

**EXAMINING THE KINSHIP CARE EXPERIENCE: THE IMPACT OF SOCIAL
SUPPORT AND FAMILY RESOURCES ON CAREGIVER HEALTH, FAMILY
INVOLVEMENT WITH THE CHILD WELFARE SYSTEM, AND PERMANENCE
FOR CHILDREN**

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ABSTRACT

KERRY ANNE LITTLEWOOD: Examining the kinship care experience: The Impact of social support and family resources on caregiver health, family involvement with the child welfare system, and permanence for children

(Under the direction of Oscar Barbarin)

This study had two purposes: (1) to describe the quality of the kinship caregiving experience for kinship caregivers and (2) to assess whether social support and family resource needs impact the health of kinship caregivers, family involvement in the child welfare system, and permanence for children living in kinship care.

In the first part, semi structured interviews were used to examine the caregiving experiences of fifteen grandmothers raising grandchildren in Pinellas County, Florida. Overall, the qualitative results shed some light on what it is like to be a relative caregiver. Most caregiving took place out of obligation, not by choice or by an explicit decision. In light of all the stressors in their lives, the caregivers in the study found much solace in their involvement with a community program.

Three case studies were used to provide examples of different experiences with caregiving.

The second part of the study used a correlational one-group posttest only design. All caregivers (N=175) enrolled in programs offered by a consortium of non-profit community organizations completed the Family Support Scale (FSS), Family Resource Scale (FRS), and General Health Questionnaire (GHQ-SF12). Hierarchical linear regression was used to estimate the relation of social support and family resources to the health of the caregiver, child welfare involvement, and permanence of child placement. Family resource needs predicted physical health, mental health and permanency. Social support predicted physical, but not mental health. None of the study variables predicted the family's involvement with the child welfare system. A further exploration into the permanency variable revealed that African American caregivers cared for children for longer periods than other ethnic groups, on average about 15 months more. Additionally, caregivers who had basic resource unmet needs took care of children for 19 months longer than those whose needs were better met. These data suggest that physical and psychological wellbeing of informal caregivers is at risk due to the needs and demands associated with caregiving and that better outcomes for children may result from more intense efforts to identify and address the resource needs of grandparents and other relatives raising children.

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I. Introduction

Background and Significance

Kinship care is the full-time care, nurturing, and protection of children by their relatives, fictive kin or member of tribes or clans. Often referred to as “grandparents raising grandchildren” or “family care,” this type of caregiving has been an important practice for families, especially in the African American community.

Bryson & Casper (1999) report that 3.3 million children under the age of eighteen are living with their grandparents. Kinship care arranged by the child welfare system due to child maltreatment is the fastest growing type of foster care (Gibbs & Muller, 2000). Although it is difficult to accurately estimate the number of children raised by grandparents without the involvement of the child welfare system, this type of informal kinship care is also on the rise.

Over the years, kinship care has experienced its share of support as well as opposition. Family taking care of family and supporting each other, especially in the African American community, has demonstrated strengths (Mosely-Howard & Evans, 2000). It reduces the number of children going into the foster care system where disproportionality already exists for African American children (Courtney &

Wong, 1996). Kinship care maintains children's ties to their culture and preserves family ties, which supports a deep commitment to family support systems (Scannapocio & Jackson, 1996). It also allows children to maintain a relationship with their biological parents more freely than if the children were placed in foster care. (LeProhn, 1994). Kinship care also allows children to maintain a connection to their siblings who remain in the care of family, rather than placed in separate foster homes.

Although kinship care offers many advantages, there are also numerous concerns regarding this type of care. The most popular criticism of kinship care is that "the apple doesn't fall far from the tree" argument. This viewpoint questions why a grandparent should have another chance at parenting when they essentially failed with their own children who are unable or unwilling to care for the children. Another criticism is that in kinship care, biological parents have more exposure to their children than if the children were placed in traditional foster care. Opponents worry about the transmission of family violence and the children's exposure to abusive parents if the child is placed in the home of a relative (Berrick, Needell, & Barth, 1999). Furthermore, some question the emotional and mental toll kinship care can take on grandparents caring for young children, especially those older caregivers with health problems (Fuller-Thomson, Minkler, Driver, 1997, Kelley, 1993). Lastly, some critics have blamed kinship caregivers who request financial support, stating that families have a moral responsibility to take care of children in

the family and should not ask for outside support (Murray, Ehrle-Macomber, & Geen, 2004).

Even in the face of these kinds of criticisms, kinship caregivers continue to raise millions of children in the U.S. and abroad. This paper will examine the experiences of kinship caregivers in Pinellas County, Florida, with an emphasis on the impact of social support and family resources on caregiver health, family involvement with the child welfare system, and permanence for children.

Historical Overview

Kinship care has a rich tradition in the African American culture. According to an overview of current kinship care and literature, Gleeson (2007) found that African American children are four to five times more likely to live with kin than Caucasian children, have the highest rates of kinship care of any ethnic group, and continue to increase in numbers (Ehrle & Geen, 2002; Harden, Clark, & McGuire, 1997a). Additionally, 38% of children in kinship care are Caucasian, 15% are Latino, and 3% are other ethnicities (Ehrle & Geen, 2002; Harden, Clark, & McGuire, 1997a).

The best way to understand the historical significance of kinship care is to trace its history to Western African family helping traditions. Extended kinship networks have been vital to the survival of families of African descent and a buffer against environmental and social stressors (McAdoo, 1978; Stack, 1974). Historically, in Western Africa, the well-being of children was viewed as the responsibility of the extended family (Scannapieco & Jackson, 1996; Stack, 1974). Extended family helped raise relative's children when work, living conditions, illness, and death called for

this type of care to occur. This reliance on kin was exemplified in the African proverb, “It takes a village to raise a child.”

African families had to adapt their reliance on kin during the Atlantic slave trade in order to acclimate to a less communal life in America. African extended family systems were ripped apart and new fictive kin relationships were developed to help endure hardships. During times of slavery, the extended family was an essential part of life for African American child rearing and social support (McAdoo, 1978).

Reliance on extended family continued after emancipation and industrialization out of necessity. During times of social change and political uncertainty, the extended family served as a stable force for African Americans (McAdoo, 1978). When the emancipation of slaves began in 1861, the extended family network remained flexible, especially to welcome newly freed slaves who found their long lost family members. The African American family was adaptive and supportive in response to social changes. This was also exemplified during Industrialization when over crowded cities with limited resources forced African American families to continue to pool resources and share living and child rearing responsibilities (Harris & Miller, 2002).

Although the Civil Rights Movement improved conditions and support for the African American family, there were increases in poverty, incarceration, and discrimination against African Americans, which facilitated a reliance on extended family. In the eighties, nothing seemed to impact the African American family more

than the crack cocaine epidemic. In 1960, only 21% of African American homes were single parent households; by the late 1970's, this number of single head of household grew to an astonishing 47% (Dressler, Haworth-Hoepfner, & Pitts, 1985; Nobles, 1974). The addictive nature, the lack of available treatment programs and the pervasive context of poverty that surrounds crack cocaine often means that multiple family members may be involved with the drug at the same time, effectively disrupting some of the social support from the next generation that previously lived in multigenerational households (Minkler & Roe, 1993; Roe, Minkler, Saunders, & Thomson, 1996).

Although the crack cocaine epidemic adversely affected African American families, there are many other factors that have contributed to the increased use of kinship care for all American families. In the eighties, more children entered the foster care system because of the growing number of parents with substance abuse problems and HIV (Scannapieco & Hegar, 1999). During this increase in children entering the child welfare system, the number of traditional, nonkinship foster homes had declined because of inadequate support and reimbursement, negative image of the system, and a rise in the number of women in the paid labor force. This simultaneous overflow of children into care and shortage of homes led to a foster care crisis and several policy responses to meet the growing needs of these children.

In 2000, many states placed over half of their foster care caseloads in the care of relatives (Geen, Holcomb, Jantz, Koralek, Leos-Urbel, & Malm, 2001). This reliance on kinship care in the formal foster care system is extraordinary, especially

when one considers that the financial and social service support for relative caregivers is considerably less than non-relative foster parents. Grandparents and policy advocates might wonder what would happen to the foster care system if kinship caregivers did not assume this responsibility and instead relinquished their grandchildren back to the care of the child welfare system.

Statement of the Problem

There are many circumstances that result in the decision of non-parental relatives to care for their younger kin. Social problems such as child maltreatment; parental substance abuse, incarceration, and mental illness; teenage pregnancies; and extreme poverty are major contributors to kin care. The impact of these social problems on the family system is often devastating and in turn forces families into making difficult decisions, such as living in multigenerational homes or taking on the responsibility of raising a relative's child.

In the U.S., 6,042,435 children under the age of 18 years, or 1 in 12, live in a household that is headed by the child's grandparent or other relative other than the child's parent (U.S. Census, 2000). For approximately 2.4 million of these children, the relative is the child's primary caregiver. Of these grandparents who take care of grandchildren without biological parent involvement, 22 % have been caregiving for less than a year, 22% caring for one to two years, and 38% have been caring for grandchildren for five or more years (U.S. Census, 2000). The National Survey of America's Families (Ehrle & Geen 2002; Harden, Clark, & McGuire, 1997b) and the U.S. Census (2000) indicate substantial growth in the number of children living with

relatives other than their parents. This growth is most dramatic among families with the least financial resources and the highest social service needs (Gleeson, 2007).

The National Survey of American Families (Murray, Macomber, & Geen, 2004) estimates that 77-78% of kinship care occurs informally, without the involvement of the child welfare system, 13% have had some type of involvement with the child welfare system but have been diverted from further child welfare involvement, and 5% to 9% (2003 AFGARS Estimate) of the children raised by relatives are in the legal custody of the child welfare system and placed with a relative in formal kinship care.

Kinship care is a growing phenomenon. Although much research and literature is available about the 5% to 9% of kinship care that occurs formally, very little is known about the 77-78% of kinship care that occurs informally. Kinship families are different than traditional foster care families, even though they are not treated differently by the child welfare system. It is necessary to better understand the resource needs, support, health, child custody, and permanence of these families and how these items affect the kinship family in order to develop more supportive programs and policies.

Statement of Purpose of the Study

This study has two purposes: (1) to describe the quality of the kinship caregiving experience for kinship caregivers and (2) to assess whether social support and family resource needs impact the health of kinship caregivers, family

involvement in the child welfare system, and permanence for children living in kinship care.

II. Literature Review

Overview of Kinship Care

Kinship care is defined as the full time care, nurturing and protection of children by relatives or any adult who has a kinship bond with the children (CWLA, 2000). While this term is usually associated with grandparents raising grandchildren, it more broadly refers to a wide range of familial arrangements and circumstances. Kinship families include grandparents providing primary care for grandchildren whether the parents reside in the same home or not. Kinship families are dynamic, because they adapt their family life to meet the needs of the children. A biological parent can place a child with a relative because of a problematic situation, but two months later the parent may return to regain the role of primary caregiver to the child. Child welfare and legal systems of care may or may not be involved to demarcate roles and responsibilities with the family members.

Although the make up of kinship caregiving families can look different depending on individual situations and circumstances, since the 1980's kinship care has been conceptualized mostly as grandparents caring for children due to issues such as child abuse or neglect, substance abuse problems, incarceration, teenage pregnancy and other problems that would motivate relatives to take responsibility

for the care of children (U.S. Department of Health and Human Services Administration for Children, Youth, and Families Children's Bureau. 2000). Some kinship caregiving families are involved with the child welfare system and some are not; the difference has often been described as informal versus formal care (Chipungu, Everett, Verdieck, & Jones, 1998; Dubowitz, Feigelman & Zuravin, 1993; Gleeson, O'Donnell & Bonecutter, 1997; Harden, A.W., Clark, R.L. & Maguire, K, 1997a&b; Hegar & Scannapieco, 1995; U. S. Department of Health and Human Services, 1997). Informal kinship caregiving refers to an arrangement where children live with a grandparent or other relative and are not in state custody or are not under the auspices of the child welfare system. Oftentimes these children do not come to the attention of any child protection services, but instead are cared for by relatives with an informal family understanding. Conversely, formal kinship care refers to children who have been reported to child protective services, are removed from the care of their legal parent or guardian, and have been placed in the care of a relative by a child welfare agency.

While the terms "formal" and "informal" kinship care have been used in practice, policy and research since the 1980's, some feel that these terms do not fully capture the experiences of families as they relate to their involvement in the child welfare system (Ehrle & Geen, 2002; Geen, 2003; Geen & Berrick, 2002). Sometimes "informal" kinship caregivers receive certain services from the child welfare system or have opted to care for the children through temporary guardianship. This means that their experiences with the child welfare system can be limited during less

stressful times or more utilized during times of need. Likewise, “formal” kinship care placements can vary depending on how they are publicly supported and the way they are monitored. For example, some community child welfare agencies could support kinship care more than others. This means that they could spend more time searching for available relatives when a child is removed, provide more resources to families once the child is placed, or monitor families providing kinship care more frequently. Although most researchers continue to use the terms “informal” and “formal,” others have adopted the terms “public” and “private” kinship foster care to differentiate between the experiences of families’ involvement with the child welfare system. However, the terms “public” and “private” can be confounded based on the privatization of child welfare services. For example, when child welfare services in Florida and other states are provided by “private” community-based care agencies, these are often referred to as “private,” even though this type of involvement would be traditionally categorized as “formal” or “public.” Because the terms informal and formal appropriately describe the kinship care experience in Florida, these terms will be used in this study.

Kinship Care Policy

In a policy and program context, child welfare provides the most common policies and programs that provide sources of financial support for kinship care. However, the education system and social service system are beginning to recognize that the elderly often take up the burden of raising children when their biological

parents are unable. In recognition of this phenomenon Agencies on Aging are beginning to respond with programs of support to help meet the needs of kin families. To better understand policy progress in the area of kinship care, federal and state policy development will be examined.

Federal policy development

Even though federal policies establish programs that provide financial assistance and social services to families involved with kinship care, assistance is not provided to kin at levels equal to the resources given to non-kin caregivers. Consequently, these policies and programs are a point of contention for families who are looking for the same financial benefits and supportive services as non-relative caregivers receive (U.S. Department of Health and Human Services Administration for Children, Youth, and Families Children's Bureau, 2000). The 1950 Social Security Act established the first income assistance program that offered services to kin families. If relatives were eligible, they could receive payment for themselves and the children in their care through Aid to Families with Dependent Children (AFDC). Relatives who were ineligible to collect assistance for themselves could receive a child-only payment because they were not legally responsible to care for the child. The child only payment is a lower rate of subsidy, and is based on the number of children in the assistance unit. For example, the per child payment amount is increased when there is more than one child living in the same household.

When the Social Security Act was reauthorized in 1962, an amendment to Title IV allowed federal reimbursements to licensed foster parents. Unfortunately, during this time, kinship caregivers did not typically receive foster care payments because they were not likely to become licensed foster parents or turn to the child welfare system for assistance. In addition, relatives who were directed to income assistance programs for help, received subsidies that were lower payments and that were tied to the number of children they cared for (Boots & Geen, 1999) at that time.

In late 1970, four children in Illinois were removed from their mother's care because of neglect. At first, all of the children were placed in foster care with non-relatives. Soon after, two of the children were transferred to the home of relatives who met the state's licensing requirements for foster homes. However, the state would not pay these relatives the foster care rate because of their relationship to the children. Legal proceedings on the behalf of the children placed with relatives initiated the *Miller v. Youakim* (1979) Supreme Court case. The ruling stated that relative foster parents caring for children who are eligible for federally reimbursed foster care payments (i.e., Title IV-E-eligible) are entitled to the same federal benefits as non-relative foster parents if they meet the same licensing standards. [For more information, see *Miller v. Youakim*, 44 U.S. 125, 99 S. Ct. 957 (1979).]

The Indian Child Welfare Act of 1978 and the Adoption Assistance and Child Welfare Act of 1980 were viewed as giving implicit preference to relative foster parents. The Indian Child Welfare Act (P.L. 96-272) stated that Native American

children in foster care should be placed near their home and with their extended family if possible. The Adoption Assistance and Child Welfare Act required that when placing children in foster care, the state should use the "least restrictive, most family-like setting available in close proximity to the parent's home, consistent with the best interests and special needs of the child (P.L. 96-272)."

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193) (PRWORA) significantly altered the federal cash assistance program. It required states to "consider giving preference to an adult relative over a non-related caregiver when determining a placement for a child, provided that the relative caregiver meets all relevant State child protection standards (P.L. 104-193)." PRWORA also significantly altered the federal cash assistance program that addressed kinship care. Instead of the Aid to Families of Dependent Children entitlement, Temporary Assistance to Needy Families (TANF) was created as a block grant with capped funds, time limits, and licensing standards for kin.

During the early nineties, many states' administrative costs and foster care rolls rose to new heights, sparking more welfare reform initiatives. In 1997, Congress passed the Adoption and Safe Families Act (ASFA) to acknowledge the unique circumstances of kinship care and permit states to treat kinship care and non-kin foster children differently. ASFA requires states to seek termination of parental rights (TPR) after a child has been in long term foster care (usually one to two years). ASFA permits states to extend this time frame if "the child is being cared for by a

relative." This act marks the first federal legislation to address kinship care as a potential permanent placement by indicating that "a fit and willing relative" could provide a "planned permanent living arrangement" (Geen, 2003). In January 2000, the final rule of ASFA was implemented by DHHS to provide clarification on federal reimbursement for kin caring for Title IV-E eligible children. This final rule provided direction to states on which types of services and assistance would be reimbursable at the federal level. The State cannot receive Federal reimbursement for foster care expenses for children placed in temporarily licensed foster homes or in foster homes that fail to meet all licensing or approval requirements (U.S. Department of Health and Human Services Administration for Children, Youth, and Families Children's Bureau, n.d.). The regulation requires States to have court hearings on the permanency plan for the child at least every 12 months for all children in foster care, including those children placed in a permanent foster home or pre-adoptive home (U.S. Department of Health and Human Services Administration for Children, Youth, and Families Children's Bureau, n.d.). Although waivers were provided for certain licensing standards on a case-by-case basis, the final rule did not allow states to assess kin differently than non-kin.

Before former President Clinton left office, he signed the National Family Caregiver Support Act into law. This provided information for caregivers about available services, assistance to caregivers in gaining access to services, organization of support groups and caregiver training, respite care, and supplemental services to

complement care provided by caregivers. Two important provisions seemed to impede benefits for kinship families. First, States were given the option of using “up to 10%” of the National Family Caregiver Support Program (NFCSP) funding for grandparents and other relatives. Many states used their discretion to only utilize 2-3% of the funding for grandparents and other relatives. The second provision that impeded the provision of benefits to grandparents was the age restriction. According to the NFCSP, caregivers must be sixty years of age or older to be eligible for this program. This meant that only 29% of grandparents raising grandchildren were eligible (Generations United, 2007).

In September, 2006, U.S. Congress reauthorized the Older Americans Act, lowering the age limit for the eligibility of the NFCP for grandparents raising children from 60 to 55 years of age. This made nearly half of all grandparent caregivers eligible for NFCP. According to the reauthorization proceedings, more than 400,000 grandparents raising grandchildren were newly eligible with the reauthorization of this law.

More recently in 2007, U.S. Senators Hillary Clinton and Olympia Snowe and U.S. Representatives Danny Davis and Timothy V. Johnson co-sponsored the Kinship Caregiver Support Act (S. 661) & (H.R.2188) 110th Congress. Provisions of this Act include: (1) The Kinship Guardianship Assistance Program, which gives states the option to use federal funds for subsidized guardianship payments to relative caregivers on behalf of the children they are raising in foster care, provided

the children are eligible for federal foster care payments; (2) A Navigator Program to help link relative caregivers (both informal and formal) to a broad range of services and supports that they need for their children and themselves; (3) Allows states to establish separate licensing standards for relative foster parents; (4) Requires state child welfare agencies to provide notice within 60 days of the removal of a child from the custody of the child's parents to all adult grandparents and other relatives of the child; and (5) Expands eligibility for the education elements of the Chaffee Foster Care Independence Program to include "youth exiting from foster care to adoption or legal guardianship." The Senate and House forms of this bill have been modified several times throughout the past four years. As of March 23, 2008, this senate bill is still in the first stages of the legislative process where the bill is considered in the Senate Finance Committee and may undergo significant changes in markup sessions. The last legislative action for the house bill was on Sep 19, 2007 in the House Education and Labor Committee where it was referred to the Subcommittee on Healthy Families and Communities

The evolution of federal policies demonstrates an increased recognition of the value of kinship support and increased commitment to this type of care. At first, federal policies were established to only meet the immediate needs of formal kinship caregivers involved in the child welfare system. Later, policies were written to provide more supportive provisions to those caregivers not involved with the child

welfare system. While one such supportive policy, NFCSP, has been established, another, the Kinship Support Act, struggles to gain more broad support.

State kinship care policies

Although federal policies provide direction for states to follow, states use their own discretion concerning how they treat relatives caring for children. This discretion impacts the way programs are implemented, the preference for kin to care for abused or neglected kin, and the amount of payment kin are eligible to receive. For example, about half of the states (24 and Washington, DC) define kin caregivers as those related by blood, marriage, or adoption. Twenty-two states' define kin caregiver as including those beyond relation by blood, marriage or adoption. In these states, step-children and fictive kin could be eligible to receive benefits. The five remaining states have no legal definition of kin (Geen, 2003).

Gleeson and Craig (1994) were the first researchers to compare and contrast how individual states treat relative caregivers. The researchers analyzed responses from 32 states that included foster care practices and payment guidelines. They found that 17 states developed policies that support practices specifically for kin or waived certain licensing requirements. Interestingly, Gleeson and Craig found that some states used licensing standards as criteria for eligibility to receive financial support, but neglected to use standards as criteria for child safety. Before this study, many policy makers and researchers believed that licensing standards were based

solely upon the principles of child safety. Contrarily, financial assistance seemed to supersede the importance of other factors such as safety, well-being, and permanence for children.

To follow up on these responses from Gleeson and Craig (1994), the Urban Institute continued to survey states' kinship care policies (Geen, 2003). States were sampled in three time periods: 1997, 1999, and 2001. Findings indicated that by 2001, only 15 states required kin to meet the same licensing criteria as non-kin foster parents (Jantz, Geen, Bess, Scarcella, & Russell, 2002). In 26 states, at least some kin are ineligible to receive foster care payments. Although states were surveyed at three different points in time, which made it easier to compare changes among states longitudinally, little specific information was obtained to closely examine how policies were implemented and how other systems of care, such as aging and education systems, have also changed throughout this time frame.

Research on Kinship Care

Strozier & Krisman (2007) have examined the state of knowledge of kinship care from a multidisciplinary perspective. This review was used to help describe research, methodological concerns, and sampling issues that have challenged the state of knowledge on kinship care.

Recent child welfare research (e.g. the Administration for Children and Families Children's Bureau State Demonstration Projects, Child Welfare League of America, Casey Family Programs, and others) has spearheaded a movement to

examine secondary child welfare data about kinship care. Child welfare studies have compared outcomes for children placed with relatives to outcomes for children placed with traditional non-relative foster parents. These child welfare studies (Chipungu, Everett, Verdieck, & Jones, 1998; Dubowitz, Feigelman & Zuravin, 1993; Gleeson, O'Donnell & Bonecutter, 1997; Harden, A.W., Clark, R.L. & Maguire, K., 1997; Hegar & Scannapieco, 1995; U.S. Department of Health and Human Service, 2000) have concluded that, compared with non relative caregivers, kinship caregivers are more likely to be female, African American, older, single, less educated, unemployed, and lower socioeconomic status.

Because kinship caregivers tend to be older, the aging field has also examined kinship care with its own framework. Instead of focusing on children's outcomes, the aging system of care is concerned with the outcomes of older adults and what kinds of effects rearing a second generation have on individual health, mental health, and life satisfaction. Compared with grandparents not caring for their grandchildren, kinship caregivers report more limitations of daily activities, increased depression, lower levels of marital satisfaction, and poorer health (U.S. Department of Health and Human Service, 2000). Although aging research has made important contributions to the field of kinship care, child welfare research is the setting for more social interventions and federal studies and demonstration projects to examine kinship care from a family-systems perspective.

According to child welfare research comparing kinship caregivers with non-relative foster parents, kinship caregivers generally receive less training and support

and fewer services (Berrick, Barth, & Needell, 1994; Brooks & Barth, 1998; Gebel, 1996; Scannapieco, Hegar, & McAlpine, 1997a; U.S. General Accounting Office, 1999). Additionally, there is strong evidence that children in kinship care are more likely to be removed from their birth homes due to parental substance abuse as compared to children in non-kinship care, who are more likely to be removed due to the mental health problems of their birth parents (Beeman, Kim & Bullerdick, 2000; Benedict, Zuravin & Stallings, 1996; Besinger, Garland, Litrownik & Landsverk, 1999; Gleeson, O'Donnell & Bonecutter, 1997; Grant, 2000; Franck, 2001; Pruchno, 1999), though how these differences might affect child outcomes is unclear (Cuddeback, 2004).

