Kinship Care and Substance-Exposed Children

Roughly half a million children are in foster care in the United States, about twice the number of children in care just ten years ago (Administration for Children and Families, 1996; Tatara, 1991). The sharp increase in the number of children in foster care has been largely attributed to the growth in the number of prenatally substance-exposed children entering and staying in the child welfare services system (Feig, 1990). Nearly two-thirds of the children in foster care in 1991, for instance, were considered at risk for serious health problems due to prenatal substance exposure, compared with just over one-fourth of children in care in 1986 (General Accounting Office, 1994). In a recent review, the General Accounting Office (1998) estimated that two-thirds of all children in care had substance abusing mothers, and that 80% of those mothers had been using drugs or alcohol for at least five years, many of them for ten years or more.

Interpreting the sparse research that exists on the developmental outcomes of substance-exposed children is difficult because the prenatal effects of exposure are often clouded by other factors such as poor maternal health, inadequate nutrition, and lack of prenatal care. Similarly, the postnatal effects of exposure are clouded by other factors such as family dysfunction, poverty, and environmental deprivation. Despite difficulties interpreting the research, studies show that substance exposure in utero does not inevitably result in poor outcome for children (Graham et al., 1994; Nulman et al., 1994; Rodning, Beckwith & Howard, 1992). The development and well-being of prenatally substance-exposed children appears to be determined, to a large extent, by their caregiving environment.

Kinship Care

More than ever, children are placed into care with extended family members. This type of care is usually called “kinship care” and is the fastest growing out-of-home placement funded by child welfare agencies throughout the United States (Gleeson, 1996). In some areas of the country, approximately half the children in out-of-home placements are in kinship care (Brooks, Webster, Berrick, & Barth, 1998; Dubowitz et al., 1994). The growth in kinship placements can be attributed to several factors including a dwindling pool of traditional foster homes and a growing emphasis among practitioners on family continuity.

Kinship care allows children removed from their parents to continue living within the bounds of their extended family. It also may reduce trauma for children who are separated from their parents, reduce stigma they experience from becoming “foster children,” and facilitate the transmission of their cultural identity. These strengths of kinship care have led to the increased recognition of kin as a valuable child welfare resource. In the past, workers often encouraged voluntary placement of children with kin as an informal and often unregulated means of resolving child protection cases. Over the past decade, though, as the growth in the out-of-home care caseload has outpaced the number of available traditional foster parents, states such as California have moved increasingly toward more formal kinship foster care arrangements. Whereas many view this as an encouraging development, it also triggers some complicated issues concerning legal custody arrangements, licensing, and funding. (See Harvey article on p. 3).

Further, some states have excluded kinship placements from their formal foster care system, eliminating the supports and protections usually required by law.

Characteristics of Kinship Care

Data show that children who are placed with kin have more stable placements than those placed with nonrelatives, and that they are more likely to remain in care for longer periods than children in other placement types. Of children who entered out-of-home care in California, Illinois, Missouri, and New York between 1988 and 1994, those placed with relatives remained in care about 30% longer than children in other forms of foster care (Wulezyn, Harden & Goerge, 1997). This may be due to a combination of factors including less intensive contact by child welfare workers with children in kinship care, more
complex problems in these families often due to substance abuse, and/or the fact that children in non-relative placements are often reunified too soon. Indeed, this last factor is supported by the finding that children who experience exits from kinship care typically are less likely to reenter foster care than those exiting from nonrelative placements. In California in 1993, the proportion of children who were placed with kin and reentered was 18%, compared with 25% for children placed with nonrelatives (Brooks et al., 1998).

In general, kinship foster care is used more often as a formal placement option for African American children. In 1996, African American children were the largest group of children in kinship homes in California, for instance, while Caucasian children were the largest group of children in foster homes, foster family agency homes, group homes, and other placements. Like African American children, Latino children were more likely than Caucasian children to be placed in kinship homes. Specifically, half of all African American and Latino children were placed with kin, compared with 39% of both Caucasian children and children from other racial and ethnic groups (Brooks et al., 1998). The use of kinship homes also appears to vary by the age of the child being placed. Most children in kinship or foster homes in California in 1996, for example, were between 6 and 12 years old. Kinship homes were used less often for infants and teenagers than for children of other ages.

Research on Kinship Care and Substance-Exposed Children

Findings from empirical studies on kinship care are mixed, but generally indicate that foster children benefit from kinship placements. Findings from a study conducted by Fein, Maluccio, Hamilton and Ward (1983) revealed more positive indicators of adjustment for children placed with kin than for those placed with nonrelatives or in residential facilities. The researchers also found less use of educational and health services by kinship providers. More recently, Berrick, Barth and Needell (1994) found that children in both kin and nonrelative placements exhibited a number of health, mental health and behavioral problems. Yet, children between the ages of 4 and 15 who were placed with kin were found to exhibit somewhat fewer problems than children placed with nonrelatives. In contrast, Benedict, Zuravin, and Stallings (1996) found that, although adults who had been placed in foster care with kin had fewer mental health and emotional problems at the time of placement than those placed with nonrelatives, both groups were functioning similarly at follow-up in terms of education, employment, physical and mental health, risk-taking behaviors and stresses and supports in their lives.

While these studies provide useful information, they do not consider the interrelated impact of drug exposure and types of caregiving environments on children’s outcomes. To compare the characteristics and outcomes of prenatally substance-exposed and non substance-exposed children in kinship and nonrelative foster care, Professor Richard P. Barth and I studied 600 foster caregivers (Brooks & Barth, 1998). The caregivers were taught how to select a child for the study who was older than two years of age and had been in their care for at least six weeks. Of the caregivers studied, 258 (44%) were caring for children who were prenatally exposed to substances; the remaining 323 (56%) were caring for children who were not substance-exposed. Caregivers in the study were asked to indicate their relationship to the child who was the subject of the study. Based on their responses, subjects and their caregivers were placed into one of the following groups: (1) non substance-exposed kin (139 families); (2) substance-exposed kin (103 families); (3) non substance-exposed nonrelative (184 families); or (4) substance-exposed nonrelative (155 families).

Findings

Analysis of our data revealed both similarities and differences in foster family and child characteristics. In terms of children’s educational performance, no differences were found among groups. Most foster children were doing well in school, making A’s and B’s (or doing “Very Well” or “Well”) in their classes, regardless of their substance exposure or kinship status. Children were different, though, in terms of their emotional and behavioral development. Kin caregivers, overall, were more optimistic than nonrelative caregivers about the type of adult into which they believed their children would grow.

Observed differences in children’s emotional development, therefore, seem to be explained by their kinship status. Differences in problem behavior, on the other hand, appear to be related to children’s substance exposure status (substance-exposed children exhibited more problem behavior than non substance-exposed children). Analysis of the data further revealed that the children least likely to exhibit problem behavior were those who were not prenatally substance-exposed and who were living with kin. These children were one-third as likely as children from either substance-exposed group, and onefifth as likely as children from the non substance-exposed, nonrelative group, to exhibit problem behavior. Another analysis showed that children not placed at birth were six times as likely as children placed at birth to exhibit problem behavior, regardless of placement type or drug exposure status.

The above findings suggest that differences in problem behavior between substance-exposed and non substance-exposed children are confounded by children’s kinship status and other factors, such as their age at placement, that are associated with placement type. Stated another way, the differences in problem behavior between the kin and nonrelative groups in our study are confounded by children’s substance exposure status. Placement in kinship care seems, then, to pose special challenges for children who were prenatally exposed to substances, but not for non substance-exposed children. The decisions to place substance-exposed children with kin should include special considerations of the family’s likely access to, and use of, services to adequately meet the potentially complex medical, educational, emotional, and behavioral needs of those children.

Continued on page 20…
The Legal Maze of Kinship Care

The prevalence of grandparents and other relatives as primary child caregivers has skyrocketed nationwide since 1983. This emergence of kinship care can be attributed to a number of complex and interwoven factors, including welfare reform, the rising rates of incarceration for women, the effect of "three strikes" legislation, the HIV/AIDS epidemic, teen pregnancy, poverty, racism, homelessness, unemployment, increased substance abuse and limited treatment facilities for drug and alcohol dependent parents, and further marginalization of low-income communities. Innocent children have been essentially orphaned or abandoned by parents unable to fulfill their caretaking responsibilities because of these grave and deep-rooted societal issues. Grandparents and other relatives have stepped in to stabilize living situations for their grandchildren, provide them with stable, caring homes, and prevent the trauma of multiple out-of-family placements.

The growing number of grandparents who are parenting a second time is quite striking. In 1995, almost 2.5 million grandparents were caring for their grandchildren, and about one-third (911,000) of these were caring for children in homes where neither parent was present (Flint & Perez-Porter, 1997). The total number of children living in households maintained by grandparents or other relative caregivers increased from approximately 2.2 million in 1970 to roughly 3.4 million in 1993 and an estimated 4 million in 1997 (Harden et al., 1997; Minkler, 1997).

Grandparent and relative caregiver headed households encounter multiple and complex issues, including lapsed or skipped generation parenting, traumatic separation of children from birth parents, economic strains on limited incomes, and parental recovery issues (including co-dependency). Grandparents must re-define their relationship to their grandchildren, especially in the area of discipline, and adjust or readjust their households financially and physically for these children. Moreover, kin caregivers must overcome personal challenges and stresses, such as declining health, lack of social services support, lack of affordable and adequate housing, and limited access to child care. Both the child and grandparent must also struggle with their relationships to the absent parent, especially when the relationship between the grandparent and grandchild becomes a legal custodial one.

