Spotlight on kinship care

Using Census microdata to examine the extent and nature of kinship care in the UK

Part 1 of a two-part study on kinship care

Shailen Nandy and Julie Selwyn

April 2011

University of BRISTOL

YOUR FAMILY YOUR VOICE

GROWING UP WITH RELATIVES OR FRIENDS

THE HADLEY CENTRE

BUTTLE uk FOR CHILDREN & YOUNG PEOPLE

BIG LOTTERY FUND

LOTTERY FUNDED

ACKNOWLEDGEMENTS

This study would not have been possible without the generous funding from the BIG Lottery Fund, the support of the Hadley Trust and the vision of Buttle UK who initiated the research. Help and advice from the Office for National Statistics, the Cathie Marsh Centre for Census and Survey Research, and the government departments who provided the Children Looked After data are also gratefully acknowledged.

Thanks are also due to the following members of the project Advisory Group, who kindly gave of their time:

Sir Mark Potter (chair)
Tim Carter, Barnado's South West
Lynn Chesterman, Grandparents' Association
Preeti Dhillon, Buttle UK
John Dicks, London Borough of Greenwich,
Helen Jones, Department for Education
Gerri McAndrew, Chief Executive Buttle UK
Danny Nugus, Winston's Wish
David Pitcher, CAFCASS
Nicky Rayner, London Borough of Newham
David Roth, Family Rights Group
John Simmonds, BAAF
Suzette Waterhouse, independent social work practitioner
Sarah Wellard, Grandparents Plus

INTRODUCTION

In the UK, there is a long history of children being brought up by relatives or friends (kinship carers). Until recently, very little was known about these arrangements. Studies (Aldgate and McIntosh, 2006; Farmer and Moyers, 2008; Hunt et al., 2008; Ince, 2009) have begun to illuminate the circumstances that lead to children living with family or friends, and the impact of these arrangements on carers and children. However, most research has focused on 'looked after' children placed by Children's Services with relatives or friends who have been approved as formal kinship foster carers. Much less is known about the informal arrangements for children's full-time care made between a parent and a relative or friend. It is thought that informal arrangements make up the majority of kinship arrangements, but there has been a great deal of uncertainty about the extent to which kinship care is used.

The numbers of children living with relatives and friends are believed to have been growing, partly because of the changing nature of family life (DCSF, 2010), growing problems with parental substance/alcohol misuse (Aldgate, 2009) and the increasing prison population (DCSF and Ministry of Justice, 2007). Moreover, in recent times a number of legislative and other changes have been introduced to encourage the use of formal kinship care. The requirement to give preference to a placement with a family member was enshrined in the Children Act 1989 (Sec 23 (2) ii) and reinforced by the amendments to the Act in 2011 (Sec 22c). And under the Public Law Outline, the potential of care by kin needs to be considered before care proceedings are brought and included in the initial care plan put to the court. These changes, together with the introduction of Special Guardianship Orders, have led to an increase in the use of kinship care. However, while there is much conjecture about the extent and nature of kinship care, there has been little hard evidence.

This BIG Lottery funded study aimed to address some of these gaps in knowledge. The study had two parts. In the first part, reported here, microdata from the 2001 UK population Census were analysed to provide more information on the extent of kinship care in the UK in 2001. The second part, to be published later, will report on face to face interviews with 80 kinship carers and young people about their experiences of kinship care.

RESEARCH DESIGN AND METHOD

The study used microdata from the 2001 UK population Census, to estimate the number of children living with relatives (i.e. in kinship care), in England, Northern Ireland, Scotland, and Wales. The Census gathered information about individuals and households, and on topics including age, gender, ethnicity, employment, housing conditions, and social and occupational class. These data are available to approved researchers, and are the most representative and best data on the UK population.

This study had two main aims. These were to:

- Provide information on the extent and prevalence of informal and formal kinship care in the UK, by country and by region;
- Describe the characteristics of carers and children living in kinship care.

A central aim of this project was to assess the extent of children living in kinship care in the UK and in particular to estimate the numbers of children who were living in informal kinship care. The term 'kinship care' is understood differently around the world. In Western societies biogenetic inheritance plays an important part in defining who kin is: the idea that kin are defined by 'shared blood'. In other parts of the world, this view does not hold. Godparents, clans, and even neighbours can all be seen as kin, and in some cultures parents may *prefer* to have their children raised by a family who are not biologically related (Bowie, 2004). While accepting that there are many understandings of the term 'kinship', working definitions of 'informal' and 'formal' kinship care were required for this study.

Part of the complexity of determining what is or is not *formal* kinship care is due to the fact that the four countries of the UK have different definitions of what constitutes a 'relative'. For example, while Scotland includes cousins in the definition of a 'relative' kinship carer, England does not. It is also the case that children can find themselves living with relatives for a range of different reasons, only some of which are the result of social work decision-making. In the guidance on kinship care published by the English government (Department for Education, 2011), informal kinship care is defined as an arrangement where a child is living with a relative or friend who does not have parental responsibility for the child. Therefore, formal kinship care includes looked after children placed officially with family or friends foster carers and also all those arrangements where there is a legal order in place (Adoption, Special Guardianship or Residence

Order). However, neither the Census nor government statistics provide data to calculate the number of children in such arrangements. Therefore, the constraints of the data have led to *formal* kinship being defined in this study as: 'looked after' children living with relatives who are approved foster carers. All other arrangements involving carers who were relatives we have termed informal kinship care

The 2001 Census contained a household matrix which set out how each member was related to every other. In each household the person with the highest economic activity[1] was defined as the 'Household Reference Person' (HRP). If two adults living in a household had the same level of economic activity, the older of the two was counted as the HRP. On the Census form, everyone else living in the household had to record their relationship to the HRP. So, for example, in many families the HRP was a father with others in the household described as the partner of, or the son or the daughter of the HRP. This matrix was important because it allowed us to identify those children in households whose birth parents were absent, who were living with relatives, and for whom this was their usual living arrangement. We have assumed in 'relative headed' households that the HRP was a/the main carer of the child, and thus have been able to identify households headed by grandparents, sisters or brothers, or other relatives such as aunt, uncles, cousins, etc. We have not been able to examine households where children were cared for by friends of the family, as this group could not be identified with absolute certainty in the Census.

