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Special Issue
Kinship Care and Child Welfare: New Directions for Policy and Practice
(Second of two issues)

Guest Editors
Mark Testa, Eunju Lee, and Charlene Ingram
Submissions to Child Welfare should be 3,500 to 5,000 words in length, including artwork and references. An abstract of approximately 75 words should preface the article. All references should be documented according to APA style (6th ed.). Full terms, as well as the online submission process, can be found at www.cwla.org/child-welfare-journal/submissions.

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137 New Directions for Kinship Care Policy and Practice: A Position Paper from the Kinship Summit at Albany, New York, September 2016
In 2013, the Child Welfare League of America published the CWLA National Blueprint for Excellence in Child Welfare (National Blueprint). The National Blueprint provides a vision for child welfare that “all children will grow up safely, in loving families and supportive communities.” Fundamental to this vision is the belief that while the formal child welfare system is accountable for its specific role as it relates to children who are at risk of or have experienced abuse or neglect, it will take the combined efforts of families, communities, other child and family systems, and the public as a whole to fully actualize the vision. The National Blueprint is intended to challenge individuals, groups, communities, and providers, inside and outside of the formal child welfare system, to understand that they play an important role in advancing improved outcomes for children and families.

The National Blueprint also serves as the foundation for all of CWLA’s work. It makes it clear that the needs of the children and families that come into contact with the formal child welfare system cannot be addressed by the child welfare system alone; the system must do its work by leveraging the knowledge and resources gained from families, communities, and other child and family serving systems. The core principles of the National Blueprint include Rights of Children; Shared Responsibility and Leadership; Engagement/Participation; Supports and Services; Quality Improvement; Workforce; Race, Ethnicity, and Culture; and Funding and Resources. In particular, the Engagement/Participation principle states, in part, that “Children, youth, and families are engaged and empowered to promote family success and build community capacity.” Also, the Supports and Services principle states that “Families, individuals, communities and systems protect children from abuse and neglect and provide an array of supports and services that help children, youth, and their
families to accomplish developmental tasks, develop protective factors and strengthen coping strategies.” To achieve this *National Blueprint* vision for children and youth, child welfare organizations—and in fact other child serving organizations must engage and extended family members to care for children when their adult children are not able to care for them and to ensure that these family members have the supports and services they need to effectively care for these children. This special issue of *Child Welfare*, “Kinship Care and Child Welfare: New Directions for Policy and Practice,” focuses on kinship families and the successes and challenges they experience, with a view toward assuring a comprehensive system of kinship care that is inclusive of all such families.

*Child Welfare* thanks our colleagues at University at Albany, SUNY, for their contributions to this special issue.
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From the Editor:

The Apple Tree Has Many Healthy Apples: Kinship Caregiving

Beatriz Johnson was leaving work when she received a frantic call from her daughter, Patrice: “Mom, the police are here, and they have the kids!” Patrice had struggled with substance abuse before she became a mom. Beatriz rushed to her daughter’s home. A neighbor had called the police when the children—Bobby, 6 months, and Patrick, 2—were heard crying, the door to the apartment was opened, and Patrice was found not to be at home. Child protective services were called; they waited for Patrice, and after an hour, the children were taken into custody. Beatriz knew that she was not going to let her grandsons stay in custody and immediately made a plan to take them into her home and care for them—after all, isn’t that what grandmothers did? The children were placed with Beatriz, who cared for them full-time with support; Patrice entered substance abuse treatment and worked to regain custody of her children. And so begins the process of kinship care.

Twenty years ago, when this journal first addressed Beatriz’s plight and others like hers in our special issue on kinship care (Wilson & Chipungu, 1996), the focus was on the formal placement of children with kin after the children were taken into public custody. This special issue focuses on the much larger number of kinship caregivers, who, as in Beatriz’s situation, either intervene on their own or accept the assistance of child protective authorities that facilitate informal arrangements without taking legal custody. It is the larger combined population of formal and informal kinship placements, to which the common definition of kinship care appropriately applies: “the full-time care, nurturing, and protection of a child by relatives, members of their Tribe or clan, godparents, stepparents, or other adults who have a family relationship to a child.”
There are many benefits to placing children with relatives or other kinship caregivers, such as increased stability and safety as well as the ability to maintain family connections and cultural traditions. Whether these kinship arrangements should be kept informal or brought under the formal governance of child protective authorities is a policy question with which federal and state governments continue to struggle: How can the respect owed informal kinship relationships on the basis of emotional ties and the family's cultural values best be reconciled with the formal placement requirements of legal custody, licensing, and regular surveillance of the quality of foster family homes?

Even after the public enforcement of so-called relative responsibility laws eventually ended in most western societies (Bell, 1965), cultural expectations still dictated in many regions that kin should provide for one another as a moral duty without being financially compensated. During the 20th century, these cultural expectations surrounding uncompensated kinship care began to change. The relative-payee Aid for Families with Dependent Children grant, which aided a family when a child came from an eligible household and was living in the home of a relative, was explicitly addressed in the Social Security amendments of 1962. Relatives also qualified as providers of home health aid under Medicaid. Then, in 1977, the U. S. Supreme Court ruled in Miller v. Youakim that relatives who met foster care licensing standards must be permitted to receive federal foster care funds and in Moore v. City of East Cleveland that relatives, especially grandparents, have heightened protections when they become caregivers. For years, many states were slow to add relatives to the foster care rolls and to enact supports for kinship families, but additional policy on the federal level and by some states has helped create momentum for change.

There are many perspectives and opinions about kinship care from the child welfare community and society at large. The old adage of “the apple doesn’t fall from the tree” is erroneously used to denigrate
the kinship connection. But as Dr. Joseph Crumbley—a leading expert in this area—often says, “we have to dispel that myth—there are many healthy apples on the tree, too.” The benefits of kinship care for children who cannot live with their birth families, in my opinion, outweigh the concerns. Yet there are many considerations that continually arise and should be assessed.

The authors featured in this special issue on kinship care cover a wide range of issues. They are among the leading experts in the field, and their contributions will undoubtedly stimulate dialogue and discourse among many in child welfare.

Gary Mallon DSW
Senior Editor
Introduction:

Kinship Care Policy and Practice:
(Second Issue)

More than two decades ago, the Child Welfare League of America (CWLA) published *Kinship Care: A Natural Bridge* (Child Welfare League of America, 1994). The report assembled the best thinking and scholarship available at the time to address the emerging issue of kinship care in the field of child welfare. Even though the alternative care of children by extended family, tribal members, and other primary groups is deeply rooted in human evolutionary and cultural history, it was only in the last quarter of the 20th century that child welfare practitioners and policy-makers put concerted efforts into reconciling the natural-customary sources of informal kinship care with the rational-legal foundations of formal foster care. Despite some progress in reconciling the informal agency relationships of kinship solidarity and customary trust with the formal agency relationships of contractual exchange and generalized beneficence (Testa, 2013), significant challenges still remain in demarcating the boundaries between informal and formal kinship care and in ensuring that kinship caregivers, birth parents, and their children receive the support and services they need from the public child welfare system.

The purpose of this introduction is to offer a conceptual framework for addressing the challenges involved in developing a coherent set of policies and practices with respect to kinship care. The challenges span two key tensions in the public protection and care of vulnerable children. The first concerns the appropriate scope of public interest in the welfare of other people’s children: Should child welfare policy be constrained to a narrow set of functions that ensure children are adequately fed, sheltered, clothed, and protected from physical harm, or should it be unconstrained in the pursuit of a diffuse array of improvements in children’s
general well-being? The second concerns the appropriate locus of agency relationships in the protection and care of children: Should actions taken by non-parental agents on behalf of the interests in children be largely the informal responsibility of the particularistic agency relationships of extended kinship, tribal affiliation, and voluntary association, or should the universalistic agency relationships of child protective services (CPS) and court authority ultimately be held accountable for ensuring adequate safety, family permanence, and equal developmental opportunities for all vulnerable children?

An agency relationship is one in which an individual or collective agent is delegated the discretion to act on behalf of the interests of another individual or class of individuals, also known as principals (Testa & Poertner, 2010). The intersection of the two dimensions of locus of agency relationships (informal vs. formal) and scope of public interest (constrained vs. unconstrained; Sowell, 2007) frame a matrix of policy choices that, on the constrained side, range from: (A) deferring to the autonomy and discretion of informal primary groups to raise children as they deem appropriate to (B) enforcing uniform caregiving practices that uphold minimal formal standards of child protection, care, and discipline. On the unconstrained side, the choices range from: (C) redistributing resources to enable informal primary groups to raise children as best they can to (D) investing in formal agency relationships of early education, mental health services, foster homes, and adoption assistance, which can supplement or substitute for primary group relationships that don’t measure up to majority expectations.

Much of the history of child welfare in general and kinship care in particular can be interpreted as evolving from policy A, under mid-19th-century poor law doctrines of family autonomy and relative liability, to policy B, with the spread of child rescue societies and the growth of orphanages and family foster care as alternatives to in-home care in the late 19th century (Costin, 1993; Meyers, 2008). Policy C emerged during the first half of the 20th century, partly in reaction to Policy B, with the creation of mothers’ pensions and the federalization of kinship
support under Aid to (Families with) Dependent Children (Leff, 1992). Policy position D appeared around the same time with the invention of the juvenile court and accelerated after the passage of Medicaid, Title IV-E, Head Start, and other “war on poverty” programs in the 1960s.

The progression from policy choices A to D, however, has not been unidirectional. Some have likened it to the swings of a pendulum (Garwood, Phillips, Hartman, & Zigler, 1989). Backing for Policy C receded in the mid-1990s with the replacement of the Aid to Families with Dependent Children (AFDC) entitlement by time-limited Temporary Assistance to Needy Families (TANF). Support for Policy D eroded with the deinstitutionalization of foster care in the 1970s and the elimination of long-term foster care as a permanency planning goal in the late 1990s. All four policy positions continue to evolve in response to changing demographic, economic, and political conditions in the early 21st century.

Figure 1. Typology of Kinship Care

![Typology of Kinship Care Diagram](image)

Typology of Kinship Care

Figure 1 presents a typology of kinship care based on the cross-tabulation of the two dimensions of scope of public interest and locus of agency relationships. The 1994 CWLA report emphasized the informal-formal distinction and focused its recommendations on formal kinship care. It defined formal caregiving as child custodial relationships that are established: “… as a result of a determination by the court and the public child protective service agency that a child must be separated from his or her parents because of abuse, neglect, dependency, abandonment,
or special medical circumstances. In formal kinship care, the court places the child in the legal custody of the child welfare agency, and kin provide the full-time care, protection, and nurturing that the child needs.” (Child Welfare League of America, 1994, p. 3)

Subsequent scholarship (Testa, 2013; Denby, 2016) broadened the definition of formal kinship care to encompass legal processes that establish relatives as permanent legal guardians or adoptive parents of the child (permanent kinship care) in addition to those that establish them as temporary foster parents (public kinship care). This broadening of the definition was in keeping with earlier scholarship concerning the contrast between informal and formal adoption (Hill, 1977). Even though permanent kinship care was only tangentially addressed in the 1994 CWLA report, this report recommended that subsidized guardianship by kin be offered as a supplemental permanency option. At the time, federal kinship guardianship assistance was still being tested under IV-E waiver authority, and adoption was just beginning to be accepted as a viable permanency goal for children in kinship care (Testa, Shook, Cohen, & Woods, 1996). The subsidized guardianship recommendation was later established in law when Congress acted on research evidence from IV-E waiver demonstrations to create the kinship Guardianship Assistance Program (GAP) as part of the 2008 Fostering Connections Act (FCA).

The 1994 CWLA report defined informal kinship care as child-caring relationships that are based on a private agreement reached between a parent and alternative caregiver. In these informal arrangements, a public agent may be involved in helping family members plan for the care of the child, but the CPS agency does not take formal custody of and assume legal responsibility for the child. The 2000 Report to the Congress on Kinship Foster Care (U.S. Department of Health and Human Services, 2000) built on this distinction and separated informal kinship care into private and voluntary types in order to distinguish the special relationship that is created when child protective authorities help facilitate voluntary kinship care but do not seek court
action to obtain public custody of the child. Because CPS involvement in voluntary kinship care arrangements can range from conducting a brief home visit or background check to opening up a CPS case and providing ongoing intervention and treatment services, the typology makes a further distinction along the constrained vs. unconstrained dimension—between voluntary arrangements that experience brief CPS involvement and those that result in an open CPS case.

The 2008 FCA also included notice provisions that mandated diligent efforts in finding kin, especially grandparents, and informing of them of their custodial options. These provisions prompted the use of other formal legal mechanisms for temporarily reassigning child custodial responsibilities, such as voluntary placement agreements, parental powers of attorney, and probate court guardianship, which blur somewhat the boundary between voluntary and permanent kinship care. The blurring is illustrated by the dotted lines in Figure 1 where the separation is less distinct than the boundaries around public kinship care.

Size of the Kinship Care Population

The 2000 ACF report grouped voluntary kinship care together with formal kinship care under the general heading of public kinship care. Figure 1 restricts the definition of public kinship care to the formal placement of children who are court-ordered into public custody. This includes foster children who are placed into unlicensed kinship homes. Estimating the sizes of the different categories of kinship care is not simply a matter of counting noses. Kinship caregivers can occupy a multiplicity of informal and formal roles. For example, caregivers can initially occupy an informal role as a grandparent, aunt, uncle, or tribal member in private or voluntary kinship care and subsequently assume a formal role as a licensed foster parent in public kinship care; still later, caregivers can take on formal roles as adoptive parents in permanent kinship care.

At any point, children in public kinship care may be undercounted in administrative data because official records may expunge a caregiver’s
informal identity as kin after they become formal foster caregivers. Similarly, licensed foster parents who previously occupied an informal role as a relative caregiver may continue to self-identify as kin and not disclose, unless explicitly asked, their formal status as a foster parent. Further, children in permanent kinship care can also be overlooked because a caregiver’s formal role as an adoptive parent eclipses their customary kinship role. Some general population surveys skip asking relatives questions about their experiences as non-parental caregivers because they have become the legal parents of the children previously under their temporary kinship care.

Given the multiplicity of roles that kinship caregivers can occupy, the best available data about the respective sizes of the different types of kinship care come from the 2013 National Survey of Children in Nonparental Care (NSCNC). These data are analyzed in the paper by Bramlett, Radel, and Chow (this volume). At the request of the editors, the paper’s authors generated population estimates of the number of children in the different types of kinship care. They weren’t able to generate an estimate of all children in kinship care, because adopted children in permanent kinship care were, by definition, excluded from the 2013 survey. Nonetheless, the authors surmised from the 2007 National Survey of Adoptive Parents that approximately 436,000 adopted children were also previously related to their parents through kinship ties (Vandivere, Malm, & Radel, 2009).

Based on the 2013 NSCNC, the estimated number of children in public kinship care was 196,000 children in 2013. This is approximately 70% larger than the 113,065 children reported to the U.S. Department of Health and Human Services (HHS) by state child welfare agencies as living in public kinship care on September 30, 2013 (U.S. Department of Health and Human Services, 2014). The discrepancy can be accounted for by the fact that the NSCNC provides a count of children in kinship homes over the course of a two-year data collection period, whereas the federal count refers to the number in public kinship care on a single day. Children who transition to permanent
kinship care or voluntary kinship care are dropped from the federal count. Another reason for the lower HHS count is missing data. When the U.S. Congress ordered HHS to submit a report in 2011 on children placed in relative foster family homes, the agency responded that it could not provide a national estimate of the number of related children in licensed or unlicensed foster care because of missing data about kinship status in some state information systems (U.S. Department of Health and Human Services, 2011).

Despite the differences in counting methods, it is noteworthy that even under the broader NSCNC definition, children in public kinship care account for only a fraction of the total population under the full-time care of relatives. Corresponding to the different types in Figure 2, the largest category of full-time kinship care includes the 862,000 children in private kinship care (39%) with no prior CPS involvement. It is followed by an estimated 374,000 in voluntary kinship care (17%) in which there was an open or prior CPS case and another 335,000 in voluntary kinship care (15%) in which there was some other type of CPS involvement. Adding to these counts, the approximate number of adopted children whose parents were also related to the child by kinship ties (20%) elevates the total estimated number of children in all four types of private, voluntary, permanent, and public kinship care to the vicinity of 2.2 million children.
Responsibility and Accountability

The reason that the boundary between informal and formal foster care may be drawn crisply around public kinship care in Figure 1 is because federal law holds child welfare systems legally liable for the safety and general well-being of vulnerable children only when they are in the formal legal custody of government (DeShaney v. Winnebago County Department of Social Services, 1989). In spite of immunity from federal lawsuits involving children not in public custody, state child welfare systems are not entirely shielded from public accountability as collective agents of the safety and well-being of children for whom they are not legally responsible. Even though responsibility and accountability are intertwined, the two concepts are separable to some degree. While parents are responsible for the safety and well-being of their own children, they are not ordinarily accountable to the public except in the narrow sense of not violating child maltreatment laws. Conversely, child welfare systems are accountable under federal law for general rates of repeat maltreatment and the provision of in-home services even though they are not legally responsible for the safety and well-being of individual children in parental or informal kinship care.

States that fail to measure up to public accountability standards can be assessed federal financial penalties if they don’t demonstrate progress in remedying audited deficiencies. This places states in the quandary of being held accountable for child-caring practices for which they are not legally responsible. Government may seek to resolve this predicament by expanding the population of vulnerable children taken into public custody. This is a general pattern that is frequently observed in the aftermath of a child’s death due to horrendous abuse by parents or other caregivers. Conversely, government may seek to alleviate the tension by limiting public accountability only to the constrained functions of protecting the child’s safety and finding them permanent homes. This was essentially the position taken by the American Bar Association and other national organizations when they declined to adopt measures of child well-being because they lacked
consensus on performance measures for which they already had direct responsibility (American Bar Association, National Center for State Courts & National Council of Juvenile and Family Court Judges, 2004). Striking the right balance between ensuring that private and voluntary kinship caregivers receive the support and services they need without bringing more children into the formal legal custody of the state remains one of the key challenges for public child welfare in the 21st century.

**Focus of the Special Issue**

The 1994 CWLA report focused on children in public kinship care. This special issue of *Child Welfare* focuses on the estimated 1.6 million children under the private and voluntary care of relatives for whom government is accountable in a general sense even if it is not directly responsible for their safety and well-being in an individual sense (A and C shaded in Figure 1). The volume also considers the smaller number in unlicensed public kinship care (the shaded half of B) for whom government is directly responsible but their caregivers face obstacles that are similar to those faced by informal caregivers (Wallace, 2016).

For most of the 20th century, American states formally excluded kinship caregivers from the licensed foster care system. Instead they supported the kinship care of dependent and neglected children under the family assistance provision of ADC/AFDC. This provision of the 1935 Social Security Act authorized federal financial participation (FFP) in assistance programs for children who were deprived of parental support and lived in a place of residence maintained informally by a relative as the children’s “own home.” The issue of whether children placed formally with kin by CPS agents could also qualify for public foster care benefits came to a head in the landmark Supreme Court ruling, *Miller v. Youakim* (1979). The state of Illinois argued that the preferred locus of alternative care rested voluntarily with extended kin and was enforceable as a family duty by denying relatives full foster care benefits even if they met formal licensing standards.
The plaintiffs countered that because kin were not legally liable for the support of related minors under modern family law, there was no legitimate grounds for arbitrarily withholding federal benefits from licensed foster parents for reasons of kinship alone. The Court concluded that responsibility for the welfare of children in public custody resided squarely with the state and ordered that equal subsidies be paid to licensed kinship caregivers the same as unrelated foster parents.

Even though the *Miller* decision outlaws the exclusion of licensed kinship caregivers from federally supported, public foster care, the decision still allows substantial discretion to states for excluding or including relatives in other ways. States may choose to restrict a relative’s participation in public foster care by denying federal benefits to children who previously resided in the relative’s home for six months or longer unless they are physically removed from the relative’s home. Alternatively, states can divert children who have been found to be abused or neglected to the informal custody of extended kin, with or without financial assistance. For children who need to be removed, states may either restrict placement into relative homes by requiring that their homes meet formal licensing standards or by placing children in unlicensed kinship homes that qualify for less financial assistance than what licensed foster homes can receive.

Looking forward, individual states undoubtedly will continue to rely on all four types of kinship care for the protection and care of abused and neglected children. An unresolved issue is the extent to which federal policy should promote the use of one type of kinship care over another or guarantee equal access to federally funded benefits and services regardless of kinship care type. For example, should placement into voluntary kinship care be facilitated and supported as the preferred response to child maltreatment whenever diversion is appropriate or should the majority of kinship care be incorporated into the formal system to ensure children’s equal rights to counsel, adequate financial support, and timely permanence? Should federal guardianship assistance be limited only to formal
kinship caregivers who are licensed and exit to permanent kinship care, or should an additional pathway to subsidized guardianship be carved out for unlicensed kinship caregivers and relatives who transition from informal caregiving to permanent legal guardianship? Should public resources be invested broadly in reinforcing informal kinship caregivers’ natural inclinations and capacities for promoting the well-being of their own children or should the dollars be spent on inducing formal agents of the state to take a long-term interest in and responsibility for the social, emotional, and educational well-being of children in public custody? These and other questions are addressed in the Position Paper that is included as an addendum to this double issue’s collection of articles.

Dimensions of Formality

Even though the simple typology illustrated in Figure 1 is handy for demarcating public responsibility, highlighting policy dilemmas, and estimating the size of the kinship care population, it is less useful for generating specific policy and practice recommendations about the appropriate scope of public interest and locus of agency relationships for ensuring the safety, permanence, and well-being of vulnerable children. Such concerns are better addressed by defining formality as an interval variable rather than a nominal one.

Drawing from the literature on informal and formal organizations (Froland, 1980; Stinchcombe, 2001), the formality of caregiving can be contrasted with informality in at least three ways. The first concerns the degree to which public interest in the welfare of children is governed by explicit rules and procedures for assessing need, determining eligibility, providing assistance, assigning responsibility, and supervising performance. This dimension of formality can vary from a narrow concern with protecting children’s safety and health to a diffuse concern with promoting children’s general well-being. The second contrast refers to the degree to which the governing abstractions are set
apart from the personal feelings, subjective biases, and power imbalances of everyday life. The third refers to the degree to which there is public accountability for the validity and integrity of agents’ actions in accomplishing the desired results.

Agency relationships that score high on all three dimensions exhibit a high degree of formality. Such relationships cluster in zone “D” of Figure 1. Even though the permanence of agency relationships is best formalized through legal guardianship and adoption of children, long-term guardianship can also be vested with collective agents that are entrusted with public responsibility for promoting the social and emotional well-being of individual children. Therapeutic foster homes and residential treatment centers for youth with emotional and behavioral challenges fall into this zone. They exhibit a high degree of formality by virtue of the collective agent’s assuming full responsibility for the well-being of the child; the governance of the agency relationship by supervisory monitoring and financial incentives that reinforce professionalism; and the agent’s ability, when called upon, to supply evidence of the validity of its actions in achieving the desired outcomes.

Highly formalized agency relationships that depart from these three criteria—for example, by ignoring children’s needs for quality care, reverting to the use of corporal punishment, employing pseudoscientific therapies, or treating children prejudicially on the basis of race, religion, or sexual orientation—constitute grounds for dismissal from the formal caregiving role. By contrast, it is highly unlikely that informal caregiving arrangements that occupy zone “A” in Figure 1 would be held to the same accountability standards regarding quality care, discipline, evidence-based practice, and favoritism. In fact, it is precisely this contrast—which according to some social theorists makes extended families, religious organizations, and other voluntary associations better equipped than formal systems for promoting children’s well-being because they are able to elicit cooperation and motivate change by drawing upon their own
cultural and social resources unlike state agencies—which must remain culturally neutral (Glazer, 1988).

**Social Capital and Relational Models**

The fact that similar parenting practices can elicit different societal reactions depending on whether they are expressed within the informality of private kinship care or the formality of public foster care brings into focus the different types of social capital (Portes & Sensenbrenner, 1993) and relational models (Haslam, 2004) that informal groups and formal organizations are able to draw from to motivate and regulate agency relationships on behalf of children. A key social dilemma in the regulation of agency relationships is whether agents will remain committed to the interests of their principals or defect from this expectation at the principal’s expense. Informal agency relationships are able to draw from two types of social capital and relational models that are typically absent from or expressly prohibited in formal agency relationships. The first is the natural altruism and communal sharing that flows from ascribed membership in primary group solidarities rooted in kinship, tribe, religion, or ethnicity. Informal kinship care assumes that the agency dilemma of cooperation or defection is best resolved by placing vulnerable children in an agency relationship in which a member of the child’s primary group can be counted on to act on behalf of the general well-being of the child as if those interests are the member’s own. Formal agency relationships typically lack access to this intrinsic source of agency motivation and regulation, and federal law expressly prohibits child welfare systems from refusing or delaying foster or adoptive placements because of a child’s or foster/adoptive parent’s race, color, or national origin.

Intrinsically motivated relationships of kinship care eventually become vulnerable to agent defection over time unless they are fortified periodically by an extrinsic source of motivation. Traditionally, informal kinship care supplied extrinsic motivation by embedding the
child in a hierarchical relationship in which the minor owed obedience and service to an elder who bore responsibility for the protection and care of the subordinate. This second type of social capital and relational model is also limited in formal agency relationships by restrictions on the kinds of duties that can be imposed on minors and the forms of discipline that can be used to exact obedience. For example, restrictions on the use of corporal punishment is one of the limitations on caregiver authority that distinguishes formal from informal kinship care.

Up until the industrial revolution, the customary trust vested with patriarchal authorities through the institutions of indenture, apprenticeship, and domestic service met majority expectations for what was considered both necessary and appropriate for the basic care, protection, and maintenance of dependent and neglected children. With the spread of formal systems of market exchange and contractual liberty, however, patriarchal systems of foster care gradually lost legitimacy. Without the softening of authority relations that particularistic ties normally afford in extended families and close-knit communities, the agency risk increased that the patron, master, or overseer would defect from his paternalistic responsibilities and bind the minor to conditions of servitude in opposition to the child’s best interests and needs. This was one of the agency risks of public foster care under the poor laws, which private child welfare agents sought to ameliorate by bringing the alternative care of dependent, neglected, and abused children under the contractual agency relationships of licensing, certification, and boarding home subsidies.

