Grand Families Count In Idaho

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KINCARE POLICY BRIEF HIGHLIGHTS

• Over 18,000 Idaho children live in households headed by grandparents and other relatives. Of this number, only 1,860 are currently in the foster care system, a ratio of 1 child in formal foster care for every 9 children in informal care with relatives.

• In 2006, Idaho had nearly 10,000 households in which grandparents were raising their grandchildren, an increase of 20.7% since 2000. This compares to an increase of 1.2 for the nation over the same time period.

• Parental incarceration and substance abuse are the two most common reasons for relatives to assume caregiving responsibilities.

• Informal kincare families are eligible to receive a child-only grant from TANF (Temporary Assistance for Needy Families) for $309 per month, regardless of the number of children being cared for. Only 1,301 Idaho families received these grants in 2003 though there were over 10 times that many households who were eligible.

• A notable advantage of kincare is placement stability. In 2002-2003, 85% of children placed in foster care with relatives lived in the same home for a year or more, compared to 58% for non-kin foster parents.

• Children in kinship care tend to lack health insurance and are nearly three times as likely as those placed in traditional foster care to receive no routine health care and less likely to receive all types of health related services.

• At an estimated $3,300 annual cost for a child in foster care, the 18,000 children in kincare could cost Idaho up to $60 million to support if they were to enter the foster care system.
Our best hope for children is that they will be raised in happy healthy homes, loved and cared for by their parents. However, family crisis sometimes requires an out of home placement for children. Parental death may leave children homeless, or long-term physical or mental illness or substance abuse may compromise parents’ abilities to raise their children. Extended parental absence through military deployment, work transfer, or incarceration may require out of home placement for an extended period of time. Out of home placements may be formally made by a social service agency with kin or non kin caregivers. More frequently though, out of home care is arranged without formal social service intervention, when relatives take children into their homes to keep them safe in time of family crisis.

Formal out of home placements are made by social services agencies when child protection court determines that there are concerns of abuse, neglect or abandonment. Under these circumstances, children are placed with foster parents who are licensed to care for children in the turmoil of family crisis. Foster parents are provided training in order to meet the unique needs of children who have survived child abuse or neglect, and receive support from social workers who provide case management for those children in foster care. Other supports include foster parent support groups, and respite care to help them manage the stress of working with children who are often troubled after years of family instability. The expenses of meeting children’s needs are covered through room and board payments to foster families, access to Medicaid health insurance, WIC, and support for child care and other expenses.

Prior to seeking out of home placement, Idaho child welfare agencies are required to make reasonable efforts to place children with related persons (Idaho Code section 16-1619). Frequently, relatives choose to complete the process of being licensed as foster parents. Relatives caring for minor family members through the foster care system must be licensed like other foster parents, therefore they have access to the benefits of the system, including room and board payments, training, and other programs. In Idaho, relatives are somewhat more likely than non-kin to serve as foster parents. Of Idaho children currently in foster care, 54.5% are in the care of kin (Idaho Department of Health and Welfare data, 2008).

Although more than half of children in foster care are in homes of relatives, even more Idaho children are in the care of their relatives through informal arrangements made within the extended family network. These informal kinship care providers do not have the financial and social supports available to formal foster placements (Berrick, Barth, & Needell, 1994). To underscore the scope of informal placements like these, the 2000 Census shows Idaho with nearly 18,000 children living in households headed by grandparents and other relatives. Only 1,860 children are currently in the foster care system in Idaho, a ratio of 1 child in formal foster care for every 9 children in informal care with relatives (Idaho Department of Health and Welfare data 2008). It’s clear from these data that families are the first line of defense in protecting and nurturing children in times of family crisis.
**Grandparents as Caregivers**

For most children in kin care, grandparents are the ones who step into the child rearing role – national data show that 59% of children in the care of kin are living with grandparents. In fact, 1 in 10 grandparents have been responsible for their grandchildren for six months or more at some point in their lives (Fuller-Thomson and Minkler, 2005). As the kin most frequently raising their young relatives, in 2000 the U.S. Census began collecting data on grandparents who are raising their grandchildren.