In recent years, child welfare research has made great strides in examining children and families' experiences with kinship care in the context of the child welfare system. One particular study, the National Survey on Child and Adolescent Wellbeing (NSCAW) (NSCAW Research Group, 2002; U.S. Administration of Children and Families, n.d.) provides a snapshot of the functioning and the potential service needs of children and families after child protective services investigations. NSCAW follows the life course of these children to gather data about services received during subsequent periods, measures of child well-being, and longer-term results for the study population. Anderson, Ramsburg, & Scott (2005), Testa (2005), and Testa & Miller's (2005) work evaluated the largest and longest running Assisted Guardianship Study for Illinois. This research has also helped to build the knowledge base about experiences of kinship caregiving families within the child

welfare system. These large studies help to provide a clearer understanding of life outcomes for children and families that come into contact with the child welfare system. While most studies using child welfare data have successfully strengthened the knowledge base of kinship care, findings have neglected to focus on those families not involved in the child welfare system: the informal kinship caregivers. Informal kinship caregivers often voluntarily care for children without child welfare oversight, avoiding social service systems because of distrust, negative perceptions of social service systems, and other barriers (Harden, Clark, & Maguire, 1997a). Cuddeback (2004) systematically reviewed the state of knowledge of kinship care. According to Cuddeback, few studies have examined informal kinship foster populations (Charon & Nackerud, 1996; Ehrle & Geen, 2002; Harden, Clark, & Maguire, 1997; McLean & Thomas, 1996) and consequently, little is known about informal kinship care. Cuddeback explains research limitations examining informal kinship care:

...informal kinship foster families probably make up a larger part of our child welfare system than we realize, yet the actual numbers of these families and how these families are functioning is unknown. Granted, informal kinship caregivers might be a difficult population to study, they make up an important part of the kinship care child welfare picture and need to be studied. (p. 633)

One of the most difficult tasks in increasing the knowledge base on informal kinship care through research is attaining a representative sample. Because these families are not involved in formal systems of care, they are not included in child welfare administrative databases, which capture the experiences of those children

formally placed with a relative through the foster care system. As Gleeson and Hairston (1999) highlight, methodological concerns and challenges for studying kinship caregiving families include: balancing generalizability and depth, establishing causal relationships, and examining trends over time. Several studies have examined aspects of the informal kinship care family (Bryson & Casper, 1998; Chalfie 1994; Fuller-Thomson, Minkler, & Driver 1997; Geen, 2003; Geen & Berrick, 2002; Rutrough & Ofstedal 1997; Saluter 1992; Simmons & Dye, 2003), but most studies have struggled to capture a representative sample. The studies that have compared informal and formal kinship caregiving include national non-probability samples, national probability samples, and studies with smaller samples. Following is a review of those studies.

National Non-Probability Samples

In the field of kinship care, national non-probability samples have been used to obtain basic demographic information on kinship caregivers. The field of aging has utilized national data from the U.S. Census 2000 to increase the kinship knowledgebase (Simmons & Dye, 2003). In Census 2000, variables were included to examine grandparent heads of households as the primary caregivers to children. Even though the sampling procedures of the Census are not based on service utilization or involvement with systems of care, many informal caregivers are not represented, including other relatives, such as aunts, uncles, cousins, or brothers and sisters who are often primary caregivers to relative children. Additionally, in Census 2000, missing data is often imputed and most socio-economic census data is based

on a sample estimate. While several improvements in Census 2000 have strengthened the sampling of race and ethnic variables, people who identify themselves as bi-racial and multiracial continue to contribute to sampling error in the Census. Other sources of error from the Census include: inability to identify all cases in the actual universe, definition and classification difficulties, differences in the interpretation of questions, errors in recording or coding the data obtained, and other errors of collection, response, coverage, processing, and estimation for missing or misreported data (U.S. Census Bureau, n.d.).

Despite the limitations of the Census data, it provides researchers with informative variables for examining the concept of kinship care. Several studies using the Census as a larger nationally representative data set have focused primarily on describing the demographics of custodial grandparents, grandparent-maintained households, or the grandchildren residing with them (Bryson & Casper 1998; Chalfie, 1994; Fuller-Thomson, Minkler, & Driver 1997; Rutrough & Ofstedal 1997; Saluter 1992). These studies omit information from other relations providing care, such as siblings, aunts, and great grandparents. While the demographic studies have provided valuable information about the number and characteristics of grandparent families on a national scale, their value to the field of kinship care is limited. Although a number of studies have provided insight on kinship care, many did not distinguish between caregivers who lived in households *with other adults present* and those caregivers who lived in households with *no other adults present*. For example, Chalfie (1994) only examined grandparent households in which *no other*

adults were present. Chalfie failed to consider approximately two-thirds of the grandparent-maintained households *with parents present*. Using the National Survey of Families and Households (NSFH), Fuller-Thompson, Minkler and Driver (1997) provided important information on the timing and duration of care and the characteristics of custodial grandparents who had raised a grandchild since 1990. In this study, grandchildren in *grandmother only, no parents present* families were the most likely to be poor and to have received public assistance, while those in *both grandparents, no parents present* families were the most likely to be uninsured. However, the study was not designed to provide information about the numbers and kinds of grandparents who are currently maintaining households for their grandchildren. Most studies do not take into account how grandparent-headed households vary by family structure and economic characteristics, which is another limitation of existing research.

National Probability Samples

The National Survey of American Families (NSAF) collected information on more than 100,000 people in two rounds of data collection in 1997 and 1999 from more than 42,000 households to make up the national probability sample from 13 selected states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin) (Urban Institute, n.d.). As in all surveys, the data from the National Survey of America's Families are subject to sampling variability and other sources of error (Geen, 2003; Geen & Berrick, 2002). The sample of children in many publications on

kinship care resulting from the NSAF was obtained by randomly selecting up to two "focal" children, one under 6 years old and one between the ages of 6 and 17 from each household. This sample of children was then weighted to be representative of children in the nation. To increase the sample size of the children for statistical analyses, 1997 and 1999 data were combined. This sample was limited to those households with people under 65, which excluded many older caregivers.

Furthermore, statistical analyses are based on small samples of subgroups that often have large standard errors. Since NSAF provides only an estimate as to how many relatives are caring for children informally, it is difficult to estimate a probability sample that will have enough statistical power to conduct meaningful analysis.

Additionally, because of the dynamic nature of kinship familial relationships and changing living situations, it can be difficult to determine if this point-in-time survey sampling methodology accurately captures valid and reliable data on informal kinship caregivers.

Smaller Samples

Most of the smaller scale studies on informal kinship care have used qualitative methods with smaller samples to paint a more in-depth picture of this type of caregiving (Gibson & Lum, 2003; Gleeson, 2001; Gleeson, Talley, & Harris, 2003; McClean & Thomas, 1996; Mayfield, Pennucci, & Lyon, 2002). These qualitative studies, which will be briefly described in this section, help us better understand the caregiving process. Furthermore, these qualitative studies have

substantially contributed to the knowledge base of informal caregiving, even though their lack of generalizability limits their utility.

In the first nationally representative survey that profiled children in various types of kinship-care arrangements, Gleeson (2001) examined 215 families caring for related children in informal kinship care arrangements in Chicago in order to identify the strengths, resources, and service needs of these families and how they might change over time. This exemplary study also tests the hypotheses that the child's temperament, caregiver stress, functioning of the caregiving family, social support, and financial/material resources predict both change in the child's behavioral functioning and the stability of the child's living arrangement over an 18-month period. This study found that the overall level of caregiver stress was significantly associated with children's externalizing behavior, family resources, and marital status and that family resources moderated the relationship between family functioning and caregiver stress. Since this study takes place in a state that has been a national leader in kinship care, replication in other areas can increase future generalizability.

In another study, McClean and Thomas (1996) employed a mixed methods approach to examine similarities and differences between a group of informal kinship care providers and two formal kinship care groups. Using an evaluation of the KIDS'n'KIN Program in Philadelphia from 1992 through 1995, the authors drew data from case file reviews which included entry and exit demographics, case worker summaries, and family service description plans from a voluntary program

to access community resources and avoid the child's entering or re-entering the child welfare system. The sample included 165 children (96 in legal custody of the relative) and 60 relative caregivers. This study found that most informal caregivers are forced to seek out accessible and affordable community services on their own and describe this process as "a daunting undertaking." Although this sample included a comparison between informal and formal kinship care, the results are limited by the fact that the sample was small and drawn from only one program in one city.

Because of the paucity of data on kinship care, especially informal kinship care, it is essential that researchers continue studying basic information about these families, including demographics and basic needs. New data-gathering methods are needed to learn about informal kinship caregivers since these families are not part of a formal child welfare system, a system that has built-in data gathering methods.

This study will examine several important concepts relating to kinship care. These include: social support, family resource needs, health, involvement with the child welfare system, and permanence. These concepts will be explained in the following section.

Social Support

The relationship between formal and informal types of social support is helpful for better understanding the kinship family. This section will compare and contrast types of social support and conceptualize how they are treated in this study. When formal social services were compared with informal support, Mogery & Cseh-

Szombathy (1990) found that higher levels of help are perceived as needed and received from the informal sector. It is important to note that while the amount, quality and membership of family support networks and variations in the proximity of kin can differ, informal and formal support networks appear to have unique strengths and weaknesses. In general, there is much dispute in the literature about the overall relationship between informal and formal social support. Duner & Nordstrom (2006) contend that the relationship between formal and informal support indicate that supplementing informal care with public services leads to an increase in informal care. Furthermore, this study of transitions in the use of informal and formal care provided evidence that supports a bridging thesis, that informal care facilitates professional and formal care. Contrary to this theory, the hierarchal-compensatory model holds the view that when people rely heavily on informal networks, informal supports substitute or replace their formal supports, instead of complement them. (Geerlings, Pot, Twisk, & Deeg, 2005).

Kinship families have historically relied more on informal social support, rather than formal support for a number of reasons (Ehrle & Geen, 2002; Harden, Clark, & Maguire, 1997a). Mainly, the premise of family taking care of family exemplifies the importance of informal social support networks. Another reason why kinship caregivers tend to prefer informal social support is the lack of formal support available to kinship families throughout history. Only in recent decades have policies and programs been specifically supportive to relatives raising children. The past twenty years has seen an abundance of new formal supportive programs

for kinship families. Despite their availability, these newly developed programs are often difficult for kinship families to become aware of or to access. Relative caregivers have been reluctant to ask for help from formal supports, in part because service provision often involves the caregiver providing difficult and often disappointing details about why their own children cannot provide necessary care for children (Gleeson & Hairston, 1999; Gleeson, Talley, & Harris, 2003).

Research has examined the importance of both formal and informal supports to kinship families. Policy and practice continue to develop supportive programs for relative caregivers. Despite new knowledge about the importance of social support for these families, more information is needed to determine the reliance, quality, or effects of both informal and formal support for caregivers raising relative children.

There are many different ways to conceptualize social support. Cobb (1976) defined social support as information that a person is cared for and loved, esteemed and valued, and a member of a network of people who are interconnected with mutual commitment to each other. Cobb examined how social support relates to life transitions. He focused on pregnancy, birth, adulthood, aging, and retirement. He posited that the perception of social support not only helped people through difficult transitions in their life, but also protected people from a wide variety of health conditions and illnesses.

Social support is also defined as the resources provided by other persons that differs in type and function at different periods of life (Cohen & Syne, 1985, p.4).

Social support can consist of many things, including but not limited to: emotional,

physical, instrumental, and material aid that can promote adaptation to life events and foster positive development (Dunst, 1988). For kinship families, social support can come from family, relatives, friends, neighbors, co-workers, church organizations, clubs and social organizations, and day care centers. These sources of support can be formal or informal sources. Informal sources include both individuals and social groups who are accessible to provide support as part of daily living, usually in response to both normative and nonnormative life events. Contrarily, formal support sources include both professionals and agencies that are formally organized to provide aid and assistance to people seeking needed resources.

Social Support & Health

One important way kinship caregivers utilize support is through their involvement with support groups. Grandparents raising grandchildren support groups have been providing social support to grandmothers since the early 1970's and continue to make positive contributions throughout the U.S. today (Strozier, McGrew, Krisman, Smith, 2005). There is evidence that grandparents raising grandchildren benefit from support groups (Burton, 1992; Kelley, 1993; Vardi & Buchholz, 1994; Grant, Gordon, & Cohen, 1997; Burnette, 1998; Weber & Waldrop, 2000). Additionally, research indicates that grandmothers who participate in support groups have less self-reported less mental health problems, including depression and stress (Grant, Gordon, & Cohen, 1997; Burnette, 1998)

Black, Cook, McBride, & Cutrona (2005) further examined social support and the belief that it is linked to health functioning because feeling supported and socially connected during times of illness influences the extent to which individuals are able to cope, recover, and adapt to a variety of chronic health conditions including breast cancer, rheumatoid arthritis, coronary artery disease, cardiovascular disease, and stroke (Glass et al., 2000; Hurdle, 2001; Lanza & Revenson, 1993; Murry, Owens, Brody, Black, Willert, & Brown, 2003; Roberts, Cox, Shannon, & Wells, 1994; Spiegel, Bloom, Kraemer, & Gottheil, 1989). In addition, social support that is either formal or informal can enhance self-worth, a sense of purpose and belonging, and feelings of stability and security, which can promote positive psychological functioning and self-efficacy for maintaining healthful lifestyles (Hurdle, 2001; Kawachi & Berkman, 2001). On the other hand, lack of social informal and formal social support and feelings of social isolation have been linked to decreased psychological and physical health functioning (Berkman & Syme, 1979; House, Robbins, & Metzner, 1982). Fewer social ties with other significant individuals (e.g. friends, family members, co-workers, etc.) provides infrequent occasions of social contact, interaction, and leisure through which feelings of self-worth and positive affect can occur (Heller, Thompson, Vlachos-Weber, Steffen, & Trueba, 1991). Hence, it is hypothesized that kinship caregivers in this study who have more social support will have better physical and mental health.

Family Resource Needs

A resource need is something that is desired or lacking, but wanted or required, to achieve a goal or attain a particular end (Dunst, 1988). More specifically, a resource need is an individual's judgment of the discrepancy between what is actually going on and what is considered to be desired, normative, or valued from a help seeker's perspective (Dunst, 1988, p. 13).

McKillip (1987) & Reid (1985) further examined characteristics of need identification in Dunst (1988). These include: (1) psychological awareness: there must be some concern, problem or perception that something is not as it out to be; (2) value influence: the role that personal values and phenomenological beliefs play in determining a need must be taken into consideration and be explicitly recognized as one set of conditions that defines concerns or problems; (3) need recognition: there must me some evaluation or awareness that there is a resource that will reduce the discrepancy between what is and what ought to be; and (4) solution identification: there must be a recognition that there is a way of procuring a resource to meet the need before a discrepancy is perceived.

There is strong evidence that kinship foster families receive less training, fewer services, and less support than non-kinship foster families (Lewis & Fraser, 1987; Wulczyn & Goerge, 1992; Berrick et al., 1994; Iglehart, 1994; U.S. General Accounting Office, 1995; Cantos, Gries & Slis, 1996; Gebel, 1996; Scannapieco, Hegar, & McAlpine, 1997; Brooks & Barth, 1998; Franck, 2001). There is also evidence that kinship caregivers are less likely to refer their children for needed resources and services (Cantos et al., 1996). It is unclear as to if they receive less resources because

kinship families do not request, do not need, or refuse such services or if these differences are due to the perceptions of child welfare workers (Dubowitz et al., 1993)

Strozier & Krisman (2007) described several needs as they relate to kinship caregivers, including: financial, child care, medical care for children, medical care for caregiver, counseling for children, education for children, support groups, programs and services, and legal services. When Strozier & Krisman compared the resource needs of formal and informal caregivers, they found caregivers in both formal and informal arrangements shared common needs for services, with the exception of the need for information and counseling for children. Caregivers in formal custodial arrangements reported a significantly greater need for counseling for children and information, but only a slightly higher need for financial assistance, medical care for the caregiver and educational services. Caregivers in informal custodial arrangements reported a slightly higher need for child care, medical care for the child, support group and legal services. Kinship caregivers need information about the following: what resources are available, what support groups are in their communities, how to handle their grandchildren's school problems, how to handle the new teen culture, how to handle drug-affected children, how to handle their own adult children coming back into the home intermittently and disruptively, and how to handle their own grief over their loss of freedom and financial responsibility.

Strozier & Krisman also noted that the resource need requested least by the caregivers was medical care for themselves, a finding supported in other studies

(Gibbons & Jones, 2003; Smith, Krisman, Strozier, & Marley, 2004). This finding reflect the humility and personal sacrifice of caregivers giving so much to raise their relatives' children. Or, this could reflect other factors or dynamics, such as caregiver's lack of health care coverage.

This study will hypothesize that there is a relationship between resource needs and health for kinship caregivers. This means that when caregivers report their needs being met, they will also report less health problems. Information provision, assistance with medication, emergency assistance, and other resources will help to improve the health of caregivers.

Health

Health includes both physical health and mental health. Studies have found that assuming the caregiving role negatively effects caregiver's health (Cohon & Cooper, 1999; Kelly, 1993, Minkler & Roe, 1993) and that kinship caregivers rate their health as poorer when compared to traditional foster parents (Harden, Clyman, Kriebel, & Lyons, 2004).

Many studies have focused on how health impacts caregiving. Research has shown that grandparents and other relatives suffer from poorer health outcomes when compared to traditional foster parents and those grandparents not caregiving for children (Harden, Clyman, Kriebel, & Lyons, 2004; Cohon & Cooper, 1999). Since assuming full-time caregiving responsibilities for grandchildren, grandparents report that their medical problems increase (Burton, 1992; Minkler & Roe, 1993). Kinship caregivers also report having more physical problems and illnesses and

more clinical psychological distress (Dowdell, 1995; Kelly, 1993). In terms of health care behaviors, kinship caregivers are also less likely to participate in health screenings, psychological assessments, and substance abuse treatment (Cook & Ciarco, 1998). Although studies on kinship care have examined key differences in caregiving, the evidence is unclear how family income, age and race influence the health of kinship caregivers.

Involvement with Child Welfare System

Kinship families can have varying degrees of involvement with the child welfare system. A simple way to look at family's involvement with the child welfare system is either (1) involved with the child welfare system (formal) or (2) not involved with the child welfare system (informal). However, this dichotomy doesn't accurately describe a family's diverse experience with this dynamic system. For example, at times, child welfare may help arrange for a child to live with a relative but not ask that the court place the child in the custody of the state. In this case, although the family had child welfare involvement at the time of placement, child welfare did not continue to help the family throughout care. It would be difficult to determine that this family has formal ongoing involvement with the child welfare system or an informal relationship.

To better understand the variation of kinship families' involvement with the child welfare system, it is important to know available legal custodial options. Service provision, financial assistance, and child welfare involvement are all closely

tied to the type of custodial arrangement. In Florida, there are three custodial arrangements available through Florida Courts. The only custodial arrangement that is considered a *formal involvement with the child welfare system* is Dependency Law Court Placements. This type of placement is made subsequent to a child abuse and neglect substantiation and involves a transfer of child custody from the biological parent to the State and then to the relative caregiver. In 1998, the Florida Relative Caregiver Program was established to provide support and financial assistance to kinship care families who obtain a Dependency Law Court Placement. Eligibility criteria for this program include: (1) the child resides in the fulltime care of a relative within a fifth degree of relationship to the child in Florida, (2) the child has been adjudicated dependent by the state due to child abuse, neglect or abandonment, (3) the relative possesses a dependency court order through juvenile court, and (4) a home study is approved by the state (Florida Department of Children and Families, 2001).

Two other types of legal custodial options are available for relative caregivers in Florida: probate and family court. However, if relatives choose to obtain any of these other two legal custodial arrangements besides Dependency Law Court Placements, they will be ineligible for support and financial assistance from the Relative Caregiver Program. This can be particularly frustrating, because there are two kinds of ways to obtain guardianship for children in Florida: dependency and probate. In dependency, a decision is made by the court that a child is in need of

effective care and control and that parents are unable or unwilling to provide proper care and control. Usually, a dependency petition is filed by the state because of concerns about abuse and neglect. In dependency court, a dependent child remains under the court's control until the court declares that a parent has become willing and able to provide proper parenting. By comparison, in probate court, a guardianship can be filed when someone other than the parent wants to be appointed to take of the parental responsibilities and neither living parent will file papers or go to Court to oppose the appointment. Guardians take over parental responsibilities for making decisions regarding housing, medical care, and education, among other things. Many relatives who initiate the guardianship process pursue probate court, because the child can remain in their own care, rather than state custody throughout the court process. Probate court is also less burdensome, because there are fewer parties involved, pretrial conferences, and temporary custody hearings. Caregivers who are involved with the probate court will be ineligible for support or financial assistance through the State's Relative Caregiver Program and will have an *informal* relationship with the child welfare system.

The main goal for the family court is to create a fully integrated, comprehensive approach to handling all cases involving children and families. With this model, it is important to create one system of care in cases affecting the same family. Jurisdiction of the family division includes: dissolution of marriage,

simplified dissolution of marriage, child custody and support, URESA, domestic violence, name changes, adoptions, paternity suits, and modification proceedings (Florida Supreme Court 77623, 1991). Family court procedures include a wide range of legal options for families. Because relatives often initiate entrance into the family court system, either to get court orders or medical consents, they become ineligible for social support and financial assistance through the Relative Caregiver Program. Therefore, for the purposes of this study, a relative with family court involvement will be classified as having an *informal* relationship with the child welfare system.

There are many pathways to formalizing relatives' relationships with their children through the court system. When a child enters the child welfare system because of maltreatment, they become adjudicated dependent, and can be placed in the care of a relative. This transfer of custody occurs through the Florida Dependency Court and allows the child welfare system to provide formal care to the family through the Relative Caregiver Program. The two other court options for relatives are the probate and family courts. With these two other options, a relative must initiate the custodial process; and in doing so, they make themselves ineligible for support and financial assistance from the Florida Relative Caregiver Program. Probate and family court establish an informal and intermittent relationship with the child welfare system. One might wonder why caregivers would chose custody options that don't allow them to receive needed support or services. There are a couple of reasons why these options are selected. First, it is possible that caregivers are not aware that the only way for them to receive the benefits of the Relative

Caregiver Program is through dependency court. Second, some caregivers avoid involvement with the child welfare system and choose to initiate the custodial process on their own. Once they initiate the court process, they become ineligible to pursue the Dependency Court. Last, court involvement can be costly and cumbersome to caregivers. Those caregivers who choose to avoid both child welfare and court systems have an informal relationship.

Table 2.1 Kin Caregiver Placement Definitions¹

Custodial Arrangement	Explanations
Dependency (Juvenile) Law Court Placements	Custody options for kinship caregivers within the juvenile division include: (1) court-ordered temporary legal custody to a relative under the protective supervision of the DCF, F.S. § 39.521(1)(b)3; and (2) long-term relative custody, F.S. § 39.622. In Hillsborough County, DCF initiates dependency cases through the Office of the Attorney General. However, any party with knowledge of the facts alleged may file a petition for dependency, F.S. 39.501(1).
Probate Law Court Placements	Grandparents and other relatives may also file petitions within the probate division for guardianship of minor children, F.S. § 744.3021. Depending on the needs of the children in their care, grandparents and other relatives will need assistance in determining whether the appointment being sought is for a guardian over the person, property, or both.
Family Law Court Placements	Within the family law division, kinship caregivers are awarded custody of children through petitions for: (1) temporary custody of minor children by extended family, F.S. § 751.03; and (2) adoption, F.S. § 63.112.
General Informal Placements	Informal placements are those where the children are residing with and being cared for by a caregiver other than the birth parent <u>without</u> benefit of a court order. Some examples include a grandparent caring for a grandchild while the birth parent is incarcerated, or an uncle taking a nephew in while the birth parent receives substance abuse treatment, or a neighbor caring for the teenager who was locked out of his parent's home. In informal caregiver situations, grandparents and other relatives are seldom afforded any of the rights or benefits that are provided to legally appointed custodial caregivers.

Permanence

¹ In Florida, a variety of legal custody options exist to assist kinship caregivers. However, those options appear piecemeal throughout the Florida Statutes. Currently, there are three divisions (family, probate, and juvenile) within the circuit court exercising jurisdiction over the custody of children.

