

Acknowledgements

On behalf of the Grandparents Raising Grandchildren Charitable Trust and the thousands of grandparent/kin caregivers raising kin children in Aotearoa/New Zealand, I wish to thank the **JR McKenzie Trust** for making this important research into their plight possible.

Many people also gave generously of their time and assistance to me in the research, production and editing of this report and I gratefully acknowledge fellow trustee, Kate Woodd for her support, assistance and editing work, Judy Scheffer (MSc Massey University) for her assistance with the quantitative analysis of the data and National Convenor of the Grandparents Raising Grandchildren Charitable Trust, Diane Vivian. Without Diane's vision, drive and determination to raise public awareness of the needs of grandparents/kin caregivers raising kin children, this work would not have been done.

Jill Worrall, March 2005

Jill Worrall MSW

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Grandparents Raising Grandchildren Charitable Trust

Research Report

March 2005

Grandparents and other Relatives

Raising Kin Children in Aotearoa/New Zealand

Preface

Special thanks must be given to the 323 kin caregivers who gave their time to complete this questionnaire. Thank you for sharing your experiences. Without your participation, the conditions that affect how kinship/whanau care is experienced would remain invisible.

While statistical results allow an insight into the life and circumstances of those grandparents and other relatives who are raising their kin children, it is the individual stories behind the data that should be told – stories of struggle, grief, courage, joy and poignancy. Grandparents and even great grandparents are heroically giving of their lives so as to ensure the well-being of their kin children. Regrettably, individual stories rarely change policy. The collective data of these 323 families who represent thousands of kin caregivers in Aotearoa/New Zealand must.

Jill Worrall MSW
Researcher

Introduction

“Financially, life is a disaster and ill health makes me a disaster! This isn’t the life I would have chosen or the road I would have wished to travel. It’s not the dream I had, but I am amazed to see where I have come, where I am going, where I am from! My grandchild makes life so worth waking up for. So we walk this journey together and dream new dreams together. Together life will be different.”

Grandparents who are assuming full responsibility for raising their grandchildren are an increasing phenomenon in Aotearoa/New Zealand. The 2001 New Zealand Census recorded that over 4,000 children were being parented by their grandparents (Statistics New Zealand 2001). This figure in no way represents current figures for all children in kinship care or for that matter, all children in grandparent care, as there has been an increase in Child Protection

notifications over the last four years (National Care Plan CYF, 2004:17) resulting in an increase in the number of children placed in the care of their grandparents.

Families have always cared for their kin children, however, in New Zealand, it is now a legal prescription 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 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. On the other hand, McPherson (2004) cites literature that claims that as the ethnic composition of the population is increasingly non-European, this may result in less, rather than more family support due to over representation in low socio-economic groups. McPherson also 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)

Incidence of Children in Grandparent / Kin Care

Child Youth and Family Statistics as at June 2004 show that 4674 children were in the care of Child Youth and Family, 39.8% of whom were Maori. Only 1674 (36%) of the 4674 children were placed in extended family care (National Care Plan CYF, 2004:16,18). As at 31 December 2004, 48% of all Maori children in care were placed with extended family/whanau as against 27% of Pakeha children (Year End Quarterly Report, Dec 2004 CYF). These figures do not take into account those extended families who have voluntarily

assumed care, or the many since 1989 who have assumed legal guardianship and now have no formal relationship with Child Youth and Family.

There has been no comprehensive data collected in New Zealand that examines long-term outcomes for these children or their kin caregivers. It is apparent, however, that for the many who have taken on this responsibility, it is no easy task. Children who have suffered neglect and/or abuse have special needs that require patience, skill, tenacity and commitment (Kortenkamp, K. & Ehrle, J. 2002). While many of these children come to extended family care through Child Youth and Family intervention, that is not universally the case and many grandparents assume care of their own volition, as they see the need for someone to step in.

The establishment of the Grandparents Raising Grandchildren Charitable Trust (“GRG Trust”), a national organisation for grandparents and other kin caregivers, and the emergence of 36 self-initiated support groups nationally under the umbrella of the Trust, is testimony to the fact that grandparent and other kin caregivers have particular and difficult issues that need support. While the Trust primarily focuses on the needs of grandparent caregivers, other kin caregivers are also included, as some of the issues experienced are common no matter what the relationship to the children.

Literature Review

It is now internationally agreed that policies of family continuity should underpin social work practice for children in need of care and protection (McFadden and Worrall 1999, Child Youth and Family Evaluation Unit, 2003). The practice of seeking care with relatives is also now therefore an international response (Greef 1999). In many countries there has been an exponential rise in the number of children in out-of-home placement and in the majority of Western countries, kinship care is now the preferred option. There is also the growing social phenomenon where grandparents, in particular, are assuming custody of their grandchildren. In Canada, the 2001 census data showed that there were 56,700 grandparents raising their grandchildren compared to 27,000 in 1996. According to the 2000 United States census data,

there are 2,350,477 grandparents in this situation. Ten percent of all American grandparents are raising one or more of their grandchildren.

The physical and psychological needs of children who have suffered abuse and neglect are great and the caring task is not made easier by virtue of being related (Worrall, 1996, 2001). Additionally, in most situations, kin caregivers take responsibility because of an in-family crisis. As a result, kin/whanau caregivers find themselves dealing with fractious family relationships, custody disputes and the behavioural and physical problems of the children's parents that led to the need for care. (Minkler & Roe, 1993; Greef, 1999; Worrall, 1996, 1999, 2001).

While it is argued that placement with kin usually affords the least disruptive environment for children, research has identified several risk factors that may affect their health, stability and safety. Over a decade ago, kinship care was described as a 'double-edged dilemma' (Task Force on Permanency Planning, 1990). The dilemma still exists and is one of family autonomy and empowerment versus statutory and social responsibility to keep children safe and therefore, the degree to which the state should support families who take responsibility for their own abused, traumatised or abandoned kin children. The small qualitative studies undertaken in New Zealand (Smith, Gollop, Taylor and Atwool 1999; Worrall 1996), along with overseas research (Chapman and Hannah, 1999; Dubowitz, 1994; Benedict, Zuravin, Brandt and Abbey, 1994, Berrick Barth and Needell, 1994; Task Force for Permanency Planning 1993) (TFOPP), show that these children and their families are an 'at risk' population.

Some of the issues raised in the kinship literature pertinent to this study are:

- **Health and educational status of children in kinship care;** (Connelly, 2003; Smith, Gollop, Taylor and Atwool 1999; Hegar and Scannapecio, 1995, Sawyer and Dubowitz, 1995; Worrall 1996; Dubowitz 1993,1994; Dubowitz, Feigelmann and Zuravin, 1993.
- **Substantially less support, resourcing and monitoring of kinship homes than foster care homes even though, in terms of the trauma the children experienced prior to placement, there is no difference;** (Child Youth & Family, 2003; Worrall, 1996, Smith et al. 1999, Greef, 1999; O'Brien, 1999; Walderman & Wheal, 1999; Gleeson, 1996; Link, 1996; Minkler and Rowe, 1993; Dubowitz et al, 1993).

- **Stability of kinship placements;** (Dubowitz 1994, Worrall 1995, 1996, Chapman and Hannah, 1999).
- **Caregiver stress and health problems, particularly when the caregiving is cross-generational;** (Smith, Gollop, Taylor and Atwool 1999; Worrall 1996; Hegar and Scannapocio, 1995; Minkler and Roe, 1993).
- **Legal issues around permanency planning for children placed with extended family and on-going legal challenges;** (Ingram 1996, Worrall 1996),
- **Less active work with birth parents and therefore a slower rate of reunification;** (Chapman and Hannah, 1999; Courtney, 1994; Berrick et al, 1994; Hornby et al 1996).
- **Unresolved issues of the birth parents with a subsequent stress on relationships in the kinship network that are exacerbated by the placement;** (Scannapocio and Hegar, 1996; Worrall, 1996; Chapman and Hannah, 1999).
- **Abuse allegations in both kinship and foster care;** (Hunt, 2003; Worrall, 1996, 2001).
- **Financial stress on care giving families who are often already on very low incomes and the changes on employment status brought on by the assuming of care;** (Greef, 1999; Worrall, 1996; Minkler and Roe, 1993).
- **The issue of parental drug use and the affect on the children and family relationships;** (Minkler and Roe, 1993; Brooks & Barth 1998, Hunt, 2003, Mirabelle Foundation, 2003).

The Research – Rationale and Scope

This research has been undertaken because, apart from a few small scale studies, (Worrall, 1996, Brudenell and Savage, 2000) the particular experiences of grandparents and other caregivers who have taken responsibility for kin children in need of care and protection in Aotearoa/New Zealand have not been researched, resulting in their invisibility to politicians and their policy makers. The need for statistical and experiential data to be collected has been keenly articulated by the caregivers themselves. The McKenzie Foundation Trust granted funding to the GRG Trust to enable this survey to be undertaken. A postal survey was sent to 790 GRG Trust support group members on the organisation's database held in April 2004. Responses were received from 323 grandparents and kin caregivers. Taking into account those responses returned 'address unknown' (n. 10) the response rate equates to 40.8%. This

is a high response rate for a postal survey, particularly considering the sheer workload and responsibilities of these grandparents and other kin caregivers and the fact that for some respondents, English is not their first language, and this kind of survey for some, is culturally outside the norm. The qualitative data is so rich that it is impossible to capture its total impact in a report such as this.

The research was approved by the Massey University Human Research Ethics Committee. It was piloted with the members of the GRG Trust Board who were caregivers. Minor alterations were made and some additional questions inserted. The questionnaires were distributed by a secretarial agency who randomly selected 790 names from the GRG Trust support group membership database. A return envelope was included. Participants were asked not to include any identifying information, in terms of names or addresses of any family members. The sample has been drawn from those grandparents who are listed on the GRG Trust 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 make generalisations, however the sample size of 323 responses is significant.

Section A: Demographic Analysis of the Caregivers

The 323 responses represented 526 caregivers in total. Of these, 62% were in a partnered relationship and 37.4% were single caregivers. The number of children represented in the sample was 492.

1. Age of Caregivers

Most research suggests that kinship caregivers are more likely to be older than stranger foster caregivers (Hunt, 2003). As stated previously, the data source for this survey may skew the results in terms of age. One of the primary issues that set grandparents, in particular, apart from other custodial caregivers is the effect of age. 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. Changes in education curricula and expected achievement levels over decades place academic distance between grandparents and their grandchildren. Many grandparents have commented that the different social expectations and pressures experienced by today's youth compared to when they were raising their own children emphasizes the generation gap and creates stress and doubts about their ability to cope. Usual social activities to be expected in later years are unable to be undertaken because of child responsibilities. These issues will be discussed in more detail later in the report.

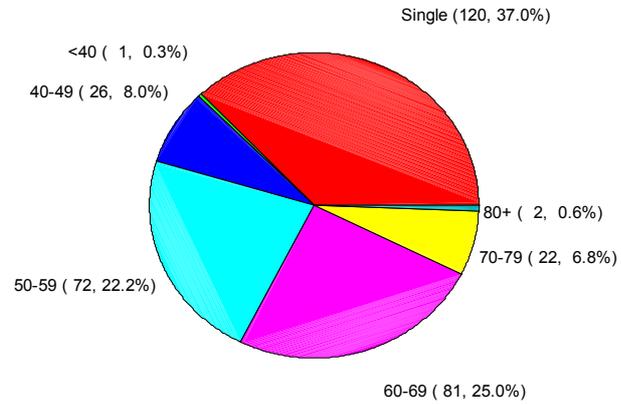
Combined Ages	Count	Percent of 526
<40	5	0.95
40-49	86	16.35
50-59	209	39.73
60-69	180	34.22
70-79	43	8.17
80+	3	0.57

The above table shows that 39.73% of respondents are between 50-59 years, followed by 34.22% of those in the 60-69 age groups. There is a significant drop in the numbers of those in the next decade, 70-79 (8.17%) and three caregivers who are over 80 years. There was a non-response from 2 participants with respect to age. One caregiver commented *“Just as my husband’s health begins to deteriorate, my grandchild enters puberty!”*

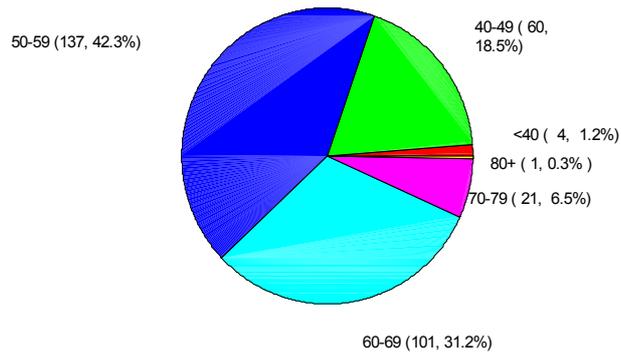
The effect of age on energy levels and physical fitness was also commented on by the participant grandparents.

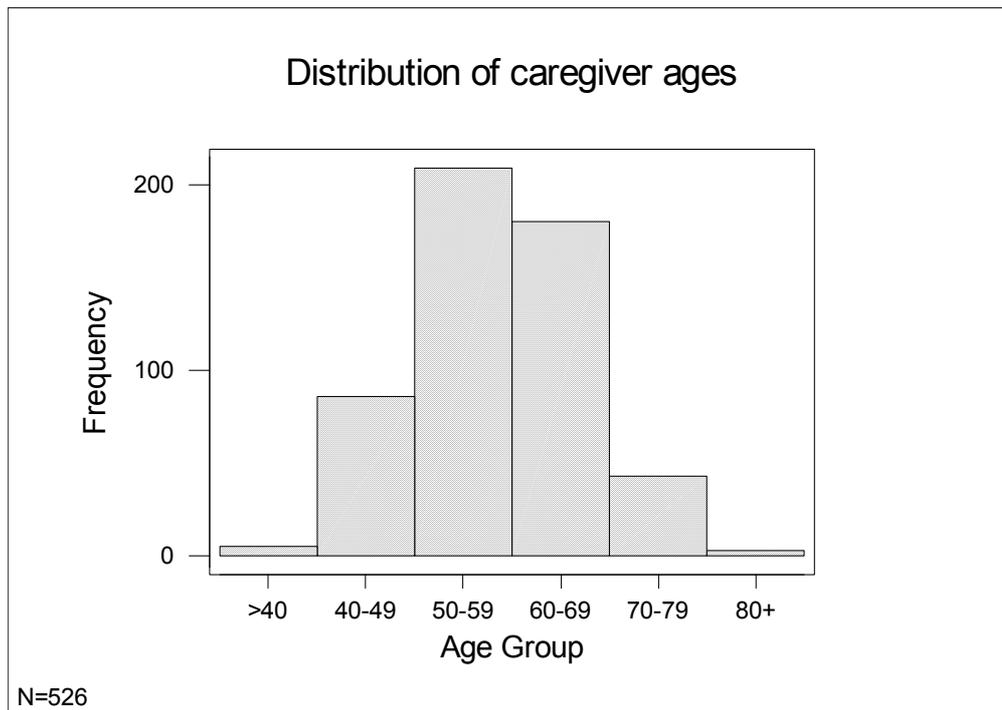
“As Grandparents, we are unable to meet the physical demands the child needs, e.g. play sport with him.”

Distribution of age of eldest caregiver if married



Distribution of age of youngest caregiver





This data can not be generalised as pertaining to all kin caregivers in New Zealand. The significantly smaller numbers of those in the 70 - 80+ cohorts could be influenced by differences in reproductive trends across age cohorts. It should also be noted that seven caregivers are great-grandparents of the children for whom they care. Additionally, there may also have been some reluctance of older caregivers to respond to a postal survey. However, in terms of future projections, as the age for first child bearing rises, more grandparent caregivers may be in the older age cohorts.

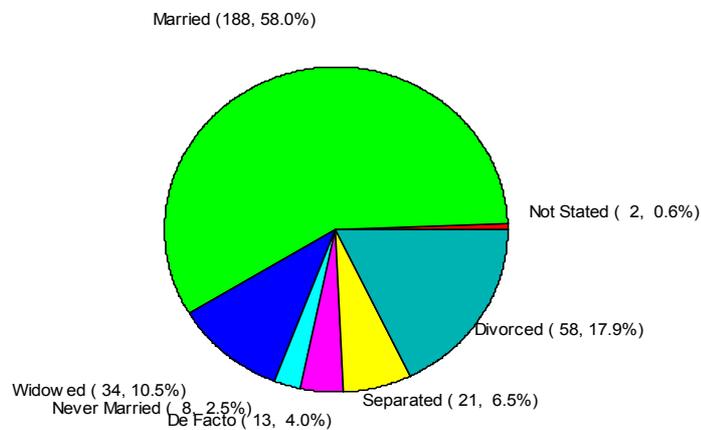
While 81% of the respondents are over 50 years of age, the largest representation being the 50-59 cohort; less than one fifth (19.7%) are under 50 and 1.4% under 40 years of age. This may well reflect the data source, being the GRG Trust support group members. However, as will be discussed later in the report, aunts, uncles, cousins and older siblings are also represented in the sample. It is generally assumed that the youngest caregiver undertakes the day to day care giving task and therefore this distribution is noted below. One of the important issues raised by the respondents is life expectancy.