In our analyses we have been able to provide a total estimate of children cared for by relatives (and whose parents were absent). By subtracting the number of children formally 'looked after' by family members and friends who were approved as foster carers from the total number of children in kinship care, we have been able to provide for the first time an estimate of the magnitude of 'informal' kinship care and more reliable estimate of the extent of kinship care.

The Census also provided data on the ethnicity, age, gender and socio-economic position of carers and children. This enabled us to present a picture of the families in which these children lived. These analyses should provide a much improved basis for developing national and local policy and practice in the area of kinship care. This paper gives a brief overview of the findings. For the full report please contact Julie Selwyn (j.selwyn@bristol.ac.uk).

[1] Economic activity in the following order; full time job, part-time job, unemployed, retired, other

THE NUMBER OF CHILDREN LIVING IN KINSHIP CARE IN THE UK 2001

Our analyses found that in the UK in 2001 approximately 173,200 children were living with relatives without their parents present in the household. Most children in the UK live in England (Table 1), and so unsurprisingly, most children living with relatives lived in England. However, if we consider the prevalence rate of kinship care, i.e. the number of children in kinship care per 100 children in the population, Wales had the highest prevalence rate of 1.4%. This means around 1 in every 72 children in Wales were living in a kinship care arrangement in 2001. Scotland and England both had prevalence rates of around 1.3% (or around 1 in every 77 children), and Northern Ireland had the lowest prevalence rate of 1.1% (or 1 in every 91 children).

TABLE 1: THE NUMBER OF CHILDREN IN THE UK GENERAL POPULATION AND IN KINSHIP CARE IN 2001

	England N	Scotland N	Wales N	Northern Ireland N	UK total N
Child population (under 18)	11.1 million	1.1. million	662,400	451,000	**13.3 million**
Children living with relatives	143,367	15,433	9,200	5,200	**173,200**

Source: Calculated from 2001 I- CAMS

Based on evidence from existing studies, we expected relatively high rates of prevalence of kinship care in Inner London, but we were surprised to find similarly high rates in the North West of England (particularly Manchester), where around 3 in every 100 children were living with relatives. Within each of the UK's countries there were areas where the prevalence of kinship care was much higher than average. For example:

- In the London Borough of Newham around 4 in every 100 children were living with relatives;
- In Merthyr Tydfil in Wales and Inverclyde in Scotland approximately 3 in every 100 children were living with relatives;
- In Belfast West in Northern Ireland around 2 in every 100 children were living with relatives.

There were also regions of the country where very low proportions and numbers of children were in kinship care. Further information on the prevalence of kinship care in individual local authorities is presented in the full report.

ESTIMATING THE EXTENT OF FORMAL AND INFORMAL KINSHIP CARE IN 2001

Based on the Census data, we estimate that around 173,200 children were living with relatives, but some of these children were being formally looked after, having been placed by Children's Services. To estimate the number of children living informally with relatives, those living with kin formally (i.e. with family and friends foster carers) were deducted from the total of 173,200. The table below (Table 2) shows how the Census data were used in conjunction with data on looked after children to provide estimates of formal and informal kinship care.

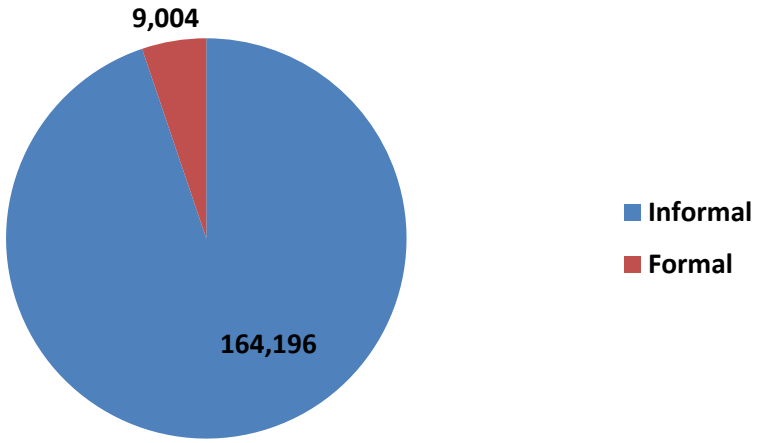
TABLE 2: ESTIMATED NUMBER OF CHILDREN IN THE UK IN FORMAL AND INFORMAL KINSHIP CARE, 2001

	All children living with relatives	Number of looked after children fostered with relatives	Estimated number of children living in informal kinship care	Proportion (%) of children in kinship care in *informal* arrangements
England	143,367	6,870	136,497	95
Scotland	15,433	980	14,453	94
Wales	9,200	620[2]	8,580	93
Northern Ireland	5,200	534[3]	4,666	90
UK Total	**173,200**	**9,004**	**164,196**	**95**

It is apparent that the vast majority – about 95% - of children living in kinship care arrangements in the UK in 2001 were doing so informally (Figure1). As such, they and their carers would not have been entitled to, and would be unlikely to have received, the same level of financial or other support provided to children living in formal placements. This fact has clear implications for policy makers and advocates working for the interests of children living with kin.

[2] Data for Wales are from 2003, the earliest year for which 'robust' CLA data were available.
[3] Data for Northern Ireland are from 2002, www.dhsspsni.gov.uk/statistics_and_research-cib_looked-after-children