Traditionally, permanence for children in the child welfare system has meant either reunification with biological parents or adoption. In terms of kinship care, reunification may not always be possible and adoption may not be consistent with cultural values and philosophies of some communities. For example, in Native American families, the legal status of adoption has little relevance or meaning. Instead, spiritual teachings and oral traditions are more valued (Simmons & Trope, 1999). Additionally, conflicting evidence suggests that kinship caregivers are unwilling to adopt children. Gleeson (1999) and Thorton (1991) suggest that kin are disinclined to adopt and Beeman & Boisen (1999) and Berrick, Needell, & Barth (1999) suggest that permanency is unclear for kin based on child welfare workers' attitudes and expectations. On the other hand, Leathers & Testa (2006) contends that kin can and will adopt if they are provided accurate information, reassurance about ongoing payment subsidies, and confirmation about the continued role of birth parents in the lives of children. Because adoption has been a point of contention for kinship caregivers, many states have some kind of subsidized guardianship for kinship caregivers who want to make a long-term commitment to the children, yet don't want to sever parental rights.

Reunification rates are similar for children placed with kin and non-kin, yet children in kinship care remain in care for a longer period of time (Courtney & Needell, 1997). Type and intensity of involvement with biological parents are strongly associated with reunification as a permanency option (Hess, 1987; Testa & Shook, 2002).

Some policy makers feel that ASFA reflects ambivalence about kin in its approach to permanency (Janz, Geen, Bess, Scarcella, & Russell, 2002). ASFA clearly encourages permanency options of adoption or legal guardianship for children in non-relative care who cannot be reunified and specifically disallows long-term foster care for non-kin; yet, it includes explicit provisions for long-term care for children placed with relative caregivers. Even if placement stability is greater for children placed with kinship caregivers (Beeman et al. 1996; Benedict et al., 1996; Berrick, 1998, Courtney & Needell, 1994), there is no guarantee that these placements won't break down over time, especially considering lack of support and resources for kin families.

A connection between social support and permanency has been made in previous research. Walsh and Walsh (1990) found that children in families with better relationships with their own extended family were less likely to disrupt while in treatment foster care. This was validated by Kalland and Sinkkonen (2001), who found associations between successful placement and family resources, as evaluated by the child welfare case worker. In addition to family resources, the authors stressed the importance of support from relatives in relation to placement breakdown. Furthermore, Kalland and Sinkkonen (2001) showed that children who received support from professionals were less likely to experience placement breakdown.

III. Theoretical Framework

Many theories have helped to inform this research. Ecological theory and social systems theory are the grand theories that provided the framework for this investigation. Other theories, such as family needs hierarchy and the cultural variant perspective, have helped to provide a deeper understanding of the needs and strengths of African American kinship care families. This section will provide a brief overview of the selected theories and describe how these theories have helped shape the five principles of kinship care practice.

Ecological Theory

The general ecological model provides a useful tool for examining several important aspects of the kinship family, including: the role of health and child permanency, social support, resource needs, involvement with child welfare system, social stressors, and cultural values in the etiology of human behavior. These important aspects are imbedded in three related contexts that are normally illustrated with three concentric circles: the individual context as the core, the family context as the middle, and the environmental context containing both. The interaction among these ecological contexts are characterized by progressive, mutual

adaptation of the family and the environment, and complex interactions of many social systems that overlap with family life and influence human development (Tseng, Chesir-Teran, Becker-Klein, Chan, Duran, Roberts, & Bardoliwalla, 2002). Figure 3.1 illustrates the contexts in a conceptual model and how they are related to the outcomes in this study. The ontogenic level of development refers to the individual traits and characteristics of caregivers. Examples of ontogenic level factors include caregiver's age, race, and income. The mezzo system is comprised of family level influences, such as informal and formal social supports. The macro-system consists of the multitude of systems of care affecting the kinship system, such as: family resource needs relating to child welfare, legal, education, health care, and other systems.

Social Systems Theory

A family is a social unit that is both independent and dependent on other formal and informal social networks. According to social systems theory, as changes in one social unit in a system occur, it directly and indirectly affects the relationships and behaviors of other social units in the system. Bronfenbrenner (1979) explains how supportive settings or environments affect family functioning by describing important external factors such as flexibility of job schedules, adequacy of child care, the help of friends and neighbors who can help out, the quality of health and social services, and neighborhood safety. A thorough examination of the environment is an important aspect of understanding the functioning of kinship families.

One important aspect of social systems theory is that in order for a system to be viable, it must be strongly goal-directed, governed by feedback, and have the ability to adapt to changing circumstances. This tenant of social systems theory complements the functioning of the kinship care family in a unique way. The goal of the kinship family to affectively rear children is governed by both positive and negative feedback. This feedback can include a supportive listening ear of a neighbor who provides advice and also the policies in place that provide more support to non-relative foster parents than relatives. Regardless of the quality of feedback, it forces the kinship family to adapt. Interestingly, the ability of the family to adapt to changing roles and new circumstances has been a longtime strength of kinship families.

Family Resource Needs Hierarchy

Dunst (1988) contends that family resource needs and their affect on behavior is directly related to family systems theory and can be connected to many other theories, including Lewin's (1931) field theory of environmental psychology, Hull (1943) and Murray's (1938) theories of motivation, and Maslow's (1954) theory of self-actualization. These theories can help carve out a needs hierarchy, positing that unmet basic needs control behavior, interfere with goals, and deter accomplishment of higher-level needs. The lack of family resources negatively affects health and well being. When resource needs go unmet, the families have to work harder to get these needs met. When families expend all their energy meeting these needs, it can take a toll on their mental and physical health.

Cultural Variant Perspective

A cultural-variant perspective views the African American family as being unique, yet functional, as opposed to being abnormal and not ideal. This challenges the deficit model often used in research with the African American family, realizing that not all families seek a nuclear configuration of living and that attention should be aimed at resources instead of a finite focus on family configuration (Cain & Combs-Orme, 2005).

Most Black family members demonstrate flexible roles across generations, but Black grandparents hold central familial roles that help to support and guide family stability, history, rituals, and traditions (Billingsley, 1992; Hunter, Pearson, Ialongo, & Kellam, 1998). Furthermore, Hill (1971) highlights the importance of African American strengths in the cultural variant perspective.

Family strengths refers to those relationship patterns, interpersonal skills and competencies, and social and psychological characteristics which create a sense of positive family identity, promote satisfying and fulfilling interaction among family members, encourage the development of the potential of the family group and individual family members, and contribute to the family's ability to deal effectively with stress and crisis (Williams, Lindgren, Rowe, Van Zandt & Stinnet, 1985, preface). Hill's (1971) identification of five core strengths of African American families has been extensively utilized in the development of kinship care practice, policy, and research (Child Welfare League of America, 2000; Gleeson, 2007).

According to Hill, the core strengths of African American families are: (1) strong

kinship bonds, (2) strong work ethic, (3) strong religious orientation, (4) strong achievement orientation, and (5) adaptability and flexibility of family roles.

Tidwell (1990) classifies the cultural variant perspective through four tenants, including: (1) a rejection of the ideal family composition or type and a single cultural commonality among racial groups; (2) an acknowledgement of strengths of African American families; (3) an emphasis on African linked family lifestyles and diverse experiences of African American families; and (4) a focus on continued cultural influences in African American family functioning, structure, and roles.

Five Principles of Kinship Care Practice

Gleeson & Mason (1997) developed four principles of best practice for children in kinship care and the National Resource Center for Foster Care and Permanency Planning (2001) added a fifth principle. These principles can help guide child welfare professional practice with kinship families and include: (1) a broad view of family; (2) ongoing striving for cultural competence; (3) collaboration in decision-making; (4) a long-term view of child rearing; and (5) inclusion of children and youth in the planning and decision-making process. Similar practice principles have been identified by others (Mills & Usher, 1996) and some consensus appears to be developing across the country that these principles facilitate permanency planning in kinship care.

A broad view of family is an essential perspective that goes beyond the child, parent and caregiver triad to identify the persons in the kinship network who can contribute to an understanding of the complexity of caregiving demands, identify

the family's need to ensure permanency for the child, and make a commitment to participate in rearing the child to adulthood.

To continually strive for cultural competence involves exploring the strengths and natural helping traditions of culturally diverse families and exploiting these strengths for the purpose of developing optimal family functioning. Informal kinship care is part of the cultural traditions of many families. It is important for professionals working with kinship families to become aware of their personal biases, to prevent these biases from influencing their view of families, and to discover the strengths in families, including their patterns of shared caregiving across generations.

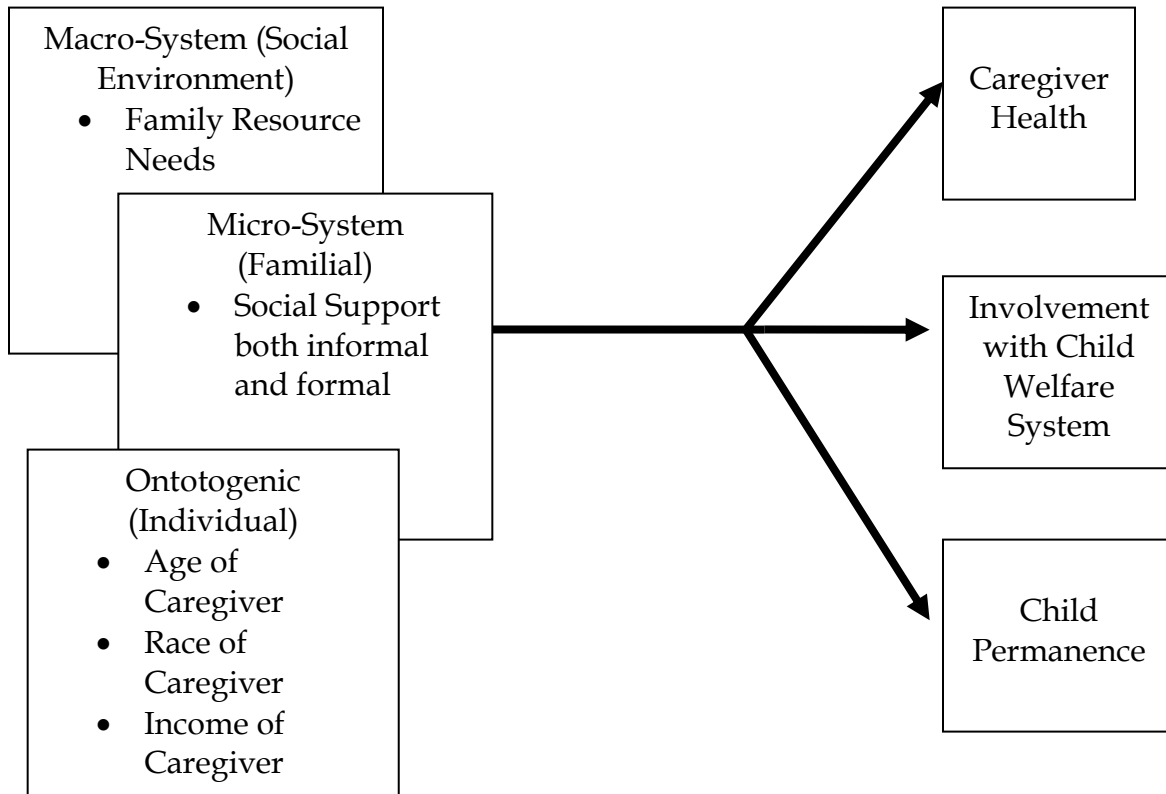
Collaboration in decision-making refers to a family's need to be involved in designing the best safety and permanency plan for the child and family. Many times this collaborative decision making process begins with an assessment of the family's support system with an ecomap and other evaluative tools. Once supports are identified, several interventions incorporate the extended family support system such as family group conferencing. In fact, federal and state policies often require a sense of urgency in decision-making and require short-term involvement with the child welfare system. This makes it even more important to get as many supportive people involved in the process as possible to shift the balance of power from professional-focused to family focused.

A long-term view of child-rearing means that permanency planning should not only focus on the administrative change in case status that represents the exit of

the child welfare system from the family's life, but it also needs to emphasize the willingness of the family support system to care for the child through adulthood. When pressure exists for professionals to reduce caseloads, it can be difficult to envision the long-term effects of this case closure for the child, caregiver, and extended family.

Including children and youth in the planning and decision-making process means whenever appropriate, children over ten and especially adolescents, should be involved in decision making that affects their lives (National Resource Center for Foster Care and Permanency Planning, 2001). Although children are considered "dependents," they can offer some very independent insight into their own planning and decision-making. Involving children and youth in the process can improve their sense of control over a situation and, in turn, improve the overall functioning of the family.

Figure 3.1
Conceptual Model



Variables and Definitions

Independent Variables

Social Support

Social support is defined as the resources provided by other persons that differs in type and function at different periods of life (Cohen & Syne, 1985, p.4).

Family Resource Needs

A resource need is something that is desired or lacking but wanted or required to achieve a goal or attain a particular end (Dunst, 1988). More specifically, a resource need is an individual's judgment of the discrepancy between what is actually going on and what is considered to be desired, normative, or valued from a help seeker's perspective (Dunst, 1988, p. 13).

Dependant Variables

Health of Caregiver

Health includes both physical health and mental health.

Involvement with the child welfare system

Generally, children are placed in foster care because a child protective services worker and/or a court have determined that it is not safe for the child to remain at home due to a risk of maltreatment, including neglect or physical or sexual abuse. It is well documented about what this outcome means for families. Children in foster care are more likely than other children to exhibit high levels of behavioral and emotional problems (Austin, 2004; Chapman & Barth, 2004). They

are also more likely to be suspended or expelled from school and to exhibit low levels of school engagement and involvement with extracurricular activities (Bass, Shields, Lowe-Webb, & Lanz, 2004). Children in foster care are also more likely to have received mental health services in the past year, to have a limiting physical, learning, or mental health condition, or to be in poor or fair health (Bass, Shields, Lowe-Webb, & Lanz, 2004; Lips, 2007).

Florida is the second state in the U.S. to establish a completely privatized child welfare system. Now, private community-based care agencies administer child welfare programs in Florida's districts. As an end user of these services, there is a potential for caregivers to be fairly confused about whether or not they are actually involved with the child welfare system and what that means for families. Moreover, what was once known as the "Florida Department of Children and Families" or "DCF" is now known in the community as YMCA or Kids Central or Hillsborough Kids, depending on the contract.

To keep this variable clear and exhaustive, relative involvement with the child welfare system will be measured by the Relative Caregiver Program eligibility. In order to be eligible for financial assistance through the State as a relative caregiver for a child, the following criteria must be met: (1) the child must be adjudicated dependant in dependency court, (2) placed in a relative's care, (3) the child must be a Florida resident under the age of 18, and (4) a home study must be conducted of the caregiver's home. If the caregiver is receiving the RCP benefits, then for the purposes of this study, the caregiver is considered involved with the child welfare

system. If the caregiver is not eligible for the RCP, the caregiver will not be considered formally involved with the child welfare system.

Permanence

Research on kinship care has measured permanence in several different ways. Some research studies have examined the placement rate, or the number of placements divided by the time in transition (Cooper, Peterson, & Meier, 1987). While this rate provides some meaningful data, it can be inconclusive for families who have recently begun to take care of relative children or those caregivers who do not know the children's placement history before coming into care. The majority of studies examining permanence in care use the number of placements and length of time in care as a measure for permanence (George, 1970; Kraus, 1973; Fanshel & Shinn, 1978; Stone & Stone, 1983; Pardeck, 1984; Berridge & Cleaver, 1987; Thorpe & Swart, 1992; Inglehart, 1994; Fernandex, 1999; Usher, Randolph, & Grogan 1999; Drapeau, Feigelman, & Zuravin, 2000; Palmer, 1996; Webster, Barth, & Needell, 2000; Wulczyn, Kogan, & Harden, 2003; Leathers, 2005).

Qualitative studies can use broader measures of permanence that, for example, might include indicators of the child's sense of belonging and perception of the likelihood of living with this family until adulthood. These studies may also include measures of the caregiver's commitment to rear the child to adulthood, the caregiver's perceptions of the child as a permanent member of the family, and the caregiver's efforts to ensure that the child feels like a permanent member of the

family. Permanence in this study will be measured by how long the child has been in the continuous care of a relative.

IV. Study 1: A Qualitative Examination of the Context, Consequences and Permanence of the decision to provide Kinship Care

Purpose of the Study

The purpose of this exploratory qualitative study was to gather information about the experiences of relatives providing care for a relative's child and organizing the themes emerging from those interviews into a framework for better understanding the kinship family experience. A non-probability purposeful sample of 15 caregivers was used. Fifteen semi structured interviews were conducted on the telephone to provide some insight into the quality of the kinship care experience.

Literature Reviewed to Develop Research Questions

Research questions for this study were developed to help provide a better understanding of the kinship caregiving experience. Previous research was reviewed to examine important concepts and determine which topics would help provide a rich understanding of the kinship family to inform Study 2: The Quantitative Study (Chapter 5).

Although Chapter 2 provides a thorough literature review that describes the state of knowledge on kinship care, a separate set of literature was appraised to

inform this qualitative study. Specifically, more information was needed on the experiences of kinship caregivers. A few studies, (Osby, 1999; Petras, 1999; Porterfield, Dressel, Barnhill, 2000; Shaver, 1998; Smith, Krisman, Strozier, & Marley, 2004; Williamson, Softas-Nall, & Miller, 2003; and Young & Smith, 2000) were especially helpful in providing more information on the experiences of kinship caregivers.

Osby (1999) interviewed 10 kinship caregivers involved with the child welfare system and attempted to understand their 'world view'. All of the participants were grandparents. Most were African American women who had taken children in their care due to the mother's substance abuse problems.

Osby found that the caregivers were strongly dedicated to their families and committed to the children, even though they felt unappreciated at times. The caregivers made many sacrifices and experienced personal isolation as a result of caregiving. The caregivers voiced frustration with service systems and their own children.

Petras (1999) studied 80 kinship caregivers involved with the child welfare system. Most were African American, grandmothers, single heads-of-households, and had at least one health problem. Petras examined the caregiver's sense of control, which she called 'caregiver denial of responsibility of success' and found that it was related to higher caregiver satisfaction with her role. This study also found that caregivers had symptoms of depression, but also reported high levels of satisfaction.

Williamson, Softas-Nall, & Miller (2003) used semi-structured interviews to explore the experiences and emotions of seven grandmothers raising their grandchildren. The authors addressed research questions that asked what changes the caregiver experiences and circumstances and emotions that surround the perceived experiences. The grandmother's stories revealed common themes of anger, frustration, loss, hurt and depression, but also love, satisfaction, pride, you, feeling needed and youthful. A key finding in this study is that grandmothers who did not report depression had positive relationships with biological parents, while grandmothers who reported depression had conflictive involvement with parents.

Shaver (1998) conducted a study that examined the experiences of 350 caregivers , including those that were not involved with the child welfare system. He found that caring for grandchildren has a major impact on the lives of grandparents, specifically impacting the caregiver's health and ability to meet basic needs. Shaver noted that the caregiving experience is most challenging when grandparents are raising children with developmental delays, learning disabilities, health problems, behavioral and emotional disorders, delinquency, or teenage pregnancy.

Porterfield, Dressel, Barnhill (2000) and Young & Smith (2000) and Smith, Krisman, Strozier, & Marley (2004) examine the caregiving experiences of grandmothers who care for children when mothers are incarcerated. Taking custody of children when mothers are incarcerated can create significant stress for grandparents, particularly with finances, health and family relationships. This

caregiving experience also involves constantly dealing with negative stigma associated with the criminal justice system.

Most of these studies would support the notion that each individual caregiving experience is unique. Some caregivers are involved with the criminal justice system, while others are involved with the child welfare system. Many are involved with both. Some grandmothers have poor finances, but good health; while others have poor health, but good finances. In order to succinctly examine the kinship caregiving experience, four important content areas were identified in the review. This section will describe how previous research helped to identify research questions and inform the interview protocol.

The first important area to study is the caregiver's story about the onset of the kinship care relationship. This introductory topic helped lay the foundation for subsequent discussion during the interview and helped to provide a context of caregiving. Although many previous studies (Chipungu, Everett, Verdieck, & Jones, 1998; Dubowitz, Feigelman & Zuravin, 1993; Gleeson, O'Donnell & Bonecutter, 1997; Harden, A.W., Clark, R.L. & Maguire, K, 1997a; Hegar & Scannapieco, 1995; U. S. Department of Health and Human Services, 1997) identify quantitative patterns that emerge in kinship families through the analyses of data, it is just as critical to study nuances and the individual lived experiences of the kinship family. The research question for this topic is purposefully general, to provide each individual caregiver with an opportunity to answer in their own way: What is the caregiver's account of their experience in taking on the responsibility of caring for kin?

Timing and permanence is the second important area which informed this qualitative study. Timing refers to how long the caregiver has been caring for their children. For those caregivers involved with the child welfare system, the Adoption and Safe Families Act sets the time limits for children to be reunified with their parents when placed with a relative or non relative foster parent. This period of time is 12 months and can be expanded to 18 months. During this time period, the family may go through many transitions. If the family is working with the child welfare system, their involvement with the system may be notably lessened after two years. For those caregivers who are not involved with the child welfare system, timing of their experience can vary greatly. Another aspect of time refers to whether or not the caregiving occurred at one point in time, or if the caregiver has been caring for the child over time in the absence of the parent(s). For those caregivers who have been caring for the children over time, it could be expected that they will experience less crisis and stress than those caregivers who receive an unexpected call in the middle of the night to take care of the children because of some kind of family crisis. The research questions for timing will examine both aspects of time: How long has the caregiver cared for children and was the onset of caregiving sudden or gradual?

Another concept that is closely related to time is permanence. In this qualitative study, permanence will be measured by how long the child has been in the continuous care of a relative and how many times the child has moved back and forth from caregiver to another home in the past five years. Permanence is a well-

studied child welfare outcome, although there is little agreement in the research about which permanency indicator is the best to study.

The third important area for qualitative study involves learning more about the decision making process for the kinship care arrangements. Decision making refers to how the decision was made that the caregiver would care for the child and who was involved in making the decision. Research in the area of family group conferencing supports the idea that all those who share a bond with the child should be at the table to make a mutual decision about what is best for the child (Hardin, Cole, Mickens, & Lancour, 1996; Merkel-Holguin, 1996). Family group conferencing suggests that the more people who care about the child are involved in the decision-making process, the more the decision will be supported. Little is known about how decisions are made for the kinship care family. To help explore the concept of decision-making for these families, the following research questions were developed: How was the decision made that the caregiver would provide care for the children? Who was involved in making the decision about the care for the child(ren)?

The last area of qualitative study will include the broader context of stress, coping and effects associated with providing kinship care. Stress is conceptualized in this study as a count and a description of difficult times/challenges related to caregiving since the time that the caregiver has taken on the caregiving responsibility. According to the Child Welfare League of America (2000), caregivers typically experience chronic emotional and physical fatigue; family and marital

conflicts; social isolation, including loss of friends, recreational opportunities, privacy, and hobbies; and feelings of anger, guilt, grief, resentment, hopelessness, and anxiety. Coping can help caregivers manage these different stressors in their lives. For this study, coping is conceptualized as a count and a description of the things the caregiver finds helpful in dealing with difficult challenges related to caregiving, a description of how caregivers deal with the difficult times and the identification of the most helpful ways for dealing with difficulties. Lastly, effects of the caregiving experience will be examined in this study. Effects refer to those ways life has changed for the caregiver since taking over the responsibility of raising children. Effects are measured by identifying what life has been like since taking over responsibility for caring for the child and how life has changed in either desirable or undesirable ways. Desirable changes would include some kind of recognition that the child is safer or somehow better than s/he was in the previous care and what the caregiver identifies as some type of improvement for themselves or their family. Undesirable changes could include any negative outcomes for the child, stress and burden for the caregiver, lack of support, and family dysfunction. Research questions that were developed to explore the area of stress, coping, and effects include: (a) What has life been like for the caregiver since taking over responsibility? (b) Has your life changed? If so, in what ways? (c) Are there some undesirable ways in which life has changed/ Are there some positive changes? (d) Since taking responsibility for caregiving, what have been the hardest times or the most difficult things or the biggest challenges to deal with? (e) How has the

caregiver dealt with the difficult times? (f) Is there anything that she has found especially helpful in coping with the hard times or difficult challenges of caring for the children? and (g) What has been the most helpful to her in dealing with these difficulties?

These four areas have helped to inform the qualitative interview protocol and provide a more complete qualitative picture of the kinship care experience. They have also helped establish the tone and flow of the interview. Since most of these concepts are closely related to each other, it helped make an easy transition from one topic to another during the telephone interview.

Methods

Design

A convenience sample of kinship caregivers was identified through their participation in the Kinship Services Network of Pinellas. Caregivers were invited to participate in the qualitative interview once we received consent to contact them through their Family Support Worker.

