

GRANDPARENTS RAISING GRANDCHILDREN TRUST
NEW ZEALAND

**Grandparents and Whanau/Extended Families
Raising Kin Children
in Aotearoa/New Zealand**

A view over time

**Research Report
2009**

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MSW**

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Jill Worrall June 2009

Jill Worrall MSW

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*Each family is so complex as to be known and understood only in part even by its own members.
Families struggle with contradictions as massive as Everest, as fluid and changing as the
Mississippi....yet when practical the preference should be for family*

Maya Angelou

Contents

Grandparents and Whanau/Extended Families	4
Preface	4
Executive Summary	5
Introduction.....	6
Literature Review.....	8
Incidence of Children in Grandparent / Whanau Care in New Zealand	9
Methodology.....	10
Section A: Demographic Analysis of the Caring Families/Whanau	12
Section B: The Children	23
Section C: Legal issues.....	44
Section D: Personal Financial Matters	55
Section E: General Health of Carers.....	61
Discussion.....	78
Recommendations	81
References.....	82

Grandparents and Whanau/Extended Families Raising Kin Children in Aotearoa/New Zealand:

A view over time

Research Report March 2009

Preface

In March 2005 the Grandparents Raising Grandchildren Trust published landmark research that examined the lives of grandparents and other kin who are raising their grandchildren or other relative children because of parental incompetence or death. Three hundred and twenty-three kin care giving families, predominantly grandparents, completed a postal questionnaire in 2004¹ providing qualitative and quantitative information on a wide range of factors that impacted on their lives and those for whom they cared. The study showed that caring for abused and traumatised children within the extended family is complex and carers stated feeling isolated, unsupported and at times, struggling to fulfil the caring role. They also spoke of the joy and satisfaction of seeing the children begin to recover with the giving of constant care and on-going security.

It is very heartening when research makes a difference. The phenomenon of Grandparent/whanau and other kin care of children who have suffered abuse and neglect has now been widely profiled in the media and debated in many circles of influence. The evidence gained in the 2005 research showed that kin/whanau carers who received the Unsupported Child Benefit received considerably less financial support than if that child had been placed in foster care outside the family and that most families were struggling financially. That evidence has been a major contributor to the fact that from April 1st 2009 Orphans and Unsupported Child Benefit weekly rates have been increased to align with Foster Care Allowance weekly board rates. This is a significant improvement, however, it is still not equitable, as other costs such as medical, clothing or education expenses are not claimable.

Those carers who gave their time to complete this 2009 study questionnaire deserve a sincere vote of thanks. Their dedication to the task has allowed us to gain the knowledge we have of the circumstances of kin carers in New Zealand and how they have sustained caring over a period of time. Some have stated that revisiting their stories was painful and yet they did it because they felt that the stories need to be known. While statistical results may give an overall picture of the lives of these carers and their children– it is their individual stories that are so moving – stories of courage, tenacity, grief, struggle to survive and changed lives.

¹ Evidence was collected in 2004, published 2005

Executive Summary

New Zealand was a leader in international child welfare legislation reform with the passing of the New Zealand Children Young Persons and their Families Act (1989). This Act mandated the extended family/whanau as the preferred placement for children in need of care and protection, respecting traditional Maori concepts of family responsibility and decision making. However, recent data raises the question of how well the Maori model of collective responsibility translates to European families.

This study was carried out to discover how well New Zealand grandparents and other kin carers had fared over the five years since the last study was undertaken. While much of the statistical data is similar to the 2005 study, two major factors stand out in this study

- Caregiver resilience and commitment to the grandchildren in spite of huge hurdles and difficulties
- The stability afforded the children that has led to a considerable level of improvement in the children's physical and psychological health
- The joy most carers described in seeing their grandchildren flourish and the loving relationships existing between the children and their grandparents.

Having said that, a ribbon of grief also runs through these stories – grief felt by all those in the kinship circle, the children, the grandparents and the children's parents. Grief arises out of disappointment that their children and/or grandchildren have gone to prison, death of their own children; death of spouses; broken marriages; lives lost to drugs and alcohol and grief in respect of injuries the children will not recover from, for example, brain injured shaken babies. There is also sorrow and anger that they have to face challenges to their custody in court from their own children and the cost of this – money taken that could be spent on their needy grandchildren.

In this study there is also evidence of financial struggle to make ends meet, stories of grandparents going to bed hungry or losing weight because they are eating less as their growing grandchildren need more and the cost of constantly clothing growing children. Carers show fortitude in the face of poverty, saying "we make do" or "we just push on – tomorrow is another day"

The affect of age on the caring role is also well evidenced here. Grandparents' health is likely to be becoming more fragile and issues of mortality are well evidenced. Grandparents tell of lowered energy levels, tiredness and caring for seriously ill spouses and disabled children.

While the Care of Children Act (2004) will hopefully make legal proceedings easier for Grandparents seeking guardianship, day-to-day care or access, many respondents are still finding the legal system complex, unfair and financially crippling.

McPherson (2003) comments that demographic changes in age, smaller families, a high rate of marital disruption and higher geographic mobility show that demands for extended family support are at a time when the potential for that is decreasing (McPherson, 2003:162). This research shows that in spite of those demographic influences, families care whether they are single, poor, employed or unemployed, on invalids benefits or having to work harder to support the extra family members. One of the key factors that have emerged in this study is the stability and tenacity of the grandparents,

great grandparents and other kin and their dedication to the children. Consequently the children are beginning to thrive and regain normality in their care. For some children, the care and the love received has given rise to extraordinary achievement against great odds. Although kinship care has its frustrations and is undoubtedly exceedingly demanding for many carers, it is also clear that it can have significant rewards for both the children and those who care for them.

However, there is still much that could be done to improve outcomes for the kin/whanau carers and their kin/whanau children. Recommendations arising out of the study are:

- Professional attitudinal change
- Training for workers in the dynamics of kin/whanau care;
- sensitive assessment processes;
- financial relief;
- respite care provision;
- preparation courses and educational assistance.

The voices of the Grandparent/whanau carers are clear about their needs and deserve recognition.

Introduction

I think these babies have been sent to me to fill my life and for me to give them all the love I can and to teach them all I've got to teach, they have given me love, they've called me, they've needed me, and I will never be idle now they tell me I'm their Dr, their nurse, cook, teacher, mother, nanny, and great Nan and heaps of other things. Most enjoyable just knowing I have them with me and to see them coming home from school with happy smiles makes me happy too so thank you, but there's always things to say.

I find it very rewarding looking after my grandsons. It wasn't in our plans having already brought up six children of our own, but when the need was there we did not hesitate, we get tired sometimes but I would not give it up for anything, their life is so different to what it could have been, they are safe happy and well cared for, they are our life and we are so proud of them

New Zealand (Aotearoa) is a South Pacific island nation of 4.17 million people, whose population is 15% indigenous Maori, 68% European (Pakeha) descent, 6% Pacific Island and 9% Asian (Statistics New Zealand 2007). Ethnic diversity is increasing: immigration policies have resulted in communities being enriched by Middle Eastern, Latin American and African peoples.

New Zealand was a leader in international child welfare legislation reform with the passing of the New Zealand Children Young Persons and their Families Act (1989). This Act mandated the extended family as the preferred placement for children in need of care and protection, respecting traditional Maori concepts of family responsibility and decision making. However, recent data raises the question of how well the Maori model of collective responsibility translates to European families.

Kinship/whanau care can occur both formally and informally. Formal kinship/whanau care arrangements apply to children who are in State custody, having been removed from the care of a parent or guardian by care and protection services (Child Youth and Family), and placed with kin, often through a Family Group Conference process. These children still fall under the care and protection of the formal child welfare system, and legally, Child Youth and Family are still responsible for providing support services and supervision to them as if they were placed in foster care with strangers. When the placement is settled, Child Youth and Family may rescind their

guardianship or custody order and the kin/whanau carers can then apply to the court for shared guardianship with the child's biological parents. Informal kinship care is care provided by a blood relative or friend of the family without the involvement of Child Youth and Family. Often, these children have not come to the attention of the child protective services and are living under an agreement among family members. All family matters are handled within the family unit and the carers may or may not have legal custody and/or guardianship status.

The number of grandparents and other kin who are assuming full responsibility for raising their grandchildren continues to increase in Aotearoa/New Zealand, as is the case internationally. Because a large number of grandparent and other kin carers do not feature in formal statistics and have an informal arrangement as described above, the exact number of children in extended family/whanau care in New Zealand is not known, however at time of print the membership of the Grandparent Raising Grandchildren Trust stood at 3,983. As at April 2009, the Unsupported Child Benefit, the most common means of support available to kin carers, was claimed by 7,743 carers. When other forms of financial assistance such as the Child Youth and Family Foster Care Allowance; the Independent Youth Benefit and the Domestic Purposes Benefit are taken into account and those carers who receive no financial support in order to retain custody, it can be estimated that there are in excess of 10,000 children in kin/whanau care.

There is very little longitudinal research on outcomes for children in kin care or their kin carers, and certainly no New Zealand research. In 2008 it was decided to gather information from members of the Grandparents Raising Grandchildren Trust who had been caring for at least four years, and in the course of that, to follow up as many of the 2005 research participants as possible to gain an understanding of how they had fared since the last survey. Owing to the preservation of anonymity it was impossible to approach the 2005 participants personally, nor is it possible to compare individual case studies across that time span. The 2005 research brought to light the issues faced by family/whanau caring for their kin children in need of care and protection as the result of abuse and neglect. Indicators of age, culture, socio-economic status and health of both the children and their carers were able to be collected and formed a picture of dedication under duress. However, this follow-up research has been undertaken because,

“Indicators are signposts, and single indicators can be interpreted in many ways. Indicators have to be interpreted; it is essential to ‘read across’ a bank of indicators, looking for trends. Social, economic and environmental indicators have to be read together, as well as separately.” (Spicker, 2006, p88.)

Families have always cared for their kin children, however, in New Zealand, it is legally prescribed that family members be sought for children in need of care and protection. Section 13(b) of the Children Young Persons and their Families Act 1989 (“CYPF Act”) states that:

‘the primary role in caring for and protecting a child or young person lies with the child’s or young person’s family, whanau, hapu, iwi and family group, and that accordingly (i)...that family should be supported assisted and protected as much as possible and (ii) intervention into family life should be the minimum to ensure a child’s or young person’s safety and protection.

This legislation, now emulated internationally, has attempted to follow indigenous cultural values and indeed, imperatives of using whanau resources and strengths to sustain its members in

times of need. The more inclusive concept of what constitutes whanau/family existing for Maori means that, ideally, there is a greater resource pool from which to find care for their children in need of care and protection, and family links and identity are sustained. The question has been raised, however, whether it can be assumed that extended family resources are as rich for Pakeha families or those of other cultures. The recent Child Youth and Family data below would suggest that Maori and Pacific Island whanau are more likely to take responsibility. McPherson (2003) comments that demographic changes in age, smaller families, a high rate of marital disruption and higher geographic mobility show that demands for extended family support are at a time when the potential for that is decreasing (McPherson, 2003:162). However, research shows that in spite of those demographic influences, families care whether they are single, poor, employed or unemployed, on invalids benefits or having to work harder to support the extra family members. The stability and dedication to children in kin/whanau care is the key to children overcoming their trauma and beginning to thrive and regain normality.

Literature Review

It is now internationally agreed that children who are in need of care and protection should, where at all possible, be placed within their extended family/whanau and that family relationships must be kept alive (McFadden & Worrall, 1999). The number of children placed with kin has risen exponentially, and in many countries, surpasses the number of children placed with unrelated foster carers. It is also the case that grandparents are the most likely family members to take on this role (Worrall, 2005).

A review of the literature presents conflicting evidence regarding the benefits and difficulties of kin taking custody of children who have suffered abuse and/or neglect. Importantly, there is much evidence to show that compared to children in traditional unrelated foster care, those placed with relatives are more likely to experience placement stability, a key factor in attaining good outcomes for children living away from their biological parents (Gleeson 2007). They are also more likely to have contact with their parents, remain with siblings, and to sustain schooling as they remain in the same neighbourhood (Rubin, Downes & O'Reilly et al, 2008). They are able to retain their identity and be surrounded by their family group. While this is encouraging, the research also shows that issues exist across the personal and socio-political milieu that could place both carers and the children in their custody 'at risk'.

- While children experience a greater level of stability in kin care compared to foster care, there is often unmonitored movement within the extended family itself (Worrall, 1996, 2005; Chapman & Hannah, 1999; Testa & Slack, 2002).
- The physical and psychological needs of children who have suffered abuse and neglect are considerable and children in kinship/whānau care are less likely to receive treatment than those in stranger foster care (Billing et al, 2002; Berman & Carpenter, 2004; Worrall, 2005; Rubin et al, 2008).
- Carers describe stress and health problems, particularly when the care giving is cross-generational (Worrall, 1996; Testa & Slack, 2002; Rubin et al, 2008).
- Legal issues around permanency planning for children placed with extended family are complex and ongoing legal challenges are common (Worrall, 2005; Crumbley & Little, 1997, Ingram 1996).

- Unresolved issues for birth parents place stress on relationships in the kinship network that are exacerbated by the placement (Sykes et al. 2002).
- Children are less likely to be reunited with their birth parents than those placed with unrelated caregivers (Testa, 2001; Gleeson, 2007).
- Abuse allegations occur in both kinship and foster care (McFadden J & Ryan P, 1991; Hunt, 2003; Worrall, 1996, 2001; NZFFCF, 2008).
- Payments for kin placements are usually less than for unrelated foster care placements (Leos-Urbell et al. 2002; Connolly, 2003; Worrall, 2005).
- Financial and housing stressors are experienced and often exacerbated by the changes in employment status brought on by the assuming of care (Sykes et al, 2002; Harden et al, 2004; Worrall, 2005 ;)
Parental drug use is a common reason for the need of care in kinship care situations and has an adverse affect on the children and inter-family relationships (Hunt, 2003; Worrall, 2005).
- The role of support in maintaining the placement of children who have suffered abuse and neglect is also well documented in both the foster and kinship care literature (Worrall, 1999; Kelley, Whitley et al. 2000; Cuddeback & Orme, 2002; Worrall, 2005; Cole, S. (2006). Kelley, Whitley et al. (2000) interviewed one hundred and two grandmothers raising grandchildren in order to assess levels of psychological stress within the group. The findings indicated that family resources, social support, and physical health affected psychological distress in grandmothers raising grandchildren. Grandmothers who reported fewer resources, less social support, and poorer physical health tended to experience higher levels of psychological distress. The study suggested that greater attention be given to interventions aimed to decrease psychological distress and improve the financial resources and physical health of grandmothers raising grandchildren.
- Children in kinship care are significantly less likely to experience change of schools than those in stranger foster care and both teachers and carers tend to rate children in kinship care as having fewer behavioural problems than do their peers in other out-of-home placement settings (Conway and Hutson, 2007). Earlier research (Dubowitz 2005), found however that many children in kinship care appeared to have serious school performance difficulties compared to their peers who are not in the care system. However, in terms of scores in physical, cognitive, emotional, and skill-based domains, children in kinship care have scores more like those of children who are able to remain at home following a child abuse and neglect investigation than do children in foster or group care.

The 2005 New Zealand study showed a consistency with overseas research. The results showed that children in kinship care experience physical and psychological trauma as a result of the abuse and neglect suffered, that they are less likely to receive help and that caring places stress on the whole care giving family. However, it was shown that kin/whanau are committed to the children and provides the stability needed to assist them to recover.

Incidence of Children in Grandparent / Whanau Care in New Zealand

Recent data from Child Youth and Family in regard to the number of children in their care as at June 2008 showed that while there was a significant drop in the number of children in State Care over the previous twelve months, there was an increase in the number of children placed with kin, the overall figure being 43% of the 4470 children in care placements. Interestingly the rate of whanau/kin placement varies across cultures. Of the 2166 Maori children in State care at the time 53% were

placed with whanau, as against 59% of the 278 Pacific Island children in State Care being placed with aiga and 31% of the 1888 New Zealand Pakeha children in State care placed with extended family (Worrall 2008).

These figures are not representative of all children in kin/whanau care and the figures are much higher if a view over time could be taken. Recently, a change in Government policy means that from April 1st 2009, the 7,743 families who receive the Unsupported Child Benefit will have board payments increased to the level of the Foster care allowance, but as this research shows, there are many families who do not receive that benefit. Additionally, both this current research and the 2005 research gives evidence that many families have permanent care of kin children without the involvement of Child Youth and Family. Whanau/families have stepped in to rescue children at risk before a case of abuse or neglect was formally reported. Unfortunately, official data does not identify child carer relationships, so it is not known how many of these are with grandparents or other kin.

Methodology

Rationale and Scope

While the 2005 study provided rich data in regard to the particular experiences of grandparents and other carers who had taken responsibility for kin children in need of care and protection, there is no New Zealand longitudinal data that identifies the strengths and resilience of this group and how they have managed the caring role over time. The Skycity Auckland Community Trust awarded funding to the GRG Trust to enable this follow-up survey to be undertaken.

The Grandparents Raising Grandchildren Trust² advertised the intention to carry out a follow-up survey in their monthly newsletter and members of the Trust who had been caring for at least four years were asked to indicate if they would agree to be part of the survey. The study was approved by Massey University Human Research Ethics Committee. Five hundred questionnaires were sent out either via e-mail or hard copy to those members who had been caring for at least four years, as indicated in the GRG data base. A total of 205 responses were received, (41%) - (e-version n=70; hard copy n=135). While the response rate was close to that of the 2005 survey (40.8%) the internal response rate was less, i.e. the number of unanswered questions within the questionnaire was higher in this study. The reported percentage rates therefore are of the number of responses to that particular question, rather than the percentage of the whole sample. As noted in the 2005 study, 41% is a high response rate for a postal survey, particularly considering the workload and responsibilities of these grandparents and other kin carers and the fact that for some cultures, this type of survey is not the preferred method of gathering information. Participants were asked not to include any identifying information, in terms of names or addresses of any family members.

Limitations

Any comparative data is indicative only. While this is designed as a follow-up study, it cannot be a true comparison between the two populations for the following reasons:

- The 2005 study was open, in that there was no limitation on length of time in the care giving role
- The sample is significantly smaller

² Hereafter referred to as GRG

- Neither are representative random samples
- 47.8% of the survey participants indicated that they completed the 2005 survey. There were 25 people who were not sure or who abstained from answering.
- The sample has been drawn from members of the GRG Trust as noted on the organisation's database, and there may be factors that exist for this group in terms of culture, age, gender, geographic location and financial status that affect the ability to generalise across the whole whanau/kin population. Relational data shows that 172 of the 205 respondents were grandparents. However the sample size of 205 responses is substantial. Apart from sample size, there is a high consistency of data results across the 2005 study and this one.

Data Analysis

In selecting a useful way to categorise the data I turned to research in related fields. Belsky (1997) in his study of determinants of parenting quality looked at what people brought to the role. He reviewed five factors: psychological resources; child characteristics; the marital relationship; social support and occupational experience. These however, proved limited and we have added other categories, in particular financial matters, legal issues and physical health – issues well articulated and examined in the kinship literature. The data is therefore examined under the following categories:

- caregiver demographic indices;
- the children's demographic indices, care histories, physical and psychological health status and educational progress;
- legal issues;
- respondent's personal financial issues and caregiver health status.

The respondents were given the opportunity to complete four open ended questions in regard to their wishes for the children, themselves, their enjoyments and any other issues they wished to voice. The qualitative data retrieved in these questions is so rich that it is impossible to capture its total impact in a report such as this. However a thorough content analysis has been undertaken to give an understanding of the complexity of the respondent's lives.

Bivariate analysis (crosstabs)

A bi-variate analysis was run by age of carer, income level, ethnicity, number of children in care, number of carer's own children including biological, whangai and foster children, duration of care and reasons children came into care. This was done on all questions asked of the full sample, and of questions specific to particular subgroups – those who answered yes to key questions – where there were sufficient numbers. Except for reasons for coming into care, which is a multiple response variable where differences between categories cannot be tested for statistical significance using SSPS multiple response programme, results are reported where there was statistical significance at $p < .05$. Relationships between key demographic variables were also tested. Surprisingly, there were no statistically significant relationships found between age of carer, income and ethnicity.

Sample:

Three hundred and ninety-four carers and 323 children³ are represented in the study.

³ Due to missing data the total number varied for different questions, up to a maximum of 323.

Section A: Demographic Analysis of the Caring Families/Whanau

1.0. Age of Carers

Most research suggests that kinship carers are more likely to be older than stranger foster carers (Hunt, 2003). This statistic may well indicate the preponderance internationally of Grandparents who take on the caring task. As stated previously, the data source for this survey may skew the results in terms of age. As in the 2005 survey, this research shows that age affects almost every other factor that is investigated. The expected lifestyle for those who have raised their own children and are nearing or have attained retirement is not a reality for these grandparents. Energy levels are less and the likelihood of physical illness is greater. Finances are limited and earning capacity greatly decreased. Housing has often been downsized. In the 2005 study participants commented on the fact of academic distance between grandparents and their children, again, a factor mentioned in this study. As in the 2005 survey, grandparents commented on the fact that because of child responsibilities they were usually unable to partake of their previous or expected age-related social activities. The social life of carers is discussed in more detail later in the report.

Age - Primary Caregiver -

Age Bracket	Number	Valid Percent
<40	2	1.1%
40-49	11	5.8%
50-59	79	41.8%
60-69	73	38.6%
70-79	21	11.1%
80+	3.	1.6%
Total respondents	189	100%

Age - Partner -

Age Bracket	Number	Valid Percent
<40	1	.9%
40-49	7	6.3%
50-59	35	31.3%
60-69	39	34.8%
70-79	26	12.7.%
80+	4	2.0 %
Total respondents	112	100%

The 2005 study gathered combined age data. While the Bell curve over the 50-59 and 60-69 age groups shown in the 2005 data has been maintained, there is a transition of the group over this

period toward older age groupings, most markedly from the 40-49 decade to the 60-69 decade and almost double the number in the 70-79 decade as there was in 2005.

Combined Ages -			
Age Bracket	(2009) Number	Valid Percent	(2005) Percent of Sample
<40	3	2.32%	0.95%
40-49	18	5.99%	16.35%
50-59	114	37.87%	39.73%
60-69	112	37.20%	34.22%
70-79	47	15.62%	8.17%
80+	7	2.32%	0.57%
Total respondents	301	100%	

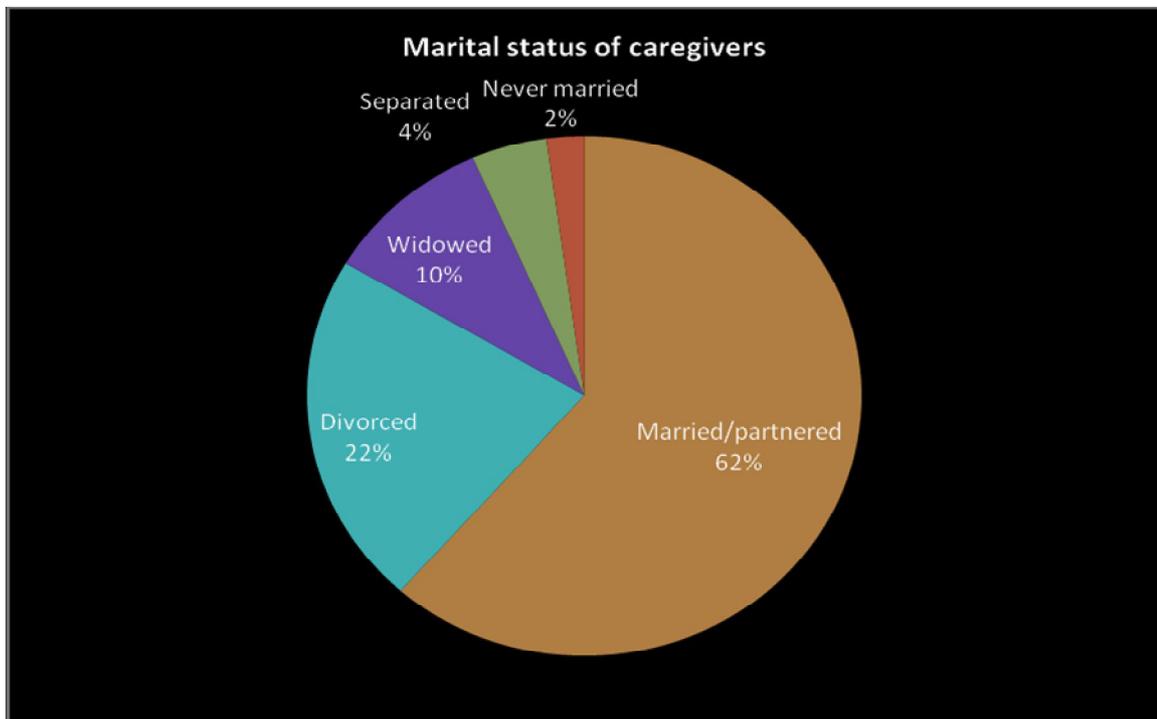
A co-variate analysis shows that Grandparents were likely to be older (60+) when children came because of physical illness (69%) or death of a parent (62%) or “other” reasons (61%)⁴. It also showed that being an older carer was related to caring for a grandchild with psychological/behavioural problems, attending GRG support group meetings and duration of care.

2.0. Marital Status

Of the 188 respondents to this question 61.2 % (n=115) describe themselves as married or partnered. Of the 38.8% single carers, 21.8% (n=41) were divorced, 10.1% (n=19) widowed; 4.8% (n=9) separated and 2.1 % (n=4) never married. Connelly (2003), in her international review of kinship research states that kinship carers were more likely to be single than compared to foster carers. Respondents were asked if the marital status had changed since taking care, and had caring contributed to this. While there were several reasons given for becoming single, such as death of a spouse, or committal to rest home or hospital care, 28 carers (13.7%) stated that a change in their marital status had occurred as a result of taking custody of the children.