As long as the scope of public interest in child welfare was constrained to meeting the basic needs of dependent and neglected children for food, clothing, shelter, and protection from physical harm, the foster boarding system functioned adequately enough to elicit the compliance of formal agents in meeting these expectations. But as scientific knowledge of the developmental needs of children for family permanence and trauma-informed care became widespread, the limits of
contractual agency relationships in sustaining unconstrained commitments to the well-being of the child at an affordable cost became more problematic. Contractual agency relationships worked best in meeting the temporary health and safety needs of children in highly formalized settings, such as hospitals and CPS, but long-term commitments to child well-being needed intrinsic sources of motivation to sustain the continuity of agency relationships. Agent recruitment practices in public child welfare shifted to the selection of fiduciary agents who, by virtue of their professional training and internalized values of probity and beneficence, could be counted on to look after the long-term interests of children impartially and equitably.

Social Dilemma of Kinship Care

The social dilemma of kinship care can be expressed in terms of lingering concerns over the adequacy of the informal agency relationships of kinship solidarity and customary trust in meeting the needs of vulnerable children for safety, permanence, and well-being. When the federal foster care program was established in the 1960s under AFDC, prevailing social work wisdom at the time was that the nuclear family form, with its breadwinner father and stay-at-home mother, was the most functional for modern society (Parsons, 1943). The prediction was that the importance and vitality of the extended family as sources of social capital and moral regulation would gradually dissipate with industrialization and the expansion of the bureaucratic welfare state (Putney, Bengston, & Wakeman, 2007).

Any lingering concerns over the continued importance and vitality of private and voluntary kinship care in meeting the permanency and well-being needs of children should be allayed by the findings presented in the first two articles in this volume. Each examines differences in the characteristics, adverse family experiences, and well-being of children in different types of kinship care. The article by Bramlett, Radel, and Chow (this volume) uses nationally representative survey data to
examine differences in kinship care along the constrained-unconstrained dimension of varying degrees of child welfare involvement.

Within informal kinship care arrangements, tests for linear trends indicate that adverse family experiences correlated with higher degrees of child welfare involvement. For example, the percentage of children who ever lived with a parent who was mentally ill rises from 17.9% for children in private kinship care to 24.3% in voluntary kinship care with other CPS involvement and 43.8% for children in voluntary kinship care with ever an open CPS case. Even though it might be expected that adverse family experiences would be most highly associated with formal kinship care, the percentage of children in public kinship care who ever lived with a mentally ill parent was nearly identical (24.2% vs. 25.4%) to the average for all children in nonpublic kinship care. Whereas CPS involvement appears responsive to higher levels of risk in informal kinship care, there appears to be no association between adverse family experiences, neighborhood violence, health conditions, and utilization of mental health services among children taken into public kinship care compared to children left in or diverted to informal kinship care. The lack of statistical association of greater formality with risk levels reinforces inklings that the decision to take a child into public kinship care is more a by-product of bureaucratic routines than a clinically informed response to child and family need.

The second article, by Wu (this volume), also allays concerns that diversion of children from the public foster care system to voluntary and private kinship care compromises the well-being of children investigated for child maltreatment. The study analyzes data from the Second National Survey of Child and Adolescent Well-Being (NSCAW II), a nationally representative sample of children investigated for child abuse or neglect. It tracks the well-being of a subsample of 654 children who were removed from parental custody and placed in public (paid) kinship care, voluntary kinship care, or private kinship care. Echoing the findings from NSCNC, the NSCAW II data also shows that caseworker assessments of the maltreatment allegations
for children in private kinship care registers less severe levels of harm and risk than the allegations for children in voluntary or public kinship care. But lower harm and risk assessments by caseworkers do not translate into lower caregiver ratings of child behavior problems. To the contrary, children in private kinship care were rated higher at baseline by their caregivers on the Child Behavior Checklist (CBCL) than children in public and voluntary kinship care. Follow-up interviews at 36 months after the close of the initial investigation, however, showed a significant decline in CBCL scores for children in private kinship care. All else equal, the average scores for both internalizing and externalizing problems registered larger declines for children retained in private kinship care compared to children who were taken into formal legal custody and placed with relatives in public kinship care.

Challenges of Informal Kinship Care

The findings from two nationally representative samples of children in kinship care provide compelling statistical evidence of the continued vitality of kinship solidarity and customary trust in safeguarding the well-being of children in non-public kinship care. There is little indication that the well-being of children who reside in or are diverted to private or voluntary kinship care would substantially improve if they instead were taken into public custody. In fact, some of the findings suggest that their well-being could possibly worsen. But these positive indications do not mean that the circumstances of children and kinship caregivers in informal care situations are devoid of challenges.

The next two contributions, by Lee, Choi, Lee, and Kramer (this volume) and by Rushovich, Murray, Woodruff, and Freeman (this volume) underscore the challenges of ensuring the well-being of children under the private or voluntary care of relatives. The former study’s analysis of survey data and administrative records indicates that a majority of children in informal kinship care had prior CPS involvement and a quarter had been previously placed in public foster care.
with non-relatives. While most of these children experienced long periods of stable kinship care, financial hardships posed a constant threat to the solidarity of kinship relationships. The strains on kinship solidarity appear to be especially acute during a child's infancy when the demands for full-time care can drain the energies and resources of kin, especially older caregivers. On the other hand, if the caregiver-child (agency) relationship is able to survive this critical developmental period, the longer a child remains under the relative's care the lesser is the likelihood that the kinship bond will be broken.

Focus groups conducted by Rushovich, Murray, Woodruff, and Freeman (this volume) identified high financial needs as significant constraints on the ability of caregivers to raise children as they deem appropriate. These authors describe a program of kinship navigator services delivered to caregivers who were looking after related children with no or brief CPS involvement. Because the program was voluntary and operated independently from CPS, navigator staff felt they were able to build cooperative relationships and gain the confidence of families and community partners that were normally distrustful of the power of CPS to break-up families. The staff viewed the formal system's restriction of foster care subsidies only to children in licensed, public kinship care as an inherent injustice that inflicted financial hardship on informal caregivers. Kinship navigator staff perceived CPS workers as unwilling to take the time to explain to relatives all of the financial ramifications of taking on the care of grandchildren, nieces, and nephews where diversion from state custody to voluntary placement was sought.

Formalization of Private and Voluntary Kinship Care

The perceived unwillingness of CPS workers to help kinship caregivers with their financial needs can be viewed as a violation of the formality of impartial administration, much like the arbitrary withholding of federal foster care benefits discriminated against kin prior to the
Many of the inequities identified by focus group participants appear to result from an absence of formality rather than too much formality. The kinship navigator services funded under the 2008 Family Connections Discretionary Grant Program (FCDGP) aimed to introduce greater formality into the process of assisting kinship caregivers in learning about, finding, and using programs and services. It also sought to promote closer collaboration between public and private agencies in ensuring that kinship families are fairly and equitably served (Catalog of Federal Domestic Assistance, 2013).

The FCDGP tacitly acknowledges that the post-WWII prediction of the steady displacement of informal by formal agency relationships is no longer a tenable assumption for social policy. The new governing abstraction is that formal systems must learn to coexist with informal solidarities. No informal agent can adequately meet the extensive responsibilities of parenting in modern society without drawing on essential goods and services provided by formal systems (Heimer & Steffen, 1998). The first task in building an effective informal-formal partnership is constructing reciprocal avenues of influence so that the public systems that are accountable for child safety, family permanence, and adolescent well-being can be better coordinated with the informal processes of parental responsibility, kin altruism, and adult authority, which make possible the achievement of broader public interests in the welfare of vulnerable children (Testa & Poertner, 2010).

Another important principle of effective partnerships is that informal relationships should not be displaced by formal agency relationships unless there is clear evidence of the superiority of greater formality in achieving desired outcomes. The use of manualized procedures, standardized checklists, and decision protocols to structure informal-formal partnerships and coordinate mutual responsibilities introduces greater formality into the interactions between primary group agents and contractual and fiduciary agents of the state. Building evidence for the superiority of formality over informality assumes a valid set of methods for evaluating the effectiveness of planned innovations.
and for monitoring the integrity of implementation by contractual and fiduciary agents accountable for effecting the intended improvements (Stinchcombe, 2001).

The article by Feldman (this volume) evaluates an informal kinship-formal agency partnership that was operated by the Children’s Home Society of New Jersey. The final phase of the program involved engaging informal caregivers in a Family Group Decision Making (FGDM) conference to formalize a plan of action and coordinate responsibilities with public agents for addressing the needs of the children and caregivers. A formative evaluation was undertaken to test the initial implementation of the program so that early problems could be spotted and corrected before the program moved into full implementation and rigorous summative evaluation (Scriven, 1997). The results indicated that initial implementation of the program was conducted in a manner consistent with its original design, but the level of program participation was much lower than projected. Even though the drop-off in participation was unanticipated, it may also be taken as welcome sign that many families are able to handle caregiving needs on their own. One of the distinguishing features of FGDM meetings compared to usual case planning is their positioning of primary group agents to lead decision making in crafting the plans and eliciting the cooperation of contractual and fiduciary agents in gaining access to the resources necessary for implementing the plan. For those families that did proceed through all phases of the intervention, the results of the formative evaluation indicated that pretest changes in parenting stress levels, family needs, and child well-being, even though not statistically distinguishable from zero change (except for health care), were all trending in the desired direction. Only the number of social supports and level of satisfaction with the supports showed no change. These promising findings support moving toward full implementation of the FGDM intervention and conducting a rigorous summative evaluation of its overall impact using comparison groups.
The article by Schmidt and Treinen (this volume) also shows high levels of self-efficacy expressed by caregivers. They reported findings from a formative evaluation of a kinship navigation program operated by Arizona’s Children Association. The pretest-posttest scores, using standardized assessment measures, showed no differences in self-efficacy scores, which most likely reflected the caregivers’ high scores at baseline. There were some statistically significant decreases in family needs, such as paying for utility bills, having time for self-care, and finding future care for the children. Additionally, of the youth in care, 87% remained in a stable placement and only 7% were subjects of subsequent child maltreatment investigation after case opening.

Wheeler (this volume) reports findings from a quasi-experimental evaluation of the Ohio Title IV-E Waiver Demonstration. Participating local agencies were able to use IV-E funds to hire and train kinship navigator staff and provide services, financial assistance, and material goods that would otherwise only be available to licensed foster parents under existing IV-E regulations. The pertinent findings from the Ohio study were that the target population of children in counties that implemented the kinship support intervention experienced shorter lengths of stay and more stable care than a matched sample of children in unlicensed and voluntary kinship care in comparison counties. Further, children in intervention counties experienced greater stability, achieved more timely permanence, and were less likely to experience subsequent maltreatment and re-enter foster care than a matched sample of children in non-relative foster care in comparison counties.

Building Sustainable Partnerships

Contrary to earlier predictions of the demise of extended families, recent demographic trends as well as the findings presented in this volume attest to the continued vitality and importance of kinship ties for the care of vulnerable children in modern societies. The notion that extended family care is a natural resource that should be conserved and not squandered is at the core of many of the policy implications that
contributors draw from their research. At the same time, there is general recognition of the need for a more nuanced theoretical and empirical understanding of the compatibility of the universalistic principles of formal agency relationships with particularistic ties of kinship solidarity. Of particular interest is whether formal systems of care and financial subsidies erode (“crowd-out”) the natural motivation and customary trust upon which informal kinship care is based or alternatively reinforce (“crowd-in”) motivation and trust by supporting relative’s sense of self-efficacy, parenting ability, and caregiver capacity to sustain the agency relationship (Frey, 2012).

The paper by Denby, Testa, Alford, Cross, and Brinson (this volume) helps to advance our theoretical and empirical understanding of the tradeoffs by examining the mediating and moderating factors that can help relatives manage the role strains, special needs, and financial pressures that drain caregiver resources and increase the risk for adverse childhood outcomes. An unexpected finding was that child well-being levels were rated higher by caregivers in families with incomes below $20,000 than in families with higher incomes. When compensating protective factors were considered, it was found that the lower income association with higher well-being was mediated by the higher expressed levels of attachment to the child and sense of caregiver efficacy. The authors caution, however, that the anomalous relationship could also arise from parents’ wariness of candidly disclosing problems, confidentiality assurances notwithstanding. Lower-income parents may feel a need to inflate reports of child well-being in order to avoid attracting the unwanted attention of child protective authorities. At the same time, the absence of a statistical association in the opposite direction raises doubts about the justifiability of basing foster home licensing standards on families’ meeting arbitrary socioeconomic thresholds related to family income and housing accommodations, at least where relatives are concerned. Perhaps a better approach, as the paper implies, is to test the feasibility of developing separate kinship licensing standards that invests in training caregivers in trauma-informed
care and reimburses them in a commensurate fashion. An achievement-oriented approach to licensing and reimbursement could go a long way toward reconciling the traditional belief that relatives should not expect any reward for honoring their familial obligations to kin with the modern practical need for financial support to fulfill these obligations. Demonstrating through rigorous experimentation the superiority of new licensing approaches to business as usual would satisfy the third evidence-building criterion of formality for ensuring that kinship caregivers, birth parents, and their children receive the support and services they need from public child welfare systems.

Kinship Care Position Paper

The Position Paper included in this issue offers guidelines for improving the formalization of the role of public child welfare systems in supporting kinship care arrangements. In contrast to most prior scholarship on kinship care, the refereed articles in this issue focus on the informal side of the kinship care continuum, which hasn’t received as much attention as formal foster care from researchers in the past. As argued in this introduction and reinforced by the articles, the simple dichotomy between informal and formal kinship care is much too arbitrary a distinction for generating practical recommendations that are in keeping with modern concepts of kinship care as a partnership between families and government. The convention of linking formal kinship care to states’ taking legal custody of children is an archaic legacy of 19th-century poor laws that made public assistance conditional on needy parents’ relinquishment of their rights of child custody (Marshall, 1964). The formalization of kinship care as a partnership between legally responsible caregivers and publicly accountable collective agents offers a more promising direction for redressing routine inequities that hinder responsible caregiving, such as withholding information, failing to arrange for TANF receipt, and tolerating low foster home licensure rates among kinship caregivers.
These inequities appear not to be a manifestation of too much formality but rather too little formality, which allows personal feelings, subjective biases, and power imbalances to consign children to private or voluntary kinship care because of feelings that families should look after their own, interests in cutting down on paperwork, or administrative reluctance to add more families to “the public dole.” Introducing greater formality into the routine interactions between relative caregivers and child welfare workers and auditing compliance with these standards should help shed light on the different ways state systems, for better or worse, opt to exclude or include relatives in systems of care for the protection and care of dependent, neglected, and abused children.

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References


Using Family Group Decision Making to Assist Informal Kinship Families

Leonard H. Feldman
The Children’s Home Society
of New Jersey

This paper discusses a three-phased service model assessed using Family Group Decision Making (FGDM) conferences with informal kinship caregivers and their families. Gain scores were compared between Phase 2 (case management only) and Phase 3 families (case management with conference). Phase 3 families had higher gain scores than the Phase 2 families on measures of parenting stress, social support, family needs and child well-being, but the differences were not statistically significant. Phase 3 families had superior consumer feedback scores.
A three-year project was funded under a U.S. Department of Health and Human Services 2011 Family Connection Discretionary grant. The Children’s Home Society of New Jersey (CHSoNJ) program compared the outcomes of two groups of informal kinship caregivers and their families in Mercer County, New Jersey. One group received only case management services. The other received a combination of case management and participated in at least one Family Group Decision Making (FGDM) conference.

CHSoNJ has extensive experience working with all aspects of improving the safety, well-being, and permanence of children and their families. The Agency was founded in 1894 as New Jersey’s first orphanage and child placement agency, and has continued to serve the state's most at-risk children, youth, and families in collaboration with the New Jersey Department of Children and Families. CHSoNJ is a founding member of the Child Welfare League of America. The Agency has provided services to kinship families since 2000 through a kinship navigator program, a Grand Family Drop-In Center and the provision of case management services through two federal demonstration grants.

**Literature Review**

“Kinship care has become increasingly important in meeting the needs of children involved in the child welfare system or at risk of becoming involved in that system” (James Bell Associates, 2010, p. 3). Nationwide, relative foster care comprised 29% (120,334) of out-of-home placements in federal FY 2014 (U.S. Department of Health and Human Services, 2015). In New Jersey, 39% of children in out-of-home care now reside in kin homes (Department of Children and Families, 2016). These public kinship homes have been licensed as resource homes. The caregivers receive a monthly stipend and supportive services, unlike private and voluntary caregivers of children in informal kinship care.
The best estimate of the number of kinship caregivers, both formal and informal, is 7,409 in Mercer County, New Jersey. Thirty-two percent of these caregivers provide care for their grandchildren with no biological parent present (U.S. Census Bureau, 2010-2014). This is likely an undercount of kin caregivers since it does not account for placements made with other relatives.

Informal kinship care providers care for kin either privately or voluntarily without a court-ordered formal placement and supervision by a child welfare agency. Thus, they are less likely to be the beneficiaries of financial support and social services from the public child welfare system (Coleman & Wu, 2016; Lin, 2014). These caregivers are generally older, have fewer financial resources, and are in poorer health (Hong, Algood, Chiu, & Lee, 2011). The long-term unmet needs of these caregivers—due to low incomes and lack of support—may have a meaningful impact on their ability to parent their kin child who may not receive needed services (Coleman & Wu, 2016; Hong et al., 2011; Lin, 2014). If the home environment is stressful, it may also directly impact the child’s well-being (Hong et al., 2011). Informal caregivers may also have less time for addressing personal issues or participating in social activities and can feel isolated (Lin, 2014). They may have to make significant adjustments in their lives and relationships. Their caregiving role may also strain their relationship with the child’s birth parents, which could precipitate or increase the kin child’s problem behaviors (Gordon, McKinley, Satterfield & Curtis, 2003; Hong et al., 2011; Kiraly & Humphreys, 2015).

Without supportive services, caregivers may not be able to meet their kin child’s needs or may be at risk of relinquishing their kin child to the legal custody of the child welfare system. One approach, funded by a three-year, 2009 Family Connection Discretionary Grant, expanded an existing kinship navigator program that offered very brief services to a program employing six case managers, providing services for up to six months per family in New Jersey (Feldman & Fertig, 2013). Using an experimental design, 437 caregivers caring for 607
children were randomly assigned to an enhanced services group or a traditional, brief services group. Despite the additional service time, no advantage was gained over the control group in increasing social supports, reducing caregiver stress levels or measuring improvements in child behavior (Feldman & Fertig, 2013).

The other kinship navigator grantees in the 2009 grant cycle that used a control group also found only modest differences between treatment and control groups (James Bell Associates, 2013).

The 2011 Family Connection Discretionary Grant cycle was an opportunity to continue developing a model of effective intervention for kinship families. The CHSofNJ proposed a novel use of Family Group Decision Making (FGDM) with kinship families. FGDM is usually employed with families involved with CPS agencies to protect children from further abuse or neglect (Merkel-Holguin, n.d.). It is an approach that emphasizes family strengths and empowers extended families to come together and develop a plan designed to aid the caregiver in protecting the child and encourages families to link with their larger community to assist with healthy and nurturing child rearing (Merkel-Holguin, n.d.). Given that the kinship families in the catchment area were found to have very similar characteristics to protective services families, the exploratory use of this well regarded service with kinship families seemed justified (Feldman & Fertig, 2013).

In a review, James Bell Associates (2015) found limited outcome studies after FGDM participation. Those studies were often inconclusive or contradictory. There was some support for the use of this approach with families (Pennell & Burford, 2000). However, Berzin, Cohen, Thomas, and Dawson (2008), using an experimental design, found no benefit to improving child safety, placement stability, or permanence. Thus, while FGDM may be a promising practice, many questions remain about its efficacy and benefit for various child welfare populations (American Humane, 2003; Crampton, 2007).

The approach employed by CHSofNJ was to use the model of FGDM espoused by the National Center of Family Group Decision
Making. “In FGDM processes, a trained coordinator who is independent of the case brings together the family group and social service personnel to create and carry out a plan to safeguard children and other family members. FGDM positions the family group to lead the decision making…” (The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, 2013).

Method

Program Structure

This initiative had three graduated, integrated service phases. Based primarily on the needs of caregivers and their families, kinship care providers moved sequentially through all three phases or could decide to benefit only from Phase 1 or 2. The phases were not mutually exclusive and families could continue to participate in all phases. The median elapsed time between Phase 1 and 2 was 43 days. Eighty-eight days (median) elapsed between Phase 2 and a FGDM conference. Four workers provided services to about 30 cases each, entering Phase 2 over the 33 months of program operation. They were expected to recruit families, provide information and referral services, develop service plans, act to resolve family needs, encourage participation in FGDM conferences, and facilitate conferences. They were also responsible for administering the research protocol and maintaining a service log.

Phase 1: Recruitment/Engagement

The Kinship Connections Program (KCP) staff invested considerable time and effort in recruiting kinship caregivers and their children. The staff visited community services fairs, disseminated program information to other community agencies, distributed flyers, and spoke to existing agency families to get the word out. When families visited the
pre-existing, Nicholson Foundation-funded, community-based CHSofNJ Grand Family Center for group activities held several times a month or accessed the CHSofNJ Kinship Navigator program for brief information and referral services, staff provided verbal and written information about the purpose and benefits of KCP participation.

**Phase 2: Trust-Building/Service Provision**

The KCP established a trusting relationship by assigning a staff member to a kin caregiver, one-on-one, when the caregiver expressed an interest in receiving help with a variety of family issues. Once a trusting relationship with program staff was established, each kin family was engaged in service planning, and received services that attempted to address the identified needs of the family such as finding a counselor for the kin child, applying for financial assistance, supplemental nutrition assistance (SNAP, aka. Food Stamps), and arranging child care or summer camp.

**Phase 3: Family Success Conferencing (Family Group Decision Making)**

After sustained engagement, the assigned KCP worker would suggest and plan a FGDM meeting in collaboration with the kinship caregiver, if appropriate. A number of strategies were employed to encourage participation, including: holding multiple discussions with families; using presentations by caregivers who had experienced a conference; and, in a few instances, “pop-up” conferences at the caregiver’s home or at the Grand Family Center if the key participants were available. The ultimate goal of the meeting was the formalization of a plan of action to address expressed needs and identification of responsible parties. Caregivers could request a follow-up conference if needed.

Changes in the scores of outcome measures at case closing, described below, were compared between Phase 2 and 3 families.
Phase 2 families were the comparison group to families participating in FGDM. A randomized control group was not employed because of the noted difficulties experienced by others in recruiting enough families to actually participate when randomly selected into the FGDM treatment group (Crampton, 2007). This caution was especially important when working with informal caregivers who were not under any child CPS mandate to participate in a FGDM. All research procedures and data collection tools were subjected to the agency’s IRB approval process.

Staffing

The project was staffed by four case managers—two with master’s degrees and two with bachelor’s degrees—and a supervisor, and was overseen by the Program Director of Kinship Services. All staff received extensive preparation for the project including in-house and multi-day training from the National Center on Family Group Decision Making at the Kempe Center, University of Colorado. Relevant training continued over the course of the project.

Target Population

Participants in the KCP were screened in if they were informal kinship caregivers and not active with the State’s child welfare agency. The catchment area was Mercer County, New Jersey, which contains the City of Trenton, where a large number of project participants lived. While it is the state capital, it is one of the poorest communities in New Jersey and exemplifies all of the urban ills of an inner city.

Research Questions

The study was designed to determine if the use of FDGM was a valued added service for a support program that attempted to improve
various outcomes for kinship families as described in Table 1. These intended outcomes included a reduction in stress as measured by the Parenting Stress Index, an increase in perceived social support on the Social Support Questionnaire, a reduction in family needs as defined on the Family Needs Scale, and increases in the scales of the Child Well-Being measure. Data about placement and subsequent CPS involvement were also collected.

A formative evaluation of implementation integrity determined whether the project was conducted in a manner consistent with its goals, objectives, work plan, and program model, including:

a) Were project milestones achieved in a timely manner?

b) Were interventions delivered in a phased delivery of services, keyed to family needs?

c) Were there ways of introducing the idea of a holding a FGDM meeting that increased participation rates of caregivers and their family and friends?

d) Were profiles of families created for Phase 2 and Phase 3?

e) Were family plans developed?

f) Did the FGDM process have fidelity to the proposed model?

The formative evaluation of intervention outcomes attempted to determine:

a) If kinship families saw value in and agreed to participate in FGDM.

b) If the FGDM process resulted in a plan that appeared beneficial to the caregiver and her or his kin child.

c) If the FGDM promoted and enhanced permanency, safety and child well-being.

d) How the outcomes for families receiving FGDM compared to kinship families that did not participate in FGDM.
<table>
<thead>
<tr>
<th>Constructs Measured</th>
<th>Instrument(s)</th>
<th>Schedule</th>
<th>Psychometric Properties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic and Descriptive Family Information</td>
<td>Demographic and Profile form</td>
<td>Intake and updated as necessary</td>
<td>Coefficient alpha = .94; Test-retest reliability = .90</td>
</tr>
<tr>
<td>Caregiver Stress Level- Child Behavior</td>
<td>Parenting Stress Index (PSI)</td>
<td>Intake and case closing</td>
<td>Coefficient alpha = &gt;.70; Test-retest reliability = &gt;.63 Validity: significantly correlated with related measures</td>
</tr>
<tr>
<td>Caregiver-Child Relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Support</td>
<td>Social Support Questionnaire</td>
<td>Intake and case closing</td>
<td>Coefficient alpha = .95; split half reliability = .96</td>
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<tr>
<td>Capacity to provide for their children’s needs (well-being)</td>
<td>Family Needs Scale</td>
<td>Intake and case closing</td>
<td>Coefficient alpha for total scale = .798</td>
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<tr>
<td>Child Well Being</td>
<td>Project developed multi-dimensional scale</td>
<td>Intake and case closing</td>
<td>Coefficient alpha for total scale = .798</td>
</tr>
<tr>
<td>Children are maintained in their homes whenever possible (Safety)</td>
<td>Self-reports of CPS involvement &amp; Out-of-home placement</td>
<td>Case closing and follow-up interview</td>
<td></td>
</tr>
<tr>
<td>Children have permanency and stability in their living situations (Permanency)</td>
<td>Self-reports of out-of-home placement</td>
<td>Case closing and follow-up interview</td>
<td></td>
</tr>
<tr>
<td>Congruence to FGDM model</td>
<td>Facilitator and Family forms: Family Team Decision Making Quality and fidelity Index  Part III and Part IV</td>
<td>Post FGDM</td>
<td></td>
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<tr>
<td>Status of the Family Plan</td>
<td>Self-report</td>
<td>3 months after case closing</td>
<td></td>
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<tr>
<td>Client satisfaction</td>
<td>Client Satisfaction Questionnaire (CSQ-8)</td>
<td>Case closing</td>
<td>Coefficient alpha = .94</td>
</tr>
<tr>
<td>Worker use of Time</td>
<td>Worker Activity Log</td>
<td>Completed Daily</td>
<td></td>
</tr>
</tbody>
</table>

1 Abidin, 1995
3 Adapted from Dunst, Trivette, & Deal (1988, p. 151).
5 Catholic Family and Child Service and Children’s Administration (ND).
6 Attkisson & Greenfield (1999).
Study Design

This was a formative study examining the value of using FGDM conferences with kinship families. The purpose of a formative study is to test implementation integrity and assess whether outcome improvements are trending in the expected direction so that early problems can be spotted and corrected before the program moves into full implementation and rigorous summative evaluation (Framework Workgroup, 2014). The study utilized a non-equivalent group design. Based on the three phases described above, all families in Phase 2 received case management services. Families self-selected their participation in Phase 3, the FGDM conference. Basic identifying information about the family was collected during Phase 1. More detailed data was collected during Phase 2. All Phase 2 and 3 families were administered a battery of measures at the beginning of the intervention. These families then completed post-intervention measures at case closing or several months afterwards, depending on the measure (see Table 1).