Grandparent and relative caregivers and those who work with them need to understand the myriad of legal issues that these families confront. Many focus on custody arrangements and access to public benefits. Peripheral legal issues affecting kinship families often include, but are not limited to, adequate housing concerns, health care coverage, educational services for disabled children and domestic violence problems. This article provides an overview of the legal custody options available to grandparents and other relative caregivers.

Informal Caregiving

In many families, the grandparent steps in to care for the child with no concern or interest in obtaining legal custody of the minor. This is generally an informal relationship acceptable to both the caregiver and the parent(s). Children may live with grandparents due to a variety of circumstances. In some instances, the child may be taken in suddenly because of the parent's incarceration or illness. In other circumstances, the parent will ask the grandparent or relative to take care of the child for a while until s/he can provide for the child. Often times, the grandparent gradually becomes the full-time, primary caregiver; however, such relatives are often averse to involving strangers in their personal, family affairs and, thus, will not venture into the court system. Frequently, they do not want to disturb the status quo because they feel the child is safe while informally residing with them.

As long as the caregiver and the parent are able to communicate and agree on where the child should reside, this informal arrangement can work very well. It also alleviates any violent or disturbing reaction from the parent, which may be expressed when a court action is filed. Clearly, legal proceedings can create family strife and provoke negative reactions from otherwise complacent/agreeable parents (Crumbley & Little, 1997).

The disadvantage of the informal arrangement is that a parent can move the child at any time s/he desires. This results in the child being frequently bounced from place to place and unable to ground him/herself in a stable home and school environment. Furthermore, without a court action to transfer legal custody, the parents retain full parental rights. Consequently, a legal vacuum looms for the child without a parental decision-maker (Flint & Perez-Porter, 1997). The grandparent may have difficulty enrolling the child in school, obtaining medical treatment or dealing with public benefits issues.

Several legal tools exist that can assist the informal caregiver with decision making for the child. The first is a Power of Attorney, which is a written instrument in which one person appoints another person to act on her behalf. A parent could therefore give power of attorney to another adult/caregiver to enroll her child in school or consent to emergency medical care if she is unavailable. This act does not legally transfer custody or terminate parental rights. However, it does grant the caregiver authority to make certain decisions for the child. The power of attorney can be a very...
effective tool if the parent consents because it achieves immediate goals, but can be revoked at any time if the parent deems it necessary (de Toledo & Brown, 1995).

A second tool is the caregiver authorization form. In 1994, two jurisdictions enacted legislation that created authorizations for informal caregivers to access medical care and/or enroll a child in school. In California, the Caregiver’s Authorization Affidavit (Cal. Educ. Code § 48204; Cal. Family Code § 6550), allows a caregiver who is 18 years of age or older to enroll a minor into school and consent to school-related medical care, such as immunizations and physical exams. Relative caregivers also have the right to consent to medical and dental care through use of this form, but they must attempt to contact the parent or guardian prior to its use. While completing and signing this one-page affidavit can secure important services quickly for the minor child, it does not allow the caregiver access to vital school and medical records.

In Washington, D.C., the “Authorization for Medical Consent for Children in the Care of Adults Other than Parents Act of 1993” was enacted to address the need of kin caregivers who must access medical care for the children in their care (D.C. Code § 16-4701). By signing this authorization form, parents and legal guardians can allow another person (presumably the caregiver) to consent to the immunization, medical, surgical, dental, developmental screening and/or mental health examination or treatment of a child (Ginchild & Perez-Porter, 1996).

Legal Guardianship

When a caregiver decides to obtain custody of the minor child, guardianship generally is sought. Guardianship is a formal legal arrangement that transfers custody of the child from the parent to another person by court order. The appointed guardian obtains legal and physical custody of the minor and is responsible for the care, custody, control and education of the child. Although a guardianship in effect temporarily suspends parental authority, the parents may be entitled to visitation and continue to be financially responsible for

The legal standards for obtaining an uncontested guardianship are whether it is: (1) necessary and convenient, and (2) in the best interests of the child. However, if the parent contests, the guardianship standard is raised to proof of detriment. A showing must be that parental custody would be detrimental to the child, and that an award to the “nonparent” is in the child’s best interest and is necessary to avert harm to the child.

The main advantages of the guardianship are the grant of decision-making authority and the stability it provides for the caregiver and the child. Once a guardian is appointed, the court rules that the parent is no longer the child’s guardian (de Toledo & Brown, 1995). However, the guardian cannot deny visitation arbitrarily.

The grave disadvantages of guardianship are the risks involved. First, the guardianship action may antagonize and provoke parents who were otherwise uninterested in removing the child from the grandparent’s care. Second, the possibility of the parents contesting is a great risk because the grandparent may have to enter into litigation against the parent if the grandparent wants to pursue legal guardianship. If this is the case, the grandparent must prove that the parent is unfit and detrimental to the child. To reach this burden of proof, the caregiver will have to disclose (with corroborating evidence) every unfavorable fact about the parent. This may include homelessness, unemployment, and any potentially harmful actions of the parent, e.g., drug abuse, physical or sexual abuse. Obviously, this often creates a very adversarial and emotionally stressful situation between the caregiver and the parent. The guardianship proceeding may also be stressful for the child, especially if the matter is contested and the child feels she or he is being forced to choose between the grandparent and the parent. Finally, the parent may retaliate against the grandparent and prevent her from seeing or visiting with the child ever again.

It is also important to note that guardianship is never really permanent, terminating when the child turns 18, marries or is emancipated. In addition, the parents may file a petition to terminate the guardianship at any time on the basis that it is in the child’s best interest for the child to be returned to them.

Standby Guardianship

Standby guardianship is another option available to relative caregivers in some states. Originally created in response to the HIV/AIDS epidemic, this mechanism allows terminally ill parents to nominate someone to care for their children (Ginchild & Perez-Porter, 1996). Generally reserved for the terminally and progressively ill, standby guardianship goes into effect when the parent becomes physically or mentally incapacitated and cannot provide care and control over the minor.

A standby guardianship allows the family, and especially the parent, to prepare before incapacity sets in. The parent petitions for appointment of the standby guardian, and the petition must include a statement from the doctor stating that the parent is terminally ill and will become incapacitated within two years. When death, debilitation or incapacity occurs, custody automatically transfers to the nominated adult. The nominee must then petition the court for confirmation of the nomination.

A closer look at the Connecticut (Conn. Gen. Stat. Ann. § 45(a)-624 et seq.) and Illinois (Ill. Ann. Stat. Ch. 755, para. 5/11-5.3) statutes suggests that standby guardianships might also be available to incarcerated persons in these states (Ginchild & Perez-Porter, 1996). In Illinois, the “guardianship of limited duration” allows parents to appoint guardians for their children with a predetermined termination date. This allows the parent to make arrangements for the child during her/his incarceration and resume custody of the child once released (de Toledo & Brown, 1995).
**Foster Care**

A grandparent or relative caregiver can become the foster care placement for a child when the child welfare system determines that the child has been abused, neglected or abandoned by his or her parents. In these situations, the child welfare agency may remove the child from the home and file a petition with court (in most states the juvenile court). Upon hearing the petition and considering the findings, the judge will make a ruling that the child is a dependent of the court. At that time, the state has legal custody of the minor, and the child welfare agency, acting for the state, searches for a permanent placement for the child. The person with whom the child is placed has physical custody of the minor, but is closely supervised and monitored by the child welfare agency. Children who are removed from their homes can be placed in foster care with either relatives or with strangers. However, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 requires states to consider giving preference to an adult relative over a non-relative caregiver when determining the placement of the child (42 U.S.C. § 671(n)).

In trying to find a placement for the child, therefore, states should look first for a grandparent or other relative to care for the child. Relatives seeking the foster care placement must nevertheless be proactive when a child is removed from the home and get involved early in the process. They should explore every possible avenue to participate in the dependency proceedings, so the worker, the attorneys and the court know the relatives would like the child placed in their care.

Relatives should (and “must” in some states, e.g., New York) be informed by the social worker that they can choose between taking the children informally with assistance from the Temporary Assistance for Needy Families (TANF) program or being a foster parent and receiving foster care funds for care of the grandchild (Flint & Perez-Porter, 1997). Foster care payments, which far exceed the TANF grants, are available for these children through the federal foster care program if the children meet the eligibility criteria, or through a state foster care program (de Toledo & Brown, 1995; Ginchild, 1995). Title IV-E of the Social Security Act (42 U.S.C. § 672 et seq.) sets forth the eligibility requirements for federal foster care funds as follows: (1) Children must be under 18 or 19 years old if still in school; (2) they must have been removed from their homes as a result of a court order or a voluntary placement agreement; (3) the state must be responsible for the child’s care; (4) the child must be living with a specified relative within six months before court proceedings began; and (5) the child must have been receiving or was eligible to receive TANF in or for the month prior to the initiation of court proceedings” (Ginchild-Abeje & Perez-Porter, 1997). Children who do not meet these criteria may be eligible for foster care benefits funded entirely by the state. States, however, have the option to deny these benefits to children in relative placement (Ginchild, 1995).

While the dollar amount of the foster care payment is significantly more than the TANF grant, there are many rules and regulations connected with it, along with the lack of legal authority over the child. Moreover, grandparents, as kinship foster parents, have certain enumerated duties and responsibilities that they do not have in other legal custodial relationships. The home of the kinship foster parent is supervised, and the caregiver cannot make major decisions for the child without the approval of the agency that has legal custody of the child (i.e., the agency acting for the state).

