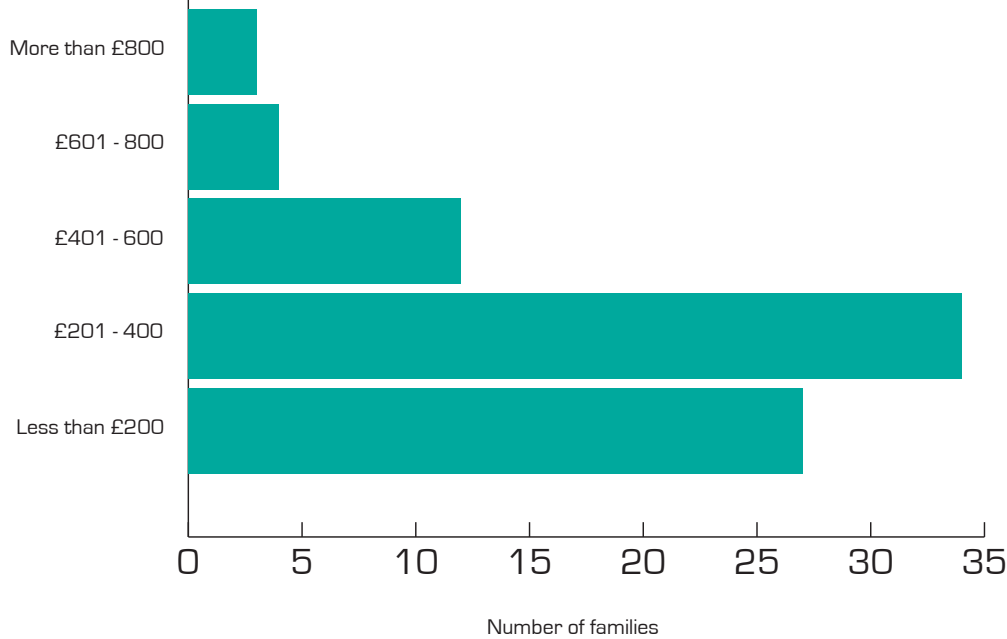


Figure 2.3: The weekly income of the kinship families after deductions but before housing costs



The low levels of income reported by the kinship carers mirrored findings from our Census analysis, which showed that many informal kinship carers live in poverty. Whilst many studies report on the financial difficulties of kinship carers [see e.g. Hunt 2003; Farmer and Moyers 2008; Wellard and Wheatley 2010; Aziz *et al.* 2012], the levels of financial hardship for these informal kin carers was greater than for formal kinship foster carers who receive foster care allowances or those on private law orders who receive allowances at an almost equivalent level.

EDUCATION AND PREVIOUS EMPLOYMENT HISTORY OF THE CARER

The majority of kinship carers did not have a history of long-term unemployment prior to taking on the children. Before becoming kinship carers, 42% had been in skilled or professional occupations, 28% had worked in sales, customer services or caring /service industries, 15% had worked in occupations requiring few skills, such as cleaners or shelf fillers and only 15% had been long-term unemployed. Some carers had retired before taking on the children, but for others, the kinship arrangement had hampered or even ended their employment prospects, seriously affecting their income. Many of the carers were well qualified. More than one in five carers had a degree and a further 27% had a vocational qualification. Table 2.2 shows the highest level of education the carers had achieved.

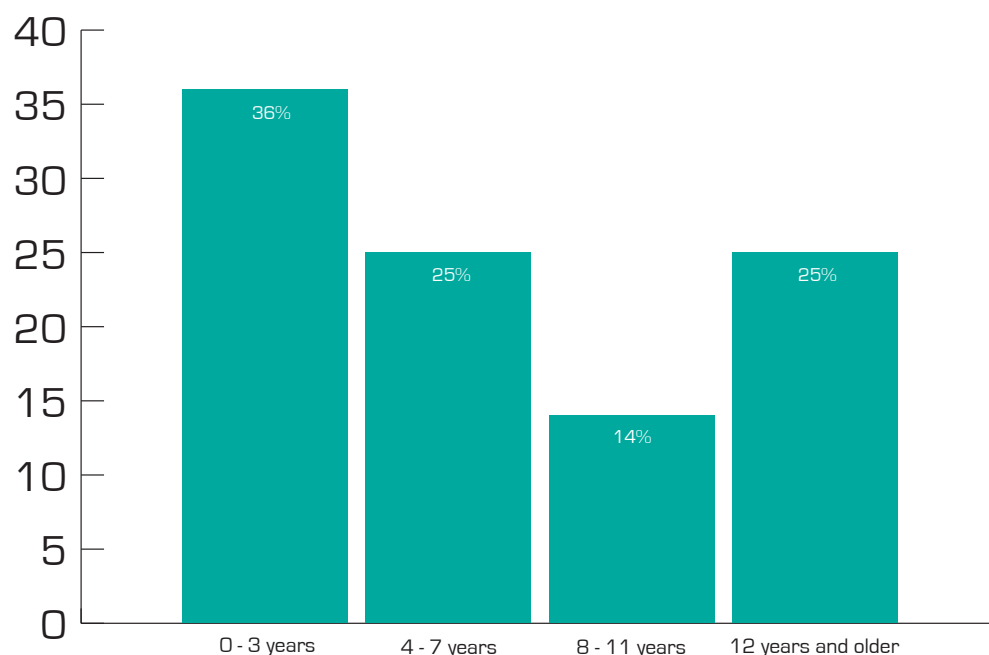
Table 2.2: Kinship carers’ highest level of educational qualification

Qualification	Kinship Carers
No Qualifications	19%
GCSE or equivalent	26%
A Level	6%
Vocational Qualification	27%
Undergraduate degree	10%
Masters degree / PhD	12%

AGE OF CHILDREN AT THE START OF THE KINSHIP ARRANGEMENT

In this study, we selected for interview children who had been living with their carer for at least six months. This was to ensure that both the carers and children had been together long enough to discuss fully the many aspects of the kinship arrangement. As can be seen in Figure 2.4, most of the children had lived with a parent for some time before going to live with kin.

Figure 2.4: Age of children at the start of the kinship arrangement



DURATION OF THE ARRANGEMENT

On average, the children had lived with their kinship carers for 6 years (range 11 months-9 years). Children living with grandparents were statistically more likely to have been there for longer and to have been younger when they first moved in, than children living with sibling carers. The average age of the children on moving in with grandparents was 4.6 years, with carers in the 'other' category 6 years, with aunts and uncles 9 years, whilst with siblings it was 11 years.

LEGAL STATUS

Although Children's Services took the view that none of the children had been formally placed by them with their kinship carer, the majority of carers did go on to obtain a legal order. Where Children's Services were involved at the outset, carers said that sometimes they had been coerced or bullied by them into taking out a private law legal order, with the threat that otherwise the child would be taken into care. However, much more often carers had obtained a legal order on their own initiative so that they were able to sign school forms, apply for a passport or for welfare benefits. In addition, carers had sometimes taken out an order to protect the children from maltreating parents who made threats to remove them from the kinship carer.

In all, nearly three quarters (72%) of the carers had secured a legal order. Fifty-six percent (n=45) had obtained a Residence Order, 11% (n=9) had a Special Guardianship Order, 4% (n=3) had been appointed as the testamentary guardian and one carer (1%) had an Adoption Order. All but one of the nine carers with Special Guardianship Orders received an allowance linked to the order, yet only 22% of carers with a Residence Order received the associated discretionary allowance. Twenty-one kinship carers (28%) had no legal parental responsibility for the child.

WHEREABOUTS OF THE CHILDREN'S PARENTS

Carers were asked about where the children's parents were at the time of the interview. Half (52%) of the children's mothers lived independently in the community, but 29% of the mothers had died, as had 10% of the fathers. Four children (5%) had lost both parents. Fathers had often had little to do with their children or the carers said that their whereabouts were unknown (14%), or they were in prison (8%) or living abroad (8%). Seven mothers (9%) were in residential facilities because of learning difficulties, ill health, or for alcohol or drug rehabilitation, whilst three mothers were missing and their whereabouts was not known.

Now that we have described the demographics of the kin carers and children, in the next chapter we examine why the children could not stay with their parents and how the move to their relatives or friends came about.

CHAPTER 3 : MOVING INTO KINSHIP CARE

Although most carers had been closely involved in the children's lives for some time, the child's transition to kinship care was often sudden and crisis-driven. One grandmother described the abrupt way in which her grandson arrived in her care:

Two o'clock one morning the phone went and it was Isaac and he was in tears. 'Granny can you come and get me? Daddy is completely drunk and I'm frightened'...I don't drive, so we got a friend. We literally went up in our nightclothes and I opened the front door and just said to Isaac, 'Just run to the car, don't worry about your dad, just run to the car'. I poked my head round the door and his dad was completely out of it, so I shut the door and we went off. Two hours later, I had the police at the door, 'Could they see Isaac because his dad had been arrested for a gun offence and they just wanted to make sure the child was alright. So...the policeman saw him, and the following morning I phoned a solicitor and said 'I want custody, this cannot go on' and we got into court.

(Grandmother bringing up a 14 year old)

Carers were asked why the children had come to live with them and most cited several reasons (Table 3.1). Parental substance misuse was common. Just over two-thirds (67%) of the families were affected by either parental drug or alcohol misuse, whilst nearly a quarter of the parents (24%) were misusing both alcohol and drugs. Exposure to domestic violence or parental mental illness was common, whilst other parents had died or been imprisoned.

Table 3.1: Parental circumstances and behaviours that led to kinship care

Circumstances	Number	Percentage
Indifference and lack of commitment	51	64
Drug misuse	44	55
Alcohol misuse	29	36
Domestic Violence	28	35
Bereavement	24	30
Mental illness	18	22
Abandonment and active rejection	21	26
Parental illness	12	15
Prison	12	15
Homelessness	9	11
Unwanted pregnancy	6	7
Maternal learning difficulties	5	6
Prostitution	3	4
Parents living abroad / deported	2	2

Many parents lived chaotic lives that put their children at risk and carers gave examples of parental behaviour that was self-centred and pre-occupied. Indeed, of all the difficulties which contributed to the children's moves to kinship care, parental indifference (64%) was most commonly identified and in just over a quarter of cases (26%) children had been actively rejected or abandoned.

We asked carers if they knew or suspected that the child had been abused. Just under half (48%) of the carers were certain that this was the case and a further 12% suspected it, but lacked proof. The proportion of children who were described as having been neglected was even higher (72%), with a further 10% where this was likely. Only ten carers thought that the children they were caring for had not been maltreated. Carers who

knew that abuse or neglect had occurred described a range of damaging circumstances that had affected the children's wellbeing. Children were reported to have been hungry, unwashed, ignored, sedated, kept out of school, physically and sexually abused. Some children of substance misusing parents witnessed drug taking or drug dealing, were taught how to roll joints, and had been exposed to dirty needles.

The descriptions of children's early lives were very similar to those recorded in the case files of looked after children. The following vignettes are examples of the circumstances that led to the kinship arrangements.

Jasmine was born to parents who misused drugs. Her mother did not bond with her and showed little interest in caring for her. When Jasmine's father developed drug-induced psychosis, her parents separated. Jasmine remained living with her mother whose lifestyle deteriorated - she became a drug dealer, allowing people to buy and use drugs in the family home. Jasmine was neglected, not fed, was poorly clothed and was sometimes found wandering the streets. Her grandmother began helping with the day-to-day care of Jasmine, whose behaviour had become increasingly difficult. She was aggressive and had begun soiling. Jasmine's mother started disappearing, sometimes for several weeks at a time. When Jasmine was seven years old, her mother stated openly that she did not want her, although she wanted to keep her brother. Jasmine's grandmother stepped in to take over her full-time care.

Ben was 12 when his mother died of a drugs-related illness. His parents had separated when he was young. Although in contact with his father at the time of his mother's death, the family did not consider the father to be a suitable carer - he had emotionally abused his children the past and had been imprisoned for drug smuggling. He also misused alcohol and had episodes of homelessness. Ben's sister stepped in to look after him following their mother's death. She did not want him to be taken into care.

HOW THE MOVE CAME ABOUT

Some children moved hastily into kinship care following the unexpected death of a parent through an accident or illness. Two children for example moved within hours of their mothers taking their own lives. Some parents simply disappeared, abandoning their children. One girl, due to be fostered by strangers, made an emotional appeal to the kinship carer promising that she would not take up much room. The suddenness of the arrangement meant that children and carers often had little opportunity to prepare for the move.

Sometimes carers witnessed a specific event that they felt had left them with no choice but to take immediate responsibility for the child. One grandmother described her actions following a visit to her newborn grandson:

They [parents] were drug addicts and I went over one day to their house when he was 6 weeks old and he was lying trying to feed his self with a bottle and all these cushions. And I just [pushed] through, you know this crowd were in the bedroom, they were doing all different things with drugs. So I just took the child out, went straight to my lawyer.
(Grandmother bringing up 10 year old)

For a few children the move into kinship care had been a more gradual process, whilst 12 (15%) children had lived with the carer since birth. Notably, one in five of the children had already lived with other relatives before moving to their current carer. One child said of his frequent moves:

I felt like a bouncy ball bouncing between different family's houses.
(13 year old living with aunt)

Most carers had had concerns about the children's welfare for some time before the kinship arrangement, whilst the children were still living with their parents. Many had kept an eye on the children and had tried to help:

I always went up there and checked and I'd had her the odd times at weekends and I'd had her for a couple of weeks when the mum went in prison previous to that...I've always kept my eye on Emily.

[Grandmother bringing up 14 year old]

However, these attempts to support the parents and keep the children with them had ultimately failed, since all the children eventually moved into kinship care.

THE INVOLVEMENT OF CHILDREN'S SERVICES

Carers had often acted on their concerns about maltreatment and it was interesting to find that nearly half (45%) had been in touch with Children's Services before the kinship arrangement began. Carers had sometimes contacted social workers shortly before taking on the child, but often they had reported their concerns about inadequate parental care many months, or sometimes even years, before they took over the children's care.

Most carers said that their calls to Children's Services had been ignored or their concerns discounted, often because social workers followed up referrals by making pre-arranged visits to the parents:

The social worker would not listen to me...People were overdosing in [mother's] flat; people were getting carried down the stairwell...When the social workers did go, it wasn't a cold call; it was a letter to say they were coming. So obviously, the flat would be cleared of the drug addicts, they'd go in, and they'd look in the cupboards. If there was food and nappies, it was fine.

[Grandmother bringing up 8 year old]

Some carers found that they were not treated as reliable or credible informants. One grandmother reported concerns that the baby was left unattended, was underfed, his nappy was rarely changed so his skin was raw and bleeding and cannabis was found floating in his baby bottle. After a pre-arranged visit, social workers informed the grandmother that she simply had higher expectations of parenting than most other parents. Another grandmother made a number of failed attempts to engage Children's Services in helping support her daughter who misused alcohol. It was only after her daughter was admitted to hospital with alcohol-induced liver failure that the carer felt that social workers really started to listen to her concerns about her granddaughter's wellbeing.

Occasionally carers spoke positively about the response of social workers and described the constructive way in which social workers had tried to work with the family:

I phoned Social Services and said I'm concerned. They came in and agreed with me that it was not acceptable. We tried to put in a combined package. Amy was with us two nights a week, she was with her [other grandparents] over the weekends, and then she was supposed to be with mother from Tuesday to Thursday, because they thought if they put in a concentrated packet she might manage.

[Grandparents bringing up 16 year old]

Most (65%) of the kinship arrangements came about without statutory involvement. Some carers, as we have seen, were unable to enlist the support of Children's Services, but often carers said that professional help was unnecessary, as they were managing the situation. Several were wary of contacting social workers because they thought they might be considered unsuitable as a carer due to their age or circumstances or because they were of a different ethnicity to the child.

On the other hand, Children's Services were actively involved in 35% of the kinship arrangements. Often these were cases where social workers had an established professional relationship with the children's families and had sometimes been involved in placing older siblings. Social workers had approached almost half of this

group of kinship carers with a direct request to look after children:

I just got a telephone call one day asking if I would look after John whilst his mother went into detox.

[Grandmother bringing up 8 year old]

The Social Services decided it...[they] said that [mother] couldn't have the child...so they decided to start doing court proceedings and they asked me then if I would take on the baby...I was a bit apprehensive, anxious and thinking 'Oh gosh not again, sleepless nights, nappies'.

[Grandmother bringing up 8 year old]

Carers said that social workers had often pressed them to apply for a private law legal order soon after the child had arrived. A few carers gave examples of veiled or actual threats by Children's Services to remove the children if they did not pursue a legal order quickly:

They said that if I didn't apply to be a Special Guardian that they would put the girls up for adoption.

[Aunt bringing up 10 year old]

Many thought that they had been badly advised by social workers on the options available to them. With hindsight, carers thought that they had been financially disadvantaged by taking out a Residence Order rather than a Special Guardianship Order, or by not insisting that they became an approved kinship foster carer. None of the children became looked after children and, as we will see in Chapter 9, carers' immediate or later requests for help and advice were often denied on the grounds that Children's Services had not placed the child and, as it was a private arrangement, the responsibility lay with the family.

CARERS' REASONS FOR OFFERING A HOME

When we asked carers about their main reason for offering the children a home, some had felt that they had little choice, as no-one else was available. However, most kinship carers spoke about not wanting the child to go into care and feeling a sense of ownership and family obligation:

Because he was my boy, he's our family. If the others weren't going to stand up to the mark then I was and I didn't know how I was going to do it. I had no idea how hard it would be. But I just knew I couldn't let him go.

[Grandmother bringing up 13 year old]

Taking on the care of the child sometimes created conflicts within families. As many as a third of the carers reported that other members of the family had disagreed with their decision to offer the child a home. Some relatives wanted the children to go into care; others wanted the parents to 'pull themselves together' and some had concerns about the possible impact on the carer's health. There were sometimes also tensions between the maternal and paternal sides of the family, with the two sides disagreeing about future child contact and fearing one side might turn the child against the other.

THE CHILDREN'S SIBLINGS

It has been argued that one of the ways that kinship care arrangements are beneficial is that they enable children to remain with their siblings more often than is the case for children fostered by strangers (see e.g. Shlonsky and Berrick 2001). However, in our study we found that many of the kinship children were in fact separated from siblings, particularly when families were large. Of the 52 children who had been living at home with brothers or sisters, more than half (54%) were separated from at least one sibling at the time of the move. Separated siblings stayed with a parent or went to live with another relative or entered care, whilst in a few cases, older siblings became independent earlier than planned. Half-siblings were sometimes separated when a family member chose to take only the child to whom they were biologically related.

CHILDREN'S UNDERSTANDING OF THE NEED TO MOVE

When we asked the children why they thought they could not live with their parents, a fifth chose not to answer the question or said that they did not know. For some of these children the reasons for the move had been particularly painful, as they had been told by a parent that they were unwanted. Most children (80%) talked about the reasons for their moves and many gave very direct answers about parents' drinking, drugs use, physical abuse, mental or physical illness, arguments, domestic violence, or death:

Well, it's illegal for you to be drunk and looking after a child under seven, and that's what was going on. So I had to come and live here.

[10 year old living with grandmother]

My father he tried beating me up when I was [a baby] and I had a fractured skull and broken bones...He was in prison and my mother...was on heroin.

[16 year old living with an aunt]

I couldn't live with my mum, obviously, because she was dead. My dad is an alcoholic so I couldn't live with him.

[14 year old living with aunt]

Some children spoke of their parents' rejection of them:

My mum is dead and my dad hates me.

[15 year old living with grandmother]

I think it was 'cos my mum didn't want me and she had a nasty boyfriend.

[15 year old living with grandmother]

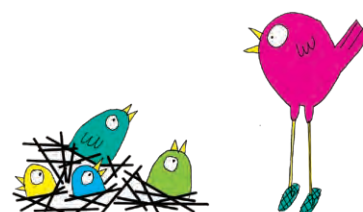
Not all the children were so clear about why they were living in kinship care. Some children lacked details:

The thing is I don't know how it all happened. I just know that my mum couldn't cope.

[18 year old living with grandmother]

Children said that leaving friends and familiar neighbourhoods had made their move to kinship care more difficult and some had been upset because they had been separated from their siblings. Most (86%) children said that their move to kinship care was made easier by the already established relationship they had with their carer and by being familiar with the home. Just one child had never met her carer before the kinship arrangement and a further 10% had had infrequent previous contact. Children who had moved with siblings to kinship care thought that this had also helped to make the move easier.

It was clear from the descriptions given by children and carers that most of the children had come from troubled backgrounds, marked by maltreatment and serious parental difficulties. The kinship children's early experiences were strikingly similar to those of children who enter the care system. However, these children had been diverted from a looked after pathway by their kinship carer stepping in, sometimes with Children's Services encouraging or pressing carers to offer them a home. In the next two chapters, drawing on the accounts of both the children and the carers, we describe the protective factors as well as the challenges and risks associated with living in kinship care.



CHAPTER 4 : LIVING WITH FAMILY AND FRIENDS: PROTECTIVE FACTORS



Previous research has identified a number of factors that relate to healthy child development. Particularly important is the presence of a protective, loving, committed caregiver, who provides clear boundaries and offers opportunities for the children's cognitive, social and emotional development (Field 2010). Some additional factors are important in the recovery of children who have been maltreated. These children need to feel physically and emotionally safe and receive consistent support from their carer to help them regulate their emotions. Maltreated children also need to have a good understanding of their history and need to know that the responsibility for the abuse they suffered lies with adults (Cohen *et al.* 2006).

Some of these factors were more evident than others in the kinship families in this study and in Chapter Five, we discuss the elements which carers found it less easy to provide. In this chapter, we examine how far protective factors featured in the kinship arrangements and include, from the children's perspectives, their feelings of emotional and physical security.

FEELING CARED FOR AND LOVED

Importantly, nearly all (n=78) the young people said that living with their kin carers was good and described feeling nurtured, valued and loved. They described safe, predictable environments with carers on whom they could depend:

It's just they look after me and make sure when I have problems...they come and sort it out.

[9 year old living with grandparents]

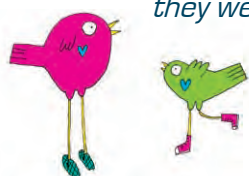
Many children emphasised how satisfied they were in kinship care, with one child describing living with her aunt as '*The best thing that's ever happened to me*'. Several children mentioned that living with kin was preferable to being in local authority care. However, two teenagers were very unhappy with the kinship arrangement and did not want to be there. Both had difficult relationships with their kinship carers and were loyal to their mothers, who had been drug addicts.

A few children were pleased that their move had relieved them of their previous caring responsibilities. These children described how they had cared for substance misusing parents or their younger siblings. A young person who had cared for her alcoholic mother for several years before her death said '*I've started getting my childhood back*'.

When we asked the children 'If you could choose, where would you most like to live?' three-quarters (74%) said with their kin carers and a further 15% said that, although the kinship arrangement was for the best, they would nonetheless prefer to be elsewhere. Looking back, although most children felt that the kinship arrangement had been the right choice, one in five said that at the time they would have liked to remain with their parent/s. This included a few children who had felt responsible for their parents and fearful that the parents would not cope without them. One young person remembered desperately wanting to stay with her drug-addicted parents:

It were difficult knowing that I had to stay here when I knew mum and dad were not in a good state and I always wanted to be there because I was worried and wanted to look after them. I wanted to live with my mum and dad just to make sure they were okay... they were on like really hard drugs.

[17 year old living with aunt]



FEELING SAFE AND SETTLED

Some children told us that in contrast to their previously turbulent lifestyles, living with their kin carers felt 'calm' or 'peaceful'. Others, who had previously lived in neglectful households, liked the stimulation of their busy kinship family's life:

I love it. I love having a really big family, just Christmas and things. It's just there's always something going on and things like that.

[14 year old living with aunt]

During our visits to kinship families' homes, we observed many warm caring relationships where children were touched, cuddled, and spoken about with affection. Most of the children said that they had always felt physically safe whilst living with kin. Only four children expressed concerns about their safety: two children were afraid that a parent would take them away; one young person was frightened by rows between his father and his carer; and another thought that if she argued with her carer she might be placed in care.

Most children (98%) were well settled with their carers and believed that their living arrangement was permanent. Children said they felt secure:

I'll be allowed to be here until I'm old and grey - I'm not planning on it though!

[18 year old living with family friend]

When I first moved here, my Nan told me that it was permanently, so I knew I was going to stay.

[10 year old living with grandmother]

The children's confidence in the permanence of their living arrangement was much greater than that reported in studies of children in unrelated foster care (see e.g. Sinclair 2005). For example, one study found that even after having lived in foster care for a year, a third of the children did not know how long they would remain living there and 13% thought that the placement was only short term (Selwyn *et al.* 2010).

It is well recognised that stability is important for children to develop secure relationships, achieve at school, be confident, have good levels of self-esteem and be able to plan ahead. Children's confidence about the permanence of the arrangement was generally well founded, although occasionally, as we will see, their carers had worried that the arrangement might be ended by others or because of their poor health.

PSYCHOLOGICAL SECURITY

The majority of the children described a close and affectionate relationship with their kin carers. They were securely attached to their carer and, on the measure we had used to assess attachment, had similar total scores to those found in the general population (see Chapter 7). The information shared by children about their network of important relationships further emphasized these strong emotional bonds. Almost all the children (94%) considered their kin carer to be one of the most important people in their lives and described their carer/s as 'family'. Without prompting, some children remarked favourably on their relationships with their kinship carers as compared with those they had with their parents:

It's better [living with my grandparents] than living with my mum...I've always felt closer to my grandparents...I've always had a better relationship with them than my parents.

[17 year old living with grandparents]

This young person's grandmother said:

Out of the blue [the young person] said 'I think I'm going to change my name ...Granddad has been more of a dad to me than anybody else, I look upon him as my father'.

[Grandparents bringing up 17 year old]

Carers (98%) too described warm adult-child relationships, characterized by deep affection and enjoyment of the child's company. Some carers were open in describing the relationship as mutually rewarding:

I've got somebody to love, who loves me as well. I've got somebody who depends on me, who I depend on as well...I want to be needed and she needs me and honestly everything is positive about looking after her.

[Grandmother bringing up 12 year old]

However, we will see in the next chapter that some of relationships between carers and children were not without difficulty. In a few families, there had been some role reversal and the children were providing emotional and practical support to their kinship carers.

THE KINSHIP CARERS' COMMITMENT AND SENSITIVITY

At the beginning of the kinship arrangement, some carers had suggested to their partners, that they might want to end their relationship rather than take on children who were not theirs. They felt that they had to put the children first. One carer explained:

I did give him the choice...that he could go. I wasn't making him stay and make the decision to keep three kids that didn't belong to him. He decided to stand by me...and he's been so good ever since, a really good dad.

[Sibling bringing up 14 year old]

Most partners had chosen to stay and many enjoyed parenting the child, particularly when they had no children of their own. However, as the next chapter shows, some relationships came under strain or broke down because of the kinship children's arrival.

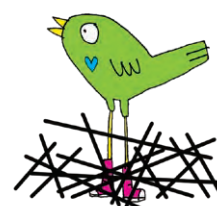
At the time of the interview nearly all the carers showed high levels of commitment to the children in that they expected the young people to remain living with them for as long as was needed. Only one carer was unsure whether the child would remain with her and the carers of four older teenagers thought that the young people themselves might soon decide to live elsewhere.

Several carers believed that their steadfast commitment to the children was far greater than that shown to children by unrelated foster carers. There were a number of children with complex behavioural difficulties who presented a huge challenge to the carers because of their disruptive and aggressive behaviour. These carers described high levels of conflict in the household, which often escalated into violence. With hindsight, several of these carers said that they sometimes wished that they had not taken on the child. Nonetheless, they too affirmed how important the young people were to them and they remained committed to raising them, even in these very challenging circumstances:

I would say no [it was not the right decision to care for the child]. I say it all the time. Sometimes I wish I never took this job on. But he's my grandson and I love him and I wouldn't have seen him go into care and that's where he would have ended up.

[Grandmother bringing up 10 year old]

Most of the carers were very sensitive to the impact of the children's early life experiences on their emotional and behavioural development. With just two exceptions, all the carers believed that many of the difficulties shown by the children were directly attributable to their previous adverse experiences. Carers described how the children had struggled to come to terms with their parents' behaviours and limitations. Many thought that the children were often angry with their parents, but not always able to verbalise these feelings or to channel their anger appropriately, so that sometimes the anger was directed at them. Carers also recognised the particular difficulties children faced in coming to terms with maternal rejection and maternal death - matters to which we will return.