Informants

Of the 175 caregivers enrolled in a larger study of kinship care, thirty one caregivers indicated interest and agreed to participate in this interview. The researcher contacted all potential respondents. Each potential respondent was contacted three times to participate. Of the thirty-one volunteers fifteen (48%) were successfully contacted and interviewed.

Procedures

On average the interviews took an hour to complete. Although the original plan was to audiotape the interviews, none were audiotaped given the sensitivity of the topic and caregiver and family support worker's concerns about confidentiality. The data in this study refers to the responses to the qualitative interviews and were gathered from February, 2007 to June 2007. The data gathered were secured in a safe location at the researcher's home and destroyed after analysis was completed.

After the interviews, the notes were organized by content. The researcher looked for patterns and trends, and organized information into categories using Atlas ti (version 5.2.15.). Narrative comments and quotes were also used.

Measures

The instrument used was an interview guide constructed for this study by the researcher to focus on four primary areas, including: (a) caregiver's story surround the onset of the kinship care relationship, (b) timing and permanence of providing kinship care, (c) decision making about the kinship care arrangements, and (d) the broader context, the stress, coping and effects associated with providing kinship care.

The first area consisted of questions regarding the family's story and background. Respondents were asked such questions as: (a) What is the caregiver's account of how she became responsible for raising relative children? and (b) What were the circumstances and contextual factors that led the caregiver to take responsibility to raise the children?

The second area focused on the timing of the caregiving experience and permanence, which examined how long the child has remained in the continuous care of the relative. Respondents were asked such questions as: (a) When did it happen? (b) At what point in time did the caregiver see herself as taking over responsibility? (c) Did it happen all at once or was it gradual? (d) How long has the child been in the caregiver's care? (e) Has the caregiver and child lived in the same home/apartment for that period of time? and (f) How many times would the caregiver estimate that the child has moved back and forth from her place to other homes in the past five years?

The third area focused on the caregiver's decision making regarding the care of the children. Here respondents were asked questions including: (a) How was the decision made that the caregiver would provide care for the children? (b) Who was involved in making the decision that should care for the child(ren)? (c) Did the caregiver have to make difficult choices? and, (d) Were there any alternatives, other people besides her who might have taken the child(ren)?

The last area focused on the context surrounding the child's placement, the effects of caregiving, stress and coping. Caregivers were asked such questions as: (a) What else was happening in your life at the time that led to your taking the children? (b) What has life been like for the caregiver since taking over responsibility? (c) Has your life changed? (d) In what ways? (e) Are there some undesirable ways in which life has changed, or Are there some positive changes? (f) Since taking responsibility for caregiving, what have been the hardest times or the

most difficult things or the biggest challenges to deal with? (g) How has the caregiver dealt with the difficult times? (h) Is there anything that she has found especially helpful in coping with the hard times or difficult challenges of caring for the children? Finally, what has been the most helpful to her in dealing with these difficulties? For additional details on the interview, see Interview Protocol in Appendix.

Qualitative Results

Demographics

Most caregivers in the qualitative study were self-referred middle-aged grandmothers caring for two children. No males participated in this study. Also, about half of the caregivers were African American and half were Caucasian.

Table 5.1
Qualitative Study Demographic Characteristics

Characteristics	N	%
Number of Children		
1	3	20.0
2	7	46.7
3	3	20.0
4 or more	2	13.3
Caregiver Gender		
F	15	100
M	0	0
Caregiver Relationship		
Grandmother	12	80.0
Aunt/Great Aunt	3	20.0
Caregiver Education		

Middle School	6	40.0
High School	7	46.7
Post High School	2	13.3
Caregiver's Age		
<39 Young	1	6.7
40-59 Middle Age	8	53.3
60 + Older	6	40.0
Caregiver Race		
African American	7	46.7
Caucasian	8	53.3
Referral Source		
Self	10	66.6
Child Welfare	3	20.0
School	1	6.7
Other Program	1	6.7

Several patterns and trends were analyzed from the qualitative data. This information was organized into four categories. These include: (a) family story; (b) timing and permanence; (c) decision-making; and (d) context, effects, stress and coping. The following section describes the information gathered from these categories.

Family Story

Caregivers were extremely generous in sharing their stories about how they came to be kinship caregivers to relative children. Many had a difficult time discussing their own children's problems with drugs, alcohol, and crime. Twelve respondents (80%) reported that their daughters or son's substance abuse was the main contributor for assuming the care of children. Two of the respondents were

living with the children's parent intermittently and one respondent was caregiving for a teenage daughter's child.

Each story was unique. In some caregiver's voices, the researcher could hear the strain or fatigue they were feeling, especially when talking about their own daughter's reluctance to help out or the daughter's problems. Many caregivers voiced frustration with the child welfare system and a reluctance to open up because they feared involvement with law enforcement or the child welfare system. Other caregivers were eager to share what they have experienced.

Eleven caregivers (73%) described their experiences with child welfare or their daughter's drug abuse in their story. These were very critical issues that played major roles in their stories. Some examples of these experiences include:

Safe Children Coalition (child welfare agency) called me after they charged my daughter with child neglect. They wanted to give me temporary custody until my daughter's medications were stabilized.

Child protective workers met me to get informal custody until my daughter gets on her feet.

The kids' parents were on drugs, so I had to do something to keep the kids safe.

My daughter kept on testing positive for drugs. She knew what was at stake. She would lose those kids if she didn't get off those drugs.

She (my daughter) is a drug addict. She has three felony warrants for her arrest and was on the run from the police.

Crack is all over her neighborhood. I tried to get her out of there, but it was too late. Now the kids have to suffer.

Twelve caregivers (80%) felt compelled by circumstance to provide care. They were in reality the default parents, the next in line, and the back-up to failing

parents who were often their own children. The alternatives to kin care were socially and culturally unacceptable to them.

Timing and Permanence

Most caregivers had a difficult time determining the exact timing that their fulltime caregiving took place. Six caregivers (40%) mentioned that they had been caregiving for children on and off since the child's birth. Five (33%) caregivers have been caregiving for two-to-three years and four caregivers have been caregiving for over five years. Six caregivers mentioned that they got a call from child welfare or the Sheriff's Office to take care of the children. This was more abrupt than the other nine respondents who took on their caregiving responsibilities more gradually, but it was interesting that even these caregivers mentioned that the kids would come to stay with them for brief periods of time before needing the full-time care. These caregivers seemed to reflect more on signs or indications that they could have used to help predict the caregiver situation. For example, one caregiver said

I was totally unprepared. The kids were dropped off at my doorstep and there was nothing I could do but take in the kids. So, in this case I guess I would have to say it (caregiving) happened all at once....come to think of it now, the kids would get dropped off here and there. Sometimes for a weekend. Sometimes for a few more days. So, maybe I should have seen something coming because it seemed like they were coming over more times.

Another caregiver noted,

I got a call in the middle of the night from the Sheriff's Office so they could drop off the kids with me. The kids had nothing. No diapers. They were hungry and confused. Luckily, I had a lot of their stuff that they needed at my place, because they were coming around about every other week to stay. They were coming around more. Maybe they felt it was safe with me.

Caregivers who described the timing of their caregiving experience as “more gradual” sounded very similar to those who had an experience they described as abrupt.

One caregiver articulated this gradual experience by stating,

They (mother and daughter) would always come by to stay. Sometimes for a couple days, sometimes for a month. I wouldn't mind caring for (the child) when my daughter was working or needed to take care of things, but most of the time she just disappeared. Before I knew it, she was gone for a week or a month. When she would return, all she did was sleep. It was like I was a mother for two.

Once children were established in the care of a relative, they seemed to remain in their care for a long period of time. Most children (n=13, 87%) have remained in the same home with their relative caregiver since they have been in care. Only two caregivers reported that the child has repeatedly moved back and forth from caregiver to biological parent more than five times. For these caregivers, it was difficult to estimate how many times the child moved back and forth from the caregiver's place to other homes in the past five years. Caregivers mentioned,

It's been more than I can count.

Too much. That is just too much to say. Sometimes the kids would be here for a weekend, others a month or two. Sometimes in the middle of the night, until the next afternoon when their mom came home.

Decision Making

The third area of focus, decision-making, seemed to be the easiest for caregivers to discuss with the researchers. Mainly, this was due to the role decision-making played in their lives as caregivers. Most caregivers were quick to respond

that they did not decide to become caregivers. There was no decision-making process. They “just did it.” They said that they take care of the children because:

They are family.

If I don't, they will go into the system (child welfare).

If I don't, no one will.

Caregivers felt that they had no choice.

Most caregivers (n=14, 93%) said they made the decision alone, without the help of other family members or professionals. They did not identify any alternatives. This was one of the most surprising areas of study. It brought to light just how isolated these kinship caregivers are and how little help they are receiving from informal and formal social support sources at the onset of their caregiving. Since most caregivers don't believe they had a decision in the matter of caregiving, they begin their caregiving experience in isolation, without any help from family, friends, or others. This is an important time for the children, because they are going through a transition and need to feel safe and secure, despite chaos. Perhaps an important question to inquire in future studies would be: *Do children feel this isolation and, if so, then how does it affect them during this time?*

The consequences of kin care giving: stress and coping

Most caregivers had a difficult time identifying other things going on in their lives at the same time that the children came into their care. They mentioned that at the time the children came into their care, they were most concerned with the well-being of the children and then, subsequently, the well-being of the child's parents. Only about half of the caregivers described how life has changed since assuming

caregiving responsibilities. These respondents mentioned negative effects and challenges such as: (a) inability to provide everything they need for the children because of finances; (b) inability to find time for themselves; (c) dealing with the biological parents; and (d) help to provide the child with a normal life when their parent(s) make mistakes. Positive effects respondents reported since taking on the responsibility of raising children included: (a) enjoying the child's smile; (b) seeing things through the child's eyes; (c) taking pleasure in the life and energy the child brings into the house; and (d) knowing the kids are safe and happy.

In terms of coping, caregivers overwhelmingly reported their appreciation for the Kinship Services Network of Pinellas. Because all caregivers were currently participating in these supportive services, it is not surprising that they would all mention this program (n=15, 100%). The aspects of the program caregivers mentioned that were most helpful in dealing with difficulties of caregiving include: (a) paying bills; (b) participating in support groups; (c) transporting the children; (d) helping with school; and (e) helping children with counseling. Comments about the KSN Program included:

The Program (KSN) has always been there when I need something. Bus passes. Ride to a couple of appointments. It's nice to talk with an adult for a change.

Wanda (Case worker) visits every other week and helped my kids get into camp twice a month. It's something I can count on.

They (KSN) are the light at the tunnel. They put my kids at the top of the list for tutoring. They really needed that. They acted like the opposite of any other people who tried to help us. They actually followed through.

I have been mad and bogged down with personal issues. Going to family events is a nice break.

Overall, the qualitative results shed some light on what it is like to be a relative caregiver. Most caregivers tried to balance their relationship with the children and their relationship with their own daughters. Most caregiving took place out of obligation, not choice or decision. In light of all the stressors in their lives, the caregivers in the study found much solace in their involvement with the KSN Program.

Qualitative Case Examples

Three informants' data were selected to provide a deeper understanding of the kinship caregiving experience. Caregiver A. and Caregiver B. were selected because their caregiving experiences were very similar to other caregivers in this study. Caregiver C. was selected, because her caregiving experience was the most unique. All of their experiences are highlighted in the following case examples.

Caregiver A. is a 69 year old African American woman who raises her two grandchildren due to her daughter's substance abuse and incarceration. The children have been in and out of her home since birth. Her grandson is ten and her granddaughter is fifteen years old. In late 2006, her daughter faced three felony warrants for her arrest, ran from the police, and dropped off the children at Caregiver A.'s for what she said would be, "the weekend." Her daughter disappeared for the next six months until she reappeared outside Caregiver A.'s place in spring of 2007. At this time, the Caregiver explained that, there was "a police sting outside my place, in front of the kids, whaling on my daughter like she

was a dog.” Since this event, the children have been in the constant care of Caregiver A. She does not know when her daughter’s release will be set.

Caregiver A resides in a 55+RV Park, which enforces age restrictions. This makes it incredibly difficult to live. When the children were not with the Caregiver during their childhood, they would reside in hotels and motels with her daughter and “various men.” Caregiver A. reported that although she feared eviction from her place, she felt uncomfortable with the children staying at “seedy motels.” In the past, child protective workers have been intermittently involved with their family when the children were found alone in motels. Her daughter has never had her parental rights terminated though.

Caregiver A. reports three main issues that have affected her life since caregiving, including: finances, health, and transportation. First, she is extremely stressed about her financial situation. She is collecting disability income, however it is not enough to raise two children. Caregiver A. reports having bad health and a constant lack of energy. Although she thought about getting a job, she realizes that her health does not allow her to do this at this time. She has a roommate who helps out with the children, but she is unemployed and does not contribute to the rent. Her roommate also has health issues. Last, Caregiver A. does not drive. She never learned how to drive, but now that she is raising two children, it is very difficult to keep up with their schedules and needs without a car.

Caregiver A reports that

I live in constant fear. I am threatened that if I ask for more help and tell people of my problems, they would take my kids away and would never give them back. She reports that her biggest challenge is I don't know what to do or what is best for the children. I am afraid I cannot afford this without my daughter's help. I want to declare Chapter 13, but don't know how that will affect the kids.

In late 2007, her daughter attempted suicide in prison. This was very upsetting to the children and Caregiver A. reports that they are having a hard time dealing with it. She reports that the kids have been misbehaving more in school and seem more withdrawn.

Caregiver A. notes that

The children are starting to resent me and saying awful things about me. I tell them that this is not how my life was suppose to be either, but they don't understand. They think it is my fault that their mom is the way she is.

Caregiver A. reports that the best thing about caregiving is knowing that the children are safe and secure.

Caregiver B. is a 61 year old Caucasian woman who raises her 3 year old granddaughter due to her daughter's mental health issues. In 2006, child protective workers removed her granddaughter from her daughter's care when she went off her medication to control her schizophrenia. Since birth, her granddaughter has been living with Caregiver B on and off. Her daughter has a room at Caregiver B.'s home, but "only stays about half the time."

Caregiver B. also reports many health issues that challenge her daily, including carpal tunnel syndrome and neck and back problems. Occupational therapy has

helped her in the past, but because of caring for her granddaughter and not having insurance, she has not been able to continue treatment.

Caregiver B. reports that she was fired from her job because she had too many incidences of leaving her job to care for her granddaughter and daughter. Caregiver B. says that she survived financially because she receives Relative Caregiver Program benefits. Although it is not much, it does help her to stay afloat, so she is not just living on unemployment.

Even though Caregiver B. says that she is overwhelmed and bogged down in personal issues most of the time, she knows that she is doing the best possible thing for her granddaughter. She is trying her best and the love her granddaughter has for her makes it all worthwhile.

Caregiver C. is a 61 year old Caucasian woman who raised three grandchildren due to her daughter's substance abuse and mental health problems. Her first caregiving experience occurred in 1999, when her three year old grandson was "informally" removed by Child Protection workers because of neglect and abandonment and placed into her custody "until the mother gets back on her feet." The mother repeatedly tested positive for drugs, missed mandated appointments, and disappeared for long periods of time. Despite the removal of the child by the child welfare system and child placement into her home, she was offered no supportive services or financial assistance. She was repeatedly told it was a

“temporary, informal placement” that would only last until the mother assumes responsibility.

A year and a half after Caregiver C. had taken on the responsibility of raising her young grandson, her daughter reappeared with a 14 month old daughter. She claimed that she was in real trouble and needed to stay with her until things settled down. Less than a week later, she disappeared again, leaving Caregiver C. to take care of a five year old boy and a 14 month old girl.

Nine years later, she discussed with the researcher her difficulties of accessing services, specifically to secure help with child emotional problems and ADHD. She says her biggest challenge has been “doing it all and letting go of the blame.” She also notes how her daughter has been in and out of the children’s lives intermittently for the past nine years. Caregiver C. would need her daughter to apply for benefits such as Medicaid, because of their informal caregiving situation. However, the daughter would let Medicaid drop because of irresponsibility.

According to Caregiver C,

As long as I did it (caregiving), she was going to let me do it. I had to do something about it and step up to the plate because if the children were returned to her, (daughter), they would immediately get reported abuse and neglect. I was not going to let that happen. The alternative was foster care. It was like the State holds the kids hostage.

Caregiver C. does not speak very highly of professional help she experienced through her nine years of relative caregiving. She mentioned that

*People that are suppose to help us, made it hard for us.
Nobody cared.
Nobody gave a damn.*

Until the kids are wards of the State, then they will help.

During the course of her caregiving experience, her daughter and the children's fathers have terminated their parental rights and have transferred formal custody to her. She describes the legal system as "an absolute quagmire" and ill-equipped to help relative caregivers with anything.

Caregiver C. provides a unique perspective of caregiving. She is an advocate for open adoptions. In fact, in 2007, she found adoptive parents for her grandson, who is now twelve. These adoptive parents live close to her home and allow her visitation. She is also working to find adoptive parents for her granddaughter, but is discouraged by the limited amount of support promoting open adoptions. She values open adoption, because she can remain in the lives of her grandchildren, while providing them with a stable two-parent home.

In 2006, Caregiver C.'s daughter returned home after a year and a half long absence with a baby girl. This time, she is convinced that she can now take better care of this baby than she has with her other children. Caregiver C. remained skeptical, because her daughter was still battling drug problems and mental health issues. Caregiver C. has taken her daughter to court to assume parental rights nine times since 2006 and continues her battle for her grandchildren.

Caregiver C. mentioned that the best part of caring for the children has been advocating for them and other relative children in Tallahassee in the *Rally In Tally*, an annual event where relative caregivers have an opportunity to speak to state legislators about their issues. Caregiver C. notes,

I am an educated woman who has owned several of my own businesses. I want policy makers to know that this can happen to anyone. I have other children that are problem free. There is this perception that we are bad parents and that is why our children are the way they are. I am here to say that sometimes, it doesn't matter what kind of parent you are. It doesn't matter how rich you are or how educated you are. They are just going to stray. Why punish us caregivers who are trying to take care of our family? Isn't that what we are suppose to do?

V. Study 2: Quantitative Analysis of the Effects of Resource Needs and Social Support

Purpose

The purpose of this study is to determine if social support and family resource needs impact differences in the health of kinship caregivers, family involvement in the child welfare system, and permanence for children living in kinship care. Other variables of interest include the age and race of the caregiver and family income.

Research Questions

There exists a budding body of literature on grandparents and other relatives raising children. Most of the theoretical and empirical data have focused on kinship care populations involved with the child welfare system. Kinship care populations who are caring for children informally have received little or no attention.

Furthermore, little is known about how social support and family resource needs is related to the family's involvement with the child welfare system, the caregiver's health, and the child's permanence.

The research questions for this study were:

1. Is social support related to caregiver health, family involvement with child welfare system, and/or child permanence?
2. Are family resource needs related to caregiver health, family involvement with child welfare system, and/or child permanence?
3. Does caregiver race, family income, and/or age influence the effect of social support and family resource needs on caregiver health, family involvement with child welfare system, and/or child permanence?

Research Hypotheses

Research hypotheses for quantitative data in this study include:

- H₁: There is a positive relationship between social support and health. Caregivers with high levels of social support will also have better physical, and mental health.
- H₂: There is an inverse relationship between social support and involvement with the child welfare system. Caregivers with high levels of social support will have less involvement with the child welfare system.
- H₃: There is a positive relationship between social support and permanence. Caregivers with high levels of social support will take care of children for a longer period of time.
- H₄: There is an inverse relationship between family resource needs and health. Caregivers who report more family resource needs will also have poorer physical and mental health.

H₅: There is a positive relationship between family resource needs and involvement with the child welfare system. Caregivers with high levels of family resource needs will have more involvement with the child welfare system.

H₆: There is an inverse relationship between family resource needs and permanence. Caregivers with high levels of family resource needs will take care of children for a shorter period of time.

Methods

The University's Committee for the Protection of Human Subjects approved the protocol for this study (See Appendix). All participants were given verbal and written information about informed consent to assure their understanding of the study purpose, benefits, and risks associated with their participation in the study. All participants in this study provided their informed consent.

Design

Due to the scant knowledge about how social support and family resource needs are related to the health of caregivers, family involvement in the child welfare system, and permanence for children, this study uses a correlational one-group posttest only design.

Informants

Implementation of this study began in July 2005 and was completed in July 2007. Caregivers entered this study through self referral or referral from community agencies and were included in the sample if they met inclusion/exclusion criteria.

For a caregiver to be included in the study, the caregiver had to meet two criteria that were set by the funders of this research: (1) participants provide the full-time care of at least one relative's child 18 years of age or younger; and (2) participants reside in Pinellas County, Florida.

This study took place in Pinellas County, Florida. Sample size was determined by using Cohen (1998) d and effect size correlation, using the t test value for a between subjects t test and the degrees of freedom. (FRS= t -value, FRS=67.319; df =193; d =9.691455, effect size r =.979363)(FSS= t -value=30.812; df =199; d =4.368409; effect size r =.9092737). The results indicated that a minimum of 70 cases were required for two independent variables of social support and family resource needs. The sample available for use in this study was 175 grandparents and other relatives. Because a non-probability convenience sample was drawn from a community-based organization, the probability of selection cannot be determined.

Additionally, the number of cases (n =175) more than meets the criterion proposed by Tabachnik and Fidell (1989) concerning the ratio of cases to independent variables for conducting regression analysis. They established the ratio at 20 times more cases than independent variables. The multivariate component of the primary data analysis plan could include at most seven independent variables (Family Resource Scale (FRS), Family Support Scale Informal (FSS_I) and Formal (FSS_F) Subscales, RACE, INCOME, and AGE. Therefore, a minimum of 130 participants will be needed to strengthen statistical power and to allow multivariate analysis.

Caregiver Characteristics

This section provides information on all of the participants in this study. Of the 175 caregiver, most were Caucasian (n=94, 54%), middle aged (n=116, 66%) grandmothers (n=125, 71%) caring for one relative child (n=92, 53%). These caregivers entered the program through self referral (n=77, 44%), schools (n=45, 26%), other programs (n=42, 24%), and child welfare (n=11, 6%). The general description of this sample of 175 caregivers was that the caregiver was a single female, 50 years old with a high school education. She takes care of two relative children for over three years. Table 5.1 illustrates demographic characteristics.

*Table 5.1
Demographic Characteristics*

Characteristics	N	%
Number of Children		
1	92	52.6
2	47	26.9
3	22	12.6
4 or more	14	8.0
Caregiver Gender		
F	170	97.1
M	5	2.9
Caregiver Relationship		
Grandmother	125	71.4
Aunt/Great Aunt	31	17.7
Other	19	10.9
Caregiver Education		
Middle School	39	22.3
High School	81	46.3
Post High School	55	31.4

Caregiver's Age

<39 Young	18	10.3
40-59 Middle Age	116	66.3
60 + Older	41	23.4
Caregiver Race		
African American	70	40.0
Caucasian	94	53.7
Other	11	6.3
Child Welfare Involvement		
Informal	131	74.9
Formal	44	25.1
Referral Source		
Self	77	44.0
Child Welfare	11	6.3
School	45	25.7
Other Program	42	24.0
	Procedures	

Kinship Services Network of Pinellas

All caregivers in this study participated in the Kinship Services Network of Pinellas. The Children’s Home, Inc. (CHI), in collaboration with the Big Brothers Big Sisters of Pinellas County (BBBSPC) and Catholic Charities Diocese of St. Petersburg, Inc. (CCDOSP) partnered with an extensive network of local service providers to coordinate a supportive system of care for relative care families in Pinellas County. These three collaborators comprise the leadership team in presenting a family-driven, community-based system of kinship resource navigation for Pinellas County.

KSN is designed to make effective use of existing resources in the community to avoid duplication in providing network navigation, case management and non-case management (referrals and support) to relative care families with an emphasis

on informal kin children placement. The KSN model includes offices in the community with a Family Support Coordinator that are strategically placed in North, Central and South Pinellas County. See Map for detailed area. (Appendix)

In addition to mirroring many program components that relate to case management, network navigation and collaboration for a kinship system of care, KSN of Pinellas includes a significant collaboration with Big Brothers Big Sisters to provide one-to-one mentoring for the children and youth in kinship care. Every child or youth that is determined to be eligible for a Big Brother Big Sister Mentor program match are assessed and referred to this program. Youth and adult support groups are also essential. KSN of Pinellas facilitates support groups at the three locations and has also assisted caregivers to link with existing groups in the community. The local faith-based community has also opened up their doors for available meeting space and assistance in recruiting KSN of Pinellas participants that currently function as informal providers of kinship care.