Further, not all grandparents are entitled to kinship foster care payments. Grandparents who have obtained guardianship, adopted their grandchildren, or are caring for the children informally are usually not eligible for kinship foster care payments. This is the great disparity and inequity in the public benefits system. For those grandparents who take on the responsibility of their grandchildren before parental care reaches the level of abuse and neglect, there is little to no financial or social services support available for them, yet the children in their care have the same needs as the children in foster care.

Foster care, whether with a relative or a stranger, is seen only as a temporary solution. The Department of Social Services is focused on permanency for children, which means the child welfare agency must make efforts to provide a permanent, stable home for children. This ultimately means adoption or reunification with the biological parents. Grandparents, who are the kinship foster parents, must be prepared for the inevitable question of whether they are going to adopt the grandchildren if the parental rights are terminated or whether they are going to allow an adoptive family to take the children (Phillips & Bloom, 1998).

In 1997, the California legislature passed the Kinship Adoption Bill, making kinship adoption a permanency planning option for children in dependency. Through kinship adoption, the grandparent or relative becomes the adoptive parent for the child; however, the child is not eternally separated from a relationship with the biological parents. (Cal. Family Code § 8714.5) Through the kinship agreement, the adopting parents and biological parents can enter into an agreement whereby provisions for visitation, contact, and sharing of information about the child can be set forth and will be a part of the final adoption decree. (Cal. Family Code § 8714.7)

**Adoption**

Although adoption is the most secure custody arrangement available to “non-parents,” it is not often the option pursued by grandparent and relative caregivers. Adoption terminates the rights, duties and responsibilities of the biological parents. Even given the Kinship Adoption statutes noted above, it permanently dissolves all legal ties between the child and parent and creates a new parent-child relationship. Grandparents who adopt their grandchildren become the children’s legal parents and can make all decisions about the children’s education, medical care, religious upbringing, and so forth. Through adoption, the child can be listed as a dependent on the grandparent’s insurance, and the child may be entitled to Social Security benefits when the grandparent retires or becomes disabled. Adopted grandchildren also inherit directly from their grandparents.

For these reasons, adoption brings up issues of family unity and divided loyalties.
For many grandparents, the child is clearly their grandchild, and they do not want to legally assume the role of parent. Adoption also signifies that the grandparent has no hope left for the parent, and many grandparents prefer to retain that glimmer of hope that the parent will become responsible for the child. Furthermore, the parental rights must be terminated before an adoption can proceed. If these rights were not terminated earlier in a dependency matter or if the parents do not consent, it can be an extremely painful battle to litigate the termination of these rights.

Finally, adoption is very costly to the family, not only with court costs, but daily living expenses. Once the adoption is ordered, the kin caregivers become financially responsible for the children’s support. Adoption impacts eligibility for public benefits because the grandparents’ income (often a pension or Social Security) will generally now be counted. Under TANF, the adoptive grandparent must apply for benefits for self and child as a household unit; the grandparent cannot apply for child-only benefits now that she has assumed the role of the natural parent (Ginchild-Abeje & Perez-Porter, 1997). In cases where a grandchild had been in foster care, adoption subsidies through the Adoption Assistance Program may be available to assist a child with special needs since the foster care payments cease upon the final order of adoption. (See Satterfield article on p. 9).

Conclusion

In conclusion, the legal custody options available to grandparent and relative caregivers present significant issues to weigh and assess. Even though each option has many benefits, each also presents many consequences that will greatly impact the family. All caregivers contemplating custody are faced with the burden of making these difficult decisions for their families, especially for the children in their care. The number of children in kinship care will continue to rise in our society, and grandparents will continue to be the source of family stability for children in the future. The legal issues impacting the kin care families will constantly need to be explored, and hopefully new laws will be enacted to support our society’s senior population in their expanding child caregiving role.

This article was written from the perspective of California law, which is where the author practices as an attorney. Other state laws are mentioned for illustrative purposes only. Before advising clients, an attorney and the laws of your state should be consulted for more details on this subject.

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The Changing Family: Psycho-Social Needs of Grandparents Parenting a Second Shift

One of the biggest and most challenging tasks facing families today involves grandparents parenting their grandchildren. Across the country, a growing number of children are being parented by relatives other than their parents. According to the 1995 U.S. Census report, approximately 3.9 million children are being raised in grandparent-headed households. The U.S. Census further reported that approximately 1.5 million (38.5%) of these children are being raised by grandparents in households in which neither parent is present. When we take into consideration other related caregivers (e.g., older siblings, aunts, uncles, and great-grandparents), approximately 3.4 million children are being raised in households headed by a relative, and 2.1 million of those children are cared for by relatives without a parent present. Some basic reasons for this phenomenon, aside from the death of the biological parents, are that the parents physically or sexually abuse the children (or each other), are addicted to drugs or alcohol, are incarcerated, are mentally ill, are too poor to take care of the children, or are incapacitated by diseases such as AIDS.

Psycho-Social Issues

Many parenting grandparents face ongoing psycho-social issues around the basic physical, emotional, and financial adjustments they must make. Primarily, these individuals experience a sense of deprivation. They are deprived, first of all, of a positive relationship with their own children (the birth parents). Many of them grieve over the emotional death of their sons or daughters. Some of them try to rationalize away their grief by disowning their children. “That’s not my daughter,” one woman said. “Drugs have taken over. That’s not the girl I raised, loved, and nurtured.”

Some grandparents may feel deprived of a normal relationship with their grandchildren. One grandfather said to me, “I just want to be a grandmother to my grandchildren. I don’t want to be their parent.”

Many grandparents feel that parenting their grandchildren has forced them to give up activities they had looked forward to in their senior years, e.g., returning to school, traveling, changing careers, or just relaxing. They feel robbed of their age-and stage-appropriate social options.

Although many of these parenting grandparents hope that the arrangement will be temporary, many have found that it is permanent. As a consequence, the arrangement frequently results in grandparents feeling angry, embarrassed, guilty, and frustrated. They feel that they can no longer trust their adult sons and daughters, and they often wonder whether they are to blame for their children’s behaviors. Having “failed” as parents with their own children, they question what they can improve this time, and wonder if they will “fail” a second time around. They also wonder how to counter the continuing negative influences of their children on their grandchildren. Throughout all this, they feel ambivalence toward both their children and their grandchildren—whom they love, on the one hand, and resent, on the other.

Many of these grandparents suffer in silence because they feel judged, criticized, and abandoned by their family, friends, and society. They may also feel embarrassed to acknowledge their ambivalent feelings and often put their physical and mental health on hold. Sometimes they are not sure whether they are just tired or really sick. On top of everything else, because the grandparents do not usually have legal custody of the grandchildren, they have a hard time obtaining basic medical, educational, and financial services for the children.

Coping with Birth Parents’ Intrusions

Because of the love that these grandparents have for their adult sons and daughters, they often have a difficult time setting appropriate limits and boundaries for them. Thus, when a son or daughter shows up (perhaps on probation from prison), a grandfather’s authority with the grandchildren may quickly be undermined by the son or daughter’s disruptive behavior. In most cases, the grandfather does not have legal custody or guardianship of the children, so the son or daughter has the legal right to arbitrarily remove the children—or, in some cases, to walk off with the monthly welfare check and spend it on drugs. As one grandmother commented to me: “Because my daughter usually gets the checks, I may get fifty dollars every four or five months for these children. I have to use my own finances to support them.” This places a huge financial burden on the grandparents.

Some grandparents have attempted to deal with this last intrusion by involving the birth parents in some of the grandchildren’s daily routines, such as homework, after-school activities, or family dinners. These grandparents hope that this involvement will encourage the birth parents to begin taking responsibility for their lives and seek appropriate treatment for their drug addiction. When this fails, and they can no longer deny their anger and frustration even to themselves, the grandparents may seek spiritual help from church groups, support groups, and/or therapists that specialize in family issues. They may also seek legal assistance to gain custody and guardianship of their grandchildren.

At some point, grandparents may have to exclude their son or daughter from the home. A grandmother in my own support group revealed how she had told her daughter she was no longer welcome:

Continued on page 8…
"You can’t come here anymore," she said. "I have your children to raise. I can’t raise you again and raise your children. You will have to stay out until you get your life together." This is an extremely painful moment for a grandparent, but sometimes there is simply no other option.

**Parenting as Grandparents**

Parenting grandchildren is totally different from parenting one’s own children. To begin with, parents do not usually have intrusive adult children to interfere with the parenting of the younger children. Also, because of abuse, drug addiction, and other problems brought on by the parents, many of the grandchildren have special medical, psychological, and educational needs. Many of them are angry at their parents, confused by their absence, and divided in their loyalties. "When my mom is home with my grandma," one girl said, "if I tell my grandma I love her, my mom will get angry. If I tell my mom I love her, my grandma will feel hurt."

Because of the emotional frailties of the children, grandparents often have mixed feelings about how to discipline them. "These kids are already having a difficult and painful time dealing with their parents," one grandmother said. "They are the innocent ones. Why would we want to cause more pain in their lives? We know they need discipline, but how can you put them in ‘time-out’ when they’re already feeling so lonely and punished by their parents?" Thus, many grandparents become overprotective of their grandchildren. At the other extreme, some grandparents set overly rigid boundaries for the children. Both groups are terrified that the children will repeat the malignant behaviors of their parents.