“We are getting on and who will care for these children if we die?”

“Because of the sudden death of my husband and our situation, I have had to keep going no matter what.”

2. Marital Status of Caregivers

Distribution of Marital Status



Fifty eight percent of the sample is married and two responses did not state marital status. More interestingly, 37.4% of caregivers are raising the children single-handedly. Of this group, 17.9% are divorced; 10.5% are widowed, 6.5% are separated and 2.5% have never married. Connelly (2003) states that international research shows that kin caregivers are more likely to be single than foster caregivers. While those figures may, of course, reflect other factors, such as a more stringent approach of some care agencies to foster parent selection, it may also reflect the fact that some international research shows that grandmothers provide more than 50% of care, many of whom may be widowed. (Scannapocio, 1999).

Several respondents stated that they had separated since taking custody of the children. This fact is also noted in the international literature, where the stress of raising traumatised children has resulted in one partner leaving (COTA 2003). In some instances involving a second marriage, the children cared for are not biologically related to one of the caregivers, and this has caused some stress, as caregivers struggle with changed lifestyles.

“My marriage has also suffered as the boy doesn’t get on with Poppa to an extent that he thinks Poppa should move out!”

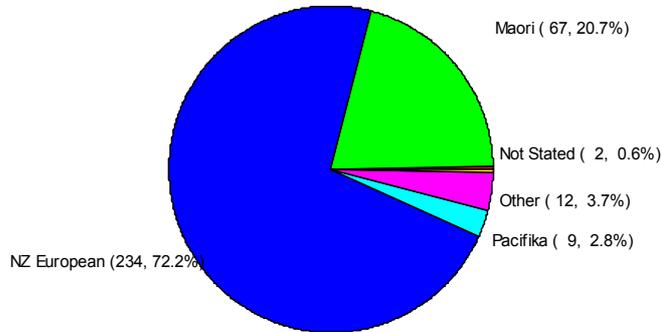
However, taking custody can result in remarriage.

“My ex-husband of 75 years (I am 61) and I married over 41 years ago...we divorced 23 years ago...we have remarried to secure a home for our grandchild and her mother, when she recovers.”

3. Ethnic Representation

As previously stated, for those children in the care of Child Youth and Family, being Maori indicates a higher chance of being placed in whanau/kin care than in foster care with strangers. In this study, 72.2% of respondents identified as NZ European, 20.7% as Maori, 2.8% as Pasifika and 3.7% as other (Dutch, English, South African, and Australian). However, this survey has resulted in a disproportionately high Pakeha/NZ European response compared to the ethnic distribution of all children in care, where Maori children are disproportionately represented. Maori children aged 0-16years comprise 24.4% of that total population (NZ census 2003) and 48% of children in the care of Child Youth and Family as at June 2004. Goodman and Silverstein (2002) found in their study on caregiver well-being that the cultural lens through which grandparenthood is viewed has a marked impact on the adaptation to custodial caregiving. While it maybe normal for grandparents in many cultures to play a part in the raising of their grandchildren, those who take total responsibility for the care of children who have suffered abuse, and or neglect is stressful, demanding and frequently overwhelms grandparents’ emotional and financial resources.

Distribution of Major Ethnicity



4. Employment

4.1 Employment Status

The respondents in either full or part time employment represented 58.55% of the survey population whereas 42.45% describe themselves as not employed. Seventy seven percent have at least one partner working, 38% have at least one partner retired, 77.5% claim no benefits,(excluding universal superannuation) and 52.6% have had changes to their occupation to accommodate their grandchildren.

Occupation	Count	Percent of 321
Not Employed	135	42.45
Employed	186	58.55

Retired	Count	Percent of 316
Not Retired	194	61.39
Retired	122	38.61

One hundred and twenty two respondents described themselves as retired and 71 as beneficiaries. However, several of those who have “retired” now work part time and are counted as employed. The high cost of child care was noted by several respondents, some of

whom who worked full time and were caring for pre-school children and some who decided that the cost was prohibitive, and would take too great a part of the earnings.

4.2 Employment Fields

Across the survey population it is apparent that the need to care for grandchildren or other kin children is irrespective of class or calling. Those employed named a wide range of occupational fields:

Education: (University Lecturers, teachers, teacher-aides, pre-school)	34
Management	29
Medicine: (Nursing (19) Doctor, chemist, dental technician, medical analyst)	24
Farm work: (farmers and farm labourers, orchardist, floraculturalist)	18
Office work: (accountants, computer analyst, secretaries and receptionists)	16
Sales Persons	15
Building Trade: (builders, painters, plasterers, electricians)	12
Driver	9
Cleaner	8
Professional Caregivers (children – (6) elderly	8
Social work	6
Law (Lawyer; Police Officers, Probation Officer)	4
Factory worker	3
Fitter and Welders	3
Engineer	3:
Freezing worker	2
Security Officer	2
Cartographers	2
Refuse Collector; Undertaker; Waterside worker, Machinist. (1 of each)	4

Of the above population 20 respondents stated that they were self employed.

The higher representation of what could be termed ‘professional’ occupations should not be interpreted as representative of all caregivers. There may have been a greater likelihood that this group would complete the questionnaire.

5. Changes in Employment Status

Employment Status	Count	Percent of 304
No Change	144	47.37
Changed	160	52.63

A change in their employment circumstances because of their new caregiving responsibilities was reported by 52.63% of the respondents. This group includes those who have retired and are now working part time in order to supplement their income, stating that superannuation does not adequately meet the increased financial needs of raising a young family.

“My husband had retired, he is 72. Now he works at the gas station pumping gas 3 days a week and also mows lawns to make ends meet.”

“In 1996 we sold our business to care for a needy new baby and a 15 month old. We could not resume, with considerable financial loss.”

“I had to give up a well-paid full time executive job to become a full-time Mum again.”

Other retirees also commented on the difficulty in managing financially and that the gaining of employment after the age of 65 is extremely difficult if not impossible in many cases. The largest number of respondents who experienced change was women who, after taking the children, had to move from full to part time work. Sixty five women stated that they had been forced to retire from their employment because of the care giving demands.

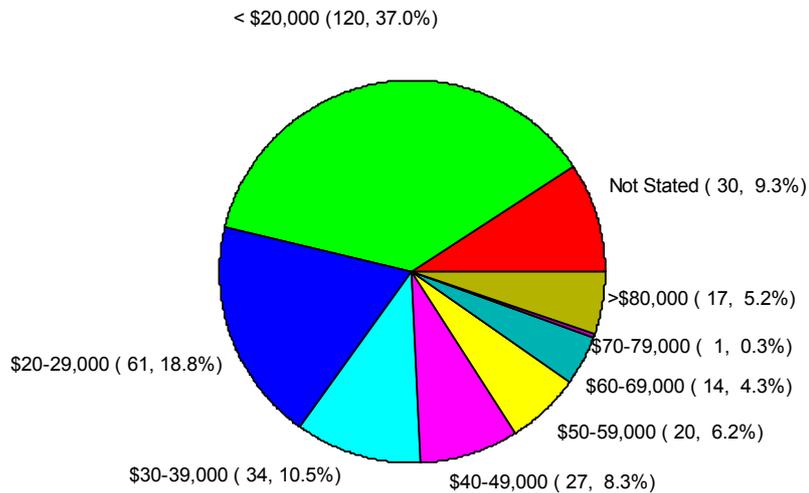
6. Income

6.1 Distribution of Income Levels

Income levels for the participants are reflective of the age distribution and the high number of beneficiaries. Total family income for 37% of the participants (the largest grouping) is under \$20,000 p.a.; with just 18.8% earning \$20-29,000 and 10.5% earning \$30 – 39,000. Less than one quarter (24.3%), have a stated income of **over** \$40,000 and 5.2% earn over \$80,000, reflective of the wide class representation of the sample. Thirty respondents (9.3%) declined to state their income. These figures do not include any benefits received for the child.

“I did not realize when I took the children on just how hard financially it would be. But somehow someone has to pick up these broken children and guide them. Back to their normal selves.”

Distribution of Income



6.2 Beneficiaries

Sixty four caregivers are supported by a benefit of some type, excluding universal superannuation

Benefit	Count	Percent of 316
Superannuation	119	37.66
Domestic Purposes Benefit	31	9.81
Sickness	4	1.27
55+	4	1.27
Unemployment	6	1.90
Invalids	18	5.70
Emergency	7	2.22
ACC	1	0.32
No benefit received	126	39.75

- Of the 31 respondents who stated that they received the Domestic Purposes Benefit, 16 have one child; seven have two children; two have three children, two cares for four; one cares for five and one cares for six children. Two caregivers currently have no children in their care.
- There are four caregivers on the sickness benefit, one of whom cares for three children, two who care for two children each and one who has the care of one child.
- Eighteen caregivers receive the Invalids Benefit, 11 care for one child each and seven for two children each. The one caregiver on the ACC benefit cares for four children.
- Of the four caregivers who receive the 55+ allowance, two care for one child each, one for two children each and one for four children.
- Those on the Emergency Benefit at the time of the survey numbered seven and, two were caring for one child, three caring for two children and two cares for three children each.
- The Unemployment Benefit supports six of the caregivers, five caring for one child and one who cares for two children.

Comments made by the caregivers to this question indicated financial stress.

“I would like to see retired Grandparents receive the same as the DPB as the UCB doesn’t even cover a pair of shoes!”

“I have gone from \$22.00 per hour full time to \$12.00 for 10 hours, plus the CYFS benefit.”

“Being on the DPB, my entire lifestyle has changed. I was working and we now have 2 mortgages on the house.”

One solo caregiver in the 40-49 years age group stated:

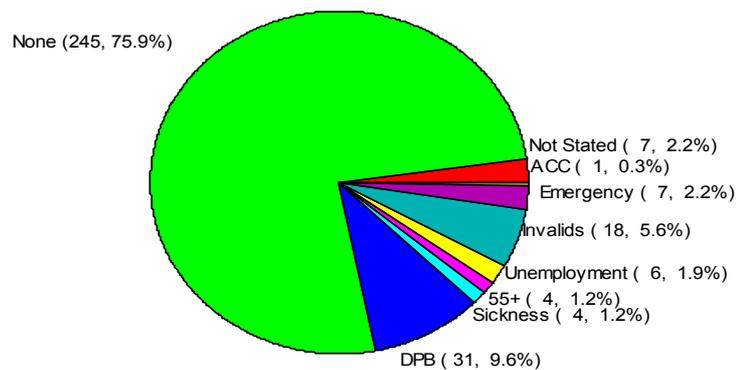
“Since taking the children I have gone from working 42 hours a week and earning \$650.00 weekly for just myself to \$200.00 per week to keep three of us.”

“I am on an invalids benefit and care for two special needs step grandchildren. It is pretty hard to manage on what I get.”

“I am getting poorer. I am now on the benefit after having to leave work to care for this child with Foetal Alcohol Syndrome.”

“Being on the DPB, my entire lifestyle has changed. I was working and now I am constantly battling financially.”

Distribution of type of benefit if any



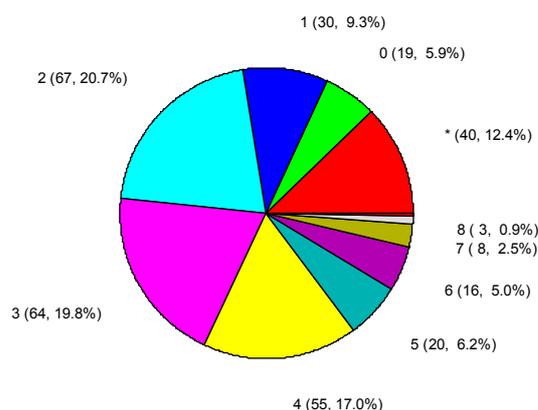
The respondents did not consider universal superannuation as a benefit, and this does not feature in the above pie chart. However, many superannuitants indicated that this was their

sole source of income. If those drawing superannuation are included in the analysis, there are more caregivers receiving some financial support from the State than not. The number of caregivers receiving invalids and sickness benefits (6.97%) is of note, when care giving responsibilities are taken into account, and the effect of that on both the caregivers and the children for whom they care. The 55+ benefit is available for those people who have retired, but are not old enough to receive universal superannuation. The rate is less than for those over 65.

7. Number of Own Children

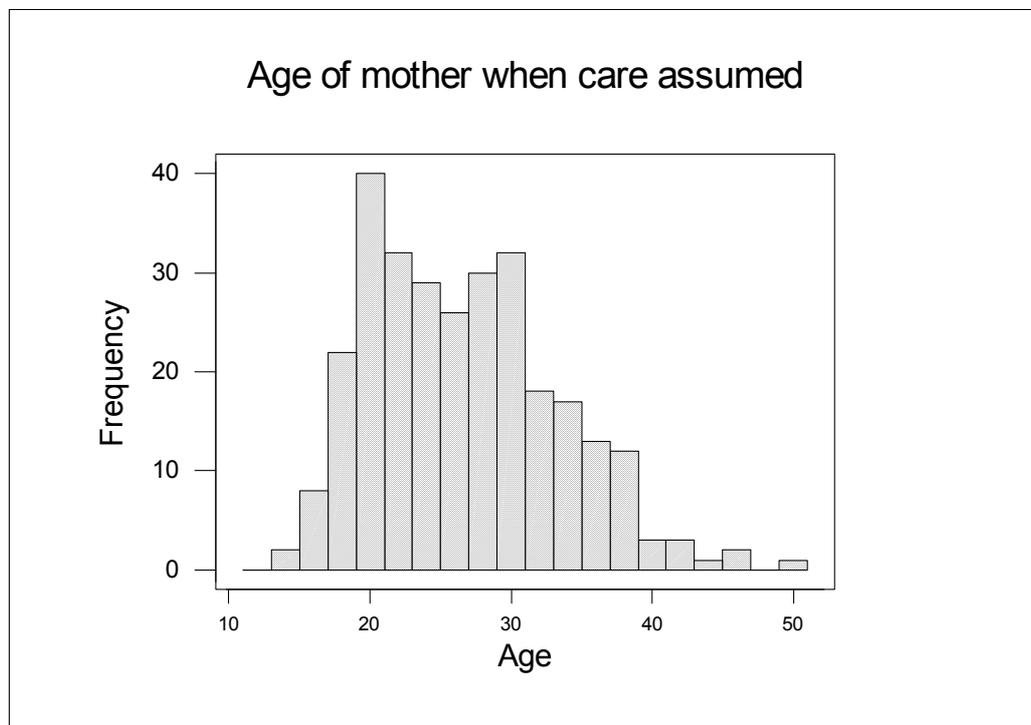
The number and ages of children in the original family of the caregivers was a question that was requested to be included by the pilot study participants. The issue was seen as important because of other family responsibilities caregivers have in addition to the kin children for whom they care. However this question does not capture all the other caregiving responsibilities of the caregivers, as some stated that they were also caring for aging parents and others had invalid spouses. The mean number of children in the caregivers' original family was 3.05 and the median 3.00. The minimum number was none and the maximum 12.

Distribution of own Children

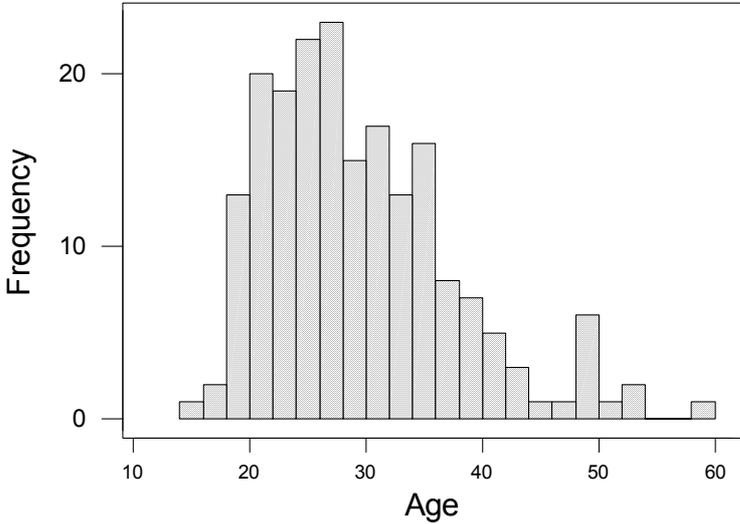


8. Ages of Biological Parents When Care Assumed

Caregivers in the pilot study also wished to test what they saw as a commonly held belief that the majority of children that came into their care were the result of adolescent pregnancies. The median age for the mothers of the children at time of entry to care is 25 years and the mean age is 26.14. The largest cohort for both genders is in the 20-30 year age group. For the fathers, the median age was 27 years and the mean age 28.97. The youngest maternal age at time of the child's entry to care was 13 years and the eldest maternal age was 50 years. The youngest paternal age was 15 years and the eldest 59 years of age. In the latter case, the mother of the children had died and the father remarried. The children are living with their grandmother.