Data collection lasted for two years from July 2005 through July 2007. It was estimated that each agency have at least 50 kinship caregivers enrolled in the study. Participants could enter the program from a variety of intake referrals. Participants entered the program through a central intake line and were assigned to each agency based on zip code (CC in southern county; BBBS in mid county; and CHI in north county). Once assigned to an agency, a family support worker would make the initial home visit to the caregiver and administer the informed consent.

Once the protection of human subjects was approved by the Institutional Review Board, several meetings were arranged with the Program Manager of the Kinship Network of Pinellas, Larry Cooper, and individual service provider agencies: Big Brother Big Sisters, Jennifer Redferring; Catholic Charities, Dyrchia Saavedra and Hector Ortiz; and Children's Home Inc, Karrie Roller. Relationships with these important people had already been established because the researcher played an integral role in the design and development of the service model and also is on staff as the Program Evaluator for the KSN. The researcher's intimate knowledge of the program helped facilitate the research process, especially in terms of data collection.

The researcher provided training for all KSN staff on multiple occasions throughout the course of the project. Formal training meetings were conducted during half-day sessions with all KSN staff in attendance and were accompanied by national expert consultants from organizations, such as Generations United and Children's Defense Fund. The researcher also met with staff in smaller groups at individual agencies on a monthly basis to discuss the research protocol, questions from the staff, and changes to procedures. This allowed the researcher to clarify roles and responsibilities and make sure staff stayed on task.

Throughout the course of the data collection, each of the three agencies of the KSN had an average of three to six family support workers who provide the case management services to families. Each family support worker (FSW) was asked to briefly introduce families to the study during their initial meeting with the family.

This meeting took place in the family's home, approximately one to three weeks following the initial intake over the referral line. During this visit, the FSW introduces the study and provides informed consent and other information about the KSN program. Paper work, including family history and ecomap, are completed with the family at this time. The demographic variables for caregiver age, race, and family income, and outcome variables such as involvement with the child welfare system and permanence are also collected at this time.

The FSW's next visit to the home usually occurred two-to-four weeks after the initial visit depending on the caregiver's schedule. At this visit, the FSW reviewed the informed consent and made sure that caregivers remembered that their participation was voluntary, may be revoked at any time without penalty, had no bearing on the receipt of service, and that their information would be kept confidential. After this instruction, the FSW administered the FSS, FRS, and SF-12, and other measures important to the program outcomes. Administration of each scale took an average of 5-20 minutes. The FSS took an average between 5-10 minutes. The FRS took approximately 10-20 minutes. The SF-12 took an average of 5-10 minutes. In many cases, FSW administered the scales to the caregivers and read responses when they were unclear of the caregiver's literacy or level of reading comprehension.

Once the demographic information, placement type and permanency variables, and survey instruments were collected, the FSW provided the data to their respective Agency Supervisor. Next, the Agency Supervisor would review the data

and deliver it to the Program Administrator, MaryAnn Bassline at the Children's Home, who organized all files and outcomes in a central location. This exchange between the Agency Supervisor and Program Administrator took place in person at a monthly KSN staff meeting. The Program Administrator organized the hard copies of the data and the signed informed consents and provided them to the researcher at a scheduled meeting. The researcher would obtain program data at least once a month. At this time, the researcher would clean and code the data and enter in an SPSS file. Feedback about the data collection process was provided to KSN staff through email and monthly KSN meetings.

Measures

Three measures were selected for this study. These include: the Family Resource Scale (FRS), Family Support Scale (FSS), and General Health Questionnaire (GHQ-SF12). This section will describe the measures.

Family Resource Scale

Family resource needs are measured by The Family Resource Scale (FRS) (Dunst, 1994), a 30-item self-report measure which caregivers rate, on a five-point scale, the adequacy of resources available to meet the family's needs. The resource need hierarchy is based on the theoretical model that examines the inadequacy of resources necessary to meet both personal well-being and parental commitment to carrying out professionally prescribed regimes unrelated to identified needs.

FRS Validity and Reliability

Validity and reliability estimates of the FRS were established in a study of 45 mothers of preschool-aged developmentally at-risk children. Coefficient alpha was averaged at .92 and split half reliability was .95. The stability coefficient for the total scale score was $r=.52$ ($p<.001$).

Brannan, Manteuffel, Holden, & Heflinger (2006) examined the reliability and validity of the FRS among families caring for children who are receiving mental health services. This study used two separate samples from two children’s mental health services evaluation projects. Exploratory and confirmatory factor analyses supported similar factor structures across different economic variables. Overall, they found that the FRS holds promise as a reliable and valid tool for assessing perceived adequacy of concrete resources among economically diverse families of children with emotional and behavioral disorders. The following table presents the factors and reliability estimates used for two separate samples:

Table 5.2

Family Resource Scale Factor Structure

Factor	Description	Items	α^{1*}	α^{2**}
Factor 1	Basic Needs	Food for 2 meals Money to buy necessities Enough clothes Money to pay bills Toys for children	.84	.82
Factor 2	Housing/Utilities	Heat/Air for apartment or house	.81	.76

		Indoor plumbing		
		Dependable transportation		
		Telephone or access to a phone		
		House or apartment		
		Furniture for home or apartment		
Factor	Benefits	Good job	.65	.67
3		Public assistance		
		Medical care for family		
		Dental care for family		
Factor	Social Needs/Self	Time to get enough sleep	.90	.85
4	Care	Time to be by self		
		Time for family		
		Time for children		
		Time to be with spouse/friend		
		Someone to talk to		
		Time to socialize		
		Time to keep in shape		
Factor	Child Care	Babysitting	.83	.84
5		Child care		
Factor	Extra Resources	Money for special equipment	.92	.87
6		Money to buy things for self		
		Money to save		
		Money for family entertainment		
		Money for travel or vacation		

a^{1}* = Standardized Cronbach's alpha coefficients reported from children's mental health services evaluation project, The Fort Bragg Evaluation Project, which included 964 participants in North Carolina, Georgia, and Tennessee (Bickman, Guthrie, Foster, Lambert, Summerfelt, Breda, & Heffinger, 1995).

*a^{2**}* = Standardized Cronbach's alpha coefficients reported from children's mental health services evaluation project, Comprehensive Community Mental Health Services for Children and Their Families Program, which included 1,026 participants from 20 sites across the country (Holden, Santiago, Manteuffel, Stephens, Brannan, Soler, Brashears, & Zaro, 2003) .

Patterns of significant correlations between resources and well-being are consistent with a growing body of research that documents the influences of social support on health outcomes (Cohen & Syme, 1985; Eriksen, 1994). Inadequate social support is consistently associated with poor health outcomes (Eriksen, 1994). Many of these studies are examined in the context of heart disease (Seeman & Syme, 1987). In patients with known coronary artery disease, inadequate social support has been associated with poor outcomes (Seeman & Syme, 1987; Orth-Gomer, Rosengren, & Wilhelmsen, 1993).

Family Support Scale

Social Support is measured by The Family Support Scale (FSS) (Dunst, Trivette, Hamby, 1994), a brief 18 item self-report measure which asks parents to rate, on a five-point response scale, the helpfulness of various potential sources of social support. The scale appears to lend itself well to program evaluations because it is very brief, easy to administer, and has demonstrated reliability and validity. This scale has been used in several studies on parent health and well-being, family

integrity, parental perceptions of child functioning, and styles of parent-child interaction (Dunst, Trivette, & Deal, 1988).

FSS Validity and Reliability

To examine the validity and reliability of FSS, 139 parents of preschool-aged, developmentally at risk children were studied by Dunst et al. (1988). Coefficient alpha computed from the average correlation among the 18 scale items was .77. The split-half reliability was .75 corrected for length using the Spearman-Brown formula.

Hanley, Tasse, Aman, & Pace (1998) examined the psychometric properties of the Family Support Scale (FSS) with a sample of 244 low income families of children in a Head Start program and conducted an exploratory factor analysis with the scale and revealed the following factor structures and reliability estimates:

Table 5.3
Family Support Scale Factor Structure

Factor	Description	Items	A
Factor 1	Community	Social groups, clubs, parent groups, co-workers other parents, church	.74
Factor 2	Spouse and in-laws	Spouse or partner's friends Spouse or partner, spouse or partner's parents, spouse or partners relatives	.78
Factor 3	Friends	Own friends,	.73
Factor 4	Specialized/Professional	Early intervention	.60

		program, professional helpers, school/day care , agencies, family/child physician	
Factor 5	Own Parents and extended family	Relatives, own parents, own children,	.65

Dunst, Trivette, & Deal (1988) reports that the averages of various studies on criterion validity of the scale were consistently related to a number of parent and family outcomes, such as personal well-being ($r=.28, p<.01$), the integrity of the family unit ($r=.18, p<.01$), parent perceptions of child behavior ($r=.19, p<.05$), and opportunities to engage in parent-child play ($r=.40, p<.001$).

Recent studies have used the FSS to make bivariate comparisons between formal and informal support (Resyes-Blanes, 2001; Project Healthy Grandparents, 2002). These studies have combined Factors 2, 3, & 5 to comprise the Informal Subscale and Factors 1 & 4 to comprise the Formal Subscale. This type of comparison is useful for examining how family and kin support differs from professional social service system support. This study will cluster the factors similarly to examine formal and informal support.

General Health Questionnaire (GHQ-SF12)

The General Health Questionnaire (GHQ-12) consists of 12 items, each assessing the severity of physical and mental health problems over the past few

weeks using a 4-point scale (from 0 to 3). The SF-12-v2 consists of 12 items scored so that high scores reflect better health.

GHQ 12 Administration and Scoring

The GHQ 12 can be completed within 2 minutes by a caregiver with a reading level of the fourth grade. In some cases, family support workers would read the items aloud and record the responses. Each item has five responses with the exception of two questions with three responses. Following the recommended scoring algorithms given by Ware, Kosinski, Turner-Bowker, and Gandek (2002), the items were converted into standard scores, multiplied by a weight factor developed from the national sample, and summed to form the mental health or physical health component scores. This algorithm was designed so that both scales would have a mean close to 50, a standard deviation close to 10, and be uncorrelated with each other. Although both scales contain all 12 items, the physical health measure (SF-12-v2 physical component) emphasizes physical functioning, role functioning, body pain, and general health status over the past 30 days. The psychological health measure (SF-12-v2 mental component) stresses vitality, social functioning, emotional functioning, and mental health status over the past 30 days. (See Ware et al. (2002) for a more detailed discussion of this scoring algorithm.) The SF-12-v2 scale has good reliability and validity, correlates well with clinical assessments of physical and mental health (Ware et al., 2002), and has been used in numerous studies worldwide (e.g., Burdine, Fleix, Able, Wiltraut, & Musselman, 2000; Fleishman & Lawrence 2003; Ware, Kosinski, & Keller, 1996).

In cases where summary measures are appropriate, the choice between the 36-item or 12-item versions is largely practical and depends on study objectives. The SF-12[®] reproduces the SF-36[®] summary scales (PCS and MCS) very well and it is much shorter.

GHQ SF-12 Reliability and Validity

277 studies were published on the GHQ SF-12 from 1995-2001. The meaning of scores and whether or not they have their intended interpretations were examined in validity studies of the GHQ 12 using data from two sources: (1) SF-36 Health Survey (McHorney, Kosinski, & Ware, 1994; Ware, Kosinski, & Keller, 1994) and (2) the Medical Outcomes study MOS, an observational study of health outcomes for patients with chronic conditions (Tarlov, Ware, Greenfield, Nelson, Perrin, & Zubkoff, 1989; Steward & Ware, 1992). Tests of validity were made that compared four groups: (1) only minor medical conditions; (2) a serious physical condition; (3) a serious mental condition only; and (4) both serious physical and mental conditions. This four group test reached the same statistical conclusions (e.g. serious worse than minor) and yielded a relative validity coefficient of .93 and .63 relative to the best SF-36 scale.

To date, 16 tests of validity have been performed for the SF-12 and results for all tests have compared with results and summary measures of the SF-36. In all of the tests based on criterion variables defining differences in physical and mental health, the SF-12 was as valid as the two other scales.

Reliability estimates were calculated using data from the 1998 and 2000 general U.S. populations. Indices of reliability indicate that scores produced by the SF 12 are consistent and reproducible. Reliability estimates and summaries for the SF-12 scales range between .78-.89 for the general U.S. population. Test-retest reliability based on intraclass correlations have been reported for patients with arthritis (PCS=.75, MCS=.71; Hurst, Ruta, & Kind, 1998), health community volunteers (PCS=.84, MCS=.75; Lenert, 2000), and among people with severe mental illness (PCS=.73-.79, MCS=.75-.80; Salyers, Bosworth, & Swanson, 2000). Overall the measures are stable and certainly reliable for group applications (Ware, Kosinski, Turner-Bowker, & Gandek, 2005).

Data Analyses

Quantitative data analysis used four methods: (1) exploratory and univariate analysis to describe the variables, clean the data, identify missing data, and recode data; (2) assessment of the internal reliability; (3) bivariate analysis to determine significant relationships between independent variables (family support and family resources), dependant variables (permanence, custody, health), and other variables of interest (race, age, income); and (4) multivariate analysis to determine the effects of the independent variables on the dependent variables when controlling for demographic variables.

Exploratory Data Analysis

SPSS v.15 was used to maintain the database for this study. Variables were screened and descriptive statistics were produced. Variables were examined based upon their ranges, means, and standard deviations.

To facilitate the analysis for this study, it was necessary to recategorize the responses for several variables. Caregiver age was obtained by using a date of birth from the participant. This date was converted into an age by subtracting the birth date from the date of data gathering and recategorized from a continuous variable to an ordinal variable to facilitate interpretation and to provide sufficient numbers in each category. The ordinal variable includes the following responses: <40 years (younger), 40-59 years (middle age), and 60+ (older). Caregiver race was examined as a nominal variable. Based on the distribution of the data, the race categories were coded as African American, Caucasian, and Other to provide sufficient numbers in each category. The variable income was collected from caregivers in a "family income" question that asked, "What is your family income?" This is coded as an ordinal variable with the following categories: >\$10,000, \$10,000-\$19,999; \$20,000-\$29,999, \$30,000-\$39,000, \$40,000-\$49,000, and 50,000+. The response variables were kept in these categories to facilitate interpretation.

The Health Variable provided a ratio score for mental and physical health subscales. These scores are the result of a raw score conversion into T-scores, multiplied by a weight factor developed from the national sample, and summed to form the mental health or physical health component scores.

The Permanence Variable was collected in ratio form and is based on the number of months the child has resided in the continuous care of the relative.

Child involvement with child welfare system was coded as an ordinal variable with the response items: Informal, Other Courts (family and probate), and Formal Dependency Court (RCP eligible).

Table 5.4 provides further information about the variables, their definitions, and respective levels of measurement.

Table 5.4
Dependent, Independent, and Demographic Variables

Variables	Definition	Level of Measurement
Number of Children	Number of children raised (includes biological children)	Continuous Variable (1-6) Recoded to an Ordinal Variable 1=1 2=2 3=3 4=4+
Caregiver Gender	Sex of Caregiver	Ordinal Variable 1=male 2=female
Caregiver Relationship	Relationship of Caregiver to the Child	Ordinal Variable 1=Grandmother 2=Aunt/Great Aunt 3=Other
Caregiver Education	The highest diploma or degree obtained from educational institution	Ordinal Variable 1=Middle School 2=High School 3=Post High School
Caregiver's Age	Age in Years	Continuous Variable Recoded to Ordinal Variable 1=<39 years old (younger) 2=40-59 years old (middle age) 3=60 years old or older (older)
Caregiver Race	Caregiver's Race	Ordinal Variable (0) White, (1) African American, (2) Hispanic, (3) Native American, (4) Asian, (5) Multiracial, (6) Other. Recoded to Ordinal Variable 1=African American 2=Caucasian 3=Other
Caregiver Income	Family Income	Ordinal Variable 0=>\$10,000, 1=\$10,000-\$19,999; 2= \$20,000-\$29,999, 3= \$30,000-\$39,000, 4= \$40,000-\$49,000, and

Referral Source	Who referred the caregiver to the program	5= 50,000+. Ordinal Variable 1=Self 2=Child Welfare 3=School 4=Other Program
Social Support	The resources provided by other persons that differs in type and function at different periods of life (Cohen & Syne, 1985, p.4).	Continuous Variable Total Score of FSS.
Family Resource Need	A resource need is something that is desired or lacking but wanted or required to achieve a goal or attain a particular end (Dunst, 1988).	Continuous Variable Total Score of FRS.
Health of Caregiver	Health includes the physical and mental health of the caregiver.	Continuous Variable Total Score of Physical and Mental Health Subscale.
Child Welfare Involvement		Ordinal Variable 1=Informal 2=Other Courts (family and probate) 3= Formal Dependency Court (RCP)
Permanence	Number of years and months the child has remained in the constant or uninterrupted care of the caregiver.	Continuous Variable included number of years and months. Recoded to an ordinal variable. 1=>one year and a half 2=1.5-<3 years 3=3-5 years 4=over 5 years

Internal Consistency Reliability

To determine the internal reliability of the indices, Cronbach's alpha was used. Higher alpha scores were associated with higher reliability. Cronbach's alpha is calculated by averaging the correlations among items by the number of items in a scale. According to Abrahamson & Abrahamson (2001), an alpha of .07 or higher is considered good. Because the FRS and FSS use a total score, the only scale needed to determine internal reliability is the GHQ-12. The alpha for the physical health index resulted in .837 with 5 items and the mental health index alpha was .823.

Table 5.5
Internal Consistency Reliability for Physical and Mental Health

Index	Cronbach's Alpha
Physical Health (5 items)	.837
Mental Health (4 items)	.823

Univariate analyses examined the frequency distributions and percentages of categorical variables and measures of central tendencies for continuous variables.

Next bivariate analyses were conducted to examine the relationships between demographic variables and between independent and dependent variables.

To determine if any relationships existed between variables, cross tabulations and t-tests were conducted. Relationships between dependent and independent variables were examined using Pearson Correlation Coefficients. Statistical significance was set at an alpha=.05. Next, hypotheses were tested using hierarchical

regression models to examine the relationships between social support and family resources and health, custody, and permanence.

Study 2: Results

This chapter presents univariate, bivariate, and multivariate analyses. At the univariate level, measures of central tendency and dispersion were used to examine the distribution of each variable. Pearson's r was used to examine bivariate relationships between all variables in the study. At the multivariate level, a series of regression equations examined the effects of independent variables on dependent variables.

Univariate Results

Univariate analyses were performed on the sample of caregivers and brought to light the following information. Descriptive characteristics were produced from frequency distributions and percentages of categorical variables and measures of central tendency for continuous variables. After descriptive analyses were conducted, bivariate and multivariate analyses were performed. Bivariate analyses were used to determine the relationships between caregiver age, race, and income with each of the independent and dependent variables and the independent and dependent variables relationship with each other. Univariate analyses were also conducted for the Family Resource Scale (FRS), Family Support Scale Total (FSS_T), Informal Subscale (FSS_I), Family Support Scale Formal Subscale (FSS_F), General Health Questionnaire Total Score (GHQ_12), General Health Questionnaire Physical Health Subscale (Health_Phys), General Health Questionnaire Mental Health

Subscale (Health_MH), and Permanence or number of months in continuous care with relative (PERM), family income (INCOME), # of other relative children in care (#CHILD). Table 5.2 describes the characteristics of these continuous variables.

For each scale, descriptive analyses were run to find out the mean for each item of the Family Support Scale and Family Resource Scale. This is particularly helpful to share with the program administrators, because this analysis helps to identify support and resource needs in the community. Figures 5.1 & 5.2 illustrate the means for the FSS and FRS scales.

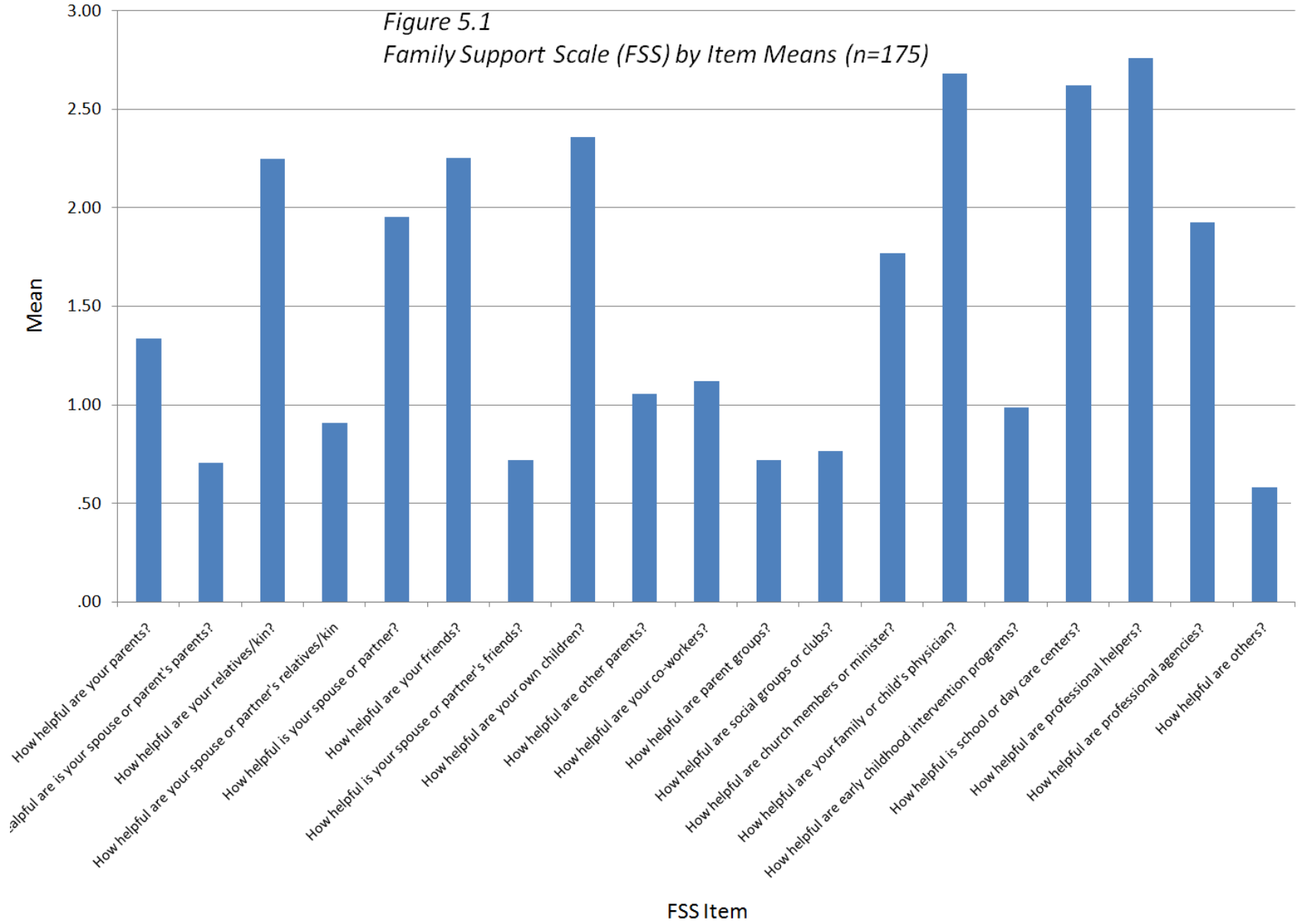
Table 5.6

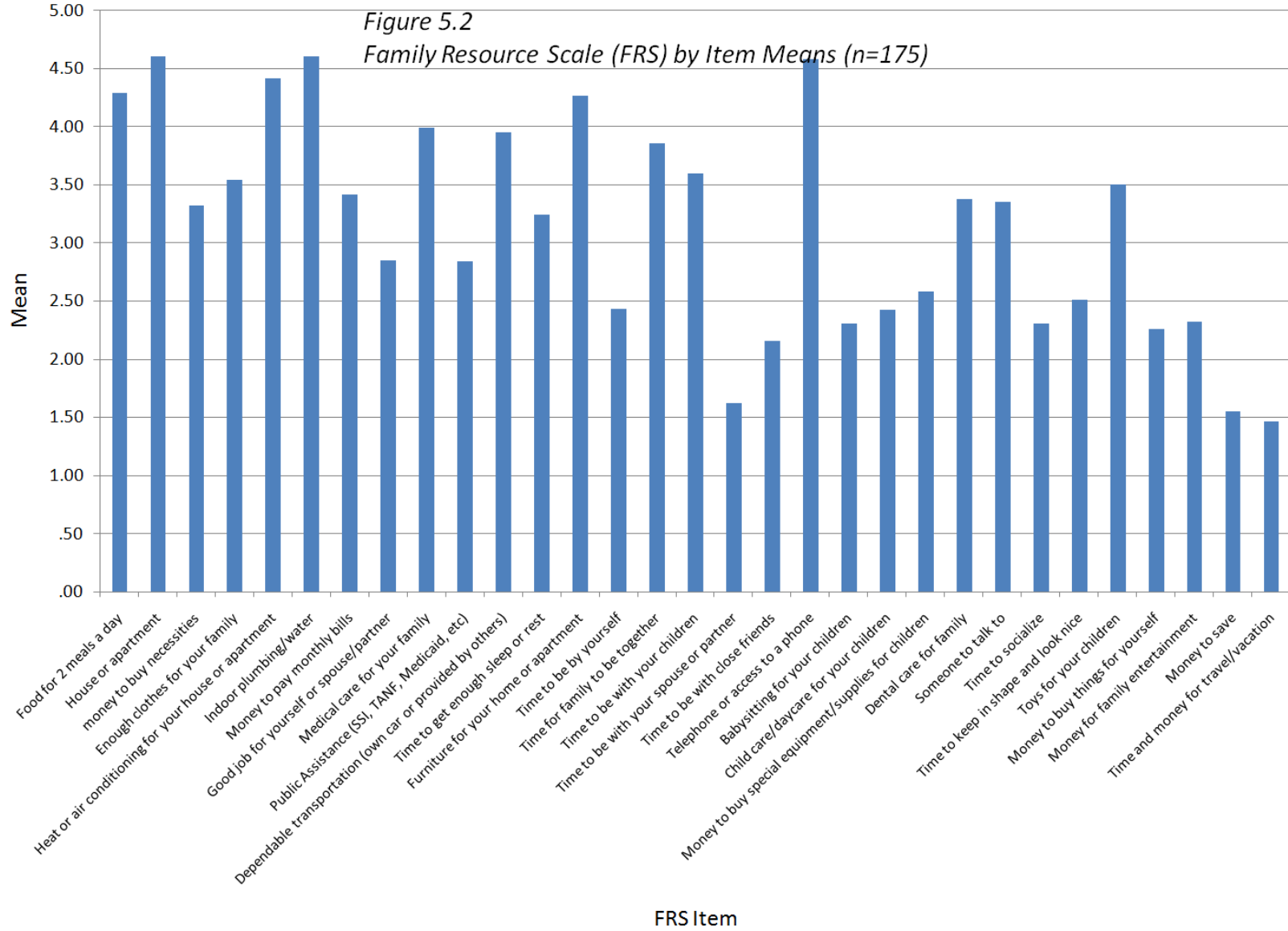
Descriptions of Continuous Variables

Variable	Mean	Median	Range		SD
			Min	Max	
FRS	98.23	99.00	27.00	150.00	19.81
FSS_T	28.77	27.00	0	77.00	13.31
FSS_I	14.66	13.00	.00	46.00	8.81
FSS_F	14.11	13.00	.00	36.00	7.40
Health_Phys	43.06	44.28	10.82	62.92	12.46
Health_MH	43.83	43.63	13.14	72.13	12.05
PERM	45.13	24.00	1	216.00	47.85
INCOME	23,742.86	25,000.00	5000.00	55,000.00	14248.09
#CHILD	1.76	1.00	1.00	5.00	.96

The mean results of the FSS reveal some interesting information. First, caregivers indicated that they felt professional helpers, their family or child's physician and school or day care centers are the most helpful in their lives. These are all considered *formal support* in further analyses in this study. Caregivers reported that their spouse or parent's parents, spouse or partner's friends, parents groups, and others are the least adequate. The supports considered *informal* scored lower than those considered *formal*. The most adequate type of informal support is the help of the caregiver's own children.