**Social Support Services**

Parenting grandparents need a social service system that can realistically and appropriately respond to their needs. Aside from financial assistance, they need support groups. In my own Grandparents As Parents Support Group, approximately twenty grandparents meet with me twice a month in a nonjudgmental setting, in which they have the opportunity to share their experiences and feelings and give each other emotional encouragement as well as practical advice. This gives them all a sense of belonging to a reconstituted family. Every six months, we celebrate with a family-style potluck party; and the grandparents receive special recognition on the second Sunday of every September—National Grandparents Day. Several times a year, I bring in experts from various disciplines to address the grandparents’ issues and open up discussion with them. For example, a pediatric neurologist discussed the problems and symptoms of prenatal drug exposure; a speech pathologist talked about children’s language development; a social worker from Child Protective Services talked about how to recognize physical abuse in children; a nurse advised the grandparents about how to protect their own health; a politician discussed legislation that would give parenting grandparents greater rights and financial assistance; a school principal talked about the educational needs of children; and a professional athlete talked about providing positive role models for children. While the grandparents in my group are meeting with each other, their grandchildren are meeting in an adjacent room. Trained childcare providers, assisted by volunteers, encourage the children to find meaningful and comfortable ways to express their feelings. This is usually done as the children engage in such activities as painting and drawing, unstructured play, theatrical skits, and storytelling. The children are also tutored to improve their social and academic skills. On the social side, we work to enhance their self-confidence and public speaking ability, among other things. On the academic side, we focus mainly on their computer literacy, writing skills, and mathematical ability. We also take the children on various outings in which they are exposed to meaningful social and educational experiences. The grandparents accompany their grandchildren on these outings, which gives them both an opportunity to relate to each other in an open and accepting environment.

Unfortunately, this kind of support group is not available in many areas of the country where there are growing numbers of second-shift grandparents. Churches, schools, community agencies, and therapists must become aware of this population and begin to address their needs.

— Lenora M. Poe, Ph.D.

**REFERENCE**

Kinship Care: What Are The Financial Options for Caregivers?

Kinship care is the parenting of children by relatives or other adults who have strong family relationships with these children. This is not a new phenomenon. Families have been providing kinship living arrangements for children for years. What is new is the growing number of children who must now live with their relatives or other adults due to the prevalence of many social ills that prevent their parents from providing them with safe, permanent homes.

Birth parents encounter social problems that do not have easy solutions or remedies. As a result, children are living with their relatives and other adults longer. Many of these children experience emotional, social, educational and behavioral difficulties, and relative caregivers are finding it difficult to provide them with the services they need to become productive citizens. Additionally, relatives often have limited or fixed incomes on which to live and provide financial support for their kin’s children. Research suggests that the average income for grandparent headed households is under $20,000 (U.S. DHHS, 1997). Grandparents, therefore, face significant challenges as they attempt to provide safe, permanent homes for their children’s children.

Financial Options for Relative Caregivers

Although limited financial and support services exist for grandparents and other relative caregivers, states are beginning to develop creative ways to respond to their needs.

Subsidized Guardianship

California, Delaware, Illinois, Maryland, and North Carolina are engaged in demonstration programs that offer monthly payments, which are less than or equal to the state foster care payment, to relatives who become the legal guardians of the children in their care. This option, called subsidized guardianship, is offered to relatives and foster parents who have been providing stable homes for at least one year (less than six months for a child for whom adoption or return home is not an option). Although each state has other criteria that relatives must meet before they can participate in the program, subsidized guardianship offers families an opportunity to be a family without the intrusion of a state agency. It also provides stability for children with family members without terminating the rights of the birth parents. (See Harvey article on p. 3).

Alaska, Hawaii, Massachusetts, Nebraska, South Dakota, and Washington were providing subsidized guardianship programs before the demonstration programs. These states have recognized that relatives are willing to care for their children but often cannot afford the financial burdens associated with providing minimum care.

Connecticut passed legislation in January 1998 to establish a subsidized guardianship payment program for children in the care of relatives. This program, implemented in September 1998, provides medical benefits as well as the subsidy.

Adoption Assistance

Federal Title IV-E Adoption Assistance and state adoption subsidy programs offer help to adoptive parents. Both programs provide a monthly subsidy for the child. However, the eligibility criteria for state adoption subsidies vary.

Under the federal Title IV-E program, the monthly subsidy can be used for any needs identified for the child. The payments are not designated for a specific purpose, such as medical expenses, living expenses, or special services. An eligible child is one who has been determined by the state to be a special needs child, e.g., free for adoption but considered hard-to-place because of a specific factor or condition. The adoptive parents do not have to meet any financial eligibility criteria to receive adoption assistance on behalf of the child.

Medical assistance is automatically available for a child who receives Title IV-E adoption assistance, and legal fees and non-recurring court costs are available to adoptive parents. A non-recurring expense is a one time expense that is necessary for the adoption of a special needs child. An adopted child may also receive social services assistance under Title XX.

State adoption subsidy programs are provided for children who are not eligible for the federal Title IV-E program. The adoption subsidies vary in different states depending on the child’s needs and the state agency’s program. State funded programs generally have three types of adoption subsidies: medical, maintenance, and special services. Each state determines the allowable subsidy amount.

If the child was adopted without an adoption subsidy, the family has a right to appeal for a reconsideration of the child’s eligibility for Title IV-E adoption assistance through the state’s administrative fair hearing system. A state cannot simply refuse to reconsider the child’s application or deny access to the fair hearing system merely because the adoption has been legalized. States have the responsibility to inform families of their rights to appeal for a reconsideration of Title IV-E adoption after legalization of the adoption.

Temporary Assistance for Needy Families

Temporary Assistance for Needy Families (TANF) replaced Aid to Families with Dependent Children (AFDC) in October 1996. Specific TANF rules mandate work requirements if a caregiver

Continued on page 13 . . .
Supporting Families through AIA Kinship Caregiver Demonstration Programs

In the fall of 1997, the Children's Bureau of the U.S. Department of Health and Human Services' Administration for Children and Families, funded three kinship caregiver demonstration projects through the Abandoned Infants Assistance program. All three programs, located in New York, Connecticut and New Mexico, provide services to families in which relative caregivers are raising young children affected by substance abuse and/or HIV. The following overview of the AIA kinship caregiver programs illustrates the struggles faced by these families, and it describes the different strategies each program is using to address the needs of relative caregivers, the children and their parents.

Yale Support Program for Family Caregivers

The Yale Support Program for Family Caregivers, located in New Haven, CT, uses federal AIA funding to respond to the broad-based needs of grandparents and other relatives who have assumed the responsibility of caring for HIV or drug affected children who can no longer be cared for by their biological parents. The program is designed to increase the stability, safety and permanency for children who have experienced parental loss through death or pervasive parental drug addiction. Each child's deep psychological and developmental need for sustained attachment to his/her extended family, and on-going connection to his history, culture and community, underscores the importance of providing support, counseling and concrete services to the adults who attempt to nurture children whose parents are not available to them.

Steering Committee

One of the initial activities of the Yale Support Program for Family Caregivers was to establish a program Steering Committee. Membership on the Committee includes two grandmothers who are providing care for their orphaned grandchildren, representatives of the state Department of Children and Families (child protection and foster care) and the state Department of Social Services (entitlements, Section 8 and other housing programs), an independent child advocate/lawyer, the program evaluator, a staff clinician, the program coordinators, and the section director.

The Committee was conceptualized as a forum in which to assess and address barriers to permanency for children in relative care, identify and commit appropriate resources to improve outcomes for both children and families, and seek creative interagency solutions to problems as they arise. Within a very short time, the Steering Committee has become an essential program element. The grandparents, who were recruited from the Family Support Service caseload to serve on the committee, are vitally important resources. Their presence ensures that the professionals hear directly and powerfully about the issues that most effect their ability to provide consistent and stable care. This information has already helped to identify key problem areas, set priorities, and inform some public funding decisions.

Program Components

The specific service components of the Yale Support Program for Family Caregivers include: in-home and community-based mental health and case management services; child evaluation and assessment; and concrete services such as facilitated access to community health, mental health, legal, welfare, housing and educational services. A clinician/family support worker team provides the in-home, relationship-based services. Biweekly, community-based peer support groups, facilitated by program staff, address the needs of relative caregivers.

Although these interventions have been available to HIV and drug affected children and families at the Yale Family Support Center, this program is designed to meet the specific needs of grandparents and other relatives for whom the responsibilities of active parenting are unexpected and untimely. It is precisely because the resumption of parental duties later in the life cycle requires significant changes in life style and expectations that an array of supportive services are essential to the stability and maintenance of children in placement with grandparents and other relatives. The relationship established by the in-home team is a source of support to caregivers and provides a safe means to explore these feelings of ambivalence and frustration with the role they have assumed. Loss, the mourning process, anger and guilt together with concrete problems of income, housing and legal custody are all issues that further complicate the care-giving process for both the child and the caregiver and threaten to disrupt the child’s placement. Services that address the complex needs of both caregivers and children can assist caregivers to provide the sense of permanency and belonging that is essential for healthy child development.