FIGURE 1: NUMBER OF CHILDREN IN KINSHIP CARE IN THE UK 2001

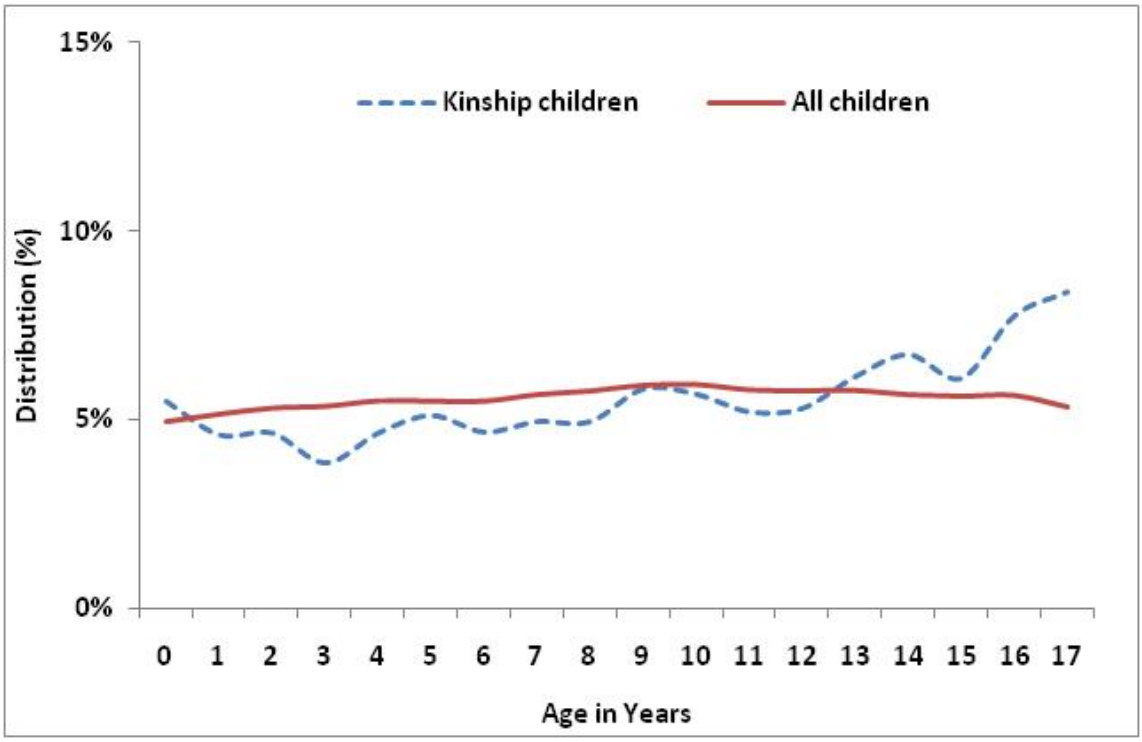


The 2001 Census collected information on the characteristics of children and the households in which they lived, and the next section shows what the Census tells us about children living in kinship care arrangements. It should be noted however, that the Census only provides a snapshot of one point in time, and as such does not contain information to explain *why* children were living with relatives and how long they had been living there.

CHILDREN IN KINSHIP CARE

One of the most notable features of kinship care in the UK, apparent in all four countries, was the fact that older children, particularly those aged between 15 and 17 years, were most likely to be living with kin. Figure 2 shows the distribution by age of the child population (solid line) in England in 2001. It also shows the distribution by age of the population of children living in kinship care (dotted line). What is clearly apparent is that older children account for a much larger share of the kinship care population than they do for the child population as a whole. Thus the dotted line rises above the solid line at around age 13, and stays above it. Younger children, on the other hand, aged between 1 and 12 years, account for a smaller than expected proportion of the kinship care population, with the dotted line below the solid line.

FIGURE 2: DISTRIBUTION (%) BY AGE OF ALL CHILDREN AND CHILDREN IN KINSHIP CARE IN ENGLAND, 2001



While the general patterns of child and kinship care population distributions differed slightly between countries it was apparent (in all four countries) that older children (i.e. 13 years +) accounted for larger than expected shares of the kinship care population. Given the low overall prevalence of kinship care in Northern Ireland it surprisingly had the highest prevalence (1.8%) among older teenagers in relative care in the UK. Around one in every 55 young people aged 15-17 years in Northern Ireland were living in kinship care arrangements in 2001.

ETHNICITY OF CHILDREN IN KINSHIP CARE IN 2001 IN THE UK

Being of minority ethnicity was also associated with being in a kinship care arrangement. In all UK countries children of minority ethnicity were over-represented among the kinship care population – i.e. their share of the kinship care population was greater than their share in the child population as a whole.

ENGLAND - ETHNICITY OF KINSHIP CHILDREN

In England, the chances of being in kinship care increased with the child's age for both minority ethnic children and white children alike. However, Black children, of both African and Caribbean origin, were over-represented among the kinship care population, although the degree of over-

representation was particularly pronounced for children of Black African origin. Mixed ethnicity children, Asian children from all groups, and children of Chinese ethnicity were also all over-represented in the kinship care population, and all were more likely than white children to be living with kin once factors like age, sex and socio-economic status were taken into account.

Black children (both African and Caribbean) made up around 3% of all children in England in 2001, but they accounted for around 9% of children living with relatives. Prevalence rates were particularly high among Black African teenage boys (9%) with around 1 in 11 of *all* African boys aged 15-17 years living in England living with relatives. Chinese children too, (boys and girls) aged 10-14 years were also over-represented, with around 1 in every 20 of all Chinese children aged 15-17 years living in kinship care. In the younger age groups, Asian (particularly Pakistani) girls were over-represented: around 3 in every 100 Asian girls aged 0-4 years were living with relatives (i.e. a prevalence rate of 3% for this particular group.

NORTHERN IRELAND - ETHNICITY OF KINSHIP CHILDREN

Northern Ireland had the smallest minority ethnic child population (1%) but they made up 5% of those in kinship care. Non-white boys and girls aged 15-17 years old, and non-white girls aged 5-9 years, were over-represented in kinship care.

SCOTLAND - ETHNICITY OF KINSHIP CHILDREN

In 2001 Scotland had a less ethnically diverse population than England. The number of minority ethnic children living in Scotland in 2001 was small (around 2% of the total) but even so they accounted for 5% of the kinship care population. Children of all ethnicities (including white) were over-represented in Scotland in the older age groups. However, unlike in England where it was mainly minority ethnic teenagers living with relatives, in Scotland it was young minority ethnic boys. Thirty percent (three out of every ten) of non-white boys in Scotland aged 0-4 years were living with relatives, compared to 1 in every 122 white Scottish boys of the same age.