The mean results of the FRS reveal information about the types of resource needs in the community. Caregivers indicate that their basic needs are most adequately met. These include: house or apartment, indoor plumbing or water, heat or air conditioning for home or apartment, access to a telephone, and furniture for home or apartment. Caregivers indicated that the following resource needs are not adequate: time to be with spouse or partner, time and money for travel or vacation, money to save, and time to be with close friends. In addition, there is not enough babysitting, child care, or daycare for the caregivers' children.





Bivariate Results

No outliers were identified in the univariate analyses. Additionally, the computation of Mahalanobis Distance equation identified no outliers at the multivariate level. Stevens (1984) and Tabachnick & Fidell (1989) suggest that only the multivariate outlier be removed from the sample before further analyses are conducted.

Pearson's correlations were computed for descriptive variables, independent variables, and dependent variables. The descriptive variables included in the matrix are those that are included in the hypotheses for this study: caregiver's race (RACE), family income (INCOME), and caregiver age (AGE). The independent variables included are: the Family Resource Scale (FRS), Family Support Scale Total (FSS_T), Informal Subscale (FSS_I), and Family Support Scale Formal Subscale (FSS_F). The dependent variables included in this bivariate analysis are: General Health Questionnaire Physical Health Subscale (Health_Phys), General Health Questionnaire Mental Health Subscale (Health_MH), and Permanence or number of months in continuous care with relative (PERM), and child welfare involvement (DCW_INVOLVE).

Table 5.7 shows these correlations.

Table 5.7
 Inter-correlations between descriptive, independent, and dependent variables

	RACE	AGE	INCOME	FRS	FSS_T	FSS_I	FSS_F	Health_P hys	Health_ MH	CW_IN VOLVE	PERM
RACE	1										
AGE	.038	1									
INCOME	.147	.040	1								
FRS	.019	-.120	.246(**)	1							
FSS_T	-.046	-.102	.110	.334(**)	1						
FSS_I	-.001	-.165(*)	.146	.341(**)	.853(**)	1					
FSS_F	-.082	.014	.023	.194(*)	.783(**)	.343(**)	1				
Health_Phys	.034	-.286(**)	.113	.273(**)	.034	.170(*)	-.141	1			
Health_MH	-.077	.072	.066	.317(**)	.055	.045	.045	.011	1		
CW_INVOLVE	.010	.055	-.014	.023	.131	.145	.064	.019	-.074	1	
PERM	-.198(**)	.161(*)	-.148	-.206(**)	-.099	-.150(*)	.000	-.215(**)	-.037	-.173(*)	1

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Caregiver's race had a slight inverse and significant relationship with the number of months the child has been in the care of the relative (PERM). The child will remain in care for longer periods of time for African American caregivers. Age has a small inverse and significant relationship with their reported informal family support (FSS_I) and their physical health (Health_phys). Age has a slight positive and significant relationship with how long the child has been in caregiver's care (PERM). This means that the older the caregiver, the less informal family support they report and the more physical health problems they experience. This also means that the older the caregiver is, the more months the child will remain in their care.

Income has a positive relationship with the caregiver's score on the Family Resource Scale (FRS). This means that the more family income the caregiver reports, the more family resources she will report. The variable Family Resource Scale (FRS) has a slight and significant relationship with many variables in this analysis, including: Family Support Scale Total (FSS_T), Family Support Scale Informal Subscale (FSS_I), Family Support Scale Formal Subscale (FSS_F), General Health Questionnaire Physical Health Subscore (Health_Phys), and General Health Questionnaire Mental Health Subscore (Health_MH). This means that when caregivers report more family resources, she also reports more total social support, more informal social support, more formal social support, and better physical and mental health. Additionally, there is a slight inverse and significant relationship between Family Resource Scale (FRS) and Permanence (PERM). Therefore, those with more family resources will care for relative children for fewer months.

The Family Support Scale Total (FSS_T) has a positive relationship with the Family Support Scale Informal Subscale (FSS_I) and Family Support Scale Formal Subscale (FSS_F). There is also a small but significant relationship between FSS_I and FSS_F. Because FSS_T is the sum of FSS_I and FSS_F, it makes sense that there is this type of relationship between these variables. Furthermore, the more informal family support a caregiver reports is related to more formal family support.

There is a moderate and significant relationship for Physical (Health_PHS) and Mental Health (Health_MH) with Family Recourses (FRS). There is no other variable that has a significant relationship with Mental Health. Physical health has a slight inverse and significant relationship with age, which means that caregiver health worsens when one gets older. There is also a moderate and significant relationship between a caregiver's physical health and their informal family resources.

Bivariate analyses reveal that while older caregivers report less family resources, family support (both informal and formal) and worse physical health, they also care for children for more months than younger caregivers. Caregivers who report having more resources, also report having more family support (total, formal, and informal) and better overall health, but take care of children for fewer months than those who have less resources. The variable Child Welfare Involvement (CW_INVOLVE) is not significantly related to any other variables.

Tables 5.8-5.10 show the results from the bivariate analyses for the variables AGE, RACE, and INCOME.

Table 5.8

Bivariate Characteristics of Race

Characteristics	African American Caregivers	%	Non African American Caregivers	%	Total (n)	%	X2
Number of Children							
1	31	44.3	61	58.1	92	52.6	4.153
2	22	31.4	25	23.8	47	26.9	
3	9	12.9	13	12.4	22	12.6	
4 or more	8	11.4	6	5.7	14	8.0	
Caregiver Gender							
M	68	97.1	102	97.1	170	97.1	.000NA
F	2	2.9	3	2.9	5	2.9	
Caregiver Relationship							
Grandmother	43	61.4	82	78.1	125	71.4	5.910**
Aunt/Great Aunt	16	22.9	15	14.3	31	17.7	
Other	11	15.7	8	7.6	19	10.9	
Caregiver Education							
Middle School	21	3.0	18	17.1	39	22.3	5.861**
High School	33	47.1	48	45.7	81	46.3	
Post High School	16	22.9	39	37.1	55	31.4	
Caregiver's Age							
<39 Young	7	10.0	11	10.5	18	10.3	.837
40-59 Middle Age	49	70.0	67	63.8	116	66.3	
60 + Older	14	20.0	27	25.7	41	23.4	
Caregiver Income							
>\$10,000,	15	21.4	30	13.3	29	16.6	10.706**
\$10,000-\$19,999	21	30.0	25	28.6	51	29.1	NA
\$20,000-\$29,999	21	30.0	14	23.8	46	26.3	
\$30,000-\$39,000	10	14.3	10	13.3	24	13.7	
\$40,000-\$49,000	2	2.9	12	9.5	12	6.9	
50,000+.	1	1.4		11.4	13	7.4	

Referral Source							
Self	29	41.4	48	45.7	77	44.0	1.30
Child Welfare	6	8.6	5	4.8	11	6.3	
School	19	27.1	26	24.8	45	25.7	
Other Program	16	22.9	26	24.8	42	24.0	

Table 5.9
Bivariate Characteristics of Age

Characteristics	<39 Young	%	40-59 Middle Age	%	60 + Older	%	Total (n)	%	X2
Number of Children									
1	7	35.0	70	51.1	29	59.2	106	51.5	11.112
2	4	20.0	41	29.9	12	24.5	57	27.7	
3	5	25.0	15	10.9	7	14.3	27	13.1	
4	4	20.0	11	8.0	1	2.0	16	7.8	
Caregiver Gender									
F	19	95.0	134	97.8	46	93.9	199	96.6	1.874
M	1	5.0	3	2.2	3	6.1	7	3.4	
Caregiver Relationship									
Grandmother	2	10.0	108	80.6	38	82.6	148	74.0	53.770***
Aunt/Great Aunt	13	65.0	21	15.7	2	4.3	36	18.0	
Other	5	25.0	5	3.7	6	13.0	16	8.0	
Caregiver Education									
Middle School	5	26.3	21	16.2	11	23.9	37	19.0	.457
High School	9	47.4	69	53.1	18	39.1	96	49.2	
Post High School	5	26.3	40	30.8	17	37.0	62	31.8	
Caregiver Race									
African American	8	42.1	59	46.1	18	39.1	85	44.0	.698
Caucasian	11	57.9	69	53.9	28	60.9	108	56.0	
Caregiver Income									

>\$10,000,	4	20.0	22	16.2	7	14.3	33	16.1	.628
\$10,000-\$19,999	5	25.0	42	30.9	18	36.7	65	31.7	
\$20,000-\$29,999	8	40.0	34	25.0	8	16.3	50	24.4	
\$30,000-\$39,000	1	5.0	19	14.0	9	18.4	29	14.1	
\$40,000-\$49,000	0	.0	10	7.4	4	8.2	14	6.8	
50,000+.	2	10.0	9	6.6	3	6.1	14	6.8	

Referral Source

Self	9	45.0	61	44.5	19	37.3	89	42.8	4.879
Child Welfare	2	10.0	13	9.5	2	3.9	17	8.2	
School	6	30.0	32	23.4	13	25.5	51	24.5	
Other Program	3	15.0	31	22.6	17	33.3	51	24.5	

Table 5.10
Bivariate Characteristics Income

Characteristics	<\$19,000	%	\$20,000- \$39,000	%	\$40,000	%	Total (n)	%	X2
Number of Children									
1	47	48.0	49	61.3	10	35.7	106	51.5	16.279***
2	32	32.7	18	22.5	7	25.0	57	27.7	
3	13	13.3	5	6.3	9	32.1	27	13.1	
4	6	6.1	8	10.0	2	7.1	16	7.8	
Caregiver Gender									
F	94	95.9	78	97.5	27	96.4	199	96.6	.339
M	4	4.1	2	2.5	1	3.6	7	3.4	
Caregiver Relationship									
Grandmother	71	75.5	54	69.2	23	82.1	148	74.0	2.387
Aunt/Great Aunt	15	16.0	17	21.8	4	14.3	36	18.0	
Other	8	8.5	7	9.0	1	3.6	16	8.0	
Caregiver Education									
Middle School	19	21.6	16	20.5	2	7.1	37	19.1	7.168
High School	48	54.5	35	44.9	13	46.4	96	49.5	
Post High School	21	23.9	27	34.6	13	46.4	61	31.4	
Caregiver's Age									
<39 Young	9	9.2	9	11.4	2	7.1	20	9.8	.786
40-59 Middle Age	64	65.3	53	67.1	19	67.9	136	66.3	
60 + Older	25	25.5	17	21.5	7	25.0	49	23.9	
Caregiver Race									

African American	45	50	35	46.7	5	17.9	85	44.0	9.296***
Caucasian	45	50	40	53.3	23	82.1	108	56.0	
Referral Source									
Self	40	40.8	36	45.0	13	46.4	89	43.2	13.531*
Child Welfare	11	11.2	1	1.3	5	17.9	17	8.3	
School	24	24.5	23	28.8	2	7.1	49	23.8	
Other Program	23	23.5	20	25.0	8	28.6	51	24.8	

Race is related to several other demographic variables in this study. There are statistically significant relationships between race and caregiver relationship, caregiver education, and caregiver income. More African American caregivers were aunts, great aunts, cousins, and sisters than non-African American caregivers. African American caregivers were more likely than other caregivers to complete middle school as their highest degree and less likely than other caregivers to attain a post high school degree. African American caregivers are less likely to earn more than \$40,000 than non African American caregivers.

Age is only related to one other demographic variable: the caregiver relationship with the child. This makes practical sense, because older caregivers are more likely to be grandmothers than younger caregivers.

Income is related to the number of children in care, caregiver race, and referral source. Caregivers who reported less income cared for fewer children than those caregivers reporting more family income. African American caregivers reported having less family income than caregivers of other races. Furthermore, caregivers with less family income are more likely to be referred to the program by the school system.

Multivariate Results

The effects of family resources and informal and formal support were examined through the use of regression analyses. In order to rule out multicollinearity between variables, Pearson's correlations were computed (Table 5.4). The only variable that showed strong and significant bivariate relationship was Family Support Scale Total (FSS_T) with Family Support Scale Informal Subscale (FSS_I) and Family Support Scale Formal Subscale (FSS_F). Because of this multicollinearity and the calculation of the family support scale total is the sum of the informal and formal support scales, family support scale total was removed from the multivariate analyses.

Determining the presence of multivariate outliers is highly recommended before conducting regression analyses (Stevens, 1992). Results of Mahalanobis Distance equations indicated the absence of any multivariate outliers.

An initial series of regression analyses tested the relationship of demographic variables to the outcomes employed in the study. When AGE, INCOME, and RACE were used as independent variables with HEALTH_PHY, HEALTH_MENT, CW_INVOLVE, and PERM as dependent variables, several of the regressions produced significant results. HEALTH_PHY, AGE and RACE were statistically significant, $F(3, 171)=7.984$, $p<.000$, but the effect was small (12.3% of variance). For HEALTH_MENT and CW_INVOLVE, none of the regressions produced significant results. For the last regression, PERM, AGE was statistically significant, $F(3, 171)=3.119$, $p<.05$, but the effect was very small (5.2% of variance).

Next, the relationship between types of social support and resources to outcomes were tested. A hierarchical or stepwise method was used for the regression analyses. Variables were entered in two stages. Social support and resources were entered in step 1. In step 2, AGE, INCOME, and RACE were included. For each stage, the criterion for inclusion in the model was a p-level of .05.

The hierarchical regression models will be presented and organized in the order of the hypotheses for this study. All results are displayed in Table 5.11.

H₁: There is a positive relationship between social support and health.

In this hypothesis, caregivers with high levels of social support will also have better general, physical, and mental health. Multiple linear regression analyses were conducted to assess the correlation between caregiver social support and health. In the bivariate analyses, only informal social support was slightly related to physical health. In the regression model where AGE, INCOME, and RACE were entered simultaneously on HEALTH_PHY, AGE and RACE were statistically significant. In the hierarchical regression models for HEALTH_PHY, FSS_Informal, FSS_Formal, and AGE were statistically significant, $F(3, 171)=8.880$, $p<.000$, but the effect size was fairly small (13.5% of variance.) Health_MENT did not produce any significant results.

H₂: There is an inverse relationship between social support and involvement with the child welfare system.

In this hypothesis, caregivers with high levels of social support will have less involvement with the child welfare system. Multiple linear regression analyses were

conducted to assess the correlation between caregiver social support and caregiver involvement with child welfare system. In the bivariate analyses, there was no relationship between social support and child welfare involvement. Also, in the simple regression model with AGE, INCOME, and RACE, no statistically significant results were found. To explore this relationship, hierarchical regression models were used. The models regressed child welfare system involvement on informal social support and formal social support. No statistical significance was produced.

H₃: There is a positive relationship between social support and permanence.

In this hypothesis, caregivers with high levels of social support will take care of children for a longer period of time. Hierarchical linear regression analyses were conducted to assess the correlation between caregiver social support and the months the child has lived in continuous care with the relative. In the bivariate analyses, there was a slight inverse and significant relationship between social support and permanence. To explore this relationship, hierarchical regression models were employed. Although the t-statistic was significant for FSS_Informal, $t(174)=-2.130$, $p<.05$, the model was not significant, $F(2, 172)=2.269$, $p>.05$ and very little variance was explained (2.6%).

H₄: There is an inverse relationship between family resource needs and health.

In H₄, caregivers who report more family resource needs will also have lower amounts of physical and mental health. In the bivariate analyses, there was a slight

and significant relationship between family resource needs and physical and mental health. To explore this relationship, stepwise regression models were used. Each of the health outcomes (both physical and mental health) produced statistically significant models. In the hierarchical regression models for HEALTH_PHY, FRS, AGE and RACE were statistically significant, $F(3, 171)=11.002$, $p<.000$, but the effect size was moderate (16.2% of variance.) In the hierarchical models for Health_MENT, FRS and RACE were statistically significant, $F(2, 172)=13.130$, $p<.000$, but the effect size was small (13.2% of variance).

H₅: There is a positive relationship between family resource needs and involvement with the child welfare system.

For this hypothesis, caregivers with high levels of family resource needs will have more involvement with the child welfare system. To explore this relationship, child welfare involvement was regressed on family resources and other demographic variables using the stepwise procedure. No variables were significant and no variance was explained.

H₆: There is an inverse relationship between family resource needs and permanence.

If this hypothesis is true, caregivers with high levels of family resource needs will take care of children for a shorter period of time. In the bivariate analysis for this variable, permanence had a slight and significant relationship with family resource needs. To explore this relationship further, hierarchical regression models were used. No demographic variables were included in statistical significant

models, but FRS was significant, $F(1, 173)=7.694$, $p<.000$. Very little variance was explained by this model (4.3%).

Table 5.11. Hierarchical Regression Models: Physical Health, Mental Health, Child Welfare Involvement, and Permanence.

	FACTOR	PREDICTOR	B	T	R²	F	
H ₁	Physical Health						
	Model 1	FSS_Informal	.170	2.268*	.029	5.144*	(df=173)
	Model 2	FSS_Informal	.248	3.169***	.074	6.874***	(df=172)
		FSS_Forma	-.226	-			
				2.896***			
	Model 3	FSS_Informal	.199	2.588**	.135	8.880***	(df=171)
		FSS_Forma	-.206	-2.715**			
		AGE	-.251	-3.466***			
	Mental Health						
	Model 1	FSS_Informal	.034	.421	.003	.260	(df=172)
		FSS_Forma	.033	.405			
H ₂	CW_Involve						
	Model 1	FSS_Informal	.144	1.787	.021	1.845	(df=172)
		FSS_Forma	.004	.048			
H ₃	Permanence						
	Model 1	FSS_Informal	-.171	-2.130*	.026	2.269	(df=172)
		FSS_Forma	.059	.736			
H ₄	Physical Health						
	Model 1	FRS	.273	3.736***	.075	13.955***	(df=173)
	Model 2	FRS	.242	3.401**	.140	13.985***	(df=172)
		AGE	-.257	-3.612***			
	Model 3	FRS	.218	3.054**	.162	11.002***	(df=171)
		AGE	-.264	-3.737***			
		RACE	-.150	-2.114*			
	Mental Health						
	Model 1	FRS	.317	4.389***	.100	19.26***	(df=173)
	Model 2	FRS	.345	4.785**	.132	13.130***	(df=172)
		RACE	.182	2.530**			

	FACTOR	PREDICTOR	B	T	R²	F	
H ₅	CW_Involve						
	Model 1	FRS	.002	.030	.000	.001	(df=173)
H ₆	Permanence						
	Model 1	FRS	-.206	-2.774**	.043	7.694**	(df=173)

Further investigation: Permanency

After examining the multiple regression models for each hypothesis, no model seemed to explain more than 16% of the variance. However, there seemed to be interesting relationships that could be further explored. Based on the previous regression models, the most interesting relationship seemed to be permanence, or the length of time the child was in the constant care of the relative. This variable is very important to child welfare and can also provide interesting information about the experiences of kinship care families in our sample. Using the coefficients in additional regression models, substantive information can be discovered about factors affecting the time in care. In order to explore the permanence variable, data was transformed into bivariate or dummy variables.

One technique that was used in this analysis was transforming variables and exploring relationships between permanence and those caregivers who scored above or below one standard deviation of the mean for each significant independent variable. For example, from the original variable Family Resource Needs, 2 new variables were created. The first variable was dummy coded for those that scored one standard deviation below the mean for the subscale *Basic Needs*. These would

include caregivers who scored low on items such as: food for two meals a day, money to buy necessities, enough clothes, and money to pay bills. The second variable was dummy coded for those that scored one standard deviation above the mean on the subscale for *Extra Needs*. Caregivers included in this code were faring better than the average caregiver, especially on items relating to extra needs, which include: money for special equipment, money to buy things for themselves, money for family entertainment, money for travel, and money to save. These new variables were created to explore two extremes of the Family Resource variable, as they relate to permanence.

For the Family Support Variable, four new dummy codes were created, including: high informal support, low informal support, high formal support and low formal support. Each dummy code was created using one standard deviation above or below the mean. Physical and Mental Health variables were coded similarly, with good physical and mental health codes using the group of caregivers who scored one standard deviation above the mean and poor physical and mental health codes using the group of caregivers who scored one standard deviation below the mean.

Age is an interesting variable to transform to a dummy variable, because there are so many options to choose from, such as young, middle aged, or older. Yet, for this particular sample, it seemed substantively relevant to develop a code that captured those caregivers whose ages are above and below the age of sixty. Most

policies, especially in the aging field, have established over 60 years of age eligibility requirements.

The variable family income was dummy coded into a variable to determine if the family was living below the federal poverty threshold. Three variables were used to calculate this dummy code. These variables include: (1) family income, (2) household arrangement (an item on the intake form that determined how many adults were living in the home), and (3) the number of kids in the home. According to the federal poverty threshold, if there are two persons living in the home including one child, the poverty threshold is below \$13,896. Additionally, for homes with three people, including two children is \$16,242; four people with three children is \$20,516; and five people with four kids is \$23,691.

The last variable in the dummy coding was race. This was coded as either African American caregiver or other race. This is the only variable with the same coding for the bivariate analysis in this study.