**Table 1: Recent increases in grandparents households raising grandchildren**

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2006</th>
<th>Change</th>
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</thead>
<tbody>
<tr>
<td>Idaho</td>
<td>8,110</td>
<td>9,792</td>
<td>+20.7%</td>
</tr>
<tr>
<td>U.S.</td>
<td>2,426,730</td>
<td>2,455,102</td>
<td>+1.2%</td>
</tr>
</tbody>
</table>

Source: U.S. Census 2000 and American Community Survey, 2006

Table 1 shows recent trends for grandparent caregivers in Idaho and the nation, including both formal foster care and informal kinship care. The most recent year for which data are available is 2006, when Idaho had nearly 10,000 households in which grandparents were raising their grandchildren, an increase of 20.7% since 2000. Recent growth in grandparenting households is considerably greater in Idaho than in the nation, which had an increase of 1.2% over the same time period. These have been growth years for Idaho’s population as a whole, increasing 13.3% since 2000. However, the number of grandparents raising grandchildren has grown at a much greater rate. As shown in Table 2, half of grandparent caregivers have been responsible for their grandchildren for 2 years or less, while about 1/3 have been raising their grandchildren for five years or more. National data show that those in kinship care tend to be older children, with 52% eleven years or older. Children six to ten years of age comprise 28% of children in kin care and 20% are five years or younger. Less than 2% are infants under one year of age. The 2000 Census showed that 13,636 Idaho children were in grandparent headed households, with another 4,128 in the care of other relatives, numbers which have likely grown since 2000.

**Table 2: Length of time grandparents have been raising their grandchildren**

<table>
<thead>
<tr>
<th></th>
<th>Idaho</th>
<th>U.S.</th>
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<tbody>
<tr>
<td>Less than 1 year</td>
<td>24.6 %</td>
<td>22.5 %</td>
</tr>
<tr>
<td>1-2 years</td>
<td>25.7 %</td>
<td>24.0 %</td>
</tr>
<tr>
<td>3-4 years</td>
<td>17.4 %</td>
<td>16.1 %</td>
</tr>
<tr>
<td>5+ years</td>
<td>32.3 %</td>
<td>37.4 %</td>
</tr>
</tbody>
</table>

Source: American Community Survey, 2006
American Community Survey data in Table 3 show a statistical profile of grandparents raising grandchildren in Idaho and in the nation as a whole. About 2/3 of grandparents raising grandchildren are under 60 years of age, while 1/3 are 60 years and older. In Idaho grandparents raising grandchildren are predominantly white, with many Hispanic households as well, each in proportion to their representation in the population. However, national trends show a slim majority of grandparenting households as white, with African American and Hispanic grandparent caregiving households about double their proportion in the population. Many of the family crises that bring grandchildren to their grandparents’ houses are over-represented in low-income families, and family incomes for minority groups in the U.S. are notably lower than those for white Americans. Because of low numbers, Native Americans are not shown separately in Table 3 at the state or national level, but other analyses show rates of grandparent caregiving at similar levels to that of African American families (Fuller-Thomson and Minkler, 2005). Asian children are the least likely of the cultural groups to be in the care of grandparents. The willingness of grandparents to step into the child-rearing role speaks well for the commitment to extended family in all of these cultural groups.

Table 3: Statistical profile: Grandparents raising grandchildren

<table>
<thead>
<tr>
<th></th>
<th>Idaho</th>
<th>U.S.</th>
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</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-59 years</td>
<td>67.9 %</td>
<td>67.7 %</td>
</tr>
<tr>
<td>60+ years</td>
<td>32.1 %</td>
<td>32.3 %</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White - not Hispanic</td>
<td>86.7 %</td>
<td>51.0 %</td>
</tr>
<tr>
<td>Hispanic</td>
<td>8.1 %</td>
<td>17.9 %</td>
</tr>
<tr>
<td>African American</td>
<td>**</td>
<td>25.0 %</td>
</tr>
<tr>
<td>Other</td>
<td>5.2 %</td>
<td>13.2 %</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>39.9 %</td>
<td>36.5 %</td>
</tr>
<tr>
<td>Female</td>
<td>60.1 %</td>
<td>63.5 %</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>76.0 %</td>
<td>70.1 %</td>
</tr>
<tr>
<td>Not Married</td>
<td>24.0 %</td>
<td>29.9 %</td>
</tr>
<tr>
<td><strong>Labor Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>64.7 %</td>
<td>58.8 %</td>
</tr>
<tr>
<td>Not Employed</td>
<td>35.3 %</td>
<td>41.2 %</td>
</tr>
<tr>
<td><strong>Citizenship</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S.</td>
<td>96.7 %</td>
<td>84.5 %</td>
</tr>
<tr>
<td>Foreign</td>
<td>3.3 %</td>
<td>15.5 %</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23.8 %</td>
<td>29.8 %</td>
</tr>
<tr>
<td>No</td>
<td>76.2 %</td>
<td>70.2 %</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At/above poverty level</td>
<td>92.1 %</td>
<td>80.6 %</td>
</tr>
<tr>
<td>Below poverty level</td>
<td>7.9 %</td>
<td>19.4 %</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own</td>
<td>83.0 %</td>
<td>72.5 %</td>
</tr>
<tr>
<td>Rent</td>
<td>17.0 %</td>
<td>27.5 %</td>
</tr>
</tbody>
</table>

** Due to small numbers, African Americans are included in "Other" for Idaho data
Source: American Community Survey, 2006
Table 3 shows that Idaho grandparents raising grandchildren are marginally more likely to be married and to be working than their peers nationally. Idaho grandparents are also somewhat less likely to be disabled and more likely to own a home.