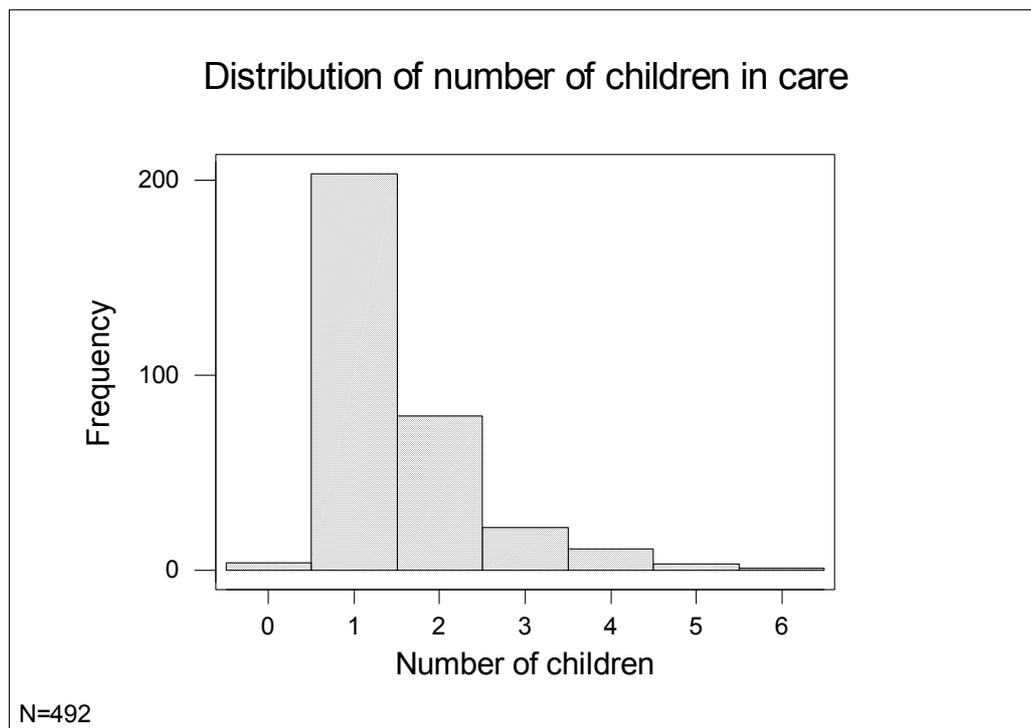
Age of father when care assumed



Section B: The Children

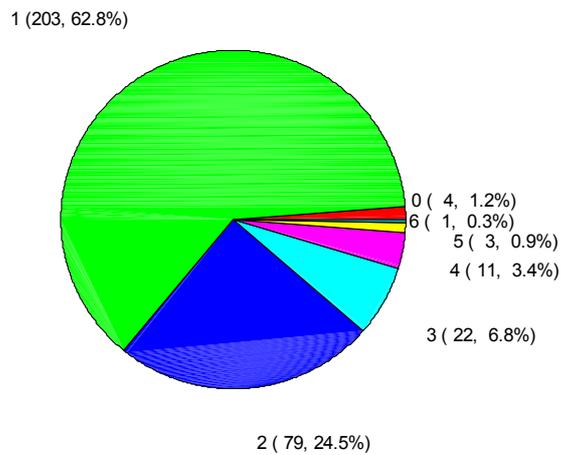
9. Number of Children Cared For

The majority of respondents (62.85%) are caring for just one child. Several of these respondents have previously cared for siblings that have recently returned to their parents, been placed with other extended family members; in the care of Child Youth and Family because of behavioural difficulties or gained independence. Four respondents currently have no children in their care. In some instances, the children were removed by Child Youth and Family under contested circumstances, and placed with other extended family members, some have returned to parents by court order and some have gained independence.

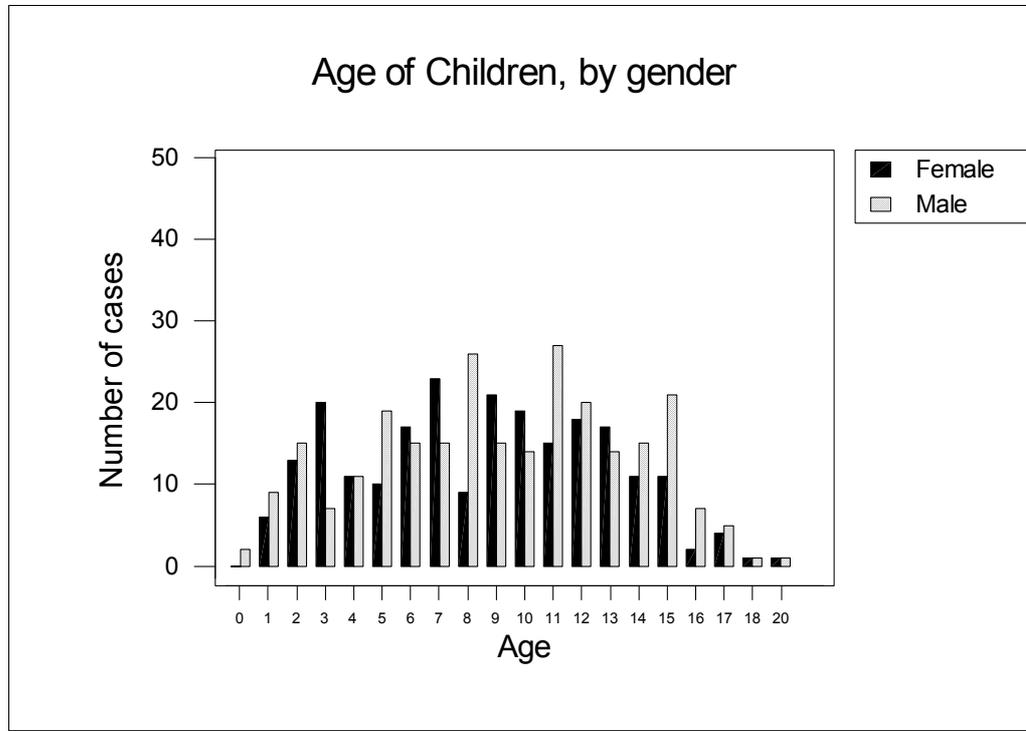


Research shows that children in kin care have a greater chance of remaining with siblings, and it is interesting to note the number of caregivers that have kept siblings together. Seventy nine caregivers have two children; 22 caregivers have three children; 11 have four children; three families have five children and one solo grandmother is caring for six grandchildren from two different families. While six is the highest number of children cared for by the study respondents, at a recent gathering of GRG Trust support group members in Auckland, two sets of caregivers were raising nine and eight children respectively. Young persons over the age of 18 are likely to have a disability. Twins account for 3.72% of cases (12 sets of twins): 24 children out of 492 (4.9%) of children.

Distribution of no of grandchildren



10. Gender and Ages of Children in Sample



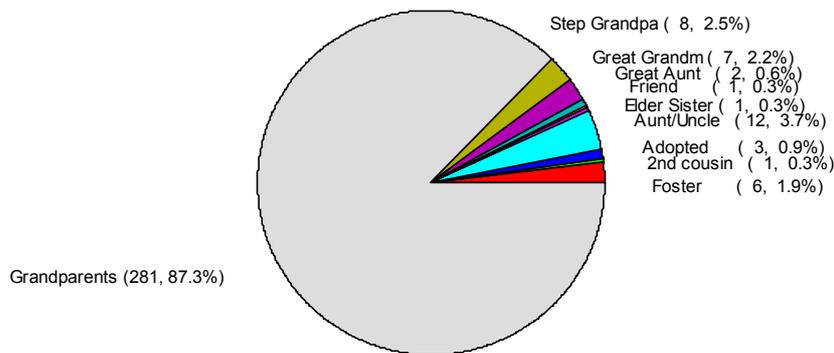
The mean age of the children is 8.8 years and the median 9 years

11. Relationship of Caregivers to Children

The kin caregivers in this sample stretch across four generations - a sister, aunts and uncles, grandparents and great aunts and a great grandmother. As would be expected by the data source (GRG Trust support group members) the largest kin cohort is that of grandparents. (n.284 - 85.09%). Thirteen are aunts and/or uncles of the children, and nine are step-grandparents. Moving into the next generation, seven caregivers are great grandparents to the children and three are great aunts. Two caregivers are adoptive grandparents, i.e the parents of the children were the adopted children of the caregivers. One elder sister has assumed custody, as had one second cousin and one friend or fictive kin. Six sets of unrelated foster parents have assumed formal guardianship of children who were under the previous

guardianship of Child Youth and Family. This situation arises out of a directive of the CYPF Act to seek permanency for children who are unable to return to their families. They have sought membership of the GRG Trust organisation because it is seen as being able to offer support not now available from the State since obtaining guardianship. Out of the 323 responses, 327 relationships have been accounted for as grandparent/step-grandparent couples.

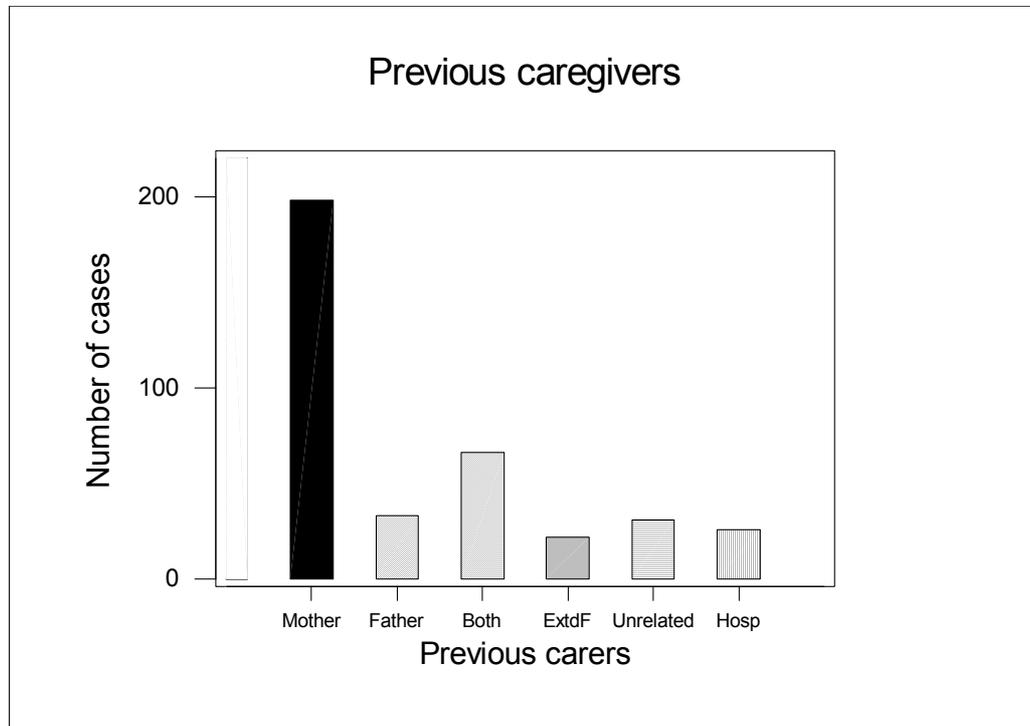
Distribution of relationship of carers to children



12. Previous Primary Caregivers of the Children

The children have come into grandparent or other kin care from a variety of sources, but by far the greatest number (n.198, 61.30%) have come from the child’s biological mother. Significantly fewer children have come from both parents (n.66, 20.3%) indicating parental relationship breakdown is a common feature for this sample. Thirty three children were in the custody of their fathers, (10.2%) and 31 (9.60%) children have come to relatives from non-relative care, presumably foster care. Twenty two (6.81%) have come from other extended family and 26 (8.44%) have come to extended family care from the hospital, as newborns.

Moving around within the extended family itself is a feature of kinship care that has been identified by other researchers (Worrall, 1996, Conolly, 2003).

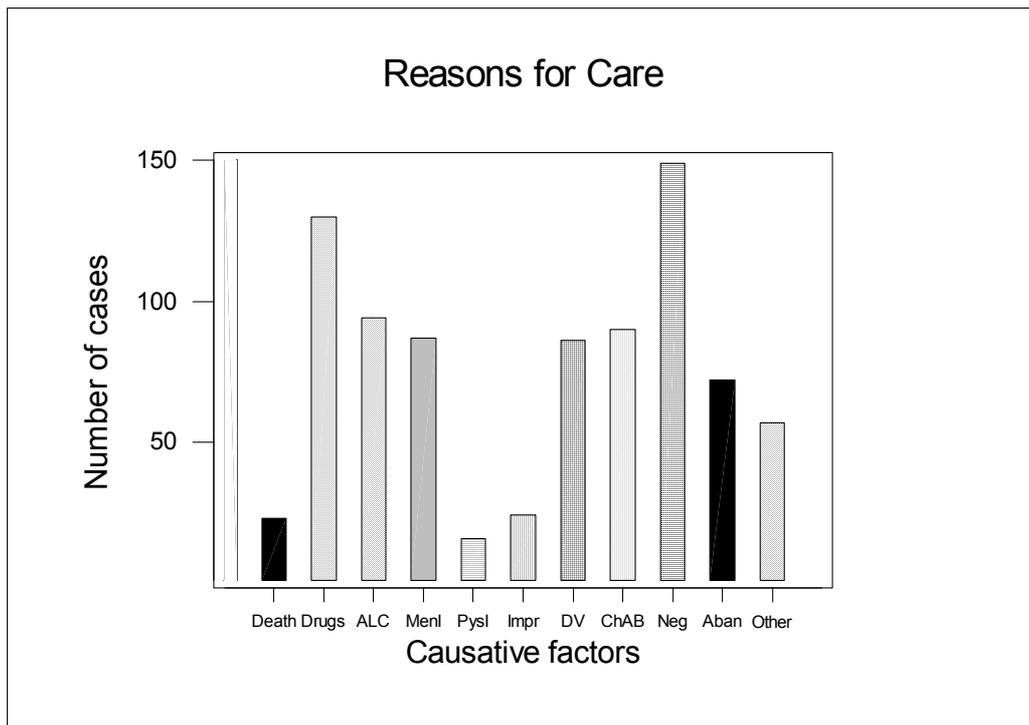


13. Reasons for Assuming Care

The caregivers were asked to list all the parental issues contributing to the need for care, and were given a list of 10 named variables and an 'other' option. Most respondents listed several contributing factors, for example, drug and alcohol use, neglect and domestic violence all being cited. This being the case, the percentages cited do not add up to 100.

Neglect, cited in 149 (46.13%) of cases, is a co-existing state with many other variables, however in some instances, it was cited as a sole reason. Excluding neglect, drug abuse is the most common reason given, cited in 130 cases (40.25%) followed by alcohol abuse (n.94, 29.10%), child abuse (n.92, 27.86%), mental illness (n.87, 26.93%) and domestic violence, (86, 26.83%). Twenty four cited imprisonment as the key factor, and 16 cited the physical illness of the childrens' parents. Abandonment was cited in 72 cases (22.29%) and this was

frequently abandonment at birth, although some respondents described how the children were taken for a short agreed period of time and the parents absconded or failed to collect the children. Death of a parent was cited in 23 cases (7.12 %) and this was described variably as due to domestic violence, suicide or illness. Several recent kinship care studies have identified drug abuse as the most common factor contributing to the need for care. Other reasons given were intellectual disability of the parent, inability to cope, rape of the mother, teen-age pregnancy, another baby on the way, new step-parents not wanting the children and gang association.