Although most of the carers were clearly committed to bringing up the children, nearly half harboured concerns that their own deteriorating health or the actions of others (including parents, wider family members or social workers) might, at some point in the future, bring the kinship arrangement to an end.

ESTABLISHING BOUNDARIES AND HELPING CHILDREN REGULATE THEIR EMOTIONS

Bringing up a child is testing for any parent and can be particularly difficult during the teenage years. Kinship carers sometimes had additional difficulties in establishing boundaries with children who were not used to having limits imposed by an adult. Whilst living with their parents some children had been allowed out until late, had no set bedtimes, watched unsuitable TV and had been given free rein on the internet. Overall, children and young people responded well to the limits set for them and three-quarters of carers described only short-lived tensions and arguments.

However, a small group of thirteen children had particularly severe behavioural difficulties (see Chapter 7) and their carers often struggled to manage their violent and abusive outbursts. The carers understood that their behaviour was linked to earlier traumatic experiences, but were unable to do much more than wait for the storm to pass. These children kicked holes in walls, smashed furniture, and tried to take control by, for example, preventing their carers from using the phone. None of the carers described any strategies that are known to be effective in managing these situations. Carers reported being very stressed by these behaviours and at a loss as to know what to do. Nevertheless, they also said that they remained committed to the children and did not want the kinship arrangement to end.

OPPORTUNITIES FOR COGNITIVE, SOCIAL AND EMOTIONAL DEVELOPMENT

All the carers were able to meet the children's basic needs for food, warmth and shelter and some children commented on the differences between their carers' and parents' homes:

The [carer's] house was tidy and like, there was food in the cupboards...because when we were living with mum there was hardly any food in the cupboards and there was no bedding and we normally slept on the floor. So it was quite a surprise that we actually had stuff.

[13 year old living with grandparents]

Children mentioned fewer arguments now that they lived with their kin carers and were grateful that their carers did not shout, get angry, or hurt them as their parents had. Some enjoyed being 'spoiled' occasionally. Children also reported feeling listened to. A teenager described how differently her carer and her mother behaved towards her and her younger brother:

[Mum] didn't really speak to me and [my brother]. She didn't really do a lot with us, you know...whereas with [my carer] she'll help with homework...and she'll ask about our day and she'll speak to us about school and college and that sort of stuff, whereas we didn't usually get that.

[17 year old living with aunt]

Children appreciated their carers' genuine interest in their day-to-day lives. They described every-day activities they enjoyed with their carers that they really valued:

I get to do good stuff with her - painting [and] drawing competitions.

[9 year old living with grandmother]

She takes me out to the adventure playground, just like the [other] parents.

[8 year old living with family friend]

However, a small group of children living with elderly carers expressed disappointment that the carers could not play with them as much as they would have liked. One child imagined that had he been living with his father, they would enjoy games of football together in the park. Another said:

I wish Nan and granddad would do a bit more [with me], but they can't because they get too tired... specially granddad.

[10 year old living with grandparents]

Grandparents, in particular, were well aware that some children missed activities because they did not live with younger, more energetic carers:

What good is going to the park with somebody who is on a scooter? What can I do with him?

[Grandmother bringing up 11 year old]

Most (93%) carers attended school events, such as parents' evenings or sports days and nearly three-quarters of the children (73%) said that their carer helped them with homework. Five carers who did not attend school events explained that lack of transport and disability prevented attendance, whilst one young sibling carer said she felt too uncomfortable to do so, as she had only just left the school herself.

Some children described busy social lives with many opportunities for developing friendships and skills:

Well...Tuesday I've got table tennis, Wednesday I've got football training and cornet... Thursday I do table tennis, Friday I do Guides, Saturday I normally go up to my friend's and Sunday I'm free.

[10 year old living with grandparents]

Carers recognised the importance of giving children experiences they had missed or that might help their emotional and social development. A grandmother explained why she spent considerable amounts of money on activities:

Because she does have issues because of what's happened to her and in the first two to three years I would say [the clubs] kept her going - she danced and she did gymnastics and she did singing club and she did drama club...I mean I'm a great believer in that... but you know that's a big expense.

[Grandmother bringing up 12 year old]

There were however a few families, whose financial situation was so dire that the children were unable to participate in activities, such as in the case of one aunt who had not been able to afford to send her nephew on a school trip in the eight years she had been caring for him. As we will see in Chapter 8, many kinship families were under immense financial strain.

PLANNING AHEAD AND ASPIRATIONS

The encouragement shown by many carers, coupled with the children's sense of stability, enabled most children to plan ahead with confidence. Many of the young people had aspirations, which were positive and ambitious (see also e.g. Broad *et al.* 2001; Burgess *et al.* 2010). Thirty-seven percent of the young people in compulsory education said that they wanted to go to university; two young people were aiming for Oxbridge. Many carers too had positive aspirations for the children and 46% hoped that they would go to university. Just under half (47%) of the children had plans to go to college, mainly to do vocational courses, such as hairdressing, fashion design, carpentry and plumbing. Three children did not know whether they would prefer to try for college or university and two had not yet decided between getting a job and attending college. Only six children were sure that they did not want to pursue further education, including three young boys who wanted to be respectively a power ranger, a professional footballer or to work in McDonalds with an uncle.



As well as asking the children about their hopes for the future, we also asked them what they thought their carers wanted for them. Whilst some children mentioned a good education, a good job, or to be successful, others said that they felt under no pressure to achieve academically and knew that, most importantly, their carers wanted them to be happy:

She always says that [my brother and I] should do whatever makes us happy and she'll always be there.

[17 year old living with aunt]

SHIELDING CHILDREN FROM FURTHER RISKS AND DISADVANTAGE

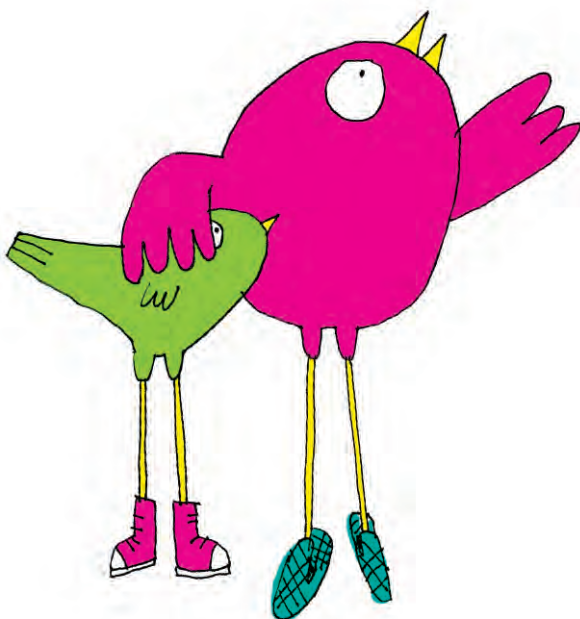
Carers tried hard to shield the children from the difficulties they faced in managing the kinship arrangement and especially wanted to ensure that the financial disadvantage they suffered as a kinship carer was not felt by the children. In particular, they did not want the young people to feel that they were any different to other children.

The carers made sure that the young people had warm clothes and hot meals, but in doing so, sometimes went without themselves. Some were in debt in order to pay for children's outings, activities, or school equipment. Their attempts to shield children from their financial difficulties were generally successful. In spite of the high levels of financial strain experienced by most kinship families (see Chapter 8), the majority of the children (66%) were unaware of any financial difficulties.

The capacity of kinship carers to shield children from the full impact of their own disadvantage has received little attention in the literature and, other than in the context of discussions about parental contact, has gone unrecognised as a key element in their care.

Certainly, kinship carers felt responsible for ensuring that the children remained safe during parental contact. Unlike foster carers, who are supported by social workers, the kinship carers had no professional assistance to call on to help protect the children from further harm from their parents. Some carers managed this situation well, but there were great difficulties for others, and as we will see in Chapter 6, some parents continued to present a risk to the children's psychological security and physical safety.

In this chapter, we have seen that the great majority of kinship carers were able to provide many core elements of good parenting, despite the disadvantages they suffered. In the following chapter, we focus on aspects of the kinship arrangement that were somewhat less favourable for the children.



CHAPTER 5 : LIVING WITH FAMILY AND FRIENDS: CHALLENGES AND RISKS



As we saw in the last chapter, there were many ways in which living with family and friends provided the children with a good environment in which to recover from their past adversities. However, there were also areas of family life that had the potential to be less positive for the children's development.

Research suggests that open family communication is a very important element of re-parenting children who have suffered traumatic life experiences (Cook *et al.* 2003; Cohen *et al.* 2006). Children who have been traumatized may struggle with feelings of unresolved loss and guilt and may have difficulties in recognising and expressing their emotions. It is therefore important for the adults in children's lives to talk to them about their experiences and help reduce any guilt and confusion they might feel. However, carers' close kinship ties to the children can make it harder to talk openly about the past, as they may have strong feelings about the reasons and sometimes feel responsible for these difficulties (Crumbley and Little 1997). In this chapter, we report on how these issues played out and consider other challenges posed by the kinship arrangements.

CHALLENGES IN TALKING OPENLY WITH CHILDREN ABOUT THE PAST

We know that children need a coherent narrative about their lives if they are to recover from trauma (Cook *et al.* 2003). The kinship children's understanding of events and their ability to integrate painful memories into a coherent story depended largely on what their carers told them. Carers had the difficult task of judging the amount of information to share with the children and how to present it. Only nine (11%) children said that their carers regularly spoke to them about their past. One young person described her unusually open family:

We talk about the whole thing quite often...If one of us is having a down day we all sit and talk about it and discuss it...We're quite an open family.

[17 year old living with aunt]

Just over a third (35%) of the carers occasionally talked to children about these issues; a few (9%) only talked about this if the children asked; whilst almost half of the carers (45%) avoided the topic. This left some children feeling troubled by matters in their past which they did not fully understand. Children told us about their difficulties in broaching the past with their carers, often because they did not want to upset them. One teenage girl revealed her strategy of timing such conversations with her carer, so that they spoke in the car where they were not sitting face to face. Some young people explained that family matters had been discussed with them briefly, when they were younger, but as they had matured they now wanted more detailed information about their personal history.

CHILDREN'S UNANSWERED QUESTIONS

For these kinds of reasons, one in five children had unanswered questions about why they had not been able to stay with their parents, were troubled by what they saw as 'secrets', events that they did not fully understand or questions that they had been unable to ask. In the interviews, children revealed nagging questions that worried them:

I'm not completely sure of the proper reason [I live in kinship care].I still find it hard to understand, just hard to get my head around and stuff.

[16 year old living with aunt]

I don't know why I'm not living with [my parents].

[9 year old living with grandmother]

Some children wanted to know about the nature of their parents' difficulties (such as alcohol misuse) or, in cases of bereavement, to understand more about their parent's death:

I want to know [how my mother died] but I just live on with life and try and put it behind [me]...not [let it] get the best of me.

[14 year old living with grandmother]

A number of children, especially boys, wondered who their fathers were or were concerned about what they saw as the secrecy surrounding their fathers' identity. It should be remembered that most of the children were being brought up by single female kinship carers and some children lacked good male role models. When asked what he wanted to know about his father, one boy said:

Who is he, what was his name and is my [Nan] keeping secrets about him? Because she keeps saying to me she didn't know him. She must have known him.

[9 year old living with grandmother]

FEELING RESPONSIBLE FOR PROBLEMS IN THE FAMILY

When asked what advice they would give to another child who was going into kinship care, some young people said that children needed to be told explicitly that what had happened to them was not their fault. For example, a teenage girl said that she would advise other children:

Not to think bad upon themselves because of their parents...it's not their fault that's happened and they've obviously been blessed to be with their gran or granddad or aunt or whoever.

[15 year old living with grandmother]

This is important since when family breakdown occurs, children's default position is often to blame themselves. This emphasizes the importance not only of open communication so that children can gain a coherent understanding about the past, but also that they are given reassurance that they were not to blame. One child wanted 'good things' to start happening to her family, which she explained was 'crumbling down because of me'. One of her parents was in prison and the other, who had learning difficulties, lived in supported accommodation. The child nonetheless felt that her difficult behaviour was to blame for the problems in her family.

DIFFICULTIES FOR THE CHILDREN WHOSE PARENTS HAD DIED

We were surprised to find that as many as 34% (n=27) of the children had a parent who had died. (This includes three children whose parents had died after the child moved in with their kinship carer). The extent of bereavement was considerably greater than that found in recent studies of children living mostly in formal kinship care, where the incidence of parental death ranged between 4% and 13% [see e.g. Aldgate and McIntosh 2006; Farmer and Moyers 2008; Hunt *et al.* 2008]. A recent survey (Wellard and Wheatley 2010) of family and friends care, which included very few (4%) formal kinship foster carers, also reported a lower incidence of parental death (14%), than we found. However, it should be noted that nearly all the carers in that study were grandparents. In our study, parental death was much more often a feature of kinship arrangements involving other types of carers (that is sibling, aunt and friend carers).

Children whose parent/s had died had some particular difficulties. Perhaps unsurprisingly, they were statistically more likely than others to worry about the health of their carers and to worry about their carers dying. A teenage boy for example, whose parents died within a three month period of each other, was fearful of losing his young aunt. He explained:

Obviously like when you're younger you don't think your parents are ever going to die, like ever, or not until you're like an adult like 40s or so and then they kind of both got taken and I'm kind of worried that it might happen to [my aunt].

[17 year old living with aunt]

As previously noted, nearly half the carers did not talk readily with the children about the circumstances that had led to the kinship arrangement. Some carers were still finding it difficult to cope with the death of the

child's parent and were struggling to deal with their own grief. As a result, bereaved children had particular difficulties in raising the subject of a parent who had died, often because they thought it was too painful for the carer to discuss:

Anything to do with the past and my mum is a hurtful thing to bring up, so I don't really talk about it...I don't really ask [my carer]. She gets really emotional about it.
[18 year old living with grandmother]

A grandmother explained why her late daughter, the child's mother, was rarely talked about:

Her mum is an emotional subject so I don't think Ruby really likes to talk too much about her, because she knows how upset everyone gets when it is spoken about.
[Grandmother bringing up 12 year old]

Although many carers had difficulties in talking with bereaved children about their parents and the past, there were a few exceptions where carers were able to help keep the memory of the child's parent alive, for example, by reminding the child about their favourite flower or typical behaviours:

[My aunt] always [says] 'She'd be proud of you' and things like that. Especially on Mother's Day and stuff, we'll get her favourite flowers and put photos around them.
[14 year old living with aunt]

Research has shown that the well-being of the carer after parental bereavement is a significant predictor of the child's well-being and the carer's ability to resolve their own grief can affect the child's overall functioning (Sandler *et al.* 2010; Melhem *et al.* 2011). Bereaved children who protect their carers by not talking about the past may have some difficulty in resolving their own feelings of loss.

As previously noted, carers thought that many children had difficulties which related directly to the experience of losing their mothers. For example, a sibling carer believed that her sister's problems were triggered by the death of their mother, which also made them 'different to everybody else'. A grandmother, who took on the care of her granddaughter after the child's mother took her own life, explained why she thought the girl was troubled:

I think it all just stems from the fact that her mother was so poorly and as a little child... the atmosphere must have been so terrible for her really and when her mother did die and they told her, she said, 'I always knew'. And so all her life she thought that her mum would die.
[Grandmother bringing up 15 year old]

LIVING WITH OLDER AND AILING CARERS

Some older carers had become dependent on the kinship children for emotional and practical support. This had an impact on the children's opportunity to maintain a broad social network, especially when they did not wish to leave their carers alone or they lived at a distance from friends. For example, 12 year old Leroy identified only three important people in his life - his grandmother carer and two younger sisters. His elderly grandmother had multiple health problems, very little energy, an extremely limited social life, and no family she could count on. Leroy took care of his grandmother by helping out with the housework:

I sometimes do the cooking, washing up, cleaning the house and the washing of the clothes...generally helping her out with stuff.
[12 year old living with grandmother]

In fact, eight children had caring responsibilities for someone in their kinship family, five of whom regularly looked after their grandmothers. These children prepared food for their carers, helped them to mobilize,

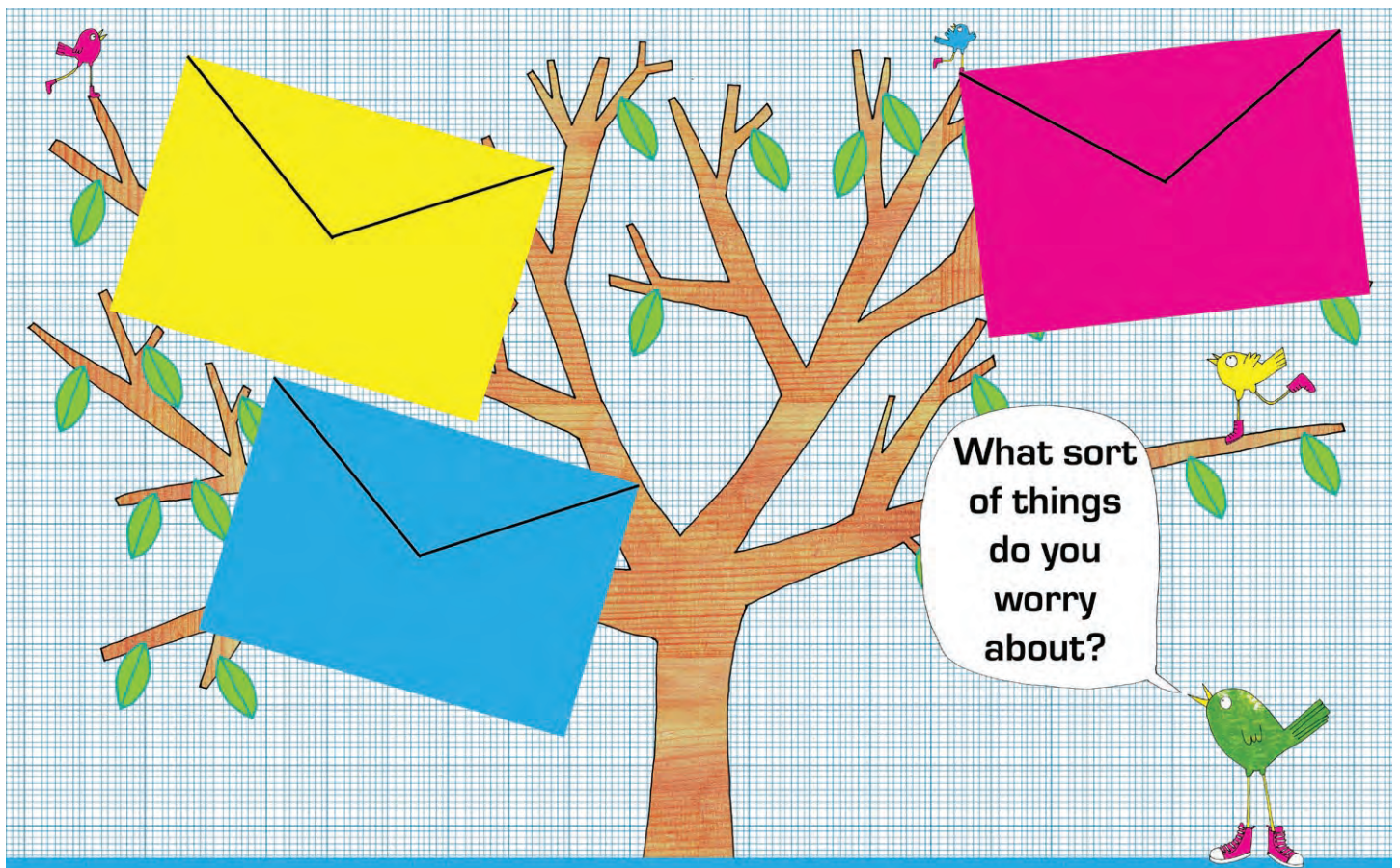
completed household chores, kept their carers company and helped with medication regimes. For example, an eleven year old girl had many caring responsibilities and was the registered carer for her elderly disabled grandmother. She cooked, cleaned the house, fixed things and helped her grandmother to get organized each morning before going to school. She also attended a weekly support group for Young Carers. She and her grandmother had a close relationship and there was no sign of any resentment over the restrictions this placed on her life. However, she had few friends and her opportunities for leisure activities were severely curtailed.

We found that children who lived with older carers had smaller social networks than others. Some children who were living with older carers had very little contact with friends or other relatives and several of their carers told us that they themselves had limited social lives and only a few people they could count on.

CHILDREN'S WORRIES AND ANXIETIES

When we asked the children what they worried about, rather than say their worries aloud, most took the opportunity to write them down on a card and place the card in an envelope on a 'Worry Tree' in their Activity Book. Six children stated they had no worries at all and a couple made it very clear that they wanted no further discussion on the topic. Whilst some children recorded worries about education, future employment, friendships, money and their physical appearance, many worried about matters that related to living with kin. Studies have generally shown that school-aged children worry mostly about school and their own or others' health. The proportion of children who worry about ill-health or death is reported to be between 16% and 23% (Henker *et al.* 1995; Silverman *et al.* 1995; Muris *et al.* 1998). As we will see, kinship children much more often harboured such worries.

Worries about death and illness



In fact, 44% of the children recorded a worry that was related to death or illness and many specifically worried that their parents or carers might have an accident, be hurt or die. Of course, a third of the children had already experienced the death of a parent. Given the older age and poor health of some carers and the risky lifestyles of many parents, the children's worries were not unfounded. Typical worries included:

- My mum and how long she's going to live.
- Worried about nan having an accident.
- Dying because I know a lot of people who have..
- If something would happen to my nanna - I don't want to lose her like I lost my mum.

Some children worried about the consequences of losing their carer and in particular were concerned about who would look after them if their carer died. They recorded worries such as:

- If my Nan dies, what will happen to me?
- If my granny and grampy die, where will me and [my sister] go?
- Death - responsibility for brothers...
- The future and being alone.
- What's going to happen when I'm older? Who will look after me if anything happens?

One of the main ways to cope with and alleviate worries is to talk about them and to have adults available who are able to help manage the strong emotions evoked. However, as we have seen, the children in our study were not always able to do this and, understandably, they found it especially difficult to share their worries about their carers' poor health and their own future with them. One teenager for example, had been worrying about what would happen if her grandmother died, but had been unable to articulate this anxiety. She started to complain of 'tummy ache' and diarrhoea. Medical investigations were inconclusive. Doctors suggested that she was probably suffering from irritable bowel syndrome and that a session with a mental health professional might help. In talking to a psychologist, the child was able to express her fears openly. Her carer explained:

[The psychologist] thought she was worrying about certain things and actually, as it turned out it was right, because I'd had an accident. I had to go into hospital and Zoe actually said 'Mummy died overnight and I was frightened that was what was going to happen to you and where would I go?'

[Grandmother bringing up 14 year old]

Children's other worries about carers

Although many children had already mentioned worries about their carer during the 'Worry Tree' activity, all were asked specifically whether they worried about their carers. Seventy-eight percent of the children did have some worries and these generally related to their carer's age, physical health and caring capacity. Some children were very sensitive to their carer's emotional wellbeing and worried about whether their carers were under stress, unhappy or lonely. One child explained why she worried about her sibling carer:

She just doesn't really seem like the happiest that she could be, I don't really know why... maybe because she doesn't go out with her friends...she needs to meet new people and start having fun.

[17 year old living with sibling]

Children also worried about the challenges their carers faced in looking after other ill or dependent partners or relatives and about their employment difficulties, whilst a few worried about their carer's financial situation.

Contingency plans

Given children's worries about who would care for them if their carers died or became too ill to do so, we asked the carers if they had made plans for this contingency. Whilst just under half (49%) of the carers had made some kind of contingency plan, importantly the details of the plan had rarely been shared with the children. However, over half (51%) of the carers had not arranged for such an eventuality. As one 75 year old grandmother in poor health explained:

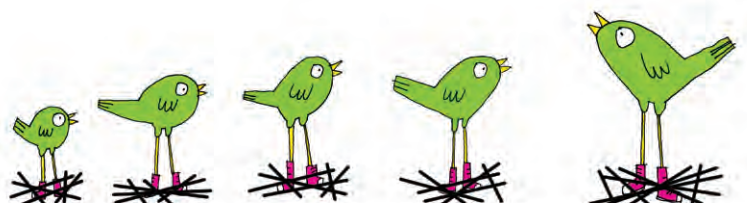
No, I don't have a back-up plan...a friend...actually managed to ask me about that plan but I avoided it...because I felt I wasn't ready to talk about it.

[Grandmother bringing up 12 year old]

Some carers, especially those with small social networks were unable to make contingency plans because they thought there was no other adult to care for the child. Understandably, carers unable to make contingency plans described this as a matter that upset and worried them a great deal.

Children's worries about their siblings

As we saw in Chapter 2, more than half of the children had been separated from at least part of their sibling group in the course of their move to kinship care. It was difficult for some children to come to terms with their siblings living elsewhere, especially when a brother or sister had remained with a parent. Occasionally children were worried about the



welfare of siblings they had left behind in the care of an abusive or neglectful parent, but more often, they were troubled by the preferential rejection shown by the parent (Rushton and Dance 2003). Some children wondered what it was about them that had led to a parent not wanting them or abandoning them and did not know why it was that a parent could care for some of their children but not others. It was also difficult for a few children to understand why a parent did not care for them, yet chose to raise someone else's child, as was the case for example with some fathers who lived with new partners and their children. These difficult issues for the children are discussed further in Chapter 6.

Some children were particularly concerned about maintaining links with their siblings, including a few who were troubled by not seeing siblings who lived with other relatives. Children's worries about siblings included:

- Jordon and Stacey living with mum who lives with an aggressive boyfriend.
- Never getting to see my brother again.
- When William gets adopted he won't want to be my brother any more.
- Are I and my sister going to be together and keep contact when older?

STIGMA, SHAME, AND BEING DIFFERENT

In addition to having worries about death, we found that more than a third (36%) of the children reported being subjected to hurtful remarks, simply because they were not living with their parents (see also e.g. Hislop *et al.* 2004). This was a surprising finding as previous research in the UK and US (Broad *et al.* 2001; Messing 2006) had suggested that kinship care was perceived by children as less stigmatizing than unrelated foster care. A teenager explained:

People that I've just met have been quite insensitive and...be like, 'It's a bit weird you don't live with your parents. Do they hate you?'

[17 year old living with grandparents]

A grandmother described the taunts her grandson had endured:

Some of the children were very unkind when he first came to me and made horrid remarks like 'I know you're with your Nan cos you're so horrible your mum and dad wouldn't want you'.

[Grandmother bringing up 13 year old]

Children were also affected by the shame associated with their parents' reputations and behaviour (see also e.g. Kroll 2004). Young people were subjected to unkind remarks about parents who were drug or alcohol dependent, who solicited sex or who were in prison. One carer explained how the child had been bullied at school after his mother had turned up drunk and naked in the playground. In another example, an 11 year old

girl was severely bullied by her peers who knew that her mother was a prostitute and abused drugs. The carer worried about the child's continued ability to cope with the shame of her mother's behaviour:

They all know, all the people round here know that her mother was a drug addict and a prostitute. She's got that going up to senior school with her.

[Grandmother bringing up 11 year old]

In fact, several carers said that children suffered sustained bullying in school because of their family situation. Such was the impact of bullying and name-calling, that a 10 year old girl when asked about her three biggest wishes in life, said she wished that people were more understanding and less 'mean' about children who did not live with their parents.

What children told their friends

We asked children what they told their friends about why they lived with their kinship carers. The children's responses showed how carefully they managed this potentially stigmatizing information. Only 14% said that they were completely open with friends about the details of their kinship arrangement. Just under quarter (24%) said that they had not told their friends anything, whilst 60% said that just a few close friends knew. Two children (2%) chose not to answer the question. One young person, when asked if he had talked to friends about why he was living with his grandmother said:

Only ever once but that was a big mistake...he kept on bringing up [my] answer to me and I didn't really like it.