Idaho grandparents have a lower poverty level than their peers nationally, which may be a reflection of the fact that more of them are healthy, married and working. However, trends in the general Idaho population often show relatively positive trends for family poverty, but higher than national rates for families between 100 and 200% of poverty. Families at this income level are generally employed at low wage work and earn too much money to qualify for state programs such as food stamps or subsidies for child care, but are very challenged nonetheless to make ends meet.

Concerns for Idaho grandparents raising grandchildren increase as they age. Many of the indicators reviewed show that challenges are greater for Idaho grandparents after the age of 60, when only 66% have the support of a spouse, as few as 27% still have the income of employment, 38.5% are disabled, and 11.8% live below the poverty level (2006 American Community Survey).

**Challenges of Transition**

An out of home placement for children with kin can be a challenge for adults and children alike. Relatives raising their kin are often thrust into the childrearing role with little warning. One grandmother described her response to the arrival of her grandchildren in terms of “shock and awe” at a Nampa, Idaho grandparent support group. Another grandparent listed the challenges she faced in protecting her grandchildren, including “seeing my grandchildren in a bad situation…. researching options, laws and supports, getting their mother’s agreement, and paying legal fees to obtain guardianship…. relationship with his irresponsible mother… juggling full-time employment with parenting, and relearning how to best parent a young boy who was deprived of love and care for his first year.” Even now, she works hard to keep up with her energetic grandchild, “I do not have the energy or stamina I had when I was young, but I make a point of racing, playing ball, and visiting the playground because he needs these activities.”

Grandparents and other relatives make major changes in their lives to care for young kin. Older relatives who are retired may need to go back to work to generate enough income to cover the expenses of the children. Relatives who are working may need to quit work to care for the children, especially when the children have special needs. Those in small living quarters may need to move to accommodate their expanding family. Older relatives may be living in senior-only residences that do not allow children, and will have to seek other housing when they add young members to their families. Relative caregivers may find themselves seeking social services for the first time to manage the expenses of the additional children in their home, and many will need a lawyer to establish their rights and authority as caregivers. Some will deplete life savings and retirement accounts to meet these many expenses associated with kincare.
Relative caregivers also experience social and emotional costs of their caregiving commitments. The addition of children to the household can shake up established friendship networks for caregivers, especially those with friends whose children have grown up and moved out of the home (Minkler & Roe, 1993). Those caring for children may be overwhelmed by the expense or the time involved in meeting the children’s needs. Married caregivers often experience marital stress as they work out disagreements about their new roles. Relative caregivers also frequently have continued conflict with the children’s parents, as well as tension with other relatives about the caregiving arrangement. Caregiver adjustments are complicated by a sudden loss of freedom and autonomy, and several report challenges working with state social service agencies (Gordon, McKinley, Satterfield, Curtis, 2003).

Many of the challenges kin care families experience in caring for the children come from the informal status of their custody arrangements. They may have the children at this time, but they are vulnerable if the children’s parents should take the children back. In some cases, children’s parents have authorized their kin to make critical decisions on behalf of their children by signing power of attorney statements, but the parents can revoke this authority and reclaim the children at any time. In many cases, kin caring for children have sought legal custody or guardianship, statuses that come with more authority but also have considerable costs in legal fees, and may exacerbate conflicts with the children’s parents. Some relative caregivers are in the formal foster care system, and have authority comparable to that of other foster parents. In a few cases, kin caregivers are able to adopt the children in their care, giving them full parental status in decision making.

Children also experience trauma in the transition, including fear and worry about their parents and wondering what the future will bring. Parental incarceration and substance abuse are the two most common reasons for relatives to assume caregiving responsibilities, developments which are troubling to children. (Bachman & Chase-Lansdale, 2005). Children in need of out of home care have often been compromised in development by prenatal exposure to alcohol or drugs, chronic stress, neglectful or abusive parenting, poor nutrition, irregular school attendance, and exposure to environmental toxins such as lead or byproducts of methamphetamine production. Children who have survived child abuse have higher rates of maladaptive coping, serious behavior challenges, attachment issues, poorer school performance, and greater rates of mental illness, substance use and abuse, along with complex medical needs.

Research in the past decade shows that the chronic stress of family conflict and instability can affect children’s developing brain architecture, resulting in heightened reactivity to stress. Such children experience higher levels of arousal in the case of conflict or trouble, and maintain that state of elevated anxiety for longer periods than those raised in a low stress environment. Long term effects of this reactivity are shown in increased vulnerability to stress-related health and behavioral problems. Development of strong bonds with stable responsive caregivers can moderate these negative outcomes for children. (National Scientific Council on the Developing Child, 2005).