WALES - ETHNICITY OF KINSHIP CHILDREN

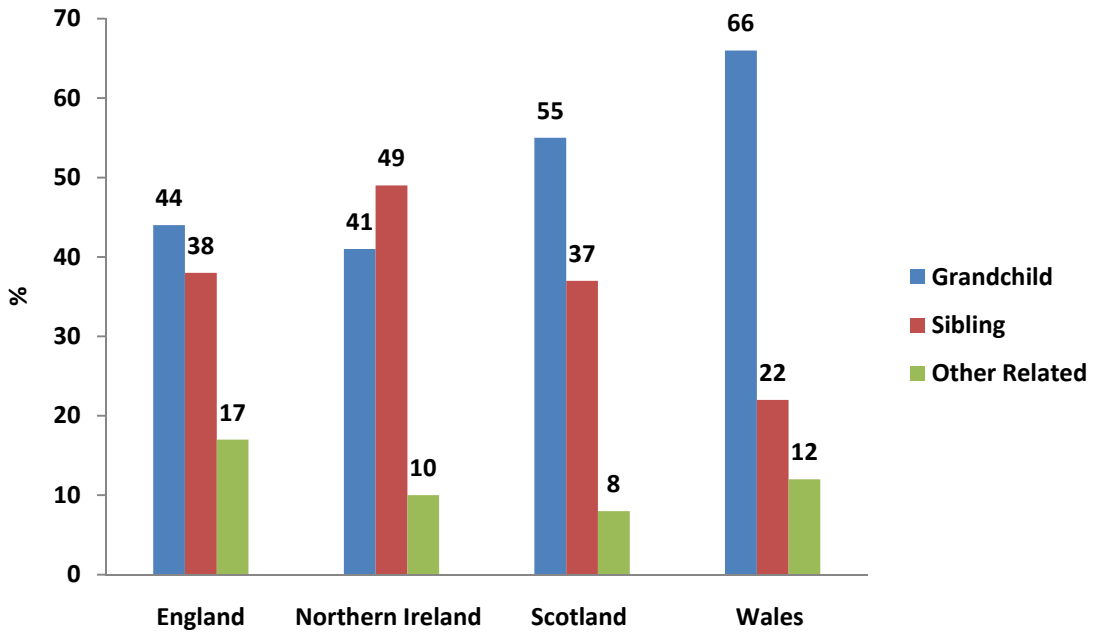
A larger proportion (4%) of children in Wales in 2001 was from a minority ethnic background than either Scotland or Northern Ireland. However, unlike England and Scotland, Asian and black children were not generally over-represented in kinship care in Wales. Instead children of mixed ethnicity were 2½ times more likely than white children to be in kinship care.

The Census does not include data which explains *why* these children were in kinship care or whether the reasons for using kinship care differed between ethnic groups. The second part of the study, with in-depth qualitative interviews, will report in more detail on these and other issues.

THE CHILDREN'S RELATIONSHIP TO THEIR KINSHIP CARERS

Our analyses identified three distinct groups of relatives caring for children: a) grandparents b) siblings, and c) 'Other relatives' such as aunts, uncles and cousins. One of our most important findings is that between one fifth and half of children living with kin were in fact living with a sibling. The Family Rights Group has recently highlighted the needs of this hitherto unknown and invisible group of kinship carers (Roth et al, 2011), and our analysis of the Census provides important additional information to supplement what little is known. Figure 3 shows that in 2001 there were differences between countries in the proportions of children living with each type of carer. Most striking was the finding that nearly half (49%) of all the kinship care children in Northern Ireland were being cared for by a sibling.

FIGURE 3: THE RELATIONSHIP OF CHILDREN TO THEIR CARER BY UK COUNTRY



Although there was variation by country and by type of relative carer, there were some general patterns in the characteristics of carers. Here, we provide a pen picture of each type of carer. Unfortunately, household matrix data for carers in Northern Ireland were not available.

GRANDPARENTS

In the UK, most kinship carers were grandparents who were of white ethnicity. As one would expect, grandparent carers tended to be the oldest group of carers. Most grandparents were in their late 50s and early 60s. However, around one in four kinship grandparents were aged 65 years or older. Unsurprisingly, given their age, over one-third reported a limiting long-term illness or disability that restricted their daily activities. Higher rates of limiting long-term illness or disability were reported by grandmothers.

As noted earlier, the Census identifies the Household Reference Person (HRP) as the person with the highest economic activity in the household. Grandfathers were the HRP in just less than half of all the grandparent kinship households. In these households, grandfathers were rarely living alone. The vast majority (over 80%) had a wife or partner. However, when grandmothers were identified as the HRP (just over half of grandparent households) about three-quarters of these women were single carers. In England and Scotland about a third of grandmothers were widowed and in Wales, the proportion widowed was much higher at 48%.

Most grandparent families were caring for only one child - the child in the kinship arrangement - but family size ranged from 1 to 9 children. The majority of grandparents had no educational or professional qualifications and were poor. About 60% of kinship households headed by a grandparent in England and Wales, and 77% in Scotland, were living in the poorest 40% of areas of the country (as defined by level of income), with most of these in the poorest twenty percent of areas. Grandmother 'headed' households tended to be poorer than those where the grandfather was the HRP. About one in three grandmother 'headed' kinship households were workless and dependent on benefits or pensions, compared to 1 in 10 households 'headed' by a grandfather.

SISTERS AND BROTHERS

Most sibling kinship carers in the UK were sisters, single, and in their early thirties. In comparison with grandparent kinship carers, a higher proportion of sibling carers had some educational or professional qualifications but significant numbers still had none. Between 39% and 50% of sister headed households had no professional or vocational qualifications. The size of sibling 'headed' households varied, with most siblings caring for two or more children, of which at least one was a child in kinship care. In comparison with the other types of kinship carer, sibling carers were also more likely to have young children (i.e. under five years old) in the household. Compared to other

kinship households, a greater proportion of sibling 'headed' households were overcrowded with around one in five having more than one person per room.

As with other kinship carers, most sibling carers were living in poor and deprived conditions. Very few sisters providing kinship care were in occupational social classes A or B (i.e. professional and middle managers); with most either in low paid semi-skilled/manual work or unemployed. It is likely, given their caring responsibilities and lack of qualifications, that many sibling kinship carers, particularly sisters, would have been working part-time and receiving low rates of pay. Indeed, sister-headed households were generally the poorest of all kinship households.

In England and Wales around a third of sibling carers were brothers, as were a quarter in Scotland. Most male sibling carers were married or living with a partner. Although they were slightly better off than female sibling carers, they were generally working in manual occupations. However, in Wales, male sibling kinship carers were also evident in occupation social classes A and B, with a third working in professional or managerial jobs.

OTHER RELATIVE CARERS

Other relative carers such as aunts, uncles and cousins made up the smallest proportion of kinship carers. They tended to be in their forties and older than sibling carers, but younger than grandparents and most were caring for two or more children.

