**Becoming a kinship carer – education and support needs of grandparents who are parenting.**

Mention the term “kinship carer” and you will generally be met with a quizzical look. This was certainly our first reaction, yet it is a word which is becoming increasingly recognised as the needs of this group of people come to the attention of politicians, multi-professionals and the general public.

A definitive meaning of the term itself is not easy to pin down. In Western countries the word “kin” is generally associated with biogenetic inheritance; shared blood. In other parts of the world “kin” is interpreted more flexibly and concerns “clanship”, where children may be brought up by godparents, friends and neighbours as well as family. (Nandy, Selwyn, Farmer & Vaisey 2011).

In England, where our research took place, kinship care is defined as: *relatives, friends and other people with a prior connection with somebody else’s child who are caring for him or her full-time* (Department for Education, 2011: 4). However, this one-dimensional statement implies that entering into kinship care is something to be taken in one’s stride; it gives no hint of the frequently complex and traumatic events culminating in a family crisis, which does not end when kinship care begins. Nor does it cover all eventualities; we found grandparents attending a support group for kinship carers in Worcestershire who had become kinship carers to two grandchildren, the existence of whom they had previously been unaware.

It was with this group of kinship carers that our research took place, responding to a request from the chairperson to discover what the parenting needs of kinship carers are. The group meet for two hours every month in a community centre; there are about 20 regular attendees and others attending more intermittently depending on their need and commitments.

Owing to the fact that many kinship arrangements are informal, the exact number of kinship families is difficult to estimate. The Family Rights Group (Richards and Tapsfield, 2003) suggest that there are probably between 200,000 and 300,000 children living in kinship care in the UK (Nandy 2011) and by far the majority of cases begin as a result of a family crisis (Broad 2004), including family breakdown (DFSF 2010), parental substance abuse (Aldgate 2009) and incarceration (DCSF and Ministry of Justice 2007).

Such was the case for one set of grandparents attending the support group. Diane had recently returned to work after retraining as a secondary school teacher. She and her husband Mike were beginning to enjoy expensive holidays with their three teenage children as well as growing independence as a couple again. This all changed when their 16-year-old daughter, Georgia, became pregnant. When the baby was born Georgia found it difficult to cope and Diane and Mike found themselves caring for him for longer and longer periods.

Initially this was on an informal basis; however, Georgia began a relationship with a new boyfriend and became pregnant for a second time. Unfortunately, her new partner introduced her to drugs. The police became involved and Georgia was charged with drugs related offences. It seemed likely that the baby would be taken into care so Diane and Mike began the process of applying for a Special Guardianship Order (SGO) to enable the children to live with them permanently. Although they were eventually successful, going through the long assessment process proved very stressful; old wounds, such as bereavement and divorce, were re-visited with no support, leaving Diane and Mike feeing vulnerable and powerless. Parenting for a second time round was a very different experience to the first time, not least because their grandchildren had both been born with Foetal Alcohol Disorder, Attention Deficit Hyperactivity Disorder and had also developed Attachment Disorder. The combination of teenagers and a young baby and toddler with these conditions all living together placed strain on the whole family.

Looking back, Diane and Mike would not hesitate to take the same decision again, and are quick to outline the rewards they receive from being kinship carers. In line with other kinship carers who talk of the positives of kinship care, they mention the relief in knowing that the children are safe and cared for by family. They feel tremendous pride when the children do well and achieve significant milestones and goals, (Langosch 2012, Wellard 2011); however, they also acknowledge that these benefits come at a high cost.

Just as the rewards reported by Diane and Mike are represented in the research literature as a whole, the issues facing the kinship carers in the support group we visited are also similar to those already documented. Financial difficulties caused by high legal bills, as well as additional incidental expenses, such as buying toys and clothes for the children, puts further financial pressure on families (Gautier and Wellard 2014). Unlike foster carers, kinship carers are not entitled to any payments or additional state benefits such as adoption leave or the Pupil Premium (Gautier and Wellard 2014). These financial difficulties are frequently exacerbated by the need for at least one of the carers to leave their job in order to care for the children, resulting not only a short term loss of income, but also loss of employer pension contributions and the depletion of personal savings in the longer term (Farmer 2009). This often leads to personal debt, and in the case of grandparent kinship carers this occurs at a life stage where there is little opportunity to replenish funds, which can lead to poverty, isolation and other adversities (Wellard 2011). Less tangibly, the kinship carer may also lose social support and esteem when they leave employment.

A lack of disposable income to pay suitable baby-sitters can intensify feelings of isolation (Farmer 2009) as they single-handedly face the challenge of caring for children who are still suffering the after-effects of neglect, abuse and addiction. Gautier and Wellard (2014) reported that 59% of kinship carers are caring for a child with a special need or disability whilst 48% are caring for children with emotional and behaviour difficulties, significantly increasing stress levels, particularly in older kinship carers (Mukherjee et al 2013). This is compounded by the fact that their contemporaries “have time, money and grown-up kids’, whereas kinship carers have ‘no time, no money and loads of kids’ (Gautier and Wellard 2014:19). Kinship carer isolation is often intensified as they find they have little in common with the first time parents seeking mutual friendships at the school gate either.

Society traditionally associates the role of grandparent with one of indulgence, so grandparents who are also kinship carers often feel that their role is ambiguous, neither parent nor grandparent, necessarily taking on the role of disciplinarian rather than kindly grandparent. Adjusting long-held assumptions of an anticipated future to a new, frequently bleak reality can provoke feelings of grief and despair. A combination of all these issues commonly leads to depression (Minkler 1999, Dunne & Kettler 2008) and puts strain on relationships (Farmer 2009, Wellard 2011, Selwyn et.al. 2013).