These background factors mean that many children come to their relative’s homes with behavioral or health challenges. The adults who care for these children need specialized training and support to meet their complex medical, emotional, and psychological needs.
Family Economics for Relative Caregivers

Families who take young relatives into their homes have many new expenses to cover. Working kin with younger children in the home will have child care expenses, and many families will need additional living space. In addition, there are expenses of clothes, school supplies, medical care, food, and furnishings required when raising children, legal counsel, medical and counseling services, and higher education costs as the children approach adulthood.

Those who raise their young relatives in Idaho within the foster care system have the financial resources of foster care payments of up to $431 per child per month, with additional funds for children requiring specialized care. Other supports include funds for school supplies, gifts, and special needs, as well as health insurance for the children through Medicaid, all resources managed by the Idaho Department of Health and Welfare.

However, kin who have taken in children informally lack those crucial supports. In general, informal kin care families are eligible to receive a child-only grant from TANF (Temporary Assistance for Needy Families), the welfare system administered by the state. In Idaho, families receive the same amount of money, $309 per month, regardless of the number of children being cared for. This is a limited subsidy at best, particularly for families caring for 2 or more children. At that, only 1,301 Idaho families received child-only TANF grants in 2003, though there were over 10 times that many households with kin raising young relatives who were eligible for the payment (Dougherty, 2004). Children in kin care are also eligible for Medicaid, an important tool for meeting their health care needs.

Despite the financial and resource advantages, most relatives raising kin avoid seeking assistance from the formal child protection system. To do so would require that the state assume custody of the children for abuse, neglect or abandonment, and the Idaho Department of Health & Welfare would then be obligated to notify and work with the children’s parents to ensure the children have a permanent living arrangement. Re-involving the children’s parents in child protection proceedings could upset the often tenuous relationships between the parent and the relative caregiver and potentially disrupt the stability of the child’s living arrangement. In addition, when a child living with a relative does enter formal foster care through child protection, the kinship caregiver must become a licensed foster parent and be in compliance with all licensing standards including substantial training. This can be an onerous requirement for kinship providers who are already struggling with the demands of raising the relative children.

Data show that kin care providers have fewer resources to meet foster home licensing requirements, including having lower incomes than non-kin foster parents and being less likely to own their homes. Kin care providers are less likely than non-kin foster parents to have graduated from high school, they are older, more likely to be single and in poorer health – all factors that may make it hard for them to qualify as foster parents (Harden, Clyman, Kleiman and Lyons, 2004).
In fact, national data show that few kin caregivers receive funds to help them meet the needs of the children in their home. The 2002 Survey of America’s Families showed that, even when children were placed by the courts with kin, only 1/3-1/2 received foster care payments. Study authors speculated that many kin families didn’t go through the process of foster care licensure. Other funds which could have been available include social security payments available to children whose parents have died (4% of children in kincare receive these funds) and SSI payments for those with a diagnosed disability (6% were awarded SSI payments; Murray, McComber and Geen, 2004). The same survey found that most informal kin caregivers received no payments at all (78%). Child-only TANF payments, for which all families would have been eligible, were received by only 6% of the homes. In addition, 10% of the homes received some other type of payment (e.g. child support). Most grandparents reported having difficulty in getting one or more services they need for their grandchild (56%), with problems most frequently cited in accessing medical or legal services.

Evidence at the national level also suggests that kincare households are financially stretched (McComber and Geen 2002). Families in both formal and informal kincare arrangements report having difficulty paying for housing or live in crowded quarters (39-40%), and experience food insecurity (48%). Kin caregivers in the foster care system were more likely to be receiving food stamps (59% vs. 37% for informal kin caregivers) and Medicaid (75% formal vs. 35% informal kin caregivers).

Despite the services available in the foster care system, even kin who are licensed foster parents receive fewer services than non-kin foster parents. They are less knowledgeable about the services available and therefore less likely to ask for help. However, they also receive fewer offers of help from social service providers, and are less likely to receive the services they request (Geen, 2003).

**Health and Well-being of Children in Kincare**

When it comes to the well-being of children in foster care, long-term placements are associated with significant improvements in health status, physical growth, and educational achievement of children (Simms, 2000; White and Benedict, 1986). A notable advantage of kincare is placement stability. That is, children in foster care with relatives experience fewer placement changes than children in non-kincare foster placements. Idaho data in 2002-3 show that 85% of children placed in foster care with relatives lived in the same home for a year or more, while only 58% of children with non-kin foster parents had placement continuity for the year. (Pew Charitable Trusts, 2007).