Their household composition differed by country: England and Scotland had a similar pattern but Wales was quite different. In England and Scotland, the HRP was a male in about half of 'Other relative carers' households, three-quarters of whom were married or living with a partner. As with other types of kinship carers, female-headed households were usually lone carers. Wales had much smaller numbers of children (only around 800) cared for by 'Other relatives'. These households were predominantly headed by women (78%) and fewer (57%) were single carers in Wales than in England and Scotland. However, a far larger proportion of 'Other relative' kincarers in Wales reported a limiting long-term illness, although the average age of the carers was not that different to other countries in the UK.

Just as was seen for other groups of carers, many of the families involved in kinship care arrangements (both formal and informal) were living in poverty. This was especially the case in Scotland. A staggering 82% of all the families where an 'Other relative' was the kinship carer were living in the poorest 40% of areas. However, there was more income variation within the group of

'Other relative carers'. In England, Scotland, and Wales, in comparison with other kinship carers, a greater proportion of adults were in skilled work. This suggests that there may be a particular sub-group of 'Other relative carers' (perhaps those who were younger or of minority ethnicity) who are particularly disadvantaged and poor.

KINSHIP CARERS WITH A LIMITING LONG-TERM ILLNESS OR DISABILITY

Many kinship carers clearly had considerable economic constraints, with few economic resources and poorly paid jobs. Many also reported experiencing a limiting long-term illness or disability (LLTI) which affected their daily life. In 2001, around 18% of the general population reported a LLTI, and of course these rates increase with age, particularly for those aged 45 years and over. Census data show that below 44 years, rates of LLTIs were 10% or less in the general population, but about twice this by for the 45-59 years age group. For the 60-74 years age group, LLTIs affected about 40% of the population, with differences between men and women only becoming apparent for those aged over 65 years. Between 60 and 74 years of age, men reported slightly higher rates of LLTIs but after 75 years, rates were higher for women. However, those who were unemployed, widowed, divorced or single all reported higher levels of LLTI than those who worked or were living with a partner (ONS 2004). We have already shown how these characteristics were associated with kinship carers and indeed kinship carers reported higher rates of LLTIs than adults in the general population (Table 3).

TABLE 3: THE PERCENTAGE OF HOUSEHOLD REFERENCE PERSONS CARERS REPORTING A LIMITING LONG-TERM ILLNESS OR DISABILITY BY GENDER IN THE CENSUS 2001

Country	Household Reference Person	Birth Parents %	Grandparents %	Siblings %	Other relative carers %
England	Male	8	33	7	22
	Female	12	47	11	18
Scotland	Male	8	28	**40**	13
	Female	14	68	18	11
Wales	Male	11	39	17	**50**
	Female	13	57	20	**43**

Source: Calculated from 2001 Household CAMS

Grandmothers, in particular reported high rates of LLTI but the shaded cells in Table 3 are to highlight those groups who reported prevalence rates of LLTIs at least twice as high as the national rate. There were surprisingly high rates reported by male sibling carers in Scotland, and by both men and women 'Other relative carers' in Wales. Wales in particular had high LLTI rates and this finding has also been noted in studies of the general population in Wales, particularly among those of working age (Kenway et al., 2005).

Disability and poor health are known risk factors associated with poverty and it was very striking the extent of poverty among children and their kinship carers. While the majority of kinship carers were living in poverty, female headed kinship household were markedly poorer.

INCOME POVERTY

When we began this study we wondered if previous findings about the high levels of poverty in kinship households would hold in a representative sample from the Census. We questioned whether previous studies might have been biased, with samples overwhelmingly drawn from low income families in contact with support agencies. However, this study reinforces and strengthens previous findings that highlighted the poverty and very real needs of children living in kinship care and their carers (Hunt, 2003; Farmer and Moyers, 2008; Dryburgh, 2010). Children who grow up in poverty tend to have poorer outcomes across a range of dimensions, including health, social development and educational attainment. As disadvantaged children grow up, a number of barriers and factors contribute to them gaining fewer qualifications, leading to a widening gap in employment outcomes and health inequalities in later life. As adults, their own children are at risk

of growing up with the same disadvantages perpetuating the poverty cycle for a new generation. Poverty has costs to society as well as the individual. By limiting children's educational attainment it reduces the skills available to employers, and impedes economic growth. It has been suggested that child poverty costs Britain at least £25 billion a year (Hirsch, 2008).

In 2001, the average risk of a child being poor in the UK was 23% (CPAG, 2006). However, the risks for some groups of children, such as those living in workless households and where the household was headed by a single parent or an adult of minority ethnicity increased the risk. Data from the Census showed that most children in kinship care were living with families whose characteristics were associated with increased risk of poverty: single female carers, dependent on benefits, workless households, a higher prevalence of reported LLTIs and an over-representation of ethnic minorities. Kinship carers too, often had fewer educational or professional qualifications than the general population and for the most part were unemployed or in unskilled jobs.

Many of the kinship families were 'headed' by a lone female carer: a sister or an aunt and most frequently a grandmother. While pensioner poverty decreased during the 1990s, this was largely the result of increasing numbers of pensioners retiring with personal and private pensions. However, as Middleton (2006) has highlighted, this disguises a sub-group of pensioners (particularly older women) dependent on the State Retirement pension which has fallen in relative value. It is likely that many grandparent kinship carers fall into this sub- group, as so few had any qualifications and would have been unlikely to receive an occupational pension. However, even if grandparents had an occupational pension, bringing up children is costly and was unlikely to have been planned for financially.

The Census provides a number of ways to examine the relationship between kinship care and poverty. The first measure we used was the income deprivation dimension from the Index of Multiple Deprivation (IMD) (Noble et al., 2004). The income deprivation domain is a measure which contains information from a number of indicators including the number of people reliant on means tested benefits; the proportion of households receiving working family tax credits or disabled person's tax credits whose equivalised income is below 60% of median income[4], and the number of supported asylum seekers. The model of multiple deprivation which underpins the IMD is based on the idea of distinct dimensions of deprivation which can be recognised and measured

[4] Being below 60% of median income has become the standard income poverty measure Gordon, D. & Townsend, P. (2001) *Breadline Europe: The Measurement of Poverty,* Bristol, The Policy Press..

separately. These are experienced by individuals living in an area and the IMD data clusters about 20 adjoining postcodes into areas. Thus IMD data do not relate to individuals or individual households, *but to areas*. Our analysis found that the majority of children living in kinship care were living in the poorest 40% of areas and many were in the bottom 20% as shown in Table 4. Data for Northern Ireland were not available.