Analysis Plan

The completed instruments were entered into various data bases by a research assistant for later analysis. Because the research design was quasi-experimental, there was no assurance that the Phase 2 and Phase 3 groups were equivalent, a threat to internal validity. Thus, ANOVA or t-tests were used to compare the mean differences of the pre- and posttest scores between the two groups on the various measures; a gain score analysis. “The treatment effect is estimated by how much more or less the treatment group gained on average compared with the control group…Gain score analysis controls for the simple main effects of initial selection differences” (Reichardt & Mark, 1998, p. 216).

Results

The implementation of the program was deemed to have been conducted in a manner consistent with its work plan and model. Outputs
were achieved through a phased service approach and included the provision of case management services and the development of family plans and FGDM conferences. The conferences were found to have fidelity to the FGDM model. Participant profiles were created to provide data about kin family characteristics and needs.

Table 2 displays the number of caregivers and kin children served by service phase.

Table 2. Caregivers and Children Serviced by Program Phase

<table>
<thead>
<tr>
<th></th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregivers/Families</td>
<td>373</td>
<td>135*</td>
<td>47**</td>
</tr>
<tr>
<td>Children</td>
<td>587</td>
<td>212</td>
<td>80</td>
</tr>
</tbody>
</table>

* 88 caregivers/families only participated in Phase 2
** Follow-up conferences were held for 17 families for a total of 64 conferences

At the end of 36 months, the program had served 83% of its target for Phase 1, 68% of its target for Phase 2 and 63% of its revised target of 75 first-time conferences for Phase 3. In addition, the project held 17 of 25 (68%) follow-up FGDM conferences.

Profile

Table 3 lists the key demographics by phase. The typical caregiver was in her mid-to-late 50s with ages ranging up to 88. More than three-quarters of the program participants were African American. Eight percent were of Hispanic ethnicity in Phase 1, 10% in Phase 2, and 17% in Phase 3. A very large percentage (80%) of these households were single-parent. Over 62% of the caregivers lived in Trenton and were low-income. Over 70% of the caregivers were the grandparents of the kin child(ren). The children’s median age was 10 to 11 years.
Table 3. Key Demographic Statistics

<table>
<thead>
<tr>
<th>Caregivers</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Age</td>
<td>55</td>
<td>55</td>
<td>58</td>
</tr>
<tr>
<td>Age Range</td>
<td>17-88</td>
<td>23-84</td>
<td>28-83</td>
</tr>
<tr>
<td>Gender (%)</td>
<td>96 Female</td>
<td>98 Female</td>
<td>98 Female</td>
</tr>
<tr>
<td>Race (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>78</td>
<td>79</td>
<td>70</td>
</tr>
<tr>
<td>White</td>
<td>12</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>Hispanic</td>
<td>7</td>
<td>(11)*</td>
<td>(17)*</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Marital Status (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>43</td>
<td>42</td>
<td>34</td>
</tr>
<tr>
<td>Married/Partner</td>
<td>21</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Widowed</td>
<td>13</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>Divorced</td>
<td>12</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Separated</td>
<td>11</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Household Location (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trenton</td>
<td>63</td>
<td>67</td>
<td>66</td>
</tr>
<tr>
<td>Mercer County</td>
<td>36</td>
<td>33</td>
<td>34</td>
</tr>
<tr>
<td>Other NJ County</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Income</td>
<td>66% of families participate in financial assistance programs such as SNAP, TANF, and Free Lunch</td>
<td>37% have incomes less than $18,530, the 2011 U.S. poverty guideline for a 3-person family (U.S. Department of Health and Human Services, 2011)</td>
<td>46% have incomes less than $18,530, the 2011 U.S. poverty guideline for a 3-person family (U.S. Department of Health and Human Services, 2011)</td>
</tr>
<tr>
<td>Median Family Size</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Median Number Kin Children</td>
<td>1 (1-8)</td>
<td>1 (1-8)</td>
<td>1 (1-8)</td>
</tr>
<tr>
<td>Relationship to the Child (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandparent</td>
<td>72</td>
<td>70</td>
<td>75</td>
</tr>
<tr>
<td>Aunt/Uncle</td>
<td>15</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Great Grandparent</td>
<td>4</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Cousin</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other**</td>
<td>6</td>
<td>8</td>
<td>8</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Kin Children</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Age</td>
<td>11</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Caregivers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age Range</td>
<td>&lt;1-23</td>
<td>&lt;1-19</td>
<td>1-19</td>
</tr>
<tr>
<td>Gender (%)</td>
<td>49% Female</td>
<td>49% Female</td>
<td>47% Female</td>
</tr>
<tr>
<td>Race (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>77</td>
<td>79</td>
<td>75</td>
</tr>
<tr>
<td>White</td>
<td>9</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Hispanic</td>
<td>6</td>
<td>(18)*</td>
<td>(21)*</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Median Time in Placement with Caregiver (Years)</td>
<td>6</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Range of Time in Placement (Years)</td>
<td>&lt;1-23</td>
<td>&lt;1-17</td>
<td>&lt;1-17</td>
</tr>
<tr>
<td>Previously known to CPS (%)</td>
<td>62</td>
<td>67</td>
<td></td>
</tr>
</tbody>
</table>

*Hispanic ethnicity classified separately, race is Black or White in Phase 2 and 3
**Other includes great aunt/uncle, siblings, and non-relatives
old, with a range from less than 1 up to 23. The children typically had been living in the caregiver’s home for more than 6 years after being placed there, primarily due to child maltreatment and/or parental substance abuse. Most of the children could be categorized as residing in voluntary kinship care inasmuch as over 62% of the children and their families were previously known to CPS (see Bramlett, Radel, & Chow, this volume).

### Primary Reason for Placement

Table 4 lists the five most cited reasons for placement out of the birth parent’s home. These reasons represent 69% of the maternal and paternal reasons for placement. The “other” reasons include parent deceased, emotionally unable, family violence, HIV or AIDS, homelessness, illness, military service, and deportation. The difference between Phase 2 and Phase 3 families was not statistically significant. While this table lists the principle reasons, placement was often due to multiple problems (Feldman, 2014).

<table>
<thead>
<tr>
<th>Principal Reason for Placement</th>
<th>Phase 2 (%)</th>
<th>Phase 3 (%)</th>
<th>Principal Reason for Placement</th>
<th>Phase 2 (%)</th>
<th>Phase 3 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuse or Neglect</td>
<td>24</td>
<td>32</td>
<td>Incarcerated</td>
<td>18</td>
<td>26</td>
</tr>
<tr>
<td>Drug/Alcohol Addiction</td>
<td>17</td>
<td>11</td>
<td>Uninterested</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Financially Unable</td>
<td>6</td>
<td>13</td>
<td>Financially Unable</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Uninterested</td>
<td>13</td>
<td>6</td>
<td>Missing</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Emotional Problems</td>
<td>9</td>
<td>6</td>
<td>Drug or Alcohol Addiction</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td>32</td>
<td>Other</td>
<td>28</td>
<td>38</td>
</tr>
</tbody>
</table>
Caregiver Health

Thirty percent of the caregivers reported their health as good or excellent while 24% assessed their health as fair or poor. In some respects, Phase 3 caregivers were in poorer health. When asked if their health limited moderate activities, 7% of the Phase 2 caregivers vs. 25% of the Phase 3 caregivers reported it did ($X^2 (2, N = 135) = 9.29, p = .010$).

Almost 19% of the caregivers reported that their health status limited their ability to climb stairs. When asked how often physical or emotional problems interfered with normal social activities with family and friends, 7% of the Phase 2 group and 23% of the Phase 3 group reported most or all of the time ($X^2 (4, N = 135) = 11.25, p = .024$).

Child Health

The great majority of the 212 kin children (94%) were reported in excellent, very good or good physical health with 69%, very good or excellent. However, a minority of the 212 children had behavioral issues that interrupted everyday family activities (17%), created tension or conflict in the home (23%) or led to family disagreements or arguments (18%). A greater percentage of Phase 3 children (9%) vs. Phase 2 children (4%) created tension or conflict in the home ($X^2 (3, N = 212) = 7.97, p = .047$).

Birth Parent Involvement

Despite relinquishing the care and custody of their child(ren), birth parents often continued to have a role in the life of their child(ren). The picture is often complex with the caregiver sometimes having to contend with multiple birth parents. Caregivers reported that 67% of the birth mothers (including a second mother in 11 homes) and 48% of the birth fathers (including a second father in 26 homes) have contact with the caregiver and the kin children. Many of those who visited did so frequently. Forty-six percent of mothers and 32% of the fathers
visited at least weekly. Conversely, 25% of mothers and 21% of fathers visited only a few times per year.

Finally, when asked how well they got along with the birthmother and father, the caregivers reported very well or well with 41% of the mothers and some difficulty, extreme difficulty, or no relationship with 59% of the birth mothers. The caregivers reported no relationship with 46% of the birth fathers and a difficult relationship with 14%. Forty percent of the relationships with the fathers had positive relationships.

**Pre-Intervention Data**

Analysis of the pre-intervention scores provided evidence that the families that opted to participate in Phase 3 were confronted with more difficulties and stress than the Phase 2 families. On the Parenting Stress Index, the mean scores on the Parent-Child Dysfunctional interaction subscale \( F(1,129) = 7.18, p = .008 \) and the Total Stress score \( F(1,129) = 4.26, p = .041 \) were significantly higher for the Phase 3 families. The number of items with the most intense need on the Family Needs Scale was highest for Phase 3 and included needing counseling for the child as one of the top five needs. Other top needs were for concrete and child related services for both groups. Phase 3 families reported fewer social supports and were also less satisfied with the people they named as resources. Finally, the scores on the Child Well-Being measure were somewhat lower (more negative) on all of the subscales for the Phase 3 families as compared to the Phase 2 families.

**Program Services**

Phase 2 families received an average of 16.1 \( (SD = 10.2) \) service hours. This ranged up to 80 hours. The workers recorded a mean of 42.8 \( (SD = 18.8) \) service hours for Phase 3 families. This ranged up to 98 hours. The difference between groups was statistically significant \( F(1,132) = 114.4, p = .000 \). These service hours were related to specific clients and did not
include the time spent on community outreach (287 hours), group work and preparation (1,946 hours), supervision (586 hours), training (520 hours) and miscellaneous tasks (58 hours).

Caregivers and kin children involved in all phases of the program were encouraged to participate in support and education groups at the Grand Family Center. There was a total of 195 groups held over the 33 months. Attendance averaged 6.4 persons with a maximum of 25. Caregivers attended an average of 6 sessions, ranging up to 47 sessions. Child activity groups ran concurrently with the caregiver groups.

Family Success Plans

Based on discussions with the caregiver along with a review of the scores from the tools delineated in Table 1, the worker and caregiver formalized and implemented a Family Success (service) Plan for all families while in Phase 2. The plans listed the mutually agreed upon goals that the worker would help the family achieve during the course of the intervention. Families averaged 4.0 ($SD = 2.7$) goals with a range between one and 24 goals in Phase 2. Families that ultimately participated in Phase 3 averaged 4.5 ($SD = 2.1$) goals ranging between 2 and 11 goals. The five most frequently listed goals were: (1) educational advocacy and support; (2) arranging counseling; (3) arranging child care, after school care, or summer camp; (4) providing housing assistance; and (5) securing financial aid. Eighty-two percent of the Phase 2 goals were resolved and 87% of the goals for families in Phase 3 were completed.

Family Group Decision Making Conferences

One hundred seventy-seven discussions were held with 130 unique caregivers during Phase 2 to promote participation in a FGDM conference, known as a Family Success conference. Sixty-four percent (114) of the discussions led to caregiver willingness to participate although caregiver follow-through did not always occur, necessitating further discussion.
The two most frequent reasons given by the caregivers for declining to participate altogether included: (1) just not interested—no benefit perceived; and (2) didn’t feel there was a need, maybe in the future.

Of the 86 caregivers who initially agreed to participate in a conference, 45% (39) ultimately did not. The principal reasons for not holding a conference included: (1) caregiver changed her mind; and (2) lack of extended family interest and involvement or inability to attend.

The three most frequently identified themes to emerge as the conference focus were: (1) helping the family get along better in order to provide support to the caregiver; (2) helping the child understand and adhere to the rules of the house while living in the home of the caregiver; and (3) incorporating the biological parent(s) into sharing some responsibility for their child’s upbringing.

Mean conference attendance was 6.3 people with a range of 1 to 12. Eighty-five percent of those invited attended. Attendance ranged from 8% to 100% of invitees. Sixty-seven percent (327 of 486) of the participants were relatives. Twenty-five service providers, external to the kinship program, attended FGDM meetings. The median length of a conferences was 3.0 hours and ranged from 1.5 to 6 hours.

A family plan was developed or amended during “family time,” the time during each of the 64 conferences when the meeting was turned over to the family and the facilitator and community resource members left the room. Improving family interactions, household management, educational advocacy, and child behavior along with arranging counseling and getting the family to work together to accomplish a goal were the most frequently identified conference goals. These were followed by planning activities for parents and children and finding child care or after school care or summer camp. A status was reported for 449 of the 461 family goals established. Sixty-nine percent of the goals were resolved or partially resolved, post-conference. The status for 23% of the goals was unchanged by the end of the program.

Fidelity to the FGDM model was assessed by using two questionnaires with 14 and 13 questions for family members and the facilitator,
respectively, as cited in Table 1. The responses to the Yes/No list of statements confirmed fidelity to the model if most of the model requirements were met, including establishing clarity about the purpose of the meeting and role of the attendees, encouraging members to share thoughts and ideas, creating a safe and positive atmosphere, and successfully developing a family plan. The degree of fidelity was determined by calculating the percentage of items marked “Yes.”

Family participants were asked to list the best things about the FGDM meeting. Their written comments were distilled into the following list:

- Being able to openly discuss family issues/problems and solutions in a safe environment.
- Coming up with a family plan with positive ideas and methods.
- Seeing the issues between caregiver and biological parent.
- Putting everything on the table in an effort to clear the air and improve the relationships between the individuals involved.
- Perceiving that family members were listening to each other.
- Willingness of family members to help the caregiver.
- Seeing program staff as very helpful.
- Appreciating agency supplied food.
- Finding the environment comfortable for the family meeting.

Family participants were also asked to list how the FGDM meeting could be improved. Comments included:

- Encourage increased attendance and participation by family members.
- Run shorter sessions.
- Give material in advance that prepares participants for how family meetings work.
- Reduce the amount of arguing.
- Encourage more participation of the kin children.
Outcome Measures

Table 5 provides a comparison of outcome data between the families who only participated in Phase 2 and those in Phase 3. On the Parenting Stress Index, the Phase 3 families had larger gain scores on all of the sub-scales and the Total Stress score. Although not statistically significant,

Table 5. Outcome Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>Means Phase 2 Families</th>
<th>Means Phase 3 Families</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time1</td>
<td>Time2</td>
</tr>
<tr>
<td>Parenting Stress Index (PSI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental Distress</td>
<td>26.4</td>
<td>24.4</td>
</tr>
<tr>
<td>Parent-Child Dysfunctional Interaction</td>
<td>21.8</td>
<td>21.5</td>
</tr>
<tr>
<td>Difficult Child</td>
<td>28.2</td>
<td>26.6</td>
</tr>
<tr>
<td>Total Stress</td>
<td>76.5</td>
<td>72.6</td>
</tr>
<tr>
<td>Social Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Supports</td>
<td>2.9</td>
<td>2.9</td>
</tr>
<tr>
<td>Satisfaction with Supports</td>
<td>5.9</td>
<td>5.9</td>
</tr>
<tr>
<td>Family Needs Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of items Needing Help &quot;Often&quot; or &quot;Always&quot;</td>
<td>6.1</td>
<td>2.6</td>
</tr>
<tr>
<td>Child Well-Being</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care*</td>
<td>22.1</td>
<td>22.6</td>
</tr>
<tr>
<td>Child’s Behavior</td>
<td>34.8</td>
<td>35.2</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>15.8</td>
<td>16.6</td>
</tr>
<tr>
<td>Education</td>
<td>18.1</td>
<td>18.1</td>
</tr>
<tr>
<td>Nurturing and Attachment</td>
<td>18.1</td>
<td>17.7</td>
</tr>
<tr>
<td>Community Engagement</td>
<td>11.9</td>
<td>12.0</td>
</tr>
<tr>
<td>Child/Family Relationships</td>
<td>7.0</td>
<td>7.1</td>
</tr>
<tr>
<td>Family Functioning/Resiliency</td>
<td>20.1</td>
<td>20.3</td>
</tr>
<tr>
<td>Child Development/Parenting</td>
<td>25.4</td>
<td>25.5</td>
</tr>
<tr>
<td>Child Well Being Total</td>
<td>141.4</td>
<td>143.2</td>
</tr>
</tbody>
</table>

* *r (100) = -3.24, p = .002

59
the Phase 3 scores showed greater improvement than the Phase 2 scores. The Social Support measure revealed no change for either group in terms of the number of supports identified and in the degree of satisfaction with those supports. On the Family Needs scale, the Phase 3 families experienced a slightly greater decrease in the number of items where the caregiver needed help “often” or “always.” Again the difference was not statistically significant. Needs as measured by this scale decreased by a noticeable amount between the pre- and posttests for both groups.

Finally, on the Child Well-Being measure, 8 of the 10 scales demonstrated a greater degree of positive change for the Phase 3 families as compared to Phase 2. However, only the Health subscale gain score was statistically significant (see Table 5).

Placements and CPS Involvement

Several months after case closing, the project supervisor attempted a follow-up telephone call with each of the 135 caregivers in Phase 2 and 3. Eighty-five surveys (63%) were completed. Caregivers were asked about any changes in the kin child’s status and about CPS agency involvement. At the time of the call, six children were no longer living in the caregiver’s home and were back with a biological parent or in foster care. Four of the six were Phase 3 families.

As far as CPS involvement or re-involvement, the caregivers reported 11 contacts with the State’s CPS agency. Seven of these contacts involved Phase 2 caregivers and the balance were Phase 3 caregivers. Two cases from each group underwent protective services investigations which were concluded as unfounded. The balance of the contacts was related to custody or other issues regarding interactions with the biological parents.

Seventy caregivers completed the Agency’s standard consumer feedback form, the Client Satisfaction Questionnaire (CSQ-8). Overall, the feedback was very positive. When compared to the Phase 2
participants, the Phase 3 families had superior ratings for all eight items. The score differences were statistically significant for the statements, “How satisfied are you with the amount of help you received?” Ninety-two percent of the Phase 3 families were “Very Satisfied” compared to 76% of the Phase 2 families. Another 24% of the Phase 2 families were “Mostly Satisfied,” $X^2 (2, N = 67) = 6.21, p = .045$.

**Conclusion and Discussion**

Family participation in the program was lower than anticipated despite delivering services in a phased manner that was attuned to family needs. The projection was to serve 450 Phase 1 families, 200 Phase 2 families, and 75 Phase 3 families. The reason for not meeting these targets is unclear. Recruitment did slow down appreciably during the third year of the project. Perhaps not enough outreach and effort was devoted to encouraging participation from caregivers living outside of Trenton in the rest of Mercer County. Two-thirds of the study cases were residents of Trenton. In addition, recruiting Phase 2 families to participate in a FGDM conference was labor intensive and more difficult than anticipated. Many caregivers saw no benefit from participation or had concerns about getting other family members to participate with them. The project implemented FGDM conferences as a voluntary component of the program whereas in CPS implementations, participation can be mandatory. To encourage FGDM participation, a number of strategies were utilized. While helpful in increasing participation, these approaches were not able to increase participation greatly. Other challenges involved getting the caregiver to agree to invite the birth parents, if appropriate. Staff spoke with the caregivers about the importance of including birth parents but, in most cases, did not work directly with the birth parents as this was outside the scope of the project. To boost relative participation, staff drew from the list of relatives identified by the caregiver on the social support questionnaire.
With respect to intended outcomes, families who participated in either Phase 2 or Phase 3 had improved change scores on the Parenting Stress Index, Family Needs Scale, and Child Well-Being scale. The magnitude of the gains were almost always greater for the Phase 3 cases, but the comparisons to Phase 2 were not statistically significant with the exception of improving health care on the Child Well-Being measure. According to participant feedback, the Phase 3 conferences brought families together and allowed them to communicate concerns and successes. It gave families a safe way to make their needs known to other family members and ask for support.

The plans developed as a result of the conferences were mostly completed and the caregivers found value in the process. Project services also assisted families with linkages to essential community resources which are believed critical to better family functioning and child well-being in the longer term.

Implications for Policy and Practice

An increasing number of children may be needing kinship care in the future. Recent media coverage of heroin and opioid use suggest a growing problem (Lapari & Hughes, 2015) which may increase parents’ reliance on extended family for kinship care. Most of this care is likely to be arranged privately or voluntarily with the assistance of CPS workers who do not take formal legal custody of the children. Unfortunately, informal kinship families receive minimal help from the community, including CPS agencies despite the fact that about two-thirds of the kin children were known to CPS in the past (see Table 1). Additionally, the primary reason for placement in the kinship home was due to abuse/neglect or parental substance abuse (see Table 4). In other words, a substantial percentage of “CPS like” children are “informally” placed in kinship homes without the resources and services received in the formal foster care system. These families would likely benefit from state-funded resources which includes financial
support and comprehensive, ongoing service availability. For informal caregivers, these services could be provided by a state or county funded drop-in facility such as a Grand Family Center. Family situations are fluid and are prone to periodic crises given low incomes and the difficulties of raising second families in high-need urban communities. Thus, drop-in sites could provide help as needed, supplemented by educational groups and family activities. Within a service center, support and educational groups offer a useful and cost-effective intervention. These group sessions allowed caregivers to maintain social connections with peers and create opportunities for periods of respite. An allocation from the federal Title IVB (Child and Family Services) or other Title such as Title IVE (Federal Payments for Foster Care and Adoption Assistance) may be a way to fund state initiatives in this area for the long term, extending the services offered by brief kinship navigator programs.

Providing ongoing case management and resource linkages is an essential part of any program of this nature. The post-intervention follow-up revealed that the majority of the caregivers considered their relationship with their worker to be “Excellent” even if all the Family Service Plan (FSP) goals were not successfully achieved. Anecdotally, the staff’s willingness to assist and listen to the caregiver on a one-on-one basis seemed of great value to the caregivers.

FGDM conferences provide another useful tool to help families. They were most frequently requested by the caregivers who needed assistance helping their child understand and adhere to the rules of the house or to incorporate the biological parent into sharing parental responsibility. By design, the findings of a formative study are too preliminary to determine with a high degree of confidence the types of families that would most benefit from this service. However, it was noted that the families that did agree to participate in a FGDM conference (Phase 3 cases) tended to be those with more negative initial scores on the various measures employed. They may have had a stronger incentive to participate.
Families that participated in Family Success Conferences rated services more positively than those who did not. What was most promising was that those families who participated in FGDM perceived them as helpful and were willing to encourage other families to try that process. Including the kin child’s birth parents in FGDM conferences, when possible, may be beneficial for both the kin caregiver and the child.

Possible strategies that may increase the degree of caregiver buy-in to the FGDM process include: use of social media or other audio/visual material to aid in disseminating information about the experience of participating in a FGDM, further pre-work with the caregiver and identified relatives to reduce their reluctance to participate or reduce the caregiver’s fear that the relatives will not participate, and finally, additional discussion with the caregiver about how the experience would benefit them. Encouraging and empowering families to move forward to utilize modified FGDM conference strategies, independently, at home with family members as a problem solving strategy would be an ideal endpoint. Perhaps, effort could be devoted to training a family member to be an effective facilitator.

Further rigorous study of the benefits of using FGDM with this population is warranted by the findings from this formative study. Future research could focus on identifying those most likely to benefit from FGDM. Federal funding under Section 427 of Title IVB (Family Connection Grants) is one potential source to consider. Other areas to consider for study include how and when to involve birth parents in FGDM conferences.

Limitations

The quasi-experimental nature of this study and its relatively brief study period of activity (33 months) limit the generalizability of its findings in a number of ways: (1) this type of design is subject to a number of threats to internal validity including selection and history;
(2) the participation of Phase 2 and 3 families in the same group activities may have also caused some contamination of any incremental effect of the intervention; (3) the relatively small number of caregivers participating in a FGDM conferences along with their self-selection may have impacted the ability to differentiate outcomes between Phase 2 and Phase 3 families; (4) the incremental nature of the FGDM experience itself may not have caused a sufficiently large enough impact over and above the case management services; and (5) the relatively brief study period may not have allowed enough time to differentiate outcomes between the Phase 2 and Phase 3 groups where multiple conferences over time might have proved more efficacious.

References


Michele Cranwell Schmidt
LeCroy & Milligan Associates, Inc.