Children living with relatives also report feeling less stigma with their out of home placement than children in non-relative kincare homes. Children in kincare also have fewer school changes, and more visits with siblings and parents (Conway & Hutson, 2007, Pabustan-Claar, 2007). Another unique benefit of kinship care is the ability for children to remain in homes that are racially and culturally similar. By maintaining racial and cultural ties positive self image, feelings of belonging, and self-worth are achieved (Casey Family Programs, 2008).
Critics of kincare placements voice concerns about the health outcomes of children in kin care homes. Numerous studies have demonstrated that children in kinship care are at high risk, with health outcomes very similar to children in other types of out of home placements, particularly traditional foster care. The most common physical health problems seen in kincare children include impaired visual acuity and hearing, obesity, short stature, dental caries, and asthma (Dubowitz, Feigelman, Zuravin, Tepper, Davidson & Lichenstein, 1992). In a large study comparing the health needs of young children (under age 6) by placement type, it was found that all children in the child welfare system, regardless of placement type, were likely to have numerous physical health, developmental, or mental health issues (Leslie, Gordon, Meneken, Premji, Michelmore, & Ganger, 2005).

Children in kinship care, like children in foster care, are often not adequately immunized and fail to receive other types of preventive care, including well child care and dental care. According to the results of a study conducted by the United States General Accounting Office (1995), children in kinship care were nearly three times as likely as those placed in traditional foster care to receive no routine health care. In addition, kinship care children were less likely to receive all types of health-related services. This finding is particularly of concern, given the fact that children in kinship care tend to remain in their placements longer. Preterm infants, an especially vulnerable group with complex health needs, who are raised in kinship placements have also been shown to receive inadequate health care follow-up, including immunizations, and have more rehospitalizations than children living with their parents (Gennaro, York, & Dunphy, 1998).

In relation to mental health and behavioral problems, some studies indicate that children in kincare have lower levels of mental health problems compared with children in traditional foster care (Iglehart, 1994, Berrick, Barth, & Needell, 1994) while others studies showed no difference (Leslie, et al, 2005; McMillan, Zima, Scott, Auslander, Munson, Ollie, & Spitznagel, 2005; Dubowitz, Zurvin & Starr, 1993). Children living in informal kinship care, however, tend to have the lowest utilization of mental health services (Academy Health, 2004). The limited access to health insurance for children in informal kinship care no doubt exacerbates this problem.

From a long term perspective, studies shows that serious health concerns continue into adulthood for children raised in both kincare and traditional foster care. Adults who were raised in kinship and nonkinship families show similar risks in terms of limited educational attainment, unemployment, physical and mental health challenges, risk-taking behaviors and the stresses and supports in their lives (Benedict, Zuravin, & Stallings, 1996). Women raised in kinship care, similar to those raised in other types of out of home placements, have been found to have a younger average age of both first intercourse and first conception and have greater than the median number of sexual partners, compared to young women raised in biological families (Carpenter, Clyman, Davidson, & Steiner, 2001).
Thus, it appears that from a health and well-being perspective, children raised in kinship care are fairly similar to other children raised in traditional foster care and other types of out of home placements. Considerable research has addressed the specific health characteristics and needs of foster children in general, including physical, mental, and developmental aspects. In terms of physical health, it is important to note that most children enter the foster care system in poor health states, having received inadequate preventive health care. Many have also had negative prenatal factors, particularly drug exposures, which predispose them to chronic health problems. Upon entry into foster care, the most common health problems include acute infections, anemia, elevated lead levels, respiratory problems, skin problems, and developmental delays. After entering foster care, the health status of some children improves, with many children experiencing a period of dramatic catch-up growth in height during the first year.

Complex physical, emotional and developmental health problems are often contributing factors to children’s need for out of home placements. Day to day management of these often multiple and complex health concerns can be extremely challenging for caregivers. Children in out of home placements in the foster care system are at high risk for behavioral and emotional problems, in part due to a history of abuse or neglect along with the trauma of multiple placements. The most common types of mental health problems include “externalizing behaviors” such as aggression, attention problems, and delinquent behaviors (Kools & Kennedy, 1999). Similarly, it is estimated that up to 60% of children in foster care have some type of developmental delay, particularly language delays (57%), cognitive problems, (33%), gross motor problems (31%) and growth problems (10%). Children with developmental delays tend to stay in foster care longer.

In light of these concerns about the health status of children in kinship care, issues related to health care access and utilization must also be addressed. As indicated above, children in kinship care tend to lack health insurance and utilize all health care services, particularly preventive services and mental health services, less than children in other types of out of home placements. These utilization patterns may in part be due to the fact that foster and kinship caregivers often find it difficult to find health care providers who are willing to accept their children as patients due to the complexity of their needs, low reimbursement by Medicaid, inadequate health history information, excessive paperwork, poor communication with care providers and social service agencies, and the risk of mandatory court appearance. In addition, kinship caregivers may need education regarding the importance of regular preventive health care for children. Greater efforts are needed to improve access and utilization of health care for children in out of home placements through creative collaboration between child welfare and health care systems (Simms, Dubowitz, & Szilagyi, 2000).
Life Changes and Health for Caregivers

Kin who accept the responsibility of raising relatives’ children experience a dramatic change in lifestyle. Taking children into the home can result in the loss of close friendships, forever altered family relationships, severed connections in the community through work, church, and other sources as child rearing becomes a priority, and sudden and drastic changes in future plans.