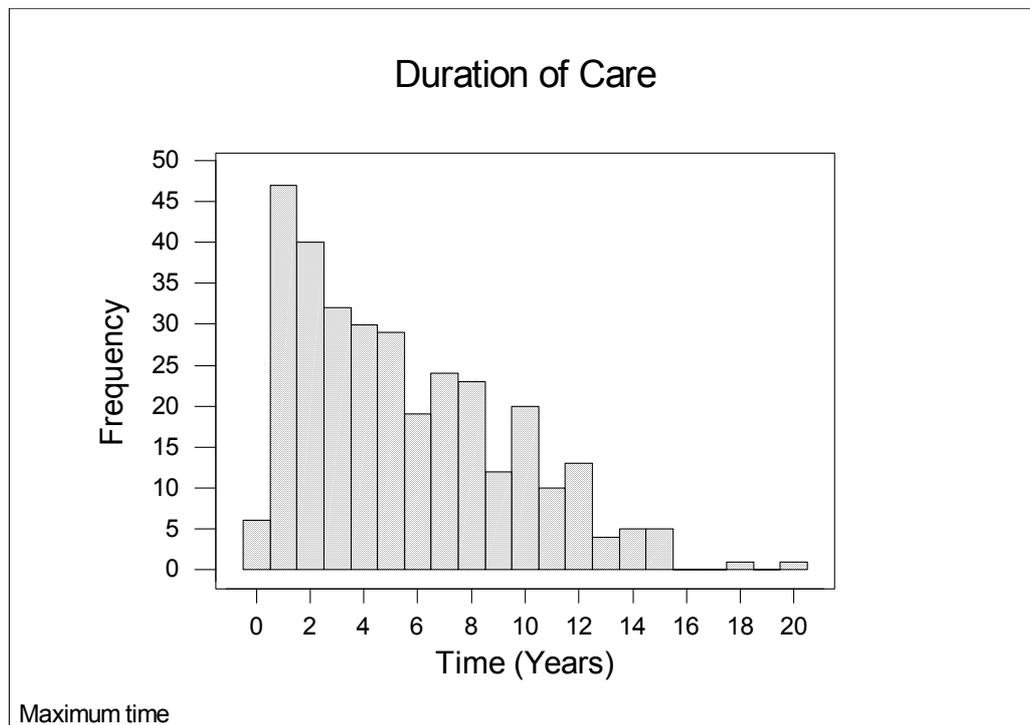


Key:

Alc	Alcohol	MenI	Mental Illness
PysII	Physical Illness	Impr	Imprisonment
DV	Domestic Violence	ChAb	Child Abuse
Neg	Neglect	Aban	Abandonment

14. Duration of Care

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 (Greef, 1999; Berrick, 2000; Kortenkamp & Earle, 2002). Webster, Barth and Needell's longitudinal study also found a significant likelihood of placement stability for children placed with kin (Webster, Barth & Needell (2000). Several studies have found that a number of grandparents have taken responsibility for their kin children since birth (Minkler & Roe 1993). Almost one quarter (n.78, 24.84%) of the caregivers who answered this question (n.314) has been caring for the children since birth for a variety of reasons. Drug abuse, mental illness, abandonment, parental incapacity or incapability has been cited in these cases. Some caregivers described being called to the hospital to collect a child they had not known existed until that point.



The mean length of time in care to date for the children in the sample is 5.4 years and the median 5.00 years. A large scale study of New Zealand children in stranger foster care

published in 1981 (McKay 1981) showed that for every five years in the care system, children were experiencing an average of 6.5 placements. The children in this kinship care study are experiencing a far greater measure of stability than previous studies show. Commentators have suggested that these two populations are not comparable because of a range of factors (Worrall, 1996). However, such a comparison is important in terms of the level of security achieved and the continuance of attachment relationships for the children placed with family. Attachment research literature strongly confirms that relational security is central to ensuring positive outcomes for children across the developmental trajectory of childhood (Howe, 1995; Whitelaw Downs et al, 2004).

15. Ages of Children When Caregivers Commenced Care Formal or Informal)

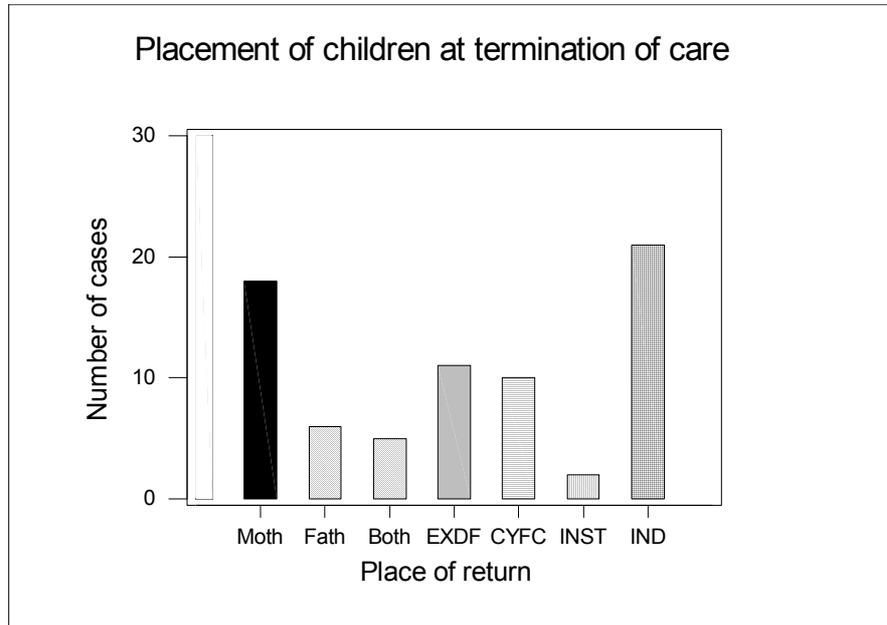
Seventy five out of 492 children (15%) were placed with caregivers within three months of birth. Eighty children were below one year. One caregiver took over the care of three children, all at birth, eight took two, and fifty-six took one. A grandmother took an eight weeks premature baby into her care at 3 weeks and another took the child into their care within two hours of birth.



16. 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 are more likely to be maintained in kin care and achieve permanency and continuity of family and community relationships (Greef, 1999, Berrick, 2000, Webster, Barth and Needell, 2000). Additionally some researchers have found that kinship care may minimise disruptions as children are re-placed within the extended family itself, (Worrall, 1996, Hunt 2003). Worrall (1996), in her small New Zealand study found that there was movement of children within the extended family itself, and Connelly (2003) also cites studies where children were with other family members, particularly biological mothers.

Sixty three respondents (20.19%) stated that children had left their care and the majority of these respondents are still caring for other siblings or other kin children, while 79.81% have had no children leave their care. Of those who had left (73 children), 18 returned to their mother's care, 10 to Child Youth and Family, 11 to other extended family, two to institutional care, six to father, five to both parents, and 21 have gained independence. Whether the move to independence was a natural developmental progression or as a result of disruption is not known. This issue deserves further study.



KEY: Moth Mother Fath Father Both M&F EXDF Extended Family
 CYFC Child Youth & Family Care INST Institution IND Independent

“The children have now gone to live with their aunty, my daughter. I couldn’t cope any more. Our health is failing, - my husband in particular, and I don’t have the energy any more.”

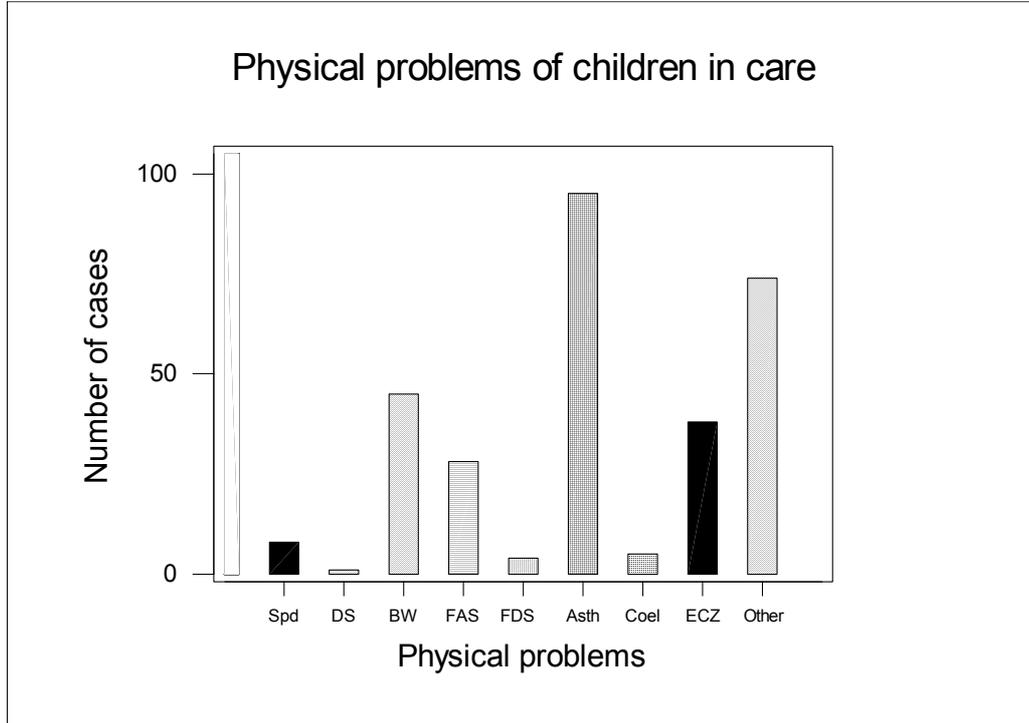
17. Physical and Emotional Well-being of the Children

International kinship care studies show that children placed with extended family, who have suffered any form of abuse and/or neglect, including being subjected to intra-uterine drug and alcohol exposure will have health problems, both physical and psychological (Dubowitz et al,1993, Dubowitz, 1994; Hegar and Scannapocio, 1995; Greef,1999). Recent international kinship care studies have found that children placed in the care of stranger foster parents and children placed with kin had similar levels of health and behavioural difficulties. Specifically, the children suffered from failure to thrive, asthma, eczema, attention deficit syndrome, (ADD/ADHD), hyperactivity, bed wetting, and many behavioural problems (Dubowitz,1993; Dubowitz,1994; Hegar and Scannapieco,1995).

The respondents in this study were asked to identify what problems the children in their care had experienced, and what interventions they had been able to access to assist in the care of these children. The questions did not ask the respondents to list the issues for each child in their care; therefore the incidence could be higher if more than one child in the family experiences the same problem.

17.1 Physical problems of children

It was identified by 274 respondents that their children had experienced some form of physical illness or disability either currently or in the past. Forty-nine respondents either stated there were no problems or failed to answer the question. Asthma was the most common physical complaint noted listed by 30 % of respondents. Thirty-eight (11.6%) stated that their child had eczema and these conditions were sometimes co-morbid. Chronic bed wetting was noted to be a current problem by 14% of respondents, although several noted that this had resolved either as the child matured or in response to a settled environment. Eight respondents cited a severe physical disability and respondents noted that some were wheel-chair bound and several of these children qualified for 28 day respite care. One child has Down's syndrome and 28 (8.67%) have been diagnosed as suffering from Foetal Alcohol Disorder. Four have Foetal Drug Disorder and five have Coeliac Disease. Seventy-four respondents noted other physical complaints than those listed in the questionnaire. One grandparent describes her grandchild as having severe multiple disabilities - blind, epilepsy, probably caused by infant vaccinations. Some of the 'other' conditions noted were talipes, deafness, blindness, scoliosis, premature lung disease, prematurity with one kidney and no bladder control, speech problems, tongue tie, soiling and lactose intolerance.

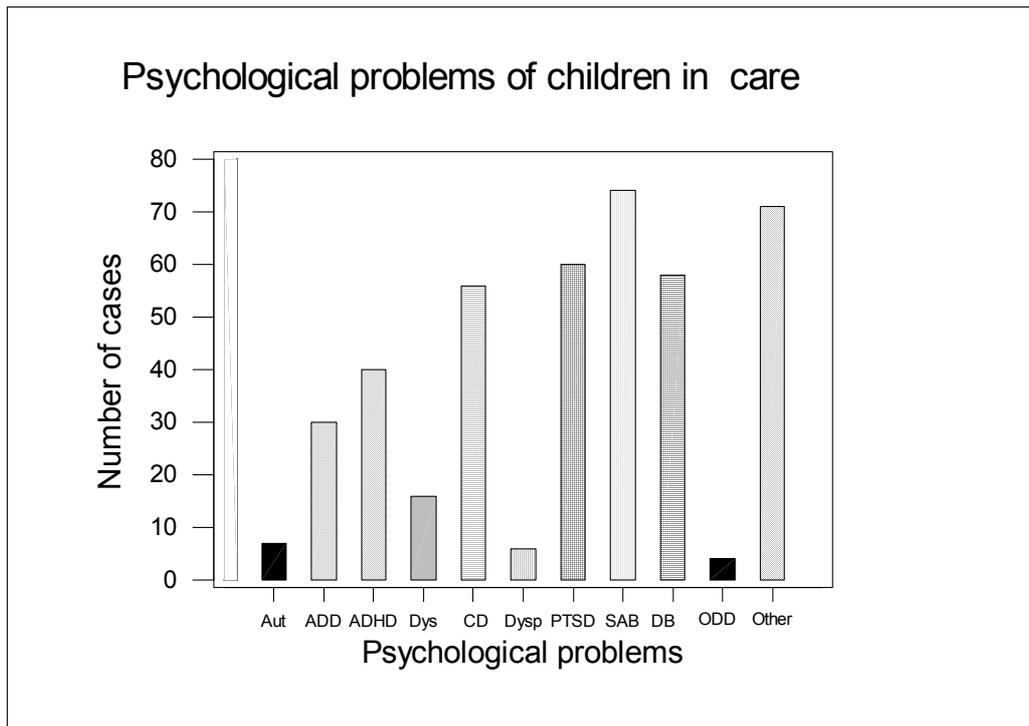


Key	SPD	Severe Physical Disabiity	DS	Downs Syndrome
	FAS	Foetal Alcohol Syndrome	FDS	Foetal Drug Syndrome
	Asth	Asthma	Coel	Coeliac Disease

17.2 Psychological problems

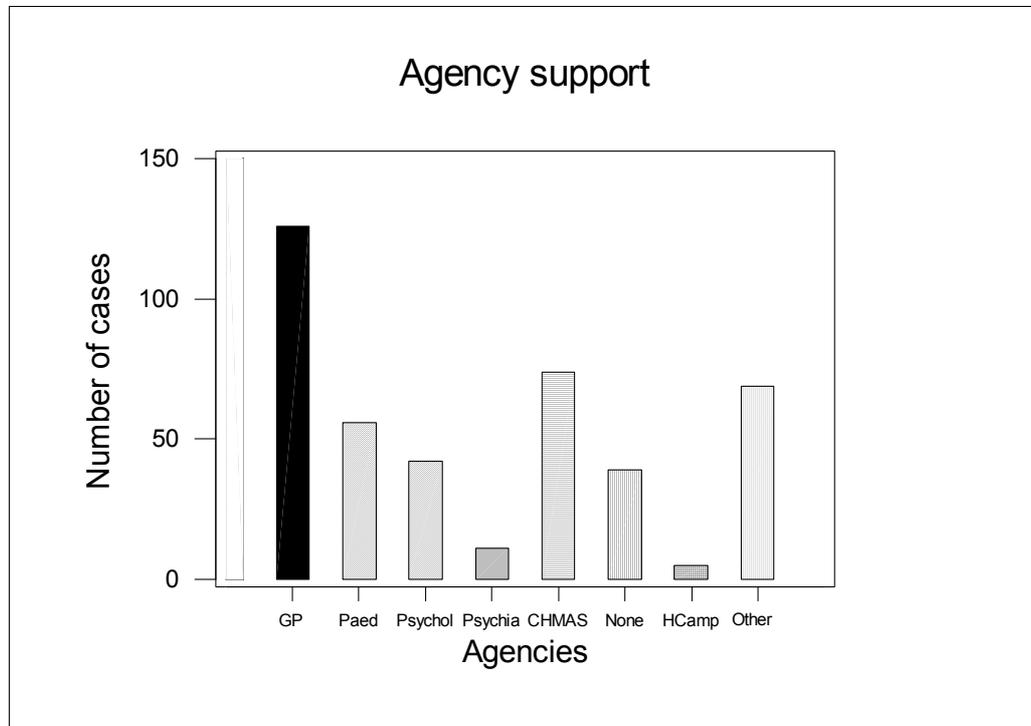
More respondents noted the presence of psychological difficulties than physical issues. Seventy four (22.91%) respondents stated that the children in their care exhibited severe aggressive behaviour and 58 (18%) stated that the child was destructive towards their property and that of others. Fifty six respondents (17.34%) cited that their child/ren had been diagnosed as having Conduct Disorder, however, whether this was an actual DSMIV diagnosis was not recorded. Thirty children (9.29%) were noted as having Attention Deficit Disorder, and 40 as having Attention Deficit Hyperactive Disorder (12.38%), some caregivers noting that the children were receiving medication for these conditions. Seven children were recorded as having some type of autism and Post Traumatic Stress Disorder was considered as an explanation for behavioural problems by 18.58% (n.60) of caregivers. Six children had dyspraxia and four had Obstructive Defiant Disorder. ‘Other’ conditions noted by the caregivers were eating disorders, reactive attachment

disorder, learning disabilities including dyslexia, skin shredding, paranoid obsessional disorder, developmental delay and night terrors.