Caring for our grandchildren was definitely a factor in our separation. My husband of 36 years had no patience with the children so it was either him or them and I chose the children as they have a lifetime ahead of them that need loving and caring and to be taught all the facts. It was hard but there was really no choice (what they had come from). After 6 yrs I know I did not make the wrong decision they are a pleasure. (Hard work yes) but all the good points out do the hard work; Love the 3 of them

⁴ Associations between demographic characteristics of the grandparents and reasons children came into care have not been statistically tested as this is a multiple response variable, but the highest and lowest relationships are reported.



My partner and I have separated. Caring for my grandchild was a factor but I see this as a positive. If she was not here it may have been difficult to end the relationship, which was right to end

Just recently, after 38 years of marriage we separated and caring for a grandchild may have partially contributed to this

My husband said that he didn't want a baby in the house and if I didn't like it to leave, so I did. He is older than me and very grumpy so it was [for] the best (stepfather to my daughter)

Before caring for my grandchildren, I cared for my ex husband's brothers/sisters children. He didn't want the kids around and become abusive

The need to provide a stable environment for the children influenced some couples to either marry or reunite after separation.

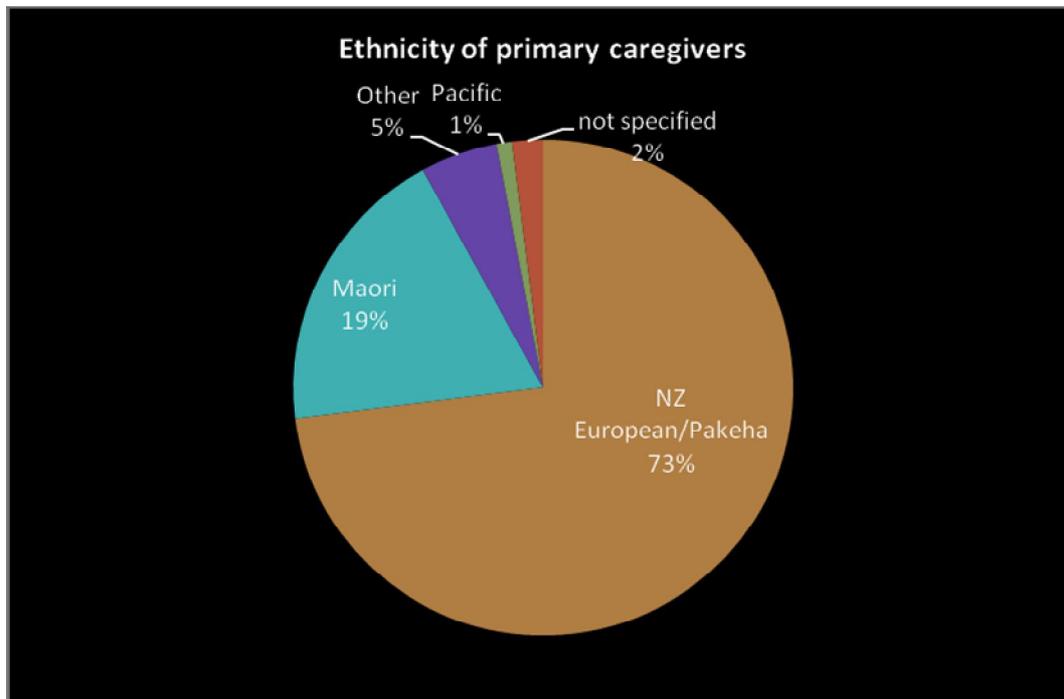
Yes it was too much for my partner. We had separated for 18 months. We are together again trying to help our grandchildren and each other

We married in 2002; to some degree felt a more stable environment with marriage would be beneficial

3.0. Ethnicity

Goodman and Silverstein (2002) found in their study on caregiver well-being that the cultural lens through which intergenerational relationships are viewed has a marked impact on the adaptation to custodial care giving. New Zealand is now a multi-cultural society and for many cultures it is normal for grandparents to play an active part in raising their grandchildren. As indicated in the recent Child Youth and Family statistics cited above, for those children in the care of Child Youth and Family, being of Maori or Pacific island ethnicity makes the likelihood of being placed in the care of whanau/fono significantly higher than if the child is New Zealand /European Pakeha.

Three generations of the whanau have traditionally brought up grandchildren and it's not an unusual lifestyle.



As in the previous study, neither Maori nor Pacific Island ethnicities are proportionately represented in the study when compared to all kin carers in New Zealand. This may well be due to a cultural bias in answering postal questionnaires. The response rate for these cultures could be proportionate for the current membership of the Grandparents raising Grandchildren Trust; however ethnicity of members has only been collected recently. In this study, 72.7% (n=149) of those with the primary care giving responsibility identified as New Zealand European/Pakeha; 19% (n=39) as Maori; 1 as Pacific Island and 5.4% (n=11) as of another ethnicity, (Dutch; South African; British; Australian). Partners of the primary carers identified as 39.5% New Zealand Pakeha; 10.7% as Maori and 2.9% as Pacific Island. N=18 or 9% were mixed ethnicity partnerships, 13= Maori/Euro, 4= Pacific/Euro and 1= Maori/Other.

A co-variate analysis of findings by ethnic group was run only for Maori and NZ European/Pakeha as there were insufficient numbers in other groups for analysis. Statistically significant differences were found in three areas: health of carer, number of children in care and changes in parental contact over last four years. However, there were only 39 Maori in the study, so these results should be treated as indicative only.

Alcohol addiction and domestic violence were more common reasons for coming into care where the main carer was Maori, while mental illness and abandonment were less common for Maori. 56% of Maori came because of alcohol addiction compared with 23% of NZ European/Pakeha, and 41% of Maori came because of domestic violence compared with 27%. On the other hand, 29% of NZ European/Pakeha came because of mental illness compared with 18% of Maori, and 23% for abandonment compared with 12% of Maori.

4.0. Employment

4.1. Employment Status

Two hundred and seventeen persons were employed, either full or part time. As evidenced in the 2005 research, taking care has a direct effect on the employment circumstances of carers. Some have stopped work to care, others have continued to work after expected retirement age, or the main income earner has had to change jobs to get sufficient income to maintain the family.

Stopped working to take grandchild as a baby, haven't returned yet

Continuing to work after 65 years of age due to grandchild's education needs

Husband taken out of town job as we needed extra cash; no security in previous job, obviously need to work longer now to support child

I had a nervous breakdown and quit Real Estate. I had been in the job for only a short time when we took our 18 month old granddaughter in and years of ugly circumstances piled up and I lost the plot basically. I had 10 weeks off and found a job of a regular nature and got back on track

Continue to work part-time, whereas without the grandchildren I would be fully retired but fully employed doing voluntary work

From part time to "stay at home Mum"; Too expensive to pay for extra care over school holidays etc; we have no support system i.e. family (immigrated from South Africa) to help...

For those grandparents who are still employed, particularly for the main carer or a solo caregiver, managing work and the caring role is stressful. Trying to balance all the needs of the children and the demands of the job is difficult for all working parents, but when the children have the histories of neglect and abuse that are evident in this study, and taking into consideration the older age of the carers, the situation is very taxing.

I had to give up work, as my grandchildren were to emotionally damaged, and they were terrified of me leaving them

4.2. Changes in Employment Status

Went from fulltime to part-time, then retired for approx 1 year, then had to resume work again due to having two grandchildren to raise

Being self employed, I had to forego a lot of lucrative employment in the early years, but increasing tiredness was the catalyst in my early retirement

Have had to take up school bus driving to help to try and make ends meet

Having to change employment status because of assuming the caregiver role was cited by 57% (n=106) of the 186 respondents to this question. Of these, 25.2% went from full to part time; 9.3% from part to full time; 8.4% from retirement to part time; 1.9% from retirement to full time; 20.6% took early retirement; and one person took on an extra job on top of full time employment and 34% (n=36) cited other arrangements:

I used to work 80 hours a fortnight. Now it's 48-70 hours a fortnight

I have had to work less hours to fit the circumstances. I am fortunate to be self-employed so I can do this. But when my granddaughter is sick my income is down and I do not get paid sick leave or annual leave

I dropped to ½ time when my granddaughter came to live with me (she 2 years: me 62. I fully retired at 68 years)

I gave up employment to care for three grandchildren due to urgent care needed...

Change in employment status of the carer was less likely where children had come into care because a parent had died (31%) and most likely where there was drug or alcohol addiction, mental or physical illness (69% each). Employment was likely to have decreased if the child came because of physical illness (80%) or domestic violence (60%) and more likely to increase if a parent had died.

Those on less than \$20,000 p.a. income were more likely to have experienced a change in employment status because of assuming care, (77% compared with 57% overall) and this was usually to retirement, some early, or to becoming a beneficiary.

4.3. Employment Fields

While there was a wide representation of occupations across the sample, the main carers (usually women) were highly represented in the caring professions of teaching, nursing, counselling, and therapy. The partners were represented in farming, engineering, building, bricklaying, labouring, driving, company director and the law. The most common part time work mentioned was nursing.

4.4. Beneficiaries

One hundred and five participants recorded their employment status as 'retired'. Of these 66 had retired over the last four years, being 22.2% (n=38) of the primary carers and 25% of partners (n=28).

In the list of occupations held, 11 stated they were invalids or sickness beneficiaries and 4 Domestic Purposes Beneficiaries. As stated above, becoming a beneficiary is related to representation on the lowest income bracket.

I was working fulltime but the need of the children and no caregiver at home when they got back from school I had to give up any thought of full-time work. Since then I have had to go on the sickness benefit

Not able to work anymore due to health issues relating to care

Had to stop work and go on DPB when he was a baby. I am now working as not entitled to DBP and the UCB

Getting UCB and had to return to work at WINZ⁵ request (no longer working now)

I have really struggled at times to care for these children. I have asked to go on a benefit & rung several times only to be told I have not adopted them so don't qualify for a benefit. When I was asked did I have any money saved, and I said my super, it was suggested I cash it in and live on that!!! Needless to say I'm still working but at reduced hours. I would like to see education put out there in the services we utilize whilst raising these children, e.g. government departments

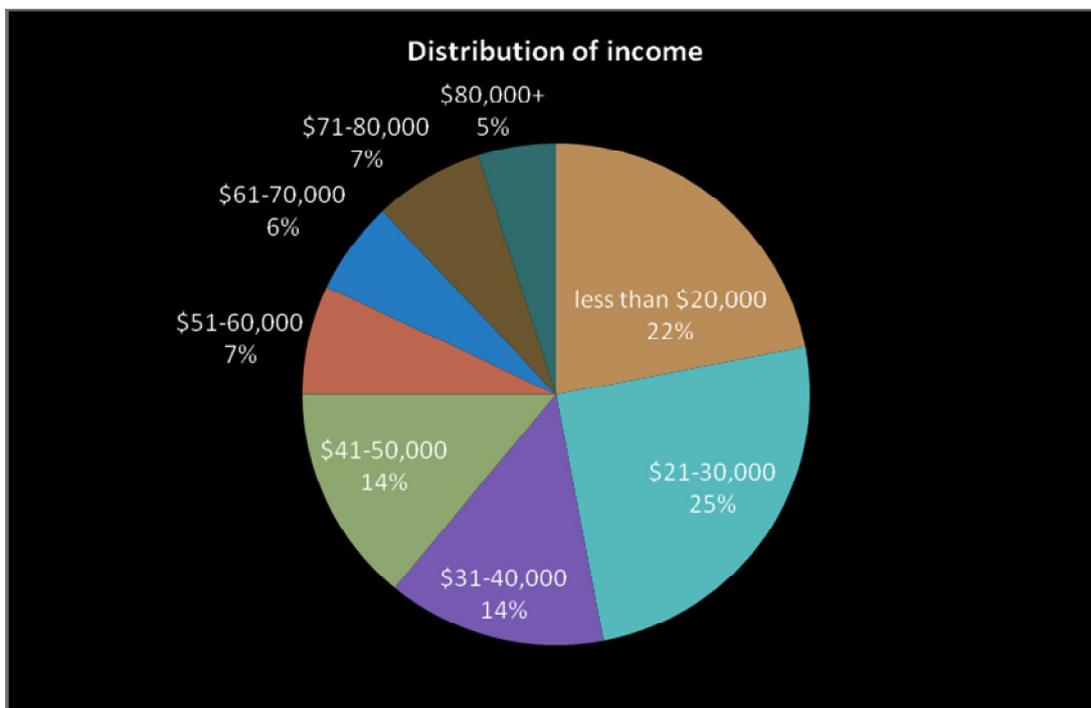
Irrespective of a carer's income, the Unsupported Child Benefit is available as of right to people who have become surrogate parents because of the biological parents' inability to care. Some carers have had their UCB application refused by WINZ because they are receiving another benefit, such as the Domestic Purposes Benefit, or sickness benefit, and even superannuation. Some carers who have been on the Domestic Purposes Benefit stated that they have been told to seek work if the child is of school age, even if the work is of a temporary nature. This has caused stress to those carers, especially when they are the sole carers of the child, and have had to somehow manage after school care and school holiday care.

5.0. Income

5.1. Distribution of Income Levels

As a basis of comparison, the average annual household income in 2006/7 in New Zealand was \$67,973. (<http://www.stats.govt.nz/store/2007/11/household-economic-survey-year-ended-jun30-07-hotp.htm> retrieved 21.4.09 http)

Interestingly, reported levels of total family income were higher in this survey than those recorded in 2005. Total Family income (before tax) was recorded for 178 respondents. For 39 families (22%) total family income from all sources was under \$20,000 p.a.; 45 families (25.3%) earned between \$21-30,000; 25 families (14.0%) earned between \$31-40,000; 24 families (13.5%) earned between \$41-50,000 p.a. 13 (7.3%) between \$51-60,000, 11 (6.2%) between \$61-70,000 12 (6.7%) between \$71-80,000 and 9 (5.%) of families earned in excess of \$80,000 per annum.



In 2005, 41% of the survey families were recorded as receiving under \$20,000 per annum compared to 22% of the 2009 sample. Just over a third (36%, n=14) of those earning under \$20,000 in 2009 were retired, and a further 23% (n=9) were on a benefit. A further two people described themselves as homemakers, but the rest (n=14) were doing some paid work.

Comparative Income levels		2005	
2009	%		%
Under \$20,000	22	Under \$20,000	41
\$21-30,000	25	\$20-29,000	21
\$31-40,000	14	\$30-39,000	12
\$41-50,000	14	\$40-49,000	9
\$51-60,000	7	\$50-59,000	7
\$61-70,000	6	\$60-69,000	5
\$71-80,000	7	\$70-79,000	0.3
\$81,000 or more	5	\$80,000 or more	6

Totals do not amount to exactly 100% due to rounding

Placing this data in context, between 2005 and 2008 median household income increased 21%⁶. In 2006 12% of families with dependent children earned less than \$20,000, down from 20% in 2001⁷.

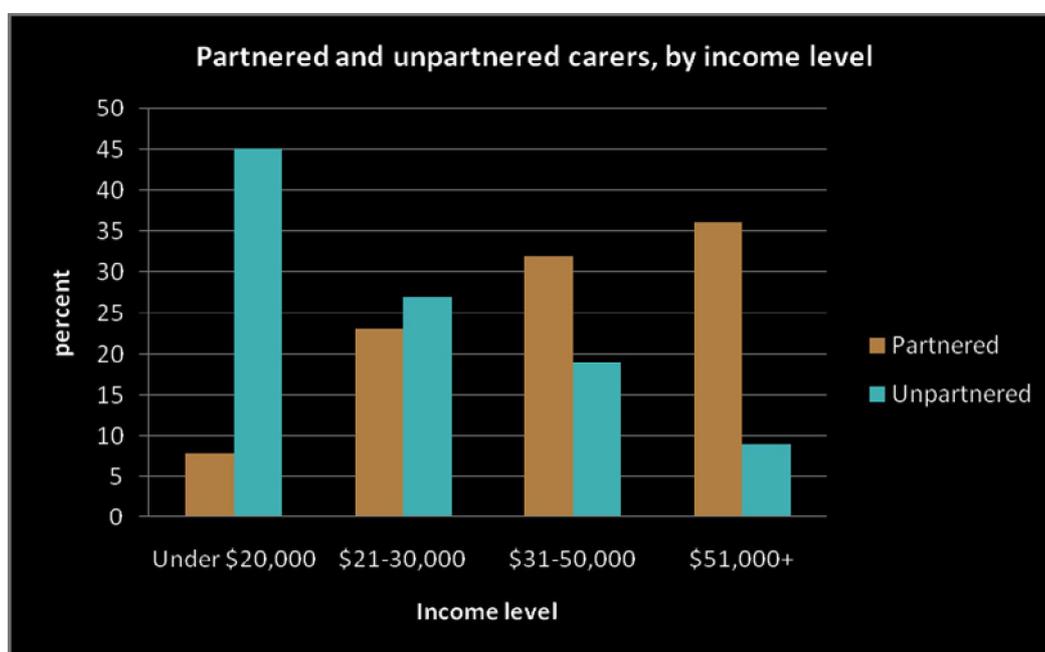
There is therefore a relatively high proportion of respondents with an annual income of under \$20,000. Just over a third (36%, n=14) of those earning under \$20,000 in 2009 were retired and a

⁶ Statistics New Zealand, New Zealand Income Survey: June 2008 quarter revised 17 October 2008, p.8

⁷ Statistics New Zealand, 2006 census, Total Family Income by Child Dependency Status, for families in private occupied dwellings, 2001 and 2006, Table Builder, downloaded 23/4/09

further 23% (n=9) of those under \$20,000 were on a benefit. A further two people described themselves as homemakers, but the rest (n=14) were doing some paid work.

Overall, the 2009 results were more favourable with 61.3% of families earning under \$40,000 per annum, compared to 75.7% in 2005 and 38.7% earning over \$40,000 p.a. compared to 24.3% over \$40,000 in 2005. However, when the cost of living index is added to this computation for those families whose income is less or the same over the four year period under examination, the struggle to manage can be seen. Retrospective CPI Index figures published by Statistics New Zealand show that the Consumer Price Index has increased by a total of 17% over the six year period from June 2002 to June 2008. There have been marked increases in food costs, housing and household utilities, and electricity. While retirees may be mortgage free, those who were not may be facing high accommodation costs in the form of mortgage repayments or rents. Income levels are again reflective of the data source and the number of superannuitants and those on Invalids or DPB benefits.



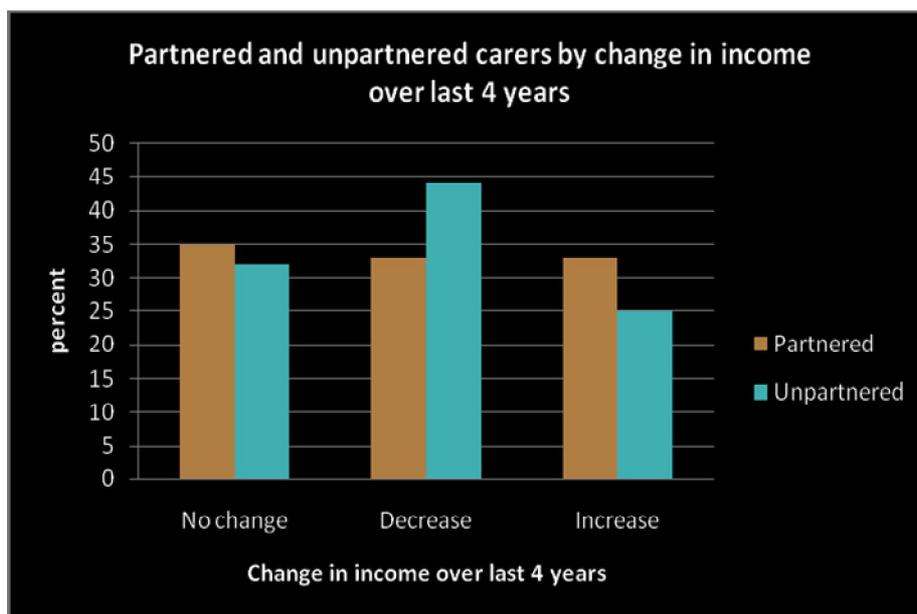
5.2. Changes in Income

Although the income levels appear higher overall from the 2005 data, 38.2% of respondents stated that they had had a decrease in income over the last four years, and this could well be those who moved from paid work to retirement or benefit in order to care. An increase over that period was recorded by 29.6%, which could be due to an age-related increase in Unsupported Child Benefits; 32.3% stated that their income levels have remained the same.

Those with two or more children were more likely to report an increase in income since the children came into care (42% compared to 25% with only one child) and less likely to report a decrease (27% compared to 48% of those with one child). Similar proportions reported no change.

Income was most likely to have decreased when children came into care because of physical (57%) or mental illness (50%) or child abuse (50%) compared with 38% overall, and was most likely to increase when the reason was imprisonment (55%) of parents compared with 32% overall. Death of a parent had least effect on income with 50% reporting no change compared with 30% overall.

Income was likely to be lowest (less than \$20,000) when children came because of physical illness (54%) and least likely to be low when they came because of death of a parent (15%). Low income was related to a change in employment status because of assuming care, receiving legal aid and other funding support, health deterioration of grandparents as a result of assuming care, attending GRG meetings and solo caring status.



Because of husband's retirement and no retirement fund our finances dropped by over a half of what our income was.

I have had a major reduction in income over last 12 years while full time solo parenting a high functioning autistic child

I work less hours which means less pay. My savings are being used. So I worry about the future as I get older and realise I will need to cut down on hours because of my age; whereas my granddaughter is growing up and expenses are increasing

Un-partnered carers were more likely to be on low incomes. However, they were not more likely to have experienced a change in income, but those who did experience change were more likely to have a decrease and less likely to increase than partnered carers.

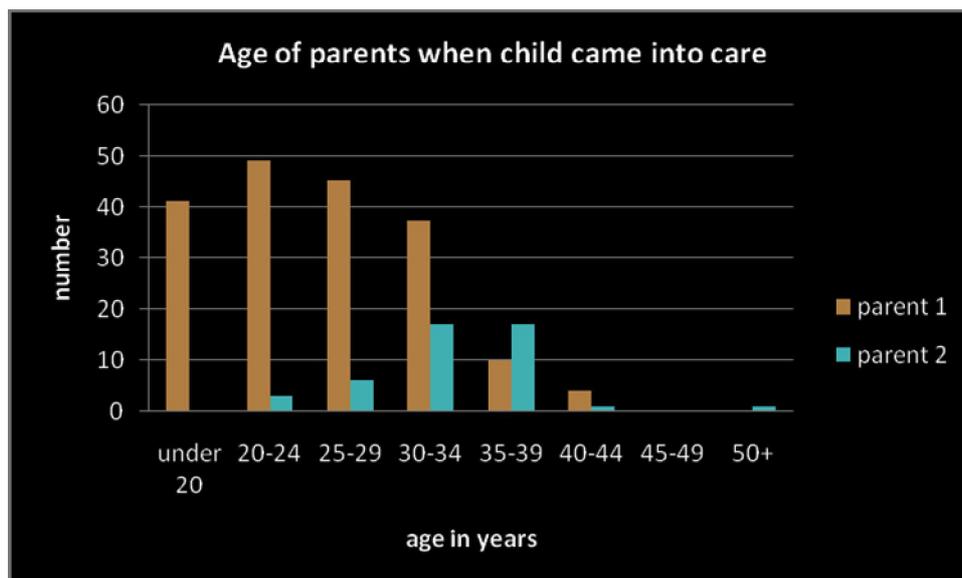
6.0. Biological Children

Respondents were asked how many biological, foster or whangai children they had children they had. The mean number of biological children plus foster or whangai children, was 2.37, median was 2.00⁸.

⁸ The figure was intended to omit the grandchildren/nieces/nephews they had in their custody or long term care. On undertaking the analysis of this question, it would appear that some respondents may have included the kin children

Valid percentages show that 45.7% of those who responded had only one child; 23.1% had two; 10.8% had three 3.2% had five 2.2% had six and 4.3% had over six children, one having 19.

7.0. Ages of children's parents when care first assumed



Fifty percent of the biological parents were in their 20's and 20% were aged 30-34. Less than 10% were over 35 years of age.

For those grandparents who had one child in their care, (n=186 responses), 22 % (n=41) of the child's parents were under 20 years of age and of these, 6 had a second parent aged 20-34; 26.3% (n=49) were 20-24 years ; 24.2% (n=45) were 25-29 years ; 19.9% (n=37) were 30-34 years; 5.4% 9 (n=0) were 35-39 years and 2.2% (4) were 40-44 years.

Parental ages at time of taking the second child into grandparent care (n=45) were 20-24 years (n=3)- 6.7%.; 25-29 (n=6) -13.3%; 30-34(n=17) -37.8%; 35-39 (n=17) – 37.8%; 40-44 (n=1) - 2.2% and 50+ (n=1) – 2.2%.

Where a third child was in care (n=3) parental ages were 30-34 - 1 child; 35-39 -1 child and 45-49 - 1 child.

As would be expected, the highest representation of parental age cohorts increased as more children were consigned to relative care.

There were only 45 cases where age was given for a second parent. Those aged 20-29 were most likely to have a second parent. The second parent was always older, mostly in their 30s (see graph).