*Table 5.12
Dummy Coding for Permanence Variable*

Variable	Transformation	Dummy Codes
Family Resources	Low Basic Needs: 1 Standard Deviation Below the Mean of The Basic Needs Subscale of the FRS	LOWBASIC
	High Extra Needs: 1 standard deviation above the mean of Extra Needs Subscale of the FRS	HIGHEXTRA
Family Support	High Informal Support: 1 standard deviation above mean of FSS_I	HIGH_informal
	Low Informal Support: 1 standard deviation	LOW_informal

	below mean of FSS_I	
	High Formal Support: 1 standard deviation about the mean of FSS_F	HIGH_formal
	LOW Formal Support: 1 standard deviation below the mean of FSS_F	LOW_formal
Physical Health	Good Physical Health: 1 standard deviation above the mean of Health_phys	Good_Phys
	Poor Physical Health: 1 standard deviation below the mean of Health_phys	Poor_Phys
Mental Health	Good Mental Health: 1 standard deviation above the mean of Health_phys	Good_MH
	Poor Mental Health: 1 standard deviation below the mean of Health_phys	Poor_MH
AGE	60 years of age or older	AGE_60
INCOME	Poverty: Family income below the federal poverty line	POVERTY
RACE	African American	AA

Table 5.13 lists the frequency for each dummy variable response.

Table 5.13
Dummy Variable Response Items Frequency

Original Variable	Dummy Variable	Response	N	%
Family Resources	LOWBASIC	Yes	27	15.4
		No	148	84.6
	HIGHEXTRA	Yes	28	16.0
		No	147	84.0
Family Support	HIGH_informal	Yes	24	13.7
		No	151	86.3
	LOW_informal	Yes	20	11.4
		No	155	88.6
	HIGH_formal	Yes	26	14.9
		No	149	85.1
	LOW_formal	Yes	25	14.3
		No	150	85.7
Physical Health	Good_Phys	Yes	36	20.6
		No	139	79.4
	Poor_Phys	Yes	37	21.1
		No	138	78.9
Mental Health	Good_MH	Yes	29	16.6
		No	146	83.4
	Poor_MH	Yes	26	14.9
		No	149	85.1
AGE	AGE_60	Yes	41	23.4
		No	134	76.6
INCOME	POVERTY	Yes	68	38.9
		No	107	61.1

RACE	AA	Yes	70	40
		No	105	60

Table 5.14 examines the means and standard deviations for newly coded variables.

*Table 5.14
Descriptives for Permanence Variable*

	Mean	Std. Deviation
Permanence	45.1257	47.84753
FORMAL CW	.2514	.43508
HIGHEXTRA	.1600	.36766
Age_60	.2343	.42477
AA	.4000	.49130
Good_MH	.1657	.37289
LOWBASIC	.1543	.36226
POVERTY	.3886	.48882

Table 5.15 examines the correlations among dummy coded variables.

Table 5.15
Correlations for Permanence Variable

	Permanence	AA	LOWBASIC	HIGHEXTRA	Age_60	Good_Phys	Good_MH	POVERTY	FORMAL_CW
Permanence	1								
AA	.204(**)	1							
LOWBASIC	.185(*)	.168(*)	1						
HIGHEXTRA	-.145	-.038	-.143	1					
Age_60	.096	-.066	-.050	.016	1				
Good_Phys	-.123	-.127	-.178(*)	.125	-.081	1			
Good_MH	.103	.013	-.063	.225(**)	.080	.001	1		
POVERTY	.060	.139	.146	-.220(**)	.002	.058	-.072	1	
FORMAL CW	-.224(**)	-.043	.008	-.001	.022	.031	.025	.051	1

Regression

The first regression model included all variables that were shown (above) as having a statistically significant relationship with permanence.

Table 5.16
Permanence: First Model

Variables	B	Std. Error	Stand. β	T
(Constant)	38.767	6.233		6.220***
FORMAL CW	-24.660	7.827	-.224	-3.151***
HIGHEXTRA	-19.512	9.746	-.150	-2.002**
Age_60	12.436	8.042	.110	1.546
AA	16.444	7.083	.169	2.321*

Good_MH	18.081	9.385	.141	1.927
LOWBASIC	19.893	9.658	.151	2.060*
POVERTY	.318	7.234	.003	.044

N=175; R2=.124 *p ≤ .05; **p≤.01; ***p≤.001

The next model did not include the Age_60 and Poverty variables.

Table 5.17
Permanence: Final Model

Variables	B	Std. Error	Stand. β	T
(Constant)	41.916	5.361		7.818***
FORMAL CW	-24.432	7.822	-.222	-3.124***
HIGHEXTRA	-19.728	9.572	-.152	-2.061*
AA	15.829	7.027	.163	2.253*
Good_MH	19.207	9.364	.150	2.051*
LOWBASIC	19.413	9.616	.147	2.019*

N=175; R2=.148 *p ≤ .05; **p≤.01; ***p≤.001

Although the model does not have very good predictive qualities, we can use the coefficients to make permanency estimates. For example, if the caregiver is involved with the child welfare system and receiving relative caregiver benefits, the caregiver will be taking care of children for two less years than those caregivers taking care of children on an informal basis. Those caregivers with many extra resources, such as money to save and vacation, take care of children for 20 less months than those who don't have many luxury resources. African American caregivers are taking care of children for 15 more months than other races. Those caregivers who scored at least one standard deviation above the mean on the mental

health subscale take care of children for 19 more months than those that scored lower. Lastly, those caregivers who scored relatively low on the basic resources subscale of the Family Resource Scale take care of children for 19 more months than those who are better at meeting their basic needs.

VI. Discussion

Qualitative and quantitative data were provided by participants in the Kinship Services Network of Pinellas. The quantitative study sample includes all the participants in the Kinship Services Network of Pinellas. In any study questions often arise about the generalizability of findings. This section addresses the issue of how much the findings of this study can be extrapolated to the broader population of informal caregivers in Pinellas County, Florida and the nation.

This program through which the study sample was recruited involves collaboration among Children's Home, Inc., Big Brothers Big Sisters of Pinellas County, and Catholic Charities, Diocese of St. Petersburg, Inc. These agencies are not known in the community as human service organizations which provide foster care or child protective services. More specifically, these agencies are not your typical child welfare agencies with all that it implies by way of coercive removal of children from homes. In the community, they are considered to be in the realm of supportive service agencies. Their reputation as human service organizations may have resulted in a sample with more informal caregivers who otherwise would have avoided

traditional child welfare system, but are willing to engaged and receive community-based services that are less stigmatizing.

Forty-four percent (n=77) of caregiver participants called the central intake line and self-referred themselves to the program. This could mean that a good portion of the sample is made up of caregivers who acknowledge they need help and follow through to make a connection to the program. This could exclude caregivers who consider struggles associated with kinship caregiving as part of their normal, everyday life, despite how many resources they need or are available to them. These caregivers who were not included could be the most socially isolated and in need of services.

The qualitative study sample is made up of informants from the 175 caregivers in the quantitative study. It could be considered a sub-sample of the larger study. These caregivers volunteered to participate in an in-depth interview over the phone with a researcher. These caregivers could have been experiencing less shame, disappointment, or embarrassment about their caregiving, than those caregivers who did not volunteer.

Although there are several threats to the generalizability of the findings in this study, the results can provide some valuable insight, specifically to community service providers. The Kinship Services Network of Pinellas is designed to make use of untapped resources in the community to meet the diverse needs of kinship caregivers. Social service agencies in other communities could consider these findings helpful when they reach out to these informal kinship caregivers.

Discussion on Univariate Results

Demographics

Demographics for this study resemble the characteristics of caregivers in other studies (Chipungu, Everett, Verdieck, & Jones, 1998; Dubowitz, Feigelman & Zuravin, 1993; Gleeson, O'Donnell & Bonecutter, 1997; Harden, A.W., Clark, R.L. & Maguire, K., 1997; Hegar & Scannapieco, 1995; U.S. Department of Health and Human Service, 2000), specifically that caregivers are more likely to be female, older, single, less educated and lower socioeconomic status. However, this study's race is much more evenly distributed than other studies, whose race is overwhelmingly African American. In this study, 53% are Caucasian. This is an important distinction, because Caucasian families do not have the same historical roots in extended family care as African American families. Hence, they can experience kinship care much differently. The large percentage of Caucasian caregivers could be the result of a large population of Caucasians in Pinellas County, FL (84%). Since most research describes the experiences of a predominantly African American sample, this study could provide valuable insight into an understudied population of Caucasian caregivers.

Family Resource Scale

Several studies have used the Family Resource Scale in the evaluation of kinship care. Gleeson (2007) reported mean results of the Family Resource Scale for 207 kinship caregivers in Illinois. In his study, caregivers reported a mean of 87.42,

slightly less than this study. Project Healthy Grandparents, a family support program for kinship caregivers, reported mean results for 92 kinship caregivers in Georgia. The results of Project Healthy Grandparents was 101.28, slightly closer to this study mean.

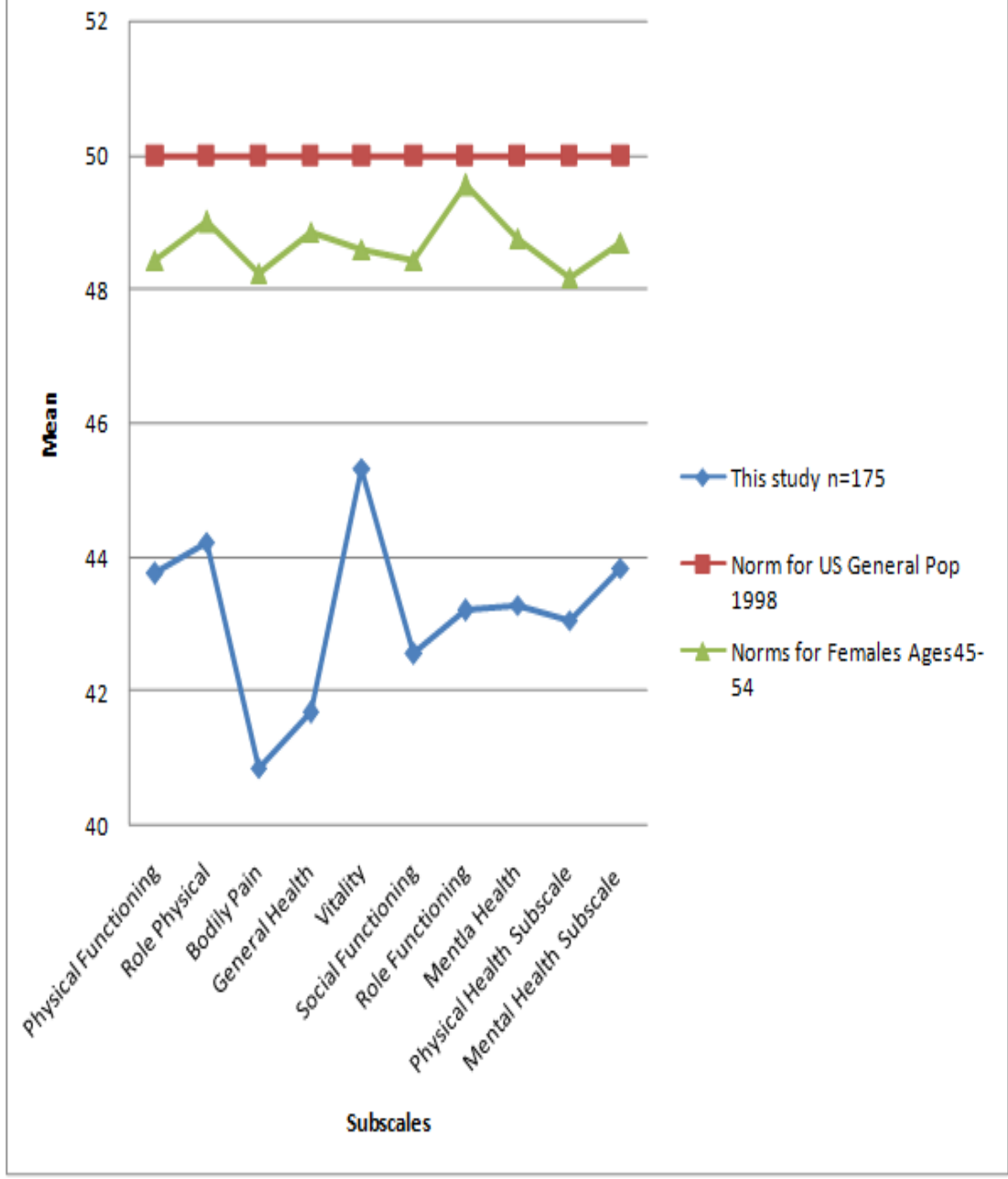
Family Support Scale

Project Healthy Grandparents also reported means for the Family Social Support Scale Total of 27.41 for the same sample of 92 caregivers. Again, this is very similar to the present study's mean. The trend in social support for kinship caregivers is that they report receiving more informal support than formal support (USHHSA, 1997), similar to the distribution in the current study.

General Health Questionnaire

Figure 5.1 compares this study's General Health Questionnaire results to the U.S. General Population and norms for females ages 45-54 (the mean age range of caregivers in this study). The caregivers in this study scored lower than each of the comparison groups. This means that the lower the score, the more health problems. Caregivers in this study scored the lowest on the bodily pain item and the highest on the vitality item. Caregivers scored slightly higher on the mental health subscale, compared to the physical health subscale. This trend was similar to norms for females ages 45-54 in the U.S.

Figure 6.1
Health Subscale Norm-based Comparisons



Discussion on Multivariate Results

Social Support as a predictor of Physical Health and Mental Health

According to the regression models, formal and informal social supports are important predictors of physical but not mental health. There was no multicollinearity between physical and mental health and it would seem as though there is little connection between these two measures of health. However, the development of each subscale used similar items from the General Health Questionnaire. Each subscale just emphasized different components. For example, the physical health measure (SF-12-v2 physical component) emphasizes physical functioning, role functioning, body pain, and general health status over the past 30 days. While the mental health measure (SF-12-v2 mental component) stresses vitality, social functioning, emotional functioning, and mental health status over the past 30 days. Then, if these measures are so closely related, why does social support predict only physical health?

To better answer this question, it may be important to examine kinship caregivers' perception of their own mental health. Since relative caregivers are older, it is possible that this generation of caregivers have not historically accessed mental health services for themselves. Additionally, other studies (Smith, Krisman, Strozier, & Marley, 2001; Strozier & Krisman, 2007) have reported that kinship caregivers are more likely to take care of their children's needs and neglect their own needs. It is possible that kinship caregivers utilize informal and formal social support to assist

with their children. They could be discounting their own need for mental health help. Additionally, the qualitative interview provided a good opportunity for caregivers to discuss coping and mental health issues. During the interview, caregivers were forthcoming when offering information on their grandchildren's ADHD, emotional difficulties, or mental health issues and their own children's mental health issues and alcohol and drug dependence, but no caregiver seemed to expand on their own mental health concerns. This further validates the idea that caregivers have difficulty identifying and communicating about their own mental health needs and issues.

As expected, caregivers with less social support experience worse physical health. This study confirms findings from other studies that portray grandparent caregivers as socially isolated from peers due to demands of raising children (Kelley, 1993; Minkler & Roe, 1993). However, this study does not indicate any strong differences between informal and formal social support. Perhaps using the subscales of the Dunst Family Support Scale (FSS) was not the most effective way to measure informal and formal supports for kinship caregivers. Previous research on informal and formal social support for grandparents raising grandchildren use several other measures to help differentiate between these types of support. Landry-Meyer, Gerard, & Guzell (2005) found that formal and informal social support did not buffer stressors on grandparents wellbeing using the Support subscale of the Parenting Ladder (Pratt, 1995; Pratt, McGuigan, & Katzev, 2000). Gerard, Landry-Meyer, & Guzell-Roe (2006) revisited their measurement of social support by

drawing their attention to a broader array of social support dimensions, which included network, perceived, and enacted support. For the measurement of informal support, the Lubben Social Network Scale (Lubben, 1988) and the 12-item Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlmén, Zimet, & Farley, 1988) were used. For the measures of perceived and enacted formal support, the Attitudes Toward the Use of Formal Help or Community Services and an index of service utilization were used. They found that among all the dimensions, buffering effects were detected only for enacted formal support. Goodman, Potts, & Pasztor (2006) found effects for formal social support by using a “yes or no” response to a list of services and enumeration for assistance for informal social support. They found that formal kinship caregivers used more formal supportive services and informal caregivers relied more on informal support. Perhaps future research could benefit this field of knowledge on informal and formal social support by replicating many of these other measures to better determine their utility.

Child Welfare Involvement as an Outcome Variable

Nothing seemed to predict involvement with the child welfare system. This could be an artifact of how this variable was measured, however, because this variable was coded in a case review by one researcher, there was little response bias and interrater reliability was not an issue. This finding is more likely to represent reality. There are many pathways to child welfare involvement. Not all of these pathways involve the caregiver or kinship family, per se. Some pathways to child welfare are strictly policy and practice driven. For example, some child welfare

agencies could be interpreting policy differently. This affects their placement rates and the type of placements that they prefer. If certain community child welfare agencies are looking to receive additional federal matching dollars for their placements, they could be more likely to work towards reunification with biological parents or placement with non-relatives, instead of placement with relatives. This is just one example of how the child welfare system influences their involvement with the kinship family, instead of the family controlling their own destiny with the system. Another example is the usage of “temporary custody” in Florida. When child welfare agencies place children in the temporary custody of a relative, there is no formal relationship, no termination of parental rights, and most importantly to caregivers, no eligibility to collect financial assistance and other services for the family. Unfortunately, if the child welfare agency is saving money, they often are rewarded with more federal funding. When this happens, caregiving families suffer and become ineligible for goods and services.

Then, a better question might be how much control do families have in determining their involvement with the child welfare system, especially if family support and resource needs don't predict involvement. In the qualitative study, caregivers discussed how child welfare agencies initiated contact with them when the children were removed from homes because of suspected abuse or neglect. However, no caregiver discussed any continuity of care by the child welfare system. Mainly, they discussed fear or mistrust with the child welfare system. Perhaps Caregiver C. had the most interesting experience with child welfare agencies: *People*

that are suppose to help us, made it hard for us. Nobody cared. Nobody gave a damn. Until the kids are wards of the State, then they will help.

Lastly, using child welfare involvement as an outcome variable could be problematic if caregivers and service providers alike do not fully understand the pathways to child welfare involvement. For example, it is possible that a caregiver achieve formal custody of their grandchildren through Family Court. Even though they formalized their relationship and made a permanent commitment to the child, they would be ineligible for child welfare services and financial support through the Florida Relative Caregiver Program. It would make sense to question the reliability of this variable if in reality there is much confusion about how it is interpreted and practiced.

Despite the lack of evidence connecting social support and family resource needs to child welfare involvement in this study, other studies have found some differences between families involved with the child welfare system and families without this involvement. Goodman, Potts, Paszlor, & Scorzo (2004) found that children in formal kinship care arrangements are more likely to be victims of child abuse and neglect. Swann & Sylvester (2006) found that the child welfare system serves the neediest kinship care families, including caregivers who are older, less educated, less likely to be employed. However, Swann & Sylvester also found that informal caregivers are more likely to live below the poverty line and experience food insecurities. Future studies will need to continue to examine how social support and family resources are related to child welfare involvement.

Family Resource Needs as a Predictor of Physical Health, Mental Health, and Permanence

Family resource need is the most consistent predictor in this study. It predicted physical health, mental health and permanency. This is consistent with what other studies have found, including: families with more resources will have better health (Burns, Costello, Angold, Tweed, Stangl, Farmer, & Erkanli, 1995; Dunst & Leet, 1987) and more permanence (Brannan, Heflinger, & Foster, 2003). Formal kinship caregivers have also acknowledged that meeting resource needs is something important for them to promote or inhibit their successful caregiving (Coakley, Cuddeback, Buehler, & Cox, 2007). Unfortunately, the literature does not have a consistent operationalization of family resource needs.

As mentioned in the literature review, kinship care is a growing phenomenon. Growth is most dramatic among families with the least financial resources and the highest social service needs (Ehrle & Geen, 2002; Harden, Clark, & McGuire, 1997). It would seem that this study only scratched the surface of researching the importance of family resources to kinship families. Insufficient or inadequate services and resources have continually been associated as a barrier to permanency planning in the child welfare field (Gleeson, 1999; Testa, 2002). Biological parents indicate that their lack of resources is a reason they were unable to care for the children before kinship care occurs (Gleeson, 2007).

Family resource need was also a common theme in the qualitative study. Caregivers voiced many concerns about resources that were available to them.

Caregiver B. described how the lack of financial and transportation resources have negatively impacted her life. Her disability income is not enough to sustain her family and without a car, it is difficult to take her children to doctor's appointments or after school activities. Without meeting these resource needs, one might wonder how long Caregiver B. will be able to maintain her caregiving responsibilities.

Caregiver B.'s experience could be an example of how resource needs can help to predict permanency. On the other hand, if she receives more financial assistance and help with transportation, she may be better equipped to continue her role as primary caregiver. Because the caregiver continues her enrollment in the KSN, it is hopeful that she will receive the services to meet her resource needs.

Limitations

There were several limitations of the qualitative and quantitative study. Both studies were cross-sectional and are confined to a specific point in time when the qualitative interview took place and when the quantitative data was collected. This only provides a snapshot of the sample population and does not reflect any changes over time.

The qualitative study used a convenience sample drawn from the participants in the KSN of Pinellas. Therefore, all participants in this study were willing to discuss with a researcher their experiences. This might mean that those caregivers who had a challenging or negative experience with KSN workers or the program itself may not have felt compelled to volunteer for this study. This could skew the results to be more favorable than expected if their participation was randomly

assigned. Also, during some of the interviews, it was not possible to record each caregiver's response to the open ended questions verbatim. Instead, the researcher attempted to record the main ideas of the caregivers, though in most instances quotes were recorded. Although the researcher used Atlas ti to conduct the content analysis of this data and to help organize each open ended item, the researcher looked for patterns of responses or similar ideas and presented them in the findings. Consequently, use of the results of the qualitative data must be tempered with the recognition that the distinctions drawn could reflect those of the researcher.

The quantitative study had further limitations. First, the data were not collected to specifically test the proposed hypotheses. The study was based on secondary data analysis of the Kinship Services Network of Pinellas Evaluation. All participants in this study were provided with a full array of services by the KSN of Pinellas. This means that these caregivers may not represent those caregivers who do not receive any support for their caregiving experience. These are the caregivers that could be in real need, but are not being served by any formal social support network. Furthermore, 25% (n=44) of the participants had some kind of involvement with the formal child welfare system. This means that these caregivers could be receiving formal social support in addition to the KSN Program services. This could skew some of the results, especially those related to social support.

This study relied on the caregiver's own assessment of family support, resource needs, and health. Caregivers were reporting to Family Support Workers, who could provide case management, financial assistance, or other services to the

family. This could influence how caregivers score on the assessments. Hence, response bias could influence the validity of the caregivers' responses and the results of this study.

According to the parenting literature, fewer social supports are related to fewer economic supports and a variety of other challenges to individual well-being. For example, single parents have been consistently found to be more economically disadvantaged and more stressed in the parenting role than their married counterparts (Weintraub & Gringlas, 1995; Brody & Flor, 1998). An additional analysis regarding the presence of another adult in the home would have implications for how the single parent status of caregivers is understood and how it could impact social support.

Permanence seemed like a very interesting variable because it could be interpreted by coefficients to examine length of time caregiving. However, this analytical approach has a noteworthy limitation in its interpretation. When the permanence variable was collected, it examined the length of time the child remained in the constant care of the relative. However, the age of the child was not taken into account. Because of this, there could be an overestimation of how much longer older children remained in care than their younger counterparts. A better measure of permanence in future studies could include disruption rates. Unfortunately, because the KSN program is an average of six months in duration, the only disruption rate examined was the disruption occurring during this period of six months program enrollment time. This did not provide an accurate estimate of

permanence. The best available option was the permanence variable used in the study.

Implications for Social Work

How family support and family resource needs impact the lives of kinship caregivers is an important issue for today's family. Currently, little is known about the assessment of social support and provision of family resources for kinship families. The service community has mainly relied on conventional wisdom to guide much of the work relative to the provision of kinship care services. For the most part, the child welfare community treats the kinship family the same way it treats the non-relative foster family. There are few studies that address social support and family resources for informal and formal kinship caregivers. This gap in the literature can make it difficult for practice decisions to be made.

This study is unique in that it examines kinship care from the perspective of both formal and informal kinship caregivers. Even though much of what we know about kinship care is based on the child welfare, it is important for social workers to not ignore the service needs of the caregivers not involved with formal systems of care. These could very well be the caregivers in the most need for help. Plus, if informal caregivers are supported better, it would be less likely for them to become involved with the child welfare system at a later point. This is one way to keep caseloads down and improve future child welfare practice.