TABLE 4: THE PERCENTAGE OF CHILDREN IN THE GENERAL POPULATION AND IN KINSHIP CARE LIVING IN THE POOREST 20% OF AREAS IN EACH COUNTRY

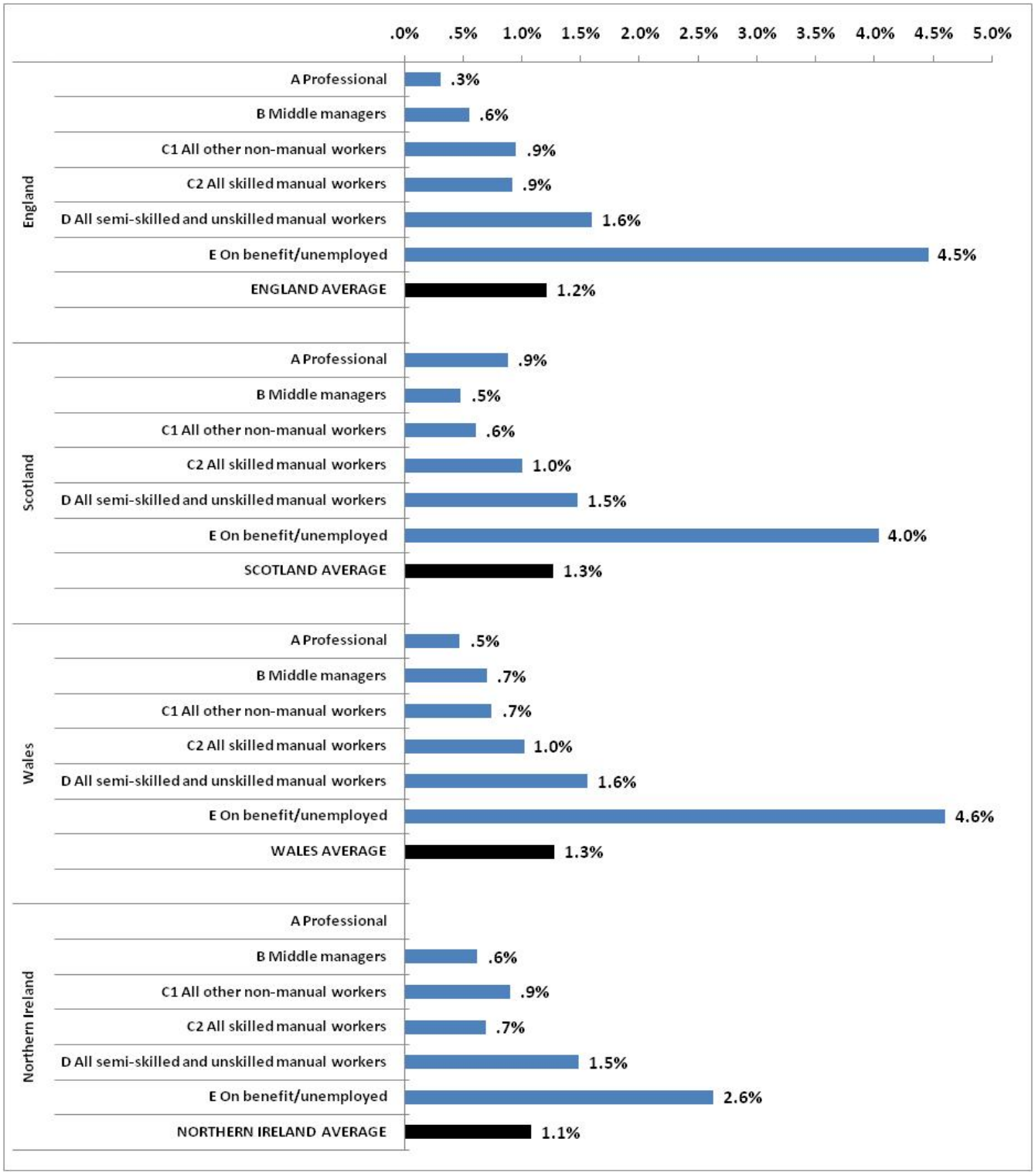
	England %	Scotland %	Wales %
Children in the general population	24	23	28
Children in kinship care	44	45	38

Source: Calculated from 2001 I-CAMS

Of course, not everyone living in a deprived area is necessarily poor and therefore we also considered a second measure of income: the occupational social class of the HRP. This information was collected on individuals who returned the Census questionnaire. Occupational social class is a 6-level indicator[5] and ranges from Professionals and Middle Managers in classes A and B, to the unemployed and those on benefits in Class E. These data confirm that most children in kinship care were living in poverty. Figure 4 shows how the prevalence of kinship care in all countries of the UK were highest in what are considered the poorest social classes, i.e. classes D and E.

[5] Occupational Social Class: A (Professional), B (Middle managers), C1 (All other non-manual workers), C2 (Skilled manual workers), D (Semi-skilled and unskilled manual workers) and E (Unemployed/benefits).

FIGURE 4: PREVALENCE RATES (%) OF KINSHIP CARE AMONG CHILDREN IN ENGLAND, SCOTLAND, WALES AND NORTHERN IRELAND BY OCCUPATIONAL SOCIAL CLASS OF HRP, 2001



SOURCE: CALCULATED FROM 2001 I-CAMS

Around 1 in every 39 children in Northern Ireland in social class E were living with relatives compared to around one in every 167 children in social class B (no children in social class A were recorded as living in kinship care in Northern Ireland). In Scotland around one in every 25 children in social class E were living in kinship care, compared to one in 22 children in England and Wales. Far lower prevalence rates were seem among children in households where the HRP was classified as being in social classes A: 1 in 333 children in England, 1 in 200 in Wales and 1 in 111 in Scotland. The occupational social class of the HRP and the location of kinship households in the poorest areas confirmed that most children in kinship care in 2001 were living in poverty.

Reports published by the Joseph Rowntree Foundation (e.g. Hirsch 2008) have shown how State benefits leave people far short of the minimum income needed to live in the UK, and with most kinship families located in social class E (i.e. on benefits) it is likely most will be in need of support and assistance.