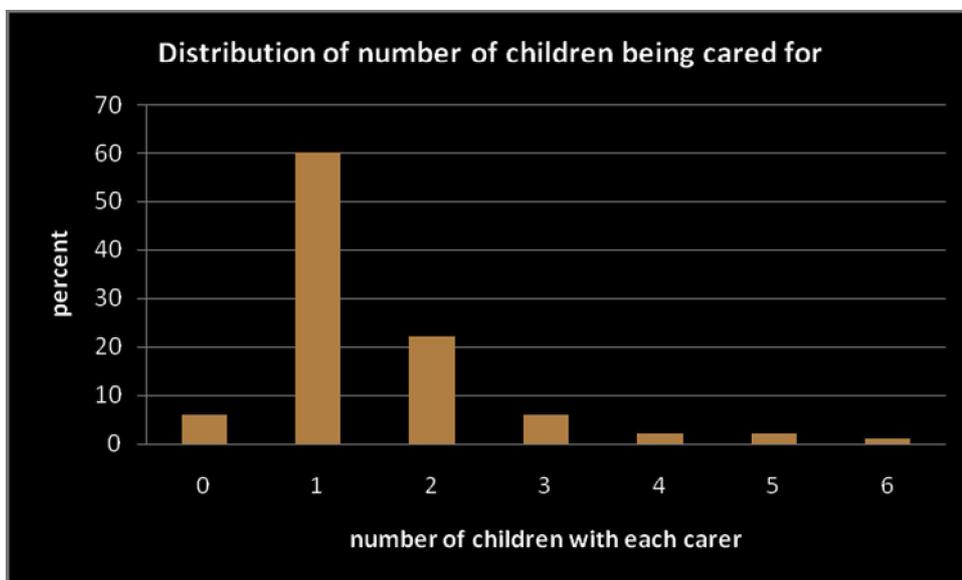
Section B: The Children

8.0. Relationship of Carers to Children

The kin caregiver relationships in this sample stretch across three generations. As would be expected by the data source (GRG Trust members) the largest kin cohort (84%) is that of grandparents (n=172); four great grandparents (3 having more than one child); two step-grandparents; one foster grandparent (foster parents to the children's mother); two aunts and uncles; one great aunt; one sibling carer; one adoptive grandparent (child's mother adopted) and three others who have no biological relationship.

[This is my] great grandchild. We have also brought up the great grandchild's mother from the age of 4 yrs. She is now 24 yrs old

9.0. Number of Related Children Placed With Carer



One hundred and two respondents (60%) have just one child; 37 (22%) have two; 10 (6%) have three; 2.5% have 4 and 5 each and two families are caring for 6 kin children.

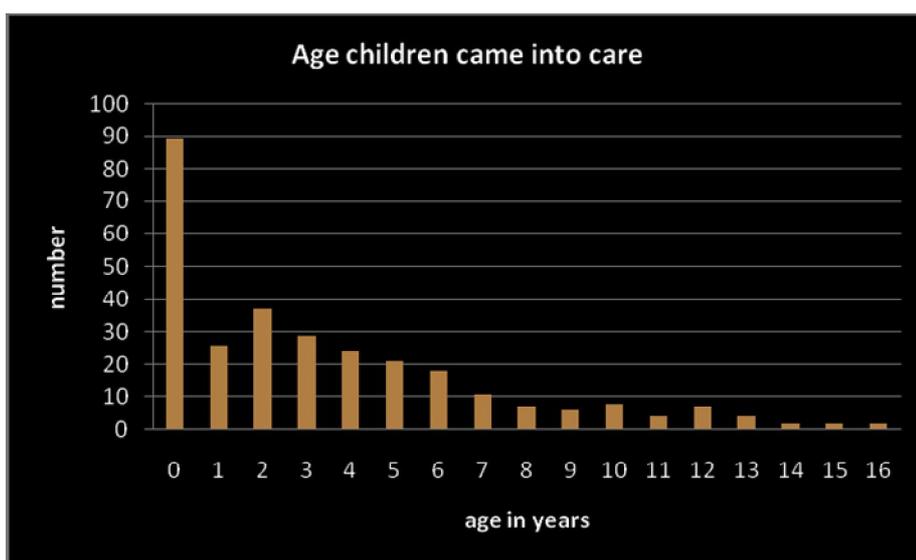
Some have previously cared for more but the children have become independent or returned to parents, other family/whanau members or to Child Youth and Family care. Two respondents had no children in their care, having lost custody to other family/whanau members or to biological parents under contested circumstances.

The number of children who are placed with siblings is worthy of note. Research shows that children in kin care have a greater chance of remaining with siblings. Where there has been neglect and abuse children often have siblings as their primary attachment figures. While this may cause some behavioural challenges for carers, it also reduces the separation trauma these children invariably

experience (McFadden, 2008). Maori carers were more likely to be caring for more than one child (53% compared to 32% non-Maori).

The number of kin children cared for was related to a decrease in income over the last four years; the children having psychological/behavioural problems, and to other changes observed in children since coming into care.

10.0. Age of Children When They Came into Care



Almost one quarter of the sample (24.2%) had been with the carer since birth, and one third of the children (33%) were under one year. Another 26.4% were under the age of three years when taken into grandparents/kin care. The majority of children came in to care in their pre-school years with 80.4% of the sample being under the age of five. Children who came into care at younger ages were more likely to have been in care for ten or more years; 47% of those coming at under age three compared with 21% of those who came at age three or older. There was more likely to be more than one child in care when they came at older ages: in just over half of cases with more than one child in care, the children came into care at age three or older.

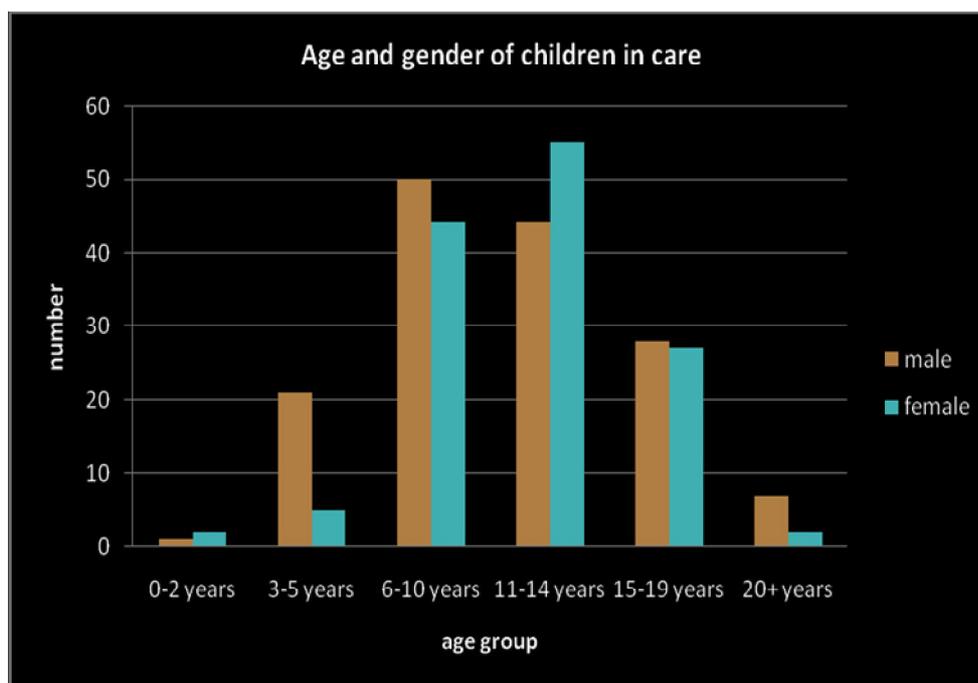
The length of time children had been in the care of grandparents was related to whether they were placed in their care at birth and the age that they came into care; change in legal status; older age of grandparent; and number of children in care.

Children were more likely to come into care at birth when the reason was physical illness of the parent (43%), death of a parent (39%); abandonment (35%); or “other” reasons (39%) and least likely to come at birth when neglect was the reason (17%) or imprisonment (18%). Children were more likely to come into care when aged 6 years or more as a result of imprisonment or death of a parent.

Fregly (2007) in examining her sample of kin carers comments on the unplanned nature of the placements and the stress experienced in relation to unexpected costs, in terms of bedding, clothing, and food., a factor identified in international research (COTA 2003:31; Richards and

Tapsfield, 2003:7; Jones and Kennedy. 1996P:640). The set-up costs for the number of children in this sample that entered care under one year would be substantial.

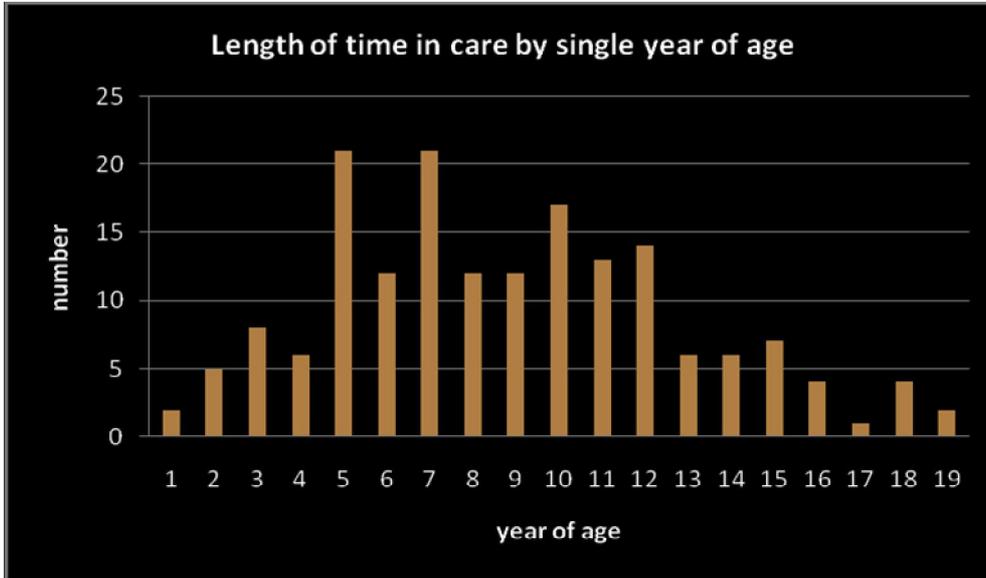
11.0. Age and Gender of Children in Care



Because the children have been in care for at least four years, there is a higher representation of children in older age ranges than in the last survey. Those children noted as being under four years of age are siblings of the children who have been there for four years or longer and have come into care later. Girls are older than boys –there are more boys aged 3-5 and more girls aged 11-14. There are also more males aged 20+. The stability of the kin placements is noted and the graph should be read with the following data on length of time in care.

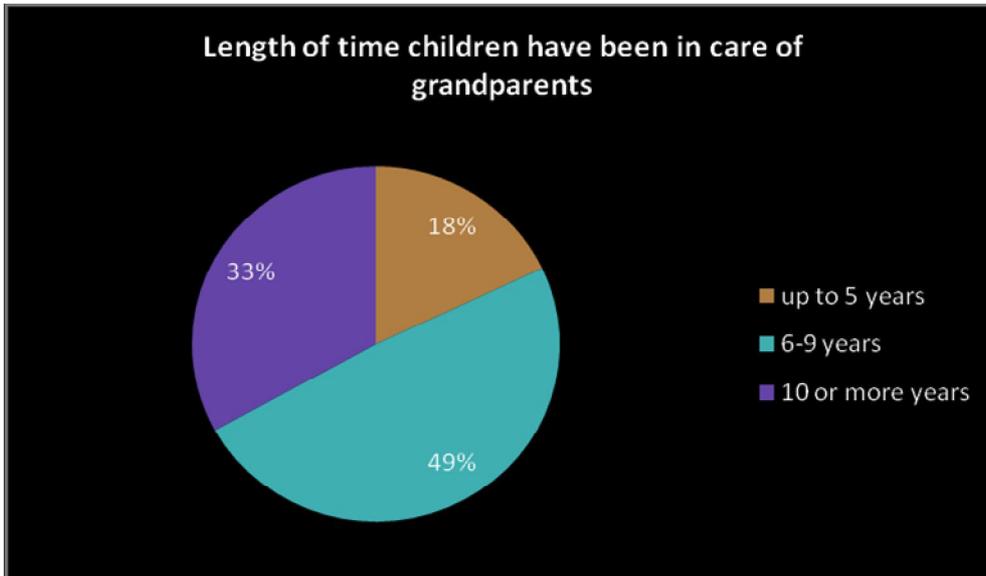
12.0. Duration of care

Changes in child welfare legislation that now make attempts to place children with kin as mandatory have arisen out of New Zealand and international research that showed for many children, foster care has not afforded the stability they needed (McKay, 1981; Worrall 1996; Worrall, 2007). Many studies have shown that children in kin care are more likely to experience a higher degree of placement stability and continuity of care than children in foster care (Webster, Barth and Needell, 2000; Kortenkamp & Earle, 2002; Worrall, 2007). This study aligns with overseas research showing that grandparents taking the child from birth, is common practice and that carers are committed to kin children in spite of the many difficulties they encounter.



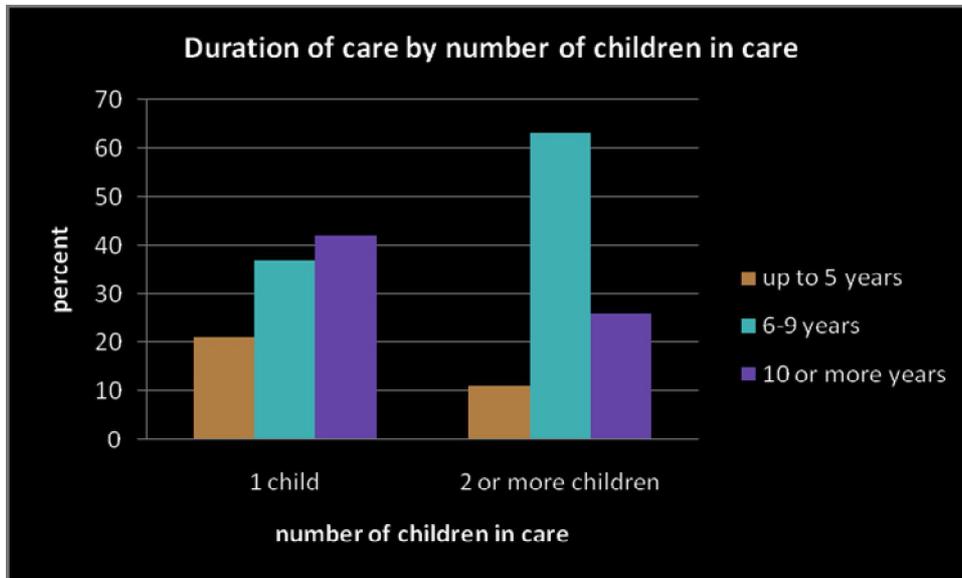
Mean time in care was 8.7 years, median was 8.1 years.

To run cross-tabulations/bivariate analysis, duration of care was grouped into three categories: up to 5 years, 6-9 years, and 10 or more years, distributed as shown in the following figure.

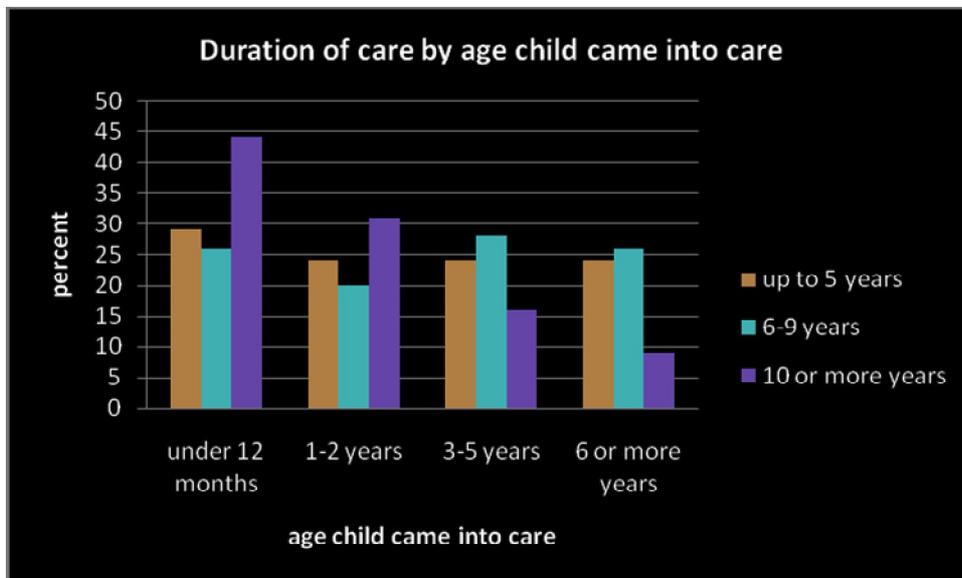


Duration of care was longer when there was only one child: 42% comparing for 10 years or more compared to 26% when there was more than one child.

Duration of care was longest when the children came because of mental illness of the parent (50% ten years or more) and less likely to be that long when they came as a result of domestic violence, child abuse or neglect (less than 30% for ten years or more).



Older grandparents were more likely to have been caring for grandchildren for longer – 55% of those aged 60 or more had been caring for 10+ years, and only 12% of those under 60.

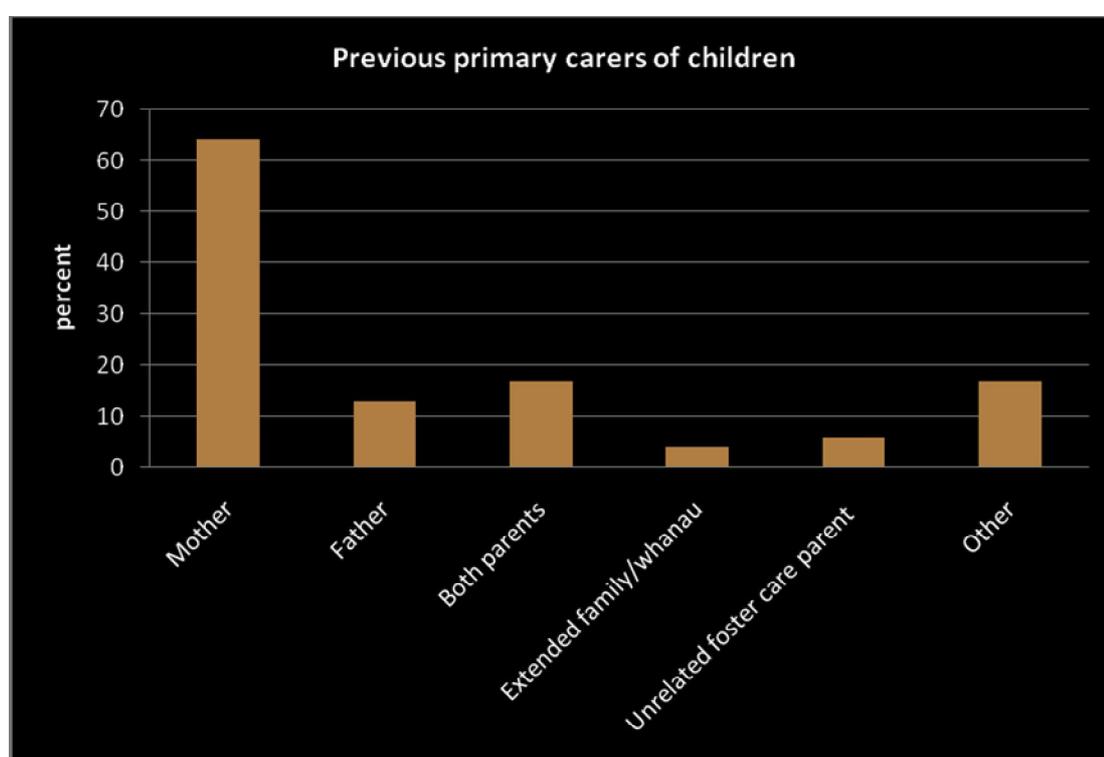


The best time used to be when he went to bed and I could relax now its a joy to sit at the dinner table enjoying animated intelligent conversation with grandson & friends knowing that however difficult it has been I have done a splendid job raising an amazing kid who despite his rough start in life has grown into an even more amazing young man

Children were more likely to have been with grandparents since birth where a parent had died (42%) or where there was parental illness (43%). They were less likely to have been in care since birth where the reason was imprisonment or child abuse (5% each). As would be expected, duration of care was longer when the children had been placed at birth. Thirty-eight percent of those placed at birth had been there 10 years or more compared to 16% of those who came into care when they were older.

13.0. Previous Primary Carers of the Children

While the children have come into grandparent/kin/whanau care from a variety of places, the biological mother of the child is the most common previous carer, accounting for 64.4% of the sample. Significantly fewer have come from both parents (17.1%) indicating parental relationship breakdown is a common feature for this sample. Twenty-seven children (13.2%) were in the custody of their father, and 8 children (3.9%) came from whanau/family members. Thirteen children came from unrelated foster carers. As many respondents had more than one child, and they were able to select from more than one option, totals therefore add up to more than 100%. Of the fifty-five who said 'mother', 18 also said father, 11 said both parents, 6 whanau/ext family, 8 from foster care, and 12 other. Eight who said 'father' also said both parents and foster care, and in those instances there was more than one child in care with different care histories.



Significantly 34 children are noted as having come from other places, most commonly from hospital, either at birth or some months later, or as a result of hospitalisation after being abused.

Premature birth straight from the hospital age 3 months

Child/mother was discharged from maternity hospital to me

Straight from the Maternity hospital aged 3 months.

Mother for the first eight months who lived in my family home. Although she lived at home, I cared for grandson since his birth. She left him with me when he was 8 months.

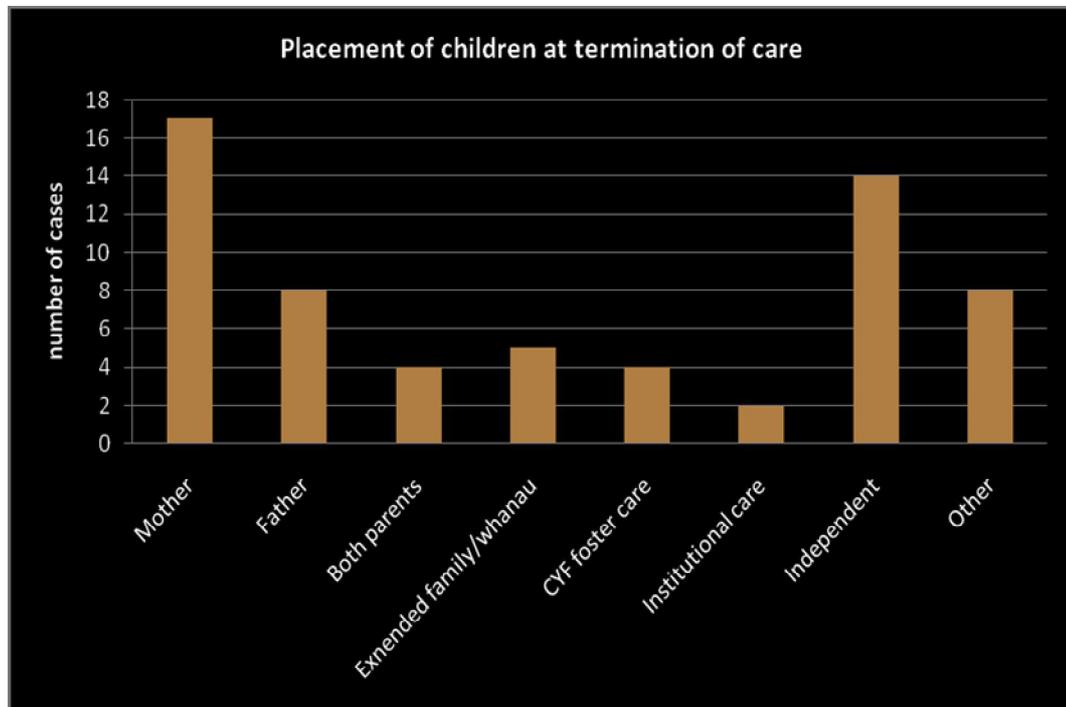
CYFS, truthfully, these kids looked after themselves and were left with anybody and this means drug dealers, paedophiles and the like

14.0. Termination of Care

As discussed previously, the stability of kin placements compared to stranger foster care placements has been the subject of international research and the overall results show that children enter care at an earlier age and are more likely to be maintained in kin care, build attachments, and achieve permanency.

Forty-eight grandparents/kin carers (24.1%) out of a total of 199 respondents had cared for children that had now left and for 41 carers this was over the last four years. Of the children who had left, 17 returned to mother; 8 to father; 4 to both parents; 5 to other extended family members; 4 to Child Youth and Family foster care, 2 to institutional care with Child Youth and Family and 14 to independence. This was a multiple response question to accommodate those families where more than one child had left their care.

Has learned to be an independent young adult, still making errors but surviving! With no adult input, except for expensive overseas phone calls. Note: he is now 18 years old



Several grandparents had lost custody of the children as the result of a parental challenge and a court decision in the natural parents' favour. Some had been caring for the child for many years, and for one grandmother, since birth. This has had a significant financial and emotional cost to these grandparents.

I had two children in my care, my daughter's children to her 1st husband, now 16 & 13, who are now with their other grandmother. I now have 3 other grandchildren in my care.