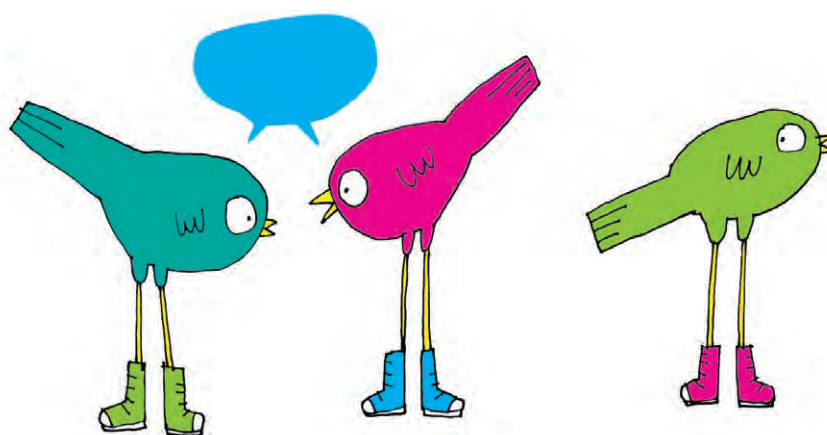
[15 year old living with grandmother]

Many children said they disliked everyone knowing, or feeling they always had to explain to others, why they lived with their carers. Some did not want to be seen as 'different' and felt it important to control carefully how many people knew about their circumstances. For example, a teenage girl said that she did not want information about her personal circumstances 'getting out'. Interestingly, she had refused counselling at school because it exposed her as being different. Her carer explained:

I have tried to get some [school] counselling for Jamilia, but she was very against it... she just, I think was very conscious of her life circumstances and didn't want the other children at school to find out about it and felt like if she was singled out for counselling then everybody would know. So it got to a stage where it was counterproductive.

[Parent's cousin bringing up 16 year old]

Children who were over the age of 11 at the time of the interview were three times more likely to be secretive about the reasons for the kinship arrangement than those aged 11 and under. We examined whether there was an association between children's sharing of information and the reasons for the kinship arrangement. Nearly two thirds (63%) of the children who were secretive with friends about why they lived with their carer had at least one



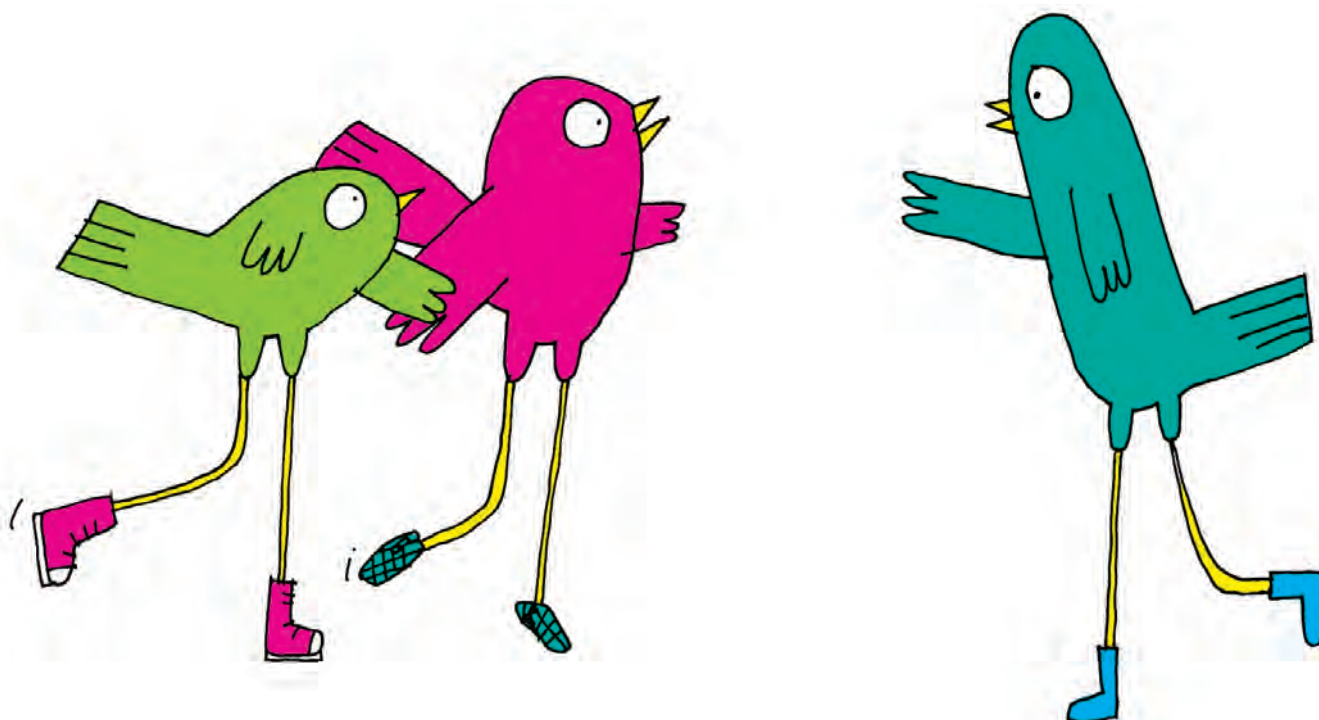
parent who misused drugs and more than a third (37%) had a parent who was in prison, although neither factor was statistically significant. However, we did find that children who went to kinship carers following the death of a parent were statistically less likely to be secretive with friends about their living arrangement. This is understandable since the death of a parent is likely to carry much less stigma than the kinds of problems that leave other parents unable to care for their children.

There is clearly a need for carers to get advice on discussing with children from the outset how they can best talk to other young people about their situation. However, carers' ability to protect children from the impact of a parent's local reputation is likely to be limited.

PROXIMITY OF PARENTS

Quite often at least one parent lived in the same locality as the kinship carer and whilst this benefited some children, there were distinct disadvantages for others. We have seen the difficulties some children faced in coping with the stigma of a parent's local reputation but there were other consequences too. Whilst proximity made it easier for parents to visit, it could also make it harder for children to understand if they were unreliable or inconsistent in their contact. Moreover, as will see in the next chapter, when parents lived nearby, some regularly called unannounced at the kinship home and children also had to deal with the impact of meeting parents by chance in the street.

Having considered some of the challenges of the kinship arrangements for children, in the next chapter, we examine the influence that parents continued to have on them and the ways this placed some children at risk of poor mental health.



CHAPTER 6 : PARENTS' CONTINUING INFLUENCE ON THE CHILDREN

Children's parents often played a large part in their lives, either through contact or lack of it or because of the impact on the children of their behaviours past and present. As we have seen, many of the children had been living with parents who misused alcohol, drugs or both and had been neglected or abused. Children's feelings about their parent/s were likely to have been affected by their experiences and would have influenced how they had made sense of events.

EXPERIENCES OF REJECTION AND REPEATED REJECTION

We know that children in adoptive or foster care who have been preferentially rejected by their parents tend to make less progress than those who have not (Rushton and Dance 2003). More than a quarter (26%) of the children in our study had been rejected or abandoned by a parent before their move to kinship care. Some parents had simply walked out of the children's lives. Other parents had told children that they were unwanted, including two whose fathers had simply dropped the child at the kin carer's house and left:

There was a knock on my door. By the time I got to the door [the child] was stood there and the car had driven away - a white-faced shocked child age 6½. In one hand... he had some pants and socks in a carrier bag, in the other hand he had some soiled underwear...and that's all he had.

[Grandmother bringing up 13 year old]

As we have seen, for some children the rejection was compounded by parents who had continued to parent the child's sibling/s, whilst in about a quarter of the families, since the kinship arrangement began, new babies had been born who had remained with a parent. In addition, several parents were raising children with a new partner and chose not to maintain contact with the kinship child from a previous relationship.

Unlike children in unrelated foster care who might be placed at a little distance from their family home, many of the children in our study remained living in the same neighbourhood in close proximity to their parent/s. This exposed almost a fifth (17%) of the children to episodes of repeated rejection. Some parents who lived locally, for example, ignored the children, even when they passed on the street:

[His mother] doesn't come over, although she comes past [the house]. I know at one time I found Max crying on the door and I said, 'What's the matter?' He said 'Mum has just gone up the road in a car and she didn't even wave to me'.

[Grandparents bringing up 15 year old]

One 10 year old boy, who regularly saw his mother in the school playground collecting his siblings, said:

It's hard...because I see my mum picking [my brother and half-sister] up [from school] and I think 'Why couldn't that be me?'

[10 year old living with aunt]

This experience of daily rejection was said by the carer to be affecting the child's educational performance and there were often tears in school. Indeed, carers commented on the particular difficulties children faced in coming to terms with maternal rejection:

She hasn't had her mother there consistently...her mum comes and goes and comes and goes...and we basically had to sit down and tell her that she was never going to go back to her mother...but I don't know what goes on in her head, when your mother sits there and tells you that she doesn't want you.

[Grandmother bringing up 11 year old]

Children often harboured feelings of deep sadness or anger about their early experiences or subsequent rejection. Some children took their anger out on their kinship carer. When talking about the advice they would give to another child going to live with kin, some children spoke of the importance of not taking angry and upset feelings out on their carers:

Fair enough if you're angry, but try and respect the fact that [your carers] don't have to be doing what they're doing, even though they may feel like they do. But then it's all right to feel how you do.

[18 year old living with mother's ex-partner]

CHILDREN'S CONTACT WITH PARENTS

A considerable number of children (46%) had no contact with their mothers and even more had none with fathers (56%), whilst a fifth (22%) of the children had no contact with either parent, because of death, disappearance, or imprisonment. In 18 cases (22%), a court order had been or was in place restricting contact with birth parents (although only two of these carers had been given support in managing these contact arrangements). This left over half (54%) of the children who did see their mothers and 44% who had contact with their fathers. Whilst a quarter of the children saw their mothers at least weekly and 13% saw their fathers this often, for most of the remainder, contact was much less frequent. In addition, two-fifths of the children had some phone contact with their mothers and a third with their fathers, although the frequency of such indirect contact varied widely. Quite a few (40%) children had at least weekly phone calls with their mothers or fathers, some initiated by the parents and some by the children:

I'm on [the phone] every day. I ring [my mum] on the way home from school.

[12 year old living with grandmother]

A few children said that their carers had forbidden contact of any kind, but not all the children complied with such restrictions. One child, for example, admitted to secretly speaking to her mother on the phone.

When we asked children to identify the most important people to them, 41% of the children did not identify either parent. Most of these children were in contact with their parents, albeit often infrequently. These findings are somewhat different to those found in a study of formal kinship care (Aldgate and McIntosh 2006) which suggested that children considered both parents and kinship carers to be important to them.

CHILDREN'S ACCOUNTS OF CONTACT WITH THEIR PARENTS

Children's descriptions of what it was like seeing their parents varied widely. Many valued the time spent together:

We're more like sisters than daughter and mum, because it's like we get on quite well, me and my mum.

[12 year old girl living with grandmother]

However for others, contact with parent/s was difficult and upsetting. An 18 year old girl, for example, who had not seen her father for a year, described their last contact as 'awkward' because her father had been drunk and had cried. An eight year old who had visited her father in prison tearfully described the experience as 'quite upsetting really'. Several children were critical of their parents' behaviour during contact, such as a young person who disliked the way her father shouted at his girlfriend. Others continued to feel angry or resentful towards parents who had abandoned or rejected them:

I see my mum when I'm up at my nanny's house, the odd time. I just wouldn't go out of my way to go and see her...I was sixteen in July and I didn't see her over my birthday...I suppose I've always been angry with her...for what she's done.

[16 year old living with aunt]

Parents' drug and alcohol problems had an impact on the quality of their contact with the children:

My mum] gets drunk and I don't like that...I hate her...because we always get into fights.

[8 year old living with grandmother]

Some children felt an abiding sadness over parents who disappointed or lacked interest in them and in response to these experiences, a few children had become resigned to being let down:

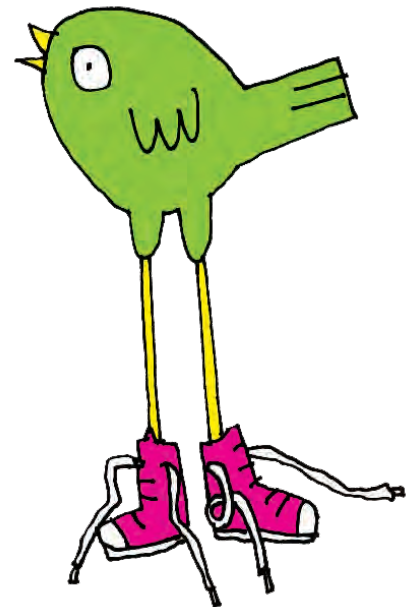
Well, I see her a few times a year because she's not very good at turning up every week.

[10 year old living with grandparents]

Some children had lowered their expectations accordingly. When asked if she minded that her father often forgot her birthday, one girl replied:

Not really. I don't really expect much from him.

[15 year old living with aunt]



Impact on children of difficult contact

In our sample of 80 children, 18 children scored themselves in the clinical range on the Birleson measure of depression and/or as very low on the 'happiness and free from anxiety' dimension on the Piers-Harris 2 measure and 13 children were scored by themselves and their carers as having significant behaviour difficulties. There was some overlap, with six children being depressed and having behavioural difficulties. These 25 children, who had identified themselves on the standardised measures as having severe difficulties, were significantly more likely to: have contact that was described as difficult by their carer; the carer and parent were more often in conflict; and the children were less securely attached to their carer. These children and young people who had behavioural difficulties also had very low levels of empathy, with several stating categorically that they never worried about how their carer was.

Children who longed to see more of their parents

Some children remained positive about their parents in spite of their limitations and wished or longed to see more of their mothers (14%), fathers (12%) or both (4%). Occasionally, when children said that they wanted to see more of their parents, they added that this was in spite of knowing that a meeting was unlikely to go well. Thus, sometimes children idealised their parents and some held contradictory and ambivalent feelings about them. One 10 year old child, whose drug dependent mother had stopped visiting, said:

I used to see my mum but not any more. Last I saw her was...almost three years ago... Even though I hate her for what she's done to me I'd still like to see her...Well she's meant to come up twice a week but she stopped...She's not phoned, she's not texted, she's not wrote.

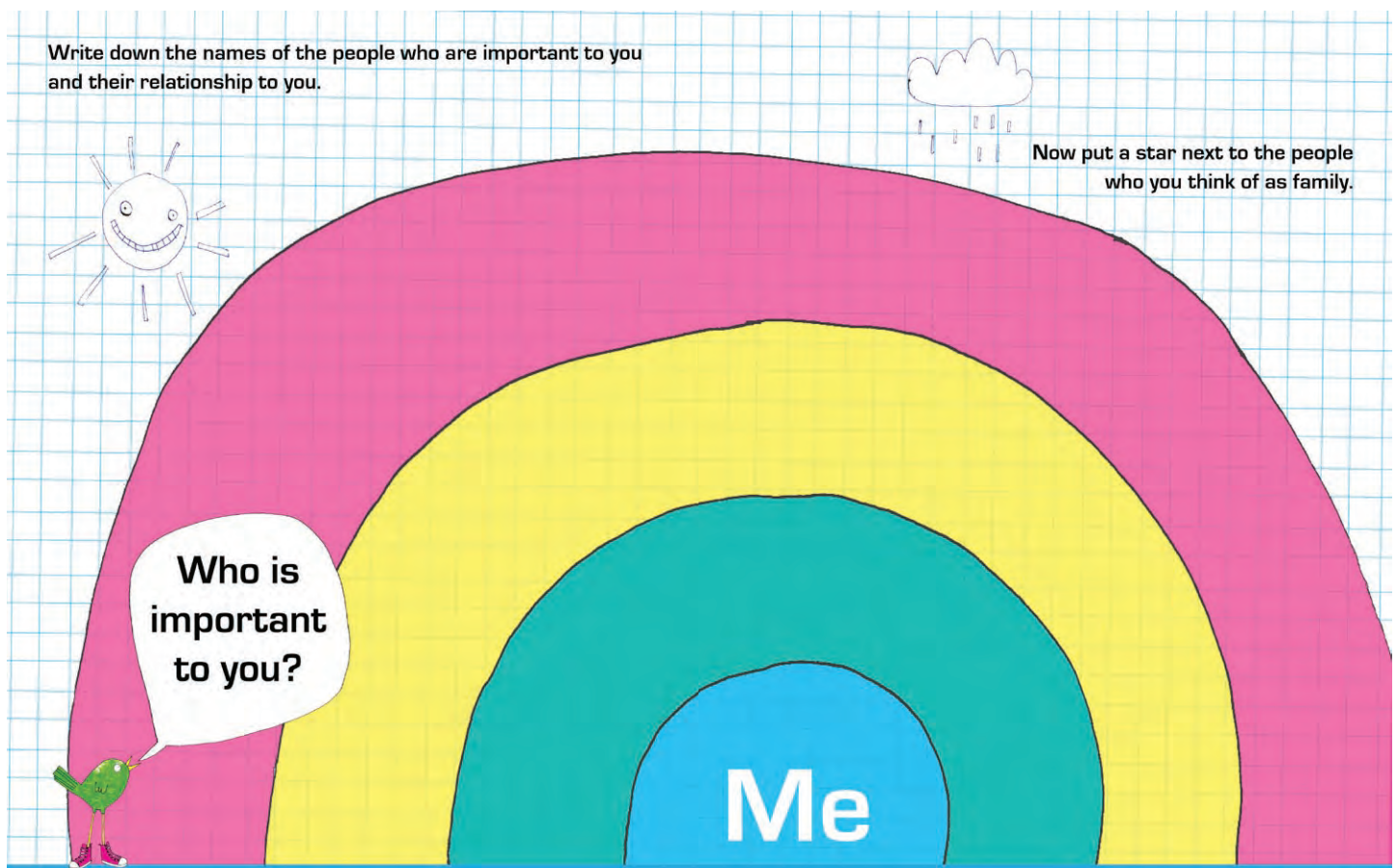
[10 year old living with grandparents]

One boy, who was said by his grandmother to crave male attention, spoke wistfully of the violent father he had never known:

I do want to meet him when I'm older. I do want to find him...I don't even think he'll remember me.

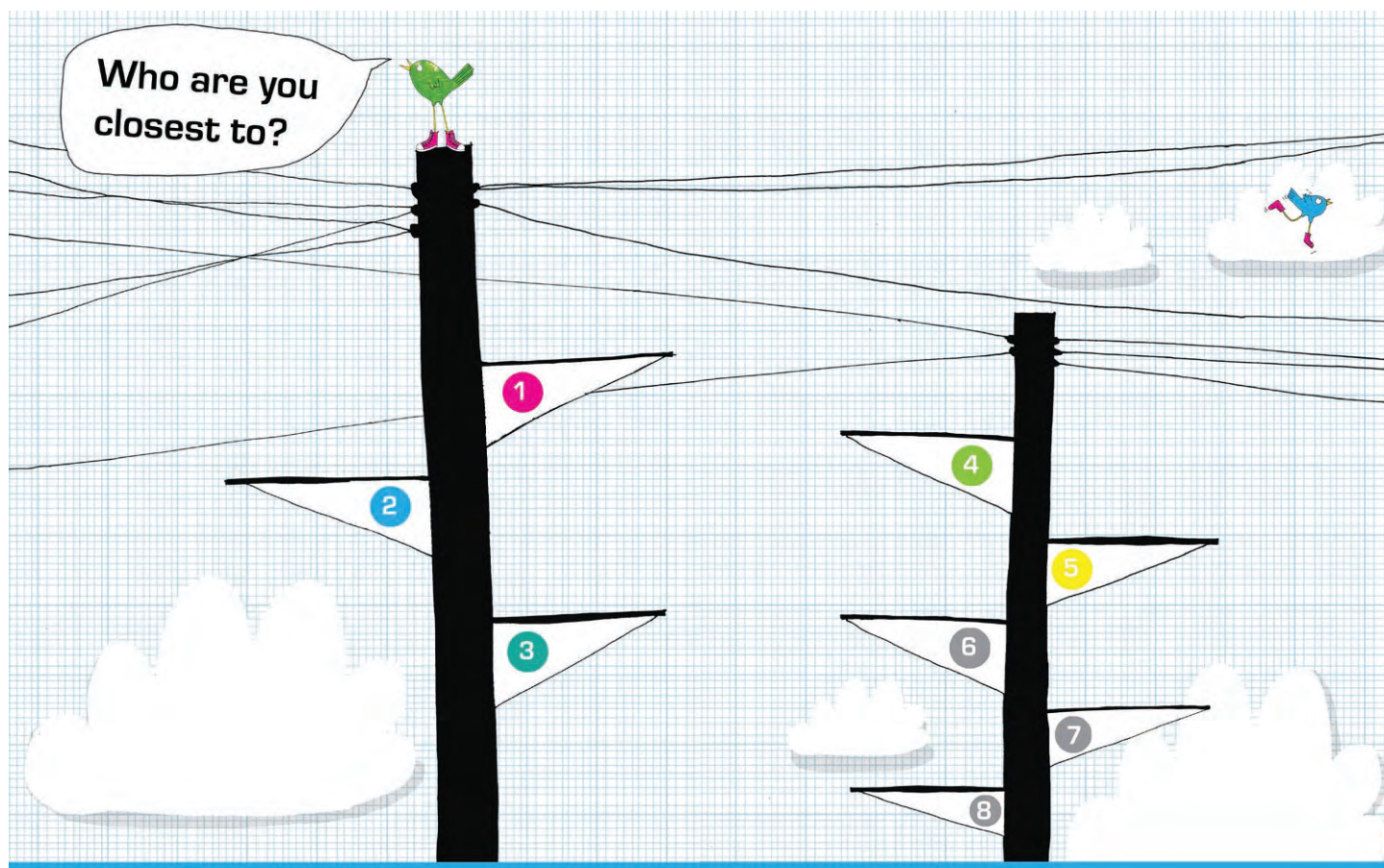
[15 year old living with grandmother]

Absent parents appeared to play on children's minds, as revealed by one teenage girl whose contact with her alcoholic mother had been temporarily banned by her carer and who told us that one of her three wishes was to 'get back' her father who had died when she was young. A teenage boy, both of whose parents had died, wished 'To let my mum and dad know that even though they are not here, that I love them very much'.



It was noticeable that a number of children, who lived with older grandparents in poor health and with few supportive relatives or friends, often included a parent as one of the most important people in their lives, even when contact was infrequent. For example, a twelve year old boy said his kin carer and parents were the most important people to him and he wanted to see more of his parents. He had been abandoned by his mother who had 'chosen' his violent step-father over him and his own father showed little interest in him. Such children's longing to see their parents might have been intensified by the isolation some of them experienced.

When asked to identify who the children saw as part of their family, four included mothers who had died. For these children their mothers appeared to be psychologically present. A further four children said that they regarded their fathers as family, even though they were not in their lives. In addition, a few children were actively trying to engage with parents who were alive but who had no contact. For example, one teenage girl who saw neither parent had started writing to her father and mother, although neither of them had replied.



Children who wanted less contact with their parent/s

Only a small number of children said they wanted to see less of their parents. One was a teenage girl, who was left on her grandmother's doorstep at the age of five, after being told by her father and step-mother that she was unwanted. She had decided that she no longer wanted occasional visits from her mother and brother who had stayed with the mother, as she found this contact *'awkward and weird'*. A ten year old boy chose not to ring his mother in case her violent boyfriend answered the phone and another child had deleted his father from his Facebook page because he *'made trouble'*.

HOW PARENTS FEATURED IN THE CHILDREN'S THREE WISHES

We asked children to think of three wishes and write them in their Activity Book. A fifth of the children (21%) had wishes about their parents, especially their mothers. Seven children wished that a parent was alive or would return to their lives and five wanted their parent to *'get better'*, *'not be addicted'* or *'sort themselves out'*. Four other children's wishes were: *'Just for a day to see what it would be like living with my mum'*; *'Still be with my mum'*; *'See mum and dad more often'* and *'Talk to my mum'* (who had not been in the child's life since she was a baby and had since died).

A teenage girl told us that she wished she could *'get over worrying'* about her parents who had both died. Similarly, another child suggested that young people should *'forget about your past and think of your new life'*. Seven other children made wishes about their family as a whole, such as *'That my family could have all problems sorted'*; *'My whole family to be safe from danger and have lots of love in my family'* and for *'Everyone to get along'*.

Whilst most children who made wishes about their parents or carers also wished for other things, two children made wishes only about their parents and carers, suggesting that they were very focused on past losses and present worries about close family members. One child's wishes were: '1) *My mum will be well*; 2) *My granny will be well*, 3) *My mum will be happy*'.



CHILDREN'S RELATIONSHIPS WITH PARENTS WHICH AFFECTED THOSE WITH THE KIN CARERS

One in five of the kinship carers thought that the quality of their relationship with the child was affected by the child's relationship with, or feelings about, a parent (or occasionally another family member), and the children concerned were significantly less well attached to their carers than others. For example, some children took their parent's side when there was conflict between the carer and parent. One grandmother said:

Her mum stirs things up against us...for instance Phoebe said to me only yesterday morning 'No wonder mum can't stand you, you never ever stop going on'. I can well imagine that's what mum's been saying...I suppose she has a loyalty to her mum. Her mum puts her pennyworth in about how controlling we are.

[Grandparents bringing up 16 year old]

Another grandmother of a 10 year old boy described how he often became critical of her following contact with his mother, who gave him more freedom. He would say: 'Oh mummy's better than you...mummy will let us do this'.

In addition, the closeness of a few children to their mothers meant that they were over-exposed to their parents' difficulties. This was true for one girl who said it was 'pretty good' when she saw her drug using mother at weekends and they 'hung out' together. The grandmother was concerned that the girl would end up becoming her mother's carer, taking over the grandmother's role.

CARERS' RELATIONSHIPS WITH THE CHILDREN'S PARENTS

The context for parent and child contact and the conflict that sometimes ensued, was the relationship that kinship carers had with parents, to whom they were usually closely related.

Good relationships

A quarter of the carers said that they had good relationships with the children's parents. Many of these carers worked hard to maintain a good relationship with the children's parents, partly in order to preserve the kinship arrangement and also for the sake of the children. Some relationships were described as good because the parent had been able to make positive changes in their lifestyle. Other relationships however, were good only as long the carer continued to give the parent money. One grandmother who regularly sent money to her daughter said:

I speak to her two or three times a week maybe, if I can. [Our relationship is] fine so long as the money is there for her.

[Grandmother bringing up 18 year old]

Stressful and distant relationships

However, the remainder of relationships with parents were described by the carers as stressful, variable or distant. Carers often described stressful relationships with parents who were misusing drugs or alcohol [see also e.g. Kroll 2004 and 2007]. Some carers had deliberately distanced themselves from the children's parents. It saddened and deeply disappointed them that their own adult children (or brothers or sisters) had turned out to be poor parents [see also Barnard 2003] and left some carers wondering if they were to blame. For example, a grandmother described feeling 'mad' with her daughter for choosing a lifestyle that was to the detriment of her children:

Choosing her partner and drugs [over her children] is wrong. You have kids, they need to be looked after, not just shoved to one side.

[Grandmother bringing up 9 year old]

Sometimes relationships were changeable, depending on the parent's mood or state of mind. One grandmother summarized the relationship with her daughter, a heroin addict, saying:

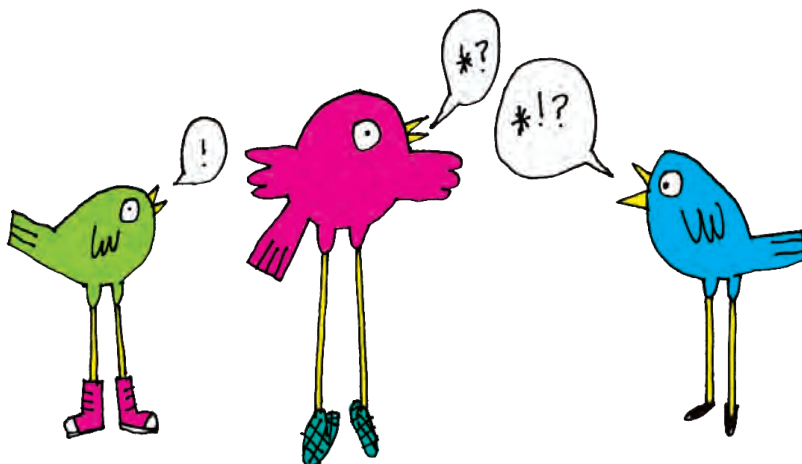
It can be marvellous one day and the next day it could be horrendous.

[Grandmother bringing up 8 year old]

CARERS' MANAGEMENT OF CONTACT

Reviews of the kinship care literature suggest that relationships between parents and kinship children are more likely to be maintained than relationships between parents and children placed with unrelated foster carers (Flynn 2002; Hunt 2003; Cuddeback 2004). Previous studies have found that for young people living in kinship care, contact with parents is not only more frequent than in non kin foster care but is also usually arranged informally (Ehrle and Geen 2002; Farmer and Moyers 2008). However, contact can be fraught with difficulties and is not always beneficial for the children (Aldgate and McIntosh 2006; Farmer and Moyers 2008; Hunt *et al.* 2008).