Julie Treinen
Arizona’s Children Association

This study examined if kinship navigation services can improve family needs, caregiver self-efficacy, and placement stability of children in the care of their grandparents or other relatives. A total of 63 caregivers and 134 children received navigation services during a period that ranged from 2 to 23 months and participated in both baseline and follow-up data collection. The study design utilized a single-group pretest-posttest, using standardized assessment measures administered at baseline (case opening) and at six-month increments up to 24 months after case opening to monitor changes in caregiver perceptions over time. Additionally, state child welfare administrative data were used to determine placement stability outcomes of kinship children at the end of the study—September 30, 2015—which covered a period that ranged from seven to 32 months after case opening. Paired samples t-tests showed that caregivers reported a significant decrease in four areas of needs after case closure. None of the areas of caregiver self-efficacy measured showed a statistically significant change, as caregivers reported a high level of self-efficacy at both pre- and post-assessment. Of youth in care, 87% (n =117) remained in a stable placement and 93% (n = 125) had no subsequent child welfare investigations. Implications for policy and programming, and recommendations for future research are discussed.
Studies have identified the need to provide services to kinship caregivers to maintain children safely in their homes (Littlewood, 2015; Sutphin, 2015; Wallace & Lee, 2013). Common needs include financial resources, child care, legal services, and material goods. Many grandparents raising their grandchildren are low-income and have a high need for financial resources (Ehrle & Geen, 2002; Lee, Choi, & Clarkson-Henderix, 2016; Nelson, Gibson, & Bauer, 2010). U.S. Census data (2014) reports that 28.8% of grandparent caregivers have an income that places them at or below the federal poverty level (FPL). Kinship caregivers also need childcare, which is often excluded from state-provided supports for kinship caregivers (Ehrle & Geen, 2002; Gerard, Landry-Meyer, & Roe, 2006). Kinship caregivers who participated in a navigation program reported statically significant reduction in needs from pre- to post-assessment in areas of self-care, financial resources, access to public assistance, and medical and dental care for the family (Littlewood, 2015).

Caregivers often lack legal information and access to legal services to help them understand legal custody options (Ehrle & Geen, 2002; Treinen, Schmidt & Espino, 2015; Wallace & Lee, 2013). In a preliminary report of this current study (Treinen, Schmidt, & Espino, 2015), over half of caregivers faced barriers in seeking and obtaining custody, guardianship, licensure, or adoption of their kinship children. Other needs of kinship caregivers included awareness of permanency options, understanding the courts or dependency process, representation in court, and understanding of benefits for which they may be eligible.

Placement Stability Outcomes of Children in Kinship Care

Kinship care can help protect children; maintain strong family, community and cultural connections; and preserve secure attachments to children’s caregivers and birth family (Hegar & Rosenthal, 2009). Children in formal kinship care have equivalent or better safety and stability outcomes compared to children in non-kinship placements (Jonson-Reid, 2003). Children in kinship care experience fewer placement changes/disruptions (Koh, 2010; Koh & Testa, 2011) than children in non-kinship
foster care. Youth fare better when they experience fewer placement disruptions (Hegar & Rosenthal, 2009): they are more likely to experience fewer school changes, less trauma and distress, fewer mental health and behavioral problems, greater academic achievement, and develop secure attachments with adults. While most past studies pertain to children in formal kinship care, Littlewood (2015) demonstrated that 99% of informal kinship children whose families participated in a navigation program did not enter the child welfare system at 12 months follow-up.

**Kinship Navigation Program Model**

The kinship navigation program model has been developed by sites across the United States that were funded by Children's Bureau Family Connections Discretionary Grants (FCDG). Notable FCDG funded programs include the YMCA Kinship Support Services of San Diego County (Hernandez et al, 2014), Children's Home Society of New Jersey (Feldman & Fertig, 2013), and Florida Kinship Center at the University of South Florida (Littlewood, 2015). Within these models, Kinship Navigators (KNs) provide flexible and responsive services based on family needs. The goal of navigation is to assist caregivers in identifying and removing barriers to service receipt, and in accessing public benefits, legal services, and existing community systems. The model empowers caregivers to support and advocate for each other, fostering interdependence and a natural support system.

Arizona Kinship Support Services (AKSS) is a KN program operated by Arizona's Children Association and based on the above referenced models. The AKSS program model was refined and expanded from one to four Arizona counties with FCDG funds from 2012–2015. The program's overarching goal was to enhance the safety, permanence, and well-being of youth by supporting both formal and informal kinship caregivers. The service model begins with KNs completing an intake and assessment of client strengths and needs. All clients receive Information, Referral, and Connection (IRC) services, which includes referrals to community-based services and resources.
They can participate in any on-site service, such as clinics and support groups. Clients with a higher level of need are offered more intensive navigation services through an open case. Clients participating at this service level were invited to participate in the pre- and post-assessment evaluation of the intervention. The purpose of this study was to understand if KN services improved the management of family needs, caregiver self-efficacy, and placement stability (including child safety and permanence) of children in informal and formal kinship placements, at least six months after case-opening.

Methods
The study design utilized a single-group pretest-posttest, using standardized assessment measures administered to caregivers at baseline (case opening) and at six-month increments post-case opening, up to 24 months. Additionally, state child welfare administrative data were used to determine placement stability outcomes of kinship children at the end of the study: September 30, 2015. Follow-up time ranged from seven to 32 months after case opening.

Participants
A total of 63 caregivers who were caring for 134 children participated in both baseline and follow-up data collection. All participants received open-case navigation services for 2 to 23 months ($M = 11.6; SD = 5.8$).

Adult Demographics
Table 1 summarizes the demographic characteristics of caregivers who participated in this study ($N = 63$). The majority are female (95.2%, $n = 60$), with a mean age of 58.3 (range 33-80; 10.1 $SD$), and self-identified as Hispanic/Latino (44.4%, $n = 28$) or White/Caucasian (33.3%, $n = 21$).
Table 1. Caregiver Sociodemographic Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N (63)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>60</td>
<td>95.2%</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>4.8%</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>28</td>
<td>44.4%</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>21</td>
<td>33.3%</td>
</tr>
<tr>
<td>African American</td>
<td>9</td>
<td>14.3%</td>
</tr>
<tr>
<td>Native American</td>
<td>5</td>
<td>7.9%</td>
</tr>
<tr>
<td><strong>Primary Language</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>43</td>
<td>68.3%</td>
</tr>
<tr>
<td>Spanish</td>
<td>11</td>
<td>17.5%</td>
</tr>
<tr>
<td>Bilingual (English and Spanish)</td>
<td>9</td>
<td>14.3%</td>
</tr>
<tr>
<td><strong>Relationship Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/partnered</td>
<td>21</td>
<td>33.3%</td>
</tr>
<tr>
<td>Single</td>
<td>42</td>
<td>66.7%</td>
</tr>
<tr>
<td><strong>Annual Household Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$10,000</td>
<td>10</td>
<td>15.9%</td>
</tr>
<tr>
<td>$10,000-$20,000</td>
<td>19</td>
<td>30.2%</td>
</tr>
<tr>
<td>$20,001-$30,000</td>
<td>16</td>
<td>25.4%</td>
</tr>
<tr>
<td>$30,001-$40,000</td>
<td>5</td>
<td>7.9%</td>
</tr>
<tr>
<td>$40,001-$50,000</td>
<td>4</td>
<td>6.3%</td>
</tr>
<tr>
<td>$50,000+</td>
<td>9</td>
<td>14.2%</td>
</tr>
<tr>
<td>Household is at or below 150% of FPL</td>
<td>52</td>
<td>82.5%</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time (30+ hours/week)</td>
<td>15</td>
<td>23.8%</td>
</tr>
<tr>
<td>Part-time (&lt; 30 hours/week)</td>
<td>7</td>
<td>11.1%</td>
</tr>
<tr>
<td>Retired</td>
<td>12</td>
<td>19.0%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>18</td>
<td>28.6%</td>
</tr>
<tr>
<td>Not in labor force</td>
<td>11</td>
<td>17.5%</td>
</tr>
<tr>
<td><strong>TANF-Child Only Receipt</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before AKSS</td>
<td>7</td>
<td>11.1%</td>
</tr>
<tr>
<td>After AKSS</td>
<td>10</td>
<td>15.9%</td>
</tr>
<tr>
<td>Never received</td>
<td>46</td>
<td>73.0%</td>
</tr>
<tr>
<td><strong>Caregiver’s Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle school or less</td>
<td>9</td>
<td>14.3%</td>
</tr>
<tr>
<td>High school, no diploma</td>
<td>7</td>
<td>11.1%</td>
</tr>
<tr>
<td>High school graduate or GED</td>
<td>17</td>
<td>27.0%</td>
</tr>
<tr>
<td>Vocational, trade, or business program</td>
<td>4</td>
<td>6.3%</td>
</tr>
<tr>
<td>Some college, no degree</td>
<td>14</td>
<td>22.2%</td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>5</td>
<td>7.9%</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>4</td>
<td>6.3%</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>3</td>
<td>4.8%</td>
</tr>
</tbody>
</table>
Child Demographics

Table 2 summarizes the demographic characteristics of children in this study ($N = 134$). Over half of children are male (56.0%, $n = 75$), with a mean age of 8.8 years (range of infant to age 19; 4.7 SD), and over a third are Hispanic/Latino (38.8%, $n = 52$). Most children are cared for by a grandparent or great-grandparent (86.6%, $n = 116$) with 55.2% ($n = 74$) in informal and 44.8% ($n = 60$) in formal kinship care (i.e., Department of Child Safety or DCS was involved at intake).

Table 2. Sociodemographic Characteristics of Kinship Children

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>$N$ (63)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>59</td>
<td>44.0%</td>
</tr>
<tr>
<td>Male</td>
<td>75</td>
<td>56.0%</td>
</tr>
<tr>
<td>Age Range</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth-4 years</td>
<td>33</td>
<td>24.6%</td>
</tr>
<tr>
<td>5-7 years</td>
<td>23</td>
<td>17.2%</td>
</tr>
<tr>
<td>8-11 years</td>
<td>39</td>
<td>29.1%</td>
</tr>
<tr>
<td>12-17 years</td>
<td>34</td>
<td>25.4%</td>
</tr>
<tr>
<td>18-19 years</td>
<td>5</td>
<td>3.7%</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>52</td>
<td>38.8%</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>26</td>
<td>19.4%</td>
</tr>
<tr>
<td>African American</td>
<td>14</td>
<td>10.4%</td>
</tr>
<tr>
<td>Native American</td>
<td>13</td>
<td>9.7%</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>10</td>
<td>7.5%</td>
</tr>
<tr>
<td>Not Reported</td>
<td>19</td>
<td>14.2%</td>
</tr>
<tr>
<td>Caregiver’s Relationship to Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandparent/Great-Grandparent</td>
<td>116</td>
<td>86.6%</td>
</tr>
<tr>
<td>Adoptive Parent</td>
<td>7</td>
<td>5.2%</td>
</tr>
<tr>
<td>Aunt/Uncle/Great Aunt/Uncle</td>
<td>6</td>
<td>4.4%</td>
</tr>
<tr>
<td>Non-Relative</td>
<td>4</td>
<td>3.0%</td>
</tr>
<tr>
<td>Cousin</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>Kinship Care Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal (DCS involved at intake)</td>
<td>60</td>
<td>44.8%</td>
</tr>
<tr>
<td>Informal (DCS is not involved at intake)</td>
<td>74</td>
<td>55.2%</td>
</tr>
</tbody>
</table>
Table 3 summarizes the multiple reasons why children were placed into kinship care. The top three reasons include: DCS removal of the child (59.0%, n = 79); parental incarceration (50.0%, n = 67); and parental substance abuse (35.1%, n = 47).

Table 3. Reasons Children are in Kinship Care

<table>
<thead>
<tr>
<th>Reasons</th>
<th>N (134)</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child welfare removal</td>
<td>79</td>
<td>59.0%</td>
</tr>
<tr>
<td>Parental incarceration</td>
<td>67</td>
<td>50.0%</td>
</tr>
<tr>
<td>Parental substance abuse</td>
<td>47</td>
<td>35.1%</td>
</tr>
<tr>
<td>Poor or unstable housing</td>
<td>24</td>
<td>17.9%</td>
</tr>
<tr>
<td>Abuse/neglect</td>
<td>20</td>
<td>14.9%</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>14</td>
<td>10.4%</td>
</tr>
<tr>
<td>Immigration status</td>
<td>9</td>
<td>6.7%</td>
</tr>
<tr>
<td>Financial hardship</td>
<td>8</td>
<td>6.1%</td>
</tr>
<tr>
<td>Parent mental or physical health</td>
<td>5</td>
<td>3.7%</td>
</tr>
<tr>
<td>Death of parent</td>
<td>4</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

* Total > 100% because caregivers could select all that applied.

Table 3 summarizes the multiple reasons why children were placed into kinship care. The top three reasons include: DCS removal of the child (59.0%, n = 79); parental incarceration (50.0%, n = 67); and parental substance abuse (35.1%, n = 47).

Service Utilization

Table 4 shows the number and percentage of caregivers that utilized AKSS KN services. Services commonly utilized by over half of caregivers include legal services referrals and support, attended AKSS support groups, and/or received basic needs supports.

Measures

Family Needs

Change in family needs over time was measured using the Family Needs Scale (FNS), which is a 34-item self-report instrument adapted from the original 41-item scale (Dunst et al., 1998). After piloting the original scale, the evaluators removed items that were not applicable to
Table 4. Services Utilized by Kinship Caregivers

<table>
<thead>
<tr>
<th>Services</th>
<th>N (63)</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Services Referral and Support</td>
<td>36</td>
<td>57.1%</td>
</tr>
<tr>
<td>Caregiver Peer-led Support Group</td>
<td>36</td>
<td>57.1%</td>
</tr>
<tr>
<td>Basic Needs Support (Materials and Goods)</td>
<td>32</td>
<td>50.8%</td>
</tr>
<tr>
<td>Caregiver Topical Education Sessions</td>
<td>29</td>
<td>46.0%</td>
</tr>
<tr>
<td>Title 8/Permanent Guardianship and Adoption Training</td>
<td>21</td>
<td>33.3%</td>
</tr>
<tr>
<td>Support for Navigating Child’s Education System</td>
<td>19</td>
<td>30.2%</td>
</tr>
<tr>
<td>Kinship Information Session (for Formal Caregivers)</td>
<td>14</td>
<td>22.2%</td>
</tr>
<tr>
<td>Arizona Grandparent Ambassadors/Advocacy</td>
<td>14</td>
<td>22.2%</td>
</tr>
<tr>
<td>Respite, Childcare, Family Recreation Activities</td>
<td>12</td>
<td>19.0%</td>
</tr>
<tr>
<td>Title 14/Voluntary Guardianship Clinic</td>
<td>11</td>
<td>17.5%</td>
</tr>
<tr>
<td>Referrals to Health Care Services</td>
<td>11</td>
<td>17.5%</td>
</tr>
<tr>
<td>TANF Cash Assistance Referral</td>
<td>10</td>
<td>15.9%</td>
</tr>
<tr>
<td>Support with DCS</td>
<td>5</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

* Percentages total over 100%; caregivers could utilize multiple services.

caregivers in this study. The 34-item FNS demonstrated strong internal consistency, with a Cronbach Alpha score of .96 at baseline and .93 at follow-up, which is consistent with the original scale development (Dunst et al., 1998) and similar research on kinship caregivers (Lee, Choi, & Clarkson-Henderix, 2016; Littlewood, 2015; Sutphin, 2015). A Cronbach Alpha score of .70 or higher demonstrates strong internal consistency or average correlation of items in a survey instrument (Cronbach, 1951). Each item is rated by the caregiver using a 5-point scale (from 1, “Never a Need,” to 5, “Always a Need”). Caregivers could also indicate that an item was “Not Applicable,” which was excluded from computed average scores.

**Caregiver Self-Efficacy**

Change in caregiver self-efficacy was measured using the New General Self-efficacy (NGSE) Scale. This scale is an eight-item self-rated
instrument using a 4-point scale (from 1, “Not at all True,” to 4, “Completely True”) to assess caregivers’ perceived self-efficacy. This scale showed good internal consistency, with a Cronbach Alpha score of .84 at baseline and .87 at follow-up survey, which is consistent with findings reported by the scale developers (Chen, Gully, & Eden, 2001).

**Placement Stability**

Administrative data were obtained from the Arizona DCS to determine placement stability outcomes. Safety was measured by whether or not AKSS study children had a substantiated child maltreatment report with DCS from the caregivers’ case opening to study completion. Permanence was measured by comparing caregiver self-report data and DCS records to determine if the child remained safely in kinship care or reunified with their biological parent(s) at the time of follow-up.

**Data Analysis**

Caregivers’ pre- and post-responses to the FNS and NGSE were analyzed in a manner consistent with related research (Littlewood, 2015; Sutphin, 2015). Data were analyzed with the Statistical Package for the Social Sciences (SPSS) Version 22. The evaluators performed exploratory and univariate analyses to describe the variables, clean, and recode the data. Mean scores were computed for each FNS and NGSE item (excluding “Not Applicable” responses). A higher average FNS score indicates that the area is a greater need for caregivers; a higher average NGSE score indicates greater self-efficacy. A paired-samples t-test was performed for matched pre- and post-FNS and NGSE items to determine change over time. An independent samples t-test was also performed to determine significant relationships between child demographics and placement outcomes. Results were deemed statistically significant when the p-value was ≤ .05.
Procedures

The study protocol was pilot tested and approved by a local Institutional Review Board. The evaluator provided training and ongoing support to staff who administered the informed consent and client surveys. The evaluator checked in with the nine KN staff on a quarterly basis, individually or as a group, to discuss the informed consent and data collection process, review the field questions, and modify procedures to facilitate data collection from caregivers. This review process, along with administrative documentation of data collection, allowed the evaluator to monitor and ensure fidelity to the data collection protocol.

KNs initiated and completed the informed consent process (in English or Spanish) with caregivers at their case opening and administered the baseline survey (in English or Spanish) at the time of consent or within two weeks. KNs could complete this structured interview with caregivers by telephone or in person at an office or home visit, recording responses on paper or an online survey. A total of 98 caregivers consented to and completed the baseline survey (68% participation rate of 145 open navigation cases).

The evaluation team conducted the follow-up survey (in English or Spanish) starting at six months post the caregiver’s baseline completion. The evaluation team attempted to survey caregivers every six months, for up to 24 months post-baseline. A total of 79 follow-up surveys were completed: 47 caregivers completed one follow-up and 16 completed two follow-ups. In total, 63 caregivers who were caring for 134 children participated in both the baseline and follow-up data collection. Follow-up surveys were completed a mean of 13.7 months post baseline (range 6 to 24 months, SD 4.0).

Results

Changes in Kinship Family Needs

Using the FNS, caregivers rated the adequacy of their resources and the extent of their family’s needs in the past six months. Table 5 shows
Table 5. Means, Standard Deviations, and Paired Sample t-test for Responses to the FNS

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean Pre (SD)</th>
<th>Mean Post (SD)</th>
<th>Paired t</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Having food for at least two meals for your family.</td>
<td>2.05 (1.14)</td>
<td>2.21 (1.39)</td>
<td>-.894</td>
<td>58</td>
</tr>
<tr>
<td>2. Finding time to cook healthy meals for your family.</td>
<td>2.16 (1.28)</td>
<td>2.12 (1.37)</td>
<td>.168</td>
<td>58</td>
</tr>
<tr>
<td>3. Having enough food to feed your child or children.</td>
<td>2.02 (1.11)</td>
<td>2.12 (1.25)</td>
<td>-.585</td>
<td>57</td>
</tr>
<tr>
<td>4. Having clean water to drink.</td>
<td>1.44 (1.09)</td>
<td>1.29 (0.75)</td>
<td>.955</td>
<td>57</td>
</tr>
<tr>
<td>5. Finding or keeping a place to live.</td>
<td>1.54 (1.18)</td>
<td>1.68 (1.19)</td>
<td>-.715</td>
<td>57</td>
</tr>
<tr>
<td>6. Paying for utility bills like water, electricity, and AC/heat.</td>
<td>2.50 (1.20)</td>
<td>2.06 (1.23)</td>
<td>2.639*</td>
<td>53</td>
</tr>
<tr>
<td>7. Completing chores, home repairs or improvements.</td>
<td>2.62 (1.41)</td>
<td>2.43 (1.37)</td>
<td>1.055</td>
<td>51</td>
</tr>
<tr>
<td>8. Adapting your house to meet the needs of your child or children (e.g., handicapped accessible).</td>
<td>1.88 (1.23)</td>
<td>2.00 (1.47)</td>
<td>-.309</td>
<td>25</td>
</tr>
<tr>
<td>9. Having money to buy necessities and pay bills.</td>
<td>2.77 (1.14)</td>
<td>2.56 (1.34)</td>
<td>1.257</td>
<td>57</td>
</tr>
<tr>
<td>10. Budgeting the way you’ll spend money.</td>
<td>2.08 (1.21)</td>
<td>2.13 (1.34)</td>
<td>-.290</td>
<td>58</td>
</tr>
<tr>
<td>11. Paying for any special needs of your child or children.</td>
<td>2.08 (1.21)</td>
<td>2.14 (1.34)</td>
<td>.296</td>
<td>27</td>
</tr>
<tr>
<td>12. Saving money for the future.</td>
<td>3.21 (1.56)</td>
<td>3.39 (1.58)</td>
<td>-.680</td>
<td>53</td>
</tr>
<tr>
<td>13. Planning for a future job for your child or children.</td>
<td>2.38 (1.61)</td>
<td>2.83 (1.66)</td>
<td>-1.036</td>
<td>24</td>
</tr>
<tr>
<td>14. Getting a job.</td>
<td>2.32 (1.76)</td>
<td>2.00 (1.12)</td>
<td>.753</td>
<td>19</td>
</tr>
<tr>
<td>15. Having a job that you enjoy.</td>
<td>2.06 (1.44)</td>
<td>2.40 (1.45)</td>
<td>-.734</td>
<td>15</td>
</tr>
<tr>
<td>16. Getting where you need to go.</td>
<td>2.17 (1.31)</td>
<td>1.93 (1.24)</td>
<td>1.491</td>
<td>58</td>
</tr>
<tr>
<td>17. Transporting your child or children.</td>
<td>2.00 (1.29)</td>
<td>2.04 (1.39)</td>
<td>-.202</td>
<td>57</td>
</tr>
<tr>
<td>18. Getting special travel equipment for your child or children (e.g., a car seat).</td>
<td>1.95 (1.39)</td>
<td>1.49 (1.99)</td>
<td>1.960**</td>
<td>37</td>
</tr>
<tr>
<td>19. Paying for gas.</td>
<td>2.60 (1.27)</td>
<td>2.40 (1.40)</td>
<td>.919</td>
<td>55</td>
</tr>
<tr>
<td>20. Getting in touch with people that you need to talk to (e.g., a doctor, child's teacher, etc.).</td>
<td>2.12 (1.17)</td>
<td>2.17 (1.26)</td>
<td>-.242</td>
<td>58</td>
</tr>
<tr>
<td>21. Having someone to talk to about your child or children (e.g., friend, counselor, religious leader, etc.).</td>
<td>2.25 (1.31)</td>
<td>2.19 (1.27)</td>
<td>.285</td>
<td>57</td>
</tr>
<tr>
<td>22. Having someone to talk to, in general (e.g., friend, counselor, religious leader, etc.).</td>
<td>2.01 (1.27)</td>
<td>2.23 (1.25)</td>
<td>-1.448</td>
<td>57</td>
</tr>
<tr>
<td>23. Having medical and dental care for your family.</td>
<td>1.98 (1.39)</td>
<td>1.96 (1.26)</td>
<td>.073</td>
<td>57</td>
</tr>
<tr>
<td>24. Finding special medical and dental care for your child or children.</td>
<td>1.84 (1.04)</td>
<td>1.73 (1.11)</td>
<td>.559</td>
<td>49</td>
</tr>
<tr>
<td>25. Having time to take care of yourself.</td>
<td>3.14 (1.31)</td>
<td>2.50 (1.40)</td>
<td>3.176*</td>
<td>58</td>
</tr>
<tr>
<td>26. Having emergency health care.</td>
<td>1.61 (.94)</td>
<td>1.56 (.92)</td>
<td>.358</td>
<td>54</td>
</tr>
<tr>
<td>27. Planning for future health needs of you or your family.</td>
<td>2.14 (1.28)</td>
<td>2.10 (1.15)</td>
<td>.175</td>
<td>51</td>
</tr>
<tr>
<td>28. Managing the daily needs of your child or children.</td>
<td>2.21 (1.15)</td>
<td>2.18 (1.24)</td>
<td>.209</td>
<td>56</td>
</tr>
<tr>
<td>29. Caring for your child or children during work hours.</td>
<td>2.00 (1.29)</td>
<td>2.00 (1.20)</td>
<td>.000</td>
<td>26</td>
</tr>
<tr>
<td>30. Having emergency child care when you need it.</td>
<td>2.40 (1.37)</td>
<td>2.11 (1.26)</td>
<td>1.007</td>
<td>46</td>
</tr>
<tr>
<td>31. Getting short term or temporary relief (i.e. respite care) from caring for your child or children.</td>
<td>2.85 (1.50)</td>
<td>2.40 (1.42)</td>
<td>1.774</td>
<td>52</td>
</tr>
<tr>
<td>32. Finding future care for your child or children.</td>
<td>2.64 (1.49)</td>
<td>2.10 (1.19)</td>
<td>2.194**</td>
<td>50</td>
</tr>
<tr>
<td>33. Getting special equipment or therapy for your child or children.</td>
<td>2.14 (1.35)</td>
<td>2.46 (1.45)</td>
<td>-1.104</td>
<td>28</td>
</tr>
<tr>
<td>34. Having time to take your child or children to appointments.</td>
<td>1.73 (1.05)</td>
<td>1.64 (1.01)</td>
<td>.566</td>
<td>56</td>
</tr>
</tbody>
</table>

*p ≤ .01, **p ≤ .05
the mean scores, standard deviations, and results of the paired samples \( t \)-test for each item. Four items showed a statistically significant decrease in need from pre- to posttest: “6. Paying for utility bills like water, electricity, and AC/heat;” “18. Getting special travel equipment for your child or children;” “25. Having time to take care of yourself;” and “32. Finding future care for your child or children.” One area that remained the highest need from pre- to posttest was “12. Saving money for the future.”

**Changes in Caregiver Self-Efficacy**

Table 6 shows the pre- and post-scores for items on the NGSE scale. Higher scores indicate greater perceived self-efficacy in that area. None of the areas showed a statistically significant change due perhaps to a ceiling effect. Caregivers reported a high level of self-efficacy at both pre- and post-test, with average post-scores ranging from 2.93 to 3.40.