To ensure that the caregivers receive what they need from the peer support group, program staff held focus groups in which they encouraged caregivers
to identify their needs and consider the ways in which a support group might address them. While the need for more money and larger living spaces were clearly expressed, the most pressing wish was for a safe place where they could voice concerns, talk with other relative caregivers, receive support for the efforts they were making, and feel appreciated for the responsibilities they had assumed. Some of the specific issues raised by the group during its regular luncheon meetings have included: boundary setting with substance abusing adult children; identifying strategies for dealing with systems that caregiver families find intimidating and disrespectful; and the exhaustion of caring for children who have been exposed to considerable stress. In addition, the group has discussed the absence of time in which to attend to their own needs, and the loss of their independence and freedom. Since the group’s formation, it has become evident that the peer support offered to group members has led to positive changes in almost all of their families.

**Project Return’s Family Support Services Program**

Project Return Foundation (PRF), located in New York, NY, is a multi-faceted human services agency with over 25 years of drug treatment experience with homeless men and women, women with coexisting mental health and substance abuse problems and their children, battered women and their children, and persons with HIV/AIDS. Established in 1997, PRF’s Family Support Services Program (FSSP) uses federal AlA funds to support caregivers of infants and young children at-risk for abandonment by establishing mutually nurturing relationships between the caregiver, the child(ren) and the child’s parent who is in PRF residential drug treatment.

**The Caregiver**

In contrast to the Yale program, many caregivers in FSSP are providing temporary care for children who have plans to reunify with their parents. FSSP’s ultimate goal, therefore, is to support caregivers in order to simplify the process of reunifying the parents and their children.

The relative caregivers involved in FSSP struggle with doubt, fear, and frustration as they try to rebuild trust with the parents of the children in their care. Enabling and co-dependency are common methods family caregivers use to cope with their struggles. Often these caregivers take on more than they can handle. As they become burdened with more responsibilities, the children for whom they are providing care suffer from the consequences. Additionally, their family histories often present major obstacles and triggers that do not exist for non-kin caregivers.

Continued on page 12 . . .
The Parent

The FSSP serves 40 families involved in two of PRF's residential treatment programs. Thirty-five of the families participate in the Starhill Therapeutic Community, a 6-12 month residential treatment program for men and women. Many children of these individuals reside with relative caregivers while their parents are in treatment. The remaining five families are from the Dreitzer Women and Children's Treatment Center, which provides residential treatment for women (who have a history of mental illness and substance abuse and are at risk of homelessness) and their children (newborn to three years old). The mother-child dyad resides in this program for 12-24 months. Older children often reside with relative caregivers.

All the parents in both programs are in the early stages of recovery and have not had the opportunity to explore the mental, physical or spiritual aspects of addiction. Weekly groups and individual assignments help the parents deal with their anger, fear, shame, guilt, self-esteem, and their spirituality.

Additionally, FSSP has actively sought fathers to participate in the program. This has presented a unique range of issues related to machismo, battering, being a non-custodial parent, fathering in a "blended family," and other basic issues of fatherhood. To address these issues, FSSP formed a Fathers' Group, called the Joseph Project, to assist male clients in exploring their unique issues. The group also assists participants in identifying positive aspects of their own fathers that they would like to pass on to their children. The men who have participated in the Joseph Project have become more proactive in bonding with their children and working with their children's mothers toward reunification.

The Child

FSSP provides a range of services for the children of parents in the residential treatment programs. Whether these children were exposed to neglect or abuse, the foster care system, or simply very poor parenting, they often have low self-esteem and depression and are socially isolated. They may blame themselves for their parents' difficulties. Many are angry about their parents' behavior before treatment; others are angry that their parents disappeared from their lives to get treatment. They generally have trouble managing anger and developing trust. They suffer reality distortions because of their parents' inconsistencies, and they frequently have impaired social and emotional skills. Most of these children feel estranged from their parents if and when they are reunited, and they are not prepared for their parents' return as changed individuals.

To address their anger, isolation and depression, and to help children develop trust for a successful reunification, FSSP provides early intervention through assessments, family therapy, and age appropriate groups. The program also offers activities for the parent-child-caregiver triad. This has included a kick-off event; visits to the local library, the community art museum and community college; and a picnic. These events have been successful in allowing the triad to interact and develop positive relationships.

One of the biggest challenges for FSSP has been defining the client. The program was designed to serve relatives caring for children of parents (typically mothers) involved in one of PRF's residential treatment programs. In some instances, the caregiver may choose to participate in the program, but does not wish to re-engage with the parent, a PRF client. It has also been a challenge working with fathers who want to reunify with their children but not necessarily with the children's mother.

To help facilitate the reunification process and mend family relationships, the Family Program at Starhill Therapeutic Community runs a family day when friends and family of the residents are invited to the facility for a two-hour program explaining how treatment works. Families who attend can participate in a support group for families. This program helps identify the needs of caregivers, and helps the caregivers better understand what the parents (often their children) are experiencing. At the same time, the residential treatment programs help to remove obstacles that often sabotage parents' efforts at reunifying with their children.

Los Pasos' GRO Project

Since 1990, the Los Pasos Program in the Department of Pediatrics of the University of New Mexico (UNM) in Albuquerque, NM, has been funded by the Children's Bureau through the Abandoned Infants Assistance (AlA) Program. Its original focus was the care of prenatally drug-affected young children and their mothers. As the years progressed, staff found that oftentimes relatives, and more specifically, grandparents, were assuming the caregiving tasks for the children in the program. This caregiver group required special social and emotional support with respect to their conflicting roles of mother and grandmother (e.g., they were feeling responsible for a vulnerable grandchild and guilty or angry that their own child was incapable of providing this care). They also were burdened with having to address legal custody issues in order to
receive benefits and medical care for the child and to master an ever-changing social welfare service system. Further, they had to learn how to care for a child with special medical and developmental needs when their own health might be failing, and to adjust to a life that now included childcare responsibilities in addition to retirement planning. In an effort to address these growing concerns, Los Pasos staff initiated the GRO (Grandparents and Relatives Outreach) Project in 1997.

Unique Program Features

GRO uses the following unique program features to assist grandparent caregivers’ in accessing critical services. The project developed legal document prototypes of Guardianship and Power of Attorney, which the case manager can generate on a portable laptop computer in the relatives’ homes. GRO also provides home visits by an interdisciplinary team including a case manager, a developmental specialist and a solution-focused specialist. Additionally, GRO provides participating families with access to an interdisciplinary service clinic which offers medical, developmental, and behavioral health services to grandparents and children.

Assessments

In an effort to identify the specific needs and conditions of families served by GRO, the project has developed two instruments: (1) a Risk Assessment, which considers child risk and safety factors, and (2) a Legal Needs Assessment that looks at custody and visitation status, domestic violence and immigration. In response to findings from the legal needs assessment, GRO’s law consultant is seeking legislative reform to enable grandparents to petition for guardianship in the state of New Mexico. The developmental specialist and solution-focused specialist are in the process of planning a grandparent group that will focus on providing emotional and social support as well as parenting in a developmentally appropriate manner.

Solution-Focused Approach

GRO’s approach is based on the solution-focused philosophy that builds upon grandparents’ successes by making use of what they are already doing that works. The following illustrates this approach. Mr. and Mrs. M had been raising Mr. M’s grandson, J, since birth because Mr. M’s daughter was unable to care for him due to her drug and alcohol abuse. When the case worker asked Mr. and Mrs. M what they had done with J that was helpful, each had an example. Mrs. M noted that they have him on a schedule with a very consistent routine regarding bedtime, naptime, and snacks, which helps keep him calm and happy because he knows what to expect. Mr. M revealed that he gets on the floor and wrestles with J, kisses him on the forehead, and tells J he loves him. Although different, these are both successful approaches that the family and the caseworker can draw on when they face difficulties as J develops. Asking about and emphasizing their competencies is far more helpful than focusing on why they think Mr. M’s daughter “went bad.”

Conclusion

The three AIA kincare demonstration projects have adopted very different philosophical orientations and service approaches to meeting the needs of relative caregivers and their drug- and HIV-affected families. As this population continues to grow in number, more child welfare and community-based agencies are being forced to expand or restructure their services to address the unique situations of these families. Ongoing evaluation of the AIA demonstration programs will provide more information on effective strategies in the coming years.

— Jean Adnopoz, MPH, Janice Currier-Ezepchick, MSW, Betty Ellis, Yale Support Program; Bebecann Bouchard, MEd, GRO Project; Roger Jeff Cunningham, MFCC, Project Return Foundation

requests financial assistance for herself and the child(ren). State policies vary in this area, and some states allow waivers for caregivers in certain situations. For example, if a caregiver is near retirement age, s/he could be exempt from the work requirements. Also, some caregivers may be exempt from these requirements if the child in their care has special medical problems or is very young.

Relative caregivers also can apply to receive TANF grants specifically for the children in their care. This so called “child only” grant is much lower than the payment received from foster care. Although the children can also receive medical assistance, the caregiver does not receive any additional services for the child that are or could be provided by the foster care program.

Florida recently created a “Relative Caregiver Program,” which will allow caregivers to receive up to 82% of the foster care rate for the children for whom they are caring. TANF savings in the state are being used to fund the program. This is a new way to offer a higher benefit payment to children who are being cared for by their relatives.

Conclusion

The financial options for children living in kinship care arrangements are limited. Caregivers are finding it increasingly difficult to provide the basic necessities for the children in their care. They are unable to provide after-school activities, basic school supplies, personal hygiene items, money for social activities, and other everyday essentials for the children. However, they do not want to relinquish these children to the custody of the state. The child welfare systems in many states are responding, but more needs to be done to support this invaluable resource.