Lived on the streets ran away, 2) put into foster care had 22 foster homes, 4) did a lot of crime, 5) now serving a 2 year prison sentence, 6) broke our hearts, 7) but still visiting him and supporting

With other extended family” & boarding or flatting. Grandson, almost 18 years, has a job but drinking & smoking heavily as well as doing dope. Has been treated for ADD with dyslexia thru the Dare Centre successfully, but these vices are presently to the fore & in control. Wilful & abusive but over the last year, slight improvement. We had our grandson from 12 years i.e. 5 years. Parents not in the picture

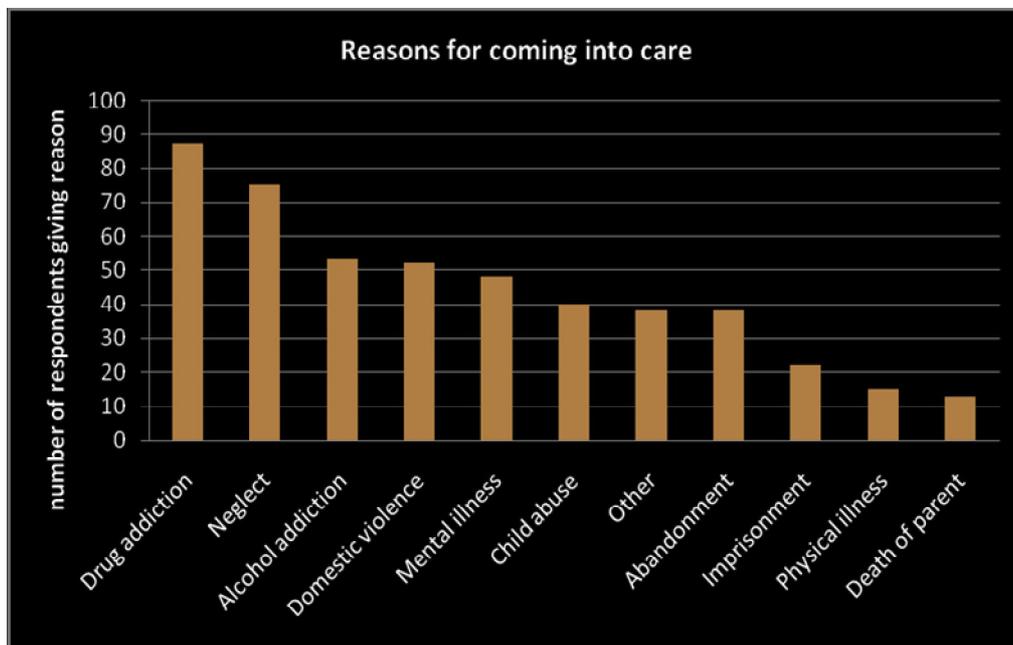
The granddaughter I had for four years left due to the fact that she got into (P) and other substance abuse

Moved: 1) father; 2) returned to me; 3) to mother in Australia; 4) now independent in Australia

Returned to mother; please note this child was in and out of my care part time from 3yrs of age but come to me at 8 full time for 5 yrs

Returned to father; the two granddaughters now returned to me due to the father returning back to drugs, alcohol and gangs

15.0. Reasons for care



This was a multiple response variable, where a respondent could tick more than one reason. Cross-tabulations were run using SSPS multiple response variable function, but this does not enable tests of statistical significance of differences between categories where the same person could be in different categories. Therefore the findings are not statistically significant and are reported on the basis of results that were much higher or much lower compared to those for other reasons for coming into care.

Summarising across all reasons in relation to all other variables, the reasons that stood out as most frequently having a more negative outcome on other variables was physical illness, followed by child abuse and mental illness⁹.

As recorded in the 2005 study, drug addiction was the most prevalent reason stated for the need for care, (42.4%; n=87). While it was not linked particularly highly or lowly (relative to other reasons) with many other variables, it was co-morbid with neglect (45 cases); alcohol (45 cases) Domestic Violence (37 cases); child abuse (30 cases); mental illness (21 cases); abandonment (22 cases) imprisonment (19 cases); physical illness (9 cases) and death of a parent (1 case).

Physical illness of the parent as a reason for children coming into care (n=15) was more likely to be associated with coming into care at birth; having a change in employment status involving working less; a decrease in income; having a low income (under \$20,000); the child having physical problems; a change in health status of the carers; particularly worsening of partner's health, as a result of taking the child into care; changes in parent contact in last four years; attending or wanting to attend GRG support meetings and being older (60-69 or 70+). However, it is also associated with having fewer children to care for and fewer total number of children including biological children, and being less likely to have legal status contested in court. However, only 15 respondents had taken children into care for physical illness reasons, so these numbers are small and findings only suggestive of differences. These findings cannot be considered definitive.

Child abuse as the reason for coming into care (n=40) was associated with decreased income, physical, psychological/behavioural problems and other observed problems of the children. Child Abuse is also associated with having legal status contested in court and changes in legal status; carers health worsening as a result of taking child into care, wanting therapy or counselling (but only 54% were successful in accessing this). Carers were also more likely to have a higher number of children in care and children were more likely to be under 6 years old but less likely to have come at birth. On the other hand carers were more likely to have accessed funding support other than legal aid.

Mental illness as the reason for coming into care (n=48) was associated with changed employment status – but not more likely to be an increase or a decrease compared to other reasons, decreased income, physical, psychological/behavioural and other problems in the child/ren, worsening health of both carer and spouse as result of taking the children into care, both longest and shortest duration of care, and less likely to have access to funding other than legal aid.

The reason for coming into care that had the most positive outcomes in relation to other variables was death of a parent. However, it should be noted that only a small number of respondents (n=12) were in this category, so these comparisons and relationships are only indicative. In this case there was less likely to be a change in employment, a decrease in income or low income, psychological/behavioural problems, changes in legal status, health problems of carers as a result of taking child into care. Carers were highly likely to receive legal aid and other funding support, to participate in social activities, to increase their employment hours and not need therapy. They were likely to be older, especially 70+ and for the children to be either over 6, or have come at birth. The children were the most likely to be making excellent progress at school. The only negative outcome for this group as being more likely to have their legal status contested in court (36% compared to 20% overall).

⁹ These differences are not tested for statistical significance as this was a multiple response variable – a respondent could be in more than one category (i.e. reason).

Some of the ‘other’ reasons cited were divorce of parents; poverty; father unwilling to work; prostitution; young maternal age; fragile health of infant/child; other extended family placement breakdown;

Daughter was only 14 and living at home when he was born. Too young to cope, abuse from child’s father and finally left me to care for the child. She was unsure about how to cope with anything. Couldn’t cope 14 years with a baby and only a child herself!!

Mother of child asked us to take on the responsibility of child as she was due to have her 2nd child when our son passed away

Mother unable to care for child – Neglect is too stronger word. We agree thru the court and parents of the child he is best with us as he was extremely sick and is a permanent outpatient of Starship Hospital. Had we not taken over his care and preserved with the hospital system we are in doubt (as are the specialists at Starship) he would not have seen 18 months

Guardians no longer able to cope with behaviour, knew the child through friends and offered her a home, unaware child had intellectual disability

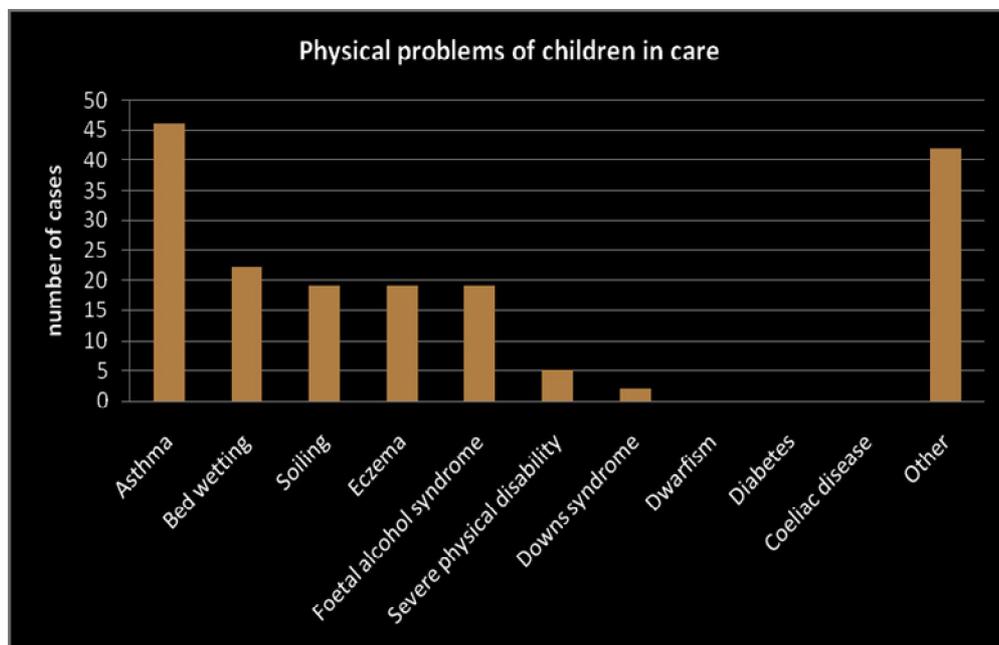
Child was lifted by CYFS and given to grandmother but after four weeks she couldn’t cope, so we took over (Great grandmother!)

Father drug addict left relationship, (our son); mother IHC/brain damaged after teenage car accident able to care for self not capable of remembering to care for child

16.0. Physical and Emotional Well-Being of the Children

16.1. Physical problems of children

Physical problems were cited by 52.6% (n=91/173) of the sample. Five children were described as a having severe physical disabilities; 2 children had Downs Syndrome; 22 children had enuresis (bed-wetting); 19 soiling problems; 19 Foetal Alcohol Syndrome; 46 Asthma; 19 Eczema and 42 cited ‘other’ issues. The most common physical health problem experienced by the children in care was asthma, with 46 (22%) of carers encountering this. There was no dwarfism, diabetes or coeliac disease.



Many carers described multiple physical problems experienced by the child and complex conditions that required constant care and skill to manage. The more serious of those are listed hereunder to emphasise the commitment of these grandparents to the difficult and taxing task of caring for their grandchildren.

Pierre Robin Syndrome (cleft palate, severe eye problems, jaw malformation, teeth malformation); Sotos Syndrome; Long QT syndromes generic heart disease; Immune deficiency ; Spastic quadriplegia dystonias ; Atypical Moebus Syndrome; 24 wks premature, chronic lung condition, weighing 650grams; Minor epilepsy (birth damage) health 'break down ' due to losing mother ; Cancer, epilepsy, autism, major learning disabilities; Scoliosis (bent spine); blind left eye; Attention Deficit Disorder, learning difficulties, language processing problems; He had his bout of pneumonia at 7 weeks old, followed by 5 more hospitalised bouts he was diagnosed at Starship with bronchiectasis and aspiration of fluid into the lungs; Hypogamaglobulinaemia (immune deficiency); Neurogenic bladder; seizure disorder, septoptic dysplasia; cerebral palsy (previously diagnosed, now not confirmed) Global Delay, Twisted feet, shaken baby syndrome ; Cortically blind and developmentally delayed with a left arm/hand hemiplegia from stroke ... result of being shaken as a baby ; Foetal Alcohol Syndrome Effects; developmental delays, possible Aspergers or Autism; obesity.

Grandparents whose children were disabled as a result of “shaken baby syndrome” also described the grief experienced when that damage was executed by their own children. Children were more likely to have experienced physical problems where parental physical illness (77%) or mental illness (67%), and child abuse (78%) or neglect (68%) were the reason for coming into care, compared to 53% overall.

16.2. Improvement of Physical Problems over Time

The effect of stability and committed care has resulted in 83.7% (n=87) of the respondents stating that in spite of the seriousness of the issues, the problems experienced by the children had improved since coming into their care.

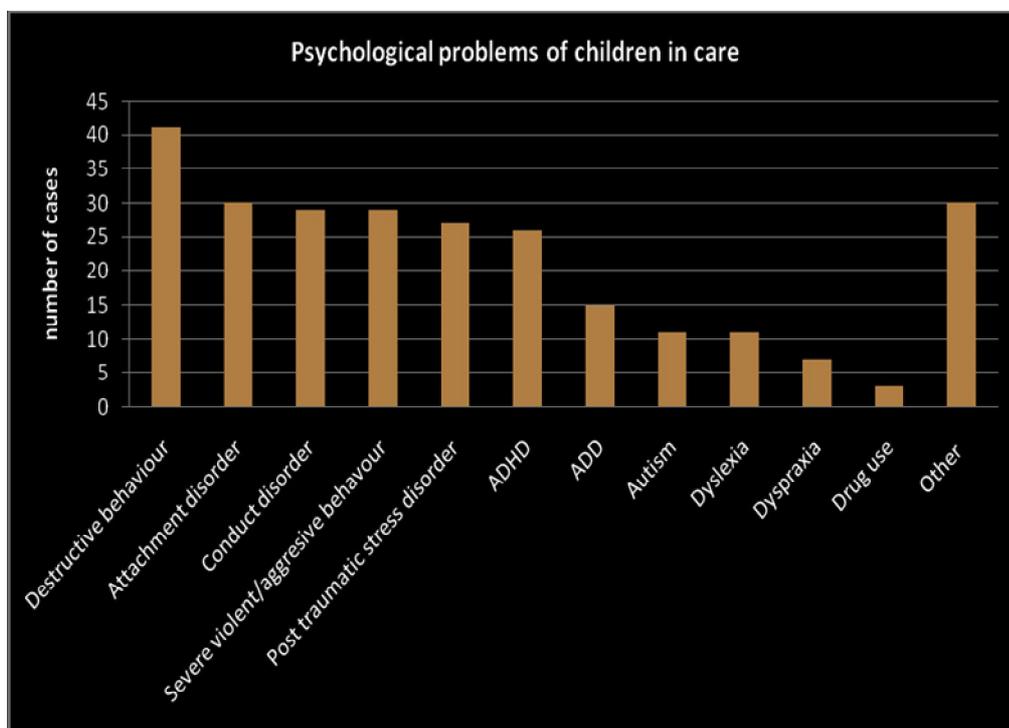
The joy has been watching this sick wee boy grow and learn and get better. Each day is a day filled with love and laughter, learning & growing – he truly is a special boy and I think we were blessed with him for a reason

To see her go from a tiny babe not able to swallow to a grown 12 year old that has been a blessing for me. It is a blessing that her health has been the opposite to the prognosis and the opposite to what I was told she would never do

...the two boys we have had since babies, one was not suppose to live but has beaten the odds including that he is not a vegetable but is in fact top of his class at school.

16.3% (n=17) said they had not improved and 9 respondents stated that the conditions had in fact worsened and in some cases this was due to the child having a condition that was expected to deteriorate over time.

16.3. Psychological or Behavioural Problems of Children



The 2005 report recorded a higher percentage of children with psychological difficulties than physical problems. This latest research has shown that the number of respondents citing psychological or behavioural problems (52.3% n=90) as almost equivalent to those citing physical problems, and commonly, the two were co-existent. (In 67% of cases reporting either physical or psychological/behavioural problems, both were present, n=53 out of 156). A breakdown of actual conditions showed:

Eleven children were diagnosed with Autism; 15 with ADD¹⁰; 26 with ADHD¹¹; 30 with attachment disorder; 11 had dyslexia; 29 with diagnosed conduct disorder; 7 with dyspraxia; 27 with PTSD¹²; 29 with severe violent aggressive behaviour; 41 were described as destructive; 3 with drug use and 30 with other psychological conditions, namely: cutting; sleeping disorders; eating disorders; nightmares; speech problems; sexual panic attacks; faeces smearing; lying and stealing and not keeping themselves safe; Attachment disorder / Fear of being left by herself; not motivated; depression; anorexia; learning & behavioural due to Sotos Syndrome & foetal alcohol effects; bi-polar disorder; high anxiety; sexual abuse – sexual playing out and self injury.

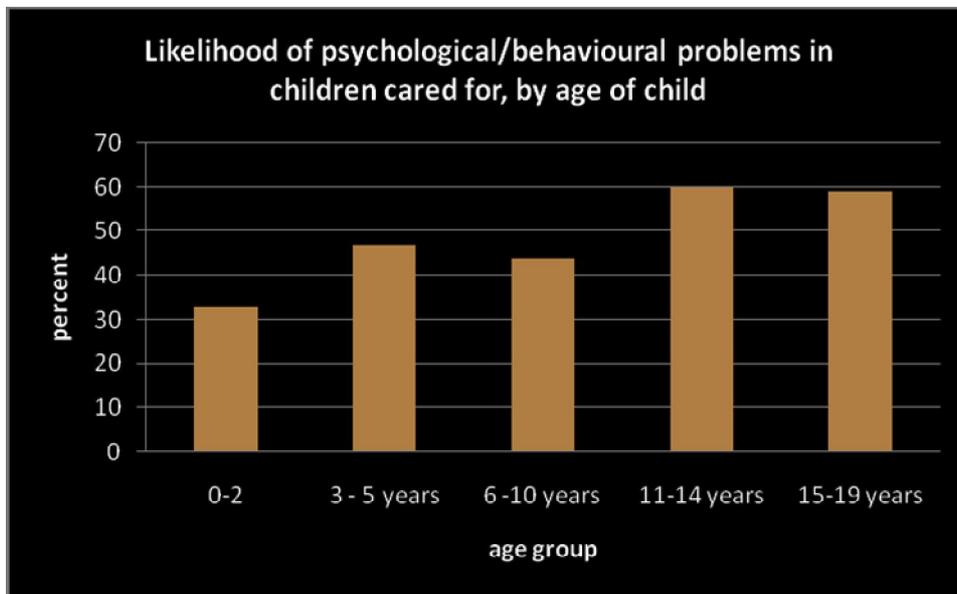
He has learnt fear, he still after all this time watches people and gauges the mood of people around him

When I first took the 3 children into care they had trauma, stress, depression, insecurity, unsettled. Had been abused by a “P” addict mother who also took ecstasy, alcohol and had mental health problems and anger

¹⁰ Attention Deficit Disorder

¹¹ Attention Deficit Hyperactive disorder

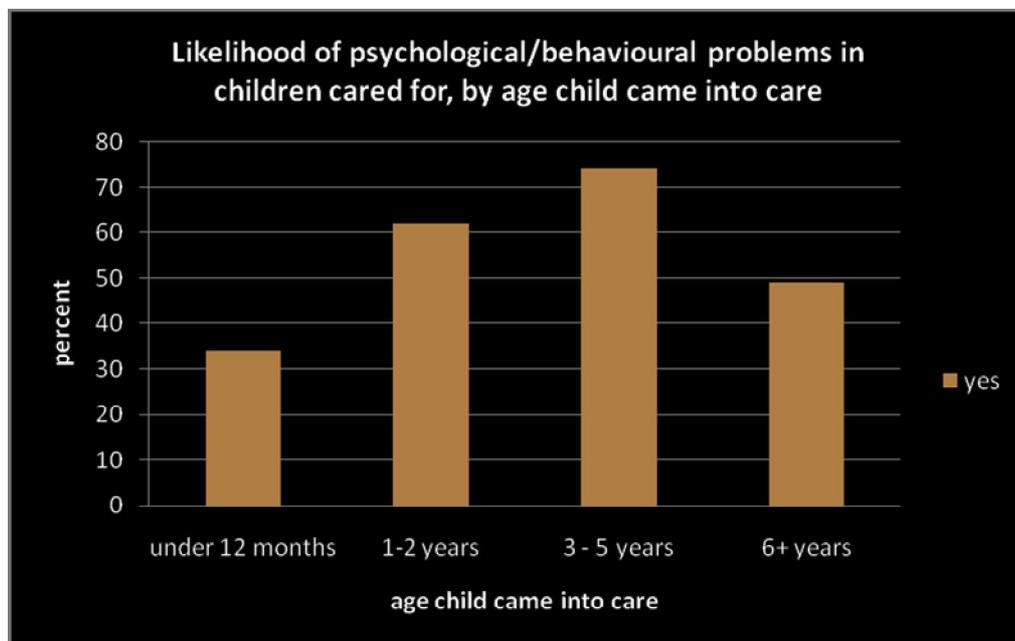
¹² Post Traumatic Stress Disorder



Grandparents in their 60's were more likely to be caring for grandchildren with diagnosed psychological/behavioural problems (66% compared to 52% overall and only 23% of those under 50). This is partly because older grandparents were caring for older children, and older children were more likely to have psychological/behavioural problems: (60% of those aged over 11, 44% of those aged 3-10, and 33% of those aged 0-2 (see graph).

There were more likely to be psychological/behavioural problems when there was more than one child in care (73% compared to 42% with one child only) and more than one child in total, including biological (60% to 42%)¹³. There were also more likely to be other changes observed in the children since coming into care when there was more than one child in care (78% compared to 58%). Psychological and behavioural problems were most common when the children came into care at ages 3-5 (74%), followed by 1-2 (62%).

¹³ The statistical relationship was stronger for the number of children in care than for the total number of children including biological. Also, the percentage with a psychological or behavioural problem was higher when there were only two children in total than when there were three or more. This suggests the relationship is with number of children in care, rather than whether there are also biological children.



16.4. Improvement of Psychological and Behavioural Problems over Time

Again, the effect of stability and committed caring had a marked effect on the children with 86.5% of (n= 83/ 96) stating that the children had improved since coming into care. 21 said that the problems had become worse. Other changes in the children since coming into care were more often observed when the reason for care was child abuse (88%), domestic violence (81%), mental illness (79%), neglect (79%), or alcohol addiction (75%) compared to 65% overall.

Psychological or behavioural problems were most common where child abuse (69%), neglect (66%), domestic violence (64%), abandonment (62%) or mental illness (61%) were the reasons for coming into care, compared to 53% overall. There were no statistically significant relationships with change in psychological/behavioural problems since coming into care.

17.0. Injury to Carers

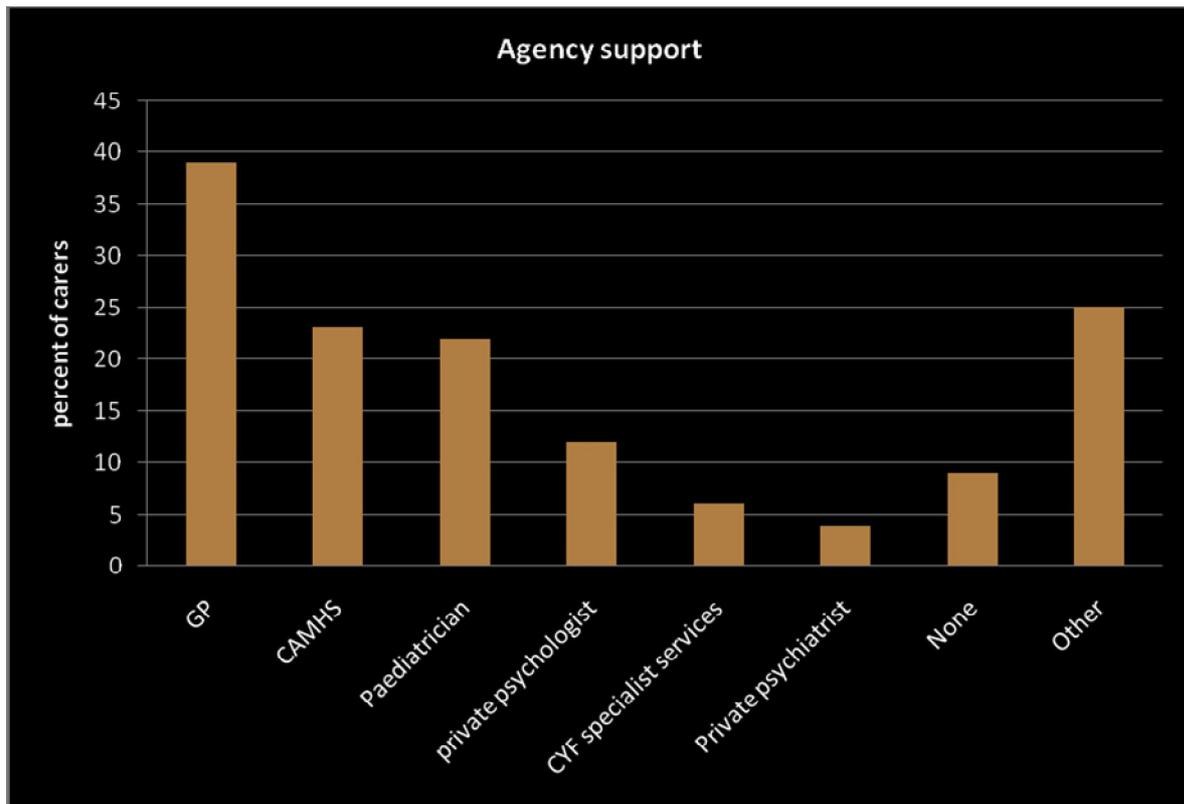
Because of anecdotal evidence received by the Grandparents Raising Grandchildren Trust, and in an attempt to quantify the issue, respondents were asked if they or other family members had received any assaults from the children in their care. There were 117 responses to this question. Thirty-six (38.3%) stated that they or their family had received physical injury and 72 (61.5%) stated that they suffered verbal abuse. The ability to comment on the situation drew 44 responses. Carers reported suffering verbal abuse, pushing; slapping; kicking; threatening to kill resulting in one grandmother returning the child to Child Youth and family care.

Outbursts of verbal abuse; slapping my face; pushing me around; became unsafe in my own home. Time for CYPS to take over

The physical abuse got very close with her threats to kill us and the grabbing of knives to do this -both to her older sister and me (grandmother). This happened on a regular basis. The cat did suffer physical abuse, she punched it many times; as a result the cat is a nervous wreck

Kicking my pregnant daughter in the tummy and plenty of verbal abuse to myself

18.0. Professional Assistance and Support



CAMHS = Child and Adolescent Mental Health Service

Respondents were asked to identify what help they had been able to access to assist them with the physical, emotional and behavioural challenges they faced. Research has shown that children in kin care find it more difficult to access support services than children in stranger foster care Whitelaw Downs, S; et al (2004) . and for some grandparents this was the case. Some Grandparents stated that they felt 'abandoned' by Child Youth and Family Services.

CYFS said he was too young for counselling so I've battled on alone for over 3 years

Nobody cared enough to worry!

CYFS did nothing about help even though this second child was diagnosed by them on two occasions. No help was forth coming until CYFS were ordered by the courts to get their act together. Courts ordered a private psychologist and now the child is getting therapy from a private therapist paid by CYFS

However in other cases CYF did respond to the need when grandparents could not cope:

CYF supplied a tracker but she [grandchild] was so bad CYF took over custody for 28 days and put her in a Family Group Home for respite as we were exhausted, CAT team, Police & Psych nurses were involved regularly for a time. She also spent 10 days in the family unit at Starship and is on medication.

As in the 2005 study, the general practitioner was the most commonly cited source of help, 38.5% (n=79), followed by Child and Adolescent Mental Health services (22.9% n. 47), Paediatrician, (22.0% n.45); private psychologist (11.7%, n.24); CYF Specialist Services (5.9% n.12); and private psychiatrist, (3.9% n.8). Some stated that they had accessed none (8.8% n.18). Fifty-one (24.9%) stated other assistance: Non-government helping agencies, such as Barnardos and Open Home Foundation; school psychologist and school counsellors and social workers; Cerebral Palsy unit; IHC; Child and Health disability services; Family Therapist and parenting programmes. One cited the Child Youth and Family Foster Care training programme.