Income poverty is an important risk to a child's development and one that impedes achieving potential. However, it is a uni-dimensional measure and there are other factors that increase the risks of poor outcomes. Although poverty and disadvantage are often used interchangeably, it has been argued that a clear distinction should be made between them (Nolan and Whelan, 1996). Poverty is a lack of money or material possessions while deprivation is when people lack the resources to escape from poverty (Townsend, 1987). Deprivation therefore includes other unmet needs - not just financial.

MULTIPLE DEPRIVATION

The *Families at Risk* review (Social Exclusion Task Force, 2008) estimated that around 140,000 of the 13.8 million families in England experienced at least five of the risk factors that are known to be linked to poor outcomes, and noted that these were often passed from generation to generation. The children of these families are, for example, ten times more likely to be in trouble with the police, and eight times more likely to be excluded from school. The risk factors included in the *Families at Risk* analysis were: no parent in the family in work; family living in poor quality or overcrowded housing; no parent with any qualifications; mother with mental health problems; at least one parent with a long-standing limiting illness, disability or infirmity; family with low income (below 60 per cent of median income); and family cannot afford a number of food and clothing items.

The 2001 Census did not collect information on all of these factors, so instead we followed a method set out by Dorling and colleagues (2007) who had also used the 2001 Census to create a child deprivation index. We selected indicators known to be associated with deprivation, such as households where no-one worked, high overcrowding, children reporting an LLTI, single parent families, and families with no access to a car, etc., to give a more comprehensive picture of multiple deprivation (and social exclusion) faced by children living with relatives. In relation to all children in Great Britain, Dorling and colleagues (2007) found that most children (71%) did not experience any of the risk indicators or, if they did, they experienced only one disadvantage. However, around 29% of children in the general population did experience two or more of the indicators associated with deprivation – i.e. multiple disadvantage. There were, however, significant differences by children's ethnicity. Most striking was the finding that in the general population the majority of Bangladeshi and black African children experienced multiple deprivations.

Turning to children in kinship care we found that the majority (about 71%) of kinship children in the UK experienced two or more forms of deprivation and only 29% had none or only one. A greater proportion of children in Scotland (76%) were living in kinship households with multiple deprivations in comparison with children from the other nations. Rates of multiple deprivation among children in kinship care were consistently much higher than the national average.

DIFFERENCES BETWEEN THE UK COUNTRIES

Generally in the UK: the prevalence of kinship care increased with the age of the child; grandparents were the group providing the majority of care; kinship families were poor; and in every country children from minority ethnic backgrounds were over-represented. Here we comment only on the major differences in patterns of kinship care between the four UK countries.

England

Girls were slightly more likely than boys to be living with relatives, and prevalence rates for children from all groups began to increase from ten years old. The highest prevalence rates of kinship care in England were found in Inner London. England has the most ethnically mixed population of all the UK countries and about a third of kinship children were of minority ethnicity. In relation to children's carers, most of the relatives were white but 15% of grandparents, about a third of sibling carers and nearly a half of all the 'Other relative carers' were from a minority

ethnic background. In comparison with the other UK countries there were more large kinship households (i.e. containing more than 5 people) and this may reflect the greater proportion of minority ethnic kinship families in England.

Scotland

Girls were slightly more likely to be in kinship care, and the prevalence rate for children in kinship care began to increase from age five. In comparison with England and Wales kinship households were headed more often by single women and these households tended to be poorer than kinship carers in the other nations. Nearly half of sisters providing kinship care lived in the poorest 20% of areas.

Wales

Unlike the rest of the UK, girls were less likely to be in kinship care than boys and the difference in prevalence rates by the age of the child were not as pronounced. Children of mixed ethnicity were over-represented in kinship care but those of black and Asian ethnicity were not. In comparison with the other countries, Wales had the largest proportion of grandparent kinship carers and all kinship carers were of white ethnicity. Kinship carers in Wales reported the highest level of LLTIs. There was less uniformity within the 'Other relative carer' group in Wales and they were distributed more evenly across occupational and social classes than in the other countries.

Northern Ireland

Northern Ireland had the lowest rates of kinship care in the UK but the biggest gender differential. Girls accounted for over half (54%) of all the children living in kinship care but boys aged 15-17 years were also significantly over-represented in kinship care. Unlike the rest of the UK, *most children in kinship care in Northern Ireland were living with a sibling* (not a grandparent) and none were living in households where the occupation of the HRP had been classified as professional. However, in comparison with the other UK countries a much smaller proportion of children were living in workless households.

POLICY AND LEGISLATION

In response to the *Families at Risk* review (2008), the last government produced a set of reforms set out in England in *Think Family* (DCSF, 2009). The reforms were intended to secure better outcomes for children by improving the identification of families most in need, delivering better

targeted and co-ordinated services and aimed to strengthen the ability of family members to care for each other. *Think Family* stressed the importance of identifying the families most at risk and that both the identification and response was a multi-agency responsibility involving GPs, schools, and Children's Centres. Our analyses have shown that in any such strategy, children in kinship care should be considered as a group who are likely to need additional help and services.

The previous government also attempted to reduce the numbers of children in poverty and established through legislation (*Child Poverty Act 2010)*, four separate child poverty targets to be met by 2020/21. The Coalition government (2011b, 2011a) announced that it was committed to working towards these targets but wished to take a broader approach to tackle the underlying causes of poverty and the intergenerational transmission of poverty and disadvantage. The Government stated that a new child poverty strategy would include identifying the children who face the highest risks of socio-economic disadvantage; reforming the benefit system to ensure that works pays; and ensuring that the most vulnerable families receive the support they need and encouraging financial independence.

Part 2 of the Child Poverty Act (2010) placed a duty on local authorities and named partner authorities to co-operate with a view to reducing, and mitigating the effects of, child poverty in their local areas. One element of this co-operation involves producing a needs assessment which describes the distribution and characteristics of child poverty across local areas and the extent and nature of the challenge in each authority. It is intended that the needs assessments should inform the child poverty strategies, which each local area are required to produce.

It is therefore essential that local authorities take account of the needs of children in kinship care in their child poverty needs assessments and subsequent strategies. The evidence in this report shows that they are a group who face high risks of socio-economic disadvantage and that they should be recognised as a group with special needs. However, the financial circumstances of these families could worsen. The Kinship Care Alliance (2011) has already drawn attention to the unintentional detrimental effect of the provisions in the Welfare Reform Bill (2011) because the needs of kinship families have gone unrecognised.