**Table 6. Means, Standard Deviations, and Paired Sample \( t \)-test for Responses to the NGSE Scale**

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean Pre (SD)</th>
<th>Mean Post (SD)</th>
<th>Paired ( t )</th>
<th>( n )</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You can always manage to solve difficult problems if you try hard enough.</td>
<td>3.33 (.74)</td>
<td>3.37 (.67)</td>
<td>-.314</td>
<td>57</td>
</tr>
<tr>
<td>2. You can find the means and ways to get what you want.</td>
<td>2.84 (.98)</td>
<td>3.00 (.85)</td>
<td>-1.242</td>
<td>57</td>
</tr>
<tr>
<td>3. It is easy for you to accomplish your goals.</td>
<td>2.77 (1.00)</td>
<td>2.93 (.68)</td>
<td>-1.102</td>
<td>57</td>
</tr>
<tr>
<td>4. You are confident that you can handle unexpected events well.</td>
<td>3.09 (.87)</td>
<td>3.21 (.79)</td>
<td>-.895</td>
<td>57</td>
</tr>
<tr>
<td>5. You can solve most problems if you invest the necessary effort.</td>
<td>3.38 (.78)</td>
<td>3.39 (.65)</td>
<td>-.145</td>
<td>56</td>
</tr>
<tr>
<td>6. You can remain calm when facing difficulties because you can rely on your coping abilities.</td>
<td>3.02 (.81)</td>
<td>3.23 (.68)</td>
<td>-1.804</td>
<td>57</td>
</tr>
<tr>
<td>7. When you are confronted with a problem, you can usually find a good solution.</td>
<td>3.28 (.70)</td>
<td>3.40 (.56)</td>
<td>-1.224</td>
<td>57</td>
</tr>
<tr>
<td>8. You can usually handle whatever comes your way.</td>
<td>3.18 (.79)</td>
<td>3.18 (.72)</td>
<td>.000</td>
<td>55</td>
</tr>
</tbody>
</table>
Placement Stability

Table 7 summarizes the child placement stability outcomes, conceptualized in this study as permanence and child safety outcomes.

Table 7. Child Placement Stability Outcomes

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>N (134)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Permanence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placement stable/reunified with biological parents</td>
<td>117</td>
<td>87.3%</td>
</tr>
<tr>
<td>Kinship placement disrupted, placed with a foster parent, a group home, or a non-relative caregiver</td>
<td>9</td>
<td>6.7%</td>
</tr>
<tr>
<td>Never placed with kinship caregiver, kin supporting child’s case plan</td>
<td>6</td>
<td>4.5%</td>
</tr>
<tr>
<td>DCS removal post-reunification for subsequent maltreatment perpetrated by birth parents</td>
<td>2</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No subsequent DCS allegation or report</td>
<td>125</td>
<td>93.3%</td>
</tr>
<tr>
<td>Unsubstantiated DCS report</td>
<td>5</td>
<td>3.7%</td>
</tr>
<tr>
<td>Substantiated DCS report</td>
<td>2</td>
<td>1.5%</td>
</tr>
<tr>
<td>DCS report, results pending</td>
<td>2</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

Permanence

At post-assessment (6 to 24 months after case opening), 87.3% (n = 117) of children in the study remained in the care of their original kinship caregiver (76.1%, n = 102) or were reunified with their biological parent(s) (9.0%, n = 12). In 1.5% of cases (n = 2), a pair of siblings was placed into formal kinship care by DCS, the caregiver received AKSS services, then the siblings were reunified with their birth parents by DCS, and later removed again by DCS for subsequent maltreatment perpetrated by their birth parents. The placement of these children after their second removal was not provided to the evaluation team. In 6.7% (n = 9) of cases, the kinship caregiver placement was disrupted.
and the children were placed with a foster parent, a group home, or a non-relative caregiver. An independent-samples t-test revealed that children in disrupted placements were more likely to be older (mean 12.1 years, 6.0 SD) compared to children who remained in stable placements or were reunified (mean 8.7 years, 4.4 SD) ($t = 2.204$, $p = .03$). A few of the caregivers in the study (4.5%, $n = 6$) never became the child’s placement for various reasons (e.g., unable to pass a background check); however, when appropriate, AKSS supported these caregivers in maintaining relational permanence with the child.

**Child Safety**

DCS provided administrative data on child abuse and neglect reports, allegation findings, and removal dates for children in the study, over time from case opening date to study completion (range 7 to 32 months, $M = 20.6$, $SD = 5.3$). During this time frame, 93.3% ($n = 125$) of children had no subsequent allegation or report filed with DCS on their behalf. In nine cases (6.7%) a DCS report was filed during the time frame: five were unsubstantiated (3.7%); two were substantiated (1.5%); and two had results pending at the time of this report (1.5%).

**Discussion and Recommendations**

This formative evaluation of the AKSS program demonstrates the continued need to provide KN services for kinship caregivers in order to support family needs and child placement stability outcomes. FCDG funds enabled AKSS to expand and evaluate the KN program model over three years. Given the promising outcomes observed in this evaluation in terms of reduced family needs and enhanced child placement stability, policy-makers should prioritize the allocation of federal and state dollars to support KN programs. This allocation of funds is especially crucial given that states typically emphasize kinship care as the first option for out-of-home placements when children cannot remain in the care of their biological parents.
The promising results of this study suggest that other communities could benefit by replication of the AKSS KN program model. Key services of this program model include: providing information, referrals, and connections to community resources; providing access to basic needs items (materials and goods); making referrals to legal services and supporting families during this process; facilitating peer-led support and advocacy groups; and offering topical education sessions based on caregivers’ needs and interests. KN service providers and policy-makers should continue to develop policies and strategies that meet the needs of formal kinship caregivers involved with state child welfare and informal caregivers who are not.

Kinship Navigation Programs Support Family Needs

Participants receiving AKSS KN services showed an increased ability to meet their families’ immediate needs from baseline to after case closure in four areas. A significantly decreased need was observed in: paying for utility bills; obtaining travel equipment for a child (e.g., a car seat); making time for caregiver self-care; and finding future care for their child or children. These finding suggests the importance of several KN program model services. A key component is providing caregivers with basic needs items and/or referring them to services and resources in the community for acquiring material goods and/or financial resources. Basic needs services was utilized by 51% \((n = 32)\) of caregivers in this study. Another key service in which 57% \((n = 36)\) of caregivers participated was peer-led support groups. This component of the AKSS KN program model has the goals of reducing caregiver stress, promoting self-care, information sharing, and empowering caregivers to support and advocate for each other. Interestingly, none of the areas of caregiver self-efficacy measured in this study showed a statistically significant change because caregivers reported a high level of self-efficacy at both pre- and post-assessment. This finding may be related
to caregivers generally being older (a mean age of 58.3 and range of 33-80 years) and having lifelong experience as caregivers, since 87% \((n = 116)\) are grandparents or great grandparents to the children in their care.

**Kinship Navigation Programs Support Placement Stability**

Placement stability results from this study show that children in supported kinship care placements experienced greater stability and permanence, fewer disruptions, and increased safety by the end of the study. At post-assessment (6 to 24 months post-case opening), 87.3\% \((n = 117)\) of children remained in the care of their original kinship caregiver or were reunified with their biological parent(s). These figures are compared with a low disruption rate of 7\% \((n = 9)\). Likewise, 93.3\% \((n = 125)\) of children had no subsequent allegation or report with DCS from the time of their case opening to the end of the study, which ranged from 7 to 32 months and averaged 21 months. These findings are consistent with previous research on kinship navigation services. Littlewood (2015) reported that 12 months after participating in a Florida kinship navigation program, 90\% of children did not enter the child welfare system. Koh and Testa (2011) also found that children in kinship foster homes experienced greater stability during their out-of-home care placements than children in non-kinship foster homes. AKSS KN program model services designed to support placement stability include referrals to legal services, utilized by 57\% \((n = 36)\) of caregivers, and clinics, trainings, and information sessions that provide caregivers with information about various permanency options available to their situation (e.g., voluntary guardianship, permanent guardianship, adoption, licensed and unlicensed kinship foster care, etc.). Nearly three-quarters of caregivers in this study (73\%, \(n = 46)\) attended one or more of these sessions.
Continued Need for Financial Support for Kinship Families

Results from this study show that “Saving money for the future” ($M_{-\text{pre}}$ 3.21; $M_{-\text{post}}$ 3.39) was a high needs area for which a lack of change was observed from pre- to post-assessment. Socio-economic characteristics show that the majority of AKSS caregivers in this study, who have taken on caring for one to eight kinship children ($M = 2.6$, $SD = 1.5$), are economically disadvantaged. Nearly 83% ($n = 52$) of caregivers were at or below 150% of the FPL; 72% ($n = 45$) had an annual household income of $30,000 or less; 65% ($n = 41$) were retired, unemployed, or not in the labor force; and 52% ($n = 33$) had a high school or less education. These findings are consistent with literature that reports that relative caregivers, typically retired grandparents, with less education and living on fixed incomes, frequently experience socio-economic challenges (Ehrle & Geen, 2002; Strozier & Krisman, 2007).

A report by the Annie E. Casey Foundation (2012) states that most immediate need of kinship families is for additional financial resources to pay for the added costs of caring for a child or children. As kinship caregivers are more likely to be poor or low income, older, less educated, and living on a fixed income, adding the expense of caring for one or several children poses a significant challenge to these families.

The literature shows that a lack of access to financial support for kinship care (such as TANF child-only grants) is a major obstacle to sufficiently providing for the needs of kinship children (Annie E. Casey Foundation, 2012; Ehrle & Geen, 2002; Strozier & Krisman, 2007; Wallace & Lee, 2013). The majority of kinship caregivers are not aware of and, therefore, not receiving financial support for which they are eligible (Annie E. Casey Foundation, 2012; Nelson, Gibson & Bauer, 2010). An Annie E. Casey (2012) report states that less than 12% of kinship families receive TANF child-only support, when nearly all of these children are eligible for this cash assistance. Similarly, Nelson, Gibson, and Bauer (2010) found that utilization rates of TANF-child only grants among eligible kinship youth were between
10% and 25%. In this current study, 16% \((n = 10)\) of caregivers received TANF child-only grants, according to state administrative data obtained from the Arizona Department of Economic Security (ADES) Family Assistance Administration (FAA). This underutilization of available financial resources among kinship families indicates a need for KN programs to strengthen cross-system collaborations with state child welfare, TANF, and other agencies, in order to provide families with greater information about and access to eligible resources.

Two of the overarching goals of the AKSS KN model was to enhance community-based and government responses for kinship families, ensuring they have access to benefits for which they are eligible. In analyzing ADES FAA administrative data on TANF child-only receipt for the entire AKSS caregiver population served (including the 63 who participated in the pre- and post-test study and the 4,783 caregivers who received basic IRC services and did not participate in the study) an indicator of systems change was observed over the three years of FCDG funding (LeCroy & Milligan Associates, 2015). Data from ADES FAA showed a statistically significant increase in AKSS kinship caregivers’ receipt of TANF child-only cash assistance on an annual basis: 6% \((n = 97)\) receiving TANF child-only in FY1 of FCDG funding; 12% \((n = 198)\) in FY2; and 20% \((n = 322)\) in FY3 of FCDG funding \((x^2 = 140.728; p = .000)\). This finding suggests that incorporating cross-agency collaboration and training as a “systems change component” of a KN service model may improve family awareness of and access to eligible benefits over time.

**Study Limitations and Recommendations for Future Research**

Several limitations in this research should be noted. This study is limited due to the small number of participants. Caregivers self-selected into service components and fidelity of treatment from one caregiver to another is highly variable based on caregiver need. This phenomenon
will impact the generalizability of the results. Future research on this study data should investigate individual service utilization components for informal and formal caregivers who use navigation and how service receipt impacts specific outcomes.

Additionally, this study did not have a comparison group or random assignment, so it is uncertain if the outcomes observed were caused by the intervention itself or other factors. Although the results indicate significant differences observed between pre- and posttests on several family needs items, these differences could possibly be attributed to extraneous variables that were not captured in absence of a comparison or control group. Additional research on KN program models is needed using a more rigorous study design, such as a randomized controlled trial or quasi-experimental comparison group to better understand the attribution of family outcomes to service receipt.

References


Supporting Kinship Caregivers: Examining the Impact of a Title IV-E Waiver Kinship Supports Intervention

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*Human Services Research Institute*

Justin Vollet  
*Human Services Research Institute*

This study examined the impact of a kinship supports intervention implemented in 16 children services agencies. Children placed with kin experienced greater stability, reached permanency more quickly, and were less likely to experience subsequent maltreatment or re-enter care than children placed in non-relative foster care. Furthermore, children receiving intervention services experienced shorter, more stable placements than children placed with kin in comparison counties. Policy and research implications are discussed.
Child welfare administrators across the United States are increasingly accepting kinship care as best practice, allowing children to be cared for by kinship caregivers whenever possible, thereby maintaining familial, cultural, and community connections. This shift in policy has been driven, in part, by an accumulation of research that has illuminated the many benefits of kinship care. Kinship caregivers provide children with a sense of family support (Iglehart, 1994) which, in addition to the familiarity and continuity offered by kin placements, may lessen the trauma a child experiences when placed in out-of-home (OOH) care (Ehrle & Geen, 2002). Evidence from a small but growing body of research also suggests that children placed in kinship care experience better outcomes in comparison to children placed in non-relative foster care (Bell & Romano, 2015; Winokur, Holtan, & Batchelder, 2015), including increased placement stability (Iglehart, 1994; Koh, 2010; Koh, Rolock, Cross, & Ehlen-Manning, 2014; Perry, Daly, & Kotler, 2012; Winokur, Crawford, Longobardi & Valentine, 2008), fewer subsequent allegations of abuse or neglect (Connell et al., 2009; Winokur et al., 2008), and fewer re-entries into OOH care (Koh & Testa, 2011).

While evidence of the benefits of kinship care has begun to accumulate, research has also shown that kinship caregivers typically have access to and receive fewer economic and social resources than non-relative foster parents, despite often being in greater need of these types of supportive services (Clyman et al., 1999; Cuddeback, 2004; Ehrle & Geen, 2002; Harden, Clyman, Kriebel & Lyons, 2004; Saki, Lin & Flores, 2011; Wallace & Lee, 2013; Webster, Barth, & Needell, 2000). In some cases, kinship caregivers may refuse supportive services; however, federal policies and funding streams also impact the types of supports child welfare agencies are able to provide to kinship families. For instance, within the traditional child welfare funding system, the large majority of federal funds are Title IV-E, designated for the support of licensed foster care, and only a fraction of federal dollars can be spent to support unlicensed kinship placements. IV-E funds operate as open-ended entitlements for eligible children, meaning
states receive unlimited reimbursements for every eligible claim submitted for foster care administrative and placement costs. While kinship caregivers may have the option of becoming licensed foster parents, licensing rules and regulations vary from state to state, and the requirements may deter kin from doing so, thus limiting the services and supports they are eligible to receive. The Fostering Connections to Success and Increasing Adoptions Act (2008) offered some improvements in the form of federal support for kin care, including the option for states to operate Title IV-E Guardianship Assistance Programs (GAP) and the establishment of grants to fund a limited number of Kinship Navigator Programs (KNP). However, criticisms of the federal child welfare financing system remain, including “…a lack of state flexibility in the use of federal funds, lack of (or perverse) fiscal incentives contrary to the overall goals of the child welfare system…and insufficient levels of funding for certain programs” (DeVooght & Cooper, 2012). Due in part to these funding policies, child welfare agencies are limited in their ability to create kinship support staff positions and in the funds they can use to assist kinship families.

Ohio’s IV-E Waiver Demonstration Kinship Supports Intervention

Ohio is one of 26 states participating in a Title IV-E Waiver Demonstration Project, which allows participating Public Children Services Agencies (PCSAs) in Ohio to use IV-E funds flexibly, with the goal of improving safety, permanency, and well-being outcomes. As a part of Ohio’s waiver demonstration, the 16 participating PCSAs implemented a kinship supports intervention (KSI), designed to promote kinship placement as best practice and increase attention to and support for kin placements, caregivers, and families. In Ohio, the large majority of child welfare-involved kinship placements are not licensed foster care settings, meaning most kinship caregivers are not eligible for the same services and supports that licensed foster parents receive.
This population includes both voluntary kinship cases (for which the state does not hold custody of the child) and unlicensed, public kinship care cases (for which the state holds custody of the child).\(^1\)\(^2\) Therefore, the KSI focuses on ensuring that the needs of unlicensed kinship caregivers are assessed, and that resources needed to support the children in their care are provided to these caregivers.

In each participating PCSA, a trained kinship coordinator with knowledge regarding best practice in supporting kin families serves as an expert resource within the PCSA. Prior to or at the time a child is placed in kin care, several kinship-specific tools are used to ensure that kinship caregivers can support the children in their care, and that services and supports are aligned with their needs. First, a kinship home assessment is used to assess the caregiver’s ability and willingness to ensure safety, permanence, and well-being for the child(ren) placed in his or her care. Second, a needs assessment is used to identify the services and supports the caregiver needs, and the strengths and resources of the kinship family. Third, a caregiver support plan is developed in accordance with the needs assessment, and the needs assessment is subsequently updated on a quarterly basis to ensure that services continue to address changes in needs over time.

The intervention represents an overlay to standard child welfare practice; the flexibility offered by the IV-E waiver allowed participating PCSAs to enhance their existing practice by using IV-E funds to train staff and create kinship specific positions. Furthermore, the flexibility also allowed PCSAs to utilize IV-E funds to provide kinship caregivers with services, financial assistance, and hard goods that would have typically only been available to licensed foster parents under the traditional IV-E funding approach.

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\(^1\) When kinship care is used in Ohio’s county-administered child welfare system, custody status is often indicative of county-specific policies rather than case-level characteristics. For this reason, these two populations were grouped together.

\(^2\) Unlicensed kinship foster care settings include households in which the caregiver is not a licensed foster parent, and therefore not eligible for daily foster care reimbursements; however, the state holds custody of the child and the household has undergone a homestudy process and been approved as a placement setting.
Evaluation Approach

The evaluation of Ohio’s KSI sought to understand the impact of the model on child safety, stability, and permanency outcomes. This was done in two steps. First, differences in outcomes between children placed with kin receiving the intervention and children placed in non-relative foster care in comparison counties were examined to understand differences in outcomes by placement setting type. Results from these analyses were expected to be consistent with prior research, finding that safety, stability, and permanency outcomes among children placed with kin would be more favorable or equivalent to comparison children placed in non-relative foster care. Second, the effect of the intervention itself was explored further by examining differences in outcomes between children placed with kin receiving intervention services and children placed with kin in comparison counties not implementing the intervention, to understand the impact of the intervention, specifically. It was expected that, with a comprehensive kinship supports practice in place, children placed with kin in counties implementing the intervention would experience more favorable outcomes in comparison to children placed with kin in counties not implementing the intervention and operating under the traditional IV-E funding approach. Therefore, the KSI focuses on ensuring that the needs of unlicensed voluntary and public kinship caregivers are assessed, and that resources needed to support the children in their care are provided to these caregivers.

Methods

For the present study, data were collected on 8,715 children placed in OOH care within 32 counties in Ohio. Of these 32 counties, 16 used flexible IV-E funds to implement the KSI and 16 were comparison counties that relied on traditional IV-E funding without a consistent set of kinship support practices. Two sets of analyses were conducted, each comparing a treatment group to one of two separate comparison groups.
The treatment group (TG) included 2,600 children placed in voluntary or public kinship care whose unlicensed caregivers received intervention services in one of the 16 counties operating under a title IV-E waiver. One comparison group included 2,365 children placed in non-relative foster care (CGF) across 16 comparison counties receiving traditional IV-E funds. The other comparison group included 3,750 children placed with unlicensed kin (CGK) across 16 comparison counties receiving traditional IV-E funds and not implementing the KSI. In general, unlicensed kinship households in CGK counties received less support and financial assistance compared to kinship households served in TG counties. Children were included in one of these three groups if at least 90% of their total OOH days were spent in a specific placement type (kin or non-relative foster care), and if their last or latest placement was in the specified placement type. Within all three groups, children were involved in open and ongoing child welfare cases and the placement was facilitated by the child welfare agency.

This study examined differences between the treatment group and each comparison group with respect to child safety, stability, and permanence. These outcomes included: rates of substantiated or indicated re-reports of child maltreatment, as a marker of safety; number of placement moves, as a marker of stability; and time in placement, re-entry into OOH care, and exit types, as markers of permanence.

Because this was a quasi-experimental design, steps were taken to strengthen the validity of the causal inferences from the findings. In order to approximate balanced equivalence between the treatment group and the two comparison groups, weighted propensity scores derived from a logistic regression model using a set of 43 covariates that may have alternatively explained group differences in outcomes were used. Balance statistics for a selection of these covariates are shown in Table 1. These covariates included child-level (e.g., child characteristics, prior involvement in child welfare, allegation information, etc.), family-level (e.g., adult characteristics, number of children in the home, history of domestic violence, etc.), and county-level variables (e.g., county size, type, etc.). Table 1 provides a selection of covariates used for matching purposes. Weighted propensity scores were
Table 1. Cross-Group Equivalence in a Selection of Propensity Score Weighted Covariates

<table>
<thead>
<tr>
<th></th>
<th>Treatment Group</th>
<th>Comparison Group (Foster)</th>
<th>Treatment Group</th>
<th>Comparison Group (Kinships)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(m)</td>
<td>(SD)</td>
<td>(m)</td>
<td>(SD)</td>
</tr>
<tr>
<td><strong>Child-Level Covariates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 years or younger</td>
<td>.34</td>
<td>.47</td>
<td>.34</td>
<td>.47</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>.19</td>
<td>.39</td>
<td>.19</td>
<td>.39</td>
</tr>
<tr>
<td>6 to 12 years</td>
<td>.30</td>
<td>.46</td>
<td>.28</td>
<td>.45</td>
</tr>
<tr>
<td>13 or older</td>
<td>.15</td>
<td>.36</td>
<td>.16</td>
<td>.37</td>
</tr>
<tr>
<td>Child Sex (Female)</td>
<td>.50</td>
<td>.50</td>
<td>.49</td>
<td>.50</td>
</tr>
<tr>
<td>Child Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>.19</td>
<td>.39</td>
<td>.18</td>
<td>.38</td>
</tr>
<tr>
<td>White</td>
<td>.69</td>
<td>.46</td>
<td>.72</td>
<td>.45</td>
</tr>
<tr>
<td>Other</td>
<td>.10</td>
<td>.30</td>
<td>.09</td>
<td>.29</td>
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<td>.14</td>
<td>.01</td>
<td>.10</td>
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<tr>
<td><strong>Allegation Type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medical Neglect</td>
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<td>.10</td>
<td>.01</td>
<td>.11</td>
</tr>
<tr>
<td>Neglect</td>
<td>.39</td>
<td>.49</td>
<td>.37</td>
<td>.48</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>.25</td>
<td>.43</td>
<td>.22</td>
<td>.42</td>
</tr>
<tr>
<td><strong>Case-Level Covariates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver Age</td>
<td>30.42</td>
<td>9.08</td>
<td>31.28</td>
<td>9.05</td>
</tr>
<tr>
<td>Two or More Children in Home</td>
<td>.62</td>
<td>.48</td>
<td>.60</td>
<td>.49</td>
</tr>
<tr>
<td><strong>Case Type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Abuse &amp; Neglect</td>
<td>.82</td>
<td>.39</td>
<td>.79</td>
<td>.41</td>
</tr>
<tr>
<td>Family in Need of Services</td>
<td>.05</td>
<td>.22</td>
<td>.07</td>
<td>.26</td>
</tr>
<tr>
<td>Dependency</td>
<td>.13</td>
<td>.34</td>
<td>.14</td>
<td>.35</td>
</tr>
<tr>
<td><strong>Risk and Family Assessment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Abuse History</td>
<td>.33</td>
<td>.47</td>
<td>.31</td>
<td>.46</td>
</tr>
<tr>
<td>Substance Abuse History</td>
<td>.48</td>
<td>.50</td>
<td>.45</td>
<td>.50</td>
</tr>
<tr>
<td>Physical Abuse History</td>
<td>.44</td>
<td>.50</td>
<td>.41</td>
<td>.49</td>
</tr>
<tr>
<td>History of Neglect</td>
<td>.53</td>
<td>.50</td>
<td>.50</td>
<td>.50</td>
</tr>
<tr>
<td>Severe Financial Difficulty</td>
<td>.25</td>
<td>.43</td>
<td>.28</td>
<td>.45</td>
</tr>
<tr>
<td><strong>County-Level Covariates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Population Size</td>
<td></td>
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<td></td>
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<tr>
<td>Metro County</td>
<td>.54</td>
<td>.50</td>
<td>.47</td>
<td>.50</td>
</tr>
<tr>
<td>Large</td>
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<tr>
<td>Medium</td>
<td>.13</td>
<td>.33</td>
<td>.13</td>
<td>.34</td>
</tr>
<tr>
<td>Small</td>
<td>.05</td>
<td>.22</td>
<td>.07</td>
<td>.26</td>
</tr>
</tbody>
</table>

**Notes:** Means and standard deviations shown are propensity score weighted. Categorical variables were dummy coded, and as such means of categorical variables are interpreted as percentages (e.g., across all groups, 34% of the data was on children 2 years or younger, adjusting for propensity score). For brevity, a sample of variables representative of the 43 covariates used to derive the propensity scores used in analyses are shown. For a complete report of between group balance, see (Human Services Research Institute, 2016).
computed separately for use in sets of analyses comparing TG and CGF and for sets of analyses comparing TG and CGK, and were included in analyses as control variables. Data for this study were collected from individual case records entered into Ohio’s Statewide Automated Child Welfare Information System (SACWIS). Data relating to OOH information on children comprising the three groups described above whose placements occurred between March 1, 2012 and April 31, 2015 were collected. In addition, data related to individual and case-level characteristics were collected for group balancing purposes.

Results

Child Safety & Stability

Re-Reports of Child Maltreatment During and After Placement

Child safety was assessed by examining the number of substantiated and indicated re-reports of abuse or neglect, both during and after placement in OOH care. Differences between treatment and each comparison group in the prevalence of substantiated and indicated re-reports were examined separately using logistic regression (Table 2). In each of these models, treatment group type was entered as a predictor of the occurrence of maltreatment, controlling for placement begin date and imbalance between groups as captured by the weighted propensity score. For analyses examining the relative odds of re-reports of maltreatment following discharge from placement, only data on children whose first placement episode had ended were used.