Considering these transitions, promoting the health of kinship caregivers is a critical consideration. The health status of older kinship caregivers, especially grandparents and great grandparents, is particularly important given the goal of permanence for the children. Caregiving grandparents often voice concerns related to staying healthy and living long enough to see their grandchildren reach adulthood. Thus, promoting the health of kincare providers should be a goal for the family in concert with health care and social service agencies.

Most of the research that has examined the health of kinship caregivers has focused on grandparents and has shown both positive and negative outcomes. Some studies report that custodial grandparents have poorer physical and mental health, role overload and confusion, and more isolation from age peers and noncustodial grandchildren (Hayslip & Kaminski, 2005). They report higher rates of depression, diabetes, hypertension, insomnia and limitations with activities of daily living than their age peers. This may be due to the fact that the demands of child care may reduce grandparents’ time for self care, including exercising and accessing health care, and may also exacerbate poor health behaviors, such as smoking (Burton, 1992; Waldrop & Weber, 2001; Roe, Minkler, Saunders & Thomson, 1999).

Parenting grandchildren can also strain grandparents’ marital relationship, disrupt their life plans, and reduce family income. Custodial grandparents face significant stressors, including tension/disappointment with the grandchild's parent, grief over losses related to their adult children’s issues, concerns related to their grandchildren’s physical and/or emotional health, social isolation and inadequate social support. Nevertheless, most custodial grandparents express positive feelings related to their situation, citing the opportunity to maintain close relationships with their grandchildren along with an enhanced sense of purpose related to maintaining the family identity and well-being.

Many custodial grandparents see their current situation as a “second chance” at parenting (Gatti & Musatti, 1999). In the most definitive study to date, Hughes, Waite, LaPierre, and Luo (2007) found little support for the negative effects of childrearing on the health of custodial grandparents. In this large national longitudinal study, custodial grandmothers showed a decline in self-rated health after their grandchild moved in, but the negative effect disappeared over time. Grandmothers in this study showed some increases in depression, obesity, and reduced exercise while providing care for their grandchildren. Interestingly, grandmothers developed more functional limitations after their grandchildren moved out, suggesting a positive effect of childrearing. These researchers concluded that “For most grandparents, the demands of grandchild care appear to be balanced by the benefits of caregiving and available resources. Only when demands are heavy and resources are scarce will grandchild care itself lead to health declines.” (p. 11). These important findings suggest that kinship care may actually be a health promoter for grandparents, if adequate support and resources are available.
Ensuring support for kinship caregivers, thus is critical, but unfortunately these families typically seek and receive less formal support from the child welfare system than non-relative caregivers. However, we know that social support is a key factor for grandparents successfully raising their grandchildren. When grandparents have strong formal and informal social support, they report better health, less parental role strain, and less depression (Emick and Hayslip, 1999). Hayslip and Kaminski (2005), based on their review of the literature, conclude that “social support appears to be crucial to the physical and mental health of custodial grandparents, as well as their ability to cope with the demands of parenting” (p. 6). If our goal is the health and well-being of kinship families, then, it is logical that enhancing both informal and formal social support systems is indicated. The limited research to date that has evaluated intervention programs with kinship families indicates that grandparent support groups are particularly beneficial (Hayslip, 2003). Given the fact that most kinship placements are informal and kinship providers receive limited social services, the need for intervention focused on strengthening social support networks is clear.

In summary, the physical, mental and developmental health of children in kinship care is a major concern, exacerbated often by lack of access to health services and health insurance. Concomitantly, the health of kinship caregivers, particularly grandparents, can be at risk due to the demands of caregiving, age, and limited resources. Health promotion and family support programs provided by health care and social service agencies can help ensure that these families stay healthy, stable, and intact.

### MEETING THE NEED: POLICY CONSIDERATIONS

In overview, in Idaho as well as in the nation, the great majority of children in out of home care are living in informal arrangements with relatives rather than in the formal foster care system. The state invests substantial funds in payments and programs for children in foster care, but families caring informally for their kin lack access to these supports, and are minimal users of the few programs they are eligible for.

The Idaho Department of Health and Welfare estimates the annual cost of a child in foster care at $3,300. At this rate, the nearly 18,000 Idaho children in the care of their kin (U.S. Census 2000) would cost up to $60 million to support if they were to enter foster care. Relatives currently caring for their family members are stressed in many ways to meet the children’s needs, including access to medical and psychological services, legal counsel, food, housing and child care, and support and training for their new caregiving responsibilities – many of the same supports that would be available if they were in the formal foster care system.