Where children were in contact with their parents, 60% of the carers reported difficulties. Carers described how they trod



a fine line between wanting to facilitate parental contact, whilst needing to ensure that the experience did not harm the children. The proximity of parents or the nature of their problems, made managing some contact particularly challenging and carers made great efforts to protect children from parents who placed them at risk by, for example, exposing them to substance misuse, involving them in criminal activities or looking after them inadequately. Some carers had to deal with the fall-out from parents who made promises that they did not keep, such as the mother who would visit and be very affectionate towards her ten year old daughter, vowing to have her back soon, but would then disappear for another year. Indeed many parents were unreliable or inconsistent in their contact:

[The children's mother] would say that she was coming. The girls would be sitting there waiting and she'd never turn up. Out of 79 contacts [arranged], she actually took 11 of them up and 5 of them she was late with. Its funny how those figures stick in your mind isn't it?

(Step-grandparent bringing up 13 year old)

Carers reported that managing contact was emotionally draining, with some carers explicitly linking the associated stress to their own feelings of depression.

Contact that was difficult to control with parents who were dependent on the carers

Just under a third of the kin carers were still supporting the children's parent in some way. Most were grandparents, although two were aunt carers who were supporting their sibling as well as raising their children, and one was a friend carer. Whilst a few of these parents had learning difficulties or mental health problems, most (four-fifths) had on-going problems with addiction:

She still expects me...to do things for her all the time. She wants me to look after her and she's ill a lot and she's not ill because of the HIV, it's usually because of the drugs.
(Grandmother bringing up 8 year old)

Some parents relied on financial support from the carers even when the carer's budget was already stretched. Grandparents paid household bills for their adult children, bought them food, clothes, tobacco and gave them money. The parents visited the kinship carers to get their own needs met, sometimes with little regard for their children who lived there. These visits could be difficult to control and very upsetting for both the carers and the children. One father who misused alcohol and was on methadone often went to his mother's (the carer's) house at night, drunk, shouting and banging on the door to be let in. This was so stressful for the carer and child that the grandmother told us that she sometimes wished her son was dead. In a similar vein, another grandmother said:

I've had to put [the child's mother] out of the house a couple of times. She's been really drunk and she's been bringing alcoholics into the house as well...It's the mother who brings the troubles to the house. If she wasn't about, the children would get on with their lives...But she keeps coming up like a bad penny and disrupting them...I sometimes wish she was dead and [feel] terrible saying it.

(Grandmother bringing up 12 year old)

Arguments between the parents and carers

Some parents who knew that they were unable to provide adequate care were nonetheless overwhelmed with feelings of anger and resentment against the kin carers who had stepped in to look after their children. Some parents verbally abused the carers or accused them of 'stealing' the child or of being too indulgent or too strict. They sometimes threatened, harassed or assaulted the carers. For example, a grandmother said:

She put me in hospital once, she hit me so hard I was taken into hospital...I had bruises, the police here and everything...I need her to say sorry for that...that would close it in my eyes.

[Grandmother bringing up 11 year old]

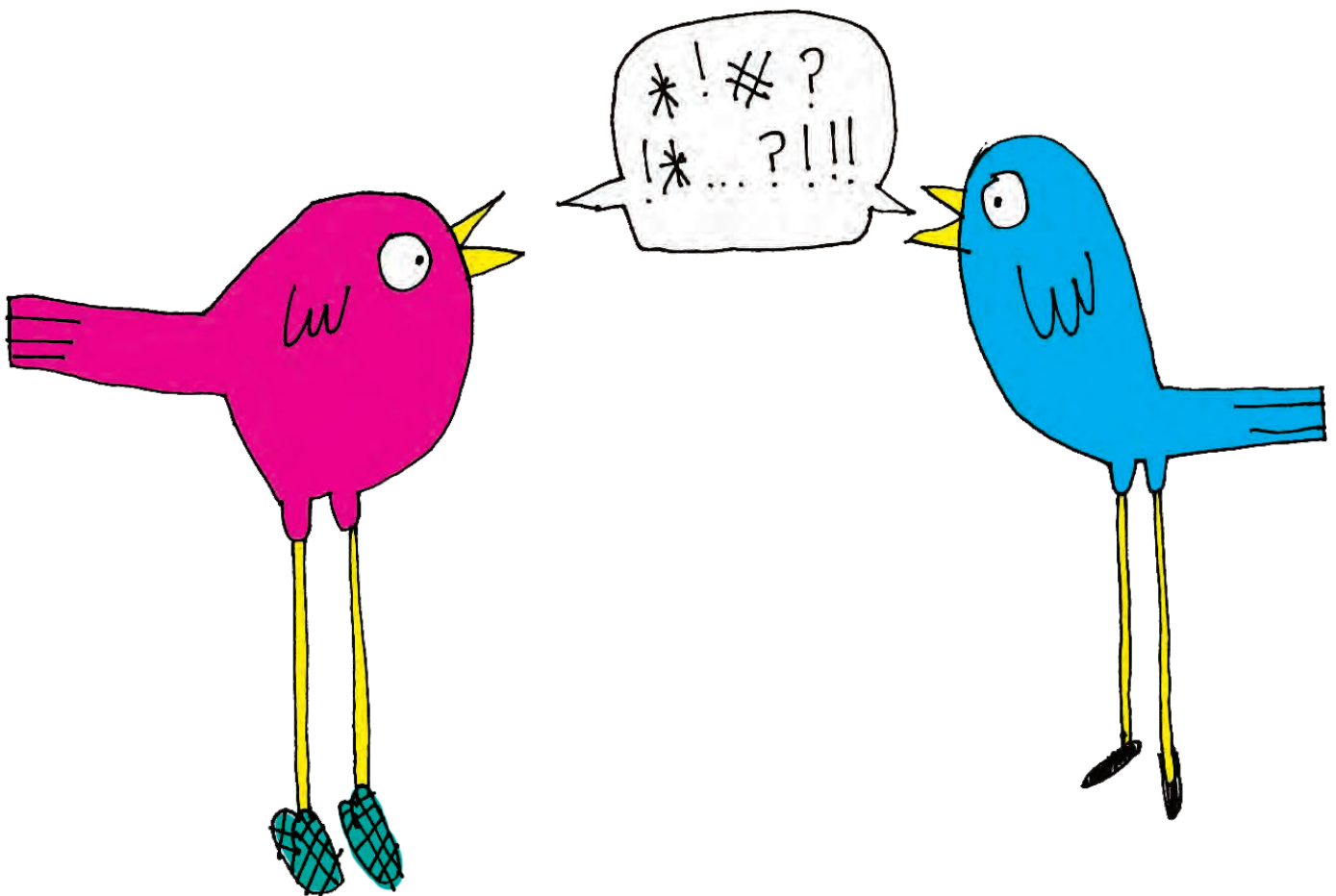
Contact could be a time when parents and kinship carers argued about the care of the child. Children, who witnessed arguments between their parents and their carers, found this very difficult indeed. It created divided loyalties and left children feeling confused and unhappy. As one teenager said:

Sometimes she (mum) gets angry...she argues with grandma...it's hard.

[16 year old living with grandmother]

Managing positive and safe contact between the children and their parents (nearly always without professional support) was a major task for the kinship carers, but one that non-kin foster carers much more rarely undertake (Farmer and Moyers 2008). As we have seen, difficult contact or witnessing parent-carer conflict was statistically associated with children having poorer mental health.

Having explored the ways in which parents could continue to have an impact on the kinship children, in the next chapter we consider the children's progress and their emotional and behavioural development in more detail.





CHAPTER 7 : THE WELLBEING OF THE CHILDREN

Research findings on the wellbeing and progress of children living in kinship care have been limited and inconclusive (Hunt 2003; Cuddeback 2004; Winokur *et al.* 2009). Studies have reported broadly positive findings, although they have been limited by methodological weaknesses. In addition, most of the available information originates from carers' reports in studies of formal kinship care. In the UK, children's own views of these matters have been largely absent. We contribute to the evidence by reporting the results from the standardised measures used in our study to assess the children's wellbeing.

Social, emotional and behavioural wellbeing contributes significantly to the quality of children's lives. Children who generally feel good about themselves exhibit an enthusiasm for life and welcome opportunities to develop and learn. However, experiencing social, emotional or behavioural difficulties can be associated with depression (e.g. Heim and Nemeroff 2001), educational under-achievement (e.g. McClelland *et al.* 2000), bullying (Duncan 1999) and, in adulthood, impaired relationships with partners and family (Buchanan 1999), poorer physical health (Flaherty *et al.* 2008) and vulnerability to alcohol and drug addiction (Volkow and Ting-Kai 2005).

We begin by considering the kinship children's emotional and behavioural strengths and difficulties, their educational progress and friendships and provide information about how far the older children said they engaged in risky behaviours.

CHILDREN'S EMOTIONAL AND BEHAVIOURAL STRENGTHS AND DIFFICULTIES

Carers completed a set of 30 questions that make up the widely used Strengths and Difficulties Questionnaire (SDQ, Goodman 1997). Five subscales were generated from this set of questions.

These cover:

- Emotional Symptoms (e.g. 'Child has many fears, is easily scared.')
- Hyperactivity/Inattention (e.g. 'Child is constantly fidgeting or squirming.')
- Conduct Problems (e.g. 'Child often fights with other children or bullies them.')
- Peer Relationship Problems (e.g. 'Child is rather solitary, tends to play alone.')
- Pro-social (positive) Behaviour (e.g. 'Child is considerate of other people's feelings.')

By summing the first four scales of problematic behaviours a Total Difficulties score was generated, which classifies children as normal, borderline or abnormal. In our study, 55% of the children fell into the normal category, with 11% identified as borderline and 34% as abnormal. Thirty-four percent of children with scores in the abnormal range is a higher rate than that found in the general population (10%) but lower than for children in non-kin foster care in the UK (45%-74%) [see e.g. Minnis *et al.* 2001; Meltzer *et al.* 2003; Sinclair 2005]. These scores are similar to those for children in formal kinship care (Holtan *et al.* 2005; Ford *et al.* 2007; Farmer and Moyers 2008; Hunt *et al.* 2008; Hunt and Waterhouse 2012).

In this study, as in many others, boys were statistically more likely than girls to have an abnormal total score. Several children with SDQ scores in the abnormal range, had



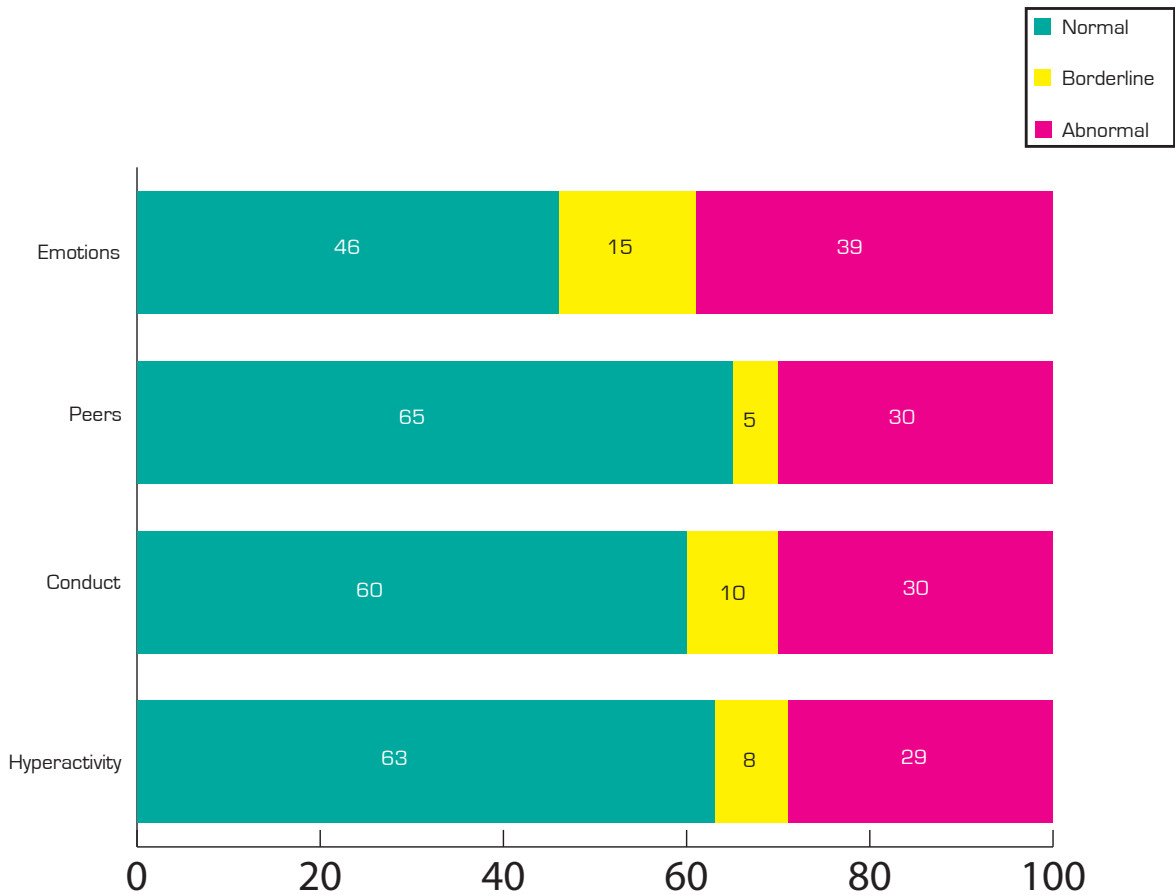
complex and multiple over-lapping difficulties. Their carers faced a huge challenge in managing the children's troubled and troublesome behaviour.

One grandmother, for example, who looked after her 8 year old grandson, described him as aggressive and angry. He got into fights, ran away from home, destroyed furniture and lied. The carer was in daily conflict with the child and felt under intense strain. Despite his young age, he had already been excluded from school. He was known to CAMHS and had been diagnosed with ADHD, autism, an Attachment Disorder and was being investigated for Tourette's Syndrome.

An aunt and uncle caring for their nephew said that he lied, stole, broke furniture, displayed inappropriate sexual behaviour and had sleep problems. He had been diagnosed with an Attachment Disorder and ADHD. He had a special educational needs statement and attended a school for pupils with emotional, behavioural and social difficulties. His behaviour at the school was so disruptive that the headmaster had asked the carers to keep the child off school during a three day Ofsted inspection.

As we have seen, the SDQ assesses children's adjustment on the four dimensions of emotions, behaviour, hyperactivity, and peer relations (Figure 7.1). Boys were more likely than girls to have difficulties with hyperactivity and peer relationships. Carers described these children as unpopular, isolated and having few friends. However, overall the greatest area of difficulty for the children was in their ability to express and manage their emotions, where as many as 39% scored in the abnormal range. This meant, for example, that carers stated that it was true that the children had many fears, were easily scared, often complained of headaches or stomach aches, and were often unhappy, downhearted or tearful. We do not know exactly why children had these raised anxiety levels but some of the issues which are likely to contribute are discussed in Chapter 10.

Figure 7.1: Percentage of children classified in the normal, borderline and abnormal range on the four dimensions of the Strengths and Difficulties Questionnaire



Global Self-Concept

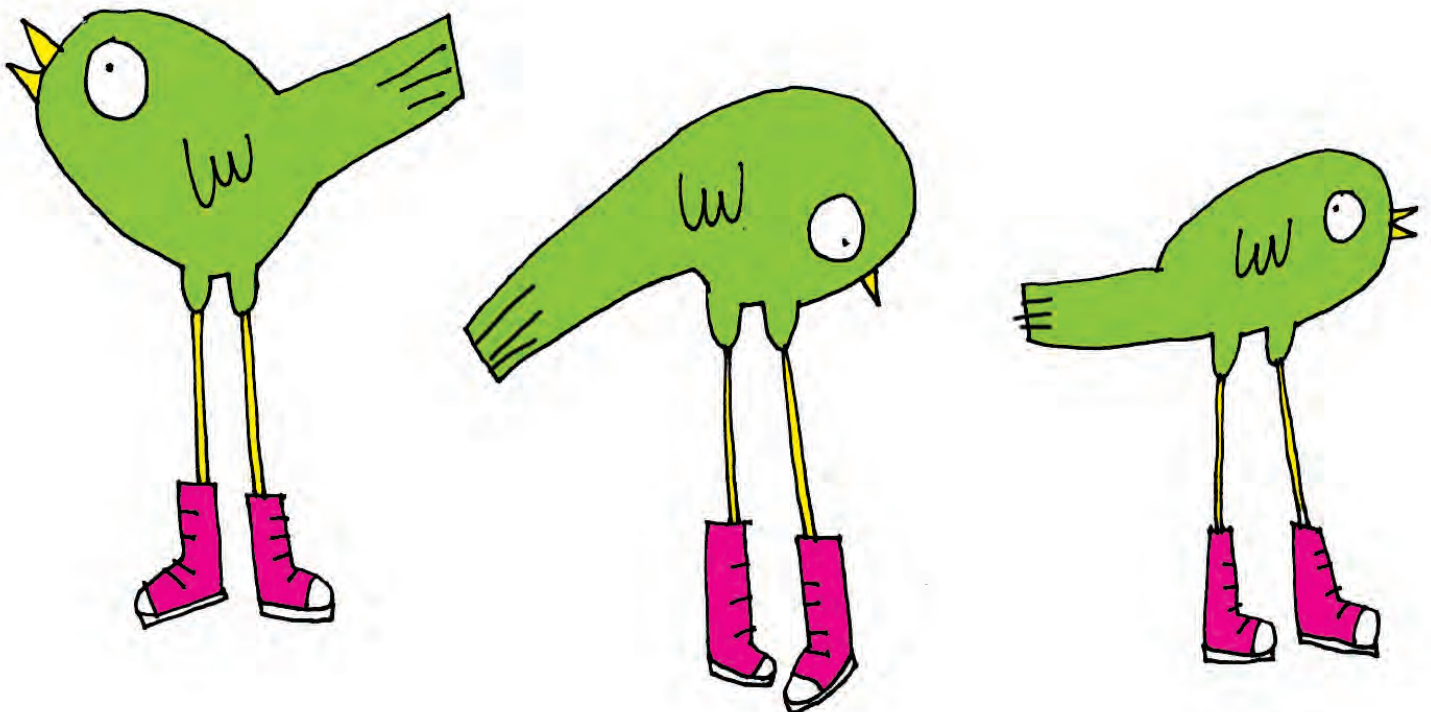
The Piers-Harris 2 scale was used to measure the children's self-concept. It contains items that express how children feel about themselves and their behaviours. More than four-fifths (84%) of the children had total scores within the high or average range, suggesting a balanced self-evaluation, with acknowledgement of both positive and negative aspects of self.

However, 16% of the children had very low total scores, indicating that they had serious doubts about their own self-worth and viewed themselves as less competent than their peers. Low total scores on the Piers-Harris 2 have been associated with disturbances in mood and behaviour and are likely to indicate that the child has a diagnosable psychiatric disorder, such as a major depressive disorder, anxiety disorder or conduct disorder. Low total scores usually reflect true disturbances in self-esteem, since negative exaggeration ('faking bad') is rare in children. There were no statistical differences in scores by the child's gender or by type of carer.

The Piers-Harris 2 features six different areas or domains of self-concept. These domains are useful in identifying relative strength and vulnerability in a child's self-concept. For example, children may see themselves as doing very well in one domain (e.g. friendships) but poorly in another (e.g. education).

Most children (n=71) reported that they were happy and content with life. However, nine agreed with the statement 'I am unhappy'. Five of these children also had scores on the depression measure that would suggest a depressive illness and two were critical of one of their most fundamental personal qualities, in that they responded negatively to the statement 'I am a good person'.

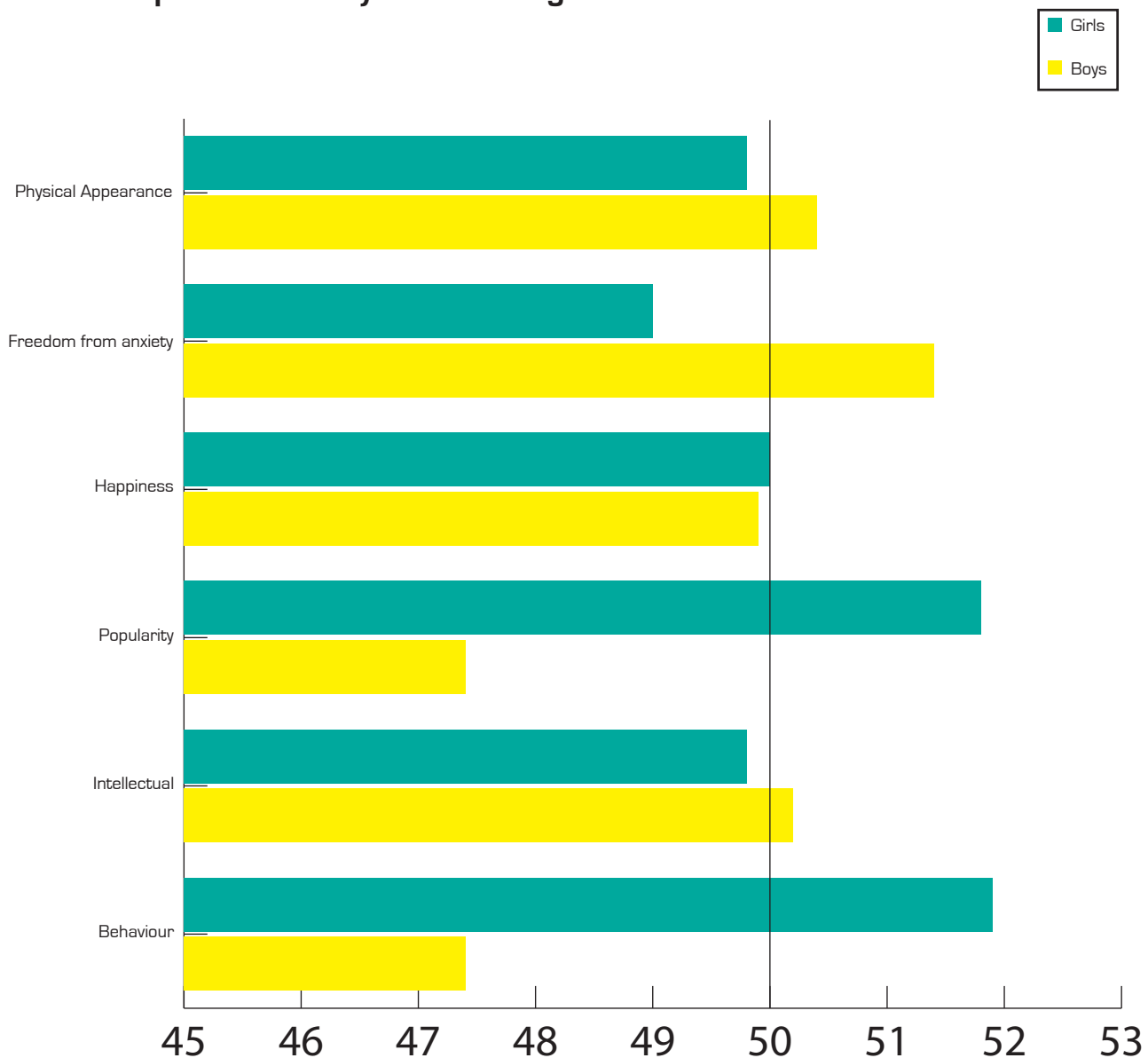
Sophie aged 12, reported that she was unhappy. She lived with her step-grand parents and had not seen either parent for many years. She said that she hated talking to people about her worries and instead confided in the dog. She described herself as 'not very smart' and thought that she would be unable to get into a college. She said 'I'm pretty rubbish at everything really.'



The girls were confident about their popularity and behaviour but their average scores were slightly lower than children in the general population on the freedom from anxiety domain. This domain taps into emotions such as worry, nervousness, fear and sadness. On the other hand, the boys were least confident about their popularity and behaviour. These gender differences have been noted in other studies (Piers and Herzberg 2002).

Figure 7.2 shows the average standardised T scores of girls and boys on the six domains. A score of 50 corresponds to the average score in the general population.

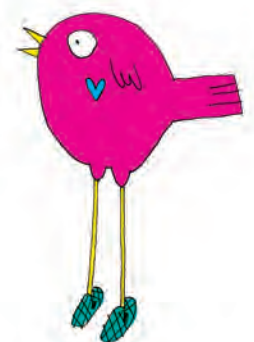
Figure 7.2: Children's average scores on the six domains of the Piers-Harris 2 self-concept measure by the child's gender.



ATTACHMENT TO CARERS

The children completed a measure (IPPA-R) that assesses children's perceptions of the positive and negative aspects of their relationship with their primary carer. It examines, in particular, how the main carer serves as a source of psychological security. No statistically significant difference was found in the children's total score averages and those reported in general population samples (Gullone and Robinson 2005). Given the extensive difficulties in the children's backgrounds, these scores of attachment to carers are very positive indeed.

The total score on the IPPA-R was also correlated with our other measures - higher attachment scores on the IPPA-R were correlated with higher self-esteem scores, whilst lower attachment scores were correlated with higher depression scores and higher SDQ scores. However, there was a difference in one sub-scale of the IPPA-R - the quality of communication, where the kinship children scored on average significantly lower than



children in the general population. In this sub-scale children were asked about the extent to which they agreed with statements such as: 'I feel it's no use letting my feelings show around my carer'; 'My carer can tell when I'm upset about something' and 'My carer has her own problems so I don't bother her with mine'.

DEPRESSION AND ANXIETY

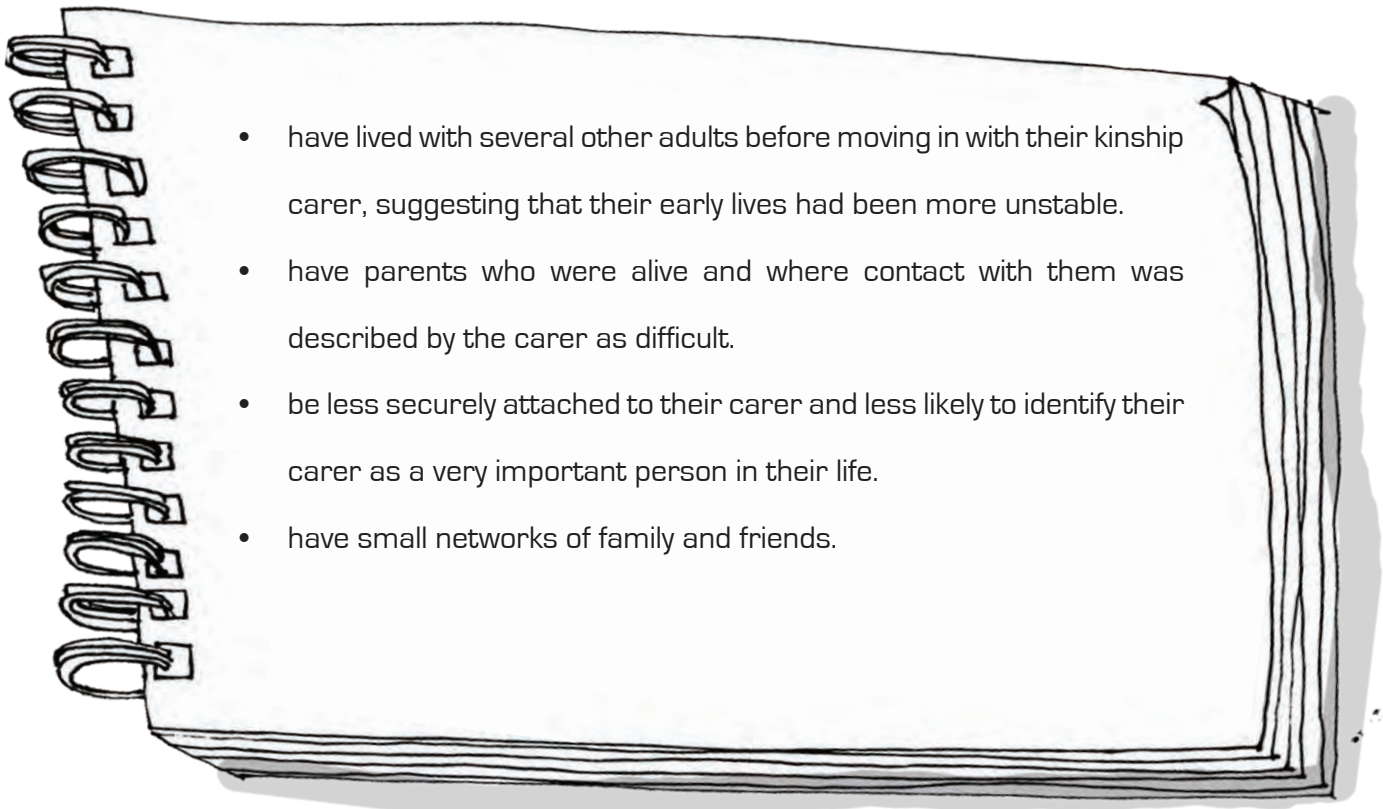
A self-rated depression scale (Birleson 1980) was completed by all the children and nine (11%) had scores which suggested a possible depressive disorder. Worryingly, three of these children responded 'most of the

Helen who was 16 years old was born following a serious sexual assault on her young mother by a much older man. Her mother's life spiralled out of control and Helen witnessed her mother's suicide attempts, was isolated and missed much of her schooling. Helen moved in with her grandmother in her teens, whilst her mother was treated for depression, but described feeling 'torn apart' because her mother desperately wanted Helen to remain living with her. Helen felt keenly the mystery of her father's identity and would ask about him. Her father began to ask after Helen and then invited her to his home. He confirmed that he was her father but also that she was unwanted. Helen became very distressed; she threatened suicide and went missing. At the time of the interview she was taking anti-depressants and when we asked her to identify three wishes, in which anything could happen, she wrote 'A new and happy life.'

time' to the statement 'I feel so sad I can hardly bear it'. We were surprised to find that younger children were just as likely as the teenagers to have a score indicative of depression. All the nine children who were likely to be clinically depressed had been exposed to either parental substance misuse, parental mental illness or both before moving to kinship care.