The rates of substantiated and indicated re-reported abuse or neglect during placement among children in the treatment and each comparison group were very low. While the rates of re-reports of maltreatment during OOH placement were lower among children placed with kin (TG and CGK; 2.5% and 2.1%, respectively) than children placed into non-relative foster care (CGF; 3.2%), these differences were not statistically significant (i.e. not distinguishable from no difference).
Table 2. Logistic Regression Results of Predicted Relative Odds of Re-Reports of Maltreatment

<table>
<thead>
<tr>
<th>During Placement</th>
<th>β</th>
<th>SE</th>
<th>Wald $X^2$</th>
<th>df</th>
<th>p</th>
<th>OR</th>
<th>d</th>
<th>Likelihood</th>
<th>Comparison Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 6 Months End of Placement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group (TG and Foster Comparison)</td>
<td>.25</td>
<td>.17</td>
<td>2.06</td>
<td>1</td>
<td>ns</td>
<td>1.28</td>
<td>2.5%</td>
<td>3.2%</td>
<td></td>
</tr>
<tr>
<td>Group (TG and Kin Comparison)</td>
<td>-.24</td>
<td>.17</td>
<td>1.84</td>
<td>1</td>
<td>ns</td>
<td>.79</td>
<td>2.5%</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Within 12 Months End of Placement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group (TG and Foster Comparison)</td>
<td>.59</td>
<td>.23</td>
<td>6.70</td>
<td>1</td>
<td>.01</td>
<td>1.81</td>
<td>.33</td>
<td>1.8%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Group (TG and Kin Comparison)</td>
<td>.02</td>
<td>.24</td>
<td>.04</td>
<td>1</td>
<td>ns</td>
<td>1.02</td>
<td>1.8%</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>Within 18 Months End of Placement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group (TG and Foster Comparison)</td>
<td>.36</td>
<td>.16</td>
<td>4.90</td>
<td>1</td>
<td>.03</td>
<td>1.43</td>
<td>.20</td>
<td>4.2%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Group (TG and Kin Comparison)</td>
<td>-.32</td>
<td>.17</td>
<td>3.68</td>
<td>1</td>
<td>ns</td>
<td>.73</td>
<td>4.2%</td>
<td>3.1%</td>
<td></td>
</tr>
</tbody>
</table>

Notes: For analyses examining re-reports of maltreatment during placement, the full samples were used. For analyses examining re-reports after the end of placement, only placements that had ended (n = 1,905 for TG; n = 1,373 for CGF; n = 2,586 for CGK). In each model, weighted propensity scores and placement begin dates were entered as control variables. The effect size (Cohen’s D) was calculated from the odds ratio, using the following formula (Chinn, 2000):

The rates of re-reports of abuse or neglect after discharge from placement among children in the treatment and in each comparison group were also very low. However, significant differences in the likelihood of re-reports of maltreatment within six, twelve, and eighteen months after discharge from placement were found between TG and CGF. Specifically, children in the treatment group were less likely than children in the non-relative foster care comparison group to experience abuse or neglect within 6 months (1.8% vs. 3.4%), 12 months (3.4% vs. 5.3%), and 18 months (4.2% vs. 6.3%) of discharge from placement.

Accounting for the control variables in the model, placement in the treatment group compared to non-relative foster care (TG vs. CGF)
significantly predicted the odds of re-reports of abuse and neglect within six, $X^2(1) = 6.70, p < .01$, twelve, $X^2(1) = 5.94, p < .05$, and eighteen months of discharge from placement, $X^2(1) = 4.90, p < .05$. The odds of re-reports of maltreatment for children placed in non-relative foster care (CGf) were greater than the odds for TG children supported by the KSI within six ($OR = 1.81$), twelve ($OR = 1.54$), and eighteen months ($OR = 1.43$). No significant differences were found between TG and CGk in the relative odds of reported maltreatment after discharge from placement.

Placement Stability

Differences in placement stability between the treatment and each comparison group were examined using ANCOVA (see Table 3). For these analyses, only children who had been discharged from care were included, and thus sample sizes were reduced. Weighted propensity scores were entered into each model as a covariate control variable. As such, means and standard deviations reported below are adjusted for this covariate.

The average mean-level difference between TG and CGf in number of placement moves was significant, $F(1, 3208) = 109.78, p < .001$. On average, children placed with kin served by the KSI experienced fewer placement moves ($m = .17, SD = .43$) than children in the non-relative foster care comparison group ($m = .39, SD = .74$). The mean-level difference between TG and CGk in number of placement moves was also significant, $F(1, 4476) = 43.59, p < .001$. On average, children placed with kin served by the KSI experienced fewer placement moves ($m = .16, SD = .42$) than children in the kinship comparison group ($m = .26, SD = .55$). Effect sizes for both sets of analyses were small ($d = .26$ and $.14$, respectively), according to conventionally applied rules of thumb (Cohen, 1992).

Overall, children in the treatment group experienced greater placement stability than children in the foster care and kinship comparison groups. Among children in the treatment group, 85% experienced no
Table 3. ANCOVA Results of Placement Stability Differences Between Groups

<table>
<thead>
<tr>
<th>TG and Comparison Foster</th>
<th>Treatment Group</th>
<th>Comparison Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>m</td>
</tr>
<tr>
<td>Number of Placement Moves</td>
<td>1805</td>
<td>.17</td>
</tr>
<tr>
<td>TG and Comparison Kinship</td>
<td>1805</td>
<td>.16</td>
</tr>
</tbody>
</table>

Note: These analyses included only placements that had ended (n = 1,805 for TG; n = 1,373 for CGF; n = 2,586 for CGK).

placement moves during their first placement episode. By comparison, 78% of children placed with kin not supported by the KSI and 73% of children placed in non-relative foster care in comparison counties experienced no placement moves during their first placement episode.

Permanency Outcomes

Time in Placement

Survival analysis was used to examine differences in time spent in OOH care between the treatment and each comparison group. Cox Proportional-Hazards models examined treatment group type as a predictor of “survival”—which, as used in this context, reflects continued OOH placement—adjusting for when the placement began and weighted propensity scores. Likelihood ratio tests indicated that treatment group type, the variable of interest, predicted time spent in placement in the model comparing TG and CGF, $X^2(1) = 85.14, p < .001$, and the model comparing TG and CGK, $X^2(1) = 27.92, p < .001$. As shown in Figure 1, discharge from placement occurred more quickly among TG children (280 median days in OOH placement$^3$), compared to CGF children (350 median days in OOH placement$^1$) and CGK children (325 median days in OOH placement$^3$).

$^3$ Median days in OOH placement are adjusted for imbalances between placement type groups captured by a weighted propensity score.
Figure 1. Differences Between Treatment and Comparison Groups in Time in Placement

Note: For analyses comparing TG to CGF, adjusted median time in OOH placement was 280 days among children in TG and 350 days among children in CGF. For analyses comparing TG to CGK, adjusted median time in OOH placement was 290 days among children in TG and 325 days among children in CGF.

Re-Entry into OOH Care

Logistic regression was used to examine differences in the odds of re-entering OOH care within 12 months of placement discharge between the treatment group and each comparison group (Table 4). For these analyses, only children who had been discharged from placement were included. Models were specified with treatment type group as a predictor of the likelihood of re-entry into OOH care, controlling for imbalance between groups as captured by weighted propensity score. Inclusion of treatment type and the weighted propensity score as predictors in the model comparing TG and CGF improved the predictive utility of the model ($X^2(2) = 28.70, \ p < .001$) over that of the constant-only model, suggesting that
Table 4. Logistic Regression Results of Predicted Relative Odds of Re-Entry into OOH Care

<table>
<thead>
<tr>
<th>During Placement</th>
<th>β</th>
<th>SE</th>
<th>X²</th>
<th>df</th>
<th>p</th>
<th>OR</th>
<th>d</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group (TG and Foster Comparison)</td>
<td>1.13</td>
<td>.37</td>
<td>11.22</td>
<td>1</td>
<td>.001</td>
<td>3.09</td>
<td>.07%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Weighted Propensity Score</td>
<td>-3.25</td>
<td>1.31</td>
<td>6.11</td>
<td>1</td>
<td>.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>-2.60</td>
<td>.91</td>
<td>8.17</td>
<td>1</td>
<td>.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group (TG and Kin Comparison)</td>
<td>-24</td>
<td>.17</td>
<td>1.84</td>
<td>1</td>
<td>ns</td>
<td>.79</td>
<td>.07%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Weighted Propensity Score</td>
<td>-53</td>
<td>.40</td>
<td>1.71</td>
<td>1</td>
<td>.19</td>
<td></td>
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</tr>
<tr>
<td>Constant</td>
<td>-4.40</td>
<td>.46</td>
<td>90.36</td>
<td>1</td>
<td>.001</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: For analyses examining re-reports of maltreatment during placement, the full samples were used. For analyses examining re-reports after the end of placement, only placements that had ended (n = 1,805 for TG; n = 1,373 for CGF; n = 2,586 for CGK). In each model, weighted propensity scores and placement begin dates were entered as control variables. The effect size (Cohen’s D) was calculated from the odds ratio, using the following formula (Chinn, 2000): Effect sizes are reported only where effects were significant.

Treatment type group, adjusting for imbalances between groups, predicted the likelihood of re-entering OOH care. Results indicated that treatment type was a significant predictor of the odds of re-entering care (Wald X²(1) = 11.22, p < .01), and that the re-entry odds for children in CGF were three times greater than the re-entry odds for children in TG.

In a separate model comparing TG to CGK, inclusion of treatment group type and the weighted propensity score as predictors did not improve the model’s predictive utility over that of the constant-only model (X²(2) = 2.58, p > .05), suggesting that treatment type group, adjusting for the weighted propensity score, did not distinguish between re-entering OOH care and not re-entering OOH care. Treatment type was not a significant predictor of the likelihood of re-entering care (Wald X²(1) = .000, p > .05), suggesting that children in TG were neither more nor less likely to re-enter OOH care than children in CGK.
### Table 5. Prevalence of Exit Types Among Matched Cases of Children in Foster Care and Kinship Care

<table>
<thead>
<tr>
<th>Exit Type</th>
<th>TG</th>
<th>CGF</th>
<th>CGK</th>
<th>TG/C GF Comparison</th>
<th>TG/C GK Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>X^2</td>
</tr>
<tr>
<td>Reunification</td>
<td>455</td>
<td>30.8</td>
<td>905</td>
<td>72.1</td>
<td>461.83*</td>
</tr>
<tr>
<td>Custody to Kin</td>
<td>940</td>
<td>63.7</td>
<td>163</td>
<td>13.0</td>
<td>725.02*</td>
</tr>
<tr>
<td>Custody to Third Party</td>
<td>1395</td>
<td>94.6</td>
<td>1068</td>
<td>85.1</td>
<td>69.01*</td>
</tr>
<tr>
<td>Adoption</td>
<td>45</td>
<td>3.1</td>
<td>98</td>
<td>7.8</td>
<td>30.92*</td>
</tr>
<tr>
<td>Emancipation</td>
<td>2</td>
<td>.1</td>
<td>33</td>
<td>2.6</td>
<td>33.32*</td>
</tr>
<tr>
<td>Other Exit</td>
<td>16</td>
<td>1.1</td>
<td>11</td>
<td>.9</td>
<td>18.09*</td>
</tr>
<tr>
<td>Unknown/Missing</td>
<td>330</td>
<td>18.3</td>
<td>118</td>
<td>8.6</td>
<td>60.44*</td>
</tr>
</tbody>
</table>

**Note:** Percentages for known exit types were calculated without including Unknown/Missing exit types. As a result, between 18% and 40% of exit type data was unknown or missing across the three groups. Results should therefore be interpreted with caution.

^1 An OR greater than 1 indicates a higher likelihood for TG children; an OR less than 1 indicates a lower likelihood for TG children. OR = 1 indicates no difference in likelihood between groups.

^2 Percentages for Unknown/Missing exit types were calculated using all data on placements that had ended.

**Exit Types**

Exit type rates among children who were discharged from placement were examined (Table 5). Many children had unknown or missing exit types, ranging from 18% to 40% across the three groups, and cases with missing exit data were omitted for the purposes of these analyses. Because dropping cases with missing data is warranted only when it can be assumed that the missing cases are a random subsample of all cases, results should accordingly be interpreted very cautiously. Among the available data and across the three groups, most children exited to kin (48.1%) or were reunified (43.4%). A small proportion exited to adoption (1%) or emancipation (2%).
Notable differences were found between TG and CG\textsubscript{F} in the prevalence of some exit types. Specifically, reunification was less likely among children in TG (31%) compared to children in CG\textsubscript{F} (72%), $X^2(1) = 461.83, \ p < .001$. However, exiting to kinship custody was more likely among children in TG (64%) compared to children in CG\textsubscript{F} (13%), $X^2(1) = 725.02, \ p < .001$. In fact, when parental reunification and custody to kinship caregivers were examined together, a higher likelihood of experiencing these more favorable permanency outcomes was found among children in TG (95%) compared to children in CG\textsubscript{F} (85%), $X^2(1) = 69.01, \ p < .001$.

No significant differences in the prevalence of any of the exit type categories were found between TG and CG\textsubscript{K}.

**Discussion**

This study examined the merits of a Kinship Supports Intervention, currently implemented in Ohio, which allows participating PCSAs to be better able to train staff and create kinship specific positions, and to utilize IV-E funds to provide unlicensed kinship caregivers with services, financial assistance, and hard goods that typically are only available to licensed foster parents under the traditional IV-E funding approach. Specifically, the study examined the benefits of the KSI in fostering safety, stability, and permanency outcomes among children served by the state’s county-administered child welfare system. Results suggest that use of kin care, broadly, and of the KSI, more specifically, was associated with better child outcomes.

Compared to children placed in non-relative foster care, children placed with unlicensed kin and whose caregivers received KSI services spent fewer days in placements, experienced greater placement stability, and were less likely once discharged from placement to re-experience maltreatment or re-enter care. These favorable outcomes support the growing body of evidence of the benefits of using kinship care. With regard to exit types; however, findings were mixed. Children placed with
kin in counties implementing the intervention were less likely to achieve reunification than children placed in non-relative foster care in comparison counties. However, they were more likely to achieve permanency with kin than their counterparts in foster care. While reunification is typically considered to be the most favorable exit type, permanency with kin may also represent a favorable exit type. Consequently, this may not necessarily be an unfavorable finding. This said, the differences in exit types observed between the placement groups raises questions. Some child welfare professionals believe that when children are placed with kin, parents may feel more comfortable than they would if their children were in non-relative foster care, and thus may not be as motivated to comply with child welfare requirements necessary to reunify with their children. It is also possible that, in cases where it became evident that reunification would not be possible, the trained intervention staff assisted caregivers through the process of gaining legal custody of the child. Interestingly, when reunification and custody to kin were combined, children in the treatment group were found to be more likely to experience these favorable outcomes than children placed in non-relative foster care in comparison counties. However, a substantial portion of exit type data were missing or unknown, so these results in general should be interpreted with caution. Given the mixed nature of findings from previous research on exit types (Koh, 2010), additional work examining more explicitly the reasons for the differences seen across studies is needed.

Analyses centered more narrowly on effects of the intervention found that children placed with KSI-supported kin experienced greater placement stability and less time in OOH care when compared to children placed with kin in comparison counties not implementing the intervention. While fewer differences were found in the kin-to-kin comparison, the differences that did emerge are consistent with the primary purpose of the intervention. The goal of the intervention is to ensure that caregivers have the resources they need to support kinship placements. Activities undertaken by the participating counties to achieve this goal (e.g., conducting assessments and support plans, and
working to increase resource availability for caregivers) are most likely to impact shorter-term outcomes. In particular, financial assistance for unlicensed caregivers who are not eligible for daily foster care reimbursements may be critical to maintaining kinship children in their homes, and thus increasing the stability of placements. Similarly, the resources the kinship staff are able to provide to unlicensed kinship families may be a primary factor in reaching permanence quickly, particularly in cases for which custody to kin becomes the permanency goal.

Taken together, these results support prior findings that have pointed to the benefits of kinship care over non-relative foster care (Bell & Romano, 2015; Winokur et al., 2015), and extend the evidence base by underscoring how some of these benefits may be further enhanced when targeted supports for kinship caregivers are in place and are well funded. However, limitations related to the data and the study design are present.

Ohio has a county-administered child welfare system and, while all counties are required to record placement information related to children for whom PCSAs hold custody, the extent to which placement information for non-custody placements is recorded in SACWIS varies among counties. However, due to varying kinship custody arrangements and data entry policies across the counties, limiting analyses to children in custody of the child welfare agencies presented its own set of problems. For this study, all available data on custody and non-custody unlicensed kinship placements were used. In an effort to account for differences among counties, information on data entry and custody arrangement policies were used as covariates in propensity score procedures. However, even with these measures taken, the extent to which data were missing may also have impacted findings.

Furthermore, because a randomized control design was not used, causal interpretations of these findings are somewhat limited. Although much effort went in to maximizing equivalence between comparison groups for all analyses, it cannot be determined with great confidence that either kinship in general, or the intervention specifically, caused...
improved child outcomes. While this certainly represents a significant limitation, the methods used in the present study to ensure near group equivalence have been recognized as being among the best available alternatives to RCT.

Presently, much variation exists from state to state related to kinship care practice and policies. The varying definitions and policies related to kinship care may impact both the quality of data and the comparability of data from state to state. As such, results from the current study may be limited in their generalizability across states. Future work examining the impact of kinship interventions would benefit from a broader, multi-state focus. Additionally, as noted by Ehrle and Geen (2002), previous studies have defined kinship care differently, making it difficult to draw concrete conclusions from the growing body of research. As this variation is still evident today, a synthesis of findings related to kinship definitions (as proposed in the Introduction to this volume) policies, and data-entry requirements would be advantageous in informing future kinship studies.

Despite limitations of the findings presented by this and other studies on kinship care, placement with kin, when appropriate, is widely considered best practice among child welfare professionals. While it is promising that the evidence base for these practices is expanding, especially when the increased rigor seen in more recent kinship studies is considered, more work is needed. There remains a need for research on the impact of kinship care in general and, perhaps more so, on the impact of kinship support interventions specifically. While this study has contributed to our understanding of the benefits of interventions designed to support kinship caregivers, additional work would be advantageous toward contributing to conversations around strengthening child welfare policy and practice that is in the best interest of children and families.
References


Much has been written about the tremendous risks faced by children who do not live with or who are not cared for by their parents. Similarly, existing literature warns of the less than optimal child outcomes associated with kinship care, given that caregivers themselves can be vulnerable because of their advanced age, health difficulties, lack of resources, and fragile living conditions. Still, research has demonstrated the beneficial effect of kinship care on children. However, little is known about what produces these observed positive effects. In this empirical analysis of kinship caregivers \((N = 747)\) and children \((N = 1301)\), researchers sought to determine the protective factors that mediate against risks and produce optimal levels of child well-being for children being cared for by kinship caregivers. Although the findings are preliminary, such aspects as low income, high stress, caring for children who have special needs, and caring for multiple children, long thought to place children at risk for poor outcomes while under the care of relatives, can be mediated by protective factors (e.g., readiness/capacity, childrearing/parenting skills, motivation/sustainability, and family involvement/support) that kinship caregivers may inherently possess. This finding supports a strengths-based orientation associated with the contextual distinctions of kinship care. Based on the findings, direct practice and clinical support strategies designed to assess and enhance caregivers’ protective factors are discussed. Moreover, policy and research implications are offered that can stimulate investigation of kinship care’s restorative benefit.
Children who live apart from their parents and are cared for by relatives often experience many risks that threaten their general well-being and can result in their experiencing poor developmental outcomes. Children who reside in kinship care are vulnerable to substance abuse, juvenile justice system involvement, mental health disorders, early pregnancy, and incomplete educational attainment (Denby, 2016). Moreover, other risk factors include economic and material disadvantage (Ehrle & Geen, 2002), compromised caregiver health (Harden, Clyman, Kriebel, & Lyons, 2004), limited educational stimulation, and supports (Guo & Harris, 2000), lack of a secondary caregiver (Font, 2014) and caregivers’ inadequate parenting capacity (Shlonsky & Berrick, 2001).

Although much is known about the risks that children face when living in kinship care, very little is known about the protective factors that families possess, which may mediate and potentially moderate those risks. According to Development Services Group and Child Welfare Information Gateway (2015), “protective factors are conditions or attributes of individuals, families, communities, or the larger society that, when present, promote well-being and reduce the risk for negative outcomes. These factors may mediate risk exposure and, importantly, may ‘buffer’ the effects of risk exposure by helping individuals and families negotiate difficult circumstances and fare better in school, work, and life” (p. 1). The protective attributes of individuals include a sense of self-efficacy, purpose, self-regulation skills, relational skills, problem-solving skills, and involvement in positive activities (Development Services Group and Child Welfare Information Gateway, 2015). The purpose of the study was to determine what, if any, are the caregiver protective factors that mediate risk factors and potentially moderate adversity and improve levels of child well-being for children being cared for by kinship caregivers.
Literature Review and Empirical Framework

Strengths Perspective and Family Resilience

A growing appreciation of extended familial bonds has broadened contemporary views of family life in American society, which include family configurations beyond the nuclear family. Kinship care has contributed to this expanded notion by demonstrating the major roles that grandparents, aunts, uncles, adult siblings, and other relatives play when custodial needs cannot be met by parents. When support services, training, and access to resources—both therapeutic and educational—are readily available, family members providing care for their young relatives are apt to feel empowered to do so. The belief that within each family’s ecosystem there are inherent strengths that explicitly and tacitly serve as pillars to undergird a member’s well-being is the very foundation of a strengths-based perspective. The strengths-based model mirrors social work values, including self-determination, empowerment, and the inherent worth and dignity of all people (Corcoran & Pillai, 2009; Cummins, Sevel, & Pedrick, 2006). As Saleebey (1996, 2008) and Weick, Rapp, Sullivan, and Kishardt (1989) remind us, all people have natural abilities, assets, and competencies to address their situations, no matter how dire or problematic their situations may look.

Everyday realities may place some prospective caregivers near the lower end of the socioeconomic ladder. Confidence in their motivation and capacity to parent, and the availability of support from other relatives, are critical to assessing their readiness to assume the valued role of kinship caregiver. Child-rearing patterns and parenting skills, for instance, differ depending on one’s cultural and socioenvironmental upbringing. Denby and Curtis (2013), Grant (2012), and Lin (2014) highlight the importance of the way workers probe and inquire about the needs, skills, and capacities of prospective caregivers. In assessing a kinship caregiver’s ability to parent, the child’s needs are best served by workers engaging in solution-focused questioning and respectful dialogue about parenting styles as a way to affirm the dignity of potential
providers. We must always believe in the competence of parenting capabilities and never negate areas of concern associated with the home certification stage should they arise (Adkison-Bradley, 2011; Denby, 2011).

**Kinship Caregivers’ Protective Capacities**

Researchers (Benard, 2006; Denby & Curtis, 2013; Newland, 2014) remind us that a focus on protective factors is a more effective approach to working with children and families than dwelling only on risk factors. A person benefits from the trust, love, support, and availability that he or she receives from caring relationships (Higgins, 1994). When caregivers and parents are provided an opportunity to participate in problem solving, they have the potential to flourish. McFarlane, Bellissimo, and Norman (1995) illustrated that it is parenting styles, not family structures, that aid in effective family functioning. When families are supported and their resilience is fostered, they are able to model such resilience to the children in their care (Benard, 2006).

**Method**

**Overview**

This study was conducted after expedited Institutional Review Board review and approval in collaboration between university-based researchers and a child welfare system-of-care team and stakeholders comprising caregivers, the public child welfare authority, a child and family advocacy group, and a number of private nonprofit and public child and family-serving agencies. The study was implemented under the U.S. Children’s Bureau Improving Child Welfare Outcomes through Systems of Care Initiatives, which funded nine federal demonstration projects. The study served as the needs assessment that was undertaken prior to the implementation of the multiyear, comprehensive service implementation in which smaller subsamples of families received an array of services and mentoring from peer caregivers.
The analysis presented in this study focuses on a subset of 747 caregivers and 1,301 children.

**Design and Data Collection**

Using survey research methods, caregivers self-reported their experiences using a 150-item questionnaire that they received through the U.S. mail. The survey and the data collection process were designed with strict adherence to Dillman’s Total Design Survey Method (TDM) (Dillman, Smyth, & Christian, 2008). The respondents were identified using the TANF payment and the foster care licensing data systems and were engaged over a seven-week period using initial hard-copy surveys, reminder postcards, and follow-up surveys. The survey respondents were provided a $25 gift card. At the end of the seven-week period, we obtained a 70% response rate. The good response rate reflects the engagement of multiple stakeholders in the project, including kinship caregivers, voluntary family organizations, local authorities, and state child welfare officials.

**Sample**

The study advisory team worked together to define the target sample, finalize the variables of interest, and disseminate the tool. Of interest to the advisory team was a strong desire to learn about the perceptions and experiences of a host of different caregivers. The sample was comprised of caregivers who were providing care voluntarily (children with a history of child protective services involvement but not currently in state custody) and publicly (licensed or unlicensed foster caregivers). Additionally, a portion of the sample included permanent kinship caregivers whose legal relationship to the children was formalized by a court (e.g., adoption or legal guardianship). Finally, some of the caregivers fell into what this volume terms private kinship care, and in the case of this sample, this category of caregivers had no current formal child and
family-serving system involvement. Some were *in loco parentis* placements or informal guardianship arrangements made privately between birth parents and relatives. The study sample excluded any caregiver who had not provided care for at least 6 months.

**Operationalization of Variables**

**Well-Being**

We asked the caregiver to rate the child in the following categories: living adjustments; physical and primary health; mental and behavioral health; school performance; neighborhood and peer experiences and interactions; and involvement with their biological parent.

**Risks**

Risk factors included: high school education or less; annual income less than $20,000; receipt of Supplementary Security Income (SSI) for the child; caregiver stress and strain scale; low levels of family involvement and social support; residing in government assisted housing; child has special needs such as medical problems, emotional/behavioral problems, born drug addicted; caring for multiple related children; caregiver age; and caregiver marital status.

**Mediating Variables**

Three main mediating variables were of interest in this analysis, as discussed in Denby (2011):

- **Motivation and sustainability**: this measure assesses the reasons why caregivers originally assumed care of the children and those conditions that compel them to continue caring.

- **Childrearing and parenting ability**: this measure assesses caregivers’ parenting values and beliefs and investigates the caregiver’s sense of attachment to the child and sense of caregiving efficacy.
Caregiver readiness/capacity: This measure assesses caregiver preparedness with questions pertaining to the caregiver’s health, patience, and level of involvement with the children in their care. It also measures the caregiver’s ability to deal with the children’s special needs and their involvement with child welfare agency activities. Finally, this measure positions caregivers to evaluate the extent to which they are effective in their role.

**Instrumentation**

As described in Denby (2011), the Kinship in Nevada (KIN) tool is a 150-item Likert scale designed to measure caregivers’ perceptions and experiences. Most of the items contained in the 11 subscales provide respondents with five choices: all of the time (scale rating of 1); most of the time (scale rating of 2); sometimes (scale rating of 3); never (scale rating of 4); or NA. The subscales include Reasons for Caring for Relative’s Children; Caregiver Motivation and Sustaining Factors Scale (CMSF); Caregiver Perceptions and Experiences Scale (CPE); Service Needs and Community Resources; Caregiver’s Perception of Children’s Needs and Well-being; Childrearing Experiences; Caregiver Readiness and Capacity Scale; Family Involvement and Social Support Scale; Caregiver Strain Scale; Permanency Intentions; and Caregiver, Child, and Family Characteristics.