Key	Aut	Autism	ADD	Attention Deficit Disorder
	ADHD	Attention Deficit HyperactiveDisorder	Dys	Dyslexia
	CD	Conduct Disorder	Dysp	Dyspraxia
	PTSD	Post Traumatic Stress Disorder	SAB	Severe Aggressive Behaviour
	DB	Destructive Behaviour	ODD	Oppositional Defiant Disorder

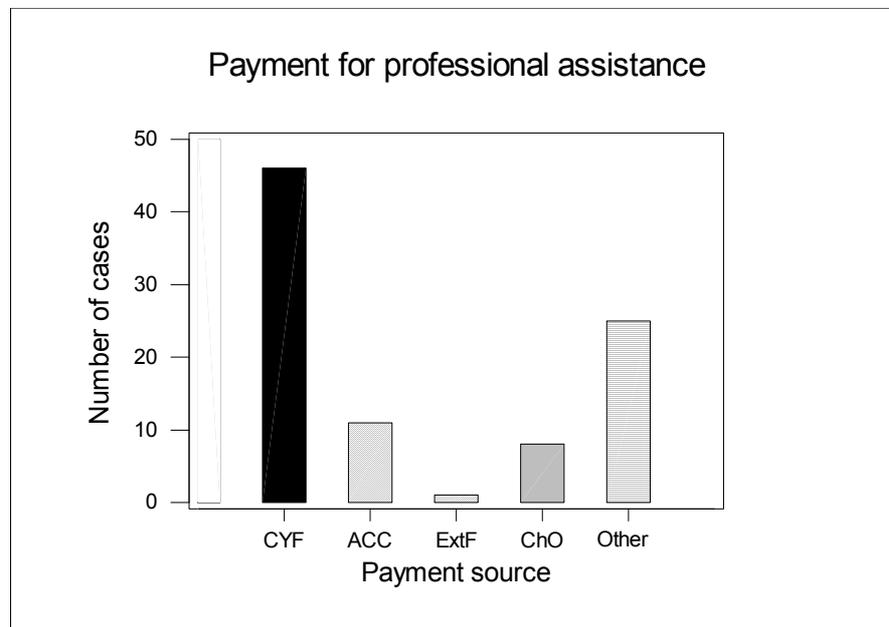
18. Professional Assistance and Support



The TFOPP (1990) study revealed that little effort was made by workers to assist caregivers to gain access to support or remedial services. However, the caregivers seldom sought help from social workers on this issue, not seeing them as a resource. The respondents in this study were asked what help they had been able to access to assist with the physical and emotional challenges they faced. Respondents ticked all the services they had accessed. The General Practitioner was the most likely source of help (n. 126, 39.01%). The Child and Adolescent Mental Health Services were accessed by 74 respondents (22.91%) and 56 (17.34%) had consulted a paediatrician. Forty two had engaged the services of a private psychologist and 11 had been to a child psychiatrist. Only five caregivers stated that their children had been to Health Camp. Thirty nine caregivers (12.07%) stated that they had not been able to access any help. Other avenues of assistance mentioned were Barnardos, Parentline, Counselling, School, CCS, Speld, and speech therapists.

19. Financial Assistance

A high number of the children have psychological and physical disabilities and in many cases the grandparents/caregivers have not been able to access financial help and have had to pay for specialist fees themselves. Two hundred and two out of the 259 respondents to this question stated that they had not been given financial aid to pay for professional assistance, while only 57 stated that they had been given assistance. Some respondents ticked more than one box, accounting for different children in the family receiving payment from different sources. Ninety one children in total had received help. Of those who had gained assistance, Child Youth and Family had assisted 46 children, ACC payments were received by 11 children and eight families had sought help from other charitable organizations. Twenty five respondents stated that they had received assistance from other sources. Only one respondent stated that they had received financial assistance from the extended family. Worrall's small scale New Zealand study found that although other extended family members had promised assistance at the Family Group Conference, this rarely eventuated. This was explained by the fact that other family members had problems of their own, unemployment being the most frequently mentioned (Worrall, 1996).



Key	CYF	Child Youth & Family	ACC	Accident Compensation
	ExtF	Extended Family	ChO	Charitable Organisation

20. Changes Observed in Children Since Care Commenced

Two hundred and sixty (86.38%) of respondents stated that they had observed changes in the child since taking custody. Forty one (13.62%) stated that they had not observed any change and there were 22 non responses. While most of the changes noted were positive, some felt that the child's emotional state and consequent behaviour was becoming worse, rather than improving. Some respondents did not identify any particular physical or psychological problems, as previously specified, but in this question described general behavioural characteristics such as impatience, aggression, forgetfulness and an inability to cope with stress.

She has learned to walk properly,(initially she could only walk a short distance), to swim reasonably and with speech therapy she can speak much better. When she came into our care at 4 years she could barely speak. She screams much less (FAS child who has been in grandparents care eight years)...

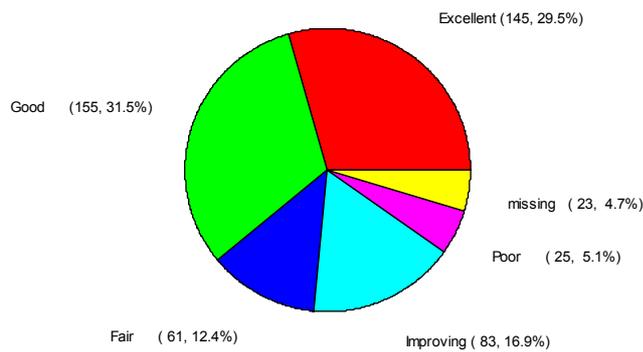
21. Educational Progress

Sawyer and Dubowitz (1995), studied a sample of 372 children in an urban public school system, who had been formally placed with relatives by the State, to assess their educational attainment. The median age of the children was 9.4 years, and the median length of time in care was 2.3 years. It was found that many children in kinship care appeared to have serious school performance difficulties, compared to their peers. Forty-one per cent of the children in kinship care and sixty-three percent of the adolescents had repeated one or more grades.

The respondents in this study were asked to rate the educational progress of the children since they had been with them. As demonstrated in the pie graph below, the majority of caregivers (61%) assessed that their child was doing very well since coming into their care, in contrast to the literature. Out of the 469 children who were accounted for in the responses, 300 were assessed as making excellent or good progress. Eighty three were noted to be improving and 61 were assessed as fair. Twenty five children were considered to be achieving poorly. As would be expected, progress appears to be related to the degree of psychological and physical problems and

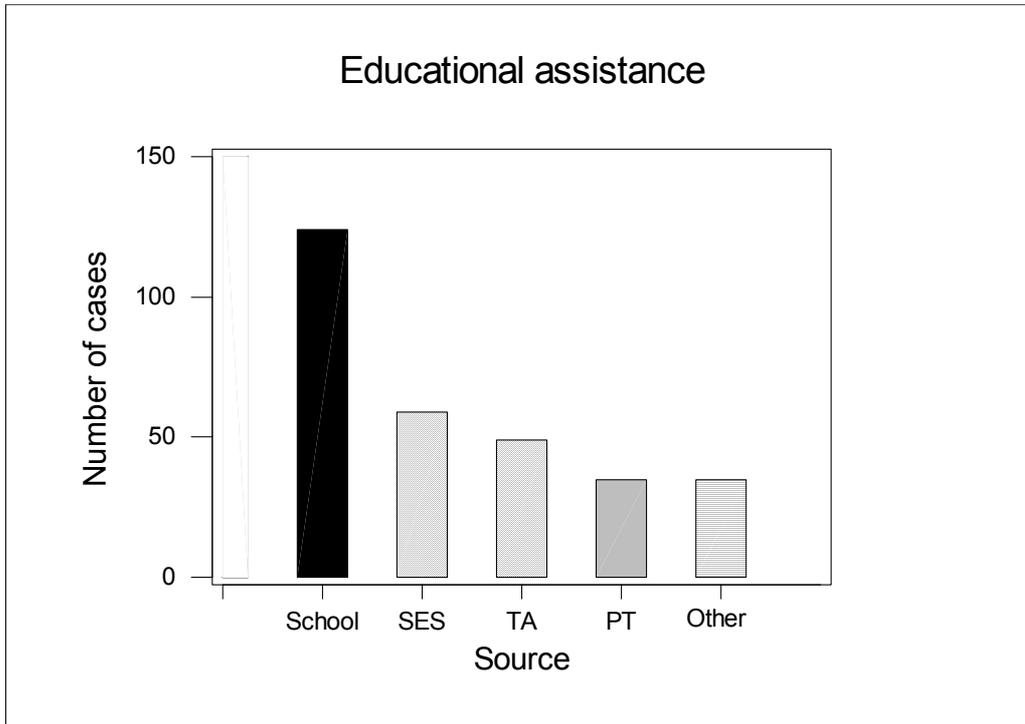
length of time in kin care. Cross tabulations were undertaken between length of time in care, ethnicity and financial status and educational progress, however, no relationships between educational progress and any of these variables could be established.

Distribution of state of progress



22. Educational Assistance

The school has been cited as the highest source of assistance given, with 38.39% of respondents giving credit to the teaching received. Fifty-nine children had been under the care of Special Education Services (18.27%) and 49 had been assigned Teacher Aid assistance. Thirty five caregivers said that they had not accessed any help .One stated that no one could help and the school expelled her giving no assistance. Other help received was noted by 35 respondents and frequently mentioned was Resource Teacher, Learning and Behaviour (RTL) teachers and Linmark. Ease of access to school teachers, frequency of contact and their availability may be the reason that the school is cited as the support most frequently accessed as compared to other services – that may be more appropriate, but less accessible.



Key: SES Special Education Services

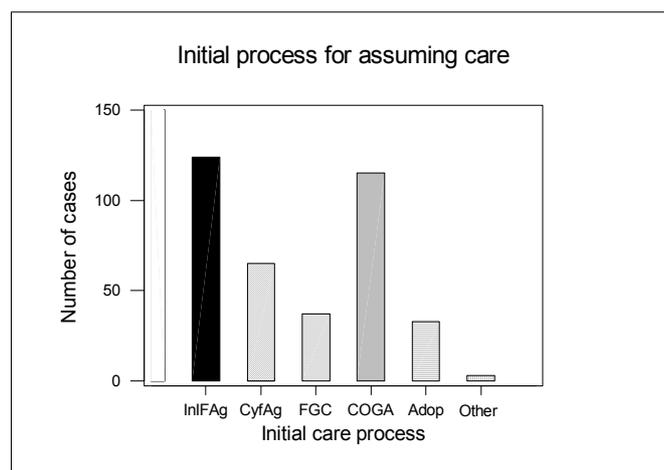
Section C: Legal Issues

The establishment of legal status for kinship caregivers is seen by most international commentators as complex and problematic and it has been suggested that permanency options, such as guardianship, adoption and even formal custody, distort natural family relationships (Worrall, 1996, Leos-Urbel, 1999, COTA 2003). McFadden,(1993) commented on the fact that the 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. However, against these arguments is a need to secure safety, stability and permanency for the children and their caregivers, particularly when challenged by capricious biological parents. Many respondents in this study expressed their need for legal protection, but commented on the fact that they found the legal system frustrating, confusing and very

expensive. Such comments have also been made recently by Australian grandparents in the same situation (COTA, 1993) and in particular, issues in regard to access rights, custody and legal aid mirror the concerns of the participants in this study.

23. Initial Process for Assuming Care

The initial agreement under which the children came into care was related to the underlying risk factors that provoked the need for protection. Five alternatives were given and caregivers were asked to tick only one box. Some ticked two boxes because they had more than one child who was under a different status. It is interesting to note that 124 caregivers (38.39%) initially took the children by informal agreement with the child’s parents, without any formal intervention of Child Youth and Family. These caregivers had often cared for the children for extended periods of time, prior to care becoming permanent, as they tried to support the biological parents to care. Sixty five (20.12%) respondents assumed care through the drawing up of a Family/Whanau Agreement through Child Youth and Family, after a social work investigation. Thirty seven caregivers assumed care after a formal Family Group Conference under the CYPF Act. One hundred and fifteen caregivers assumed care by means of a court order obtained under the Guardianship Act 1968 (“Guardianship Act”). Of the eight other categories, three stated adoption was how the children came into their care. This has been interpreted as a misunderstood question.



Key: Inl Fag Informal Family Agreement CYF Ag CYF Family/Whanau Agreement
 FGC Family Group Conference COGA Custody Order (Guardianship Act)
 Adop Adoption

24. Current Legal Status

The information received from the survey participants in regard to current legal status under which care is taken, shows a shift to permanency, as would be expected under the CYPF Act. Respondents were able to select more than one box to indicate both custody and guardianship status. Sixty eight caregivers (21.05%) have no formal legal status. Of these, 48 had informal family agreements initially. The remaining 20 could be children who have since left care or missing data. Seventy eight of the 124 who began care with an informal agreement have since assumed a legal status. One hundred and fifty eight (48.92%) have a custody order under the Guardianship Act, 73 have shared guardianship with the biological parents and 49 have shared guardianship with Child Youth and Family. Four have formally adopted the children and eight are whāngai¹. In seven cases, Child Youth and Family have interim custody and the children are in kin/whanau care. Some grandparents have no formal custody status, but informal agreements for a variety of reasons. Some grandparents feel that the children are safer this way and the parents will bring the children to them when there is a need, such as psychiatric illness or domestic violence. Should the grandparents seek custody or report their concerns to Child Youth and Family, the parents would, in all probability, contest that and the safe haven for the child would be endangered. This situation often results in placements with grandparents that are inconstant by nature, while at the same time representing a long term scenario during some stages of the child's growing up period. Several respondents have commented that they did not consider that the lawyer or counsel for the child understood the issues and others have commented that they felt that the judge was not listening or 'was in a hurry.'

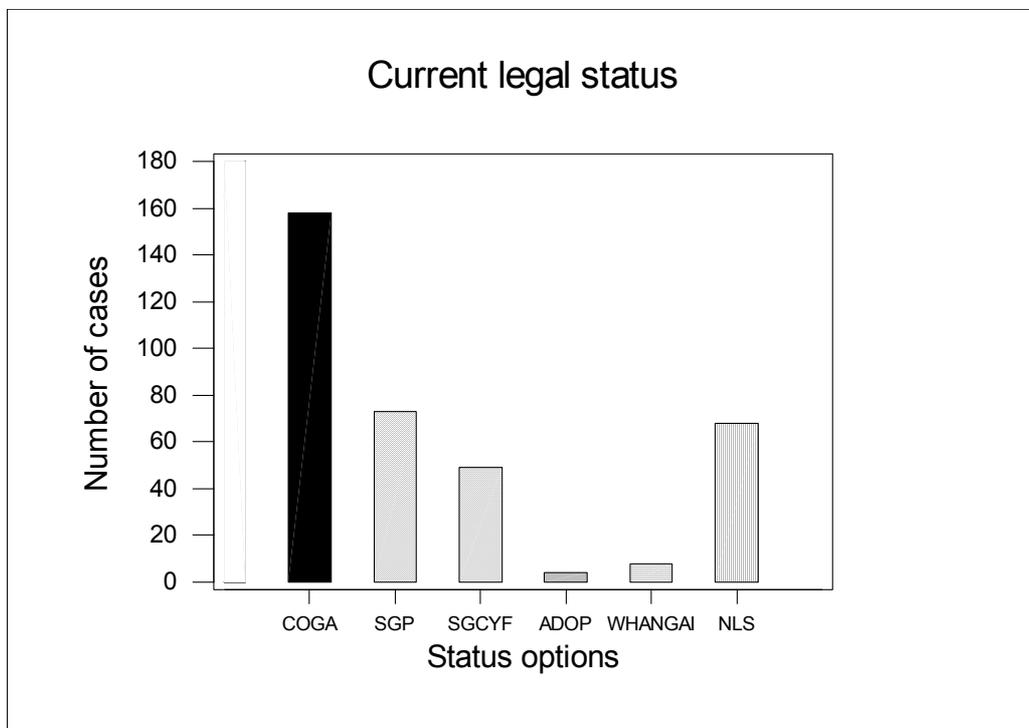
We have never considered taking legal steps as we were not impressed when we attended a family court sitting because our daughter was not well and saw how things were handled and how the lawyers failed to address issues, although payment was expected at a level we could not have considered.... The judge made a decision that was not to anyone's satisfaction and it appeared he was only interested in finishing as quickly as possible. My daughter was

¹ Whāngai is a customary Maori concept of assuming total care of a child who may or may not be related to the caregiver, usually either whanau or whanaunga. It is usually considered to be a permanent status. The literal translation of whāngai is to feed or nurture

granted Legal Aid, but in the end the charge was recovered from her estate after her death and it was her child who was penalised because of this.

In this case, the daughter committed suicide after the father was given custody.