In addition, a further nine children scored themselves as very low on the 'happiness and free from anxiety' dimension on the Piers-Harris 2 measure. Therefore, a total of 18 children (23%) had symptoms of clinical depression and anxiety. These children were also more likely to report that they self-harmed or had run away from their carers.

There were no statistical differences in the likelihood of depression/anxiety by the children's gender or age, nor were differences associated with the age of carer or the carers' own depression rating. However, we did find that depressed and anxious children were statistically more likely to:

- 
- have lived with several other adults before moving in with their kinship carer, suggesting that their early lives had been more unstable.
 - have parents who were alive and where contact with them was described by the carer as difficult.
 - be less securely attached to their carer and less likely to identify their carer as a very important person in their life.
 - have small networks of family and friends.

COMPARISONS WITH CHILDREN IN THE GENERAL POPULATION AND WITH CHILDREN IN OTHER TYPES OF CARE

Most of the children who entered kinship care had experienced a range of serious adversities. As we have seen, many had moved from abusive and neglectful homes and 88% of the children were thought by carers to have been maltreated. Research has consistently found that a history of child maltreatment is linked to a greater likelihood of psychological and health problems in childhood and adulthood (see e.g. Asmussen 2010).

Despite these adversities, our findings from the standardized measures, together with the accounts given by both carers and children, suggest that most of the children were developing within the normal range. When compared with the general population, children’s evaluations of their self-concept and the security of their attachment to their main carer were very similar¹.

That said, a minority of the children had serious problems across a range of dimensions. In the following table, we show the proportion of kinship children who scored in the abnormal range on the study’s measures and, where available, compare these with results from previous studies.

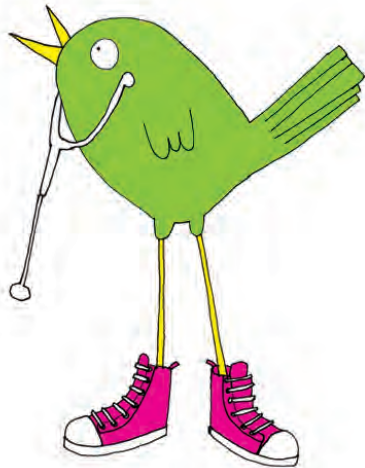
Table 7.1: Percentage of children with abnormal scores in this study, in the general population and in other types of care

Measure	Kinship care (informal) %	General Population %	Kinship care (fomal) %	Unrelated foster care %
Strengths and Difficulties Questionnaire (SDQ)	34	10 -16 ²	31.5 ³ - 35 ⁴	45 - 74 ⁵
Birleson Depression Scale	11	4 ⁶	-	28 ⁷

Whilst, as we have seen, more of our children in informal kinship care had abnormal scores on the SDQ than children in the general population, the proportion with difficulties was smaller than for children growing up in unrelated foster care. A similar pattern can be seen for the scores on depression. The scores on the SDQ were similar to those reported for children growing up in formal kinship foster care.

CHILDREN’S PHYSICAL HEALTH

Forty-three percent of the children reported physical health conditions that affected their daily lives. Most commonly reported were allergies and asthma, but children also reported rarer conditions such as Aarskogs Syndrome, autism, Noonan Syndrome, Sturge-Weber syndrome, and diabetes.



¹ Kinship children’s self-concept average score 47 whilst general population average scores 45-55. Kinship children’s attachment security average score 23 whilst general population average score 22

² www.sdqinfo.com

³ Ford *et al.* 2007

⁴ Farmer and Moyers 2008

⁵ Minnis *et al.* 2001; Meltzer *et al.* 2003; Sinclair 2005

⁶ Geen *et al.* 2005

⁷ Mount *et al.* 2004

EDUCATIONAL PROGRESS

At the time of interview, most children (77%) were in mainstream education and 5% were at boarding schools, 3% at a special school, 3% were excluded and home tutored, whilst 12% had left school. More than half (57%) of the children in compulsory education described school as good or very good, 27% said it was OK and just 16% reported that they did not like school. Many children seemed to be making satisfactory educational progress, with just under three-quarters of the carers reporting that the children were doing well or at least OK in school.

Nine (13%) children had a statement of special educational needs for specific learning difficulties and two children were registered as exceptionally gifted and talented. Although few had been formally statemented, about a third (34%) of the children had been identified by schools as having additional educational needs and received extra help and support. Examples of this help ranged from a little extra weekly tuition in specific subjects, to a support worker present throughout the day to help manage behaviour.

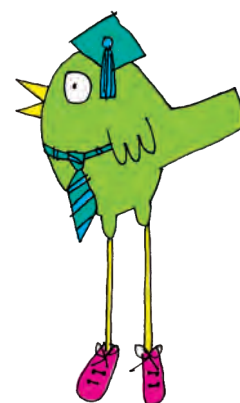
We asked about the exam results of the 17 children who were of an age to sit GCSEs. Forty-three percent of the children had gained 5 A*- C grades, including two young people who had achieved 10 or more A*- C grades. Four other children had gained five passes between A*- G, one child had one pass at GCSE and two children had no qualifications. These results compare very favourably with the 13% of looked after children in England who achieved 5 A*- C grades (DfE 2011b). The proportion of kinship children with good GCSEs (43%) was lower than that achieved by the general population, where 58% achieve good grades. However, it could be argued, given the low incomes of the kinship families, that a more appropriate comparison is with children in receipt of free school meals in England, 35% of whom achieved five good GCSEs (DfE 2012). The kinship children in our study seemed to be doing better academically than those in unrelated foster care and better than those from a similar socio-economic group. However, it must be remembered that only 17 children were old enough to take exams and these findings must be treated with caution.

Ten young people were no longer at school. Seven of them were in full-time education at college studying for 'A' levels or on courses in preparation for specific careers. One young person for example was working towards a diploma in aeronautical engineering. Three young people were not in any form of employment, education or training (NEET).

DIFFICULTIES IN SCHOOL

Carers were asked if there had been any difficulties in the past few years that had necessitated contact with teaching staff. About a third of the carers (32%) reported no difficulties, but many had gone into school to discuss problems, often relating to concerns about the children's disruptive or aggressive behaviour or poor attitude. Carers gave examples of children fighting with and bullying others and of children truanting. One carer on a low income had been fined £30 after her grandson had set off a fire extinguisher. A few described daily problems in school. When asked how often she spoke to teachers about her grandson's difficult behaviour, one carer said *'Every day. He's been excluded for bullying and hitting the teachers, fighting, swearing, and throwing things'*. In fact, the behaviour of eleven children had led to at least one episode of school exclusion.

Other carers had initiated visits to the school for reasons other than disruptive behaviour. Some were concerned that the child had been bullied or had been upset by the behaviours and actions of others. Carers said that several children had been taunted at school because they did not live with a parent; another said that her grandson's Scottish accent had singled him out for bullying in an English school. Carers gave examples of racist remarks by staff, of children being terrified by teachers who shouted and of children's distress when Mother's Day or Father's Day was discussed in school. Some carers recognized how difficulties at home had an impact on the children's behaviour and progress at school. As we saw in Chapter 6, young people were particularly affected by conflict between their parents and their carer and their distress could spill over into school.



RISKY TEENAGE BEHAVIOURS

We asked the young people who were aged 12 years and over ($n=38$) if they had even been in trouble with the police. Eight (21%) young people said they had received a caution and three had been convicted of an offence. We also asked about their involvement in risky behaviours such as smoking, drinking, drugs misuse and school truancy. Experimenting with alcohol and cigarettes is very common during adolescence. Just over a quarter (26%) of the young people admitted smoking and slightly more (29%) said that they drank alcohol at least once a week. This is a lower proportion than that reported in the looked after population and similar to rates in general population samples (Meltzer *et al.* 2003; NHS 2011).

However, a small group of six young people in kinship care self-reported harmful patterns of regular binge drinking. Five of these six teenagers were also regularly misusing drugs, two of whom used Class A drugs. These young people had serious problems with substance misuse and their difficulties also included school exclusions, truancy and emotional and behavioural difficulties.

FRIENDSHIPS

We asked the children how many friends they could rely on to talk to if they were really upset about something. Nearly all the children (98%) identified at least one friend, and most identified more than one. Two children said that, although they did have a friendship group, they could not identify any one particular person with whom they could share their troubles and one teenage boy, when asked about confiding in friends, commented, 'I don't do that. I don't do stuff like that'. The majority of children (92%) were satisfied with the number of friends they had. Carers generally agreed with children's perceptions of their popularity and ability to make friends. However, carers thought that some boys (21%) had more difficulty making friends than they themselves had reported and had no close friendships.

Some children spoke about the importance of the friends they had made at a very young age and with whom they had grown up. They felt that long-standing friends more readily accepted their kinship arrangement. One girl described the warm relationship between her grandmother and those friends she had known for years:

About five of my friends are pretty involved with my carer...when they come in [to my house] they speak to her, they greet her, they have a conversation with her, because all my friends I've known like all my life and their mum was friends with my mum, so I've carried on being friends.

[15 year old living with grandmother]

WHAT MIGHT EXPLAIN THE EMOTIONAL AND BEHAVIOURAL DEVELOPMENT OF CHILDREN IN INFORMAL KINSHIP CARE?

The presence of protective factors in many children's lives (see Chapter 4) clearly had a positive impact on children's development. Particularly important was the availability of a protective, committed carer and the benefits of this could be seen in most children's secure attachment to their carers. Children said they felt safe and most believed that they would remain with their kinship carers for as long as they wished. Thus, the developmental progress of most of the kinship children was normal.

Nonetheless, a significant minority of children did have some difficulties, particularly in expressing and managing emotions (feeling anxious and fearful) and in communicating openly with their carers. We saw in Chapter 5 that open communication between the carers and children was particularly difficult for both carers and children. Being able to help children make sense of their personal histories is important and, as we saw, this did not always happen. In addition, some carers were also unable to prevent poor quality contact and this was statistically associated with children's poorer mental health. However, the strongest predictor of children having poor mental health was the lack of a secure attachment to their kinship carer. Given the centrality of the kin carers to the children, we look now at the wellbeing of the carers themselves.

CHAPTER 8 : THE WELLBEING OF THE CARERS

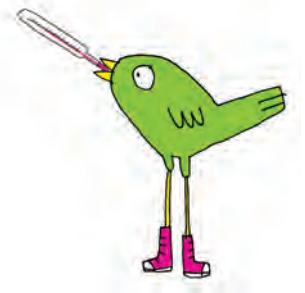
The impact of being a kinship carer on the carers' wellbeing is the particular focus for this chapter. There is a large literature, primarily from the US, focussing on grandparent carers, which exposes the detrimental effects of kinship care on the caregivers' health (e.g. Minkler and Fuller-Thompson 1999; Grinstead *et al.* 2003). However, research (Hughes *et al.* 2007; Baker and Silverstein 2008) also suggests that the poor health of grandparent carers can predate kinship arrangements and then existing health conditions are exacerbated by the stress surrounding their change in circumstances. These latter studies found that carers' poor health peaked at the time of the children's transition into kin care, but generally abated as carers adapted to their role. However, when the demands on grandparent carers were high and their resources limited, their health continued to deteriorate (Hughes *et al.* 2007). Health related matters have received little attention in the UK literature and in neither country have health issues for younger and non-grandparent carers been given much consideration.

Theories of stress suggest that the interplay of stressors and resources has a direct impact on psychological distress, especially on depressive symptoms (Ensel and Lin 1991). Stress becomes problematic when it overwhelms a person's capacity to cope because the available resources that an individual can draw on are insufficient. For kinship carers, the primary stressors on them include the circumstances that triggered the kinship arrangement and the disruption caused by adopting the kinship role. Secondary stressors are also present in the daily hassles and sacrifices that come with executing the carer role (Giarrusso *et al.* 1996). In this chapter we consider the multiple stressors that the carers faced. We begin by describing the carers' physical and mental health.

PHYSICAL HEALTH

Carers completed a standardised measure, the Health Status Questionnaire (SF-12-v2™QualityMetric 2010) to assess their health-related quality of life. The measure produces two norm-based scores of physical health and wellbeing. In addition, we asked carers to identify any long-standing illnesses they had and to describe the impact of these on their daily lives.

Nearly three-quarters (73%) of the carers had been diagnosed with physical conditions or disabilities which had troubled them for some time and which were likely to continue to affect them over the coming year. In fact, more than half of all the carers (53%) in our study detailed at least two such health conditions. More than two fifths (42%) reported musculo-skeletal problems (usually arthritic or rheumatic disorders), 29% were affected by heart disease and circulatory problems, 16% by respiratory conditions and 11% by stomach and bowel disorders. Other health problems were reported, which affected fewer carers, including serious conditions such as cancer, diabetes, epilepsy, thyroid and auto-immune diseases. Physical health problems were prevalent in all types of kinship carers, except the sibling carers.



Pain is often reported by those with muscular-skeletal conditions (Kaye *et al.* 2010) and this was the case for carers in this study. Over a third (37%) of the carers, many of whom had joint problems, said that their daily lives were restricted by chronic pain. We also found that carers over the age of forty were likely to complain about pain - so this was not simply a problem for older carers. Often the carers' pain was not well managed, as revealed in the following two interview extracts:

I get such dreadful pains and I daren't put any weight on [my right leg] and no I haven't been to the doctors because I haven't got time...I stand up and I'm like that, in agony... it's horrible and it disturbs my sleep as well. It's like I never get comfortable.

(Grandmother bringing up 8 year old)

Some days I can literally barely get out of bed to start with. If I were bad [the child] will bring me some painkillers and [then] I can just get out of bed, but once I get moving about a bit it eases. Pain never goes away, it's constantly there but you get used to it.
(Aunt bringing up 13 year old)

In the general population, pain in older people is a common complaint and one that is often unrecognised and under-treated. Inadequate pain management can be associated with depression, social isolation, immobility and sleep disturbances (Magni *et al.* 1993). It can also lead to complications and accidents. Research in older populations suggests that there are a number of barriers to receiving treatment, such as patients seeing pain as a normal process of ageing or inevitable because of specific conditions, a fear of drugs and a failure by GPs to assess adequately (Cavalieri 2002).

These factors may have been present in our sample of kinship carers, but other factors too were acting as barriers to treatment. Carers said they were so busy caring for the child that they had little time to care for themselves; they complained about the cost of prescriptions, some had low expectations and most were depressed.

The impact of the carers' physical health problems on their daily lives was considerable. One in five reported that their health limited moderate activities, such as pushing a vacuum cleaner and more than a quarter (26%) had difficulty in climbing stairs. As we saw in Chapter 4, the restricted mobility suffered by carers prevented some from enjoying physical activities with the children. Day to day activity for a few carers was extremely impaired:

The furthest I have been in the last two years is to the city hospital and back again and [my partner] has taken me out on the odd occasion and we've got maybe half a mile down the road and it's a case of just taking me home and putting me to bed again, because I have been pretty bad...I use my sticks. I'm now into a wheelchair.

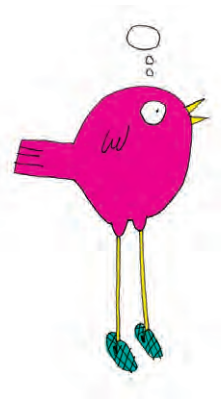
(Grandmother bringing up 12 year old)

PSYCHOLOGICAL WELLBEING

It seems paradoxical that whilst many carers described the satisfaction they derived from raising the children and spoke about the fun, laughter and joy that the young people had brought into their lives, most were nonetheless deeply unhappy. Just over a quarter of the carers (27%) told us that they had been diagnosed with depression, several of whom also had an anxiety disorder. However our findings from the standardised measure of health and wellbeing (SF12v2) showed that as many as two-thirds of the carers (67%) would probably be diagnosed as clinically depressed had they presented for a mental health assessment.

The link between pain and depression is well documented (Magni *et al.* 1993) and we too found a statistical association between carers with symptoms of depression and those who reported chronic pain. However, we do not know the direction of the effect. Did chronic pain contribute to the carer's low mood or did low mood influence their perception of pain? Unsurprisingly there was also a statistical association between carers with symptoms of depression and those who reported a long-standing physical illness.

Importantly, we found no significant difference in the likelihood of suffering from depression by type of kinship carer and younger carers were just as likely to be depressed as older ones. Nor did we find any indication that carers who had been raising children for a long time were any less likely to be depressed than carers who had more recently started doing so. However, carers who had taken on very young children were statistically more likely to be clinically depressed than those who had taken older children. There may be several explanations for this. Perhaps carers recognised that the arrangement was likely to continue for many years and therefore felt more despondent about their own futures. Some carers described feeling as though they had lost their life and their sense of self:



I haven't got a life no more. My life has stopped.

[Grandmother bringing up 9 year old]

I just don't feel as though I've got a life anymore...I've lost me, I've gone, I feel as though I am a nonentity.

[Grandmother bringing up 8 year old]

I have given up my life for this...my life has gone.

[Aunt bringing up 16 year old]

Previous research (Hughes *et al.* 2007) has suggested that the considerable demands placed on kinship carers may trigger or worsen ill health and several carers explicitly made the link between their poor health and stress. Kinship carers in our sample faced multiple stressors.

STRESSORS IN THE CARERS' LIVES

To help shed some light on matters that may have contributed to the high levels of significant strain and unhappiness amongst the kinship carers, we asked them about the stressors in their lives. Carers spoke in detail and often with great emotion about the pressures they faced, and these stressors are described in the next section. We begin with the demands of caring for children on a daily basis.

Day to day care

Parenting children is tiring and physically demanding. We have already described the additional challenges some carers faced in coping with problems associated with their own ill-health and chronic pain. We knew too that a significant minority were struggling to cope with children who had complex and extreme behavioural difficulties. A grandmother linked her poor health with the child's disruptive behaviours:

She's draining all [the energy] out of me. She's draining everything I've got. Her disruptive behaviour goes on for hours...[I am] just run down with all the carry-on and I've been taking really bad headaches, but I think that's just stress, because I'm not sleeping.

[Grandmother bringing up 12 year old]

Some of the carers who were parenting teenagers felt particularly challenged as they tried to balance the young people's wish for more independence against the necessity to set limits. This was made more difficult when children had had few restrictions on them when living with their parents. Carers and teenagers argued over a range of matters, including their choice of friends, the places they went, the clothes they wore, the times they were required home and the amount of spending money they were given. A number of carers looking after younger children worried a great deal about the prospect of increased conflict with the children as they moved into adolescence:

I just hope she keeps on the straight and narrow. I do worry about her teenage years because of her mum and what I went through with her mum and I just couldn't go through that again.

[Grandmother bringing up 8 year old]

I'm not going to be a very tolerant guardian when he's a teenager and not coming home at night and I'm kicking 70, having to roam the streets looking for him.

[Grandmother bringing up 8 year old]

Sudden and unexpected change in the carer's life course

Carers often talked about the sudden and unexpected change to their life course because of becoming a kinship carer and the resulting loss of freedom to enact their life plans. Researchers have referred to such non-normative transitions in the life-cycle as being 'time-disordered' and these have been associated with

greater stress (Roe *et al.* 1994; Pinson-Millburn *et al.* 1996). Many older carers, rather than looking forward to a leisurely retirement, had returned to an earlier stage in their life-cycle by taking on childcare responsibilities for a second time:

I should be enjoying my life, going on holiday when I want to and everything. Like my friend, she's going to Las Vegas, America. I should be going with her, because that was what our plans were to do. But of course all that's fallen through now.

(Grandmother bringing up 10 year old)

We've totally lost our freedom...we can't even have a day trip. I mean before the children came we had sort of simple pleasures. We'd go off, according to the weather, 'Nice day today, let's go down to the seaside'.

(Grandparents bringing up 10 year old)

In contrast, sibling carers and young aunts had been thrust forward into an accelerated transition to parenthood - and crucially some had been forced to abandon or delay their further education. These very young kin carers had lost the freedom to pursue their own aspirations or, in some cases, to find a partner. The resulting restrictions on their lives could feel hard to bear, as a sibling carer explained:

I feel like I'm trapped, I feel like I'm in a cage. It's felt like prison for a long time.

(Sibling bringing up 16 year old)

Carers had also had major changes in their employment or work patterns. Forty percent of carers had given up work altogether in order to care for the children. Two sibling carers had abandoned their career plans before even starting out. Other carers had given up good careers to bring up the children, turned down promotion because it involved travel or longer hours or moved from full-time to part-time work.

Whilst the research literature has shown the sacrifices and losses incurred by kinship carers, less attention has been paid to the specific issues for sibling carers and young aunts who begin caring in their twenties or early thirties (Roth *et al.* 2011). Young kinship carers said:

I do feel that [my sister is] having a good life at a detriment of my own. I had to give up all my dreams and aspirations to go and do what I wanted to do because of her...but...I don't hold any grudge against her at all.

(Sibling bringing up 12 year old)

It's just been a massive impact on me. I feel like I've missed out a lot. He's been such a huge responsibility and it has caused some of my problems by loss of confidence and anxiety. Like I don't resent [the child] for it at all but just, I resent the whole situation, because it's just, I feel like it's not fair.

(Sibling bringing up 16 year old)

Although there were only seven kinship carers who were very young (sibling carers and young aunts aged 22-32), it was worrying to find that all of them scored as clinically depressed. This is likely to be linked at least in part to the sacrifices made in making this 'time-disordered' transition into parenting, the financial pressures involved and to the effects of loss and bereavement.

Loss, guilt, anger, disappointment and conflict with the children's parents

Carers looking after children whose parents had died had their own particular difficulties and many described how the death had affected their own mental health. Indeed, we found a statistical association between caring for children following parental death and carers being clinically depressed. Often grieving carers were struggling to come to terms with their feelings of loss. Whilst the children had lost a parent, carers had lost sons and daughters, sisters and brothers and in the case of sibling carers, a parent too. One grandmother,

whose daughter died from a medical complication following childbirth, poignantly remarked:

People say time heals, but not when you've lost your daughter, it doesn't.

[Grandmother bringing up 9 year old]

On the other hand, where the children's parents were alive, carers often had difficult relationships with them, some of whom were still heavily dependent on the carers for support. Many of these carers were in effect, parenting two generations simultaneously. Not infrequently, they were also dealing with the backlash from parents who, although unable to provide adequate care, were nonetheless angry that they were not living with the children. As we saw too in Chapter 6, it could be very taxing to ensure that contact between the children and their parents was safe and positive.

Many carers described their difficulty in coming to terms with the circumstances leading to the kinship arrangement, which often involved parental drug and/or alcohol misuse, child abuse and neglect. As we have seen, some carers had strong feelings about their adult children (or brothers or sisters) turning out to be such poor parents. As we will see in the next chapter, a few carers were so troubled by their relationship with the children's parents that they had sought counselling. Grandparents sometimes wondered if they were to blame for the situation and were particularly sensitive to unkind remarks by others about the children's parents, as they felt that this was an implied criticism of their own parenting.

Loss of friends and a social life

Carers' friendships, even longstanding ones, were affected by the decision to become a kinship carer. Some older carers felt estranged from friends of their own age who did not have childcare responsibilities. Grandparents said:

I find friends are very thin on the ground...You stop getting invited out...People sort of don't come to visit you - people whose kids, you know, have grown up...they don't really want to be involved with younger kids.

[Grandmother bringing up 8 year old]

Well, I haven't got very many [friends] now as you can well imagine...because I had a big social life and lots of friends, but once you can't get childcare and once you keep telling somebody 'Sorry I can't get a babysitter', eventually they stop asking, don't they?

[Grandmother bringing up 11 year old]

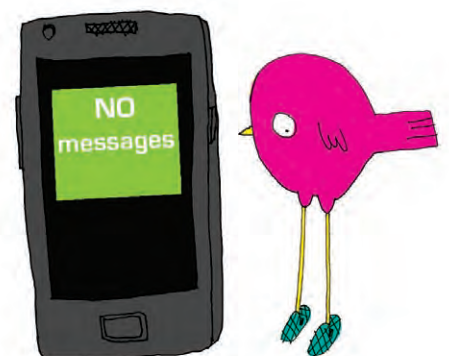
Younger carers too described difficulties in maintaining friendships. A sibling who began caring for her sister shortly after she had left school explained:

Yes, a lot of my friends in sixth form they actually, like, stopped talking to me. I did lose a lot of friends and I stopped going out.

[Sibling bringing up 17 year old]

As well as losing friends, carers also explained how opportunities to make new friends were limited. One grandmother, for example, said whilst she felt unable to join in with the activities and interests enjoyed by her peers, she also felt excluded, because of her age, from the social networks of parents at the kinship children's school. Another grandmother described being an older kinship carer as a 'very friendless position'.

Forty-four percent of the carers said that they never went out in the evenings without the child and fewer than one in five (17%) said that they had a regular night out with friends. Several carers said that they felt extremely isolated and lonely.



Difficult relationships with partners and extended family

Over half (51%) of the carers were single and whilst some were happy to be so, others said that they would have liked to settle down with a partner, but that their kinship care responsibilities had prevented this from happening. A grandparent said:

When he asked me out, I couldn't get out, you know - babysitters. So I just said I can't be doing wi' it, you know, the relationship. At the moment got enough on.

[Grandmother bringing up 11 year old]

More than half (58%) of those carers who were part of a couple said that their kinship care responsibilities had caused difficulties in the relationship with their partner, including nine relationships that had broken down (23% of the couple relationships). This included one grandmother who separated from her husband after more than 30 years of marriage. She said that the pressures associated with the kinship arrangement 'all got a bit much' for him. Partner relationships often deteriorated because couples were unable to go out in the evenings or spend much time alone together. One grandmother, whose husband ended their marriage, described the freedom they used to enjoy before the children's arrival:

We were free, 50 odd years of age and we were free and we could come and go as we pleased. We didn't have to look for babysitters and we could come in at whatever time we liked. We'd go out for the night...out for a meal and then go on for a show...[then] our lives just turned completely upside down.

[Grandmother bringing up 12 year old]

A sibling carer, whose relationship with her partner was strained, described how caring responsibilities had had an impact on their lives:

We argue all the time because obviously we're like young and we want to go out and do things and we've been restricted over the years. So it's been really difficult.