In addition to the depression caused by financial issues, isolation, and caring for a child with additional needs, kinship carers also frequently suffer from illness and conditions attributed to increased stress brought about by their situation (Leticq 2008, Harnett et al 2012, Mukherjee et al 2013, Purcel et al 2014). As well as caring for their children kinship carers are also often caring for other relatives and/or trying to negotiate equitable relationships with their other children and grandchildren, contributing further to a sense of loss of self and exhaustion. However, their own emotional and physical health needs are rarely able to take priority as there is no one to help with caring for the children (Wellard 2011).

It is clear that kinship carers face multiple-adversities and have complex needs, defined as presenting both breadth and depth in terms of scale and difficulty (Rankin and Regan 2004). A protective factor, commonly described as a “lifeline” by many individual kinship carers that we spoke to, was attending the support group meetings. Whilst there, they experienced relief as they found acceptance and understanding, which may well make the difference as to whether kinship carers cope or not (Langosch 2012). This strength could provide the key for enabling the success of the kinship care placement.

Due to the unexpectedness of becoming a kinship carer many feel resentment that they have found themselves in a position that they neither wanted nor anticipated (Harnett et al 2012, Langosch 2012). In psychological terms, when individuals compare the justice in their own situation with the perceived justice of others, any lack of parity produces feelings of anger and resentment (Stets 2003, cited in Backhouse & Graham 2012). Combined with the other stresses experienced by kinship carers there is a danger that they could succumb to a mindset of a learned helplessness (Dweck 2000). This not only adversely impacts on the kinship carer’s mental and physical health, but also on the child (Farmer 2009). Bearing in mind the protective influence of kinship care group membership, factoring this into any solution would seem essential in averting a destructive cycle. Maximising the social capital benefits for all members through the promotion of a community strengths model may encourage self-advocacy and empowerment.

Fostering a culture of empowerment was the aim in supporting the group to put together a patchwork programme of events as part of the monthly meetings designed to meet the specific education and support needs of kinship carers. The patches cover some or all of three themes; firstly, to support practical needs, secondly to address emotional needs and finally to offer support with parenting issues. Examples of how these are already starting to be implemented in the group, as well as suggestions for future development, will now be outlined.

There was a clear need for instrumental support in the form of access to legal guidance and signposting to other practical advice. The skill and expertise of other organisations have been drawn upon; for example, the training of some members of the group by the Citizens’ Advice Bureau to enable them to answer commonly occurring queries. This ensures that the community strengths model is sustainable. The group have also enlisted the expertise of a fuel and energy advisor on how to secure the best gas and electricity tariff and established a good relationship with solicitors who have built an expertise in kinship cases.

Supporting the emotional well-being of carers is addressed by running sessions on the importance of finding time to eat well and take regular exercise in order to try and decrease kinship carer susceptibility to self-neglect. More targeted emotional support also needs to be given, particularly in the early days of new placements where stress levels are at their peak (Leder et al 2007, Leticq 2008). Experienced members of the kinship care group could be trained as mentors to support new carers; this would help alleviate the perceived lack of visibility and support from multi-professionals and society as a whole (Hughes et.al. 2007), as well as prevent burn-out for the leaders in the organisation.

Although it may seem initially that these first two themes are not related to the parenting needs of kinship carers, the stress that they feel by having to deal with practical and emotional issues is likely to be inadvertently passed on to the children. Poelmann et.al (2008) found that depressed kinship grandparents were more likely to have grandchildren with challenging behaviour. The opposite was also true; that is, kinship grandparents who were not depressed and were able to adopt warm and affectionate dispositions, did not report significant behaviour concerns. Dealing with these practical and emotional needs will therefore indirectly impact positively on the physical and emotional health of the kinship carers and thus will also benefit the children. This could mean that kinship carers are then open to suggestions of how to employ more responsive parenting techniques, the third theme of the patchwork sessions. Specialist attachment-based behaviour management techniques have been shared in a session run by a specialist consultant and have proved very effective. Other sessions have focused on how to support children with Foetal Alcohol Syndrome, Attention Deficit Hyperactivity Disorder, Asperger’s Syndrome and other chronic health conditions. When kinship carers experience success in dealing with the children the benefits are bi-directional and a positive cycle begins.

The further development of the patchwork of support sessions for kinship carers will go a long way in enabling them to cope on many levels. This is important because, if all goes well with kinship placements studies show that the children have better long term outcomes than those in foster care (Farmer 2009, Wellard 2011, Backhouse & Graham 2006, Harnett 2012, Montserrat 2014) particularly when instigated at a young age (Palacios & Jimenez 2009). However, in the short term, nearly half of kinship carers reported having difficulty coping with the children, compared to one third of foster carers (Farmer 2009). This suggests that support for kinship carers is not given the same priority as foster carers and that their needs are not being met. This is borne out by national findings, which reveal that, at best, support for kinship carers is inconsistent (Hunt 2008).

There is a limit to how much can be achieved even with a very strong network of kinship carers and many report being close to breaking point, particularly in the short term (Farmer 2009). To increase the likelihood of positive outcomes for kinship families it is vital that they are given timely support. Given that 61% of service providers contacted by kinship carers are those in health or education (Selwyn et.al 2013), training these professionals in the needs and associated issues surrounding kinship care, as well as how to recognise when a placement is at risk of deterioration, could instigate timely intervention that would save the placement by the involvement of multi-agency support on the family’s behalf to prevent further trauma for both the kinship carer and the child.

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