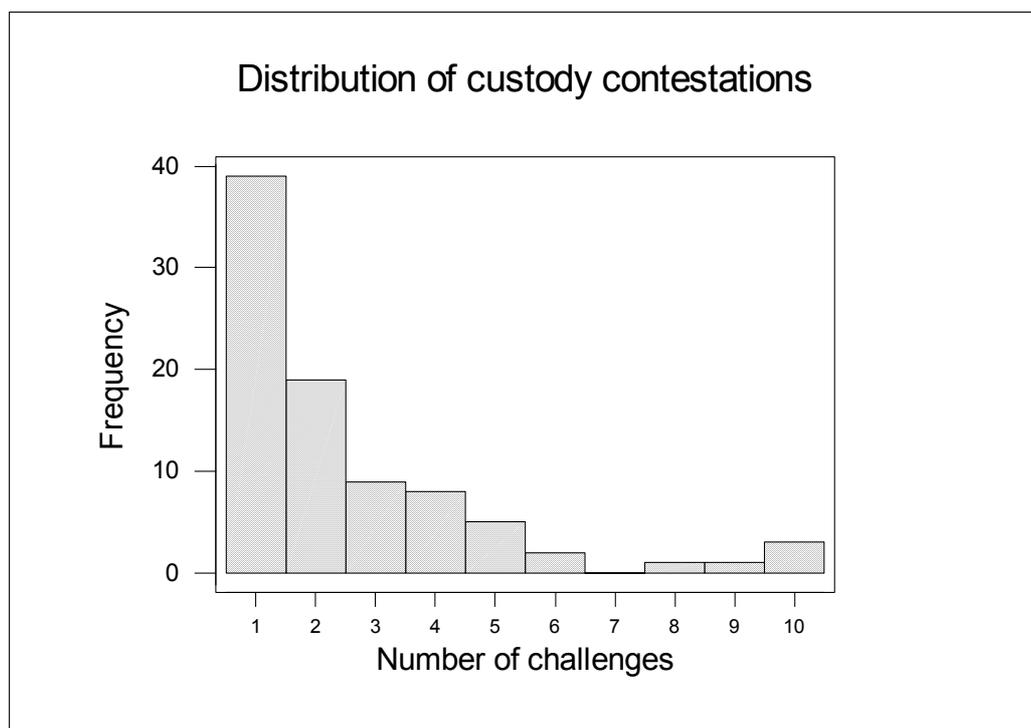
False information was given by CYF and Counsel for the child. We were told it was compulsory to secure legal custody, now we know it isn't so. CYF refused financial assistance and would not consider us as foster parents.



Key: COGA Guardianship Act Custody Order SGP Shared Guardianshipwith Parents
 SGCYF Shared Guardianship with Child Youth and Family ADOP Adoption
 WHĀNGAI see footnote 1 NLS No Legal Status

25. Challenges to Legal Status

Anecdotal evidence from the GRG Trust support group members obtained over the past five to six years has indicated that a considerable number of caregivers have to face constant legal challenges to their custody and guardianship status. Almost one third of the respondents have been in this position. While permanency is the desired goal for children ongoing challenges are counterproductive to achieving that goal. Neither the caregivers nor their children can rest assured that the placements are secure. One hundred (32.57%) of the 307 respondents to this question have faced legal challenges and some are still experiencing the ongoing stress associated with it. Two hundred and seven stated that they have not had their care challenged. Sixteen caregivers did not complete the question.



26. Continuation of Legal Challenges

Caregivers were asked if custody and access arrangements were still being contested in court. Sixty three caregivers (19.52%) answered this question affirmatively. Two hundred and forty three (80.20%) responded negatively and one respondent stated that they were unsure whether this was the case. Twenty participants did not answer the question. The length of time it takes to get a hearing has also been mentioned by caregivers. More importantly, the fact that the biological parents can keep taking the matter to court means that the stress is on-going and cumulative. The caregivers were asked the length of time the case had been before the court, and how long it took before the court settled care arrangements. The length of time that the matters had been before the court varied, the length of time the child had been with the caregivers being a dependant variable, therefore the data is not comparable. However, it is apparent that many caregivers face on-going litigation that has cost them much in terms of financial and psychological stress.

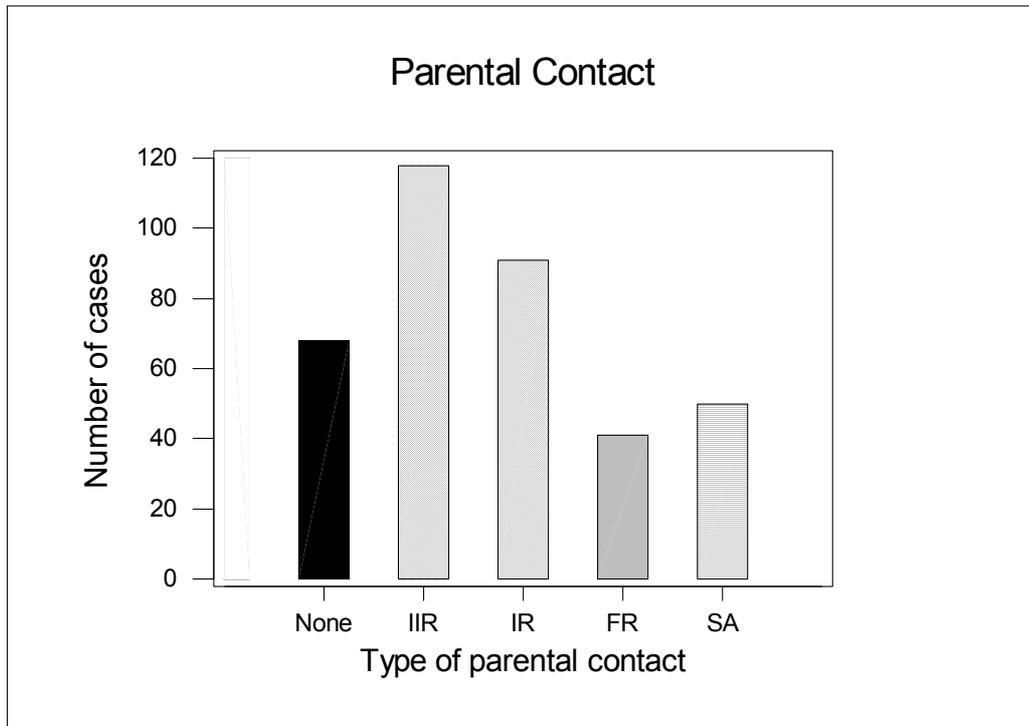
Length of time cases have been before the court	
Period	No. of Cases
0-6 months	9
6-12 months	20
12-18 months	6
18 – 23 months	0
2-5 years	17
5-10 years	5
12 years	1
16 years	1

Of the sixty three responses received to this question four responses were non-specific, one stating that the issue came before the court every six months and three emphasizing the on-going nature of the contestation of custody.

Where care arrangements have been settled, the length of time it took to receive a final order was also questioned. One hundred and twenty five responses were received to this question. Many cases were settled immediately, the longest period of time cited was 16 years.

Time Taken to Settle Care	Number of cases
Immediately	11
Within one week	3
Within one month	6
Two to six months	28
Seven to 12 months	19
12 to 18 months	11
18 months to two years	1
Two to five years	19
Six to ten years	6
Sixteen years	1

27. Children's Contact with Parents



KEY IIR Informal irregular IR Informal regular
FR Formal regular SA Supervised access

The importance of children remaining in contact with their biological parent in terms of their well-being and likelihood of return to parental care has been well documented over decades (Worrall,

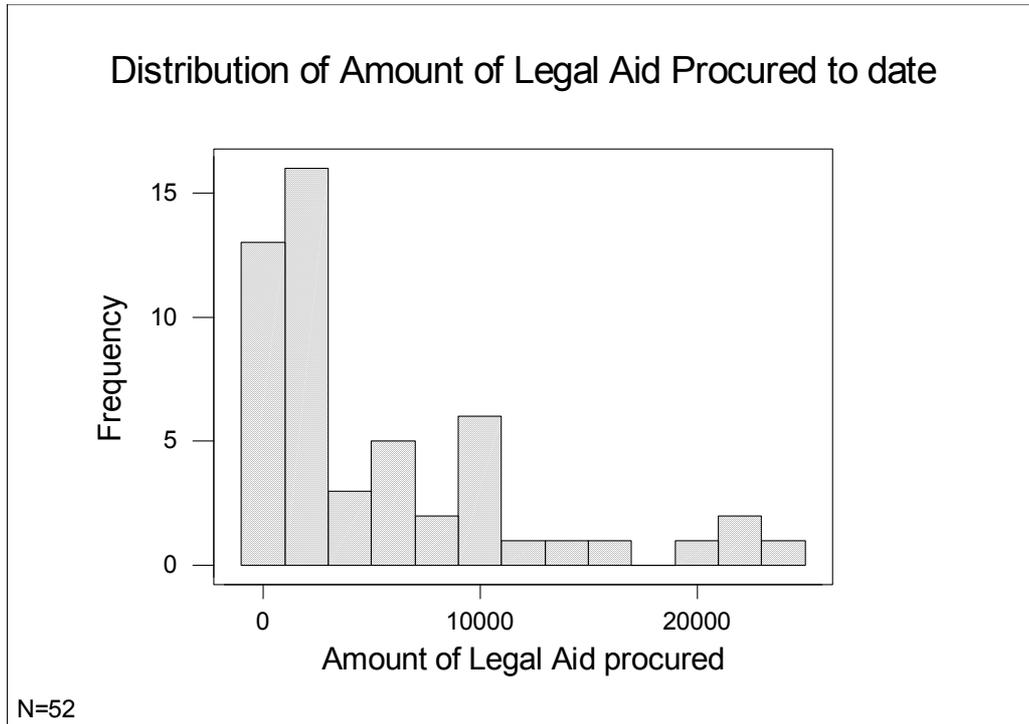
1996). Contact is far more likely in kinship care than stranger foster care (Greef et al 1999). However, international commentators have also stated that the reason for care needs to be considered when the type and duration of contact is decided, and the wishes of the child taken into account while maintaining safety.

Sixty eight (21.05%) respondents reported that the children in their care had no contact with either of their parents. Over one-third (36.53%, n.118) stated that contact did occur but it was *informal*, that is, not ordered by the court, and *irregular*. Ninety one caregivers (28.17%) stated that contact was *regular, but informal*. Only 41 cases (12.69%) had *formal regular* contact. In 50 cases, (15.48%), parental contact only occurred through the process of *formal supervised access*. In most instances where both biological parents had access, the terms of this access were different for both parents.

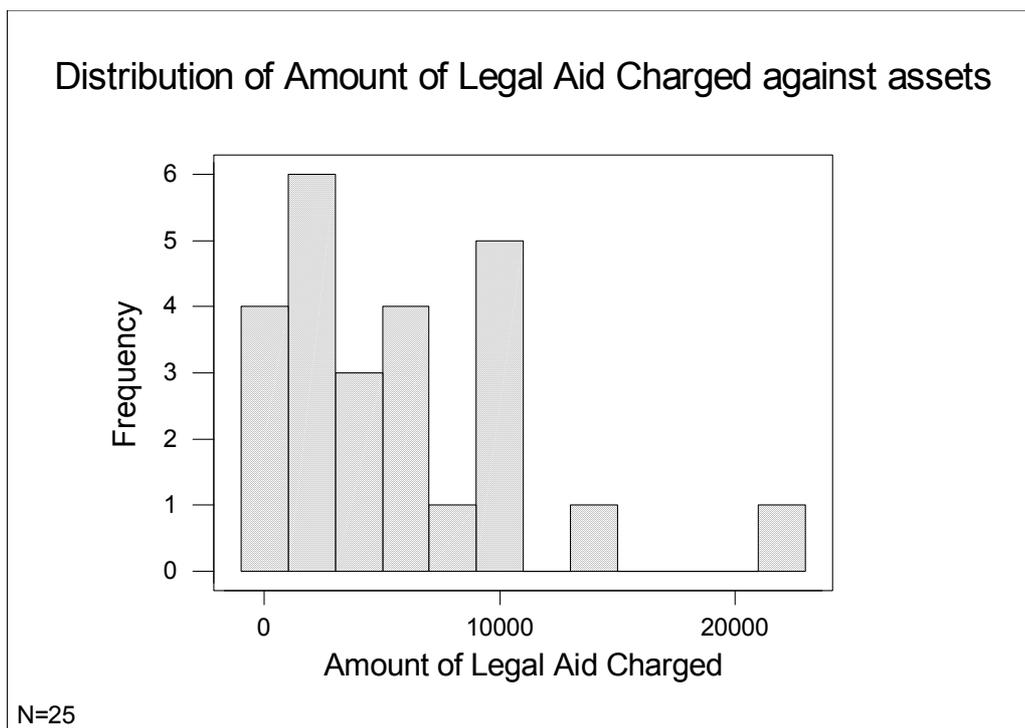
28. Legal Aid

Three hundred and seventy responses were received to the question as to whether they were in receipt of legal aid. Of these, one third (n.179 - 32.9%) have had to face court proceedings with respect to the on-going custody of the children in their care and 23.97% (n.76) have sought legal aid. This seems surprising when the income level distribution analysis is taken into consideration. However, the data in this question does not tally. It could be interpreted that a) the respondents did not understand the legal terminology of the question or b) that those who have been in receipt of legal aid are not fully aware of its nature.

Of the 76 who affirmed they had received legal aid, 52 were able to specify the amount received to date.



The nature of legal aid is that is a repayable loan, which, if not repaid at the conclusion of the case, enables the Legal Services Agency to register a Statutory Legal Aid Charge against any property owned, particularly a home. The question was asked of legal aid recipients if a Statutory Legal Aid Charge exists against any of their assets. Only 14.5% (n.30) of the 212 responses were in the affirmative and of these five were unable to state an amount. One hundred and eighty two (85.5%) answered that no Statutory Legal Aid Charge existed. Of these, several of the respondents had already paid back the loan.

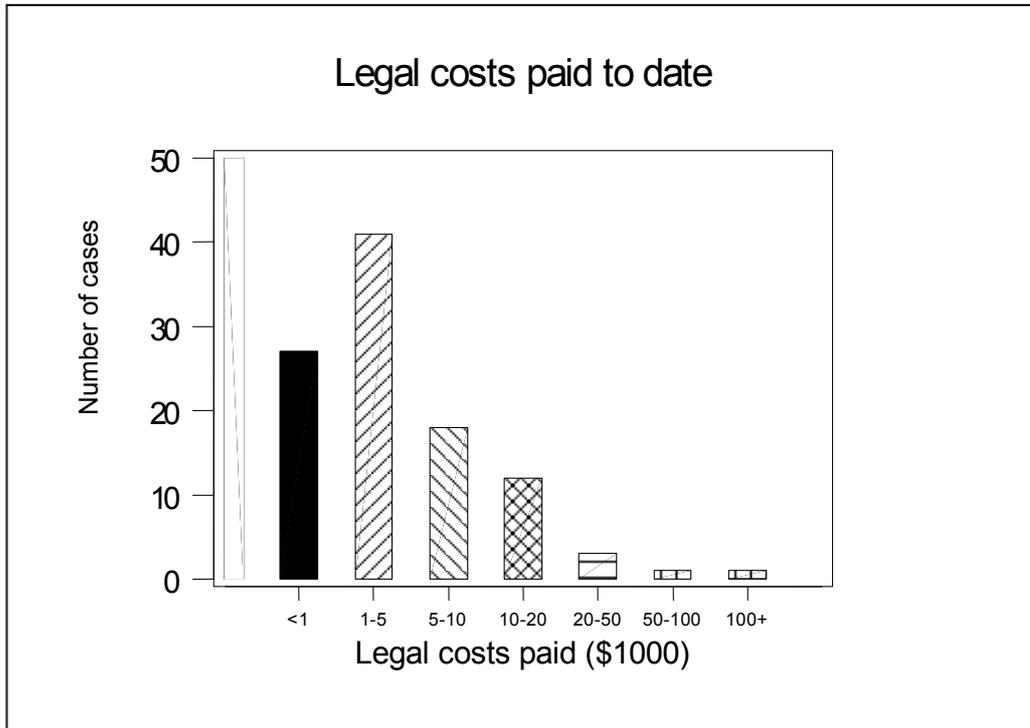


The amount specified as being a known existing charge against assets ranged from \$125 to \$22,000.

Of the respondents that had not received legal aid (n.103) the legal costs faced were considerable. Of the 323 respondents, 27 (8.36%) had paid under \$1000; 41 (12.69%) had paid \$1000-\$5,000; 18 (5.57%), \$5-10,000; 12 (3.72%) \$10-20,000; three had paid \$20-50,000 and one \$50-100,000. One respondent had paid in excess of \$100,000.

Rather than seek legal aid, respondents stated that they had raised mortgages on their homes or had borrowed from other family members, and some replied that they had initially obtained legal aid, but now had paid back the amount loaned. Some stated that they had made part payment, but there were still outstanding amounts.

“The cost of preparation towards custody order was \$3,000. We completed it ourselves. as we could no longer afford a solicitor.”



Section D: Personal Financial Matters

“We have become broke. We go without holidays, clothes, nights out, replacing our aged car maintenance on the house or replacing furniture. We have spent \$20,000 on legal fees and been to court ten times. We have had to add on 2 bedrooms. The [parity] difference between foster and unsupported child benefits is unfair and discriminating, against us who take on these children out of love for family unity. We do not do it for the money. It is hard to find the cash for legal fees, clothes and sometimes food and pocket money that would be paid by the State (CYFS) if our children were in foster care. The foster parent would not have to face all these costs , nor the financial or emotional drain that we as Grandparents face when we take on these little ones.”