— Mattie L. Satterfield, Director, Kinship Care Services, Child Welfare League of America

REFERENCE

Kinship Foster Parents—Are We Part of the Problem or the Solution?

Susan (age 15), Bobby (age 6), and Asia (age 6 months) were removed from their home on Monday afternoon and taken to emergency foster care. When the police and child welfare came to remove the children, Mama Rose claimed that she had no living relatives. A cocaine habit had blurred her vision about many things. She was a long-term welfare mom who had never married the father of her three children. The father, Big Jim, had lived in the household for 17 years and held responsible jobs with the State and a housing agency. Jim brought cocaine and marijuana home for their pleasure. Mama Rose had become addicted and could no longer look after herself or their children. Jim continued his work, faring better than the mother of his children.

As Mama Rose’s sister and the children’s aunt, my partner was deeply concerned for the children’s well being. For eight hours on Monday, she and I tried to get a message to the children—“Hold tight. We will meet you in court and bring you to live with us.” “I am sorry,” said the child welfare worker, “I can neither contact the children to deliver your message nor give you their number to call. Rules are rules. You cannot interfere with our procedures. There will be a court date soon.”

At 3:00 AM on Tuesday morning, Susan took Bobby by the hand and Asia in her arms and sneaked out of the emergency foster care home. After walking a few miles in a strange part of town, Susan hailed a car service that agreed to take the three children to grandma’s. At this point, everything speeded up.

Becoming Kinship Foster Parents

Big Jim, Mama Rose, Grandma, my partner and I all went to court on Tuesday morning. Family Court in New York City is unlike any place in the world. Security is the only well staffed unit. Public service lawyers run from room to room, mothers are crying, children are screaming and everyone is waiting . . . . all day! The judge recommended that all three children be placed in kinship foster care with my partner and me. Three children would move into our two-bedroom “adults only” apartment. We purchased a crib to put in our room for the baby. Susan would sleep in the second bedroom with a double Murphy bed, and Bobby would sleep in the dining room alcove, which we would set up each night as his bedroom.

The children arrived at our apartment Wednesday at 8:00 PM exhausted, crying and confused. Proud that we had purchased all the beds and diapers and food in one day, we showed the children their sleeping arrangements. They brushed their teeth and all three body-locked themselves together on the double Murphy bed. “We can either get a crowbar or just let them go to sleep,” I remarked as my partner and I emotionally collapsed into bed.

Ironically, I had asked my staff of 12, just one week before, for a volunteer to learn more about kinship foster care. As I arrived at my office with stories of the previous day in court and the previous night of a thousand tears, we all decided that the spirits had nominated me to become the expert in the kinship system.

Challenges of Kinship Foster Parenting

First on the list of “to do’s” was medical care. Second was a foster care assessment interview, and third was figuring out what to do with three kids during the summer while their two foster parents worked full time.

Medical Care

The children had Medicaid cards, but no private providers would take such little reimbursement. We shopped for and found a community health center that took Medicaid, was walking distance from the apartment, and could give us appointments that week. The baby (born with positive toxicology) had received no medical care. Bobby thought that he had one or two shots but he was not sure. A family physician gave the children full medical exams and found them quite healthy. The children were scheduled for all required shots.

Foster Care Interviews

We had at least two three-hour interviews. The worker had good enough intentions, but he had very little interest in our answers as long as he had words to fill each line on his sheet. He could not answer any of our questions. He gave us a number to call that was always busy. He was only interested in completing our exhaustive personal histories. He had no suggestions about what to do with the children while we worked. His questions about my deceased mother’s maiden name and medical history made me wonder if I was not in the twilight zone.
What to do with the children

In our one-hour of decision making, we had bought beds, diapers and food. What to do with three children for ten hours a day was going to take some work. I remember saying, "There are 25,000 other children in kinship foster care in New York City...there must be an agency that helps people like us—we cannot be the only folks in this spot!" I continued, "Let's visit one of the settlement houses in our neighborhood. I think one of my doctoral colleagues is an associate director at Henry Street."

Three children and two adults trooped off to find him. We arrived tired and without an appointment. That seemed typical of how we arrived everywhere. My doctoral friend could not have been more surprised. He ushered us in to see one of his social workers, who assured us that she was there to help us. This was a welcome relief after the inquisition by the foster care worker, who made clear to us that he was a monitor and not a helper.

Henry Street Settlement provided us with a number of options. We paid tuition for Bobby to attend eight weeks of day camp. The agency provided Susan with a modest stipend as a counselor-in-training at another of their day camps. Henry Street had no day care available for the baby, but they gave us phone referrals to call in the neighborhood. By the end of the week, we were lucky and had found a licensed worker who took care of three babies in her apartment. It was located about a 30 minute walk from our apartment so getting everyone off in the morning and picking them all up in the late afternoon proved to be a great challenge. Just one rainfall would push us to the brink—until we got used to being wet. Dinner was another challenge we overcame with the assistance of inexpensive restaurants. Full time jobs, children's pickups, laundry, house cleaning, and five baths with one tub made cooking an impossible dream.

Unlike most kinship families, who are more likely to receive AFDC (33%) than their unrelated foster care counterparts (6%) (Thornton, 1991), we were not under financial strain. We tripled our spending after the children arrived, but we did not regret using savings for this emergency. We knew that we might recoup some foster care reimbursement but we were sobered by the situation of the New York City system, which was terribly backlogged in paying kinship parents.

The Expected and Unexpected

On day one, I called a premier foster care administrator at Leake and Watts Services, Inc, a private child welfare agency in New York. "Phyllis," I asked, "could you tell me what I need to know about raising three foster children?"

That's easy." She said, "Don't, under any conditions, for any reasons at any time, ever argue with the birth parents."


I got home from work to find the birth parents in our apartment. They made an unannounced visit, began rearranging our furniture, gave the eldest child a beeper and began outlining when, how and where they would see their children. They were demanding unsupervised overnight stays, which are against foster care rules.

The next day I called Phyllis. "I am taking your advice and will not argue with them, but murder is not out of the question." Ralph Waldo Emerson said that a man himself not rejuvenated ought not go out to save the world. I say that parents who have their children removed from their home due to abuse and neglect should not dictate to others how to parent their children. I found myself in a constant rage. In deciding to take the children, I had not for one moment thought about their parents. My naive fantasy of their being grateful was usurped by their fear, anger, jealousy and drug grogginess.

The three children were amazingly resilient. At 15, Susan thought it was her responsibility to take care of her two younger siblings. She had been trying to protect and care for them for a few years. It took a few weeks for us to convince Susan that parenting was our role and, though we appreciated her help, her job was to be a teenager. We took her for a hair cut and manicure and gave her some movie passes. We taught her to ride the subway, which was hard for her.

At six, Bobby was all boy. He loved to go to the park, play catch and play on the monkey bars until he had blisters.

One day on our way to the park I asked Bobby if he knew why we lived with us. "Nope" he quickly replied. I took out a dollar bill and asked him to guess for a dollar. He thought for a minute and said, "I think it's cause my mom smokes cigarettes." I told him it was a great guess and gave him another dollar for another guess. "I think the cigarettes are the funny kind you are not supposed to have." I let him know that was a mighty good guesser. I also let him know that he would be staying with us until his Mom felt stronger and then he would move back with her. I asked him if he had any questions for me. "Where can I get some candy with my two dollars?" he asked. I believe that Bobby was reticent in the beginning because he feared that I would criticize his mom. Knowing that we all loved him and that we were not going to fight seemed very reassuring to him.

Baby Asia had the hardest and most dramatic adjustment. She came to us with such a sad face and was so jittery at night that she rarely slept more than two hours without waking up. A regular schedule with lots of holding and cooing was just what she needed. She never stopped awakening every two hours, but she began smiling and cooing all day long. My partner and I were worried about neurological damage from prenatal maternal drug use. The doctor said that he needed to wait awhile to tell.

Big Jim and Mama Rose wanted the children to live with them on weekends. We would not agree. We compromised by having the children spend some weekends at their grandma's house, which was close to the parents' apartment. When the children returned on Sunday night, they were upset and disoriented. I did not like their leaving on weekends. I believed that the parents needed an incentive to correct their drug use, and getting their children back could have been the best incentive.

Continued on page 16...
After two months, we got a call from the child welfare worker. “Have the children packed and ready to be picked up between 9 AM and 6 PM tomorrow.” I was shocked and very upset. No one had consulted us. The thought of sitting eight hours in an apartment waiting for a minibus from child welfare was more than I could bear. I called back the worker, “I will deliver the children with their belongings to your office at 9 AM.” My partner and I sat down and told the children that they were returning to almost the same situation. The court, the parents, and child welfare all had taken the easy way out, and the judge decided to return the children to his custody. Neither the parents nor the child welfare worker had told us that this petition was coming before the court.

The morning that we dropped the children at the child welfare office was one of the hardest days of my life. The children were being returned to the identical household from which they had been removed. The father had pretended that he lived somewhere else and was now telling the judge that he would move home to care for the children. Mama Rose had attended a 12-step program sporadically which appeared to reduce her drug habit for the time being.

I was not sorry that we had taken care of the children, but I was devastated that they were returning to almost the same situation. The court, the parents, and child welfare all had taken the easy way out. I resolved not to fight any of them. The children were very important to me and I would not initiate anything that would have those who loved them fighting. I wanted to remain a loving and supportive force in their lives.