The English government (Department for Education, 2011) has also published guidance for local authorities on the provision of support to family and friends carers. For many years there has been concern that kinship carers have received less support than foster carers and that financial and other types of support have varied enormously depending on where carers resided. The guidance

makes it clear that children and young people who are unable to live with their parents should receive the support that they and their carers need to safeguard and promote their welfare, whether or not they are looked after. It requires each local authority with responsibility for Children's Services to: identify a senior manager to hold overall responsibility for the family and friends care policy; and by September 2011 (in collaboration with local partners), to publish an accessible policy setting out the authority's approach towards meeting the needs of children living with family and friends carers. The policy is intended to be informed by evidence.

This study should provide some of the evidence that will enable local authorities to draw up their policies. It has provided the first representative estimates of the numbers of children living with relatives and the characteristics of the children and their carers. We were unable to estimate the number of children cared for by friends. Previous estimates (Richards and Tapsfield 2003) of the UK kinship population (often quoted as between 200,000-300,000) have been rather higher, but their estimate included friends and may have also included children not usually resident with a kinship carer. However, in Scotland existing estimates of the numbers of children in kinship care may have been under-estimated. Using household survey data from 2005/6, the Scottish Government (2009) suggested around 9,000 children were in kinship arrangements. However, this study has shown that in fact well over 15,000 children were living with relatives in Scotland in 2001. It is extremely unlikely that the number of children in kinship care would have decreased between 2001 and 2005/6. Given the difficulties facing families and the policy interventions designed to increase the use made of kinship care, we would expect the prevalence and extent of kinship care to have increased since 2001, something which can be tested when data from the 2011 Census are made available.

We hope our findings provide a much better basis for the development of national and local policy, and that they will, in the future, act as a baseline from which to measure changes in the extent and circumstances of children in kinship care. It is clear that some local authorities will face significant challenges to provide for the large numbers of children cared for by relatives in their area. Our analysis of the 2001 Census has highlighted the poor health of some of the carers, the high levels of child poverty particularly in female 'headed' households, and the multiple deprivation that many of these children experience. Given that kinship carers are an example of the 'Big Society' in action, it is of concern that much of their caring occurs against a background of such high levels of need. These are issues which require urgent attention.

REFERENCES

Aldgate, J. (2009) Living in Kinship Care: A Child Centred View. *Adoption and Fostering,* 33**,** 51-63.

Aldgate, J. & McIntosh, M. (2006) *Looking after the Family: A Study of Children Looked after in Kinship Care in Scotland*. Edinburgh, Social Work Inspection Agency.

Bowie, F. (Ed.) (2004) *Cross-Cultural Approaches to Adoption.* London, Routledge.

Coalition Government (2011a) *The Coalition: Our Programme for Government*. London, HM Government

Coalition Government (2011b) *Consultation: Tackling Child Poverty and Improving Life Chances*. London, Department for Work and Pensions, Department for Education and HM Treasury.

CPAG (2006) *Meeting the Government's Child Poverty Target: Progress to Date.* London, Child Poverty Action Group.

DCSF (2009) *Think Family: Improving the Support to Families at Risk*. London, Department for Children, Schools and Families.

DCSF (2010) *Support for All. Family and Relationships Green Paper.* London, DCSF.

DCSF & Ministry of Justice (2007) *Children and Offenders Review.* London, DCSF.

Department for Education (2011) *Family and Friends Care: Statutory Guidance for Local Authorities*. London DfE

Dorling, D., Wheeler, B., Shaw, M. & Mitchell, R. (2007) Counting the 21st Century Children of Britain: The Extent of Advantage and Disadvantage. *Twenty-First Century Society: Journal of the Academy of Social Sciences,* 2**,** 173-189.

Dryburgh, K. (2010) *Relative Value: The Experiences of Kinship Carers Using the Scottish Cab Service*. Edinburgh, Citizens Advice Bureau.

Farmer, E. & Moyers, S. (2008) *Kinship Care: Fostering Effective Family and Friends Placement.* London, Jessica Kingsley Publishers.

Gordon, D. & Townsend, P. (2001) *Breadline Europe: The Measurement of Poverty.* Bristol, The Policy Press.

Hirsch, D. (2008) *Estimating the Costs of Child Poverty.* York Joseph Rowntree Foundation.

Hunt, J. (2003) *Family and Friends Carers.* London, Department of Health.

Hunt, J., Waterhouse, S. & Lutman, E. (2008) *Keeping Them in the Family: Outcomes for Children Placed in Kinship Care through Care Proceedings*. London, British Association for Adoption and Fostering.

Ince, L. (2009) *Kinship Care: An Afro-Centric Perspective.* Institute of Applied Social Studies. Birmingham, University of Birmingham.

Kenway, P., Parsons, N., Carr, J. & Palmer, G. (2005) *Monitoring Poverty and Social Exclusion in Wales*. York, Joseph Rowntree Foundation.

Kinship Care Alliance (2011) *Second Reading Briefing on the Welfare Reform Bill 2011* London, Family Rights Group.

Middleton, S. (2006) *Poverty Policy in the UK.* Centre for Research in Social Policy, Loughborough University

Noble, M., Wright, G., Dibben, C., Smith, G. A. N., McLennan, D., Anttila, C., Barnes, H., Mokhtar, C., Noble, S., Gardner, J., Braswell, S., Covizzi, I. & Lloyd, M. (2004) T*he English Indices of Deprivation 2004*. London, Office of the Deputy Prime Minister.

Nolan, B. & Whelan, C. (1996) *Resources, Deprivation and Poverty.* Oxford, Clarendon Press.

Office of National Statistics(ONS) (2004) *Focus on Health, Census 2001.* ONS available at http://www.statistics.gov.uk/cci/nugget.asp?id=916

Richards, A & Tapsfield, R. (2003) *Family and friends care: the way forward*. London: Family Rights Groups.

Roth, D, Lyndley, B. & Ashley, C. (2011) *Big Bruv Little Sis.* London, Family Rights Group

Scottish Government (2009) *Moving Forward in Kinship and Foster Care, Getting It Right for Every Child in Kinship and Foster Care Reference Group*. Edinburgh, Scottish Government.

Social Exclusion Task Force (2008) *Families at Risk Review*. London The Cabinet Office.

Townsend, P. (1987) Deprivation. *Journal of Social Policy,* 16**,** 125-146.