Overwhelmingly, the literature identifies that kinship caregivers are being disadvantaged financially, and many children are described as living in poverty (Hunt, 2003 in Connelly 200:22). The financial impact of caring for another child is significant. When the child has on-going physical, emotional and educational needs, the cost can be unmanageable. As discussed previously, 75% of the sample earns under \$40,000 and 37% under \$20,000.

The respondents made it clear that they were under increasing financial strain and that financial reserves were quickly diminishing.

As previously mentioned, most international studies have noted that families caring for kin children were usually poor and economic vulnerability was already a fact of life. Low income families caring for kin children have complained of severe hardship in many studies. Without adequate financial support they were unable to meet the costs of another child, especially when that child was abused and neglected, with a host of special needs (Worrall, 1996b; CWLA, 1994; Dubowitz et al, 1993; TFOPP, 1990). Minkler and Roe (1993:40) stated that 78% of the caregivers in their study reported that their income had decreased since assuming caregiving, and 69% said that they had managed financially before the children came, but since assuming care, could not.

The above finding echoes the responses from the majority of caregivers in this study. As discussed in the employment section, 52.63% of the caregivers had a change in their employment status since assuming care, with many female caregivers having to leave work, go on the Domestic Purposes Benefit or take early retirement, if married.

“I subsidise my grandchildren’s expenses from my pension.”

“The UCB is not enough to cover food and clothing. I go to the Food bank and the Salvation Army for clothes.”

“I did not realize when I took the children on just how hard financially it would be. But somehow someone has to pick up these broken children and guide them. Back to their normal selves.”

“I am on an invalids benefit and care for two special needs step grandchildren. It is pretty hard to manage on what I get.”

“If our grandchild was in foster care it would cost the Government a lot more. We are on pensions and feel we should be rewarded equally for our efforts to keep these children together.”

“Our finances are dramatically down. We almost lost our house because of falling behind in the mortgage, now my wife can’t work.”

“I would like to see retired Grandparents receive the same as the DPB, as the UCB doesn’t even cover a pair of shoes.”

“I am getting poorer. I am now on the benefit after having to leave work to care for this child with Foetal Alcohol Syndrome.”

“Being on the DPB, my entire lifestyle has changed. I was working and now I am constantly battling financially.”

The most common reason cited for financial stress is the necessity to give up work because of the child care responsibilities, followed by legal fees. Many grandparents have charges registered against their homes after receiving legal aid. Several respondents mentioned aid in kind, such as food parcels, clothing and furniture from the Salvation Army, the Auckland City Mission and the GRG Trust.

29. Financial Support Received for the Children

“If our grandchild was in foster care it would cost the Government a lot more. We are on pensions and feel we should be rewarded equally for our efforts to keep these children together.”²

One hundred and seventy three (53.66 %) respondents are receiving the Unsupported Child Benefit. Fifty six (17.34%) are currently receiving the Child Youth and Family Foster Care Allowance. Only 22 (6.81%) are receiving a Liable Parent Contribution. Six young persons receive the Independent Youth Allowance, and 34 (10.53%) of respondents receive a disability allowance for the children. Thirteen caregivers stated that they received the Domestic Purposes Benefit, 16 caregivers receive the Care Supplement and 49 caregivers stated that they receive no financial assistance at all. Of the 49, several have stated that the reason they have not claimed any support is because the childrens’ mothers are getting the DPB. They stated that claiming income assistance for the children would affect the mothers’ entitlements to the DPB and without formal custody orders in place they feared that the

² The Child Youth and Family Foster Care Allowance provides substantially more financial assistance as a weekly support payment than the UCB and also provides additional allowances for a range of needs.

parent may take the child back. Others said that the mother cared for other children and she needed the DPB.

“To allow our daughter’s benefit to go towards her cost of living, we have never been able to claim any financial assistance and our pensions have been sorely eroded.”

Several respondents stated that they had been turned down by Work and Income New Zealand (WINZ) for the Unsupported Child Benefit because they were receiving a sickness or invalids benefit and had been told that they could not receive two benefits.

“We were definitely given incorrect information by Case Managers... at WINZ as regards qualifying for the UCB and were dissuaded from applying for it. My case manger said “I have to look after my child – why can’t you? After seven years.....we were advised that we qualified and should have had the UCB when our grandchild came into our carea gross injustice!”

“I am a sickness beneficiary and WINZ told me I therefore can’t qualify for the UCB. I have 2 children and get \$50.00 on top of my benefit.”

“Since taking on my grandson in a legal way I have been told I do not qualify for any financial help at all from WINZ – nothing, not even for clothing educational needs medical fees, nothing. This all has to come out of my Invalids Benefit. Looking back I would have been better off if he had been put in CYFS care under my custody then they would have paid for his needs.”

“We have been to WINZ but they have offered us no support at all, not helpful in any way, in fact I think they withhold valuable information. We get nothing for our grandchild at all.”

“When both of us became superannuitants we no longer qualified for family care as it is means tested.”

One superannuitant grandmother who has cared for five children over a period of twelve years after her two daughters died has only received the UCB since 2003 because no one told her she was eligible for any sort of financial assistance. The children were aged 18 months, 3 years, 4 years, 5 years and 17 years when they came into her care. Others cited a need for an emergency fund for when the children come into care. At that point in the resumption of care grandparents are in a state of shock and trauma and not able to meet all the financial demands. Others cited a need for money for respite care, day care and after school care.

“I would like to see retired Grandparents receive the same as the DPB, as the UCB doesn’t even cover a pair of shoes!”

“The UCB is not enough to cover food and clothing. I go to the Food bank and the Salvation Army for clothes.”

“I subsidise my grandchildren’s expenses from my pension.”

31. Changes in Financial Circumstances since Assuming Care

International research has shown that the financial circumstances of caregivers who have assumed the role of primary caregiver to their kin children has been significantly affected (Schwartz (2002). In this study 274 (90.13%) of the caregivers stated that their financial situation had been affected by taking the children into their care. There were 30 non responses to the question. Many respondents reported a drop in income levels, disposable income and savings since care of their kin children commenced.

“Our financial status has deteriorated since the children came, through a reduction in income. We now have huge debts and we may have to declare bankruptcy. We have had to sell our home. Legal costs have been crippling to keep our children safe.”

“We have a financial loss. We have had to sell our business to care for the children.”

“Our retirement nest egg is fast dwindling. We are taxed on income, including the benefits.”

“Our finances are dramatically down. We almost lost our house because of falling behind in the mortgage, now my wife can’t work. I gave up my job which gives me \$275.00 less a week and living and repairing my home (every door now has holes in it) up 100%, plus my health has gone down 100% Doctors visits up 100% Stress levels up 100%.”

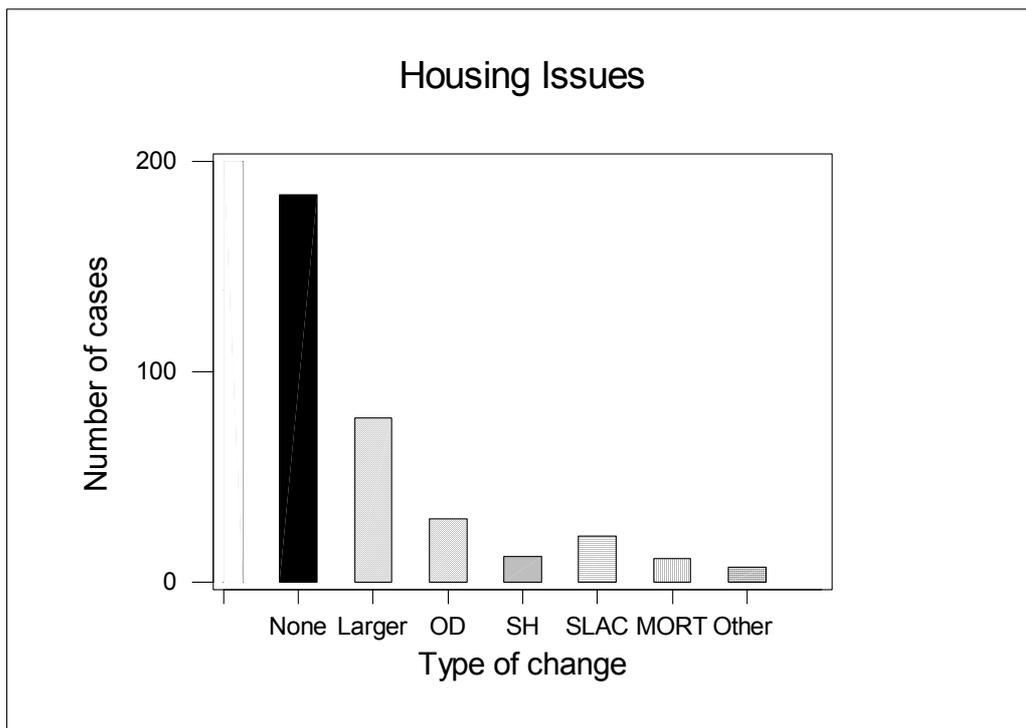
“I am totally broke ALWAYS. I am constantly battling financially”

“We are saving hard for the future of the children, so not spending on ourselves, no holidays overseas, especially to see other grandchildren or aging parents both of

whom live overseas. We are poorer because of paying legal fees-cannot upgrade our home as the money is needed for education.”

“From \$60 - 70,000 p.a. to student allowance and part time work with unsupported child benefit - \$25,000 p.a. (Grandparents of four children).”

32. Housing Issues



Key: OD Other District SH State House
SLAC Statutory Legal Charge Mort Mortgage

A small New Zealand study in kinship care identified housing problems, with families having to move house to accommodate the kin children, especially when it involved a sibling group and/or the grandparents had downsized to smaller accommodation (Worrall 1996). In this research just under half of the respondents reported a negative impact upon their housing status. Seventy eight respondents (24.15%) had needed to move to a larger house, 30 (9.29%) had needed to move to another district, 12 (3.72%) had moved to a state house, 22 stated that they had a charge registered against their property because of legal aid and 11 had taken out a mortgage on their existing house, or had increased their mortgage.

“We now have 2 mortgages on the house, when we had none.”

“We do need a bigger house but I can’t afford it so we all live in my 2 bedroom cottage. I first had to sleep in the lounge, now I share my bedroom with my IHC 21 yr old and the boys have the other bedroom.”

The adverse effects of overcrowding are well known and constitute a risk factor that must be addressed if the placement is to survive with the least detriment to all family members. A full accommodation assessment should be made that takes into account the family’s projected housing needs and the financial status of the family, excluding the unsupported child allowance. 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.

Section E: General Health

33. Changes in Health Status

“I have high blood pressure and diabetes. The doctor says it is the stress!”

The well documented relationship between social class and illness, together with research over the last decade on the health consequences of family caregiving, has led kinship care researchers to examine this issue (Briar and Caplan, 1990; Miller 1991; Minkler and Roe, 1993). While many studies have drawn together the relationship between deterioration in health, financial status and the stresses experienced in kinship care (COTA, 2003; Worrall, 1999, 1996; Hegar and Scannapieco 1995;. Minkler and Roe; 1993) other studies found that caregivers reported improving emotional health as their kin children improved in their care (Goodman and Silverstein, 2002).

While some degree of health deterioration is to be expected in the major age cohort of this study, the results reflect international trends. Just under 60% (n.189, 58.9%) stated that their health had declined since taking the children into their care and 36.8% (n.119) stated that

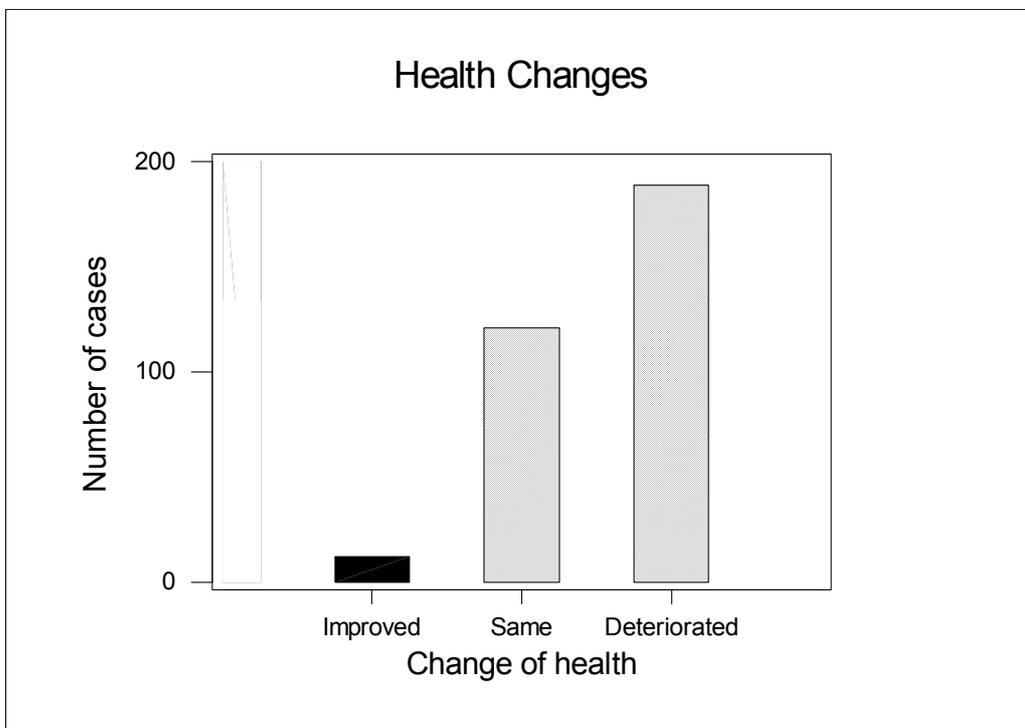
their health has remained the same. However, 3.7% (n.12) of the caregivers stated that they now experience better health than prior to taking responsibility for their kin children.

“I have early Alzheimers and chronic arthritis”.

“My husband has advanced Alzheimers and he needs a great deal of care too!”

“I have lost a lot of weight (+++) and I was not fat to start with!”

Several caregivers cited money problems as a reason for not seeking health care, stating that the children’s health needs are costly and come first before those of the caregiver.



34. Social Activities

The degree to which people are able to socialize with their peer group is an indicator of and contributor to general health status (Opie, A; 1992). Several studies have shown that the ability of caregivers to socialize with people their own age is constrained or impossible since taking the children. The caregivers in this study were asked to respond to an open ended question; “What social activities do you have?” Responses were received from 203

Caregivers. Over half the group (n.161 – 53.31%) stated that they had no social activities while 46.69% (n.141) responded affirmatively, listing art clubs, indoor bowling, walking, swimming and biking as social activities. Maori Women's Welfare League and marae activities were also named. Thirty caregivers listed going to church as their social activity. Activities listed by the caregivers that they used to enjoy, but now could not were; bowls, bridge, golf, croquet and Rotary. A significant number of caregivers indicated that the only forms of socialization they engaged in were the activities of the children, such as school and sporting activities.

The following were typical responses to this question:

“None. Funerals appear to be the only time we go out without a child in tow.”

“We have very few [social activities] now as we would need a baby sitter... Friends don't ask us to dinner anymore because of the children.”

“None since my grandson came to live. Even going to church is a rare occasion because of behaviour problems and it is hard to get some one to baby sit him.”

“Are you joking? Our social calendar is empty, the children's is full. Our activities became impossible with three children in tow, one a three year old!”

“.....Our life is on long term hold!”

“We cannot do all the things we would like to do or as others our generation are doing – we must always consider the child.....Grandparent's own relationship has been affected by the demands that raising a child places on it.”

The sense of isolation and loneliness felt by many of the respondents was evident in this section and in the context of other questions in the study. The fact that a significant number of caregivers cited the Grandparents Raising Grandchildren Charitable Trust and support groups as their only source of social support is of concern. The link between poverty, isolation, stress and child abuse has been made by many researchers (Whitelaw Downs et al, 2004). While there is no suggestion that this is an inevitable outcome for the research participants, it must be an issue of concern for social workers and policy makers.

35. Sources of Support

“I have never felt so alone and alienated from family and friends. My life has become a merry-go-round of school visits, problem solving, police courts, counselling, lawyers, Family Group meetings and the ADHD parenting course, Child Health visits. Family has been divided over CYPS involvement and therefore we have parents’ arguments on the door step and the family taking sides. So you could say – “life is a ball!”

As many children who have suffered neglect and abuse have particular needs often requiring a more specialized degree of care, the behaviours and difficulties described by the survey respondents are not surprising. While Child Youth and Family often invite kin caregivers to foster care training, they very often need support to assist in recovery from the trauma that led to care and training to cope with inter family stress (Greef, 1999; Smith, Gollop, Taylor & Atwool, 1999; Worrall 1996; CWLA, 1994:49).