The KIN tool was developed using an extensive multi-phased approach beginning with qualitative techniques and ultimately resulting in a quantitative pilot study. The study’s advisory panel oversaw the construction of the tool and participated in validity testing along with a sample of caregivers. Reliability checks were performed using a test-retest and split-half testing approach, resulting in Cronbach alpha scores ranging from .82 to .94.

**Data Analysis**

The following steps were taken to analyze the data: First, we regressed Caregiver’s Perception of Children’s Needs and Well-being Scale
against each of the nine risk factors separately to estimate bivariate associations. Next, we estimated partial regression coefficients for all the variables with statistically significant bivariate associations in order to identify those risk factors that no longer remained statistically significant when all other risk factors were held constant. We repeated the same steps for the mediator variables. The two models were combined to examine the degree to which the influence of the risk factors were mediated or “explained” by the mediator variables. The mediating variables that remained statistically significant in the combined model were regressed against the risk factors in order to estimate direct effects and indirect effects on child well-being. Finally, we tested for interaction effects between the risk factors and mediating variables in order to discover whether the direction and strength of the relationship between well-being and the risk factors were moderated by any of the protective factors.

Findings

Sample Sociodemographic Characteristics

Caregiver Characteristics

A statewide sample was drawn from a large state situated in the southwestern region of the United States. This sample largely comprised non-married (65%), urban-area dwellers (91%), female caregivers (90%) of color (60%) with an average age of 54 who described themselves as the grandparent (68%) to the child in their care. Nearly half (47%) of the caregivers were employed, and just over half of them (52%) had annual incomes ranging from $10,000–$30,000. About 58% of the sample lived with family or friends, rented their residence, or were using government assistance for housing. Thirty-six percent (36%) of the sample had a high school diploma (or equivalent) and another 36% had attended college. In terms of caregiver status, there
were six possible categories that respondents could select: (a) child welfare system placement/custody (licensed caregiver); (b) child welfare system placement/custody (unlicensed caregiver); (c) Temporary Assistance to Needy Families – TANF system (Non-needy Caretaker Program); (d) TANF system (TANF program for grandparents 62+); (e) community-at-large (no current affiliation w/formal systems; some w/adoption and some informal guardians); and (f) legal guardian (private arrangement made between caregiver and the child’s biological parents, no child welfare involvement, and no TANF). About half of the sampled caregivers were caring for only one child. More than half of the respondents derived from the sampling frame obtained from the TANF Non-needy Caretaker Program. The child welfare system–involved caregivers (licensed or unlicensed) composed about 17% of the sample. Similarly, another 16% of the sample described themselves as private families having no involvement with any public system, but only 6% of the private subsample had legal guardianship in place.

Child Characteristics

About half of the sample of children were described by the caregivers as having at least one special need. The average age of the children being cared for was 9.23 years, and they had been in the care of the person studied for an average of 4.72 years. Gender was nearly evenly split and nearly half (49%) of the sample of children were described as having only intermittent contact with their biological parents. The caregivers selected multiple options when describing the financial means they used to provide for the children in their care. Most notably, the children’s income was a combination of TANF assistance and Supplemental Nutrition Assistance Program–SNAP (food stamps).

\[1\] At the time of this study, there was a stipend program administered through Nevada State Welfare that utilized TANF funds to support caregivers, but the program imposed an age stipulation for eligibility and the caregivers had to show proof of legal guardianship. Also, at the time of the analysis, the Guardianship Assistance Program (GAP) had not been implemented.
### Table 1. Ordinary Least Squares (OLS) Regression Coefficients

<table>
<thead>
<tr>
<th></th>
<th>Caregiver Perception of Child Well-being</th>
<th>Child Rearing &amp; Parenting Ability</th>
<th>Caregiver Readiness/ Capacity</th>
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</thead>
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<tr>
<td></td>
<td>Bivariate Association</td>
<td>Model 1</td>
<td>Model 2</td>
</tr>
<tr>
<td>Education: HS or less</td>
<td>ns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Income: Under $20,000</td>
<td>.082**</td>
<td>.057*</td>
<td>ns</td>
</tr>
<tr>
<td>Low family Involvement Scale</td>
<td>-.105**</td>
<td>Ns</td>
<td></td>
</tr>
<tr>
<td>Not married</td>
<td>ns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government Assisted Housing</td>
<td>ns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Special Needs</td>
<td>-.353**</td>
<td>-.250**</td>
<td>-.238**</td>
</tr>
<tr>
<td>Number of related children</td>
<td>-.051**</td>
<td>Ns</td>
<td></td>
</tr>
<tr>
<td>Receiving SSI</td>
<td>-.268**</td>
<td>-.155**</td>
<td>-.148**</td>
</tr>
<tr>
<td>Caregiver Age</td>
<td>ns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress/Strain Scale</td>
<td>-.359**</td>
<td>-.280**</td>
<td>-.214**</td>
</tr>
<tr>
<td>Caregiver Readiness/Capacity</td>
<td>.292**</td>
<td>.146**</td>
<td>ns</td>
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<tr>
<td>Childrearing and Parenting Ability</td>
<td>.413**</td>
<td>.323**</td>
<td>.217**</td>
</tr>
<tr>
<td>Motivation and Sustainability</td>
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<td></td>
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<tr>
<td>R squared</td>
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<td>.190</td>
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<tr>
<td>N</td>
<td></td>
<td>564-641</td>
<td>476</td>
</tr>
</tbody>
</table>

**p < .01 *p < .05

*N varies due to differing amounts of missing data. The Ns for the different models based on list-wise deletion of missing data.

### Risk Factors for Caregiver Perceptions of Child Well-Being: Bivariate Associations

We first note that neither gender nor ethnicity were associated with levels of child well-being and hence will not be considered as predictors in the results reported hereafter. Also, there were no significant bivariate associations between child well-being scores and caregiver’s educational attainment, marital status, housing arrangements, and age (see Table 1, bivariate association). Six of the hypothesized risk
factors accounted for variation among children perceived to have higher well-being versus those whose were perceived as faring less well: (1) income less than $20,000, (2) caregivers’ level of stress and strain, (3) low involvement of extended family members in the care of the children, (4) child special needs, (5) the caregivers’ responsibility to provide care for more than one related child, and (6) the receipt of SSI for the child.

The results were mostly consistent with expected patterns with the exception of one category: there were more low-income caregivers ($20,000 or less) than expected by chance who rated their children higher in well-being than higher income families \( (b = .082, \ p < .05) \). Other patterns of association were in line with prior expectations. Perceptions of child well-being were negatively associated with caregiver stress/strain \( (b = -.359, \ p < .01) \). Caregivers with weaker levels of family involvement and support were less likely to perceive their children as doing well compared to caregivers with stronger levels. Children with special needs (medical problems, emotional/behavioral problems, or born drug addicted) were also rated lower in well-being than children without these special needs \( (b = -.353, \ p < .01) \). There also was a statistically significant negative association between child well-being scores and each additional child being cared for by the relative \( (b = -.051, \ p = .01) \). Further, children who were receiving SSI were assessed by their caregivers as faring less well than children who were not receiving this form of public assistance.

**Partial Regression Coefficients**

The correlational nature of these data cautions against drawing any firm inferences about the cumulative effects of each of the above risk factors on child well-being. Even though it is plausible to infer that caregiver stress/strain, child special needs, or caring for multiple children, among other factors, adversely affect not only caregiver perceptions but also the well-being of the child directly, it is equally
plausible that some of these associations are spurious or an epiphe-
nomenon of the effects of other risk factors on well-being. The partial
regression coefficients listed under Model 1 in Table 1 provide estimates
of the effect of changing each factor by one unit holding constant all the
remaining factors in the model. The partial effects of the number of
related children and low family involvement and support diminish to
statistical insignificance, leaving four factors that account cumulatively
for almost 40% of the variation in caregiver perceptions: low income,
child special needs, SSI receipt, and caregiver strain/stress.

**Mediating Variables: Association with
Child Well-Being Subscale**

The bivariate results and the partial regression coefficients from
regressing well-being on the three mediating variables are also reported
in Table 1. Each of the three factors was statistically significant pre-
dictors of well-being in the bivariate analysis, but only two retained
their significance when considered simultaneously in multiple regres-
sion analysis: caregiver readiness/capacity and childrearing and par-
tenting ability. The motivation and sustainability measure is co-linear
with these other hypothesized mediators and explains a negligible
amount of the remaining variation after the effects of the other two
are taken into account. Both of the significant mediators are posi-
tively associated with caregiver perceptions of child well-being. The
stronger the caregiver’s sense of attachment to the child and sense
of caregiving efficacy is, the higher the caregiver rates the child’s
well-being (b = .323, \( p < .001 \)). In addition, the greater are the pre-
paredness and capacity of the caregiver to manage the child’s special
needs and involvement with the child welfare system, the higher
the child is scored on well-being measures (b = .146, \( p < .001 \)). In
both cases, childrearing and parenting ability and caregiver readiness/
capacity appear to function as protective factors in reinforcing care-
givers’ perceptions of the well-being of the children.

Mediating Effects of Protective Factors

The goal of mediation analysis is to establish the extent to which each of the putative risk factors influences caregivers’ perceptions of child well-being through one of more of the protective factors. For example, Model 1 indicates that children with special needs who also received SSI are rated .455 points lower by their caregivers on the well-being scale, holding other risk factors constant, compared to children without special needs and not receiving SSI. Perhaps these risk factors adversely affect perceptions directly; or perhaps the effects are indirect by taking a toll on the caregiver’s sense of attachment to the child and sense of caregiving efficacy. The extent to which risk factors operate directly or indirectly through protective factors can be estimated by combining Models 1 and 2 into a combined multiple regression Model 3 (see Table 1). The addition of the two significant factors from Model 2 into Model 1 boosts the explained variation in well-being scores from 38.5% to 42.9%, but most of the increase in explanatory power comes from the addition of the childrearing and parenting ability subscale. The independent influence of caregiver readiness/capacity becomes statistically negligible once its collinearity with other risk and protective factors are taken into account.

Even though childrearing and parenting ability only slightly mediates the risks of special needs and SSI, it partially mediates the influence of the stress/strain subscale and totally explains away the anomalous association of low income with high child well-being. These results are reinforced by the estimates reported under Model 4, which regresses the childrearing and parenting ability subscale against the risk factors specified in Model 3 (see Table 1). As expected from comparing the coefficients from Model 1 to Model 3, special needs and SSI are unrelated to ability. On the other hand, low income and high stress/strain are significantly associated with childrearing and parenting ability but in opposite direction. Whereas higher strain/stress weakens ability, low income is associated with a stronger sense of attachment to the child and caregiving efficacy ($b = .065, p < .05$), which helps explain why the bivariate association between income and well-being was in the unexpected direction.
**Moderated Mediation Analysis of the Effects of Risk and Protective Factors on Well-Being**

The final step of the analysis assesses whether the size or sign of the effects of risk factors is moderated in one way or another (“interacts with”) by any of the other hypothesized risk or protective factors. We have already shown that childrearing and parenting ability partially mediates the effects of income and caregiver stress/strain on well-being. Next, we estimated a series of models in which the direct effect of an index of significant risk factors (stress/strain, child special needs, SSI receipt) and their indirect effects through parenting ability is moderated by or conditioned on one of more of the hypothesized risk or protective factors that were not significant predictors in Model 3. These include: caregiver readiness/capacity, motivation/sustainability, high school education or less, annual income less than $20,000, level of family involvement and social support; residing in government assisted housing; caring for multiple related children; caregiver age; and caregiver marital status.

These analyses were conducted efficiently using the PROCESS macro developed by Hayes (2013), which provides estimates of direct and indirect effects as well as “bootstrap” confidence intervals to help assess whether the point estimates deviate far enough from zero to rule out “chance” as an alternative explanation. Figure 1 illustrates the moderated mediation model that was estimated. The risk index is a simple sum of the dichotomized (0,1) variables for each of the significant risk factors listed under Model 3 in Table 1: child special needs, SSI, and high stress/strain scored 3 or higher. As shown in Figure 1, the bivariate association between the risk index and well-being is statistically significant \((b = c = -.258, r = -.490, p < .01)\). After the childrearing and parenting subscale was included in the model, the direct effect reduced to \((b = c' = -.221, p < .01)\). The indirect effect of the risk index through the mediating variable of child rearing and parenting ability can be estimated by multiplying the partial regression coefficients...
coefficients along paths a and b (ab = -.112 * .326 = -.037). The bootstrap confidence interval for the indirect effect of the risk index on well-being is -.055 to -.024, which is far enough from zero to rule out chance occurrence. Adding the direct effect of the risk index to its indirect effect through parenting ability (-.221 + -.037 = -.258) recovers the bivariate association (c = -.258) shown in Figure 1. Approximately 14% of the bivariate association between the risk index and child well-being is explained by its indirect negative influence on parenting ability. In other words, greater levels of risk are associated with a weakened sense of attachment and caregiving efficacy, which in turn is associated with lower assessments of child well-being compared to conditions of lesser risk.

Figure 1. Moderated Mediation Model of the Direct and Indirect Effects of Risk Index on Child Well-being
In order to examine whether any of the direct and indirect effects of the mediation model are moderated by other measured protective and risk factors, separate moderated mediation models were estimated, which substituted at each iteration a different variable as a potential moderator. With multiple tests, however, one of more interaction effects can exceed statistical thresholds of significance simply by chance. Therefore, we started with the protective factors that were hypothesized to act as “buffers” and then proceeded to test the interactions for the other risk factors in the order they appear in Table 1. It should be noted beforehand that the association between the risk index and well-being was not contingent on the level of parenting ability.

Considering first the protective factors of caregiver readiness/capacity and motivation/sustainability, there were no interaction effects for the former but the later moderated the indirect effect of parenting ability on well-being (path b in Figure 1). Caregivers with weaker levels of motivation and sustainability rated child well-being much lower than caregivers with higher levels but the gap narrowed considerably at the upper reaches of parenting ability. The adverse effects of low motivation on perceptions of child well-being weaken at the higher levels of parenting ability.

Testing moderation effects separately for each of the risk factors in the order listed in Table 1 showed no significant interactions for less than a high school education or income under $20,000. But the measure of family involvement and support did exhibit a significant interaction along the direct path from risk index to child well-being (path c’ in Figure 1). Higher risk caregiving conditions were associated with lower ratings of child well-being, but the strength of the relationship weakened when there was higher levels of family involvement. Caregivers in situations of high risk perceive the child as doing better when extended family is more involved. Lastly marital status appears to moderate the negative effect of high risk on childrearing and parenting abilities. The negative relationship between risk and parenting ability is weaker among never married, divorced, and widowed caregivers than
married couples. Married caregivers voice a diminished sense of attachment and caregiving efficacy compared to unmarried caregivers at the higher risk levels of caring for children.

Discussion

Kinship caregivers who perceived the well-being of their children as high followed mostly expected patterns with the exception of the income category. We found that those children thought to be doing well were the ones whose caregivers reported low levels of stress and strain. Likewise, children residing in kinship care have higher levels of well-being when they do not have special needs and are not receiving SSI income assistance. This is consistent with Backhouse and Graham’s (2012) study that found physical and emotional problems experienced by children exerted a tremendous bearing on caregivers’ experiences in caring for them.

An unexpected finding in this study is the existence of high child well-being among low-income caregivers. We did not anticipate that children residing in households with annual incomes of less than $20,000 would be perceived by their caregivers to be faring well and experiencing functional health, mental health, behavioral conditions, and positive peer interactions in school and their neighborhood. When compensating protective factors were considered, however, it was found that the anomalous income effect was explained away by the higher levels of attachment to the child and sense of caregiver efficacy. Perhaps this finding is best understood using Moos and Moos’s (1994) theory that the family environment should be viewed as it is (real), as it would be in a perfect situation (ideal) and as it can potentially be (expected). Despite the hardships, limited financial resources might elicit compensatory feelings of attachment and strengthen confidence in parenting ability, which not only influence perceptions of the child’s behavior but also possibly affect it directly by conveying to the child that he or she is cared for and loved. Monetary means may be less consequential for child well-being than a strong commitment to the child’s healthy growth and development.
Another key finding is that the risk factor of caregiver stress/strain in influencing perceptions of child well-being is partially mediated by the caregivers’ childrearing and parenting skills. Child special needs, and SSI receipt are factors that affect perceptions directly. The indirect effect of these risks on child well-being through parenting ability is moderated by the marital status of the caregiver and caregiver motivation and sustainability. At higher levels of risk, unmarried parents retained a greater sense of attachment and parenting efficacy than married caregivers in the same circumstances. Likewise the indirect effect on well-being through the mediating influence of attachment and parenting efficacy appears to be moderated by motivation and sustainability. Caregivers with weaker levels of motivation and sustainability rated child well-being much lower than caregivers with higher levels but the gap narrowed considerably at the higher levels of attachment and parenting ability. Lastly, we found that the direct effect of risk factors on well-being is moderated by the degree of extended family involvement in the care of the child. The negative association between well-being perceptions and risk is buffered by the level of extended family involvement and support. Caregivers in situations of high risk perceived the child as doing better than what would normally be expected when the extended family was more closely involved in the care and support of the child. Other researchers’ studies corroborate these findings. For example, Inchaourondo and colleagues (2015) investigated the protective factors associated with kinship care and found that the level of formal and informal support that the caregivers received helped them overcome difficulties and become strengthened.

Even though the challenges posed by conditions of risk for children’s healthy growth and development must not be underestimated, it is also true that high levels of childrearing/parenting ability and high levels of family involvement and support can help compensate for these risk factors. Taken together, these findings suggests that those kinship families faced with tremendous stress and strain and living with very minimal financial resources still can shape children’s well-being in a positive manner especially when family and social support is available and caregivers possess high levels of ability and capacity. These findings, coupled with
other authors’ research—for example, Harnett, Dawe, and Russell (2012) who found that practical and emotional support given to caregivers is both desired and highly valuable in the care of children—direct attention to the need for us to consider the restorative effect of a caregiver’s inherent protective factors.

**Limitations**

In this study, caregivers self-reported their experiences and perceptions and assessed the children’s well-being. The difficulties associated with self-reported studies are applicable here. Mainly, the most important limitation and one that may be influencing the study findings is that of social desirability. A majority of the respondents in this study were participants in the TANF Non-needy Caretaker Program, and despite assurances of confidentiality, it is probable that some of the caregivers may have felt that their information could be shared with the welfare authority from which they received benefits or the public child welfare authority. Consequently, caregivers may have been prompted to inflate their sense of well-being and that of the children in their care.

As described by Steenkamp, de Jong, and Baumgartner (2009), we designed our study in such a way as to minimize the presence of socially desirable responses from the caregivers. We attempted to minimize social desirability through our data collection methods and the choice of wording in the questionnaire; for example, we explained in writing that no one outside of the university’s research team would have access to their data. Likewise, we informed the caregivers that their personal identifiers would not be linked to their responses. We were careful to use neutral language in scale construction, thus assuring the respondents that there were no “right” or “wrong” answers to the survey questions. Finally, despite concerns over limitations over self-administered surveys, we opted for the self-administered tool to ensure privacy.

Additionally, the sample in this study is disproportionately composed of caregivers who did not have an open child welfare case at the time
of data collection. We suspect that although many of the children in the care of relatives who received support from the TANF Non-needy Caretaker Program did not necessarily have an open child welfare case, many of them were caring for children for whom there had been an allegation in the past of maltreatment. We did not determine the proportion of cases that had been diverted from formal kinship care, placement facilitated by child welfare, referred to TANF for assistance, and then the case closed. Although knowing that would not have given us definitive answers about risks, it would have aided our determination about the extent to which the large presence of non-child welfare TANF Non-needy caretaker sample may account for the higher levels of well-being observed in this sample. Indeed, researchers have noted that a significant number of kinship families in need of services and support are diverted away from foster care and into informal kinship care (Wallace & Lee, 2013).

Aside from the two main limitations—the self-administered survey process and the disproportionately high number of TANF Non-needy caretakers—the data presented here are of a cross-sectional nature and only report the experiences of a cohort of caregivers solely on a point in time experience. Therefore, readers should be mindful of the fact that we are limited in our ability to draw causal inferences.

Implications and Conclusions

Several important implications are readily identifiable in these data results. These implications pertain to practice at the micro and macro levels.

Micro Implications

First, at the micro level, these data suggest that kinship families should be viewed in a favorable light. We must consider the entirety of a family’s experiences and in doing so, move beyond a deficit-oriented perspective. Our definitions and assessments of kinship families should be based
on a shared and common vision in which they are valued and perceived based on their protective capacities and not risks. Shifting our view of kinship families to a more strengths-based perspective is closely aligned with social work values and ethics.

Second, in devising appropriate clinical interventions and supports, we must work to enhance and expand kinship caregivers’ protective capacities. Given that the data reported here suggest that caregiver readiness and capacity mediate stress and strain, and high childrearing and parenting skills mediate the effects of low income, we must expand interventions and supports targeting these areas. Case manager and clinician training should emphasize the therapeutic and “restorative” effect that kinship care seems to have on children, as it may be an important ingredient in promoting functionality and child well-being. Likewise, training for the professionals who work with kinship families should emphasize the importance of viewing the “client” as both the primary and the extended family. We must optimize the family environment (which includes extended family members), especially in the case of those caregivers who are caring for more than one child or for those providing care for children who have special needs. Practitioners should be trained to be inclusive and to appreciate the plausibility that there is restorative value in kinship care. Finally, the use of peers or kinship liaison (Denby, 2011) can be a tremendous support to families and a way to augment formal intervention.

**Macro Implications**

At least two macro implications can be gleaned from this study. First, in order for us to truly understand the restorative effect of using protective capacities and how doing so supports child well-being, we must be able to study the issues in a more rigorous and structured manner. In this study, we were challenged to recruit an adequate and equal representation of all caregiver types. This challenge implies that in order for future research to be more instructive, we must have robust tracking and
monitoring systems so that we can identify kinship families and collect data about and in support of them. Future research should seek to determine if the protective factors identified here are present in all caregiver families and equally effective in increasing child well-being no matter the type and level of risks that children and caregivers face.

Second, this study sheds light on how funding can be used to support kinship care families. These data show that for low-income kinship families, high levels of childrearing and parenting skills are especially important in order to cultivate child well-being. Although there has been some progress made in getting support (e.g., TANF Non-needy Caretaker Program, Guardianship Assistance Program [GAP]) for kinship families, a significant portion of these families still require monetary support, particularly those who are not eligible for or do not desire to access the funding streams currently available. Given the restorative value, therapeutic benefit, and preventative nature of kinship care, and its positive effect on children’s well-being, we should pursue more targeted strategies to expand Title IV-E and Medicaid funding to reimburse caregivers for the vital service they are providing. The expansion of Medicaid to provide reimbursement to caregivers would reach a variety of kinship caregiver types, going beyond just those engaged with formal child and family-serving systems. Additionally, the Quality Parenting Initiative (QPI) that is being used by child welfare authorities across the nation recognizes the importance of promoting parenting excellence, and it could be a springboard for the manner in which we reshape the perception of kinship care. Kinship caregivers’ investment in becoming trained in parenting and their care of their relatives’ children should be valued and then reimbursed in a commensurate fashion.

A stronghold of child welfare practice has been its emphasis on a strengths-based perspective. Rather than focusing on individual or familial deficiencies, a strengths-based orientation affirms promise over pathology and resilience over deviance. Likewise, a strengths perspective is appropriate for accentuating the crucial role protective
factors serve in the lives of children and the kin who provide care to them. A futuristic focus is represented through a strengths perspective, building on individual and familial competencies already in existence (Johnson & Yanca, 2010). While achievement of new skills is valued, understanding the totality of one’s existing skill set and how it can be utilized for the greater good is important. A strengths model embraces exploration of support systems and promotes the worthiness of extended family involvement in kinship care.

References


New Directions for Kinship Care Policy and Practice: A Position Paper from the Kinship Summit at Albany, New York, September 2016

Collaborative partnerships are a major factor in achieving positive outcomes for children, youth, and families. They can lead to a common and unified understanding of the needs of children, youth, and families; identification of gaps in services and supports; and coordinated efforts to address those gaps across child welfare and other human and social services. While it is recognized that progress has been made in developing policy and defining standards of practice related to supporting kinship families, there remains a need for continuous assessment of current policy and practice and future directions for enhancing outcomes.

University at Albany, New York State Kinship Navigator, and the Child Welfare League of America (CWLA) formed a collaborative partnership to plan and host a Kinship Care Summit in Albany, New York in September 2016.1 The Summit included presentations by authors of kinship manuscripts that were accepted for this special issue. Building on the information shared by authors and reactors to the presentations, the latter half of the Summit was devoted to an examination of selected current kinship care issues. Summit participants worked in groups to discuss the issues and develop recommendations for the future. The focus was on all kinship families—those in which child welfare is involved, and particularly those without child welfare involvement.

1 On September 21-23, 2016, participants met on the University at Albany, State University of New York campus. The event coincided with Kinship Care Month, which is celebrated in New York and seven other states.
The remainder of this paper presents the seven selected issues and related recommendations developed by the participant work groups:

1. Continuity and permanence of kinship care.
2. Child welfare engagement with kinship caregivers.
3. Barriers to transition into public kinship care.
4. Utilization of Voluntary Placement Agreements.
5. Temporary Assistance to Needy Families (TANF) child-only grants, adoption and guardianship financial supports.
7. Kinship care research.
There are many important issues related to kinship care policy and practice, that can be considered from many perspectives. This paper represents one perspective for the reader’s consideration.

**Shared Kinship Care Philosophy and Values**

The Summit Work Groups shared a common kinship care philosophy and set of values as a starting point for their discussions on the seven selected kinship care issues. The philosophy and values were centered around understanding the history of kinship care as a child welfare program and service, and principles outlined in the 2000 Report to Congress (U.S. Department of Health and Human Services, 2000) that address kinship as a means of achieving child and youth safety, well-being, and permanence. It was acknowledged that much progress has been made in recognizing the importance of kinship relationships as sources of family and child support, a focus of improved policy and practice, and the subject of research over the past 20 years. The goal of the discussions was to develop recommendations that can enhance kinship care policy, practice, and research for the future and for families in all types of kinship family arrangements.

**Kin as Family Resources and Kinship Care Arrangements**

Child welfare engagement with kin still is evolving. Kinship care policy and practice was preceded by recognition of its historical roots as an informal tradition among many cultural and ethnic communities. Work by several sociologists supported this recognition. Carol Stack’s *All Our Kin: Strategies for Survival in a Black Community* highlighted the value and strength of kinship networks. Sociologist Robert B. Hill authored *Informal Adoption Among Black Families* in 1977.