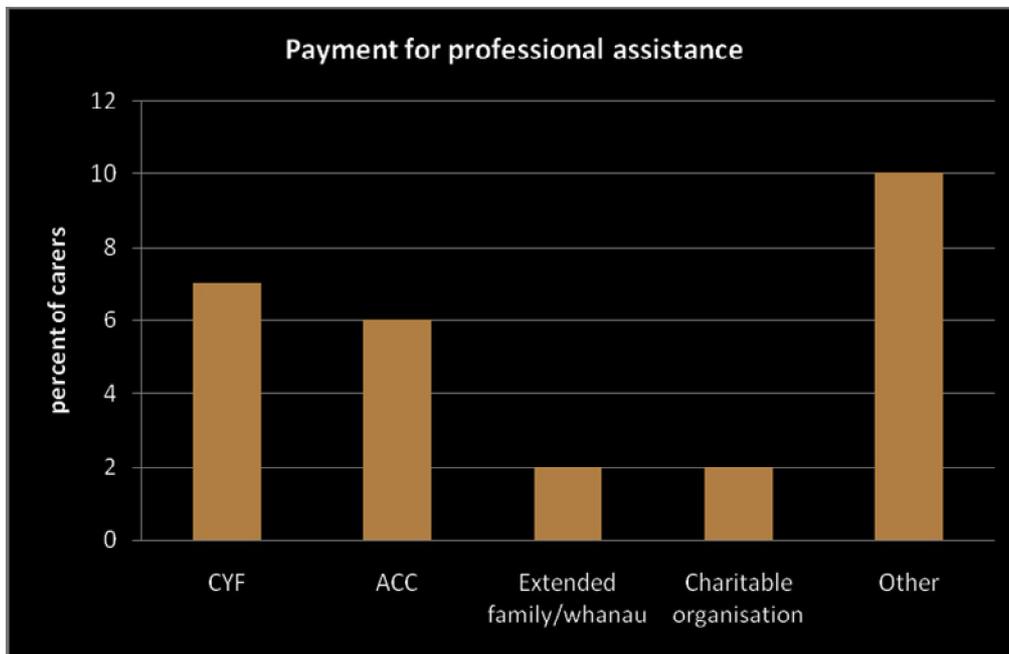
19.0. Financial Assistance

Society has no idea how hard this type of care giving is. Respite care regularly is desperately needed. As we age our finances become fixed but as the children grow their financial needs increase. More recognition for the job we do! If on a benefit, we should [not] be forced into the work force, we are needed at home to care for these vulnerable children. We need more financial assistance. Free counselling for the children to heal past abuse as long as it is needed. It is not rocket science, if the Govt does not pay for counselling at one end (with a chance of it being successful) they certainly will be paying for them at the other to be in prison. If it were not for us where would these children be! In transient Foster care, then what? Help us to help them, do not penalise us for what we do.

One hundred and seven respondents (78.7%) to this question stated that they had not been given any financial assistance to pay for specialist fees and that had the child been placed in stranger foster care in State custody this would be less likely to be the case. Some grandparents are receiving the UCB even though the child is under the custody of CYF and still cannot qualify for extra help¹⁴.

I would like to see Grandparents who are receiving the UCB get clothing allowance, medical and legal issues paid for – the same as CYF carers get PLEASE Thank you!! (Children are under joint guardianship with CYF!)

¹⁴ Data was collected before the latest changes to the Unsupported Child Benefit which aligns weekly UCB payments with CYF foster care payments, but does not pay for any other ancillary costs.



As in the 2005 study, many grandparents made the point that they had paid for help out of their own pockets.

At \$100 a week for a year at a time - it worked.

We have spent 1000's dollars with Kip McGrath for extra tuition in reading, writing maths.

We have used our retirement funds

Only 29 (21.3%) out of the 136 respondents to this question stated that they had received any financial help to manage the children's physical and/or psychological problems. Sources of funding for these were: Child Youth and Family: 6.8% (n=14); ACC 12 (5.9%) extended family / whanau: 5 persons (2.4%) Charitable organisation: 3 persons (1.5%). Twenty one persons described other means of financial support they had managed to access.

I have fought like hell for any dollars, WINZ has reluctantly provided minimal counselling, most help came through CCF (Child Cancer Foundation) – this is the silver lining to having a grandchild with cancer

Teen Adders, organised money for anger management course

School uniforms (McKenzie Trust) MOE¹⁵ Boarding assistance for Boarding School, Ngai Tahu as the 15 yr old has a Ngai Tahu bloodline and is registered Ngai Tahu

Child disability allowance received payment from ACC because child's father was killed but this is about to stop

R is described as an accident!!! He was shaken at 4months

We have used our retirement funds!

¹⁵ Ministry of Education

20.0. Other Changes in the Children Since Entering Care

Grandparents largely commented on positive changes observed in the child over the last four years in their care. The children and young people were described as becoming independent, gaining confidence and self esteem; making good choices; a growing ability to socialise with others; self control; doing well at school; secure, attached, studious, focussed; improved health and sleeping patterns; not needing to hide food or hide from strangers; moving on from the trauma and fitting in with the family – calling the carers Mum and Dad.

From being a nit-riddled, starving, emotionally traumatised and neglected toddler she has blossomed into a very delightful, bright 7 year old who thrives on everything and greets it all with great enthusiasm

Loves life, sociable, articulate, intelligent, kind, helpful, takes initiative, active, creative, pretty, artistic, listens, thinks, sleeps well, eats well, good grooming, clean, tidy.

A gradual change to good interactive behaviour with family and peers, teachers and other encountered adults

We have one grandchild only. Since she is now calmer she doesn't freeze in overwhelming fear and can now think and articulate her distress so that she can ask for comfort and explain to people what is going on

They give and show a lot of affection, very apologetic care for each other, these two children I have are sister & brother very protective to each other when with other children but very friendly too

They love the security of a home and caring, loving family. Their Dad is always in 'touch' no friction

The children's ability to play without fighting, swearing, smashing belongings

Some children were still showing extreme emotional trauma even after four stable years in their relative's care. Many grandparents commented on the fact that this was, in their eyes, related to having parental contact or in some cases, unresolved grief through death or parental abandonment.

Since he now has access times with his father and stays one [night] every 2nd weekend, he has become very withdrawn, won't eat. Wants to die – "I'm dumb, stupid etc" This has got worse now we are going through court and his father tells him he is going to take him away. Knowing they are loved and this is not a job. We are blessed to have them in our lives. Makes for a happy family

As they grow older fears about their mother's death grows, and the reasons why she couldn't cope with life & what will happen to them

All was ok till Dad went missing & then found murdered

As she gets older more anger comes out, more worries about abandonment (God I wish) sometimes I get too overwhelmed with it all

Going through extreme trauma in last 3 ½ years; child had 4 amounts of counselling

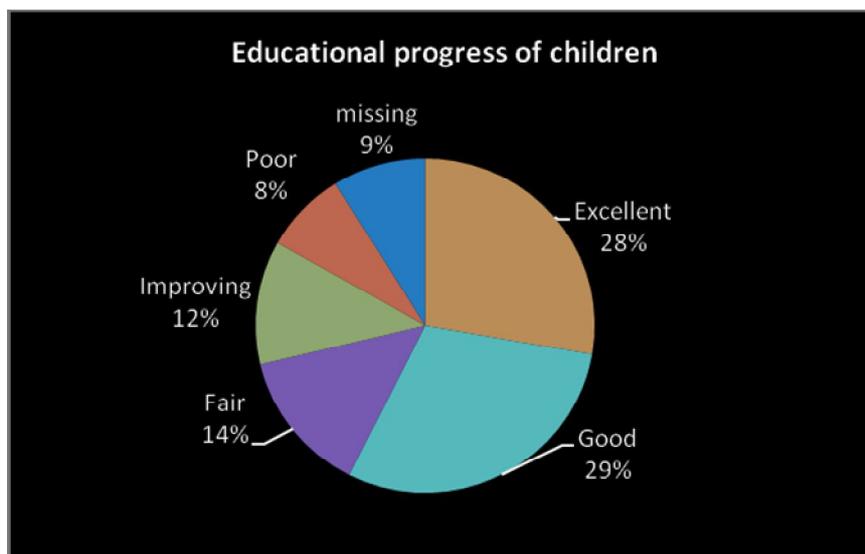
Access visits to mother always followed by fear, aggression, mood swings, non-compliance and attention seeking behaviours

Some children have permanent conditions that will not improve. For others, the trauma received that led to care has left permanent damage - brain damage, severe attachment disorders; manipulative behaviour; intra-uterine damage from maternal drug and alcohol abuse leading to an inability to socialise or be empathetic.

21.0. Education

21.1. Educational Progress

As stated in the Literature review, commentators have made the point that in terms of scores in physical, cognitive, emotional, and skill-based domains, children in kinship care have scores more like those of children who are able to remain at home following a child abuse and neglect investigation than do children in foster or group care. Children are significantly less likely to experience change of schools than those in stranger foster care and both teachers and carers tend to rate children in kinship care as having fewer behavioural problems than do their peers in other out-of-home placement settings (Conway and Hutson, 2007). Earlier research (Dubowitz 2005) found that many children in kinship care appeared to have serious school performance difficulties compared to their peers who are not in the care system.



Fifty-seven percent of respondents classified their children's educational progress as excellent or good. In the 2005 study 61% of carers rated their children as having made excellent or good progress.

My grandson is very bright. Maybe because he has been in my care since birth and he is happy with his secure attachment. Calls me mamma. He is top in his class at reading and maths and is very social.

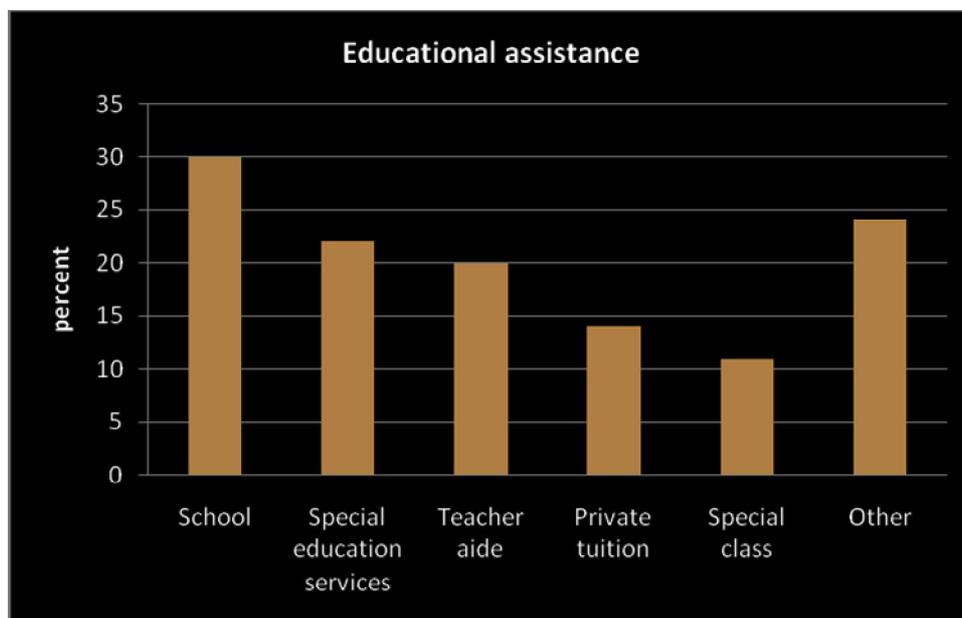
However for other grandparents, the special needs of the children meant that they needed special education either at a Special school or Correspondence school

Child home schooled due to separation anxiety, bullying etc

Special needs and all that goes with it

Home schooling until end 09, approved by correspondence School Dept recently

Educational progress cannot be interpreted as a single factor, but depends on many other variables such as health, disability and intellectual status of the child; extent of abuse trauma; stability and length of placement; caregiver involvement in the school and ability to assist the child in his/her studies. While the study showed no statistically significant relationships between educational progress and other variables, on the multiple response variable of reasons for coming into care, which cannot be tested for statistical difference, educational progress was more likely to be reported as excellent when they came as a result of a parent dying, and more likely to be reported as poor when imprisonment was the reason.



21.2. Educational Assistance

Respondents were asked to describe all avenues of help they had been able to access for the educational needs of the children and 62 (30%) stated that they had received assistance from the school. Another 22% had received assistance from Special Education Services (SES); 19.5% had a teacher aide; 14.1% paid for private tuition; and 11.2% stated that their child was in a special class. Other resources described were: gifted child program Year 6-7 ; Marinoto Psychologist; Education psychologist; NZ Correspondence; boarding school; special needs boarding school; public Health Nurse; Reading Recovery teacher; RTL¹⁶ Teacher. Several grandparents were teachers themselves and ensured that the children received all the help that they could,

I am a retired teacher and advisor on children with severe behaviour problems. I have invested time & money on education and extra-curricular activities

¹⁶ Resource teacher learning and behaviour

Having been a teacher (with letters in music)I have always provided educational, extra mural and sporting activities for my granddaughter

I paid for 3 terms of Kip McGrath now paying \$10,000 p/a for child to attend a Montessori School

Because school said finance wasn't available the eldest has been pushed around the where one high school asked me to lie on paper to put him into alternative education. He is now depressed, withdrawn and without Te Ora Hou would be a recluse on correspondence which he won't work at

Granddaughter had a Teacher Aide for awhile, but isn't considered bad enough for help to continue, am trying to sort something out with their new school, but both children are 'border line' for much assistance

Kip McGrath grant came from CCF child cancer. I don't take no for an answer and know where to go and how to fight for all dollars, no dollars for school but have one in special class because I won't take no for an answer

An OT comes to child once a week at school. He is not severe enough to warrant a teacher aid while there is an autistic boy in his class who does. This child does not even speak English yet gets the assistance of a teacher aid which annoys me no end. We pay for him to go to private tuition in an effort to improve his abilities

We sent her to a private school because she is very bright but it closed down and the cost of alternatives is prohibitive. We persuaded her state school to put her ahead so she keeps being challenged and stimulated

Riding for disabled to help her focus and not to be distracted by others around her. Reading recovery (school & Kip McGrath)

None because she isn't far enough behind for them to consider her bad; She is 12 to 18 months behind

We have chosen to pay privately for tutoring our children. Also, they are at a private school, which we pay for to try and give them a better and more fulfilling education

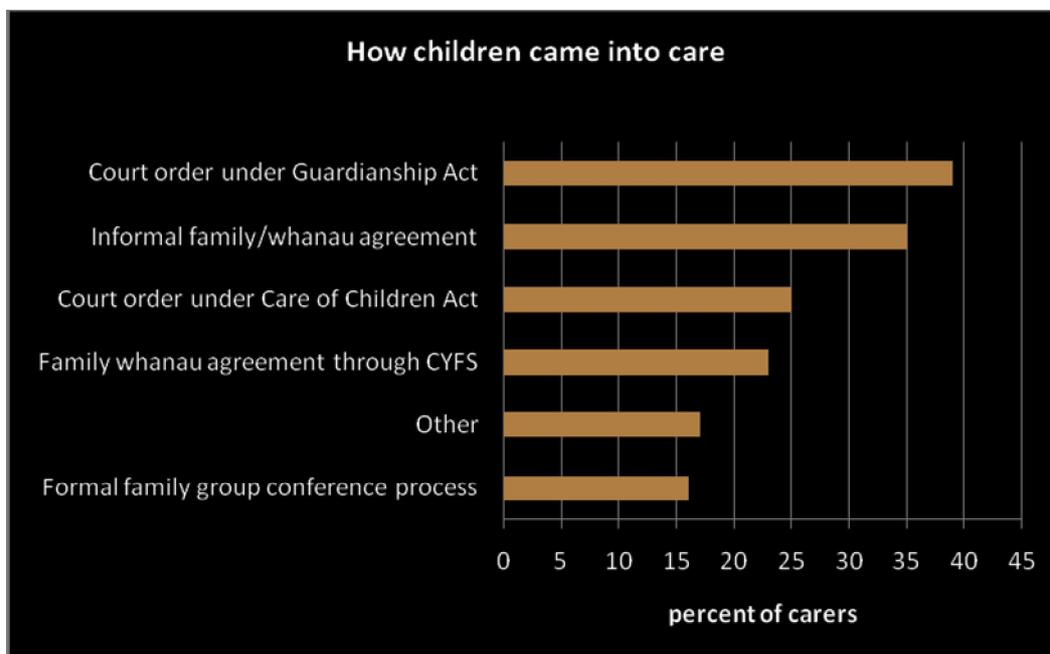
Section C: Legal issues

The New Zealand Children Young Persons and their Families Act clearly states that children unable to live with their biological parents should be given the opportunity to develop significant psychological attachments, and preferably within the extended family/whanau. Only in very exceptional cases should the State remain as legal parent (Worrall, 1996). The establishment of legal status for kinship carers is seen by most international commentators as complex and problematic and it has been suggested that permanency options, such as formal custody, guardianship, and adoption McFadden, (2003) commented on that the distort natural family relationships (Worrall, 1996, Leos-Urbel, 1999, COTA 2003). Commitments of family members to care for their own should be honoured and not forced to fit within narrow legal definitions established by the white dominant culture. Other commentators have suggested that moves by the State to achieve legal permanence with kin are cost-saving measures, rather than a reflection of the needs of the children. Kin carers are often reluctant to take formal proceedings because of the cost and also for fear of upsetting the stability of the placement (Frengly, 2007; Bonecutter & Gleeson, 1997; Duncan & Worrall 2001; Worrall, 2005). However, against these arguments is a need to secure safety, stability and permanency for the children and their carers, particularly when challenged by capricious biological parents. Many respondents in this study expressed their need for legal protection, but commented that they found the legal system frustrating, confusing and very expensive. As in the 2005 study, issues in regard to access rights, custody and Legal Aid are of particular concern for the participants in this study.

22.0. Initial Process for Assuming Care

As indicated previously, the route to care may be formal or informal and is related to the underlying factors that place the children at risk. Five alternatives were given and the respondents were asked to tick only one box. However, some ticked more than one box as they had children who were each under a different legal status. In some instances this was because the first child came through Child Youth and Family and a second was up-lifted by the Grandparents themselves “*1st with CYFS, 2nd with Family conference, 3rd in and out of court; eventually court order.*”

Over one-third of the respondents (35.1%; n=72) initially took the child through an informal family/whanau agreement with the child’s parents without any intervention from Child Youth and Family. Sometimes this was initially to be short term but became permanent.



Our daughter asked us if we would take him to give her a break - he never went back.

Mum had a breakdown and asked us to have kids until she got herself sorted out.

She abandoned him to go and live with boyfriend who was into drugs and alcohol in a big way.

She couldn't handle him (on drugs at the time). She said she didn't want him, hence I said "live with me mate."

Grandson asked if he could live with us as mother was leaving alone.

Many grandparents were unaware of the fact that their grandchildren were in danger until the need for care arose. Forty-seven respondents (22.9%) assumed care through the drawing up of a Family/whanau agreement through Child Youth and Family following a social work investigation.

Our daughter agreed to have a break in order to recover from domestic abuse which we knew nothing about for years. He was an alcoholic (believe he probably still is)

Pressure from CYFS resulted in my daughter sending the grandchildren to me

Complaint from school principal to CYFS.....CYFS bought him to us!

Thirty-two respondents (15.6%) assumed care after a formal Family Group Conference under the Children Young Persons and their Families Act.

Eighty respondents (39%) assumed care by means of a court order under the now rescinded Guardianship Act 1968 and 52 respondents had either a custodial or guardianship court order under the Care of Children Act 2004, which has replaced the Guardianship Act. In some instances, the child came from foster care and Child Youth and Family paid for the legal costs to obtain guardianship and custody for the grandparents.

Born three months prem. straight from the hospital under foster care with CYF until aged 2 then court order for care, custody and guardianship

Granddaughter was in CYFS custody at time of Mother's death, custody transferred to us later. Grandson was under Court orders with CYFS blessing

High court orders over custody upon death of my daughter. Interim custody, then High Court orders protects child access to me

In most instances this was instigated by the respondents themselves in order to keep the children safe and provide stability.

The boy first came to us when the younger of the two was two months old he has stayed permanently but the older boy was back and forth

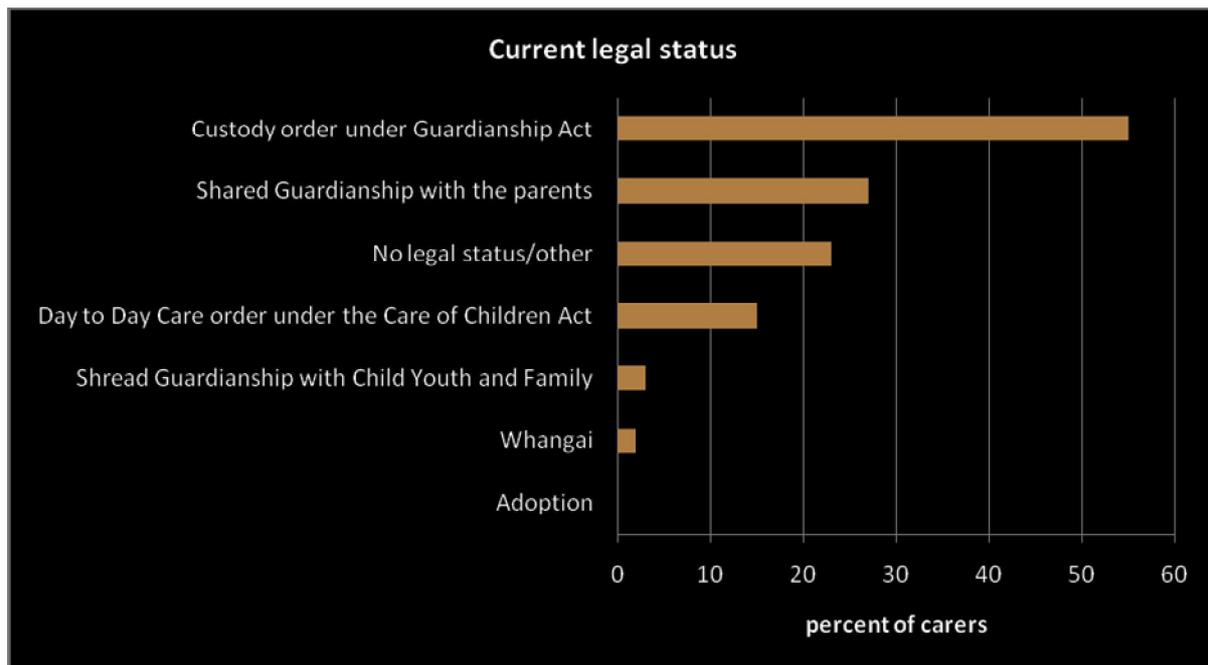
I decided to look after them forever and gain guardianship

Mother gave consent legally (in Australia)

I took my grandson then went through the courts

We went to court and got interim custody and became additional guardians

23.0. Current Legal Status



The majority of grandchildren (55%) are under a custody order, 27% shared care with parents, 16% day to day care order under the Care of Children Act and 2.6% shared custody with Child Youth and Family. Forty seven (22.9%) of respondents have no legal status.

There are only a few aunts and uncles who have care and they are equally spread between custody, day to day care, shared guardianship with parents and whangai.

Of those who described their relationship to the children as 'other' 50% have a custody order, 18% a day to day care under the Care of Children Act, 18% have no legal status, 11% shared guardianship with parents and one shared with Child Youth and Family.

The awarding of sole guardianship is rare, even to Child Youth and Family, and most guardianship orders are shared with the biological parents. The comments from the grandparents showed a desire to make sure that their grandchildren/moko were safe and secure. The length of time the children have been with their carers has meant that for 112 respondents (54.6%) legal permanency was achieved through a custody order under the Guardianship Act. Thirty-one respondents (15.1%) have a Day to Day Care Order¹⁷ under the 2004 Care of Children Act; 55 (26.8) replied they had shared guardianship with the parents and a small number, (6 = 2.9%) had shared guardianship with Child Youth and Family. There were no adoptions and four children were described as whaangai¹⁸.

There were 47 (22.9%) respondents who still had no legal status after four years of caring.

No legal status (no parental contact, addresses unknown) as secondary education is beginning next year may be compelled to look. But would prefer not to as that access issues doesn't it and I don't believe that would be to child's advantage at this stage of life (prepubescent)

Where the child had been taken by grandparents through a family/whanau meeting, organised by Child Youth and Family that was seen by some to be 'legal enough!' For others, the process of gaining a legal status was seen as likely to destabilise the placement.

We simply have an agreement with the mother and when we discussed it with a lawyer years ago they said "let sleeping dogs lie." She has been with us so long now it doesn't even occur to us to think of the custody thing

Why? If only 1 phone call from Mum in 4 years and 7 months & none from Dad. They shouldn't have any say in his life. They don't now BUT that is an ongoing worry

No legal status (no parental contact, addresses unknown) but as secondary education is beginning next year may be compelled to look. Would prefer not to as that [involves] access issues doesn't it and I don't believe that would be to child's advantage at this stage of life (prepubescent)

We have spent \$10K on legal fees and got nowhere with the family court for child 1; with child 2, CYFs initiated his removal and we said that we were not going to spend any more money in the Court system and that's how things currently stand

The holding of shared guardianship is not without its complications. One grandmother has shared guardianship with the child's parents and described it as a "balls-up" as the parents will not respond to contact, have challenged her guardianship in court and, although the parents are still using drugs, on reaching independence, the young person has returned to the parents. This grandparent feels that there

¹⁷ Equivalent to a custody order under the 1968 Guardianship Act

¹⁸ An informal whanau agreement that the child be given to other whanau members to raise, often grandparents or whanau members who are unable to have children of their own.

should be some other way of settling the issues without having to take the matter to court, where it becomes adversarial. In some cases, Guardianship is given to one member but the family decides who should have custody.

My eldest son is legal guardian and agreed to my caring for the boys which enables them to have a home of their own rather than sharing with cousins. The other family lives close by and are in close contact. All cousins (4) go to the same school

Others describe more complex guardianship states:

There are 4 legal guardians, father, 2 grandparents, uncle (late mother's brother)

Full custody and Guardianship of Grandson, Full custody shared Guardianship of granddaughter with their father

24.0. Change in Legal Status

In order to gain insight of engagement in legal processes over the past four years, carers were asked if the original status had changed. Thirty-one (15.1%) carers stated this was the case and 30 people offered a comment as to why and how this had happened. Some had taken legal custody and/or guardianship either by default of the parents or because Child Youth and Family were stepping out of the picture. Some had lost custody or guardianship either because of a legal challenge from the biological parents, or because Child Youth and family determined it was safe for the child to return.