The Outcome

It is now five years later. The children visit often and stay with us for the weekend about once a month. I speak to them every week, and we are all together on holidays. We have given the children the message that lots of people love them. The parents stopped resenting us after about three years and reluctantly expressed their thanks on one occasion. Big Jim and Mama Rose are happy now to get a break for the weekend and do not cancel or inconvenience us as they often did the year following the summer that the children were removed from them.

Is this a happy or a sad ending? It would be far too simple to know the answer. Yet, it is a typical ending in kinship foster care. The children have love, the birth parents take too many drugs, and the child welfare system thinks it protected the children. My dreams of how it would work out were crushed. My fantasy had Mama Rose in residential drug treatment for six months, her transition out of depression and welfare, and a future with optimism and organization for both the parents and children. I am left to wonder as a kinship foster care parent whether I was part of the problem or part of the solution. This question remains unresolved and I think about it enough to want to write about it five years later.

Conclusion

It is interesting to read literature from the National Adoption Information Clearinghouse about “making the decision” (National Adoption Information Clearinghouse webpage). They suggest that potential relative caregivers explore the following issues:

- Are they ready to make significant changes in their life?
- How do other family members feel about it?
- How will potential caregivers relate to the child’s birth mother or father?
- How do they feel about the child?
- Can they afford the cost?
- Does their health allow them to make this commitment?
- What services and resources are available?

Answering these questions thoughtfully takes a few weeks, yet many of us make the decision to care for our kin in less than one hour. The impulse of family members to care drives rational people to make a leap-of-faith decision that feels like no decision at all. Therefore, it is critical to provide kinship caregivers with the information and support they need in order to make the process less difficult. Each situation is different, and each caregiver has different needs that must be considered on an individual basis. However, some systemic changes could prove helpful. Things that might have helped us, for instance, include:

- a foster care worker who informed the children while they were in emergency care that family members would be taking care of them shortly;
- a court that examined both parents’ roles and drug use;
- a foster care worker with the knowledge and training to advise as well as monitor.

What did help us? Advice from Phyllis, assistance from Henry Street Settlement, and disposable income. Few kinship caregivers are so fortunate to have these resources.

— Barbara Draimin, DSW

Dr. Barbara Draimin is founder and Executive Director of The Family Center, a New York City agency of 30 staff who help parents with illnesses such as AIDS and cancer plan for the future of their children. The Family Center provides in-home legal and social services to families, conducts research, and provides skill-based programs for children. She wrote this piece as a former consumer in the kinship foster care system of New York City. Her views are drawn solely from personal experience.

REFERENCES


Our Family’s Struggle

It all began with a telephone call early in the morning of January 2, 1992. My sister-in-law was calling asking for help. Her grandson had been detained by Child Protective Services. This was the second of her grandchildren taken into protective custody in a year. The mother, Lisa*, is my husband’s niece. Rumor was Lisa, who was addicted to drugs, was about to lose parental rights to her older child whose foster parents wanted to adopt him. My husband suggested that we could adopt the baby if he wasn’t able to return to his biological parents. I was apprehensive, not sure that I wanted to get involved. It was, after all, the kind of situation I dealt with in my job as a caseworker with Contra Costa Social Services Department. I also reminded my husband that the family had sabotaged our efforts to intervene with Lisa’s first child. Nevertheless, I agreed to pursue the placement.

Details and court dates were difficult to confirm because of confidentiality. My professional knowledge of the child welfare system and previous association with the county agency didn’t help. The grandmother (Lisa’s mother) confirmed the date and time of the court dependency hearing, and my husband and I made plans to travel to Southern California where the hearing would take place. We also wrote a letter to the court and social worker expressing our desire and intent to care for the new baby.

Becoming a Relative Caregiver

January 22, 1992, was my husband’s birthday, the day of the court hearing and the day my son came into my life. Unlike the birth of my daughters when there was time to plan and physical labor to endure, the arrival of my son occurred in an office surrounded by social workers and distraught parents and grandparents. Still, the moment this tiny baby boy was placed in my arms, my life changed forever. He looked so helpless and so small.

We took baby Joey home, committed to helping his parents reunify and ready to give him all the love and care he needed. I watched as Joey suffered through unpredictable tremors, as he came to recognize my touch and my voice, as my daughters and husband interacted with him, and I fell in love with him. Through all of this, however, I kept reminding myself that he had parents who he would return to some day. I developed a ritual to protect myself from loving him too much (or so I thought). I took special care to always have his baby clothes clean and neatly folded in case the social worker called to tell me he was leaving.

We were careful to follow the visitation plan, flying to Southern California and back in one day, or driving down for the weekend. We also welcomed Joey’s mother, Lisa, to our home for overnight visits. We talked to her about the baby’s needs and all the wonderful things he was doing. We watched in disappointment as she propped the baby’s bottle instead of holding him and as she smoked in his presence. There were many areas where I felt Lisa did not use good judgment, and I couldn’t resist the natural temptation to step into the social worker role. I wrote down my observations and assessments and made note of all telephone calls, visits, and failed visits. As the months came and went, it became clear to me that Lisa was not going to reunify with her son. She was missing her visits, she was not in treatment, and there was talk in the family that she was pregnant again. She knew we had fallen in love with her son, and our relationship with her and her parents began to deteriorate. I had become Joey’s mother, and I felt compelled to protect him.

The Court System Interferes

In October 1992, the judge ordered that Joey, who I now considered my son, be moved out of our home. When I read my detailed notes from the witness stand, I was accused of interfering with reunification. Representation by a private attorney proved to be of no use. The court ordered that Joey be placed in the county of his mother’s residence and that our family be excluded as potential caregivers. When it was all said and done the parents and grandparents cried with us outside the courtroom, as if they understood the pain we were going through and the pain they were about to inflict on our son. What happened to justice and doing what is in the child’s best interest? I wondered if this was a case of attorneys making decisions for their clients. I was overcome with guilt. Perhaps if we had a better relationship with my niece, this could have been prevented.

We tried everything we could to prevent Joey from being taken from us. We offered to move to Southern California, we promised to bring him for weekly visits, we tried to bargain our way out of our loss. Our church community, friends and family offered their prayers and support. However, it was difficult for some of our extended family because this had become a struggle within the entire family.

Saying Goodbye

Despite our best efforts, the court stuck to its decision and granted us a few weeks to prepare for Joey’s move. The social worker was given the task of finding a foster home that would allow Joey’s biological parents to visit him twice a week. The plan was to take Joey to his new foster home after Thanksgiving.

Continued on page 18...
We began five long months of loss and . . .

order. Lisa, her other five children, and her grandmother threatened us with a court the midst of family and friends. Then God Thanksgiving Day as we privately wept in the most of our son but his mother and grandmother home" the day after Thanks-

burying my father-in-law, we packed promised him that we would be back soon. called his foster mother everyday, some-

life-for his sake and for ourselves. I 

renewed hope. As a family we made a commitmen to remain visible in Joey's

AlA RESOURCE CENTER VOLUME 9, NUMBER 118

failing to visit and cooperate, set a date for two occasions.

After a few visits, Joey seemed to know that we would return and would crawl to the door or window as if he was waiting for our arrival. Every moment with him was precious, and leaving him was always painful. The drive home after the visits were strained and unpleasant as my husband and I blamed each other for the turn of events and grieved the loss of our son. I remember writing Joey's biological mother a letter during this time wishing her well in her efforts for recovery and telling her I loved her son. I wanted her to know that I loved “our son” unconditionally and that I grieved for him.

Another Turn of Events

On May 5, 1993, the jurisdictional court hearing was finally here, five months and four days later. Throughout this time, I had remained in contact with the social worker, extended family and the foster mother. I knew Joey’s parents had visited on only two occasions.

The judge admonished the parents for failing to visit and cooperate, set a date for termination of parental rights, and reversed the order preventing us from being caregivers. The parents’ attorneys objected and the matter was set for trial. We were ordered to cooperate with visits and to be available for subsequent hearings. I recall my husband asking, “What does that mean?” My response was, “We can take him home.” This time, there was no anger outside the courtroom as we met with Joey’s biological parents and grandparents. They appeared resigned to the inevitable.

What we didn’t know at the time was that Lisa had given birth at home to another baby three months before and that she was hiding the baby from social services. I wanted to hold “my son” and never let him go. The foster mother cried when we took him but acknowledged that this was best for Joey. The wait at the airport seemed like an eternity.

The Road to Permanency

Joey came home confused and frightened. He was not verbal and did not know how to express his anxiety other than to unexpectedly arch his back and cry. We had five sets of arms in our home—my husband, my three daughters and me—to hold him, console him, and rock him for hours. He gradually relaxed and developed into a very happy, outgoing, and affectionate child. I believe he still has a fear of abandonment. He does not do well with unexpected changes and needs to be reassured about our return whenever we leave him. However, he is now almost seven years old and an absolute joy. He is bright, does well in school, loves to sing, and most importantly loves people and life. Everyday I tell him God gave me a son to love. We talk about adoption in general terms as we are preparing to tell him his adoption story.

Our road to adoption was not difficult or prolonged. Joey’s birth mother was able to let go and acknowledge that her son did not know her and that he had a family that loved him and would take care of him. The agreement to allow us to adopt him took place away from attorneys and the court. We were outside the courtroom when my son fell and came to my arms for comfort. Joey was precious, and leaving him was always painful. The drive home after the visits were strained and unpleasant as my husband and I blamed each other for the turn of events and grieved the loss of our son. I remember writing Joey’s biological mother a letter during this time wishing her well in her efforts for recovery and telling her I loved her son. I wanted her to know that I loved “our son” unconditionally and that I grieved for him.