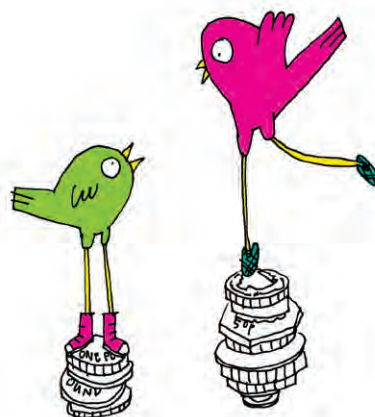
[Sibling bringing up 17 year old]

Some grandparents were saddened because looking after the kinship child had affected relationships with their other grandchildren, for whom they now had less time. Adult sons and daughters sometimes resented the kinship arrangement and the reduced level of attention given to them and their children, leaving carers in a difficult position in which they could not please everyone. One grandmother for example was worrying about how she should respond to her son's invitation to a birthday meal. She wanted to go but could not find a babysitter for the child - her daughter's son.

A surprisingly high proportion of carers (38%) described how other relatives, neighbours or work colleagues had caused them upset and stress by making unkind or insensitive remarks about the carer's situation. For example a couple of carers had been accused of looking after the children 'for the money' and one carer described how she lost her business partner who told her that she did not wish to be associated with someone caring for a child from 'a grotty background'.

FINANCIAL STRAIN

Health research consistently shows that poverty is associated with poorer mental and physical health, so the kinship carers' poorer health may have been linked to their low socio-economic status and income. In the light of our knowledge from the Census data, and the low weekly income of many carers (see Chapters 1 and 2), we were not surprised that so many of the carers in our study described financial strain. We were however taken aback by the severity of the financial hardship endured by many carers and their accounts of its impact. Almost half of the carers told us that they worried about money virtually all the time:



[I am] trying to work out how I'm going to get the boiler fixed and if we're going to make it through the winter with heating...I'm in debt up to my eyeballs. I have about two hours sleep a night 'cos I worry about money. You know that feeling when you go to the cashpoint and you think please, I just need £10, just to get home.

(Aunt bringing up 17 year old)

Ability to afford a basic standard of living

We gave the carers a list of eight items considered by most of the population to be necessities. The list has been used previously in a study of parents and poverty (Ghate and Hazel 2002). Carers were asked to identify anything on the list that they could not afford (Table 8.1).

Table 8.1: Percentage of kinship carers (n=80) who could not afford basic items

	Grandparents %	Aunts %	Siblings %	Other %	Total %
Annual family holiday away from home	69	62	100	50	67
Day trips or outings once a year	24	12	20	20	21
Heating whenever it is needed	29	19	20	20	25
Basic toys and sports gear for children	22	19	20	10	20
Warm winter clothes for each adult	43	25	40	30	37
Warm winter clothes for children	4	6	40	10	7
Cooked main meal each day for each adult	8	12	0	0	7
Cooked main meal each day for each child	0	0	0	0	0
We can afford all these things	31	31	0	40	31

Less than a third (31%) of the carers were able to provide all the basic items, whilst many carers had to do without at least one of the things on the list. Whilst 18% percent of the general population cannot afford an annual holiday (Gordon *et al.* 2000), this was the case for as many as 67% of the kinship carers. One in five carers could not even afford a day trip. A quarter could not afford to put the heating on when needed, yet only 1% of the general population cannot afford to do so (Kempson 1996; Gordon *et al.* 2000).

Carers generally prioritized the children's needs over their own and did without necessities. For example, a third of the carers said that they could afford warm winter clothes for the children, but not for the adults, in the family. Six carers could not afford a cooked meal each day for themselves, but all could afford a daily cooked meal for the children, although for two sibling carers being able to provide even this was a constant worry.

The experience of financial strain and worries about debt

Despite their limited means and debts, just over a third (36%) of the carers described themselves as managing well, often because they were resourceful. One grandmother for example had spent months watching and bidding on eBay (an online auction website) in order to 'win' a cheap bed for her granddaughter. Some carers had a sense of pride in their ability to manage their finances and make a little go a long way:

If we actually break down our money, what comes in and what goes out, we can't afford birthdays, Christmas, to run the car, but we do it. I don't know how we do it, don't ask me how.

(Aunt bringing up 15 year old)

Forty-four percent of the carers reported that they were just getting by but a fifth said that they were not managing at all well. Carers worried about paying bills, especially those for fuel. Some described how they economized, for example, by heating only one room:

I always worry about the heating and the electricity because that's an unknown, depending on the weather.

[Grandmother bringing up 16 year old]

Two fifths (39%) of the carers were in debt. Many were behind with the rent, mortgage or household bills, some owed money on credit cards or Hire Purchase agreements. A few had taken out door step or Payday loans, with hugely inflated interest rates:

I use these Payday loans. Don't even ask [about the interest rate] it's outrageous. But you do what you have to do when you have to survive.

[Grandmother bringing up 14 year old]

Four carers had been declared bankrupt. Some had signed up to debt consolidation plans but others were overwhelmed by their dire financial situation and had piles of unopened bills around them. One grandmother was expecting the bailiffs a few days after we saw her. Several told us that they had been under threat of eviction.

Financial impact of caring for the children

Carers reported particular financial stress at the beginning of the kinship arrangement. The majority (68%) had been forced to use savings, take out loans or borrow money from friends to buy essential items, such as clothes, beds and bedding. The immediate financial problems were exacerbated by difficulties in sorting out benefit payments. Child benefit has been, until recently, a non-means tested tax free payment available to those raising a child, which is usually paid to the carer with whom the child lives. Almost half of the carers (46%) had not received child benefit within the first six months of the child moving in and five carers (6%) were still not receiving payments at the time they were interviewed. Carers spoke at length about their difficulties in getting child benefit transferred to them. Often parents continued to claim the allowance or ignored requests for information by the benefit office to help process the carers' claims.

Some carers had been unable to claim child benefit until a Residence or Special Guardianship Order had been secured. When carers did apply for child benefit they sometimes received insufficient help. As a grandmother explained:

I applied for his child benefit, and we waited, and we waited, and I phoned them...and they said, 'We can't give it to you because the mother needs to sign' and I said, 'But we don't know where she is. I can get you a letter from the hospital or the school to state that he is living with me'. No, not good enough. So in the end I actually wrote to my MP and lo and behold within a week I had the child benefit. But what happens to people who can't do these sorts of thing?

[Grandmother bringing up 16 year old]

Nearly all the carers (94%) identified significant additional expenditure that they had incurred since taking on the children. More than a quarter had paid for the cost of obtaining legal orders, which in some instances had been a huge expense. One grandmother for example had been repeatedly taken to court by the child's parents. Whilst the parents received legal aid, she incurred a bill of £6,000.

Carers spent money on transport for the children and almost 40% had needed to buy a car or a larger vehicle. More than a third had incurred major costs associated with moving house or conversions to their homes to create more space. Some carers had used their life savings for these purposes. More than three-quarters (77%) of the carers spent money on items connected with the children's education, such as school uniforms, computers, books and internet subscriptions. A few had paid for extra tutoring for children who were struggling academically.

Carers also incurred costs for after-school clubs where the children enjoyed activities such as dance, drama

and sport. They also spent money on toys, home entertainment (like games consoles or satellite television) and outings (to the cinema or to fast food outlets for example). Carers emphasised the importance of providing these things so that the children felt that they were treated in the same way as their peers:

It's just making sure that he's got everything the same as any other child. I don't want him feeling that he's different.

(Grandmother bringing up 9 year old)

Four carers described how the children's behavioural problems created additional expense. These carers regularly had to replace broken furniture or make repairs to the house that had been damaged by the child, as an aunt explained:

He damages everything. If you notice all the doors, there's big holes in the bottom, big holes in my walls...It looks terrible with the doors at the moment, so I've just got to save up now [to replace them].

(Aunt bringing up 16 year old)

A few children had in the past, or were currently, attending independent day or boarding schools, which provided a supportive environment to meet the children's emotional needs or difficult behaviours. Although most carers received charitable grants for school fees from Buttle UK and elsewhere, some were required to pay a top-up. One sibling carer was proud that she had been able to arrange for her sister to attend an independent school, although she felt under financial pressure to ensure that the child did not stand out as being too different from her more affluent peers.

MULTIPLE STRESSORS AND ROLES

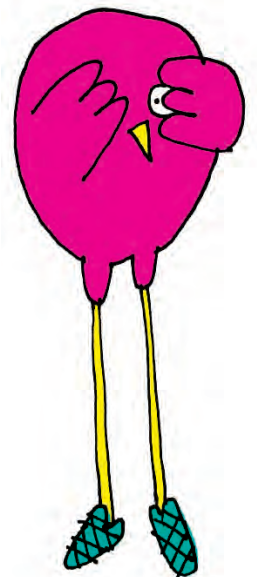
Many carers felt burdened by the combination of stressors and the multitude of roles they were attempting to fill. Some carers had a real sense of helplessness and hopelessness about their situation and said that they could not see an end to their difficulties. A grandmother with serious financial struggles, longstanding physical health problems, an alcoholic daughter whom she continued to care for, concerns about her granddaughter's emotional wellbeing and very limited social support, said of the pressures she faced:

It's probably a mixture of everything, everything across the board. Nothing seems simple any more...sometimes...in the middle of the night...I do feel close to despair...because I don't know where it will all end and I dream of packing my bags and just going.

(Grandmother bringing up 14 year old)

The carers faced a range of stressors and challenges, including poverty, ill health, pain, children's difficult behaviour, grief, conflict with and disappointment about the children's parents, other deteriorating personal relationships and the impact of the sudden and unexpected change to their life course. Notably, bereavement and living with chronic pain were strongly associated with carer depression.

Since previous research has found that wellbeing depends on the balance between the demands on the caregiver and the resources available (Hughes *et al.* 2007), in the next chapter we examine the extent of support and advice that the carers and children received.



CHAPTER 9 : SUPPORT PROVIDED AND NEEDED BY THE CARERS AND CHILDREN



Having considered the multitude of stressors and challenges faced by many carers, we turn our attention to the support they received. Research shows that social support can act as a protective factor by providing assistance in times of need, whilst the absence of support is a risk factor for a range of parenting difficulties. Lack of support is also associated with higher levels of physical and emotional health problems. When we examined the help the carers had received, we focused not only on what was provided, but also on how carers perceived this support (Ghate and Hazel 2002). We considered three types of support - informal, semi-formal, and formal support.

INFORMAL SUPPORT TO CARERS

Informal support was defined as the support that was provided to carers through their own personal networks. We asked the carers how many friends or family members (excluding the people they lived with) they felt they could count on. The majority identified at least one person, but networks were small and carers mostly named only two or three people. Unlike the general assumption that kin carers can call on extended family networks for help, we found that most carers had *more friends than family members on whom they could rely*. Four single grandmothers all looking after young grandsons (aged between 8-10 years) said that they were very isolated and had no support from anyone in their family or friendship networks. The ethnicity, age, lone carer status and income level of carers were not statistically associated with the number of supportive family or friends they had. Unsurprisingly, there was a statistical association between carers who were clinically depressed and those who had fewer family and friends they could count on, although we do not know the direction of this link. Did small informal networks of support contribute to carers' depression or vice versa?

Although the majority of carers did identify an informal network of support, albeit often small, we were surprised by how many were reluctant to ask for help from them. For example, 40% said that they would never ask to borrow more than £10 and more than a third (34%) said they would never ask to borrow even a small sum of money (less than £10). Even when they were prepared to ask for help, some carers lacked confidence that the support would be forthcoming. Twenty-nine percent doubted whether they would be able to find someone to look after the child for them during the day and 26% did not think they would find someone to care for the child overnight. Worryingly, nearly two-fifths (38%) of the carers could not identify someone who would help look after them if they were ill.

The carers' lack of confidence in being able to get help when needed suggests that their informal networks were not always adequate. However, carers were more certain about getting help with practical matters such as a lift or asking someone to do the shopping and, encouragingly, over half (58%) were very confident that they would be able to find someone in their informal network to confide in.

With a few notable exceptions, we were struck by how infrequently the extended family stepped in to help the carers. On the contrary, for nearly a third (30%) of the carers, the kinship arrangement had caused tensions in the wider family, usually because of concerns about the burden on the carer or because of the impact of the carers' loss of time and attention for others in the family. This in turn had led to some carers feeling more isolated in their task of raising the children. One grandmother, for example, felt downhearted by the ongoing arguments within her wider family over her care of the child. Despite having four adult children, three of whom lived locally, she felt that she could not turn to any of them for support. One son, the child's uncle was particularly critical of her:

[My son] says lots of stuff to me. [He says] 'Because you have Jacob all the time you don't even see our kids, you don't bother with our kids. Our kids can't come and stop here because you've got him all the time and you're too busy wrapped up in him'.

(Grandmother bringing up 10 year old)

SEMI-FORMAL SUPPORT TO CARERS

Many carers (85%) had received some support during the kinship arrangement from neighbourhood groups, community based programmes or charitable organisations. The semi-formal services used most frequently were after-school clubs, Sure Start, local church groups, Buttle UK and the Grandparents Association. The majority (86%) described the support they received as helpful. One elderly carer said of the after-school clubs her grandchildren attended:

Well for me they were helpful...because I knew where the children were. They were getting activities rather than coming home to me, an old person who is not going to be able to do anything with them. So in my mind they were helpful.

(Grandmother bringing up 12 year old)

An aunt, struggling to cope with her responsibilities, described how Sure Start had helped her:

I actually was so depressed, so down, so not coping, so overwhelmed by the whole situation, two years ago, I actually rang the Sure Start Centre in tears and asked them for advice and they very quickly came out and saw me...I ended up with somebody coming out once a week...just to chat and I got some really good support. They were fantastic...I'd just hit rock bottom...friendships had gone, people were just, kind of, judging me for having Lucy. I didn't know where to turn, who to speak to. I just was totally lost and they've given me my self-worth and confidence and life back.

(Aunt bringing up 13 year old)

Many carers appreciated the financial support they were given and some described how they had been helped by charities to pay off large fuel bills or rent arrears, including those left by the parents. Several carers had received grants, often from Buttle UK, which enabled children to attend independent boarding schools. This assistance was particularly valued by carers who thought that the children benefited from the high levels of pastoral support and individual attention provided. One grandmother described the funding she received for boarding school as a 'lifesaver', whilst a sibling carer said of her sister's private school:

I wish I could live there. It's amazing, it's such a wonderful place, and she's doing so well.

(Sibling bringing up 12 year old)

Whilst 46 different organizations were named as having provided support at some point during the kinship arrangement, it is very important to note that most carers had used only the most well known services, such as after-school clubs, and most were **unaware** of the extent of semi-formal support available.

FORMAL SUPPORT TO CARERS

We defined formal support as that which was provided to carers by statutory sector workers in social care, health, and education. We also included in the formal category the support provided by civil servants and solicitors. Carers described two types of support: (1) direct support to them (2) indirect support, arising from support primarily focused on the children.

Support from Children's Services

It is often assumed that Children's Services are unaware of the needs of informal kinship carers, but in our sample, 71% of the carers had contacted Children's Services to ask for support. Carers had generally asked for financial help or for advice and support in dealing with the children's emotional and behavioural difficulties. Some had asked for



other types of assistance, such as respite care or help to manage contact difficulties with parents. Several had contacted Children's Services to find out about the types of assistance available to them as kinship carers.

However, 42% of these requests for help were refused; often it appeared without an assessment of whether the children qualified for support as children in need. Some carers were told that social work help was unavailable because the kinship arrangement had been made privately or that their problems were not serious enough to warrant support:

I asked to speak to somebody and I said, 'I need some support' and they said no because it was a private arrangement - the children have never been known to Social Services - so therefore 'No, we're not going to help you'.

[Grandmother bringing up 12 year old]

The carers talked about repeatedly phoning Children's Services but not being called back, being offered a holiday which was then withheld or being given a few pounds to purchase a single item. A grandmother, who took over the care of her grandchildren in a crisis, was told by social workers that as she had removed the children from their home rather than wait for the police to do so, she had no entitlement to financial support. The grandmother explained what had happened:

We got a phone call...from the oldest sibling...could we help because they couldn't find mum, they'd no food, and the kids were hungry. So obviously we went down to see the kids...Their [mum] had been gone for two days so we reported her missing to the police. The police said 'Stay in the house with the children, we'll be there to see you'. Two hours later I rang the police and says 'I can't stop here I'm taking these kids back to my house, they need feeding, they want bathing and they want to be in bed'. This was like 10 o'clock at night. So we brought them back here, got them fed and bathed and got them into bed and the police obviously came and checked that the children were here and that they were okay and said Social Services would be in touch, which they did come out the following day.

[Grandmother bringing up 15 year old]

Indeed, many carers described very unsatisfactory dealings with social workers. An aunt for example, who took on the care of the child at the request of Children's Services following a court hearing, decided that she wanted to formalize the arrangement by becoming a foster carer. However once her foster care application had been approved, social workers had told her that if she did not apply for a Special Guardianship Order, the child would be recommended for adoption. She said of their actions:

It was just to secure the Special Guardianship [Order] because then it was a lot cheaper for them...if I was a Special Guardian and then they hadn't got to give me any support.

[Aunt bringing up 10 year old]

Fifty-eight percent (n=33) of the carers who approached Children's Services did receive some support, but many described it as limited (in that they had only had telephone contact or were seen once or twice) and nearly half reported that the support given or offered was not what they had requested. In one unusual example, a grandmother approached Children's Services to ask for a short period of respite care for her grandson. She was under a lot of stress following the death of her own mother, as well as dealing with the child's difficult behaviour. Rather than be offered respite care, she was instead given help to manage her finances better. Four carers were referred on to organisations that were able to provide help.

Overall, the carers' experiences with Children's Services were far from satisfactory: a finding commonly reported in other studies (see e.g. Wellard and Wheatley 2010; Aziz *et al.* 2012; Hunt and Waterhouse 2012). Just 28% of the carers rated their contact with the agency as helpful. Those who did report favourable contact had usually been given financial assistance or had received a sustained intervention:

I wanted some fencing round my front garden because it's such a high drop-off the other side and I needed a wardrobe for Beth and I think I asked for some bedding as well. They gave me the money...and then they sent a support worker [who] used to come in if I needed to ask her anything, or she'd just play with Beth.

(Grandmother bringing up 8 year old)

Fifteen percent of the carers said that they did need support, but had chosen not to contact Children's Services, believing that they would not be helped. In the light of their previous contact with social workers, some of these carers said they did not want any more to do with them. A few carers were fearful that by asking for help, their ability to care for the child might be questioned, thus jeopardizing the kinship arrangement.

Support from health, education and other professionals

At some point during the kinship arrangement, 61% of the carers had been in contact with professionals other than social workers, for advice and/or support with matters relating to their kinship care responsibilities. Most often, this help came from General Practitioners (GPs) and teachers.

General Practitioners About a fifth of the carers had approached their family doctors for help either in dealing with the children's difficulties or in managing their own problems and anxieties. GPs were instrumental in referring on to specialist psychological services or in liaising with other statutory agencies to mobilise support. Some provided direct support to carers. One young aunt, who had given up an independent life and career to take on the caring role, for example, described how she was helped:

My GP is fantastic...I phone him all the time, I tell him I need to see a psychiatrist and he goes 'Do you want to come down for a chat?' I mean it's just talking, it's not even, you know. I just sit there and cry and go 'I'm so pathetic, I can't do it' and I do that sort of, once every six months I think, I have a blow out.

(Aunt bringing up 17 year old)

Teachers Whilst many carers spoke about the support teachers gave children, about a fifth said that teachers had also provided them with valuable support. One grandmother, for example, spoke to staff about how best to manage the potentially painful scenario for her granddaughter, should class members ask her about her siblings (one had been adopted and the other had died). Another grandmother felt supported by a teacher who gave the class a lesson about 'families' in which she emphasized how every family was different, but all were normal. Some carers appreciated the advice they had been given, such as the teacher who suggested ways in which a child might resume contact with his mother after their relationship had deteriorated.

Counsellors / therapists Eleven carers had received individual counselling. Some had used the opportunity to talk about their difficulties with the children's parent/s. One grandmother, for example, said she sought counselling to help her 'survive a daughter with a drug addiction'. Others had counselling to talk about wider family matters, such as the aunt who had mixed feeling about caring for her husband's sister's child:

[The counselling] was really for me to talk about my feelings..., about how I was coping.. with the whole family. I think at times when I found it obviously particularly hard, I'd then start looking round thinking what about [my husband's] other sisters [why didn't they offer to care for the child?]. I'd be thinking 'Why is it us?' and I think things like that aren't healthy to keep inside, so it was quite good to talk about that.

(Aunt and uncle bringing up 14 year old)

Six kinship families had received family therapy to help deal with tensions and conflict within their family. Despite the high proportion of kinship arrangements that had come about following parental death, we were surprised to find that only six carers had received bereavement counselling, even though the parent who had died had usually been a close relative. Not all carers were aware of bereavement support organisations.

Other formal help Twelve carers had contacted solicitors for reasons other than to secure a legal order. Several carers wanted to know about their legal rights in caring for the child. For example, carers wanted to know whether they were legally entitled to foster the child or how to access the discretionary allowances linked to Residence or Special Guardianship Orders. Others needed advice on getting the child a passport in the absence of parental cooperation, changing a child’s surname or stopping parental contact.

Several carers had contacted their MP or local councillor to complain about the lack of help they had received from statutory agencies and asking for assistance with financial or housing matters and, as a result, some had received help to which they were entitled.

A few carers said that they had spoken to benefits advisers for assistance in accessing financial support. A sibling carer described the advice given as ‘*absolutely useless*’. She said that, as her set of circumstances did not fit into the usual type of situations, the adviser was ill equipped to deal with her. In contrast, a grandmother carer felt very satisfied with the help she had received:

The lady from housing benefit was an absolute star, I mean she turned every law, every rulebook inside out because I didn’t have child benefit, so I didn’t qualify for anything and eventually she found an emergency payment until the child benefit came through.
[Grandmother bringing up 14 year old]

ATTITUDES TO SUPPORT

To understand more about what might have affected carers’ willingness or reluctance to seek help, we asked them whether they agree or disagreed with four statements, as set out in Table 9.1.

Table 9.1: Carers’ attitudes towards seeking help

Statement	Agree %	Disagree %
If you ask friends or neighbours for help, you end up feeling in debt and that you owe them a favour	58	42
Asking for help outside the family is a sign of not coping	40	60
What I tell professionals will go on the file and could be used against me	60	40
I can always trust local professionals to keep the things I tell them as confidential	55	45

Importantly, getting assistance from friends or neighbours was not thought of as an entirely positive experience. More than half of the carers agreed with the statement that asking for help from these sources brought problems of obligation and indebtedness (Ghate and Hazel 2002). In addition, 40% of the carers thought that asking for help beyond the family was a sign of not coping and potentially stigmatizing, whilst a larger proportion were suspicious of involving professionals. Thirteen carers were mistrustful of all types of support. Reluctance to seek assistance might be due to previous unhelpful experiences with professionals, personal dislike of seeking support, fear of losing autonomy and of intrusion. Some may have had matters that they wished to hide. We know too that many carers (67%) were likely to be clinically depressed (see Chapter 8) which may have had an impact on their motivation to seek help.

PERCEIVED IMPACT OF THE HELP PROVIDED

On paper, a large proportion of carers had accessed formal and semi-formal support at some point and, with the exception of their contact with Children’s Services, most rated the help they had received favourably. Nevertheless, many carers told us how unsupported they felt. Sometimes the help they had received was not well targeted, but more often, it seems that the support provided, although valued, was simply insufficient. Many interventions were short-term and may have helped to alleviate, but not resolve the stressors that carers were managing. It is likely that the multitude of challenges they faced were so stressful that the impact of the support that carers received was muted.

Despite their often small informal networks of support, and uncertainty in being able to draw on particular types of help from family and friends if needed, half the carers told us that the assistance provided through their own personal networks had been *the most helpful*. The assistance provided from semi-formal sources was greatly appreciated, but, as we have seen, many carers knew little about the range of services and organisations that exist.

Some carers told us that by the time they sought help from Children's Services, they felt desperate and had pressing needs. However, as just noted, many requests for help were refused and social workers' responses were sometimes perceived as brusque and rejecting, which discouraged some carers from asking for help again. Other professionals, such as teachers and GPs, were considered an important source of direct help and support, but as highlighted in Chapter 8, many GPs had apparently not picked up the carers' depression.

CARERS' UNMET NEEDS

Ninety percent of the carers said that they wanted more support, confirming our finding that carers had a great many unmet needs. In view of the severity of the financial strain on the carers that we described in Chapter 8, it was not surprising that the majority said that better financial support was what they needed the most.

Several carers pointed out the large sums of public money saved by informal kinship carers keeping the children out of care:

I think it's about time we were valued more...We're saving them billions of pounds by stepping into the breach and, you know, basically, keeping these kids out of care.

(Grandmother bringing up 8 year old)

There should be more help out there for grandparents. Foster parents get it, adopting parents get it, it's just grandparents they don't get no help. [Once] you're with [the children] that's it.

(Grandmother bringing up 9 year old)

Carers also said that they needed practical help (such as respite/child care for the children), emotional support for themselves and the children (including bereavement counselling), help in managing children's behaviour, and sometimes contact, as well as better general information about kinship care.

SUPPORT FOR THE CHILDREN

As well as considering the services the carers used, we asked the children which professionals had helped them. Children had reported many worries and as we saw in Chapter 7, a minority had serious emotional and behavioural difficulties. We showed the children a list of professionals and asked them to tell us which ones they had spoken to for help and advice and to rate the helpfulness of the contact (see Table 9.2).

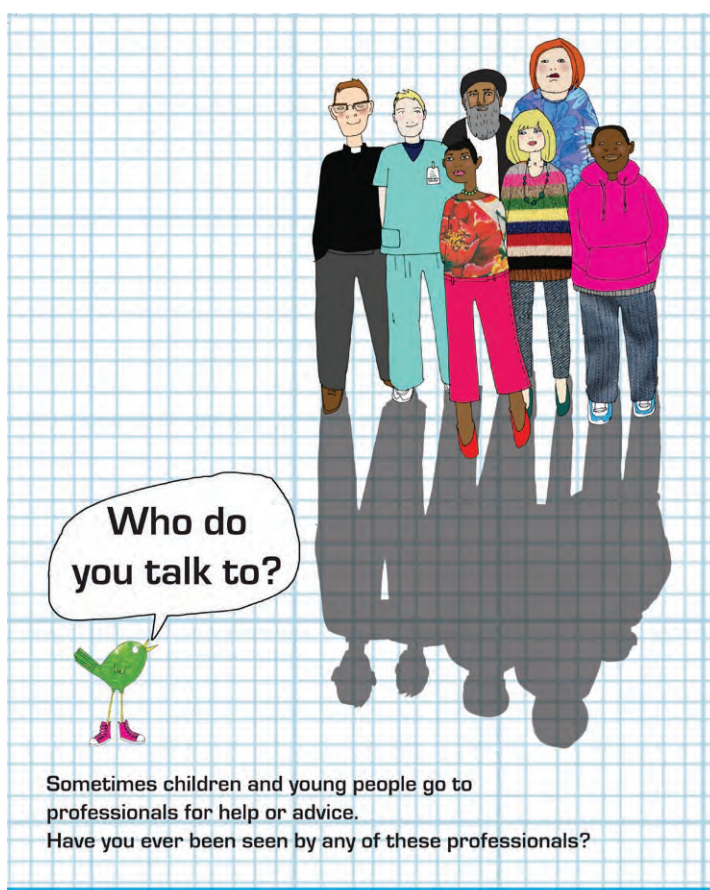
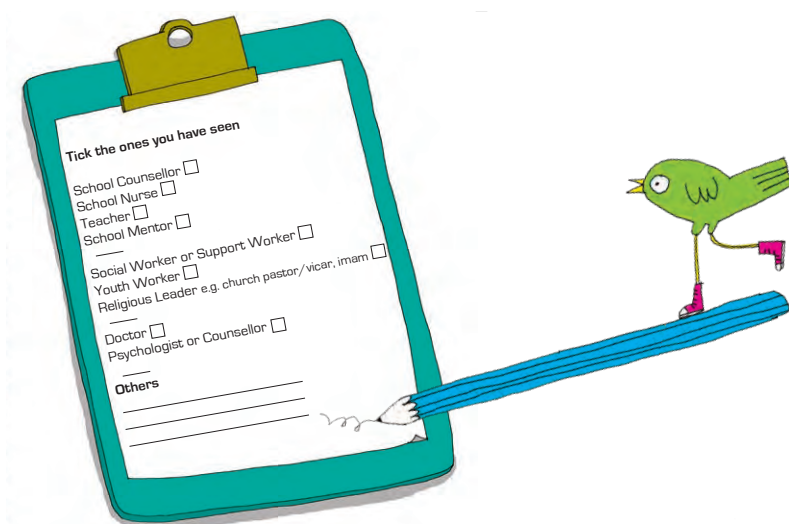


Table 9.2: Children's contact (n=80) with professionals and satisfaction with the help provided

Professional	Number of children	Helpful n %	Unhelpful N %
Teacher	52	46 (88%)	6 (12%)
Doctor	31	28 (90%)	3 (10%)
School counsellor	31	24 (77%)	7 (23%)
Social worker	31	20 (65%)	11 (35%)
Psychologist/ psychiatrist	25	18 (72%)	7 (28%)
School mentor	22	19 (86%)	3 (14%)
School nurse	20	19 (95%)	1 (5%)
Youth worker	12	11 (92%)	1 (8%)
Connexions worker	12	12 (100%)	0 (0%)
Religious leader	11	10 (91%)	1 (9%)
FRANK (drug advice worker)	1	1 (100%)	0 (0%)



Eighty-five percent (n=68) of the children said that they had spoken to at least one professional. Of the 12 children who reported no such contact, their carers told us that six children had seen someone listed in the table above.