I lost all access to my grandson due to a court order.....Once the father got sole guardianship I was systematically cut out of the boy's life.....In short, the judge stated that I needed the agreement of the father and my ex husband to maintain contact with my grandson who I had from birth for 12 years!

They came out of CYF care after I was accused of wanting to make money out of CYF by a social worker who stated that parent taking drugs was not a reason for care & protection even though schools, public health counsellor warned against return to parents after the youngest was returned to Mum, he was picked up and returned to me after 8 months.

Law change gave father more rights therefore more problems have arisen

There was less likely to have been a change in legal status in the last four years when care had been ongoing for ten or more years (8% compared to 22% of those who had been in care for less time). Change in legal status over the last four years was most common when imprisonment was the reason for coming into care (36%) and least common when abandonment was the reason (11%).

25.0. Challenges to Legal Status

'There should be a less traumatic and less expensive process to resolve the issues that we have had to deal with. The court process has supported an adversarial system (both High court and Family [court] which has not assisted in the resolution of the issues. A male counsel for the child was very

arrogant and allowed father to flaunt the High Court orders in place..I am very concerned for other Grandparents in New Zealand who perhaps are not as articulate, nor have the means to sustain repeated court onslaughts of court appearances, legal jargon, emotional stress, costs etc etc but who have legal rights to see their grandchild remain in NZ’.

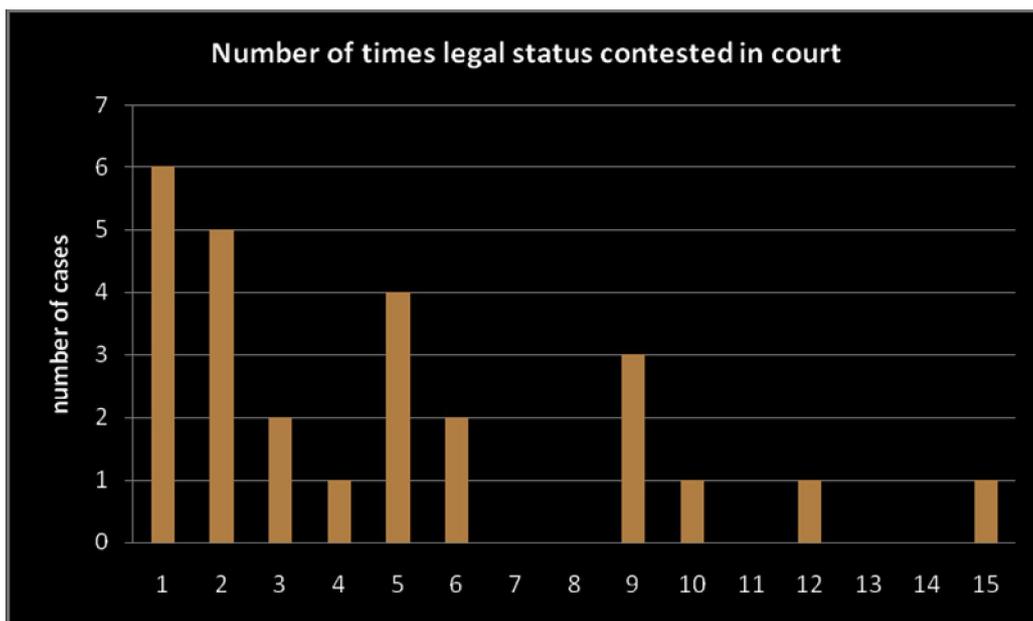
Thirty six respondents (19.5%) of the 185 respondents to this question had received challenges to their legal status, and 15/36 had experienced this over the last four years, one respondent having experienced 8 challenges in that time; one respondent has had 6, and one five. The 2005 study showed that 33% (n=100/323) of respondents had faced challenges. As the respondents were asked about the number of challenges over the last four years, these figures may indicate that many challenges were resolved before that period of time. In order to lessen the possibility of destabilising of a child’s placement, the 2004 Care of Children Act (s.41) now allows judges to limit the number of contestations that can be brought before the court.

Court has stipulated it is not allowed to be brought back to court without court consent

Over 18 yrs we spent many times in the Court with Mother’s demands. In the end the judge decided enough was enough and boys given to us with parents having reasonable access (we never ever denied the access)

Legal status of the grandparent carer was most likely to be challenged in court when death of a parent or child abuse was the reason for coming into care (31% for each of these reasons compared to 20% overall). Several lost custody as a result of the challenge. Respondents were asked how many times they had their legal status challenged.

The mean number of times legal status was contested in court = 4.7; median 3.50. The number of challenges to custody range from 1-15.



25.1. Time Taken to Settle Status in Court

We took ten years to get this child safe

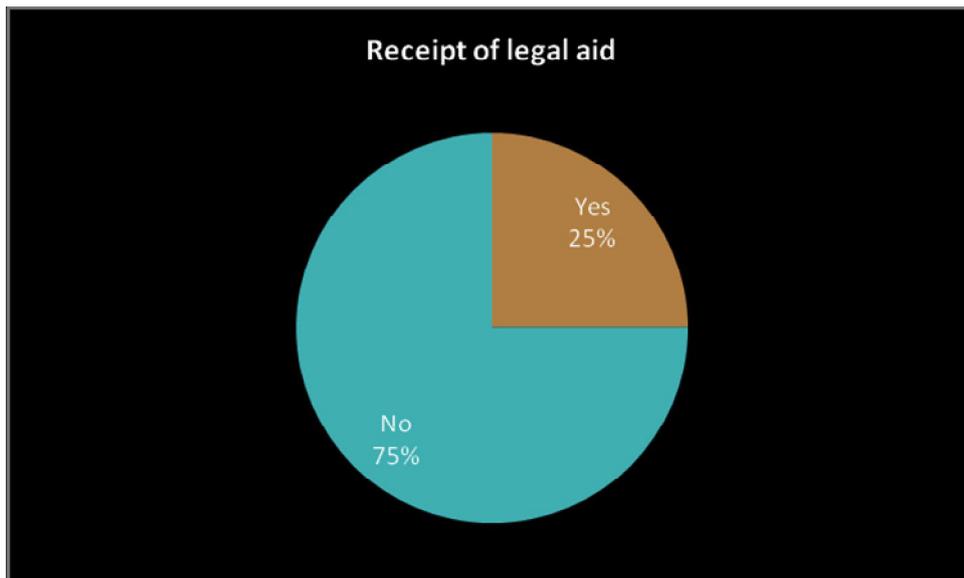
This has been going on for 10 years with all sorts of allegations made

Many up to 10 times; every six months at review time (0097)

	n	%
1-3 months	11	15
4-6 months	12	16
7-11 months	3	4
Total less than 12 months	26	35%
1 year to less than 2 years	9	12
2 years	15	20
Total 2 years or less	50	67%
2.1-3 years	8	11
Over 3 years but less than 5 years	8	11
Five years but less than 10 years	5	7
Ten years	3	4

11/154 (7.1%) of respondents said that at the time of the study, care arrangements were still being contested and before the court, the time for this averaging between 1-2 years.

26.0. Legal Aid



Forty-four /179 (24.6%) respondents have been in receipt of legal aid.

When we first went to court for custody we were not told about legal aid. So we always paid for each and every hearing we had when we could, then we went to court by ourselves when we could no longer afford a lawyer

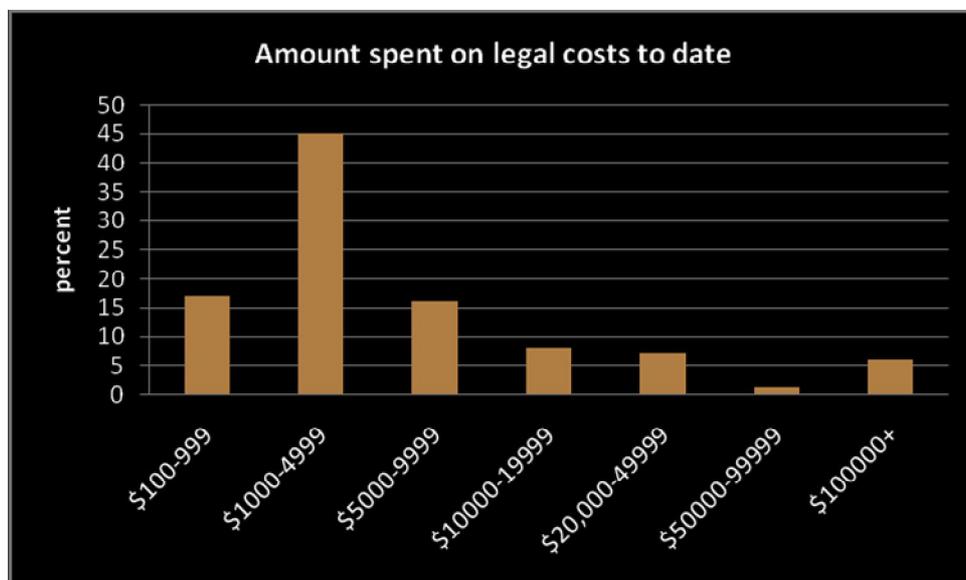
Those on less than \$20,000 income, the lowest income level, were less likely to be in receipt of legal aid than those on more than \$20,000 (39% compared to 76% overall and over 80% at higher income levels). But this lowest income group was more likely to have received other funding support – see below under financial matters.

Re the legal aid question: although we paid over \$3,000.00 for a solicitor to assist with custody/guardianship, he did not complete the task. We could not afford any more legal bills so completed the rest ourselves through the Family court. They were very helpful and supportive.

Receipt of legal aid was least common as a result of parent dying (15%) and most common when imprisonment was the reason (46%), followed by alcohol addiction 35%, domestic violence 31% and drug addiction 31%.

Twenty-nine people were able to quantify the court costs paid by legal aid to date amounts varying between \$50- 82,500. Several told of repaying the amount when their house was sold and another said “*Was caveat on my home, later, when refinanced bank wanted me to borrow more to pay back. I did.*”

Those who did not receive Legal Aid were asked how much they had spent on legal fees.



Amounts ranged from \$100-\$ \$260,000, with between \$1000-\$5000 being most common.

Legal Aid declined my application for another psychologist to critique the family Court Appointed Psychologist. I paid for this myself to write her report and interview the other psychologist and to appear in court as our witness – the amount was \$2,160

Several people had increased their mortgages.

I have a 2nd mortgage now \$25,000 from the 3rd day (?) defended hearing last year.

Several had their court costs paid by Child Youth and Family who are willing to negotiate his when the child has been under their Guardianship and they are rescinding that in favour of Grandparents.

None. CYFS paid when we refused to do so. Said we'd stay on fostering arrangement. That made them move fast!

None, we said we were very happy to keep him under foster care arrangement if they wanted that to end, they pay

27.0. Children's Contact with Parents

The form and amount of contact often varies between parents, and the carers describe having to manage complicated access arrangements with more than one set of relatives. When the carers have children from different parents the issue is even more complex and has an effect on the children themselves.

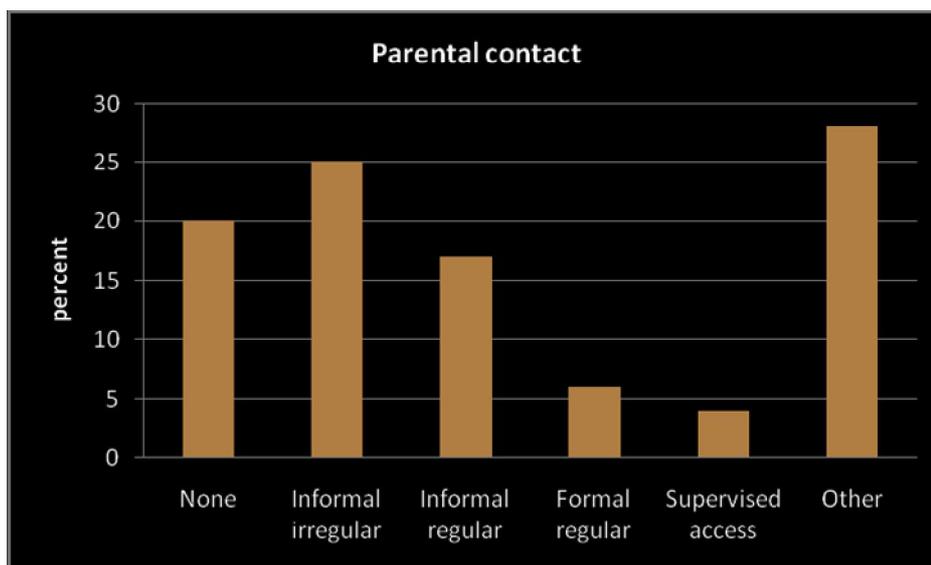
Two children have irregular access with mother (as have same mother but different fathers) 1 of these children has irregular access with her father and the other has no access with his father and another child has no access with both parents

One has formal contact regular, one formal and very irregular, one no contact at all parent can't be found very often like every 4 years or so

Mother and father are not together, mother has informal, regular and father has formal regular. When everyone makes a decision for the second child this should be supervised for the father

One dad no longer exercises his access [rights] and hadn't seen kids since June 2 weeks before we last went to court when he packed a sad when the judge said kids staying with us, other dad of one kid and mum of all 3 have regular access with variations for sickness/holidays etc

Child (1) regular visit with father (formal), mother unknown whereabouts since birth; Child (2) school holidays with mother



The less formal nature of kin/whanau care appears to influence the type of contact between the children and their parents. While 20% of the children have no contact, one quarter of the respondents

(25%) have defined the type of contact as informal and irregular and 17% as informal, but regular. Formal contact, including supervised access, as decreed by the court, occurs for only 9.7% (n=15) of the respondent families. The figures are similar to the 2005 results, with the exception of supervised access which occurred for 15.5% of the 2005 sample. While there is no New Zealand data in regard to access in unrelated foster care, by its nature, it can safely be assumed that contact is formal in nature and is very often supervised.

For some, contact is irregular and infrequent, some amounting to one visit a year and for others a biological parent lives overseas and contact is by phone or Skype, with letters and occasional visits.

Dad had son every week-end with phone calls during the week. Mum has phone calls two to three times a week and sees her son a couple of times a month

Mother died recently in a fire; 2 emails from father and birthday gift since mother's death

Every day phone contact, he can see his mum as much as he wants. The birthfather only recently got in contact with him. The father and mother are not together

Our son, Dad to grandson, lives in Germany now, but has regular contact via Skype. "Mum" lives in NZ – no contact. Maternal Grandma keeps regular contact

For others contact is negotiated with the parents amicably

Dad (1) and Mum live immediately across the road and joint picking up children from school having tea three nights a week and sleep over at least one night a week....

Frengly (2007:93) found in her study of 29 New Zealand kin/whanau carers that maternal contact occurred for 76% of her sample compared to only 17% having paternal contact.

28.0. Changes to Access Arrangements since Care Began

Seventy-three respondents (42.4%) stated that there had been changes to access arrangements since care began. These included parental disappearance; death; contact becoming erratic or stopping; increasing parental drug use; imprisonment; variable, depending on parental mental health status, or parents remarrying and then not sustaining contact. The written comments give testimony to the fact that contact is a major feature of stress for many respondents, and that grandparents in particular have fears for the safety of the children at times.

Yes much lessened; father not interested, mother violent and abusive; access always encouraged and often initiated by grandparents but too troublesome to continue

Since the father had this child for a short stay and exposed the child to hard drugs we have stopped all visits and will only allow the child to see the father with another adult present

CYFS have given supervised access to the father of the second child, and then have changed it to unsupervised, whereby the father took photos and placed them on the net, also video clips on U Tube. Now [we are] trying to get back to supervised

The father wants them after virtually nil contact over 7 years and has verbally abused us by phone and caused disruption to the girls emotional state

For some, however, contact is increasing as parents become well or more stable.

Contact has improved as mother's mental state has stabilised

Father is a lot more involved in son's life

CYPS have left it up to my discretion when the parents have access

The father has seen her twice in 5 years under our supervision. The mother has recently married, been a sober AA member for over 18 months and for the last 4 months has had the child to stay overnight occasionally. She would like to have her on a regular basis overnight once or twice a month

One getting less regular as the child gets older, one more contact as mother is in recovery, one child is now old enough to organise his own contact

It's improved, all family are much happier

Living opposite has given us peace of mind and considerable relief from past experiences. One dad has no real contact after 3 years and spasmodic before that

NZ European/Pakeha carers were more than twice as likely to say there had been changes regarding parental contact over the last four years (47% compared to 23% of Maori).

Change in parental contact in the last four years was most common when physical illness was the reason for care (64%) or imprisonment (59%).

Section D: Personal Financial Matters

Unable to work at my normal job because of hours; no money for holidays in 10years; No real access to social events because of cost, growing mortgage as I borrowed from my house. No new clothes or shoes in years; always behind on rates, power, phone, desperate at time - \$430.00 weekly mortgage. No saved or spare funds to pay excess of insurance claims

Was preparing for retirement had built retirement home which was sold and another home purchased requiring a mortgage to cover the needs for raising grandchildren. Had to return to work 2005 for husband and part-time for self to make ends meet; had to cash in all retirement saving and now broke

It's not possible to live on what is left after the rent is paid. I go without food to feed my grandson, also clothes, haircuts, I can't do volunteer work because we look so raggedy away from children activities (paint stained clothes etc)

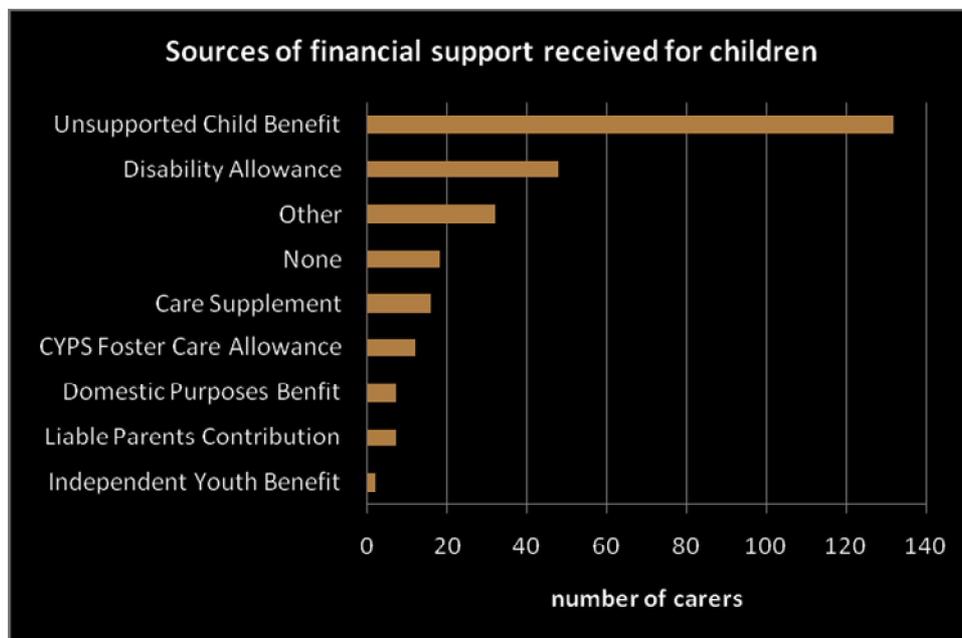
The (2005) New Zealand study confirmed the findings of international studies that grandparents and other kin carers were likely to become financially challenged as a result of giving care. The physical and psychological problems of the children; education and counselling expenses; costly and on-going legal processes; housing costs, in particular newly purchased mortgages, and failing health of the carers contributed to their financial stress. The current respondents were asked to identify changes in their financial status since caring began and 124 described the problems they have to survive financially. While a diminishing of income can be expected in retirement, the grandparents in particular described how their retirement savings have been depleted meeting the children's needs, how they have re-mortgaged the house, and many described their struggle from day to day to meet rising costs. They put their grandchildren first and themselves last. As described above, the annual income from all sources for 22% of the sample was than \$20,000 and for 47%, less than \$30,000.00 per annum. Having to change employment status because of taking care was cited by 51.6% of the 186 respondents to this question.

Almost three quarters of respondents (73%) stated that they had experienced a change in financial status since taking the children.

29.0. Financial Support Received for Children

One hundred and thirty-two (64.4%) of respondents are receiving the Unsupported Child Benefit (UCB). Twelve (5.9%) are receiving the Child Youth and Family Foster Care Allowance; 48 (23.4%) are receiving a Disability Allowance; 16 (7.8%) qualified for the Care Supplement¹⁹; seven carers (3.4%) receive the Domestic Purposes Benefit (DPB); two young people are receiving the Independent Youth Allowance; seven (3.4%) are in receipt of a Liable Parents Contribution and 18 (8.8%) of respondents receive no financial assistance at all.

¹⁹ A payment that topped up the rate of Unsupported Child's Benefit or Orphan's Benefit to the level of the Foster Care Allowance weekly board rate. On 1 April 2009 all Unsupported Child's Benefit and Orphan's Benefit weekly rates were increased to become the same as Foster Care Allowance weekly board rates. This change recognises the additional costs that carers face caring for other people's children.



This is a multi-choice question, with respondents asked to tick all relevant boxes and records numbers of respondents.

If anything this sad set of circumstances has strengthened our family. While we are grateful that we are able to offer help and support to our loved ones. Financially it is extremely expensive. Why are we not receiving any payment?

It has become obvious that there is variation in the advice WINZ gives to carers. The Unsupported Child Benefit is a benefit for the child and if a carer is receiving a benefit for themselves, they are still able to claim the UCB. Some people may choose to go on the Domestic Purposes Benefit, in which case an allowance for the child will be part of that.

I have been told as I'm a kin carer, I'm unable to have a benefit & must work ("WINZ") or live on my unsupported child benefit

Because I am on a widow's benefit I cannot claim the UCB

Am only on DP: Will be better off by \$80.00 per week when I get Superannuation + UCB

Am on the UCB until the Invalid's benefit will be granted [for the child] at 18

Some carers have found that as the State rescinds their guardianship responsibility leaving the carer in a joint arrangement with the child's biological parents they are financially disadvantaged.

When under CYFS care I had very good financial support, but now I am on UCB and Care supplement.

30.0. Expenses Incurred but not covered by Income Support

As explained in the previous footnote, the UCB is now raised to the level of the weekly foster care board payment; however there is still not total equity. Kin carers are not reimbursed for any extra expenses such as medical, educational or counselling costs as foster parents are.

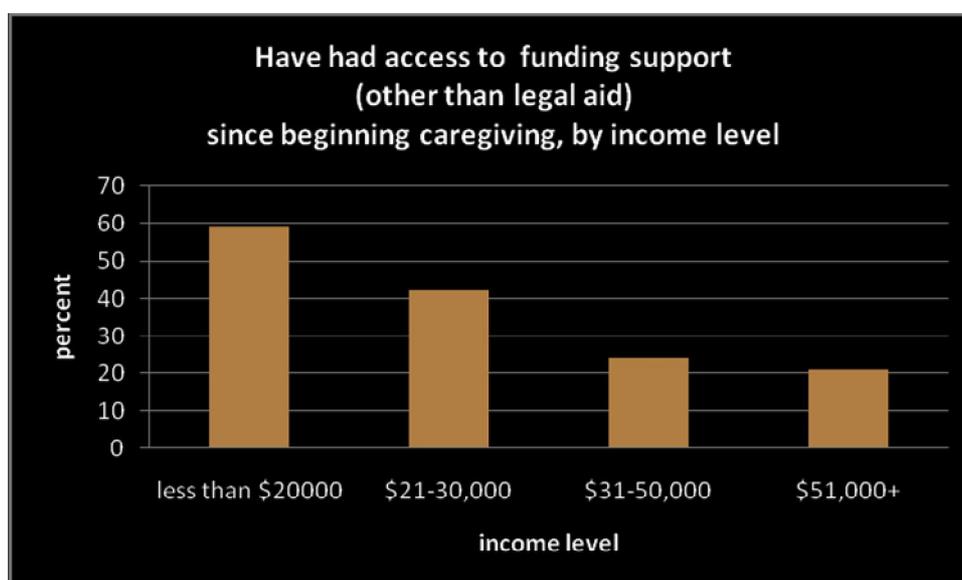
Respondents were asked to nominate all expenses incurred. These were school fees (62.0%); other educational costs (56.1%); travel (56.1%); medical costs (58%); counselling (19.5%); clothing (61.5%); camps (54.6%); extra-curricular activities (56.6%); and other 18.5%. Other costs particularly mentioned were private schooling; extra reading and maths tuition; music lessons; horse riding; cell phones; camps – sports and school camps; orthodontist treatment; presents for parties; a horse; University fees and travel to comply with access arrangements for biological parents.

Since with me the child has received swimming/tennis/music lessons; for last 2 years has had music lessons at school. Biggest factor - my ability to save for retirement has been severely eroded over the last 7 years due to constant hand in pocket whilst paying rental accommodation and living in an expensive area.