The loss was especially difficult for my seven-year-old daughter. I was too preoccupied with my own self to recognize that she was in turmoil. She had forgotten that Joey was not our birth child and cried out one day that she knew we were planning to get rid of her as we had her little brother. We had to reassure her daughter that we were her real parents and that we would not abandon her.

Grieving Our Loss & Moving On

W e began five long months of loss and renewed hope. As a family we made a commitment to remain visible in Joey’s life—for his sake and for ourselves. I called his foster mother everyday, sometimes two or three times a day and we visited as often as possible. My husband and I made the first visit alone.

On December 1, we left behind a child that sang, babbled, danced and took a few steps. On our first visit, we saw a different child. He sat stone faced and speechless staring into space. I held him, rocked him, told him I was sorry and that I loved him.

Seeing Joey so depressed motivated us even more to stay involved. For five months, on every other weekend, we drove to Southern California. We would arrive at the foster home around midnight on Friday, go into hiding for 48 hours, and not tell my mother-in-law that we were just minutes away, fearful that my niece would compete with us for time with our son.

The best for Joey. The wait at the airport seemed like an eternity.

Months later, the grandparents began to communicate with us and express their feelings of frustration over the realization that their daughter has a serious addiction and that what they believed to be true was often Lisa’s attempt to cover up. They want a relationship with their grandson. The maternal grandmother has made it her mission in life, as all of Lisa’s children (including three younger siblings) have...
entered the child welfare system, to know where every child is. Someday the siblings will meet and hopefully develop a relationship. There are now ten children living with different paternal and maternal relatives, in long-term foster care, and in adoptive homes. The maternal grandmother called about a year after the court hearing to ask for our forgiveness and to ask that we allow her to stay involved in our son’s life. Now she calls about three times a year and we take him by to see her whenever we are in the area.

A couple years ago, my husband was approached by a relative who commented on how angry we must be at Lisa for putting us through so much grief. My husband responded by saying that there was no hate or anger because were it not for Lisa we would not have this wonderful child to love. We love Lisa and pray for her recovery. We see so many wonderful traits in our son that his mother and father gave him—his beautiful eyes, his outgoing personality, his love of music. We have had the privilege of nurturing him but we cannot take all the credit for the wonderful person he has become.

### Conclusion

Living the experience with my son, foster care, and the court has changed my life forever. I can never go back to being the uninvolved social worker. The reality of what happens to a child who is removed from his parent and placed in multiple homes, and the struggles of a drug-addicted parent are real. I have a new appreciation for foster parents and relatives that care for and fall in love with the children. I know that everything we do as social workers and caregivers impacts children for their lifetime. I know that drugs took away the sweet lovable child in my niece but that in her heart she still loves her children.

— Esmeralda

*The names in this article are fictitious to ensure confidentiality.*

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**Housing Options for Grandparent Caregivers**

Grandparents face numerous stresses when they assume full-time responsibility for raising their grandchildren. One of the most tangible challenges is housing. Some elders are threatened with eviction from senior housing when they take in young children; others live in apartments strained beyond health and safety when children move in. Few grandparent caregivers have the financial resources to afford larger homes that can accommodate additional family members, and most affordable family housing is designed for younger, more physically fit parents.

In 1994, BAC-YOU (Boston Aging Concerns—Young & Old United, Inc.) established a collaborative GrandParent Caretaker Advisory Committee to address the housing, economic, and social issues affecting grandparent caregivers and the children they are raising. The first task was to develop a GrandFamilies House in Boston. As the first-in-the nation, this housing was designed specifically for grandparent caregivers raising grandchildren.

### GrandFamilies House

Following a highly interactive community planning process led by a GrandFamilies Task Force, the GrandFamilies House was co-developed by BAC-YOU and the Women’s Institute for Housing and Economic Development. The project was funded through the Massachusetts Department of Housing and Community Development, Boston’s Department of Neighborhood Development (CDBG funds), Federal Home Loan Bank, low-income housing tax credits, Massachusetts Housing Partnership and private foundations and investors. Although rental preference will go to families eligible for Section 8 housing assistance, families of all income levels are welcome. Currently, the GrandFamilies House is comprised primarily of grandmothers raising their grandchildren.

The housing development includes 26 two-, three-, and four-bedroom apartments in a four-story building, which offers architectural and program elements for elders and children. Examples include an elevator, grab bars in the bathrooms, child-safe electrical outlets, and a playground within view of many of the apartments. As the owner and manager of the building, BAC-YOU provides an on-site resident services coordinator and live-in house manager, sponsors grandparent caretaker support groups, and assists residents in accessing other social, health and educational services as needed. Additionally, the YWCA Boston includes teen residents in their existing programs and offers on-site pre-school and after-school educational and computer programs for children and physical fitness and support programs for seniors. All these programs are available to residents of GrandFamilies House, and will be offered to grandfamilies and other families living in the community as capacity allows.

### Section 8 Rent Subsidies

To help address the housing needs of the many other “grandfamilies” in Massachusetts, BAC-YOU worked with the state Department of Housing and Community Development to become the first state to set aside 50 HUD Section 8 rent subsidies for use by grandparent-headed families. The Boston Housing Authority followed suit with 50 additional certificates. The certificates are available to individuals aged 50 or older who are raising children under 18 years of age through a kinship placement. Eligible grandparents will pay no more than 30 percent of their household income for rent, and BAC-YOU will provide outreach, eligibility screening, housing counseling and referral to support services for these families.

### Conclusion

BAC-YOU is currently raising funds for an evaluation of these programs. In the interim, BAC-YOU will serve as liaison to other agencies that want to replicate all or part of their new and innovative GrandFamilies Housing Program. For more information, call BAC-YOU at (617) 266-2257.
Our finding that prenatally substance-exposed children placed with kin exhibited more problem behavior than other children might be related to other family or child characteristics (e.g., a confusing and often disruptive relationship with substance abusing birth parents), or to the services and supports they receive. Indeed, findings from a previous analysis of this sample (Berrick et al., 1994) show that kin caregivers in the sample were older, had lower incomes, and received fewer services, compared with nonrelative caregivers. Given these characteristics, older kin caregivers in our study may have found it more difficult to raise young, “high-need,” substance-exposed children without proper services and supports. Of all caregivers, kin caregivers of substance-exposed children had the lowest number of contacts with their children’s social workers. Similarly, substance-exposed children living with kin were less likely than other children to be seen by their workers. In addition, we found that kin caregivers received an average of $141 less than their nonrelative counterparts and that nonrelative caregivers received approximately $60 more when the children they were caring for were substance-exposed. Kin caregivers received only $10 more when the children in their care were substance-exposed. These findings are consistent with those from other studies (Fein et al., 1983; Walker et al., 1994) which indicate that kin foster families typically receive and/or use fewer services and supports than nonrelative families. This could be related to race/ethnicity, as African American children were significantly overrepresented among the substance-exposed kin group. The disparity in services and supports, therefore, may reflect less help seeking by African Americans caring for substance-exposed kin (Downs, 1986; Fein, Maluc cio, Hamilton, & Ward, 1983), or different help-seeking patterns. It may also reflect less effective child welfare responses with African American children and families.

**Conclusion**

Substance-exposed children may well comprise the majority of children in foster care. Both the number and vulnerability of this population demand more attention by child welfare professionals, policymakers, and researchers. Findings from the study described above show that substance-exposed children can achieve positive educational, emotional, and behavioral outcomes. The findings also suggest that placement in kinship care is related to children's outcomes and may even have a causal effect. It appears that kinship placements are particularly effective at fostering the development of nonsubstance-exposed children. Such placements may promote children's development and well-being by providing them with early and stable placements at a very early age.

Notwithstanding, decisions to place substance-exposed children with kin may require the provision of additional and more appropriate services, resources, and supports. Kinship caregivers and their substance-exposed foster children might, for example, benefit from more worker contacts, positive parenting classes, therapeutic child care, respite care, family therapy, support groups, and concrete services such as transportation vouchers or tokens. Without such a commitment, placement with nonrelatives might be more suitable for some substance-exposed children. However, the practical and ethical issues around determining which children in kinship care are or are likely to be inadequately served and should be moved to a nonrelative's home are great and complex. Providing more assistance to kin caregivers of substance-exposed children is probably a more viable alternative.
(See Poe article on p. 7). Indeed, because it seems that prenatal substance exposure, alone, does not decide the fate and well-being of substance-exposed foster children, the child welfare services system’s greatest contribution to substance-exposed foster children will be sustained efforts toward improving their postnatal, caregiving environments.

— Devon Brooks, MSW, School of Social Welfare, University of California at Berkeley


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REFERENCES


IN THIS ISSUE:

Kinship Care and Substance-Exposed Children
PAGE 1

The Legal Maze of Kinship Care
PAGE 3

The Changing Family: Psycho-Social Needs of Grandparents Parenting a Second Shift
PAGE 7

Kinship Care: What Are The Financial Options for Caregivers?
PAGE 9

Supporting Families through AIA Kinship Caregiver Demonstration Programs
PAGE 10

Kinship Foster Parents—Are We Part of the Problem or the Solution?
PAGE 14

Our Family’s Struggle
PAGE 17

Housing Options for Grandparent Caregivers
PAGE 19

Resource Reviews
PAGE 22

Conference Listings
PAGE 25