Most (65%) children said that they had spoken to a teacher for help or advice, although some of this support may have been for academic rather than pastoral purposes. Nevertheless, many carers described valuable emotional support given to the children by teachers who were aware of their family histories and sensitive to their wider needs:

They've been supportive of Bethany's emotional needs and concerns...They're quite aware of all the situation that's gone on.

(Aunt bringing up 10 year old)

So the head teacher...said... 'We tried to work out what was going wrong. We've put it down to the fact that he's lost his mother'...and he said, 'Well, we need a strategy'. He said 'I think Harry's got it in him to be a sports star, so we'll make him a sports star' and that's what they did...He was put into all the sports teams...he was given special coaching, special treatment and it had a knock-on effect right across his schooling. D'you know what, that school saved his life. It saved his life.

(Grandmother bringing up 18 year old)

Nearly two-fifths (39%) of the children said that they had been in touch with school counsellors and just over a quarter (27%) had been supported by school mentors. Many more children than carers reported that they had been supported in this way, and it seems likely therefore that a number of children had sought help in school without recourse to their carers. Some carers recognized that children wanted to talk about their difficulties privately:

She does have counselling at school...so she's got someone independent that I don't get involved with...she tells me nothing about it. I leave her [to it] because that's her business.

(Aunt bringing up 15 year old)

As we saw, over a third (34%) of the children in our study had serious emotional and/or behavioural difficulties on the SDQ. In addition, we have described the two groups of children who we identified as giving particular cause for concern. The first (n=13) were those with self-rated difficult behaviour on the Piers-Harris 2 scale, coupled with abnormal SDQ scores (carer report). The second (n=18) were children who scored on the clinical range on the Birmahon standardized measure of depression and/or who had very low scores on the happiness and free from anxiety dimension on the Piers-Harris 2 scale. (Six of the children with symptoms of depression and anxiety also displayed behavioural difficulties). Interestingly, most of the carers rated all types of assistance provided for this subset of children with self-reported severe emotional and behavioural difficulties as unhelpful.

Fewer than half of the children (48%) with abnormal SDQ scores had been seen by CAMHS, and only a quarter of those with emotional difficulties alone had been seen. For some, the CAMHS contact had been brief, but others had received extensive support. Children, who were not supported by CAMHS, had often seen other professionals, usually school counsellors, but a quarter of the children with abnormal SDQ scores had received no help at all with their difficulties.

In addition, the carers told us that 16 children (59% of those who had experienced parental death) had been in contact with a professional for bereavement support, and this had taken various forms. Some had been helped by bereavement charities (including Winston's Wish, Dragonflies, The Rainbow Trust and CRUSE), whilst others had been seen by psychologists or school counsellors rather than by specialist bereavement workers. In the main, carers spoke positively about the grief work provided and described how children had particularly appreciated the practical tasks they were given, such as making memory boxes or compiling photo albums. One sibling carer said that both she and her sister had valued a short break away in the company of other families who were also grieving. However, carers also commented that there was a need for these issues to be revisited as children matured:

Yes it [bereavement counselling], was helpful.... You almost wonder whether she almost could have done with going again a few years later, just so she had a better understanding of all the issues and everything.

(Aunt bringing up 14 year old)

Indeed, a few teenage children told us that they did want to revisit matters from their past to gain a better understanding of how key life events had unfolded. One young person, for example, said she wanted to know more about the circumstances surrounding her mother's death, adding that when her mother died she was very young and had little understanding of the situation.

CHILDREN'S UNMET NEEDS

Overall, a quarter of the children who had severe emotional and/or behavioural difficulties had received no professional support. In addition, whilst 59% of the children who had lost a parent had received bereavement counselling, more than two-fifths had not.

As we have seen, a number of children wanted to understand more about matters in their past - something which may best be explored with their carers, who will know the children's personal history and may be in a position to answer some of their questions. However, as previously noted, there were sometimes communication barriers between the kinship children and their carers. The carers would have benefited from advice on how best to address these issues with the children and who else they might call on for help, if they could not discuss them themselves.

Overall, it was clear that carers often worked very hard indeed to find the support needed by the children they were bringing up and by themselves, but the lack of information about resources and the limited response from Children's Services hampered their efforts and meant that they were often left very much alone with their difficulties.

Now that we have described the situation of the informal kinship carers and children and the services they received and needed, we turn in the next chapter to consider the implications of the study's findings for policy and practice.



CHAPTER 10 : IMPLICATIONS FOR POLICY AND PRACTICE

It's better [living here] than living with my mum...I've always felt closer to my grandparents...I've always had a better relationship with them than my parents.
[17 year old living with grandparents]

I love it. I love having a really big family...It's just there's always something going on and things like that.
[14 year old living with aunt]

There must be thousands of people in the same position as me...and I think that it is down to finance that successive governments have never ever wanted to acknowledge this underclass of caring that is going on. I can't tell you how hard it's been...and the eternal phrase 'But this is a private arrangement'.
[Grandmother bringing up 14 year old]

In this chapter, we summarize the main findings from the study and consider what can be done to improve the situation of informal kinship carers and the children who live with them. In doing so, we want to draw particular attention first to the significance of bereavement and loss in understanding informal kinship care and second that assistance at the key stage of the initial transition into kin care is likely to have long-term benefits.

THE MAIN FINDINGS

The informal kinship carers

We know from the first part of this study (Nandy *et al.* 2011) that in the UK in 2001 more than 173,000 children were being brought up by relatives and the great majority (95%, 164,196) of these kinship carers were not formal kinship foster carers. The census re-analysis also showed that most kinship carers live in poverty. In this second part of the research, the interviews with 80 informal kinship carers and 80 children and young people aged 8 to 18, shone a light on their lives and provided solid evidence about how children in this situation progress. Most of the carers (61.25%) we interviewed were grandparents, a fifth were aunts and uncles, 12.5% were friends of the family (or more distant relatives) and 6.25% were sibling carers.

We found that many informal kinship carers lived in grinding poverty, which wore them down and reduced their quality of life. Yet, this was often a **consequence** of caring for the kinship children - many had given up good jobs to take the children (see also Gautier and Wellard 2012) or in the case of retired carers, had only their pensions to live on. In addition, more than 70% of the carers had a longstanding health condition or disability. This was true for few (14%) carers under the age of 40, but for as many as 83% of those aged 40 and over.

What was more unexpected was that over a third (37%) of the carers' lives were restricted by pain (affecting all types of carers, except siblings) and that as many as two-thirds of the carers were clinically depressed on the measure we used, although only a small proportion (27%) had been diagnosed as such. This finding supports previous research (Minkler *et al.* 1997; Hughes *et al.* 2007) which found that grandparent kinship carers were more likely to be depressed and have poorer health than those without this caring responsibility. Importantly, in our study, carers were statistically significantly more often depressed when the child's parent had died, when they experienced chronic pain or when their social networks were small. This suggests that increased support might have major benefits for kinship carers' emotional health, which in turn is likely to be beneficial for the children.

There has been insufficient recognition of the significance and impact of bereavement for kinship carers,

especially when their care is informal. Almost a third of the children in the study had moved to their kinship carers because a parent had died, a reason less often reported in studies of formal kinship placements, where the incidence of parental death ranges between 4% and 13% (Aldgate and McIntosh 2006; Farmer and Moyers 2008; Hunt *et al.* 2008). As a result, when the child moved in, many carers were still grieving for the loss of the child's parent, who was usually their own adult child, sibling or, in the case of sibling carers, their parent. The children's ability to move through the process of grieving for their parent's death was likely to be affected by how far their carers had been able to do so, as well as by their own developmental stage.

Most carers were under significant strain bringing up the kinship children on low incomes, often when they themselves were unwell. Some had serious problems with the children's parents who could be unreliable over contact, abusive and threatening, pose a risk to the children or try to undermine the kin arrangements. Research reviews on drug/alcohol misusing parents (e.g. Patton 2003; Carlini-Marlatt 2005; Grandparents Plus and Adfam 2006; Mentor 2010) have identified a 'missing generation' of parents who are unable to parent because of their addiction. In this study, 67% of parents had problems with substances and were incapable of parenting, but most were not missing from the children's lives. Indeed, their very presence created many difficulties for the carers and children, such as children being exposed to their alcohol-dependent or drug-taking lifestyles or witnessing conflict between their parents and carers. Children were sometimes also affected by the impact of a parent's local reputation and by the continuing experience of rejection when parents broke promises to visit, continued to care for their sibling/s or ignored them when passing on the street. Absent or deceased parents were also psychologically present for some children and social isolation could intensify these feelings.

Carers bringing up teenagers sometimes faced difficulties, as the young people chafed against the restrictions imposed on them, especially when they had experienced few boundaries whilst living with their parents. Other carers were worn down by children whose emotional and behavioural difficulties would have challenged even the most experienced foster carers. Carers spoke with desperation about their struggles to meet the children's needs, the battles they fought to get help and about their feelings of having lost their own lives and sense of themselves.

The children's progress

The standardized measures of wellbeing completed by the children and carers provide good evidence of children's progress in kinship care. A remarkable finding is that most children were securely attached to their kinship carers, in spite of the adversities and maltreatment they had experienced with their parents. Most children also felt confident in the knowledge that they had a family for life and could stay with kin as long as they wanted - something that is more rarely experienced by children in non-kin foster care. Levels of self-esteem (84%) were also similar to those in the general population (Piers and Herzberg 2002) and most children were making satisfactory educational progress. Many children had high educational aspirations with half planning to go to college and almost two-fifths aiming for university.

However, a group of children had significant mental health problems. Just over a third (34%) had emotional and behavioural difficulties that were in the abnormal range, as scored by their carer on the Strengths and Difficulties Questionnaire (Goodman 1997). This is higher than the 26% in Hunt and Waterhouse's (2012) sample of 76 kinship children aged 3-18, as would be expected since the young people in our study were older. Overall, we found that the greatest area of difficulty for the children was in their ability to express and manage their emotions, where 39% scored in the abnormal range. This meant, for example, that they had many fears, were easily scared or were often unhappy. However, it should be noted that the proportion of children with behavioural and emotional difficulties was lower than that reported for children who are looked after.

We do not know exactly why kinship children had these heightened levels of anxiety but a number of aspects of their situation might have a bearing on this. Children with higher levels of anxiety and depression statistically significantly more often than others, had had more than one change of primary carer and had previously lived with other relatives. Importantly and perhaps connected with this, they were also less securely attached to their kinship carer. In addition, they were more often experiencing difficult face to face contact with their

parents - where, for example, there was conflict between their carers and parents - and often had small networks of family and friends.

A considerable number of children worried that their carers, especially those who were unwell, might die, leaving them without a home. The children did not feel able to broach this sensitive subject with their carers, but a third had already experienced the death of a parent and the older age and poor health of some carers meant such worries were not unfounded. Other children felt unable to raise the subject of why their parents could not care for them and wanted to know more about the exact circumstances of their move. Indeed, more kinship children had low scores on the communication sub-scale of the attachment measure than have been found in general population samples (IPPA-R: Armsden and Greenberg 1987).

Overall the weight of evidence, on the measures we used for the kinship children, showed that they were, in the main, faring significantly better than those looked after in non-kin foster care (Meltzer *et al.* 2003; Ford *et al.* 2007) but, as we would expect given their previous adversities, were functioning less well than children in the general population.

Services and support

It is generally thought that kinship carers receive support from the extended family. Although most of the kin carers did have family and friends who they could turn to for support, it is important to note that one in five carers said that they had no family members they could rely on and one in six could not count on any friends. Many said that they felt 'friendless' and, since the children had moved in, had become socially isolated. This was likely to have negative consequences for their emotional health. Their marriages and partnerships had also come under pressure with the arrival of the children.

Carers had often approached voluntary organisations for advice and were satisfied with the help they had received. Nevertheless, many carers were unaware of the range of voluntary organisations available or that those that supported parents might be able to help them too. The majority also found the assistance provided by GPs, teachers and other professionals helpful. However, this was not true of Children's Services (see also e.g. Wellard and Wheatley 2010; Aziz *et al.* 2012).

We had expected that the informal kinship carers would largely be unknown to Children's Services. We were therefore surprised to find that, since taking on the child, most carers (71%) had contacted Children's Services to ask for help. However, carers had rarely received the assistance they sought and were occasionally told that if they could not manage alone, the children would have to be fostered or adopted. Whilst these sometimes harsh attitudes are likely to be underpinned by attempts to contain costs, there appeared to be a 'silo' mentality whereby kinship carers were expected to manage without assistance. Those carers who had been refused assistance rarely asked for help again. In addition, a few carers had not approached Children's Services, fearing that they would be deemed unsuitable to care for the children because of their health, age or ethnicity.

When kin carers stepped in quickly to care for children (frequently in the midst of a crisis), Children's Services viewed these as private arrangements and turned down later requests for help, often apparently without any assessment of need. Yet from the carers' accounts, most of the children had been neglected and/or abused by their parents. In some cases, social workers had asked kin carers to take the children and orchestrated the move, but still claimed that the care arrangement had been made privately.

On the few occasions when Children's Services had provided more long-term help, it was greatly appreciated. However, support from Children's Services or voluntary organisations was usually only short-term and had not gone far enough to resolve the difficulties that the carers and children faced. It was therefore not surprising to find that as many as 90% of the carers said that they needed more support.

Before considering what could be done to ensure that more informal kin carers and children have access to the services they need, we consider in more depth what the interviews revealed about the needs of the

THE PSYCHO-SOCIAL NEEDS OF CHILDREN IN KINSHIP CARE AND THEIR IMPLICATIONS

1. Bereavement

Given our findings about the high proportion of children who had lost one or both parents, carers need to be signposted to bereavement services for themselves and the children by: hospitals; the police; registrars who record deaths; Children's Services; solicitors; GPs and other professionals. As we have seen, carer depression was significantly related to parental death. Sometimes carers had particular difficulties in coping with the death of the child's parent and were experiencing a prolonged grief reaction (Melhem *et al.* 2011). Carers' ability to resolve their grief can affect whether children do so and children's overall functioning (Sandler *et al.* 2010). We found that hospitals had referred some children to bereavement services, which was greatly appreciated, but that the carers themselves had rarely received such help.

Sometimes children had lingering fears of repeated loss and abandonment many years after a parent had died. Children need permission to grieve and to be given clear, honest, and accurate information about their late parents. Such open communication allows them to manage loss and develop normally (Furman 1974). For some children it might be helpful to have the opportunity to talk to another relative or a counsellor about the parent they have lost if the carer finds it difficult to do so (Stokes 2004 and 2007).

2. Understanding why they lived with kin and help in coping with parental rejection

A considerable group of children had unanswered questions about the past, including why they were living with kin and not with their parent/s or how their parents had died, whilst some had questions about fathers who were unknown to them. Just under half of the carers did not talk openly about the children's parents and the past. Moreover, as we have seen, some kinship children chose not to talk to their carers about their late parents and their own earlier lives to avoid upsetting them.

Carers would benefit from advice on how to talk sensitively to children about their past and about their parents' problems (see e.g. The Grandparents Association 2010). It can be difficult for a relative or friend to explain to children why they are not living with their parents, since kin may have strong feelings about the reasons and feel responsible for these difficulties (Crumbley and Little 1997). This is the kind of information that carers require at the outset of caring and which would assist in children's transition into kinship care, as well as in later adjustment. In addition, given the extent of overt and ongoing rejection the children experienced from their parents, some carers would benefit from advice about how to help children deal with this. A few children needed Life Story Work.

3. Knowing about contingency plans

Since many children worried about the possibility of their carers dying and about where they would then go, there is a need for clearer contingency plans to be made by kin carers whenever possible, which are fully discussed with children in order to reassure them. Fewer than half of our carers had made such plans. Yet a Spanish study, on the transition into adulthood of children in kinship care, found that almost 40% of the young people had experienced the death of at least one of their grandparent carers (del Valle *et al.* 2011).

It would also assist if professionals such as GPs and solicitors encouraged carers to make and share contingency plans.⁸ At the same time, we recognize that some carers, especially those who are socially isolated, will not be able make any such plans - a matter which deeply troubled some carers. In these instances, the carers might be helped by talking the matter over with a social worker, who could offer some reassurance about how the children would be cared for if they could no longer live within the extended family.

⁸ This is important in any kinship care arrangement. It is also worth noting that at present, carers with Residence Orders cannot appoint a legal guardian in the event of their death, but those with Special Guardianship Orders can.

4. Maintaining sibling links

More than half (54%) of the children, who had been living with siblings, were separated from at least part of their sibling group when they moved into kinship care (see also Aziz *et al.* 2012). For example, siblings were sometimes placed with different parts of the extended family. This was a significant loss for them and a number of children said they very much wanted to see their brothers and sisters and feared losing contact with them. The importance of contact between siblings needs to be recognised when they have to be separated. Arrangements for contact with siblings should to be considered at the outset of kin arrangements.

5. Dealing with bullying and stigma

There is a common assumption that kinship care is perceived by children as less stigmatising than other forms of substitute care (see e.g. Messing 2006), but more than a third (36%) of the children reported spiteful remarks because they were being brought up by relatives or friends and not their parents and a few had been repeatedly bullied (see also Hislop *et al.* 2004; Aldgate and McIntosh 2006). Anxiety that personal information would be used against them caused many to exercise tight control over the number of friends they told about their situation. Only 14% of the children said that they were completely open with others about their circumstances.

It would be useful if children had the opportunity to receive advice on how to manage information about where they live including, where appropriate, developing a cover story (see e.g. Fahlberg 2004) and they need to be encouraged to speak out about bullying. A few children, whose parents' reputation (for example, as drugs users or prostitutes) was being used against them by other children, might have benefited from a change of school.

6. Help for children with serious emotional and behavioural difficulties

The carer-rated SDQ showed that a third of the children had serious emotional and behavioural difficulties. They presented particular challenges for kin carers, who had neither been prepared nor trained to cope with such troubled and sometimes angry children. Many carers struggled valiantly to bring order to their fragmented lives.

Proper assessment and more assistance for children with serious emotional and behavioural difficulties are called for, as are advice and support for their kinship carers. Carers need information about how to source help when needed, for example from CAMHS or school counsellors.

THE NEEDS OF SPECIFIC GROUPS OF KINSHIP CARERS

There is a tendency to treat kinship carers as if they were a homogenous group, but of course they are not. We identified three groups of carers who require particular attention. They are young kinship carers (sibling carers and young aunts); carers with severe health problems or disability; and carers who have multiple caring responsibilities, especially those supporting the children's parents.

Young kinship carers, including sibling carers

One group of kinship carers who were particularly disadvantaged were sibling carers and young aunts (who were aged 22-32 in this study). They had many needs and few resources and provided care at a high cost to their own wellbeing. Although our census re-analysis had shown that the second largest (38%) group of kinship carers in the UK are sibling carers (households where a sibling was the only adult in residence), they proved hard to find and involve in the study. Most of those we interviewed were bringing up brothers or sisters because their mother - or in the case of young aunts, sister - had died. They took on the care of children who were often only a few years younger than themselves and at a time when they and the children were grieving. The carers had been at the start of their own young lives and sacrificed their future prospects through giving up studying at university or successful careers and their freedom to spend time with their friends. This 'time-disordered' accelerated transition into parenthood (Roe *et al.* 1994; Pinson-Millburn *et al.* 1996) meant that young kin carers often found it difficult to make new friends or find a partner, since they were out of step with other young people their age - yet some blamed themselves for this situation. None had prior experience of

bring up children and some felt trapped and lonely. All the young kinship carers scored as depressed on the standardised measure we used and were rated by the researcher as experiencing significant stress more often than the other carers.

Furthermore, the young kinship carers more often lived in overcrowded conditions than other carers and were poorer (see also Roth *et al.* 2011), partly because they were often caring for more than one child. Most were managing on a very low weekly income (less than £200 a week) and worried a great deal about how to make ends meet:

I worry about money every day. There's not been a week since my mum died that I've not worried about, had to worry about money...We're just surviving, that's the only way I can describe it...the fridge is always empty.

[Sibling bringing up 16 year old]

There is a particular injustice that young people on the brink of their own adult lives should be left to bring up their brothers, sisters, nephews and nieces with no help at all from the state. One difficulty is that there is no central point of contact for young kinship carers and they are unlikely to be in touch with organisations for kinship carers which have 'grandparent' in their title (Grandparents Plus and the Grandparents Association). Family Rights Group has played a seminal role in identifying siblings as a group in need of more help (Roth *et al.* 2011).

More could be done to ensure that young kinship carers are aware of the services and organisations which could assist them, for example by making information available to them through GPs and Further Education colleges. A virtual support group on the internet and/or a helpline which is widely advertised could be useful to some. Mentoring projects where volunteers befriend and assist young kinship carers would be particularly helpful, especially as they had not parented before (Roth *et al.* 2011). There is also a need for Children's Services to consider how best to meet their needs, when they are approached. In two cases in the study, although Children's Services were initially wary of a sibling taking on his or her brothers and sisters, they later provided a good package of assistance.

Carers with serious health problems or disabilities

A second group of kinship families who deserve special attention are those where carers have very serious health problems and become dependent on the help of the kinship child. They were mostly grandmothers. Some children had mutually satisfying relationships with these carers and did not regret the limitations their caring responsibilities placed on spending time with their friends. Others were less sanguine and felt more keenly the disadvantages of having limited peer contact. When they are involved, Children's Services should consider these children as children in need. Social workers who prepare court reports for private law orders should also consider whether these children need to be linked to Young Carers' groups or would benefit from the involvement of volunteers or mentors to support them. For some children the provision of finance for activity groups or social activities to ensure they do not miss out too much on peer relationships would be helpful, especially when they live in isolated areas or feel they cannot leave the carer unattended. There is also a need for more help in relation to carers' health difficulties, depression, and pain from GPs and Adult Social Care services. Social workers should consider referral to Adult Social Care Services for kin carers with disabilities and should be in a position to advise about disability or other benefits or to refer on to others who can provide this advice.

Carers with multiple caring responsibilities (those who combined caring for the kinship child with caring for others, particularly the child's parent)

It was common for the kinship carers to be caring for others as well as the kinship child, including their partners or their own elderly parents (see also Pitcher 1999 and 2002; Wellard and Wheatley 2010). However, the situations which caused most distress were those where kinship carers (mostly grandparents and a few aunts) were still very involved in supporting - or in other ways dealing with - the parents of the kinship child,

particularly when parents had alcohol or drugs misuse problems. Many of the grandparents concerned had been trying to deal with their children's substance misuse and attendant difficulties for many years. Some were worn down by these parents' demands and unpredictability, but very few appeared to be getting support in dealing with them. When these parents lived nearby, the kinship children too were exposed to the parents' problems.

Carers in these circumstances need specialist help and advice about coping with the situation and would benefit from knowledge about organisations that specialise in this area, such as Addaction, Adfam, and PADA (Parents against Drug Abuse). GPs, Children's Services, and other professionals can play a crucial role in signposting carers to appropriate national and local support organisations.

RECOMMENDATIONS

Policy on kinship care is developing rapidly in the four countries of the UK and for this reason, we have not discussed the separate policy issues for each country. However, it is important to mention that in 2007 the Scottish Government published a strategy for children living in kinship care and foster care (Scottish Government and COSLA 2007) and funded an innovative three-year project with Citizens Advice Bureau in Scotland to provide advice to kinship carers, whatever their legal status (Dryburgh 2010). Subsequent funding has been given to Children 1st to provide an advice service until 2014. Similarly, the Welsh Government accepted a recommendation from the Assembly's Children and Young People Committee that grandparents and other kinship carers should be included in the delivery of parenting programmes in Wales (National Assembly for Wales 2012). In Northern Ireland Minimum Kinship Care Standards which were introduced in 2012 (DHSSPS 2012) specify the requirements which Health and Social Care Trusts have to meet when placing a looked after child in a kinship care arrangement and clarify the level of service that the children and families can expect to receive. However, these relate only to looked after children in kinship care.

Whilst the rate of change in the four countries is variable, it is important to note that the messages from the children and kinship carers in each country were the same. For all the carers, the greatest area of difficulty was lack of financial support. This added immensely to their burden and made all aspects of their lives much more difficult.

FOR GOVERNMENT

Whole system change - a national allowance and amending the definition of children in need

Systems in the UK to deal with kinship carers have developed in a fragmented and piecemeal way, leading to the current complex and wholly unjust situation. As our study shows, providing kinship care is a crucial service to the community - a welcome example of society caring for its own - but it pushes carers into poverty. The backgrounds of the children who are in the 'looked after' system and cared for by kinship foster carers are very similar to those where carers are on private law orders or no orders at all. Chance dictates whether kin carers are supported financially or otherwise. As a result, whether kinship carers receive help in cash or kind in the UK is not related to children's needs or to the financial situation of the carers (see also e.g. Hunt 2003; Hunt and Waterhouse 2012). Whole system change is therefore needed so that assistance is related to need.

Some countries, such as Spain, now provide an allowance for all kinship carers and this is clearly what is required to ensure that all kinship carers have enough money to bring up the children they care for. This would offer a much more equitable way of providing financial support than exists at present and would probably enable more relatives and friends to take on this role.

The guidance on kinship care in England states that local authority policies on kinship care should be premised on the principle that support should be based on the needs of the child rather than their legal status. However, it is worrying that 42% of the family and friends policies recently published by English local authorities do not refer to this principle (Roth *et al.* 2012). This would suggest that the introduction of an amendment to the definition of children in need to include children being cared for by family members or friends, as suggested by

Aziz and colleagues (2012), would be useful.

Make allowances attached to court orders more equitable At present, there is considerable variation as to whether allowances are paid when private law orders are made. Only just over a fifth of the carers in the study with a Residence Order received an allowance, whilst an allowance was paid to most of the small number of carers with a Special Guardianship Order (eight out of the nine).⁹ The current discretionary system for providing financial allowances attached to private law orders needs to be completely overhauled.

Provide more support for flexible working

Support for flexible working might have enabled more kinship carers of working age to retain their jobs when the children came to live with them.

Easier access to better information - the development of an information network

Given the real lack of information available to our kin carers when they took on the children - and also later when problems arose - governments should back a national information campaign in each UK country. The campaign would focus on raising awareness and providing information on the needs of children in kinship care and their carers, and services that can help to meet these needs. The campaign would include: the development of a resource pack for kinship carers, a national kinship care helpline and an on-line information exchange for kinship carers. The need for this has been further heightened by changes to legal aid in England and Wales, making access to independent legal advice difficult to afford.

Resource packs

The national resource packs for each UK country should be made widely available, for example in doctors' surgeries, Children's Services departments, CAFCASS (Children and Family Court Advisory and Support Service) and solicitors' offices, chemists, post offices, Citizens Advice Bureaux and on the websites of government departments, local authorities or Health and Social Care Trusts and voluntary organisations. There also needs to be an expectation that Children's Services departments, as part of their initial response, will give or send the resource pack to any kinship carer who contacts them to ask for support, rather than simply turn them away.

The resource pack should include a user-friendly description of the options and orders which exist; the available financial help (including the Guardian's Allowance, allowances connected to legal orders, other payments which statutory child welfare agencies and voluntary organisations can make and an explanation of how to get child benefit transferred rapidly); as well as sources of advice and support from both statutory and voluntary agencies. Information about specialist voluntary organisations such as bereavement charities or services for families affected by drug and alcohol misuse should also be included, as should advice on meeting children's emotional needs. In addition, it would be useful if the resource advised kinship carers to make contingency plans early on whenever possible, in case they are no longer able to provide care, and to share the content of these plans with the children. Carers also need ideas on making and maintaining friendships alongside their kin caring responsibilities, including information about child-sitting services, support groups and respite care. Carers should also be encouraged to seek help from GPs or counsellors if they have persistent low mood or depression.