In recognition of the important role of kin caregivers for child protection in Idaho, public and private agencies have taken several steps to develop necessary supports for this family-based system, under the guidance of the state-wide Kincare Coalition. Over the past few years grants from the Brookdale Foundation have helped fund the development and maintenance of kincare support groups in regions around the state, with ongoing support from Area Agency on Aging. In addition, the Department of Health and Welfare has reviewed programs and policies to lower barriers to access for relative caregivers.
As an example, relative caregivers were often prevented from obtaining TANF funds for the children in their care because they were afraid that if Health and Welfare pursued child support from the children’s parents (a TANF requirement) the parents would take the children away. Acknowledging the seriousness of this concern for children’s welfare, Health and Welfare now finds “good cause” not to pursue child support if relatives express this concern, increasing caregiver access to TANF funds as well as Medicaid and food stamps.

A particularly noteworthy strategy to addressing the needs of kincare families is the use of navigators, who assist families in accessing formal systems and community services. Currently, there are 24 navigators serving families throughout Idaho. Navigators help families in need identify programs for which they qualify and complete the applications necessary to obtain services. Flexible funds are provided by the Casey Family Programs to navigators specifically to meet the needs of relative caregivers in raising the children. This availability of flexible funding is significant, since many of the families served do not receive or are not eligible for Health and Welfare support. This small, but highly effective program could be expanded to meet the growing needs of kincare families statewide.

Like most issues with families, children’s well being is supported best when the surrounding community and its agencies work in synchrony. Relatives raising their young kin can benefit from support from communities as well as government agencies.

Communities can support kincare families in several ways:

- Schools can lower the barriers to school enrollment. Children often arrive at relatives’ homes in an emergency, and it can be some time before authorizing documents are available. However, children will benefit if they are able to enroll in school as soon as possible, on a provisional status if necessary, including access school-based health, nutrition, and other support services.

- Nonprofit family serving agencies and faith communities can be aware of the special challenges of kincare families and allocate resources to help meet those needs. Families caring for kin frequently need legal counsel, emergency funds for housing, clothing and food, and support for child care, among other needs. Nonprofit agencies have flexibility in funding, which can help kincare families who don’t meet criteria for formal government programs. Receiving support from community agencies, such as churches, may be more acceptable to some kincare families and may be more accessible as well, particularly in some rural areas.

- Youth organizations can welcome children in kincare into their programs. Organizations often require the signature of a parent or legal guardian for children to participate in activities. Many kin caring for youth are not their legal guardians, yet the young people would greatly benefit from access to youth programs. Such programs should review their criteria for adult consent and consider extending authority to kin informally caring for youth.
Family serving professionals such as doctors, dentists, and counselors can support the needs of kincare families by accepting Medicaid patients. Many kincare families need legal counsel to help them explore legal permanency options in their roles as caregivers. Lawyers can allocate pro bono work to helping kin caregivers meet their legal needs. Professional development programs are needed to help family serving professionals understand the unique needs of relative caregivers and the children in their homes.

Employers can support relative caregivers by reviewing family-relevant policies to ensure that kincare families are included (Simon-Rusinowitz, Krach, Marks, Piktalis & Wilson, 1996). When an employee becomes the caregiver for young kin, are those children eligible as dependents for health care coverage? Can relative caregivers take family leave if needed? Do they have access to workplace child-care benefits such as on-site care or employee subsidy? Is flextime available for kin caring for youth in their families? Do the children qualify for behavioral health services through the employee assistance program? These are all ways in which work-place benefits can help relative caregivers who are working.

Government agencies can support kincare families in many ways:

- Extend efforts to connect kincare families to the programs they are currently eligible for, including child-only TANF grants and Medicaid. Studies on child well-being show the serious medical and emotional problems of children entering kincare, with marginal family incomes adding further stress for kincare families. TANF funds and access to health care and counseling through Medicaid can be important tools for families in improving outcomes for the children in their care.

- Review services, funds, and programs available to foster care families to identify those that can be extended to informal kincare families. Kin who care for young family members save the state millions of dollars by keeping the children out of the foster care system. Support can be extended to relative caregivers through subsidized guardianships, by extending training opportunities to kincare providers, as well as opportunities for support and respite care.

- Review policies that include family assets in determining eligibility for programs such as food stamps. Older caregivers may have significant retirement savings which should be excluded in determining eligibility for the resources they need to care for the kin they have taken into their home.