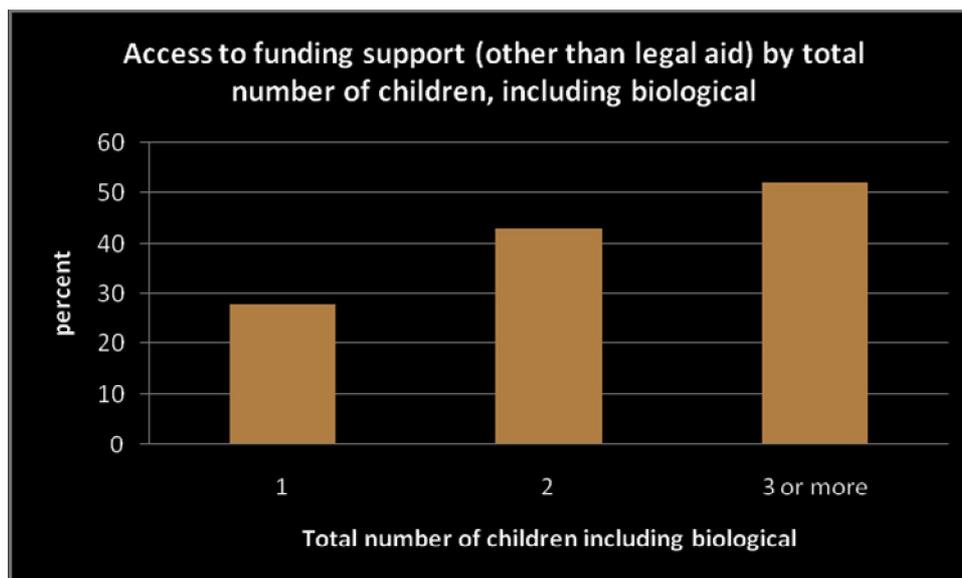
31.0. Access to other Funding Support

Of the 120 respondents to this question, 85 (41.5%) had not had access to any auxiliary funding. Seventy respondents (34.1%) had done this, some accessing several means of support: 33 had taken out a bank loan; 2 had taken a reverse mortgage; 21 a family loan; 14 had gone to a money-lender; and 36 nominated other sources. This included selling property, overdraft on credit cards; closing an insurance policy; drawing on overseas funds; finance companies; redeeming insurance policies; WINZ loan, family trust; and drawing on investments.

Those with more children in care were more likely to have received funding support other than legal aid (47% compared to 32%, although this result was only statistically significant at $p=0.6$), which may explain the increase in income, as there were no differences in employment status by number of children being cared for.



Those on less than \$20,000 income were more likely to be in receipt of other funding support since beginning caring. Access to other funding was most common on death of a parent (54%) and child abuse (50%), and least common for mental illness (39%).



Having to go ‘cap in hand to WINZ’ was described by one grandparent as ‘demoralising and something I never dreamed I would ever have to do’ Another described having to get food parcels from the Salvation Army and stated that she felt ashamed but had to do it to manage to feed the family.

32.0. Housing Issues

Both international and national research has shown that housing issues occur as a result of taking custody of kin children. Kinship care families, particularly grandparents, are likely to experience financial hardship, crowding, or have trouble paying increased housing costs (Ehrle and Geen, 2002; Worrall 2005, 1996; Frengly, 2007). Ehrle and Geen’s study showed that 39-40% of kinship families were found to have housing problems. Three previous New Zealand studies (Worrall, 1996, 2005; Frengly, 2007) found that many families had insufficient space as a result of taking the children and that this had required a move to a new district or State house accommodation. The adverse effects of overcrowding and unsatisfactory housing are well known and constitute a risk factor if the placement is to survive with least detriment to all family members.

Housing issues since assuming care

	n	%
Have needed a larger house	38	19
Have needed to move to another district	30	15
Have moved to a State house	10	5
A Statutory Legal Aid Charge is registered against this	9	4

house		
Other	44	22
None	85	42

The number of families in this current study who experienced housing issues was slightly higher than the 2005 study. Less than half of respondents had no housing issues (41.5%). Needing a larger house was stated by 38 families (18.5%); moving to another district to ensure the family's safety or for educational reasons was cited by 30 families (14.6%), and ten (4.9%) families moved to a State house, for various reasons. Forty-four respondents (21.5%) cited other housing issues. Several had to modify the house to accommodate grandchildren with a disability. Some grandparents have moved into their children's house to lessen the disruption by keeping the grandchildren within their own community and school. Some have had to sell up the family home to buy either a smaller house, a cheaper house, or rent, in order to free up capital to support the children, pay legal costs or repay a Statutory Legal Aid Charge. Additionally, Grandparents told of remortgaging the house in order to pay for extensions needed to accommodate their grandchildren, or to raise accessible capital.

Ill health & disability meant physical changes needed for house access, rails, ramp, bathroom alterations. Move to another town precipitated by need to keep child safe from drug addicted mother & partner

I have had issues with Housing NZ as mother was tenant. I removed parents out of home and settled in the children's house. I only got tenancy this year with CYFS assistance and my hard work!

My [unwell] son lives in my house and I & grandchild live elsewhere renting, for health reasons. But I am penalised by WINZ for this. The asset testing formula applied does this, but is not applied to Foster parents. I have to shift by mid-November – another hassle!!

Initially, when my daughter had the child we were all together and Housing New Zealand gave us a rental. As it was a privately owned house, the Landlord wanted the house back. Housing New Zealand informed us two months before wanting us to move. I continually phoned them. They said they would find us a house and not to worry. Then my daughter moved out with her other child and we were offered a two bedroom house in a multi-housing complex area. No way was that OK as prior to all this I had owned my own home. We are now in a private rental in a good location which is important for my grandson – great neighbours; quiet area garden trees' etc and it is a 3 bedroom space.

As discussed earlier, several grandparents described how taking the grandchildren had contributed to their own marriage break-up. For those people, this also has meant having to sell the family home and buy a smaller house, take out a mortgage or rent.

One grandparent described how they were living in a retirement village but had to sell.

Have needed to move to another district; we were living in a retirement village but neighbour complained because "visitor" is only supposed to stay for 3 months

Taking the grandchildren results in many disruptions in the lives of grandparents, and for many in this study, housing is one of these. Having to move at a late stage of life, away from existing social supports is very destabilising and can contribute to ill health.

Section E: General Health of Carers

33.0. Health Status

While some degree of health deterioration is to be expected in the major age cohort of this study, the results reflect international research that shows a significant relationship between health deterioration and the caring role. Many carers in this study have multiple caring roles. They care not only for their grandchildren, but also for partners (most frequently husbands) with deteriorating health and/or their own children with physical or mental health issues (most frequently the parents of the children in their custody). Several respondents commented on the fact that they were caring for partners with Alzheimer's, some at a very advanced stage, partners with terminal cancer and other severely debilitating diseases, such as cardiac and/or pulmonary disease.

One hundred and forty-three respondents (69.8%) described the medical problems experienced by themselves and/or their partners. Some of these are multiple, extremely serious and debilitating.

Primary caregiver: diabetes, hypertension, hypothyroidism, COPD²⁰, osteoarthritis, spondylolisthesis, migraine with aura, ulnar neuropathy, struggle with obesity! Have cataracts removed and retinal laser work both eyes, need to keep check for retinopathy problems; husband ileostomate, osteoarthritis, prostate/urinary problems, disturbed sleep

Macular degeneration but although my sight is deteriorating I can still drive and read if the print is large enough. However, my driving is limited; osteoarthritis; have had 1 knee replacement & have trouble with the other

Sjogrens syndrome & arthritis, needing a walker; my husband has had surgery for cancer, hip replacement and now in secure rest home with dementia etc

Hypertension caused by stress & now heart problems because of massive amount of medication; renal & heart specialists now involved; partner has had a stroke and ongoing seizures

I have sleep apnoea and sleep with a CPAP machine. I have arthritis. R wakes every night at 2am and if we do not grab him into bed with us quickly he is awake for the rest of the night. My husband has high blood pressure, probably from the stress of the business

The most commonly mentioned complaints were cancer; high blood pressure; arthritis; diabetes; asthma; back problems and heart complaints (CHF²¹, CORD²²). Hip and knee replacements are common and psychological problems mentioned were stress, depression, Alzheimer's, dementia and short term memory loss.

34.0. Changes in Health Status

²⁰ Congestive obstructive pulmonary disease

²¹ Congestive Heart Failure

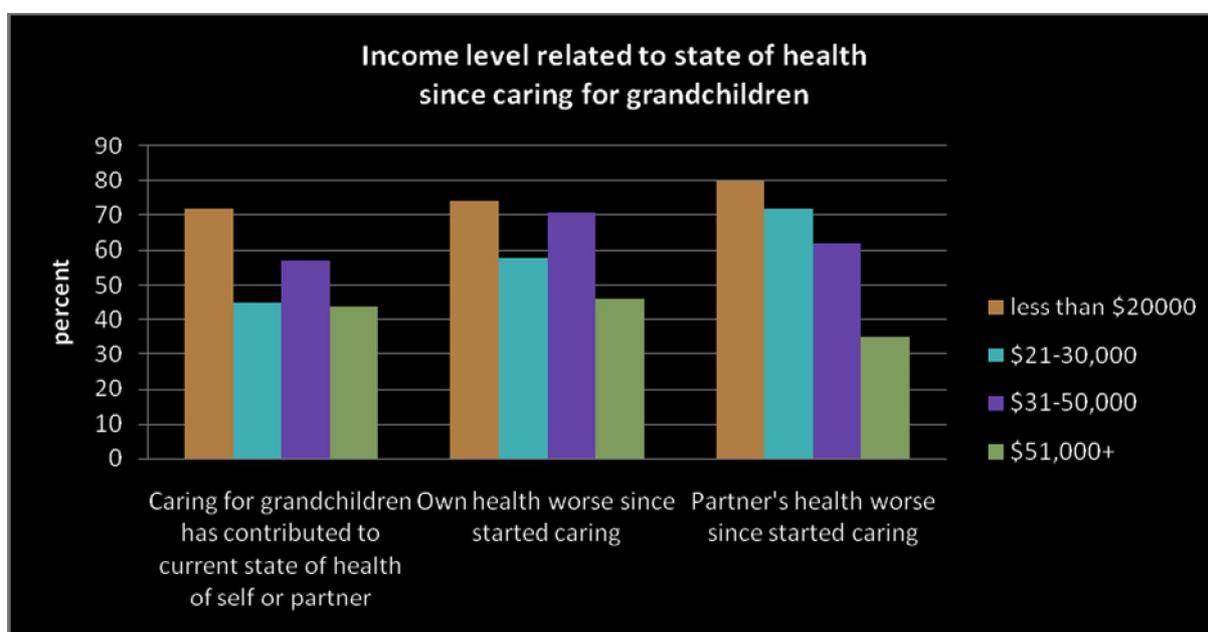
²² Chronic Obstructive Respiratory Disease

The respondents were asked to assess whether, over the last four years, their health had improved, stayed the same or deteriorated. Four respondents/182 (2.2%) stated that their health had improved over the last four years; 67 (36.8%) stated that it had remained the same and 111(61.0%) stated that it had deteriorated.

There were 114 responses in regard to the health of the partner over the same period of time. Four (3.5%) stated the partners health had improved, 42 (36.8%) assessed it had stayed the same and 68 (59.6%) reported that it had deteriorated. Co-variant analyses show a relationship between ethnicity, financial status and reason for entry to care.

NZ European/Pakeha carers were more likely to say that caring for their grandchildren has contributed to their or their partner's current state of health (59% compared to 34% of Maori) and that their health has got worse since they began caring (66% compared to 44% of Maori).

Those on the lowest income level (less than \$20,000 p.a.) were more likely to say that caring for their grandchildren has contributed to their own or their partner's current state of health (72% compared to 55% overall), and that their and their partner's health was worse.



Health status of grandparents was much more likely to have been affected by taking the children into care when a child had psychological/behavioural problems: 63% compared with 40% where there were no psychological/behavioural problems. In particular, partners of carers were more likely to report their health had worsened (73% compared to 44%). Although numbers were small for those families where the psychological/behavioural problems of children had worsened since coming into grandparents' care (n=21), it was correlated with worsening health of the main carer: 81% of those who said the child's psychological /behavioural problems had worsened since coming into their care also reported their own health as having got worse since the child coming into their care. Results were similar for their partner's health.

Health status of grandparents was more likely to be affected as a result of taking grandchildren into care when the reason for coming into care was physical illness (73%), and least

likely to have an effect on health when the children came into care as a result of parent's death (42%)²³. The caregiver's health was more likely to have worsened when the children came as a result of mental illness (77%) domestic violence (76%) or child abuse (73%) and least likely when the child's parent had died (58%) or was drug addicted (58%). Their partner's health was more likely to have worsened when the children came as a result of Physical illness (88%), mental illness (72%) or "other" reasons (73%) and least likely to be affected when they came as a result of drug addiction (47%).

35.0. Social Activities

The degree to which people are able to socialise with their peer group is an indicator of and a contributor to general health status. A co-variate analysis shows that both health and social activities of grandparents was related to their income level and their ethnicity.

As shown in international studies, the 2005 study gave a convincing picture of many grandparents unable to enjoy their previous social life because of their child rearing responsibilities. Their peers were undertaking activities that could not include children and the grandparents felt that they did not fit in the social activities undertaken by parents of their grandchildren's peers. However, Frengly's (2007) study quoted one Maori carer as saying that her Pakeha and Maori friends treated her situation quite differently. For Maori, caring was normal and there was no sense of missing out, whereas for Pakeha there was that sense that she was missing out on what was a normal stage of life.

In the 2005 study 53.1% of respondents stated that they had no social life and 46.7% stated that they were socially involved. The participants in this study were similarly divided with 54.6% of those that responded to the question (n=174) stating they had no social activities and 45.4% stating that they did. The latter described many and varied activities. Church was the most commonly mentioned activity, followed by walking; going to the gym, fishing, social outings with friends, theatre activities, Grey Power, Probus, university courses, red hatters, professional development, swimming and walking.

Some stated their social activities as those involved with their own or their grandchildren's well-being. In particular, they mentioned programs for Alcohol and Drug and anger management, head injury and epilepsy support groups; hospice, day care/day work.

For others involvement with their grandchildren's activities or joining the Parent Teachers Association was seen as their main point of socialisation

We mainly go to our granddaughters' activities, but play golf and do dog training

Those on the lowest income level (\$20,000) were much less likely to participate in social activities (21% compared to 46% overall). Participation in social activities was most common when children came to grandparents because their parent died (73%) and least common when imprisonment was the reason (10%). Conversely, attendance at GRG support group meetings, or wish to attend if held

²³ Results on associations with reasons for coming into care have not been statistically tested as this is a multiple response variable. Also only 12 respondents reported death of a parent as reason, so these results are only indicative due to small numbers in the sample for this category.

locally, were most common when the children came into care for physical reasons (50%) and least common when imprisonment was the reason (16%).

36.0. Sources and Types of Support

I do not know how I [would] have coped without the support of family & friends. The courts, police & CYF's have given no support once I got custody of the children.....CYF's do not help as they say they have no concern with the children in my care. If I did not give them a stable home they would step in.

It is a well known fact that a child's psychological and emotional stability is more easily maintained when he or she remains in the family system and that kin carers can afford the child stability and a sense of belonging that cannot be achieved in out of family foster care (Crumbley & Little, 1997).

However, the families in this study have also described stressors experienced across the whole ecological milieu which without support could have jeopardised the placement. In the 2005 study many carers, particularly grandparents expressed a sense of isolation that arose from generational dissonance, shame in regard to the situation of their own children; inability to access CYF help; and an inability to interact with community because of busyness, the difficulty of the children, their financial constraints or their own health needs.

Respondents were asked to identify who supports them in their care giving role and were able to nominate as many sources as they wished. The numbers therefore do not add up to 100%.

The need to seek support from people in like situations is commonplace. As in the 2005 study the most frequently nominated source of support was the Grandparents Raising Grandchildren Trust for 98 (47.8%) of respondents. While some kinship research shows that the wider extended family feel some sense of responsibility and offer assistance (Worrall 1996), both the 2005 research and this study show that the immediate family, i.e. the carers own children are the greatest source of help. Eighty-eight (43%) of respondents nominated their own children "*Daughter shifted back to help me care for nieces and nephews*" but only 50 (24.4%) nominated other extended family members. Friends were the next most common source nominated by 71 (34.6%) of respondents. Neighbours accounted for 9.8% and Child and Family Support Services were cited by 17 respondents (8.3%). Thirty-six respondents (17.6%) stated that they did not receive support from any source.

Where do people go when things go wrong???. Grandparent raising grandchildren was great; but at times I didn't fit in with the trouble free people; lack of funds caused the group to close down

I didn't ask [for help], I still don't, I keep to myself

Have had one night off since child has lived permanently with me that is why I am moving back to be closer to family and old friends

Support from a distance; my family lives 3 hrs away, so time out is very limited more emotional support as opposed to time out

Sources of support for caregivers

	n	%
Own children	88	43
Other extended family/whanau	50	24
Neighbours	20	10
Friends	71	35
A Child & Family support service	17	8
Grandparents Raising Grandchildren Trust	98	48
No-one	36	18
Other	33	16

The nature of support received was according to its source that is within the family micro system of family, friends and neighbours or the family exosystem such as Grandparents Raising Grandchildren, other support agencies or government agencies. Support offered by Grandparents raising Grandchildren Trust, namely the newsletter, the Handbook, camps and telephone advice from the GRG Co-ordinator was the most frequently nominated type of support, closely followed baby-sitting, and respite care, which was both informal from friends neighbours and family and formal from agencies such as Open Home Foundation. Church was also cited as offering both practical support in the form of respite care; food parcels; transport and spiritual support.

GRG. - Support on legal issues, my concerns over the child's behaviour. Knowledge on Legal Issues. Friends - seems now the only ones who have knowledge and understanding of these issues – so-called friends not there, since this. The true friends support me – yes

GRG help in a way of being there and able to have someone to talk to; Family help by occasional food & monetary, not often;. Also they will give us a day break from the children. GRG help in arranging for children to go to camps which gives us a much needed break and rest

Know we can get support from GRG... and Di is always at end of phone but find it difficult to ask as there is always someone worse off than us who needs more help

Other support types mentioned were financial help, commonly from extended family, driving and household maintenance such as painting. Lawn mowing, gardening and supplying of firewood. Formal support, in addition to respite care was occupational therapy, counselling and house modifications.

Cutting fire wood; digging the garden; repairing the house; cutting lawns; cleaning the house; care sitting husband & child; bringing trailer loads of free firewood; food parcel monthly from church; hospital occupational therapist & modification to shower etc

They [whanau] come to take my babies out to the zoo, to beaches and we go and stay overnight to be with other family member's trip to the Far North, to our huis and family tangis. To have these mokos participate in all these activities, karakia my mokos lead in these at meal times and morning and night. I keep them very occupied.

37.0. Other Family Support Responsibilities

While caring for their grandchildren is demanding, some respondents described other caring responsibilities. Other children who are solo parents and need support; unwell partners; elderly

parents, children with disabilities and the children's parents with psychiatric and physical problems were mentioned.

I [not]only take care of 2 grandchildren, but also my husband with a long term bone cancer, a son with a head injury (36yrs) 2 sons schizophrenic (35 & 31 yrs) and IHC niece (52 yrs) I have had her since the age of 16. With regards to my benefit I may need some assistance, preferable a neutral person to make sure my entitlements are correct. Thank you for allowing me to take part in this survey

Our daughter, at times when her health is worse than ours – outcome of beatings

Major involvement with my sons 2 boys ages 5 & 7 since mother left home

I have an intellectually handicapped daughter

38.0. Personal Counselling or Therapy

Eighty three respondents (40.5%) stated that they had wanted personal counselling over the last four years but only 52 or (62.7%) of these had successfully accessed this.

Have wanted this heaps - a big cup of coffee helps!

Debriefing on a daily basis with friends; I need some regular time away for just me, but no one else seems willing or able to take these kids altogether to enable this break to take place

Desire for personal counselling or therapy over the last four years was highest when the children because of child abuse (66%) or “other” reasons (62%), and least likely when the parent had died (39%).

39.0. Attendance at GRG Support Group Meetings

Many respondents have commented that Grandparents Raising Grandchildren Trust has been invaluable, “without GRG I would have given up” and “they have kept me sane”²⁴

We have belonged to GRG for 8 years or so and the support we have had from the organisation has been tremendous with lots of advice and help

What I appreciate most about caring is GRG and especially the Manual. Thank you!

In spite of the very favourable comments in regard to the support offered by the Grandparents Raising Grandchildren Trust, the majority of respondents, although members of the GRG Trust, do not attend meetings. Sixty-four (35.4%) of the 181 respondents to this question attend meetings, compared to 64.6% who do not. Reasons given for not attending were: none in area or too far to travel (23) work commitments (n=21); too busy (n=14) the group had been dis-established because of

²⁴ See also p. 77.

poor attendance (n=9); Health of self or partner (n=6); group politics (n=4); unable to leave the children or the children's problems were too severe (3). Two carers said that they did not drive.

Six respondents stated that they saw the group as dealing with problems and that their lives were now stable and they no longer felt the need to attend.

I see the organisation as being for full-time carers and when I was desperate about ongoing court action/father's behaviour etc/legal issues/cost etc I did ring and speak to 2 part-timers & believed they couldn't help. Most stories they had were for people with no money, people worst off than us, people who didn't own their own house

Two rural groups kept in contact by phone only and 4 respondents stated that they were not aware of such groups. There were many favourable comments about the newsletter in regard to content and support.

Those earning \$30,000 or less were more likely to attend GRG support group meetings (45% compared to 24% of those earning more than \$30,000).

Older grandparents were more likely to attend GRG support group meetings (43% of those aged 60+ compared to only 8% of those under 50).

40.0. Discussion and Information Sharing Forums

The training of kin carers is a contentious issue, the debate being around compulsory attendance and respect for kin knowledge. Currently in New Zealand, Child Youth and Family conduct training courses for foster carers and induction courses are compulsory. There are no compulsory or specific courses for kin carers offered and some kin carers who have attended the Child Youth and Family courses stated that they felt that while some of the content was helpful, other issues did not apply or that their particular problems were not discussed. However, 129/171 (75.4%) respondents stated that they would attend discussion forums and 42 (24.6%) stated that they would not.

I say yes, but at times I feel too embarrassed to attend these kinds of things, I cannot hear too good so I find it hard to understand what is being said

Reasons given for not attending were time, tiredness, emotional or personal issues and a reluctance to be involved with Child Youth and Family, if they were conducting the courses.

Not sure - I am not a people person as far as groups go

Limited time available; we are both in our seventies 76 & 71 and are tired out by the time we have done all the things we have to do. We would attend if we had more time

Not sure, I have attended meetings in the past, I find I have so many appointments & stuff to do I don't have the energy

No, having baby-sitting issues – do not want CYFS especially to have anything to do with our children due to past history with them

No, probably not, I tend to get my info from the Internet

Post traumatic Stress disorder gets in the way often times – I am very willing but can get very upset which in turn upsets other people

The literature now clearly identifies that kin carers need specialist education /sharing/ training forums that address their unique caring needs (Mc Fadden 1997; Greef, 1999; Frengly, 2007). Mc Fadden (1997:v) claims that expecting kin carers to benefit from foster care training is like ‘putting square pegs into a round hole’. However in the absence of specific kin/whanau care courses, some kin have attended the foster care courses and found them to be valuable.

Attend the Foster Care Training – GREAT- The GRG newsletter gives class times in advance

I have completed the training available to care givers including the care giver certificate course and feel very strongly that all care givers should complete at least the short 2 day certificate of knowledge over say the first 12 months of care giving and have to refresh them every 5 years I feel they are invaluable I believe that they would help curb some of the allegations that come through it amazes me how many carers out there have no training and support and these children are not the same as our own normal children to bring up as they have so many problems that are hidden and need bring out to be dealt with. I feel that there is a lot of financial and great support from the NZFFCF and CYF to enable carers to attend these courses that there should be no excuse as to why these are not being attended.

It is an unfortunate fact that while kin carers are usually motivated by benevolence and compassion, the risk of receiving an allegation of abuse of the children or young people placed in their care is increasingly high. Notifications of child abuse or breach of standards in foster and kinship care are increasing internationally and whether substantiated or not, all cause serious distress to children and carers (Nixon 1997). McFadden (1996:316) states that abuse in care may be related to a configuration of factors in three areas, the system, the child and the caring family itself. There are traumatic, wide reaching and long lasting effects of an allegation on the whole care giving system, most particularly of kinship family, who often cease to carry on as caregivers. The New Zealand Family and Foster care Federation have a support scheme for carers who are facing allegations. Recent data showed that one-third of those supported in the 2007/78 year were kin carers. An evaluation of the pilot project showed a very low level of foster care education and training had been undertaken by the carers who were under investigation and that a clear link could be made between caregiver training and safe caring behaviour (Worrall 2005). Nineteen kin carers in this study had experienced an allegation of abuse against the children in their care.

41.0. Involvement with Child Youth and Family

Involvement with Child Youth and Family

	n	%
Visits from social worker	47	23
Attendance at CYF training programme	14	7
Guardianship or custody/day to day issues	24	12
Allegations/complaints about your care	19	9

Issues in regard to the children	37	18
Issues in regard to the child's parents	27	13
Other	44	22

Respondents were asked if they had had any involvement with Child Youth and Family over the last four years. Several indicated that they had resolved the family problems themselves without needing to involve Child Youth and Family and hoped it would stay that way.

Forty-seven (22.9%) had received visits from a social worker; 37 (18.0%) had contact in regard to the children; 27 (13.2%) had contact in regard to the child's parents; 24 (11.7%) had contact in regard to guardianship or custody/day to day care issues; 19 (9.3%) had received allegations or complaints about the standard of care given to the children; 14 (6.8%) had attended Child Youth and Family Training courses. Forty-four (21.5%) gave other comments in regard to their relationship with Child Youth and Family, some positive and some negative

I contacted Social Welfare for advice about my daughter's behaviour which was worsening. I was concerned for my granddaughter who was looking and being neglected. Someone visited us and we all visited her, she was very helpful.

Youth justice system very good and fair to everyone

...and my social worker is wonderful....

Two people described having an investigation by Child Youth and Family and the stress that engendered:

My husband and I had an argument outside. A woman going by reported me to CYFS. No case to answer BUT!!! I had lots of stress with their visit

Busybody heard me yell abuse at husband, reported me. No case to answer but PLENTY of Stress! (0061)

Several commented that they felt Child Youth and Family were not interested in them as they were kin carers.

No contact. Child Youth & Family are not interested in UCB children. I phoned about a newsletter and was fobbed off (0063)

Even when I asked for help they either ignored me or decided I was being anti the father

Some respondents had struggled to manage the children on their own and had to resort to seeking help from Child Youth and Family.