“Grandparents need to learn new parenting skills or refreshers. Courses like Parenting with Confidence or Tool-Box would be a big bonus.”

Although some commonalities exist for children placed in foster care and those children placed in kinship care, there are also unique issues for the kinship population that demand different skills and understanding. The families have usually faced a crisis (if not several) and the caregivers are coping with the children while dealing with their own grief.

“A few social workers are really good, but most of them don't seem to really understand what we are going through. I have felt ashamed and blamed.”

Apart from financial support, the support of friends and family rates highly as an important factor in maintaining placements.

All respondents answered this question. They 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%. One hundred and forty six respondents (45.20%) nominated their own children as being a source of support. Only 86 (26.63%) stated that they received support from other extended family members with 36 (11.15%) citing neighbours as providing support. The impact of the childrens’ behaviour on their relationships with friends was mentioned by 30.03%. Several caregivers noted in the

previous question that they were no longer able to socialize with their friends. Non governmental organisations providing child and family support services did not feature highly, with only 8.36 % (n.27) stating that they had been able to access support from this source. The most frequently nominated source of support was the Grandparents Raising Grandchildren organization which was cited by 167 (51.70%) of respondents, however as the survey population was drawn from its membership that result is not unexpected. Of the respondents (n 69. 21.36%) who stated that they had no support at all, 21 persons, (6.50%) nominated church as their support system.

“After the death of my daughter I had 5 boys to care for. The needs and grief of the boys was paramount to everyone but what I was going through was completely ignored. I feel more support should be available to Grandparents to meet their emotional need.”s

“Taking [this child] has completely changed my life. My own children disagreed and I haven’t spoken to one for three years.”

The causative factors that lead to the need for care affect the grandparents emotionally. Grief, anger, shame and remorse are often feelings experienced by the grandparents. However, as the quote above illustrates, the task of caring takes precedence and the grandparents are given no opportunity to resolve these issues (Worrall, 1996, Greef, 1999).

36. Respondents' Further Comments

Respondents were asked, at the conclusion of the questionnaire if they wished to make any other comments. Two hundred and thirty eight responses (74.14%) were received to this question. To select a few does not do justice to the richness of the data or the experiences of the caregivers.

The issues that have been written about in the responses can be divided into five key issues concerning (1) the children (2) the children's parents (3) the need for support (4) legal issues and (5) their own stress.

More particularly,

- The difficulty in managing the behaviour of traumatized children
- The struggle to manage financially when income has decreased and family needs have significantly increased
- The isolation of the caregivers and alienation from their families, in some instances, and their former social communities and supports
- The complexities of the legal system and the drain on finances and stress levels when trying to achieve permanency and stability in the placement of the children
- The difficulties in dealing with the children's parents particularly where drug and alcohol dependence is involved
- Need for respite care, day care and after school care

"I stopped work to take the children who were abandoned because both parents are drug addicts. My daughter is now dead of an overdose and her partner, the children's father is in prison for 10 years for making and selling drugs. The children have foetal alcohol syndrome ADD, Conduct disorder, are aggressive and constantly absconding from school and here. I have been to Child and Adolescent Health Services and a psychiatrist to get help. The children only have contact with their father if I take them to the prison. The children are angry. We just scrape by from day to day. My husband's wages go to the budgeters to pay bills – rent, power, car payments and hire purchase for the fridge. We needed a larger house so we are now in a State house. My health has deteriorated and I have diabetes now. I have no social activities, only school things and watch T.V. I have no support to do this..."

"Caregivers desperately need tangible help, e.g. respite care and education to help ascertain their rights and entitlements (if any). This help should be free and instantly available as crises come to a head without prior warning."

"I was asked to take a second child and it broke my heart to refuse but I could not cope with the financial pressure and loneliness of being an older single parent. It is difficult to continue a marriage while having an unexpected child in mid-life. I would not change my decision but feel tougher measures on the parents would assist in [stopping] children being in this state."

“If children have mentally ill parents they will be abused and neglected. It is my experience that schools don’t give a damn. Don’t want extra work or adverse publicity.”

“I feel so isolated at times. I have a lot of legal problems over this property. I feel overwhelmed. CYFS worker sent away for your book for me. She thought it might help.”

“Too tired, too stressed, just plodding on, one day at a time; resting as much as we can to go back to work again, for the next round of trials and tribulations and trouble they get into. Would love to be able to stay at home, maintain home ourselves and be better grandparents for them after school, but power has gone up again, shoes lost or worn out and forever hungry – bottomless pits and its NOT WORMS! So we need to work.”

“We are lucky in that we have no encounters of grief situations with the law, parents CYF, fostering or false accusations cos both parents are dead. But it is so lonely and not what we would have chosen. But this is our lot and we got to lump it. We need help but there is just the UCB and it doesn’t go far (Grandparents of 4 children, 16,11,10 &8).”

And positively:

“This is the best thing that happened to us as it certainly brought us into the 21st century with a big bang and we are learning –He is keeping us really modern and up with it!”

Summary

This study confirms international studies that have found that caring for abused and traumatised children within the extended family is complex and caregivers are not given the support they need and deserve. 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, this study shows that most families care under great duress. The study also confirms the findings of international studies that these families are likely to become impoverished as a result of assuming care. Children have major behavioural and psychological problems, caregivers health suffers and many become trapped in costly and on-going legal processes as they strive to keep the children safe and provide security.

Children in grandparent and kin/whanau care and their caregivers have equal, if not greater, service and support needs than their counterparts in traditional foster care and are less likely to receive them. Caregivers are penalised by virtue of being related. The Unsupported Child Benefit is considerably lower than Child Youth and Family stranger foster care payments, particularly when all ancillary payments the latter receive are taken into account. Additionally, there appears to be an inconsistent response to qualification for the UCB. Many caregivers who are receiving other benefits, such as sickness or invalids benefits have been told they do not qualify for the UCB. WINZ workers need to be better educated as to the entitlements for grandparent and kin caregivers.

Families have stated that they need access to social workers and specialist services on a continuing basis and that taking the children into their care or obtaining legal custody does not mean the end of problems. However the kin caregivers in this study have stated that they are reluctant to engage with Child Youth and Family 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.

The philosophy of partnership that resides in the CYPF Act would suggest reciprocity exists between family and state. This is not the case. The state affirms the responsibility of care to the family, but does not affirm the resources needed to provide that care. It is the role of the state to promote the establishment of services and policies that ensure the safety of children who are in need of care and protection. The statistics gathered from the study participants and their voices show a need for system reform.

Recommendations

1. Kin/whanau caregivers must receive adequate income support commensurate with Foster Care Board Payments and financial support that is reflective of the particular needs of children placed with kin/whanau.
2. All support services should be extended to kin caregiving families and their kin children to ensure the wellbeing of the children and the total family/whanau group.
3. WINZ workers should be better educated with respect to the income support entitlements of grandparent and kin caregivers, particularly in relation to the UCB and other benefits they are entitled to in addition to the UCB.
4. Where a child has been under the care of Child Youth and Family, all legal expenses incurred to achieve kin/whanau custody and /or Guardianship should be paid for by the State.
5. Where children are placed in the care of grandparents or other kin/whanau caregivers either as the result of a finding by Child Youth and Family that the children are in need of care and protection, or where a court has ordered that the children should remain in the care of the grandparents or other kin/whanau caregivers, legal aid should be available to the grandparent/kin caregivers as a matter of right and the Statutory Legal Aid Charge should not apply.
6. More focus should be placed by the judiciary on the need of the child to have placement stability and in so doing should be more proactive in the prevention of on-going custody challenges by disingenuous parties who place their own needs above that of their children and put their children's stability and security in jeopardy.
6. Lawyers representing grandparent and kin/whanau caregivers should ensure that their clients are fully aware of the Statutory Legal Aid Charge requirements and the charges placed against property, as the study results indicate that respondents often know very little about the state of their liability in this respect.
7. Respite care should be provided as a matter of course for kin/whanau caregivers,

particularly grandparents, with significantly more resources being made available by the State to facilitate respite care options.

8. Daycare and after school care should be made available as of right to grandparent and kin/whanau caregivers who are in paid employment, are elderly or have multiple children of similar ages. The cost of daycare and after school care should be paid for over and above other income support received.
9. Free medical care should be available for all children and young people in kinship/whanau care and their caregivers.
10. Free counselling should be offered to caregivers to assist with their own emotional needs.
11. Child Youth and Family staff should be given training to better assist them in dealing with the particular issues involved in placing children with kin.
12. Where grandparents or kin caregivers assume the long term care of kin children the State should ensure that suitable housing is provided, where grandparent/kin caregivers' accommodation is inappropriate for the needs of the family.
13. Culturally appropriate in-service training should be offered to all kin care giving families, and it should be compulsory when the care order is made as the result of abuse and/or neglect.
14. Grandparent/kin caregivers should be consultative partners when social work policies and practices are being reviewed or developed. Tangata Whenua and other cultural groups should be assisted to develop their own policy and practice guidelines with respect to the safe placement of children with whanau/extended family.

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Appendix 1 – Survey Questionnaire

Grandparents Raising Grandchildren

The information collected in this questionnaire is entirely anonymous in nature. Please do not enter your name or address or any other person's name(s) or addresses in your answers.

While we would like you to answer all the questions, we understand the sensitive nature of these issues and that you may wish to omit some. The questionnaire may seem long, but all these issues have been raised as important by caregivers.

Where there are two caregivers, please both fill in Section A, Questions 1-5

A ABOUT YOU

1. **Ages** (please tick those that apply)
Under 40 40-49 50-59
60-69 70-79 80+
2. **Marital Status** (please tick)
Married widowed never married
de facto separated divorced
3. **Ethnicity** (please tick)
Maori New Zealand European/Pakeha Pacific Island
Asian Other (please specify _____)
4. **Occupation(s)** (if currently working). **Please indicate if now retired.**
5. **Any changes in your employment status because of assuming care?**
6. **Income bracket** (If you are a couple please indicate combined total income)
(Please tick one)
Under \$20,000 \$21-30,000 \$31-40,000 \$41-50,000
\$51-60,000, \$61-70,000 \$71-80,000 \$80,000 +
7. **How many of your own children do you have? Please indicate their gender (M/F) and ages.** (e.g. M 16, F 22, F 25)
8. **What were the ages of the children's parents when you assumed care?**

B. ABOUT YOUR GRANDCHILDREN, NIECES/NEPHEWS

9. How many grandchildren/nieces or nephews are currently in your care? _____

Please indicate their gender and ages. (e.g M 4, F 2)

10. What is the relationship of the children to you as their caregiver?
(e.g. grandparent, great aunt/uncle)

11. Who was the primary caregiver of the children before they came into your care?
(Please tick as many as are relevant)

- a) Mother
- b) Father
- c) Both parents
- d) Extended family/whanau
- e) Foster care parent (not related)

12. Reasons you have assumed care (Please tick as many as are relevant)

- Death of parent
- Drug addiction
- Alcohol addiction
- Mental illness
- Physical illness
- Imprisonment
- Domestic violence
- Child Abuse
- Neglect
- Abandonment
- Other (please describe) _____

13. How long have the children been in your care? _____

Have they been with you since birth? Yes No

14. How old was each of the children when they came into your care?
(e.g. M 4yrs, F 2 yrs, F 6 yrs)

15. Have any grandchildren, nieces/nephews for whom you have held custody now left your care? Yes No

If yes, where are they now? (Please tick as many as are relevant)

- a) returned to Mother
- b) returned to Father
- c) returned to both parents
- d) With other extended family/whanau members
- e) In CYF foster care
- f) In institutional care
- g) Independent

16. Have any of the children experienced physical problems? Yes No

If yes, please tick all that apply.

- (a) Severe physical disability (please describe)
- (b) Down's Syndrome
- (c) Bed-wetting (if older child)
- (d) Dwarfism
- (e) Foetal Alcohol Syndrome
- (f) Asthma
- (g) Diabetes
- (h) Coeliac Disease
- (i) Eczema
- (j) Other (please describe) _____

17. Do any of the children have psychological/behavioural problems?

Yes No

If yes, please tick all that apply

- a) Autism
- b) Attention Deficit Disorder (ADD)
- c) Attention Deficit Hyperactive Disorder (ADHD)
- d) Dyslexia
- e) Conduct Disorder
- f) Dyspraxia
- g) Post Traumatic Stress Disorder
- h) Severe aggressive behaviour
- i) Destructive behaviour
- j) Other (please describe) _____

18. What help have you been able to access for these problems?

- (a) General Practitioner
- (b) Paediatrician
- (c) Private Psychologist
- (d) Private Psychiatrist
- (e) Child and Adolescent Mental Health Services
- (f) None
- (g) Other (please describe) _____

19. Have you received any financial assistance to pay for professional assistance relating to problems identified in Questions 15-16? Yes No

If yes, who has provided the financial assistance?

- (a) Child Youth & Family
- (b) ACC
- (c) Extended family/whanau
- (d) Charitable organisation (Please describe) _____
- (e) Other (Please describe) _____

20. Have you observed any changes in the child since they have been in your care?

Yes No

If yes, please briefly describe.

21. How would you describe the educational progress of your grandchildren? *(Please tick one for each child)*

Child no. 1 Excellent Good Fair Improving Poor

Child no. 2 Excellent Good Fair Improving Poor

Child no. 3 Excellent Good Fair Improving Poor

Child no. 4 Excellent Good Fair Improving Poor

Child no. 5 Excellent Good Fair Improving Poor

Child no. 6 Excellent Good Fair Improving Poor

22. What help have you been able to access for the educational needs of the child/ren? *(Please tick all that apply)*

(a) **School assistance**

(b) **Special Education Services**

(c) **Teacher Aid**

(d) **Private Tuition**

(e) **Other *(please describe)***

C. LEGAL ISSUES

23. How did the children first come into your care? *(Please tick one)*

(a) **Informal family/whanau agreement**

(b) **Family/Whanau agreement through CYFS**

(c) **Formal Family Group Conference process**

(d) **Court Order under the Guardianship Act**

(e) **Other *(please describe)*** _____

24. **Has your legal status as caregiver been contested in court?** Yes No

If yes, how many times? _____

25. **Are the care arrangements (custody/access) for the children still being contested in court?** Yes No

If yes, how long has the matter been before the court? _____

If no, how long did it take before the court settled care arrangements? _____

26. What is the current legal status under which you care for the children?

a) **A Custody Order under the Guardianship Act**

b) **Shared Guardianship with the parents**

c) **Shared Guardianship with Child Youth and Family**

d) **Adoption**

- e) Whangai
- f) No legal status

27. What contact do the children's parents have to the child? (Please tick one)

- a) None
- b) Informal irregular
- c) Informal regular
- d) Formal regular
- e) Supervised access

28. Have you been in receipt of legal aid? Yes No

If yes, please describe to the best of your knowledge how much the court proceedings have cost to date on legal aid. \$ _____

Has a Statutory Legal Aid Charge (SLAC) been registered against any of your assets to repay the costs of legal aid? Yes No

If yes, please describe how much is secured by the SLAC? \$ _____

If no, what legal costs have you paid to date?

- a) \$100- \$1,000
- b) \$1,000- \$5,000
- c) \$5,000 – \$10,000
- d) \$10,000 - \$20,000
- e) \$20,000 - \$50,000
- f) \$50,000- \$100,000
- g) If more than \$100,000 please state: \$ _____

D. PERSONAL FINANCIAL MATTERS

29. What financial support are you receiving for the children?
(Please tick as many as are relevant)

- a) Unsupported Child Benefit
- b) CYPS Foster Care Allowance
- c) Independent Youth Benefit
- d) Liable Parents contribution
- e) Domestic purposes benefit
- f) Disability Allowance
- g) Care Supplement
- h) None

30. What expenses do you have for the child/ren that are not covered by this allowance?
(e.g. Medical, educational etc)

31. What changes have you experienced in your financial status since caregiving began?

32. **Have you had any housing issues since assuming care?** *(Please tick as many as are relevant)*
- a) Nil
 - b) Have needed a larger house
 - c) Have needed to move to another district
 - d) Have moved to a State House
 - e) A Statutory Legal Aid Charge is registered against the house

E. Your General Health

33. **Over the last five years has your health**

- a) Improved
- b) Stayed the same
- c) Deteriorated

34. **What social activities do you have?**

35. **Who supports you in your caregiving role?**

(Please tick as many as are relevant)

- a) Your own children
- b) Other extended family/whanau members
- c) Neighbours
- d) Friends
- e) A Child and Family Support Service
- f) Grandparents Raising Grandchildren Organisation
- g) No-one
- h) Other *(please describe)* _____

36. **Any other comments you would like to make.**

Once again, please ensure that no names are mentioned above. This information must remain entirely confidential. Thankyou for taking the time to share your experiences with us. This information will assist us in working to improve your caregiving role.