- Broaden the system of kincare support throughout the state. Several strong support groups have developed and are having a positive impact on kincare families. However, the state is challenged in low population areas to meet family needs for support. Alternative models such as mentorships or electronic communities may be more appropriate in areas that lack a critical mass of kincare families for a group approach.
In conclusion, this review has demonstrated that extended families throughout Idaho are providing an incredible public service by providing essential care to children in need of out of home placement. The extended commitment of relatives to nurture and protect the children in their family network is testimony to the power of relationship in today’s families. Unfortunately, however, these families receive limited support to meet the needs of the children they take into their homes, which puts them at economic, social, and health risk. Greater efforts are needed to ensure that Idaho’s kincare families thrive, with the support and encouragement of communities and government agencies.

**GRAND FAMILIES COUNT**

- Expand programs for low income families. Many of the challenges faced by kincare families are the problems of low income families in general. For example, Idaho’s child care subsidy program for low income working families is one of the most meager in the nation (Brown, Shaklee, Jensen, & Evans, 2006). Many other states enhance their federally funded programs with additional state dollars to provide access to quality care for more children when their parents are at work. Many states also have a state Earned Income Tax Credit so working low income families can keep more of their income to meet family needs. Expansion of benefits for working families such as these can help kincare families meet their needs.

- Kincare families currently benefit from the flexible fund provided by the Casey Family Programs and distributed by Health and Welfare navigators to benefit children in kincare. However, the current fund meets only a portion of the needs of these families. More flex funds like these could meet the needs of more children and help relieve overburdened kincare providers.

- Data is sparse on kinship families since so many of them are not in the formal foster care system. Child welfare is the business of the state yet we know very little about the lives of most of the children in out-of-home placements, since they are in informal family-based arrangements. State and local agencies, schools and other public entities should collaborate to develop a data base on children in kincare in Idaho, to guide planning and support for kincare families.

The Kinship Caregiver Support Act (H.R. 2188/S.661) is federal legislation under consideration that would address some of these concerns. The bill would establish a Kinship Navigator Program to connect relative caregivers to existing program and services, somewhat like the role of Idaho’s Health and Welfare navigators. It would also allow access to federal funds for subsidized guardianships for relatives, helping support kin caregivers who are not in the foster care system but can offer a permanent placement for the children. In addition, it would permit states to develop separate licensing standards for foster parents who are relatives of the children as long as they are adequate to ensure child protection.
A Special Concern for Kincare: Parent Deportation

Recent years have brought increasingly aggressive enforcement of immigration law. Undocumented immigrants who face deportation are often parents, and in many cases their children are citizens of the United States.

A recent case study of workplace immigration raids in 3 small cities demonstrated the impact of arrest and deportation on the children left behind (Capps, Castanada, Chaudry, & Santos, 2007; (Murguia, 2008). The study showed that more than half of arrested adults had children in the U.S., most of whom were U.S. citizens (born in the United States) under 10 years of age. Many arrestees had to leave the country before they could communicate with family members or with lawyers who could help them make arrangements for their children.

The impact of workplace raids in these cities reverberated throughout the community. Schools, child care providers and social service agencies scrambled to find homes for the children left behind. Many children were cared for by relatives, including grandparents, aunts and uncles, and older siblings, while others went to homes of friends and neighbors. Those caring for extra children were strained by the added stress and responsibility. Family members feared that if they went to state or private agencies for help, they and other family members would be arrested. Many hid in their homes for days or weeks. Family fears led to isolation from potential support networks.

Teachers, caregivers, and mental health professionals reported considerable evidence of mental health issues for children when a parent was deported, including feelings of abandonment, trauma, depression, fearfulness and other problems. Inconsistent child care and supervision made it even harder for the children to adjust to the sudden loss of their parent(s).

These results show that current practices in immigration enforcement threaten the welfare of children, many of whom are U.S. citizens. Discussions with social service providers in Idaho show that stepped-up immigration enforcement in the state has resulted in similar crises for children and the relatives and family friends who take them into their homes.

These concerns for children indicate that immigration enforcement procedures need to be reviewed to adequately accommodate family needs and minimize hardship for children. Enforcement procedures should allow parents to have access to legal counsel and phones so they can provide for their children’s care.

Partners throughout the community are left to handle the aftermath of workplace raids and other immigration enforcement procedures. Public and private social service agencies will need to work together to find safe and stable homes for the children left behind. Families will help their children and the service providers and family adults who will be involved if they have a plan for their children’s care in the event of parent arrest and deportation.
REFERENCES


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Idaho KIDS COUNT is a children's research and policy organization dedicated to informing policy discussions and decisions to secure better futures for all children. To carry out this mission, Idaho KIDS COUNT:

- Collects the best available data on child well-being at the state and county levels to measure progress.
- Using data, informs policy makers and citizens about the status of Idaho children and effective policy strategies to improve their well-being.
- Partners with Idaho Voices for Children and other child advocacy organizations to mobilize policy and community action.

Special thanks to Casey Family Programs for their collaborative support.