The national resource packs should be developed with kinship carers and draw on the available research and on the experience of voluntary organisations, some of which already provide on-line and other resources. A number of organisations have already pulled together some of the essential information including, for example, Family Rights Group, Grandparents Plus and the Grandparents Association. In addition, the Citizens Advice Bureau has produced an on-line Advice Guide for kinship care in Scotland, setting out some key facts and signposting carers to services offering more detailed advice (www.adviceguide.org.uk), whilst the Child Poverty Action Group (Scotland) has published detailed information on benefits for kinship carers in their handbook for children living away from their parents (Gillies 2012).

⁹ A broadly similar pattern was observed in Hunt and Waterhouse's study (2012) where 88% of the kin carers with SGOs received an allowance compared to 46% with Residence Orders.

Update and implement the statutory guidance in England

It is very important that local authorities in England implement the requirement in the statutory guidance to ensure that kinship carers have access to information about services and advice about independent organisations. At present the quality and availability of such information is very variable. The English government 'Guidance for Family and Friends Care' (DfE 2011) would benefit from being updated to include the importance of all local authorities providing information about bereavement services for children and carers (such as Winston's Wish and Cruse); the need to make and share contingency plans with children and should provide information about Guardian's Allowances. These are payable to people who are bringing up children whose parents have died, or in certain circumstances where only one parent has died. A number of kin carers in the study who were entitled to a Guardian's Allowance did not know of its existence, even though some had been in touch with Children's Services.

In addition, many local authority policies on family and friends care need to go further in identifying the range of services available, particularly in relation to children's psychological needs. A recent study, for example, found that nearly two thirds of local authorities did not mention CAMHS support in their policies and more than half did not identify sources of independent advice (Roth *et al.* 2012).

Consider how kinship social work practice can be quality assured

The government in England might want to consider how pressure can best be applied on local authorities to implement the statutory guidance - including on authorities that have yet not published a kinship policy in defiance of the guidance (see also e.g. Hunt and Waterhouse 2012; Roth *et al.* 2012). The latter study found that 45% of local authorities had not published a family and friends care policy. League tables or scorecards for local authorities in relation to the quality and coverage of their published kinship policies might assist and would allow authorities to learn from those with the best developed and thought through policies.

In addition, it is very important that kinship care is included as part of inspections of social work practice by the various care and social services inspectorates in the four countries, so that practice with kin carers is subject to quality control mechanisms, including for example the quality of the experiences of kinship children where support is requested.

Ensure kinship care is included on the curriculum of social work training programmes.

There is a considerable need for more professional, post-qualifying and in-service training on kinship care, especially as children's social workers are generally not attuned to the needs of older carers and receive little training on ageing, health or bereavement. Training in ways of working with family networks or systems (Greeff 2001; Ziminski 2005) and in mediation would be useful (see e.g. O'Brien 2000), as would further development of approaches that build on kin families' strengths and working in partnership with them (Doolan *et al.* 2004).

FOR ORGANISATIONS PROVIDING INFORMATION AND TRAINING FOR CHILDREN'S SERVICES

Organisations which share knowledge and develop best practice such as: the Centre for Excellence and Outcomes in Children and Young People's Services (C4EO); Centre for Excellence for Looked After Children in Scotland (CELCS); the Institute for Research and Innovation in Social Services (IRISS), the Social Care Institute for Excellence (SCIE); Research in Practice and Making Research Count, need to embed research findings on kinship care into their change programmes. In the light of the evidence from this study, there is a pressing need for social work practitioners and their managers to be made more aware of the extent of disadvantage and poverty amongst kinship carers (especially those who receive no allowances), the benefits of kinship care for children and the pivotal position of Children's Services in ensuring that the support needs of kinship carers and children are met. Social workers need to be aware of the psycho-social needs of kinship carers and children and the opportunity they have to make a real impact on children's lives and lessen strain on kin carers, by ensuring that the carers and children are provided with or put in touch with the services they need.

FOR CHILDREN'S SERVICES

Never say 'No'

There is a long legacy of reluctance to help family members to do what many think should be done out of a sense of kinship affection and obligation (O'Brien 2000). Only a quarter (23%) of the carers who approached Children's Services received the help they had requested. Ways need to be found to counteract the tendency for workers and team managers to refuse kin carers help irrespective of the children's needs, which is shown in this and other studies (see e.g. Farmer and Moyers 2008; Hunt *et al.* 2008, Hunt and Waterhouse 2012, Wellard and Wheatley 2010). A culture change is needed throughout Children's Services to ensure that this no longer happens, with leadership taken at the top to ensure buy-in at all levels of the organisation, underpinned by recognition of the major contribution of kinship care as a permanence option for children. Since change in practice is generally brought about by senior managers taking responsibility for making things happen, the introduction of a network of senior management champions (perhaps including the involvement of Associations of Directors of Children's Services/Social Services /Social Work) would be likely to be beneficial.

Many of the children in this study should have been offered services for children in need and workers need to be reminded that their obligations to assist children are not extinguished when cared for by kin. Kinship carers also need to know more about how to challenge a refusal to help the children in their care. It would be useful if local authorities/Health and Social Care Trusts were required to suggest appropriate onward referral for carers and their children if they are unable to help. The national resource pack recommended above and updated local resources are important to make this possible.

Assistance with the transition to kinship care

Carers stressed that advice and help should be available at the very beginning of kinship arrangements so that they could consider the whole range of options and find out what services were available. Many had instead had to search and search for help and battle with services to get assistance. Carers said that if Children's Services provided help to them at the time of the initial transition, this might forestall later problems:

[It is important] to give the right support, the right advice in the beginning so that people don't have to go through what we've been through. [It would] make the transition a lot easier. Because you feel like you're punished in a way and yet you've done the work that [Children's Services] would be doing for that child.

(Grandmother bringing up 9 year old)

Social Services...didn't give you the full picture - they didn't tell you what your options were and what they entailed...and we've had to fight tooth and nail with them mostly over financial things. I had to sell my car and we were in arrears, we were under eviction notice before I got any financial help.

(Grandmother bringing up 15 year old)

Local authorities in Great Britain, and Health and Social Care Trusts in Northern Ireland, should complete a scoping exercise to compile a full database of voluntary and other provision in their local areas and this, together with information about national provision, should be made readily accessible to all kinship carers. Their websites and leaflets should also provide information about local services for kinship carers, such as induction and carer support groups. Carers suggested that information about kinship care should be advertised along the lines of recruitment advertisements for foster carers. When Children's Services are involved in any way in planning or arranging kinship care, or later in undertaking assessments for private orders, social workers have an opportunity to provide key information to carers.

Social workers can also play an important role in brokering support, by facilitating discussions within the wider family about what help individuals might be prepared to offer, such as help with contact or the provision of occasional care. This could prompt relatives to offer the carer support with the kinship arrangement, which might otherwise not be forthcoming. Family Group Conferences provide one useful forum for putting this into practice and consideration could be given to contingency plans in these meetings. At the same time, if a Family

Group Conference is the setting where decisions about who will care are actually made, the realities of the caring task and details of the support that is or is not available should be transparent.

Provide induction/information sessions

There would be considerable benefit if Children's Services ran regular induction sessions to all (new) kinship carers with whom they have any contact, preferably at the outset of the arrangement. These could be along the lines of the routine introduction sessions run for people considering becoming foster carers or adopters. These occasional sessions would provide the transition information just discussed. They could also function as advice sessions for ongoing kinship arrangements of all types, as well as providing the opportunity for kinship carers to meet others in a similar situation. Alternatively, this service could be commissioned from voluntary organisations since they command trust from kinship carers (Wellard 2011).

Provide services, including support groups, respite care and assistance with contact

Children's Services need to consider how they can best facilitate support groups for kinship carers, either directly or by supporting voluntary organisations to do so (see section on voluntary organisations). In addition, some carers needed respite care services. Others needed help and advice on managing contact that was unreliable or harmful for the children or advice on helping children deal with the absence of contact. Support for kinship carers in relation to contact should be brought into line with that available for looked after children, especially as it has been found that in kin care there is more contact, much of which is problematic (see e.g. Farmer and Moyers 2008; Hunt *et al.* 2008, Ashley *et al.* 2011). In this study, problematic contact was statistically associated with children having emotional and behavioural difficulties.

When kinship care arrangements are first made, carers should where possible be given advice which would help them prepare for potential contact difficulties. The Family Rights Group (Ashley *et al.* 2011) suggests that carers, parents, and where appropriate, children should draw up a contact agreement, which spells out where, when and how often contact will take place and what will happen if either party is unable to keep to the agreement. Our study suggests that contact with separated siblings should also be addressed from the outset (see also Kiraly *et al.* 2012).

Importantly, children need to be consulted and assisted to ensure that they have contact with which they feel comfortable. This includes helping them to deal with family conflict, changing parental circumstances and with re-contacting parents after absence (Kiraly and Humphreys 2011). Hardly any of the families in our study had had assistance with contact and a few might have benefited from using a local contact centre (DfE 2011). Sometimes it might assist if another family member (such as a grandparent when the child is living with an aunt) could take responsibility for contact arrangements (Farmer and Moyers 2008). Carers also need to have someone they can consult when contact becomes difficult, such as a specialist kinship worker, access to peer mentoring or on-line groups (Ashley *et al.* 2011).

FOR UNIVERSAL SERVICES

Kinship carers turned for help first to universal services, such as GPs, teachers and solicitors. It is therefore very important that these professionals are attuned to the needs of kinship carers.

Solicitors: Early independent legal advice is important to ensure that kinship carers are well informed about the financial as well as legal options available. Solicitors need to have the most up-to-date information not only about legal orders, but also about the financial allowances which they can attract, and be able to advise carers how to argue for this help. However, we found that some carers had been advised against securing a legal order because the children were satisfied with their living arrangements and were of an age to 'vote with their feet.' These carers had missed out on holding parental responsibility, on the opportunity to apply for an allowance linked to a legal order or on becoming a kinship foster carer. Certainly, when applying for a Special Guardianship Order, in the countries where these apply, carers should be advised at the outset to request an assessment of need (which covers financial and support needs).

Solicitors also have an opportunity to signpost kin carers to services. A national resource pack (see above) would assist them in this and they could remind kin carers about the importance of making and sharing contingency plans with children. Of course, access to advice services is insufficient unless advisers are sufficiently well informed about the issues. In England and Wales, specialist solicitors, for example those who are members of the Law Society Children Panel, should reach these standards, but other solicitors may not. Kinship carers need information to ensure that they seek advice from solicitors who have the relevant expertise.

However, the abolition of legal aid for private family disputes in England and Wales (LASPO 2012) from April 2013 will mean that many kinship carers will no longer be entitled to legal aid. This may deter kinship carers from applying for private law orders and will remove a key source of independent advice from them, unless they can afford to pay privately for a solicitor. Steps need to be taken to mitigate the impact of this on kinship carers, including local authorities paying these legal costs. Consideration should be given to introducing a legal aid fixed fee in those countries affected, in order to allow free advice and representation for kinship carers to obtain orders that will bring permanence for children.

GPs and health professionals: GPs too play a very important part and some were providing kinship carers with much needed emotional support or had referred children to CAMHS. However, 40% of the kin carers in the study who were suffering from depression had not been diagnosed or treated. It would be helpful if GPs, health visitors and practice nurses were alerted to the needs of kinship carers so that when carers visit their doctor or bring in the children, they are asked how they are managing the children and about their mood and health needs. A good number of carers would have benefited from treatment for depression, advice on how to access bereavement services and more generic counselling. Some appeared to need better pain management. In addition, health professionals need to be aware that support to carers around the time of the children's moves is especially important, as research suggests that if the transition into kinship care is well managed, carers' health may be less badly affected (Baker and Silverstein 2008; Musil *et al.* 2010).

Child and Adolescent Mental Health Services (CAMHS): Fewer than half of the children with serious emotional and behavioural difficulties (on the SDQ measure) had been seen by CAMHS (see also Hunt and Waterhouse 2012). In addition, some of the children needed help to deal with their anger about what had happened to them, with their experiences of parental indifference or rejection and with their longings for parents who were out of their lives or dead. Their carers too needed advice on how best to support the children with these issues. Intervening early with children with mental health problems has been shown not only to reduce health costs but also to realise larger savings, such as improved educational outcomes and reduced unemployment and crime (CAMHS 2008).

There is a strong argument for CAMHS to make the children of kinship carers a priority group for support, as is the case already in some health authorities. CAMHS teams have to give looked after children priority and kinship care should be included as part of this remit. Often a small amount of assistance might help to shift kinship families towards more helpful ways of communicating or understanding each other. In addition, CAMHS workers might benefit from training on the findings of research on kinship care.

Teachers: All the children of school age had contact with teachers and many had benefited from excellent pastoral care, help from school counsellors and mentors and additional help with their schoolwork. Schools need to be vigilant about bullying and aware that children being brought up by kin may be targeted. There is also a need to ensure that opportunities are regularly pursued to teach children about (and normalise) the variety of family forms that children live in.

We suggest that every school should have a designated teacher to champion the needs of the children in kinship care, as is already required for looked after children (Children and Young Person's Act 2008). Our findings from the first phase of this study - the analysis of the census data (Nandy *et al.* 2011) - show that teachers are likely to come across far more children living in kinship care, than children in any other type of substitute care.

FOR VOLUNTARY ORGANISATIONS

The voluntary sector plays a vital role in assisting kinship carers, given that Children's Services are not providing adequate support for kinship carers, the reluctance of some kinship carers to access support from statutory services and their greater trust in voluntary agencies. However, kinship carers first need to know about the voluntary agencies available. Many carers were unaware of the range of existing organisations and this was particularly an issue at the start of kinship care arrangements. Two-thirds of grandparent carers had not heard about Grandparents Plus and half did not know of the Grandparents Association; whilst half of all the carers had not heard of the Family Rights Group.

Voluntary agencies might want to be proactive and contact local authorities/Health and Social Care Trusts to ensure that their organisation is known to social workers and included in the local authority/Health and Social Care Trust's database of local (and national) resources for kinship carers. It might also be useful if voluntary organisations which provide support for parents made it clear that their services are also available to kinship carers. The telephone help lines already provided by some agencies may also need to promote their services more widely to all types of kinship carer.

Some voluntary agencies organise kinship carer support groups, although the majority are attended mostly by grandparents. There is considerable room for these to expand and to reach out to other kinds of kinship carers. Attendance at carer support groups would provide much-needed contact with other kinship carers - especially at the start of kin arrangements - and the opportunity to share ideas and advice on managing the children, dealing with difficult contact and getting their own needs met (Pitcher 2002). Such groups are routinely provided for non-kin foster carers, who appreciate the individual support provided by other carers between sessions (see e.g. Farmer *et al.* 2004; Sinclair 2005). For those with limited mobility and for young kinship carers, virtual support groups on the internet are likely to be helpful.

Kinship carers who are under severe strain would benefit from respite care, either in the form of occasional days or weekends with another carer (or with other family members) or a support worker or volunteer to take the child out regularly. In addition, child-sitting, activities for the child or holiday programs would provide carers with much needed time to recover from the stress they experience. Consideration needs to be given to whether voluntary agencies might be best placed to increase their respite and other services to meet these needs. In addition, buddying or mentoring systems are needed and could play a very important part in assisting new kinship carers, especially young kinship carers (Roth *et al.* 2011) or those with particular difficulties¹⁰.

Conclusion

The census findings (Nandy *et al.* 2011), combined with the interviews and measures with the large sample of carers and children reported on here, provide an authoritative account of the circumstances in the UK of informal kinship carers and the children they bring up. The findings are a cause for real concern about the parlous state of many informal kin carers, whilst overall providing good news about the children.

This study provides clear evidence of the poverty of many informal kin carers and reliable information about their high rates of long-term illness, disability, pain and depression, the difficulties they often have in managing contact with parents and the proportion of kinship children with very disturbed behaviour or emotional problems who are not receiving appropriate help. In spite of this, the research shows that many kin children have good outcomes.

A number of the findings are relatively new or under-explored in the UK, for example about the extent of bereavement, about carers' health, the needs of sub-groups of carers such as young kinship carers, the psycho-social needs of the children and young people, the high levels of anxiety amongst the children and how far they and the carers received the services they needed. In a climate of austerity, there are well-founded

¹⁰ A group of organisations are piloting a peer parenting support system for grandparents called The Relative Experience project.

fears that cuts to welfare benefits and legal aid may increase the disadvantages they face even further. If the children and young people in the study with severe emotional and behavioural problems had been placed with non-kin foster carers, their placements would have been at high risk of breakdown, with detrimental consequences for the children. Research has shown that kin carers continue to care for children long beyond the point at which non-kin foster carers give up (Cuddeback 2004; Farmer and Moyers 2008; Winokur 2009). Informal kinship carers make a major contribution to providing children with security and stability and save the state from the considerable costs of foster or residential placements.

The high commitment of the informal kinship carers was key to the children feeling secure and stable and making good progress. However, these gains were often achieved at the expense of the kin carers' own wellbeing and sometimes emotional health. It is a matter of concern that carers' attempts to get services for needy children were sometimes summarily dismissed by statutory services, adding to the strain they were under. Government Guidance (DfE 2011) in England emphasises the principle that support should be based on the needs of the child rather than their legal status. There is clearly a long road to travel before the current complex system delivers what children and their kinship carers need rather than what follows from the happenstance of their legal status.

Yet all the signs are, that a little assistance would go a long way in helping kinship carers parent these children, in mitigating the strain on them and in assisting in the recovery of the kinship children from abuse, neglect, parental addiction and mental illness. All of us have a responsibility to ensure that carers who are contributing so much to children's stability and security receive the help they need. These families should remain 'the poor relations' no longer.

CHAPTER 11 : SUMMARY OF RECOMMENDATIONS

The first part of this study (Nandy *et al.* 2011) showed that in the UK in 2001 a large number of children were being brought up by their relatives (173,000) and most (95%, 164,196) of them were not living with formal kinship foster carers. In the second part of the study, in-depth interviews were undertaken with 80 informal kinship carers and 80 kinship children and young people to understand the experience of informal kinship care from the children's and carers' perspectives. The findings show that the kinship carers' commitment to the children they were caring for provided them with psychological security and stability. As a result, the children were doing well on the measures we used and considerably better than 'looked after' children. Nonetheless, a third of the children and young people had serious behavioural and emotional difficulties, which was not surprising given their experiences of abuse and neglect when living with their parents.

The census re-analysis (Nandy *et al.* 2011) had established that most kinship carers in the UK lived in poverty and that the rates of long-term illness or disability amongst kin carers were much higher than in the general population. In the second part of the study we found that carers were frequently pushed into poverty by taking on the children. They were often older people, many were socially isolated and two-thirds were clinically depressed. For a third, their lives were restricted by pain. Carers talked about the high levels of stress they experienced and their feelings of having lost their own lives and sense of themselves. The fact that most received no financial allowance from Children's Services for the children's keep was the outcome of a lottery, in which willingness to step up to take care of the children, allowed local authorities to view these as private arrangements, no matter how severe the maltreatment or other difficulties that they had experienced. Indeed, the children's family backgrounds appeared similar to those of children in the 'looked after' system.

Carers spoke with desperation about the battles they fought to get help. It is a matter of real concern that carers' attempts to get services, for those who were clearly children in need, were sometimes summarily dismissed by statutory services and that the organisations and services which could have helped carers and children were often unknown to them.

Until now, children who are cared for by informal kinship carers have been a hidden population. That is no longer the case. We now know considerably more about the circumstances of the children, their carers and their needs. These children and their carers need more help.

THE GOVERNMENTS OF THE UK

Finance and services

- At present whether kinship carers receive help in cash or kind in the UK is not related to children's needs or to the financial situation of the carers. Whole system change is needed to replace the current unjust arrangements for kinship care.
- A national kinship financial allowance is required which is funded by central government to cover the costs of bringing up the children.
- In the meantime, local authorities/Health and Social Care Trusts should have a legal duty to conduct an assessment of need when kinship carers apply for private law orders and make payments to them based on the family's financial circumstances and the needs of the children.
- Support for flexible working might have enabled more kinship carers of working age to retain their jobs when the children came to live with them.
- UK governments should impose a legal duty on local authorities to conduct a 'children in need' assessment when kinship families ask for help and provide appropriate services to them. One way in which this could be

done would be for UK governments to introduce an amendment to the definition of 'children in need' to include children being cared for by family and friends.

Housing and Legal Aid

- Kinship carers should have priority in allocation for social housing and those who have their own homes should have access to funds to extend or adapt their properties when needed.
- In England and Wales from early 2013, many kinship carers will no longer be entitled to legal aid. This may deter kinship carers from applying for private law orders and will remove a key source of advice from them. Steps need to be taken to mitigate the impact of this on kinship carers, for example, by local authorities paying these legal costs. Consideration should be given to introducing a legal aid fixed fee to allow free advice and representation for kinship carers to obtain orders that will bring permanence for the child.

Information

- A national information campaign should be launched in each UK country, which should include the development of a resource pack for kinship carers, a national kinship care helpline and an on-line information exchange for kinship carers.
- As part of the campaign, each UK country should fund the development of a comprehensive national resource pack for family and friends carers and make it widely available. This should be widely accessible to all kinship carers from the outset of caring and to those considering taking children. This is vital if the 28% of carers with no legal parental responsibility for the children are to be reached and because of the huge difficulties that kinship carers have in accessing the information they require.

Developing Policy and Implementing Guidance

- The English government 'Guidance for Family and Friends Care' (DfE 2011) should be updated to include the importance of local authorities providing information about bereavement services, contingency plans and Guardian's Allowances.
- Action needs to be taken to ensure that all local authorities in England implement the statutory guidance in full.
- Government policy developments on permanence should always include kinship care as a key permanence option, since it provides high levels of stability for large numbers of children.

Quality Assure Practice

- The various care and social services inspectorates in the four UK countries should include kinship care in their frameworks for assessing the quality of services provided by Children's Services, including for example the quality of experiences for kinship children where support is requested. This is a crucial part of bringing about improvements.

Social Work Education and Training

- Ensure kinship care is included on the curriculum of all professional and post-qualifying social work training programmes.

DISSEMINATION AND TRAINING ORGANISATIONS FOR CHILDREN'S SERVICES

- Organisations which share knowledge and inform evidence-based practice such as C4EO (the Centre for Excellence and Outcomes in Children and Young People's Services), CELCIS (Centre for Excellence for Looked After Children in Scotland), SCIE (Social Care Institute for Excellence), Research in Practice and Making Research Count, need to embed research findings on kinship care, including informal kin care, into their change programmes.

SENIOR MANAGEMENT CHAMPIONS

- Since change in practice is generally brought about by senior managers taking responsibility for making things happen, the introduction of a network of senior management champions would also be likely to be beneficial.

CHILDREN'S SERVICES

- A culture change is needed throughout Children's Services in order to stop staff refusing help to kinship carers. Leadership needs to come from the top to ensure buy-in at all levels of the organisation, underpinned by recognition of the major contribution of informal and formal kinship care as a permanence option for children. Designated managers with responsibility for kinship care in each local authority (DfE 2011) have a key part to play.
- There is a pressing need for social work practitioners and managers to become more aware of the extent of disadvantage, poverty and ill-health amongst kinship carers and the good outcomes achieved by the children. They need to be aware of the pivotal position of Children's Services in taking the lead in ensuring that carers and children, irrespective of their legal status, are provided with, or put in touch with, the services they need. Assistance at the key stage of the initial transition into kin care is likely to have long-term benefits.
- Local authorities/Health and Social Care Trusts should compile a full database of local voluntary and national services relevant to kinship care in their local area and information about their own provision, such as support groups and induction sessions for carers. This information should always be passed on to carers and be easily accessible on local authority websites.
- Children's Services should run regular induction sessions for all new kinship carers to provide information about the transition to kinship care and advice sessions for ongoing kinship arrangements. In addition, a telephone helpline operated by kinship care workers which was open for a few hours a week could be very helpful.
- Children's Services need to consider how they can best facilitate support groups and provide respite care for kinship carers, either directly or by supporting voluntary organisations to do so.
- Support for kinship carers in relation to contact should be brought into line with that available for looked after children. Carers need to have someone they can consult, such as a specialist kinship worker, when contact becomes difficult or harmful to children. Advice from other kinship carers can also be helpful.
- More kinship children should be offered services as children in need. Social workers should also be particularly alert to the need for help for young kinship carers, carers whose health problems leave them dependent on kinship children and those with additional caring responsibilities, particularly for the child's parent.
- Children's Services should be required to suggest appropriate onward referral for kinship carers if they cannot meet carers' requests for help directly.

SOLICITORS

- Kinship carers require independent legal advice at the outset of caring in order to be able to make decisions about their legal and financial options. Where this is jeopardised by reductions in legal aid, steps need to be taken by the relevant governments to mitigate the impact on kinship carers (see Governments of the UK).
- When applying for a Special Guardianship Order, in the countries where these apply, carers should be advised at the outset to request an assessment of need (which covers financial and support needs).
- Where solicitors are involved, they should signpost kin carers to services, since most kinship carers consult them early on.

GENERAL PRACTITIONERS, CAMHS AND OTHER HEALTH PROFESSIONALS

- GPs are often the first port of call for kinship carers. GPs, health visitors, and practice nurses therefore need to be alerted to the needs of kin carers, especially their high levels of depression, need for better pain management and be alert to those who would benefit from bereavement services or counselling for the children or themselves.
- There needs to be more awareness that if adequate support is given to carers at the time of the children's transition into kinship care, there is likely to be less deterioration in carers' health.
- Children in kinship care should be a priority group for CAMHS teams just as looked after children are.

SCHOOLS

- Every school should have a designated teacher to champion the needs of the children in kinship care, in a similar way to the designated teacher for looked after children.
- Schools' policies on bullying need to ensure that all staff are aware that children being brought up by kin may be targeted for taunting or bullying.
- Opportunities need to be made regularly to teach children about - and normalise - the variety of family forms that children live in.

VOLUNTARY ORGANISATIONS

- Voluntary organisations could take a lead in providing the information that kinship carers need, by working together to co-ordinate the information that they produce, supplemented by recent research findings.
- There is a need for voluntary organisations to become more widely known to kinship carers in the community.
- Voluntary organisations should contact local authorities/Health and Social Care Trusts (and their kinship care teams) to ensure that their organisation is known to social workers and included in the local authority's/Health and Social Care Trust's database of local and national resources for kinship carers.
- The telephone help lines, which are already provided, may need to promote their services more widely to all types of kinship carers.
- Organisations which support parents should ensure that, when publicising their services, it is clear that they include kinship carers.
- There is considerable room for support groups for kinship carers to expand and to reach out to other kinds of kinship carers, such as aunts, uncles and sibling carers.
- Virtual support groups on the internet are likely to be helpful for young kinship carers and family and friends with limited mobility.
- To reduce strain on kinship carers and assist isolated children there is a need for respite care, child-sitting services, support workers or volunteers to take children out regularly, children's activities and holiday programmes.
- Buddying or mentoring systems would be very helpful for new kinship carers, especially young kinship carers or those with particular difficulties.

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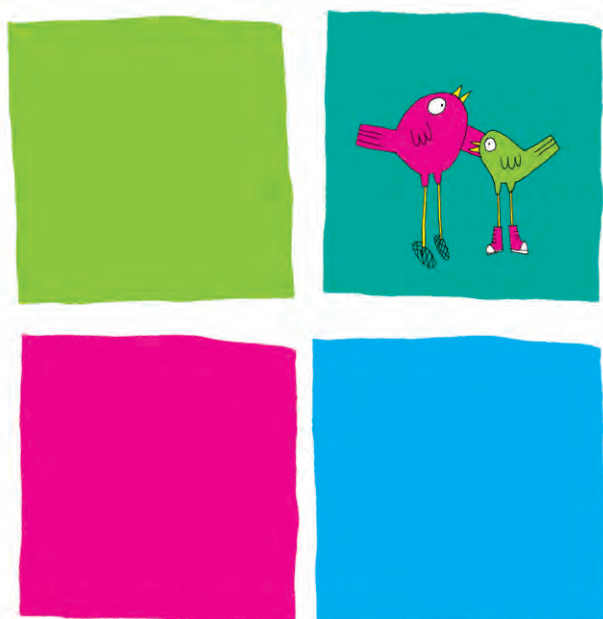


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