42.0. Wishes!!!

The respondents were given the opportunity to communicate their feelings over three areas:

- What they would wish for their kin/grandchildren;

- What they would wish for themselves;
- What they felt was the most enjoyable thing about caring.

Having the freedom to write what they wanted instead of being constrained by a questionnaire resulted in pages of data- emotional, heartfelt responses that cannot be given full credit in this report. A content analysis follows.

42.1. Wishes for Our Children

Happiness was the most common wish. *After all she has been through I just want her to be happy!* Happiness was further explained as having friends; feeling loved and wanted; knowing we will always be there for her; having healthy relationships; and having good family relationships and being fun-loving and having security.

Education was the second most desired attribute, and for many, seen as the way to achieving happiness. Some grandparents said that they had not had the opportunity to learn and they wanted their grandchildren to be ‘achieving’ ‘useful members of society; ‘successful’ ‘employed’ and ‘independent’.

Personal qualities of self esteem; security; being well-adjusted, and values of honesty; hard work; kindness and caring were listed.

Those grandparents who were caring for children with disabilities voiced a need for them to be accepted by society; to not be bullied; to be respected for who they are; treated equally and that there would be someone to care for the children ‘when we are gone.’

Some grandparents voiced a deep desire that the children would not follow in their parents’ footsteps and hoped that their grandchildren would not take drugs, offend, and have a life of criminality and that they would be protected from family issues that have led to the need for care. *“The children bear the burden.”*

The fact that the children often carry the blame for their situation was expressed and the hope that the children could see that it was not their fault and that they would learn to control their anger and resolve their grief. There were wishes expressed that the children’s parents would recover and that the children would be able to return and lead ‘normal’ family lives.

That they continue to feel safe & happy, grow up kind and loving knowing right from wrong, respect one another and themselves and anyone they contact; that they know we have given them the best start in life we could have, that they grow and share the love they have been given with their own families when they have one.; that they grow into loving happy healthy adults; that they know we will always be there for them.

I want him to grow up to have the same advantages as his peers. For him to have financial equity with his peers; I want him to feel secure in his place in the world. I want for him... love, stability, happiness, security, fun education, commitment, loyalty, humility, empathy, enthusiastic role models, friendships, adventures.

To be happy, well educated, to make friends with other children, relaxed about everyday life, capable, thoughtful, confident about own abilities, sense of humour, physically well, mentally and emotionally well, and inventive.

I wish for her that she has as normal life as possible, that she feels loved and cared for. So that she can reach her potential, because I know that she grieves for her parents. She is able to tell me how she feels, so I know she feels different to her friends. I hope she will have the emotional resilience to deal with all that has happened when she grows up, so that she is not a troubled adult.

That he will be able to grow into a well balanced, confident young man, who can look back and reflect on a past that, even if it was not always easy, helps him to feel strong and secure within himself; that he can accept the negative experiences and will be able to transform and use them as learning tools for his own well being.

42.2. Wishes for Ourselves

The disruption in expected life stage activities experienced by undertaking child rearing responsibilities again was vividly expressed by the participants. However, there was very little sign of absolute regret at what they had done, but rather a hope that life might return to normal while they still have the health and energy. The most commonly voiced wishes were in regard to achieving financial, psychological and physical health.

The evidence shows a strong commitment to their grandchildren until they can return to their parents or attain independence. However, the likelihood of a deterioration of health status at this stage of life, their impending morbidity and the effect of that in continuing to provide care was expressed as their primary concern by many respondents. They expressed this as “*dying safe in the knowledge these children will be cared for until they reach independence*” or “*to see our grandchildren into independence*”

“That I live long enough to see my grandchild fulfil most of what can be achieved. Also that my husband lives long enough to understand...”

“To see the children safely through puberty before we die”

“To still be around to watch her grow through her teen age years”

That I remain alive long enough to see her achieve anything she wants with dignity and that the cancer treatment works

That I live long enough to see my granddaughter able to lead an honest, happy and well adjusted life; that I can retain my vision & mobility for as long as possible; that I am not a burden on anyone

Just to live to a ripe old age and be able to see these children grow up into adults and have a family of their own with the hope we have been able to break the cycle (0191)

Health issues are a primary concern for many as evidenced above and several explained that they were in fact facing issues that made them think about future plans as to who would care for the children. One stating

I hope my own children will step up to the mark when I am gone...

Cancer treatment, end stage kidney failure, failing sight, hip replacements; strokes and heart issues were mentioned by some as current health issues they or their partners were contending with in the context of providing care. Several others not beset by such serious health problems, wished for less tiredness and more energy.

That I didn't have such a big mortgage, time for myself, time for friends, to travel to England to see my son, to be able to stop work or working a less stressful role

As in the last study, the precarious financial status of many of the grandparents was raised frequently. Several respondents indicated that they did not have enough money to put food on the table three times a day stated her wish as:

Not to go to bed hungry, clothes that fit, money to survive on, not to constantly worry about W&I [Work and Income] and my daughter as well

3 feeds a day and a comfortable old age

Grandparents identified that they could not afford education costs; activities, such as sporting fees; clothes for themselves and the children or holidays.

More availability to participate in school and outside activities but unable to as it costs so much; Clothing allowance would be wonderful and I am sure that now and again brand new clothes would be nice, a change from 2nd hand. They do not complain but a treat now and again is lovely.

I wish I had money to take him on holiday. I wish I had money to start a savings for his education at and after high school.

More money when you are a senior citizen the money doesn't go far enough to support their education.

Not to worry about financial stress; to be taken back to court and have to pay all the cost to keep the child

The wish for suitable and affordable accommodation was voiced by several who cared for their children in their small houses, or who had been forced into renting to accommodate the children. Additionally, the taking out of a mortgage on the house or having to repay a Legal Aid loan caused financial stress on a limited income.

A Housing Corp home; where stability is a certainty. My biggest fear is if something happened to me my littlies would not have a home as \$300.00 per week is out of reach for my younger daughter to care for them;

..... the stability of a home as renting privately is not stable and we may have to move. Tried Housing Corp no luck

To be financially secure enough to pay off mortgage \$250,000 (I can dream) to be able financially and physically to travel to see my children living overseas.Sometimes it feels enough to be able to put petrol in the car and food on the table

Another just wanted “to return to my land and home up-north”

The most frequently declared wishes were for time – time alone with their partner, go on a holiday, (with or without the grandchildren), respite care so they could get time for themselves, either to gather energy or to follow an interest for themselves or to get some ‘compatible adult company now and again.

We would love to be able to spend some time together by ourselves to enjoy those things that we have had to give up since our grandchild arrived. In 10 years we have had only one break and then it was thanks to my parents (in their 80’s) who came to look after the farm and the child. We would love to be able to spend some time with our own grown kids. All are now married and it would be nice to visit without having an extra wee pair of eyes and ears!

Being able to have time out; afford to go somewhere together & have respite care

Time out and more support with care and social activities example sport games and clubs for my grandchildren maybe a male role model, and positive peers and friendship

Quality of life was expressed in terms of wishing for ‘peace,’ ‘happiness,’ ‘security,’ to be ‘proper normal grandparents,’ and to be able to have a ‘normal retirement’

That we have more “together” time; that we have a conversation together , on our own, as little person sticking in his 2 bobs worth; that my husband can retire when he wants but I bet he can’t, we need cash for child

My husband needs to retire, but he can’t!

The wish to be free of legal wrangling and stress was also voiced by several who wanted ‘no more courts’ or ‘no allegations’

Just to have a normal life, no courts, no allegations; Waiting to see what next is going to happen; Peace of mind. My life has been turned upside down because I gave my grandchildren a loving, caring with boundaries something they did not have (home)Why when I have proven to be a good home & care giver I am subject by courts CYF’s with false allegations from the father, a father who mentally, physically, sexually abused his family has so many rights and we as the care givers have none if we do not respond to the affidavits the court rule on what we have to answer those allegations to safe guard the children

43.0. The Joy of Caring

Several participants in the previous study wished to communicate the joy they felt caring for their precious whanau/kin children. To capture the positive aspects of taking care, the grandparents were asked identify what they enjoyed about their caring role. Eighty percent of the survey participants expressed the way in which the children had contributed joy to their lives, one way or

another. Only one respondent stated that there was nothing positive at the moment! Each comment is worthy of reporting - the necessity in a report such as this to choose some above others is at risk of diminishing the richness of the heartfelt responses

The sentiments expressed were the satisfaction of being able to heal fragmented and injured children, to have joy in seeing them grow and learn new things about life; the joy of playing together; exploring together; seeing the children develop love and trust in the grandparents and whanau; seeing them achieve and develop friendships with other children Others expressed the joy of companionship; joy in the knowledge that the children are being kept safe and able to develop loving relationships; the joy of having a second chance to raise good citizens; the fact that they were learning new things; the kisses and cuddles; the joy of laughter; being together through good times and bad;

Watching the boys overcome so many issues and being part of their lives. Being able to help them make peace with what life has thrown at them. Being able to make them smile when they were sad, laugh when they wanted to cry and accept that what happened to them was never their fault. And listening to them on quiet nights chatting to each other about what they want to do when they grow up

To be able to have fun together and be child-like with him. We have fun together, stories, and dramas and games, making up songs; making scrap books and cut out models The secure attachment that we have. It amazes me how bright he is! It is good for my brain – he is always asking questions. To see how social he is and that he is keen on education himself. We do lots of library reading etc

The fun times – eeling, gathering kai moana- hiking up to the waterfall – Even in the bad times, crying together and drawing comfort from one another.

I love the boys but the most enjoyable thing is I'm liking being with them. These times are enjoyable as they grow into young men becoming more at ease with others and themselves! Becoming more responsible to others around them is making both boys into nicer young men. I believe if they get the support they need they will grow into men capable of being able to contribute to society

Having two little boys again is hard. You don't fit in with the "normal" grandparents and you don't fit in with other "parents" as you are really neither but how many people can turn around and say that they have had the pleasure of doing it all again and seeing their grandchild evolve into happy healthy young men. The pleasure they give us with their little remarks at the most appropriate time. When you are feeling as if the world is against you a little hand goes in your and a little voice tells you they love you and you are the best Nannie is something you cannot get anywhere else. It makes all the hassles of the court cases and disappointment worth it

44.0. General Comments

Finally, respondents were asked if there were any other comments they would like to make. Almost every respondent commented and the overwhelming response evidences the fact that these kin carers have much to contribute to the development of whanau/kin care policy.

Thank you for this opportunity to have a say as many of us are marginalised in our roles from our peer group as we have different needs and challenges. We also face issues that are not recognised within the political, educational and health areas as this is one way to have our voices heard

The court system, the financial support available and the age-stage dislocation were the most frequently raised issues.

- **The legal struggle to retain custody, issues of parental access and court processes**

There should be a less traumatic and less expensive process to resolve issues that we have had to deal with. The court process has supported an adversarial system (both High Court & Family) which has not assisted the resolution of issues.

I have been surprised that overall, generally courts cannot make people do what they order, and therefore there is not enough morality in the system. People are able still to lie, bully in court under oath..... I'm very concerned for the other grandparents who perhaps are not as articulate, nor have the means to sustain the repeated onslaught of court appearances, legal jargon, emotional stress, cost etc. Because the adversarial system parent is so strong, it is the grandparents/parents etc who in the end just walk away (for the wrong reasons) and lose the access altogether & perhaps lose the grandchild from their lives forever. These children are then lost to the whanau, and everyone is robbed of the delight of watching the grandchild grow and flourish and become that fulfilled adult (hopefully). Having said all that, my husband (who is a rock) & I will always 'fight' to keep the access going even if we sell our home because our grandson (one of 6 grandchildren) has the right to know the other ½ of himself through his deceased mother's side. He is the only link to my daughter and we are holders of ½ his history. (His mummy died just before he turned 4mths old).

Children's rights in family La.: My grandson has stated that he does not wish to be uplifted and wants to remain in my care. He does not feel safe staying overnight with his father who has a history of drugs and alcohol. He goes to bed crying saying he is afraid his Dad will come and take him away, and he gets serious asthma, shaking. Edgy, all the symptoms of a stressed out 6 year old. Even the neighbours have seen him hiding and not wanting to go to access....I wonder who is listening to the child? This boy is already vulnerable and sensitive. I am the one who has to MAKE him go. He comes back withdrawn, hides upset, quiet won't eat etc. The Father is going for custody but has never recognised his birthday or bought him a Christmas present and never phones!!`

- **The need to have a less contentious and equal system of financial support.**

Several commented on the fact that WINZ workers need education about qualification for the Unsupported Child Benefit.

I have experienced very upsetting treatment from cases managers. I was told that I had to go back to work full time and his mother had to look after her son. This was directly in contrast to the Court Order and the judge's direction. She gave me 3 working days to prove that my daughter was unfit to care for her son so I could go to work, also why he couldn't attend day

care. This was extremely stressful, especially given the fact that my daughter has supervised visits. W&I had a copy of the Court Order so there was no excuse or even apology. Dealing with case managersno common sense or compassion. In my experience, and this is only one example, I have many more. I have had the feeling that the W&I system would have been quite content for me to stay at work, leave grandson where he was to die. There is no doubt he would have. And yet they all beat their chests when a child dies and say "where are the families" we are here struggling and often going without basic human needs to save an innocent baby/child

I would like an activities allowance, every activity is at least \$60.00 dollars – some \$50 a month. Almost impossible. I cut hair (both of ours) It is humbling to ask for food vouchers! WINZ employee suggested that I wash hair in dish wash detergent to save \$.

- **Age stage Dislocation, solo caring respite care and grief**

As discussed above the lack of ability to socialise and the loneliness of the solo carer were expressed by several respondents. Coupled with that is the grief expressed by carers about the universality of loss, children who have lost their parents, carers who have lost their spouses, their children and their friends.

One of the things I find hardest as a grandmother raising my grandchild is I'm already older than the other mothers. I guess it is rather lonely at times. Not really fitting in with the young families; being the one out, but I do attend all my grandchild's activities

I found the experience of solo parenting an autistic child very lonely and hard. I had brought up two children on my own, worked very hard and was looking forward to some freedom to travel , do further study and continue to earn through my business . Instead I have been taking a child to therapy counselling, school and paying for private school education. I do not see an end to this as I feel she will always need a home base and a strongly supportive person in her life

The comment I would like to raise is how much we as grandparent's raising grandchildren miss out on so much. Our friends do not make as much contact because we are tied down all over again we are unable to out as babysitting fees are expenses and not only that it is sometimes unstable for the children having different people looking after them. They start to feel insecure and wonder when we are going to leave them. (They never forget their past). So the things we used to take for granted now have a big effect on their life. We are unable to just pop out without a very strong explanation of when we will be back and why we are going out. It certainly changes your whole relaxation of life that we all thought we were growing towards

The most difficult thing for me has been accessing appropriate care for the child, particularly in the long school holidays which last from 12th Dec to 2nd Feb!! I need to work most of the holidays but am thinking I may need to take some of them off without pay in future. Lack of socialisation is big. For both of us losing my husband has been a big blow as he was the child's main caregiver working part- time and being available to him and doing the 'men' things with him. I cannot fill that gap, but that would be the same with biological children too, except the remaining parent would be younger

I would like to see more help emotion help for parents whose children die in whatever circumstances. Perhaps in the form of booklets that offer suggestions on the emotional care of the children involved. We made it quite clear that the boys' father died, not lost or passed on

and talked about how things would change and how we would all deal with the changes together. When my daughter in law died the youngest boy was two; I lived a way away then but visited and stayed regularly. One day he asked me if she was coming home soon and I told him it was not like that and we talked about her. He accepted the explanation and ceased to fret. Children are more resilient than we realise. Maybe not for all children but it worked for these two boys

Caring for our granddaughter has given us great joy but is also more intense than bringing up your own children. Our friends don't have kids her age and so live a different life style that we are able to, feels a little like we don't have any support, anyone to talk to about just the normal parenting stuff that happening. Work also is not supportive if I have to take sick leave to care for her I am often asked where is her mother and why am I not getting her to look after her, seems that people need to know why you are raising your grandchild and then feel the need to give you advice about what you could do to make the mother have her. I feel I have not been able to make progress in my professional development as am too tired to do any studies, have made job changes to fit our family commitment. If I had to choose again would never make a different choice - she has added so much to our lives but as we head towards the teenage years am a little worried as we had such a tough time with her mother cannot help but think please not again!

- **Grandparents Raising Grandchildren Support**

The most repeated comment in this section was affirmation and gratitude for the GRG organisation. Respondents spoke of 'being there when needed'. 'Understanding' 'working on our behalf.'

I would like to thank GRG Trust for all the love and support they have given all of us over the past ten years..... GRG is a wonderful Trust and we enjoy the newsletter greatly

Life's a b...h! It is so hard financially, if it was not for GRG grocery parcels and sponsorship for camps, we would really be so limited. Many, many thanks to GRG (0153)

Thank you for all the effort and hard work as GRG organisation put in on behalf of us – for being our voices with the Government. We appreciate it tremendously

I would just like to take this opportunity to say that the fact that I have GRG even to just know that I am not alone in this has just been fantastic and I thank you for that

The GRG support group (local) & national office has been & continues to be an invaluable asset & God send for us. Meeting people in the same situation has kept me 'sane'. We are thankful that this sort of group/organisation is in existence

Thank you GRG for being there for anyone – not only grandparents, Grow and prosper in all matters – Tena koutou, tena koutou, tena koutou – Kia ora

Discussion

This study was carried out to discover how well New Zealand grandparents and other kin carers had fared over the four years since the last study was undertaken. While much of the statistical data is similar to the 2005 study, three major factors stand out in this study:

- Caregiver resilience and commitment to the grandchildren in spite of huge hurdles and difficulties
- The stability afforded the children that has led to a significant level of improvement in the children's physical and psychological health
- The joy most carers described in seeing their grandchildren flourish and the loving relationships existing between the children and their grandparents.

Having said that, a ribbon of grief also runs through these stories – grief felt by all those in the kinship circle, the children, the grandparents and the children's parents. Grief arises out of disappointment that their children and/or grandchildren have gone to prison, death of their own children; death of spouses; broken marriages; lives lost to drugs and alcohol and grief in respect of injuries the children will not recover from, for example, brain injured shaken babies. There is also sorrow and anger that they have to face challenges to their custody in court from their own children and the cost of this – money taken that could be spent on their needy grandchildren.

In this study there is also evidence of financial struggle to make ends meet, stories of grandparents going to bed hungry or losing weight because they are eating less as their growing grandchildren need more, and the cost of constantly clothing growing children. Carers show fortitude in the face of poverty, saying “we make do” or “we just push on – tomorrow is another day”

Unable to work at my normal job because of hours; no money for holidays in 10 years; No real access to social events because of cost, growing mortgage as I borrowed from my house. No new clothes or shoes in years; always behind on rates, power, phone, desperate at time owe \$430.00 weekly mortgage. No saved or spare funds to pay excess of insurance claims

3x trips by ambulance to hospital \$54 per trip, more is going out than what is coming in. We both wear second hand clothes. Have been to the hospital 7 times in 6 weeks, plus 2 hours each way drive there and back for a bone scan

There are also stories of hope. Many carers indicated that the children's parents were getting their lives back together again and hope expressed that the children would one day go home.

The grandparents also evidenced that many were caring in the face of deteriorating health of themselves or their spouses, some having serious problems – Alzheimer's, strokes, major heart problems and cancer. However none commented that these would stop them from caring, but concern about their impending morbidity was reflected in statements about ‘living long enough to see my grandchildren to puberty’ or ‘independence.’ Or hoping that the family will take over a disabled child when ‘I am gone’. Recent Australian research exploring the psychological health of custodial grandparents found that they scored significantly higher on anxiety and stress level measures than a

control group of non-custodial grandparents, identifying a need for increased levels of psychological support for both the grandparent and their grandchildren (Dunne & Kettler, 2007).

Children in kin/whānau care and their carers fall between the public domain of state responsibility to ensure the ongoing safety of abused and neglected children and their carers, and the private domain of family. Child welfare policies that ensure families are the first resource considered when children need care are absolutely right and serve the need for children to have the least relational disruption and preserve their own identity. The importance of maintaining the sibling bond is also more likely to be achieved when children are placed with whānau/extended family. These factors have been cited as central to current child welfare concepts by Carbino (2006) who claims that child well-being is inseparable from the well-being of the child's family. However, this research shows that for those grandparents who take total responsibility for the care of their grandchildren who have suffered neglect, abuse or who are affected by parental drug abuse, the task is stressful, demanding and takes a huge toll on grandparent's physical, emotional and financial resources.

*...It is so hard to see our grandson locked up in prison; we visit every month; put money in his bank for snacks, his courses etc; what more can we do. It's hard when family say "forget about him. Leave him where he is why visit". Answer we love him we just don't like what he does.
"THAT S WHY"*

This study illustrates well the pressure of responsibility that many carers experience in caring for the children. The stresses of child behavioural issues arising out of neglect and/ or abuse and the pressure this exerts on family relationships and the additional financial burden of care can all weigh heavily on the carer. That said, carers talked about the rewards of looking after the children, and for many, it is clearly a positive experience that counters the pressures they experience.

As evidenced above, 83.7% of respondents to the question stated that the physical problems of the children had improved over time and 86.5% stated that the psychological problems had improved over time. The commitment to the children and the ability to seek support for the children and themselves speaks to the resilience of the grandparents rather than intervention by formal support services. It is well known that children in foster care are likely to 'drift' in the system, often experiencing many placements, and many not returning home to parental care (Saunders, 2005; Maluccio, Canali & Vecchiato, 2006). This study gives testimony to the fact that in spite of huge difficulties and little if any support, the grandparents have given the children stability and love so that many have recovered from the trauma of abuse and neglect.

Ensuring that carers receive all assistance that they are entitled to is most important and a key factor in maintaining a healthy caring environment. Responding sensitively and supportively to grandparent carers in ways that acknowledge both the sacrifice they are making to ensure the well-being of their kin children and the turmoil of the kin/whānau experience is an important aspect of child welfare social work. This study gives good evidence that some State agencies whose task it is to support kin/whānau placements fall short. It must be recognised that grandparents in particular do not want to enter the realms of poverty. This research gives evidence that some carers do not get enough to eat. They do not want to go to the food bank or ask for extra money from WINZ and when they do it is desperation that drives them not greed.

McFadden (1996) makes it clear that kin carers need specific preparation for the task of caring for their kin children who have suffered neglect and abuse. The knowledge they need is not

necessarily sufficed by attending training courses designed for non-relative foster carers. The need to be assisted to manage contentious family relationships; the grief of both the children and themselves; the complexities of the law when they are seeking permanency and having that challenged by their own children in court, and managing parental access when the parent is your child or relative are issues not faced by non-kin carers, but issues that are inherent in grandparent and whanau care. There has been a belief held in some quarters that kin carers do not need training to care for their own, but these children are damaged and carers need to be given strategies to manage the problems within the kin care context. Unfortunately, kin grandparent carers are not immune from allegations of abuse (Worrall 2005b), and providing respectful and culturally responsive preparation for the caring task will ameliorate that risk and will help carers provide a strong and safe environment for their child.

While it is increasingly recognised that keeping children within their family structures and all that is familiar to them is less traumatic than placement in foster care with strangers and more likely to keep siblings together, several studies both in New Zealand and overseas show that most kin families care under duress.

I fear that the younger sibling may be experiencing or suffering from the effects of the brother's unmanageable behaviour, taking it on board and or it may be a biological spill, embarrassment and shame is high up there on a social level too.

However, reflecting international evidence (Leos-Urbel et al., 2002) New Zealand kin caregivers in both the 2005 and this 2009 study have shown a reluctance to engage with State child protection authorities and have done so only when all else failed. On-going support services may be most appropriately provided by the voluntary sector and contracted to a Child and Family Support Service at the time of the Family Group Conference.

When grandparents take custody there are issues of their impending morbidity and mortality (Crumbley & Little, 1997) that are not frequently discussed. These are, nevertheless, important issues for the family to consider when making decisions relating to the ongoing care of a child. It is important that practitioners help families to explore these issues and to consider the appointment of a Testamentary Guardian for the child who is then able to ensure that the child's best interests are preserved in the event of the grandparents being no longer able to care or deceased.

Although kinship care has its frustrations and is undoubtedly exceedingly demanding for many carers, it is also clear that it can have significant rewards for both the children and those who care for them.

I feel it is not enough to just take on your grandchild and give them the love and shelter. I feel a huge responsibility to offer him the best that I can; to be gentle with his soul and wellbeing, to foster everything that is right in the world. To nurture him, to allow him to have trust in himself and in me; to encourage him to make fantastic choices; To show him how to be a jolly good and decent human being; to teach him that he can be anything he wants, if he works hard and has goals. To be kind to other people's souls; I have felt my grandmother inside of me, when I hear myself telling him the name of plants and birds, when going on bush walks, when exploring, when baking, to feel that strong woman is a privilege and I would love my grandson to grow up feeling inspired about me.

Recommendations

- That grandparent and other whanau/kin carers are not financially penalised by virtue of being related and that they receive the ancillary payments afforded to non-related foster carers.
- That grandparents and other kin carers have access to counselling for themselves and their grandchildren
- That pre-placement assessments are strengths-based and respectful of grandparents needs
- That support families are recruited that can offer consistent regular respite care and buddies to the children.
- That a full accommodation assessment be made that takes into account the family's projected housing needs and their financial status, excluding the Unsupported Child Benefit. Assistance could take the form of an interest free home improvement loan that is repayable at termination of care, provision of a State house, or provision of the accommodation supplement – whichever is most appropriate and least disruptive to the family.
- That education costs and school fees are paid by the State where children are in grandparents and kin/whanau care and the annual family income is below \$50,000.(Grandparents have stated that they are embarrassed by not having accessible money to pay school fees and cannot afford to send their children on school trips).
- That specialised kinship care preparation and training courses are offered to kin families.
- That all kinship carers are given access to free legal aid when endeavouring to gain a permanent legal status for the child, when that is in the child's best interests.
- That consideration is given to setting up a Kinship/whanau care Support Service that is independent from Child Youth and Family.

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