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2 Carol Stack’s *All Our Kin: Strategies for Survival in a Black Community* was published in 1974 by Harper and Row.

3 *Informal Adoption Among Black Families* was published by the National Urban League, Research Department in 1977, and is one of several studies authored by Robert Hill.
Both of these works illustrate early recognition of kin as a family resource that addresses the well-being of children and youth. The impact of social conditions in the 1980s, such as substance use and poverty, on family functioning resulted in an increased need for alternative living arrangements for children and youth. This was a contributing factor to the child welfare system’s focus on kin as a means of assuring child safety and preserving family connections. Kinship care was becoming a valued child welfare service and option for children and youth who could not remain in the safe care of their parents, but initially there was uncertainty about what it should be called. The term “kinship care” was proposed by Eileen Pasztor in 1991 while serving as a CWLA staff member responsible for support to the 1990 CWLA National Commission on Family Foster Care in collaboration with the National Foster Parent Association. Commission members had raised the question of “What about relatives?” as they were considering family foster care issues.

Currently there are various kinship family arrangements and categories of kinship families. Initially, when kinship care became a policy and practice in the child welfare system, the alternative care of children by relatives was divided into formal and informal types. Formal kinship care was defined as those kinship placements that were arranged for children under the care and custody of the public child welfare system. Informal kinship care was defined as those living arrangements that were based on an agreement initiated by and confirmed between the parent and the kinship caregiver. As kinship care policies evolved, definitions have been broadened to include legal processes that establish relatives as permanent legal guardians or adoptive parents, which is referred to as permanent kinship care, and those who are established as foster parents, referred to as public kinship care. The Summit workgroups focused primarily on private and voluntary kinship care using the typology below as one factor of consideration.
• **Private kinship care:** Arranged privately among family members without the help or support of a child welfare agency.

• **Voluntary kinship care:** Arranged with the help and support of the child welfare agency but the child is not placed in the legal custody of the agency.

• **Public kinship care:** The court places the child in the legal custody of the child welfare agency, who entrusts the child to family members who may be unlicensed or licensed as a foster parent and, if unlicensed, may or may not be assisted with public subsidies.

• **Permanent kinship care:** The court establishes the kinship caregiver as the adoptive parent or permanent legal guardian of the child. The caregiver may or may not be assisted with public subsidies.

Social issues affecting families (e.g., substance use and addiction, mental health challenges, and domestic violence) can be contributing factors to children joining kinship families across all four types of arrangements.

**Observations and Recommendations:**
**Seven Kinship Care Issues**

**Increase Continuity and Permanence of Kinship Care**

It is recognized that children and youth experience two aspects of permanence: the emotional side, which supports feelings of security and safety, and the legal side which gives the kinship family the authority, for example, to provide consent for a child’s medical care, plan for the child’s educational needs, and make other important decisions. Both aspects of permanence depend in part on the sustainability of the kinship family arrangement.
Observations and Discussion Points

• The 2000 Report to Congress on Kinship Foster Care (U.S. Department of Health and Human Services, 2000) stresses the twin goals of continuity and permanence. The value of consistent, secure, and loving care is unmistakable and has a profound positive effect on children, especially those who have experienced trauma, separation from their parents, and other adverse family experiences. The intent of federal law and state statutes in preferring kinship care placements is based upon this benefit.

• Greenblatt and Day (2000) conceptualize permanence broadly as encompassing both family continuity and legal permanence: (1) a philosophy where there is a value perspective that emphasizes a child’s rights to permanence; (2) a strategy or an approach to establishing continuity in relationships; (3) a process where public policy informs the pursuit of permanence and may take the form of reunification, guardianship, or adoption; and (4) a collection of services and programs that support and preserve the continuity of the relationship and well-being of the child. In short, permanence can be thought of in terms of the emotional, social, and behavioral benefits that it provides to children, thus, creating a sense of psychological security (Denby, 2016).

• Custodial options that increase legal permanence include adoption (the most legally binding), guardianship, and custody. Relative adoptions eliminate birth parents’ rights to custody, eliminating future court challenges. Adoption can be the outcome of a child welfare initiated proceeding or a private adoption proceeding initiated by an individual other than the parent. If the parent does not consent, courts must find compelling reasons to terminate parental rights.

• Adoption presents special issues of concern regarding financial assistance. Children and youth in foster care, and those receiving Social Security Income (SSI), may qualify for federal
adoption subsidies but most private adoptions do not. When caregivers receive social security benefits, an adopted child becomes their dependent and increases the amount of the social security grant. However, many kinship caregivers do not receive social security benefits either because they are below the age threshold or they do not qualify for social security benefits because of insufficient earnings over their lifetime. Many kin will lose the child-only grant upon adoption of their child and not be eligible for social security. Thus, the gap in Social Security financial assistance presents a barrier to adoption as a permanency option for kin.

- Other legal options are guardianship and custody. Neither terminates parental rights. Kinship caregivers usually will qualify for child-only grants under the federal TANF program. Kinship caregivers who are licensed, approved, or certified as foster parents may possibly receive a federal subsidized Guardianship Assistance Program (GAP) subsidy in states that participate in GAP. Legal custody and guardianship can be critically important when kin seek to enroll children in school, get birth certificates and other legal records, and make decisions regarding children’s health care.

Legal custody proceedings are like guardianship but may involve somewhat different court procedures and standards. Likewise, they are similar but not identical in powers and responsibilities. Guardianships and custodies, unless the parents are deceased, incapacitated, unavailable, or their rights are terminated, are subject to some risk of a challenge to the order. Therefore, the legal arrangement is considered less binding on caregivers and more vulnerable to disruption that that afforded by adoptions.

- Indigent parents usually are provided court appointed attorneys, while indigent kinship caregivers are not, and must hire their own legal representation or rely on a patchwork of legal assistance.
**Recommendations**

1. Support family continuity before and after legal permanence (i.e., public, permanent, voluntary, and private kinship care) with a range of services provided by child welfare social workers and kinship navigator workers as outlined in this paper.

2. Design services to encourage approaches to listening to caregivers, children, and youth (hearing their perspectives), and providing opportunities for engagement with peers. Many caregivers rely heavily on informal exchanges of information in support groups and in other peer-to-peer settings. Mutual sharing can help support the family and provide reassurances from other persons who have had similar experiences. Similarly, children in kinship families may benefit from counseling and their own support groups.

3. Increase kinship caregiver access to attorney representation as part of enhancing legal permanence. Child welfare agencies and court administrations should provide legal assistance programs for kinship caregivers. Increasing access to attorney representation is part of increasing legal permanence.

4. Support and make available kinship navigators, legal services providers, pro bono programs, legal hot lines, and court clinics for kinship caregivers who cannot afford the costs of legal representation.

**Strengthen Child Welfare Engagement with Kinship Caregivers**

The practice concept of engagement in child welfare relates to the outreach and inclusion of families in assessing needs and making decisions. Productive decisions cannot be made without access to information that can guide understanding of needs and options to address identified needs (see Child Welfare Information Gateway, 2012).
Observations and Discussion Points

- The Fostering Connections and Increasing Adoptions Act of 2008 (Fostering Connections Act) and state laws mandate communication with kinship caregivers about custodial options when children and youth are removed from their relative’s custody; however, application is inconsistent.

- Access to public kinship care varies widely depending upon individual state and local policies and practices; ranging from states with up to 50% of their foster care placements with kin to others with less than 10%. (U.S. DHHS, 2015; AECF, 2012: Generations United, 2016). At the time of a child or youth’s placement into foster care, how caregivers are informed and what they are told is subject to variations in state and local practices. Caregivers should be given accurate information about their options and available pathways to foster care or alternatively to TANF-supported voluntary and private kinship care.

- The quality of information shared with kinship caregivers can influence their capacity to provide for their children and youth, and possibly the stability of the arrangement.

Recommendations

1. Implement reform to ensure that kinship families engaged by the child welfare system can, when needed, access foster care benefits to support caregivers who become licensed or certified foster parents on behalf of the state. Reform is also needed to ensure adequate support for kin who cannot, or who choose not to, apply for licensure, approval, or certification as foster parents.

2. Implement standards of practice in the child welfare system which support all kinship families by ensuring they receive accurate information, adequate support, and evidence-based services.
needed to sustain the continuity of kinship relationships. Kinship caregivers should be helped to understand the different benefits associated with various forms of kinship care; have full access, when needed, to the benefits of licensing, approval, or certification; court oversight; requirements for cooperation with the child support system; and other factors that differentiate public from voluntary and private kinship care.

3. Kinship caregivers who choose not to become licensed, approved, or certified as foster parents, or who cannot qualify, should be provided information about TANF child-only grants as well as any other benefits such as SNAP, child care, and Social Security, and referrals to specialized kinship services like kinship navigators. This pertains especially to families and children with whom child protective (CPS) authorities facilitate voluntary kinship care, but do not seek court action to obtain public custody of the child.

4. Child welfare agencies should use a similar pattern of performance accountability that is established under the Child and Family Service Review (CFSR) to track how, and the extent to which kinship caregivers are fully informed of their options and have realistic opportunities to become licensed, approved, or certified foster parents before they agree to take custody of children.

5. Support child welfare engagement with kinship caregivers by providing funding for implementation that does not remove funds from critical child welfare services.

6. Enhance the scope of the Child and Family Service Review (CFSR) to explore the following questions:

   • Did the agency make concerted efforts to provide information, services and arrange financial support for children who at the close of a child maltreatment investigation were not taken into public custody and were living in the home of a non-parent relative?
• Did the agency make concerted efforts to provide information about foster home licensing, approval, or certification opportunities for kinship caregivers of children who were taken into public custody and placed in the relative’s home?

7. Amend the National Child Abuse and Neglect Data System (NCANDS) requirements to identify child protective service cases in which kin become a voluntary family resource, regardless of a formal removal and placement into foster care.

8. Provide better access and more inclusive eligibility rules for child-only grants and other benefits (e.g., SNAP, child care, Social Security Income, and Social Security dependent benefits) for private and voluntary kinship families.

9. Consider the costs of private court actions for voluntary kinship families and work with kinship navigators, court administrations, and legal service providers to improve legal assistance.

Remove Barriers to Transition into Public Kinship Care

Kinship families experience different levels of opportunity to become caregivers in public kinship care. Access to relevant information concerning public kinship care may, in part, be a contributing factor. Importance is placed on the issues of licensing, approval or certification, training, and financial supports.

Observations and Discussion Points

• Licensing, approval, or certification requirements are not always designed to address the unique characteristics of kinship families.

• Training curricula offered to unrelated foster parents as part of licensing or certification requirements, does not necessarily address information and skill building that recognizes issues
such as the influence of pre-existing relationships, separation, and loss, and how these issues manifest themselves in kinship care.

• Families frequently need assistance in understanding available financial supports.

• Each year, enforcement of eligibility criteria for federal foster care benefits based on the 1996 Aid to Families with Dependent Children (AFDC) income criteria causes fewer children to be eligible for Title IV-E foster care payments. The determination of income eligibility is based on the home of the parent or other specified relative from whom the children were either physically or “constructively” removed. Further, children had to have been living with a parent or specified relative from whom they were either physically or constructively removed within six months of the date they were judicially or voluntarily removed. Not only does the AFDC financial requirement limit eligibility, but the six-month limit on the duration of private or voluntary kinship care prior to removal also restricts eligibility and may limit the children’s opportunity to enter public kinship care unless they are physically removed from the kinship caregiver’s custody. Such barriers may force kin to continue as private or voluntary caregivers rather than pursue licensure, approval, or certification as a public foster parent, which qualifies the children for federal foster care benefits. Until the six-month look-back to the home of removal is eliminated, private and voluntary kinship caregivers should be offered the option of transitioning from private or voluntary to public kinship care without penalty during the first six months after accepting the children into their homes.

• Kinship caregivers who are licensed, approved, or certified as foster parents are eligible for federal Title IV-E reimbursed foster care stipends. In general, relatives must be licensed, approved, or certified based on the same standards as non-relative foster
parents. Non-safety related standards may be waived for kinship homes and caregivers on an individual basis, however, such provisions are infrequently invoked in most states (U.S. Department of Health and Human Services, 2011). To facilitate the full support of children who are placed with kin after being taken into agency custody (through a Voluntary Placement Agreement or a court ordered removal) child welfare agencies should make efforts to align their licensing requirements with the unique characteristics of kinship care, and provide information to kin about foster home licensing, approval or certification opportunities (Beltran & Epstein, 2013).

**Recommendations**

1. Eliminate the six-month restriction on private and voluntary kinship care prior to judicial or voluntary removal and replace the 1996 AFDC look-back for income-eligibility determination for Title IV-E foster care benefits. Until elimination, caregivers should be informed that the six-month restriction can preclude their opportunity to quality later for Title IV-E benefits either as licensed, approved or certified foster parents or permanent legal guardians under the federal Guardianship Assistant Program (GAP).

2. Align child welfare agencies’ licensing, approval, or certification standards with the unique characteristics of kinship family structure and relationships.

3. Examine barriers to child welfare emergency placements and training requirements for licensing, approval, or certification as foster parents with a view toward a clear facilitated pathway to licensing, approval, or certification.

4. Consider specialized trainings such as online FosterParent College.com trainings; in-person training like Caring for Our Own (Center for Development of Human Services, Research
Foundation of SUNY Buffalo State College, 2004) or Parenting a Second Time Around (Cornell University, 2002); and child welfare staff training designed to build skill in collaborating with kinship families such as CWLA’s Kinship Traditions of Caring and Collaborating Model of Practice.

**Increase Utilization of Voluntary Placement Agreements**

Voluntary Placement Agreements (VPAs) are a tool for kinship care support. Effective use of VPAs was considered by the Summit Work Group resulting in the observations and recommendation below.

**Observations and Discussion Points**

- VPAs can be voluntarily agreed upon by parents or guardians without formal removal of children from their homes and placement into kinship care; or when children are “constructively” removed from their parent’s or guardian’s home while they are being looked after by another caregiver on a temporary basis. As long as the temporary care does not exceed the 6-month restriction on the duration of private or voluntary care, the parents or guardians can voluntarily agree to the placement of the children and the children can remain in the home of a kinship caregiver without compromising supports, services, or funding that would otherwise be available to the caregiver, parents, and child if the child had been taken into the public custody of the state. A VPA still requires that the caregiver become licensed, approved, or certified as a foster parent in order to receive full foster care benefits under Title IV-E.

- VPAs provide an option for states and counties to support children without a court-ordered removal. Funding provided to a kinship parent who is caring for a child under a VPA is federally reimbursable under Title IV-E of the Social Security Act. In
some states a child who cannot be reunified during the duration of the VPA (which is limited to 180 days) also is permitted to enter guardianship with a licensed, approved, or certified foster caregiver under the federal GAP.

• VPAs can provide another pathway into public kinship care and pathway out to subsidized permanent kinship care. VPAs can be a bridge into the public foster care system and a way to provide support to families who might later choose guardianship or adoption, enabling them to maintain eligibility for financial assistance through either subsidized adoption or GAP.

• VPAs offer a best practice model for temporarily supporting placements, enabling children to avoid involuntary removal from their parents or guardian by a court without compromising access to benefits, services, case management, or reunification services.

Recommendations

1. Increase the use of VPAs with kin to provide greater access to foster care assistance and services without court-orders.

2. Encourage states to develop best practices and guidelines to use VPAs to aid in helping caregivers transition into the public foster care system when it is in the best interests of the children.

Expand TANF Child-Only and Adoption/Guardianship Financial Assistance

Becoming a kinship caregiver usually results in some major changes in life style. Caregivers may have to postpone plans for retirement, change work hours, leave the work force, alter the physical structure of their home, or accommodate the need to alter family budgets. Financial assistance becomes an important issue for kinship families.
Observations and Discussion Points

• Kinship caregivers who are not Title IV-E eligible foster parents are often eligible for federal TANF cash assistance known as TANF child-only grants if the caregivers don’t also qualify for their own TANF payments. However, across the country access to grants remains very low with only 12% of eligible kinship families receiving child-only grants (Mauldon, Speiglman, Sogar, & Stagner, 2012).

• The TANF block grant has lost 32% of its value since 1996. Funding needs to be restored and targeted to provide direct financial assistance to needy families. States should provide child-only grants entirely from TANF funds for relative caregivers and consider providing state funds for non-relative (fictive) kinship caregivers.

• Reform is needed to ensure that adequate financial support is offered to all kinship caregivers, especially those in private and voluntary arrangements that often enables children to avoid formal admissions into public foster care.

• Federal TANF rules leave most eligibility requirements up to individual states. Determining factors may be income and resources, how much cash assistance is paid out, and how caregivers apply for assistance.

• In addition to foster care and child-only grants, federal financial support is available for families who take permanent legal guardianship (in those 33 states that have opted into GAP) or who adopt a child, but it is limited to those children who were either judicially or voluntarily removed into foster care. Federal law is explicit that in order to receive support through GAP the child must have been in a licensed, approved, or certified foster care placement or a VPA for a minimum of six consecutive months prior to the guardianship being ordered. For adoptions, the child must have a “special need” and meet Title IV-E eligibility requirements.
Recommendations

1. Provide financial payments commensurate with foster care payments. Caregiver income and resource should not be considered when determining eligibility and fictive kin should be eligible for child-only TANF grants.

2. Direct more attention to the low rates of TANF child-only utilization through outreach, facilitated applications, and removal of barriers to eligibility. Reform is needed to set more uniform eligibility rules, cash assistance amounts, and higher utilization rates at the state and local levels.

3. Ensure that all private and voluntary kinship families have better and more uniform access to child-only grants and other basic supports that enable them to sustain their caregiving intentions and commitments (Golden & Hawkins, 2012; Mauldon, Speiglman, Sogar, & Stagner, 2012).

4. Expand the pathway to federal guardianship assistance by extending eligibility for GAP to a child who transitions from public kinship care to permanent kinship care, regardless of the licensing status of the caregiver’s home if the transition satisfies other standards currently required to qualify for federal guardianship assistance.

5. Open up a new pathway to GAP for children who transition from stable voluntary or private kinship care directly to permanent legal guardianship without first requiring their removal and placement into public foster care. Eliminate any foster parent licensing, approval or certification requirements so long as the guardianship arrangement satisfies other standards currently required to qualify for federal guardianship assistance.

6. Encourage states and tribes that have not opted into GAP to consider adopting the program.
Implement Kinship System of Care and Kinship Navigator Programs

A kinship system of care refers to a comprehensive and cost effective system of services that targets all kinship families, but especially the many private and voluntary kinship families who are without public child welfare supports. These families are often on their own in facing unique challenges including accessing general services, legal assistance, and specialized kinship services. (Letiecq, Bailey, & Porterfield, 2008; Wallace, 2016).

Observations and Discussion Points

- Kinship families, especially private and voluntary, face barriers to eligibility for financial assistance, child care, and school enrollment, as well as to accessing other service systems. Their custodial rights may be less secure. They confront special challenges in maintaining family relationships because, unlike non-relative foster parents, they still are connected to birth parents. The children in their care may have numerous adverse family experiences (Radel & Bramlett, 2014). A kinship system of care includes program actions designed to address these challenges.

- A kinship system of care incorporates the full range of services offered by social services, child welfare, and temporary assistance agencies. Their collaborations with kinship navigators ensure access to agency services and specially targeted kinship navigator services.

- Kinship navigator programs are at the center of a comprehensive kinship system of care and start with core services of information, referral, and education (preferably via a statewide program) and add programmatic services focused on the special challenges and needs of kinship families.
• Kinship navigator programs offer: (1) information, referral, and education; (2) prevention and supportive services to assure stability; (3) support for achievement of permanence; (4) specialized services to meet special needs of children, youth, and families; (5) collaborative outreach and partnerships; and (6) ancillary services.

• Kinship navigator programs are at the center of introducing greater formality into the processes of strengthening partnerships and building bridges between kinship caregivers and public service systems. We recommend that kinship navigators should be central components of any kinship system of care and should be developed in every state with public support.

• Kinship navigator services start with core services of information, referral, and education (preferably via a statewide program) and add programmatic services focused on the special challenges and needs of kinship families. Depending upon the availability of funding, kinship navigators should include core services plus one or more additional elements:

1. **Information, Referral, Education**: Essential services provided by any kinship navigator program, either via virtual connections (website and/or help line) or as part of local direct services, includes information on kinship laws, benefits, referrals to agencies, and education of caregivers and professionals on kinship issues;

2. **Stabilization Services**: Aimed at stabilizing families via prevention and supportive services, includes access to financial assistance (TANF and Social Security), to legal supports (family court, assistance with administrative agency appeals), emergency assistance, and advocacy with other service agencies;

3. **Permanency Services**: Aimed at kinship families in need of ongoing interventions and case management services, includes advocacy, case management, education, support groups, and family group decision making;
4. **Specialized Services:** Aimed at kinship families with special challenges, includes mental health treatment services, parent engagement services, and trauma informed care for children.

5. **Ancillary Services:** Aimed at caregivers and professionals, includes outreach to kinship families as well as to service agencies/organizations (school districts, mental health agencies, etc.), educational services for kinship families and service professionals, education of state and local policy stakeholders, and development of referral systems.

6. **Collaborations:** Aimed at social services and other service systems, includes kinship navigator education and advocacy to improve access and response of other systems: child welfare, temporary assistance, SNAP, child care, social security, aging, education, health and mental health, corrections, judiciary, housing, and immigration. A kinship system of care posits all of these systems working with kinship navigators to identify how their services impact kinship families and how better to meet kinship family needs.

**Recommendations**

1. Serve kinship families with a comprehensive and cost effective system of services that targets all kinship families.

2. Incorporate within the system of kinship care appropriate responses to family needs by the child welfare system and other human service systems, such as health, mental health, and corrections.

3. Provide funding for kinship navigators that consists of a combination of federal and state dollars, with priority given to establishing statewide core services augmented by local services.

4. Consider housing or locating kinship navigators in facilities with social service agencies and programs.
5. Consider Kinship Navigator programs as core components of a system of kinship care, and development in every state.

Pursue New Directions for Kinship Care Research

Research informs policy and practice in child welfare and other human services. Information gathered from research related to families in the public kinship care population has increased over the past twenty years. Less research has focused on families not involved with the child welfare system. The following section reflect ideas and recommendations for future research.

Observations and Discussion Points

• There is need to test the effectiveness of various levels of intensity of services and outcomes (safety, well-being, and permanence) provided by Kinship Navigator programs, as well as evaluation of screening instruments, assessment and outcome measures for use with kinship navigators, case management and support groups. Mechanisms for ensuring replication with fidelity are needed.

• NSCAW I and II provided a representative picture of children who have contact with the child welfare system, but there are limitations that make it difficult to clearly distinguish public from voluntary kinship care, and this database does not include private kinship care. NSCAW III presents an opportunity to better understand voluntary kinship care, particularly where current or past CPS involvement led to private kinship care. As a longitudinal study, it also can help understanding of the long-term well-being of these children in comparison to children in public custody.
• Centers for Disease Control and Prevention’s (CDC) 2013 National Survey of Children in Nonparental Care (NSCNC) provides representative data on children in private as well as voluntary and public kinship care. Despite the improved coverage, this study is challenged with low non-response rates that raise questions about the difficulty of reaching and engaging the large population of private kinship caregivers which are less visible to the child welfare system. The ability to identify kinship care families in large, nationally representative data sets is particularly valuable.

• Evaluations of kinship navigator programs funded through the Fostering Connections Act Family Connection Discretionary Grants provide preliminary evidence of effectiveness in engaging families in services, child behavior, school engagement, family resiliency, support, parenting and resource needs (Littlewood. 2015). Qualitative findings suggest families valued the program, felt supported, and believed their needs were met and problems resolved (Lin 2014).

• Perhaps the best evidence of effective policies and interventions in kinship care is provided by the rigorous evaluations of subsidized guardianship demonstration projects. Results were used to justify incorporation of GAP into the Fostering Connections Act. Yet, the uptake of guardianship assistance has been disappointingly low. Future research is needed that identifies barriers as well as facilitators of the uptake of GAP.

Recommendations

1. Increased research on private and voluntary kinship care including descriptive studies and analysis of the NSCAW III and the NSCNC data linked with National Survey of Children’s Health to learn about the family experiences and the well-being of the children in their care.
2. Implementation of several pilot studies to develop and test the effectiveness of innovative clinical and practice interventions, including interventions utilizing voluntary placement agreements, interventions to enhance relational competence between caregivers and children, and interventions addressing children and caregiver trauma.

3. Design studies and service demonstrations to identify factors that enhance or limit access to TANF or other subsidies, programs for children and kinship guardianship, and kinship navigator programs

4. Develop more systematic and robust data systems for monitoring, tracking, and following up with kinship families. Although certainly needed at a state and regional level, future data systems must also be shared and capable of forming a repository of information where national trends and patterns concerning kinship care can be captured. Multiple data points should be included, including the following six: (1) outcomes variables for kinship children and caregivers; (2) how kinship children and families interface with other child/family serving systems, including education, health, mental health, economic, and legal entities; (3) whether involvement in multiple formal systems helps or hinders kinship families; (4) influence of cultural variances and types of kinship care arrangements on child outcomes; (5) effect of financial support; and (6) outcomes for kinship families diverted from foster care.

Next Steps: Promote New Directions for Kinship Care Policy and Practice

Summit participants were unanimous in agreeing that child welfare policies and practices must move toward a new direction that is more supportive of kinship families regardless of their involvement with the
public foster care system. Recommendations are grounded in the belief that a new direction starts with the recognition of the value of kinship care, especially related to the safety, well-being, and permanence of vulnerable children, and of the importance of kinship care in shaping the response of child welfare agencies across the country. Simply put, kin are the nation’s number one natural resource for children without parental care. But for too long, kinship families have not been afforded the attention and support that they deserve. More needs to be done to recognize and value these families as well as support them.

It is important to acknowledge that while federal action is needed, states have a larger role to play, and many already have begun to support private and voluntary kinship families. Many of the recommendations here can be implemented at the state level. One strategy for recognizing and supporting kinship families has begun with legislative and executive proclamations declaring September as National Kinship Care Month. Currently, seven states and the U. S. Senate have taken such action to raise awareness of the needs for policies and programs that provide adequate resources for kinship families. A national month would be an important symbolic step forward.

The recommendations in this paper outline a set of child welfare supports for kinship families, which build on research, practice experience, and the values and preferences of children and kinship caregivers. It is time to chart a new course in child welfare policy and practice—one that acknowledges the strengths of kinship care, but also recognizes the need to support all kinship families to advance the safety, permanence, and well-being of vulnerable children.
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By Emily Wampler, MSW, LSW

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