One of the main findings of this study is that family resources predicted physical health, mental health and permanency. Kinship care practitioners could

develop more easily accessible and culturally appropriate resources for kinship families in the community. Often, social workers may not be aware of the barriers to access services or the wide range of resources these families need. Particularly, in many communities, there are few mental health resources available. Social workers not only need to explore the barriers kinship caregivers face when trying to access mental health services, but also need to educate caregivers in the importance of meeting their own mental health needs.

This study found no relationship between social support and family resources and child welfare involvement. Such a finding could suggest that child maltreatment knows no bounds and affects those families with high levels of social support and family resources and those families with low levels alike. More needs to be done to address how child welfare practitioners help these two different types of families.

Regarding research and policy implications, if family resources can predict the health of kinship caregivers, it is not surprising that meeting resource needs is an established goal of Kinship Navigator Programs. Although the Kinship Support Act has not been passed by the U.S. Legislature, many states are implementing their own pilot programs to better meet resource needs of kinship families. To measure these resource needs, the Dunst Family Resource Scale is extensively used in Kinship Navigator Programs in many states (Washington, Ohio, New Jersey, Georgia, Florida, Illinois, California, etc.). If there is data from multiple states, then it would seem advantageous to begin making state comparisons of family resource needs.

This will help to determine policy and practice needs across the U.S. Future research

should take advantage of available data in this field, particularly regarding family resource needs, to make cross-cultural and state-by-state comparisons. This can help solicit more support for the passage of important legislation, such as the Kinship Support Act.

APPENDIX

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A. Approval Letter to Conduct Research



UNIVERSITY OF
SOUTH FLORIDA

January 23, 2008

Anna L. Strazier, Ph.D.
School of Social Work
MCY132
Attention: Kerry Littlewood, MSW

RE: **Expedited Approval** for Continuing Review
IRBA: 105542
Title: *Kuship Services Network Evaluation*
Study Approval Period: 01/18/2008 to 01/16/2009

Dear Dr. Strazier:

On January 18, 2008, Institutional Review Board (IRB) reviewed and **APPROVED** the above protocol for **the period indicated above**. It was the determination of the IRB that your study qualified for expedited review based on the federal expedited category number five (5): Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis); number six (6): Collection of data from voice, video, digital, or image recordings made for research purposes; and number seven (7): Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Please note, if applicable, the enclosed **informed consent/assent documents are valid during the period indicated by the official, IRB-Approval stamp located on page one of the form**. Valid consent must be documented on a copy of the most recently IRB approved consent form. Make copies from the enclosed original.

Please reference the above IRB protocol number in all correspondence regarding this protocol with the IRB or the Division of Research Integrity & Compliance. In addition, we have enclosed an **Institutional Review Board (IRB) Quick Reference Guide** providing guidelines and resources to assist you in meeting your responsibilities in the conduction of human participant research. Please read this guide carefully. It is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB.

OFFICE OF RESEARCH • DIVISION OF RESEARCH INTEGRITY & COMPLIANCE
INSTITUTIONAL REVIEW BOARDS, FWA No. 00031669
University of South Florida • 129C1 Bruce B. Downs Hall, MDC035 • Tampa, FL 33612-4799
(813) 974-5638 • Fax (813) 974-5615

B. Informed Consent

Space below reserved for IRB Stamp – Please
leave blank

Informed Consent for Grandmothers and Other Relatives Raising Children
Social and Behavioral Sciences
University of South Florida St. Petersburg

IRB Approval FWA 00001669
IRB Number: <u>105572</u>
From <u>01/18/2008</u>
Thru <u>01/16/2008</u>

Information for People Who Take Part in Research Studies

Researchers at the University of South Florida (USF) study many topics. For example: We want to learn more about grandmothers and other relatives care for children because their parents are unable or unwilling provide care. To do this, we need the help of people who agree to take part in a research study.

Title of research study: Kinship Services Network Evaluation

Person in charge of study: Dr. Anne Strozier and Kerry Littlewood

Study staff who can act on behalf of Dr. Anne Strozier and Kerry Littlewood: Larry Cooper, Program Manager-KSN, Karrie Roller, Program Coordinator-KSN, Amy Caparratto, FKC Warmline

Where the study will be done: the families' homes, KSN agencies, and support groups

Who is paying for it: Juvenile Welfare Board of Pinellas County

Should you take part in this study? Grandparents and other relatives participating in KSN

This form tells you about this research study. You can decide if you want to take part in it. You do not have to take part. Reading this form can help you decide.

Why is this research being done?

The purposes of this study include: 1) To find out more about who is benefiting from the KSN, 2) To find out if the KSN is meeting its expected outcomes, 3) To find out more about the factors associated with raising relative children in Pinellas County, and 4) Refine the KSN Program to better meet the needs of kinship caregivers in Pinellas County. The study's main focus will be on your family support, resources, health and circumstances in caregiving for relative children. We will try our best to understand each family's special life circumstances, we will also try to learn as much as we can about the unique stresses that each family faces.

Why are you being asked to take part?

We are asking you to take part in this study because you contacted the Kinship Services Network for support, you are raising relative children, and because you can provide us with some very valuable insights about how you, your grandchild, and your family are adjusting.

How long will you be asked to stay in the study?

You will be asked questions during the intake of the Kinship Services Network (KSN). These questions will help to identify your resource needs, availability of family support, and health. Upon completion of the KSN Program, you will be contacted at three and six months for follow-up questions about the program and open-ended questions to give us information about how your family is doing. The study will last this long so that we can see how you are doing at the beginning of the program, during the program and after the program ends.

How often will you need to come for study visits?

The KSN Family Support Coordinator will come to your home for home visits upon your request and based on the need of your family. During these visits, you and the Family Support Coordinator will go over your resource and support needs. At the end of the program, you will be contacted by me, USF Researcher, Kerry Littlewood, to go over open-ended questions that pertain to your experiences caregiving. This information will give us a better picture of your unique family circumstances, stresses, and ways of coping.

How many other people will take part?

About 200 caregivers, each providing care to relative children, will take part in this study.

What will happen during this study?

Once you have joined the study, your Family Support Coordinator will be working with you to get you involved with support groups and provide you with the support to meet your needs. I'll be in touch by phone to ask some questions. You don't need to do anything special or different to prepare for this phone conversation. This can take anywhere from 20 minutes to 1 hour, depending on what you want to talk about.

Here is what you will need to do during this study:

Mainly, we want you to participate in the KSN Program and participate in a phone interview with Kerry Littlewood, the USF Researcher, about your caregiving experiences. This interview will take 20 minutes to 1 hour depending on what you want to talk about. These interviews may be audio taped. This will be discussed with you in the beginning of the telephone call. This means that if you are uncomfortable with tape recording for any reason, the interview can still be completed without audio taping. Your work with the KSN Program will include completing a Family Support Scale, Family Needs Scale, General Health Questionnaire, and a Dispositional Optimism Scale with your Family Support Coordinator at the beginning and end of your enrollment in the program. These questionnaires will take 20 minutes to an hour and will be completed in your home with your Family Support Worker.

What are the potential benefits if you take part in this study?

The potential benefit to you is to have an opportunity to think about and talk about different family factors that you have experienced while caregiving for relative children. Also, society will benefit from more knowledge about kinship caregivers' experiences. This can help to better inform supportive policies and more appropriate programs for grandparents and other relatives raising children.

What are the risks if you take part in this study?

Some people report feeling a bit uncomfortable or sad in talking about difficult family circumstances. Some people also feel a bit uncomfortable at first with working with new people or talking on the phone to someone new. If you have any worries about these things, please tell the person in charge of this study or study staff at your next visit. You can also call the Florida Kinship Center at any time about family issues or about your grandchild. Also, if you wish to speak to someone separate from the USF researchers or investigator, you can contact the Kinship Care Warmline at 1-800-640-6444 for emotional support and a warm, listening ear.

What will we do to keep your study records private?



p. 2 of 4

Federal law requires us to keep your study records private.

We do several things to keep your responses private. First, we only write a code number, and never anyone's name, on all questionnaires, papers, and forms. The key linking your name to this code number is kept only by the lead investigator, Dr. Anne Strozier, in a separate locked area of the project office so that no one else can link a name to a record.

The consent form that you fill out, and all questionnaires are kept in a secure locked cabinet in the Florida Kinship Center at the University of South Florida.

After your participation in the study is over, only certain people are allowed to see your study records and by law, anyone who looks at your records must keep them confidential. Only people who will ever be allowed to see these records are:

- The study staff.
- People who make sure that we are doing the study in the right way. They also make sure that we protect your rights and safety:
 - The USF Institutional Review Board (IRB), its staff and other individuals acting on behalf of USF
 - The United States Department of Health and Human Services (DHHS)
- Our sponsors at the Juvenile Welfare Board of Pinellas County. They may also look at the study records to make sure the study is done in the right way.

We may publish what we find out from this study. If we do, we will not use your name or anything else that would let people know who you are.

What happens if you decide not to take part in this study?

You should only take part in this study if you want to take part.

You can get the answers to your questions.

If you have any questions about this study, you can call me directly at 813-974-2796 (Kerry Littlewood)

If you have questions about your rights as a person who is taking part in a study, call USF Research Compliance at (813) 974-5638.

Consent to Take Part in this Research Study

It's up to you. You can decide if you want to take part in this study.

I freely give my consent to take part in this study. I understand that this is research. I have received a copy of this consent form.

Signature
of Person taking part in study

Printed Name
of Person taking part in study

Date

Signature of Witness

Printed Name of Witness

Date



P. 3 OF 4

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect.

The person who is giving consent to take part in this study

- Understands the language that is used.
- Reads well enough to understand this form. Or is able to hear and understand when the form is read to him or her.
- Does not have any problems that could make it hard to understand what it means to take part in this study.
- Is not taking drugs that make it hard to understand what is being explained.

To the best of my knowledge, when this person signs this form, he or she understands:

- What the study is about.
- What needs to be done.
- What the potential benefits might be.
- What the known risks might be.
- That taking part in the study is voluntary.

Signature of Investigator
or authorized research
investigator designated by
the Principal Investigator

Printed Name of Investigator

Date

Signature of Witness

Printed Name of Witness

Date



p. 4 of 4

C. Site Approval to Conduct Research



Letter of Support for Florida Kinship Center

This is a Letter of Support from Larry Cooper, Program Manager of The Children's Home, Inc. (lead agency representing the Kinship Services Network (KSN) of Pinellas) to **Florida Kinship Center** to evaluate according to the human subjects protections and ethical standards detailed in the IRB for the KSN.

KSN is a community-based collaborative, funded by **The Juvenile Welfare Board of Pinellas**, that includes various social service, government, and educational agencies linked to kinship care. The collaborative is structured after a promising kinship care model operating in Hillsborough County for more than five years and a well-known national model in California.

The overriding goal of the KSN of Pinellas collaborative is to assist relative care families in accessing and utilizing a network of resources that are timely, culturally appropriate, designed for their individual needs, and effectively linked to existing and/or new services as necessary. Specific objectives to the KSN of Pinellas program model include the following:

- To maintain family stability;
- To decrease risk factors that lead to substance abuse and use, violence and irresponsible sexual behavior;
- To improve the access and utilization of essential information and resources (i.e. legal, counseling, health and financial assistance);
- To improve the well-being of the caregiver and children;
- To increase knowledge and awareness of kinship care and relative caregiver family needs;
- To strengthen kinship care services as a coordinated network and as an alternative to foster care.

We support the **Florida Kinship Center** to provide the evaluation as specified in the IRB for the KSN Evaluation. Quarterly Program Evaluation Tasks include data analyses, report writing, technical assistance to program staff, evaluation monitoring, other outcome analysis, and publication preparation, as outlined in the detailed Proposed Evaluation Tasks schedule attached. Additionally, we have adequate resources to complete this research project.

Signed and agreed to on _____, 2006 by:

Larry Cooper
Program Manager
KSN of Pinellas
Children's Home, Inc.



Letter of Understanding

Between

The Children's Home, Inc., Kinship Services Network (KSN) of Pinellas and Florida Kinship Center

This is a Letter of Understanding between The Children's Home, Inc. (lead agency representing the Kinship Services Network (KSN) of Pinellas) and **Florida Kinship Center** to promote the mission of KSN that is *to provide a coordinated network of services for relative caregiver families to achieve self-sufficiency and stability*. KSN is a community-based collaborative, funded by **The Juvenile Welfare Board of Pinellas**, that includes various social service, government, and educational agencies linked to kinship care. The collaborative is structured after a promising kinship care model operating in Hillsborough County for more than five years and a well-known national model in California.

The overriding goal of the KSN of Pinellas collaborative is to assist relative care families in accessing and utilizing a network of resources that are timely, culturally appropriate, designed for their individual needs, and effectively linked to existing and/or new services as necessary. Specific objectives to the KSN of Pinellas program model include the following:

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- To improve the access and utilization of essential information and resources (i.e. legal, counseling, health and financial assistance);
- To improve the well-being of the caregiver and children;
- To increase knowledge and awareness of kinship care and relative caregiver family needs;
- To strengthen kinship care services as a coordinated network and as an alternative to foster care.

As the lead agency of KSN, The Children's Home will provide the following: fiscal management, program supervision, consultation and experience as a lead member of the Hillsborough Kinship Care Collaborative and more than 100 years of nonprofit management of children and family services. Two core collaborative members are Big Brothers Big Sisters of Pinellas and Catholic Charities Diocese of St. Petersburg. Additionally, the community collaborating partners have extended substantial in-kind support to leverage JWB funding.

Florida Kinship Center agrees to provide the following services, goods, supplies or other support to KSN of Pinellas for the period of October 1, 2006 – September 30, 2007:

- Quarterly Program Evaluation Tasks to include data analyses, report writing, technical assistance to program staff, evaluation monitoring, other

outcome analysis, and publication preparation, as outlined in the detailed Proposed Evaluation Tasks schedule attached.

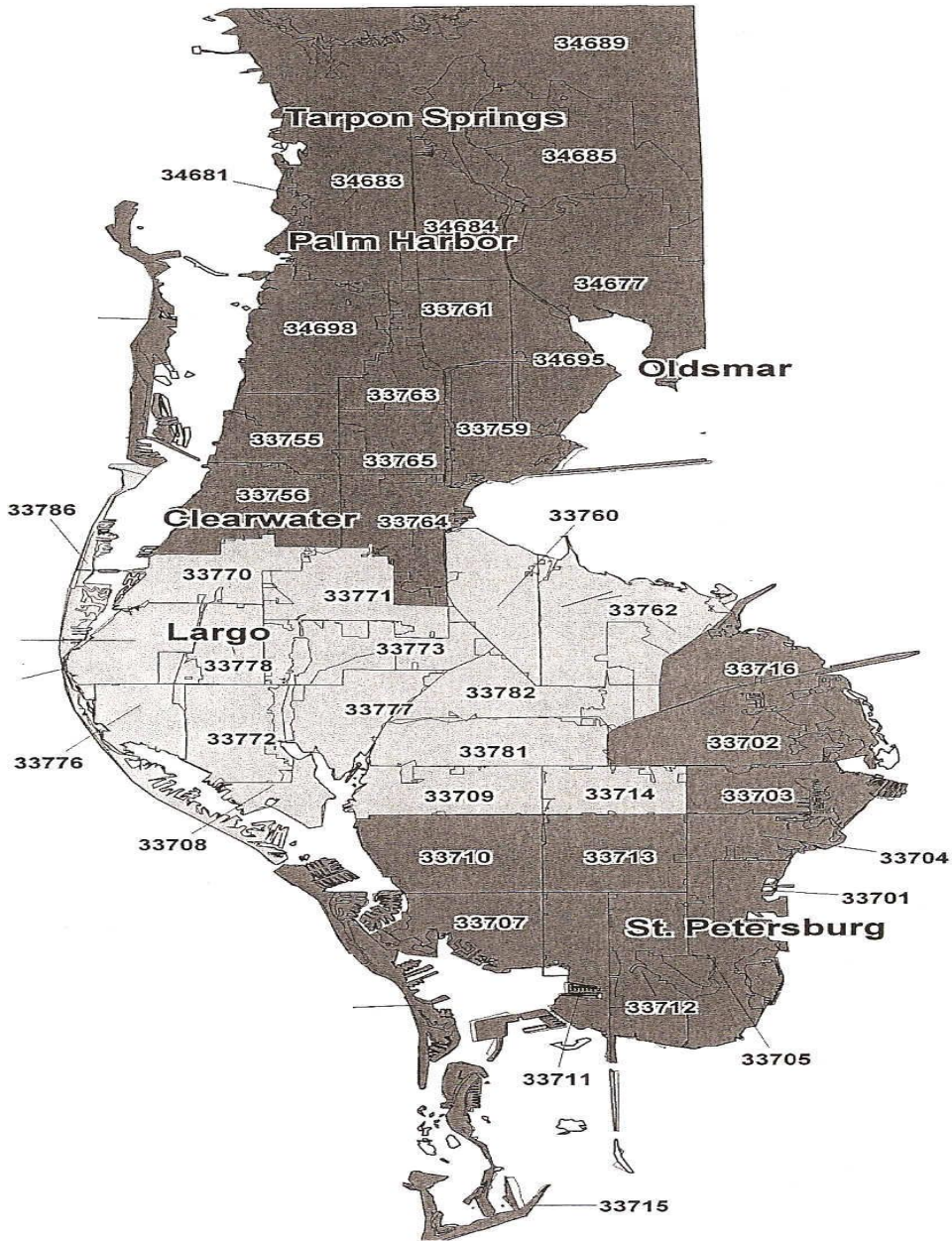
CHI, Inc. agrees to pay for services at an amount not to exceed \$22,400, payable upon receipt of quarterly invoices not to exceed \$5,600 per quarter.

Signed and agreed to on _____, 2006 by:

Gerard H. Veneman
President/CEO
The Children's Home

Pricilla Pope
V. P. of Research
University of South Florida .

D. Map of Kinship Services Network of Pinellas



E. Qualitative Interview Protocol

This is a qualitative study that will use a semi structured interview gather the information on the following themes and issues:

1. The story of the caregiver's experiences.
 - a. What is the caregiver's story about how she became responsible for raising relative children?
 - b. What were the circumstances that led the caregiver to take responsibility to raise the children?
2. Timing.
 - a. When did it happen?
 - b. At what point in time did the caregiver see herself as taking over responsibility?
 - c. Did it happen all at once or was it gradual?
3. Permanence.
 - a. How long has the child been in the caregiver's care?
 - b. Has the caregiver and child lived in the same home/apartment for that period of time?
 - c. How many times would the caregiver estimate that the child has moved back and forth from her place to other homes in the past five years?

4. Decision Making

- a. How was the decision made that the caregiver provide care for the children?
- b. Who was involved in making the decision that should care for the child(ren)?
- c. Did the caregiver have to make difficult choices?
- d. Were there any alternatives, other people besides her who might have taken the child(ren)?

5. Context

- a. What anything else happening at the time that led to your taking the children?
- b. Other factors?

6. Effects

- a. What has life been like for the caregiver since taking over responsibility?
- b. Has you life changed? (If any)
 - i. In what ways?
 - ii. Are there some undesirable ways in which life has changed/
Are there some positive changes?

7. Stress

- a. Since taking responsibility for caregiving, what have been the hardest times or the most difficult things or the biggest challenges to deal with?
8. Coping
- a. How has the caregiver dealt with the difficult times?
 - b. Is there anything that she has found especially helpful in coping with the hard times or difficult challenges of caring for the children?
 - c. What has been the most helpful to her in dealing with these difficulties?

F. Family Support Scale (FSS) (Dunst, 1988)

Listed below are people and groups that oftentimes are helpful to members of a family raising a young child. This questionnaire asks you to indicate how helpful each source is to *your family*.² Please circle the response that best describes how helpful the sources have been to your family during the past *3 to 6 months*. If a source of help has not been available to your family during this period of time, circle the NA (Not Available) response.

How helpful has each of the following been to you in terms of raising your relative's child (DURING THE PAST 3 TO 6 MONTHS):	Not Available	Not at All Helpful	Sometimes Helpful	Generally Helpful	Very Helpful	Extremely Helpful
1. Your parents	N/A	1	2	3	4	5
2. Your spouse or partner's parents	N/A	1	2	3	4	5
3. Your relatives/kin	N/A	1	2	3	4	5
4. Your spouse or partner's relatives/kin	N/A	1	2	3	4	5
5. Spouse or partner	N/A	1	2	3	4	5
6. Your friends	N/A	1	2	3	4	5
7. Your spouse or partner's friends	N/A	1	2	3	4	5
8. Your own children	N/A	1	2	3	4	5
9. Other parents	N/A	1	2	3	4	5
10. Co-workers	N/A	1	2	3	4	5
11. Parent groups	N/A	1	2	3	4	5

² Adapted from *Family Support Scale*, Source: Dunst, C. J., Trivette, C. M., & Deal, A. G. (1988). *Enabling and empowering families: Principles and guidelines for practice*. Cambridge, MA: Brookline Books.

How helpful has each of the following been to you in terms of raising your relative's child (DURING THE PAST 3 TO 6 MONTHS):	Not Available	Not at All Helpful	Sometimes Helpful	Generally Helpful	Very Helpful	Extremely Helpful
12. Social groups/ clubs	N/A	1	2	3	4	5
13. Church members/ minister	N/A	1	2	3	4	5
14. Your family or child's physician	N/A	1	2	3	4	5
15. Early childhood intervention program	N/A	1	2	3	4	5
16. School/ day-care center	N/A	1	2	3	4	5
17. Professional helpers (social workers, therapists, teachers, etc.)	N/A	1	2	3	4	5
18. Professional agencies (public health, social services, mental health, etc.)	N/A	1	2	3	4	5
19. Others (Specify):	N/A	1	2	3	4	5
20. Others (Specify):	N/A	1	2	3	4	5

G. Family Resource Scale (FRS) (Dunst, 1988)

This next set of questions is designed to assess whether or not you and your family have adequate resources (time, money, energy, and so on) to meet the needs of the family as a whole as well as the needs of individual family members.³

For each item, please circle the response that best describes how well the need is met on a consistent basis in your family (that is, month in and month out).

To what extent are the following resources adequate for your family:	Does Not Apply	Not at All Adequate	Seldom Adequate	Sometimes Adequate	Usually Adequate	Almost Always Adequate
1. Food for 2 meals a day.	N/A	1	2	3	4	5
2. House or apartment.	N/A	1	2	3	4	5
3. Money to buy necessities.	N/A	1	2	3	4	5
4. Enough clothes for your family.	N/A	1	2	3	4	5
5. Heat for your house or apartment.	N/A	1	2	3	4	5
6. Indoor plumbing/water.	N/A	1	2	3	4	5
7. Money to pay monthly bills.	N/A	1	2	3	4	5
8. Good job for yourself or spouse/partner.	N/A	1	2	3	4	5
9. Medical care for your family.	N/A	1	2	3	4	5
10. Public assistance (SSI, TANF, Medicaid, etc.)	N/A	1	2	3	4	5

³ *Family Resource Scale*, Source: Dunst, C. J., Trivett, C. M., & Deal, A. G. (1988). *Enabling and empowering families: Principles and guidelines for practice*. Cambridge, MA: Brookline Books.

To what extent are the following resources adequate for your family:	Does Not Apply	Not at All Adequate	Seldom Adequate	Sometimes Adequate	Usually Adequate	Almost Always Adequate
11. Dependable transportation (own car or provided by others)	N/A	1	2	3	4	5
12. Time to get enough sleep/rest.	N/A	1	2	3	4	5
13. Furniture for your home or apartment.	N/A	1	2	3	4	5
14. Time to be by yourself.	N/A	1	2	3	4	5
15. Time for family to be together.	N/A	1	2	3	4	5
16. Time to be with your child(ren).	N/A	1	2	3	4	5
17. Time to be with spouse or partner.	N/A	1	2	3	4	5
18. Time to be with close friend(s).	N/A	1	2	3	4	5
19. Telephone or access to a phone.	N/A	1	2	3	4	5
20. Baby sitting for your child(ren).	N/A	1	2	3	4	5
21. Child care/day care for your child(ren).	N/A	1	2	3	4	5
22. Money to buy special equipment/supplies for child(ren).	N/A	1	2	3	4	5
23. Dental care for your family.	N/A	1	2	3	4	5
24. Someone to talk to.	N/A	1	2	3	4	5
25. Time to socialize.	N/A	1	2	3	4	5

To what extent are the following resources adequate for your family:	Does Not Apply	Not at All Adequate	Seldom Adequate	Sometimes Adequate	Usually Adequate	Almost Always Adequate
26. Time to keep in shape and look nice.	N/A	1	2	3	4	5
27. Toys for your child(ren).	N/A	1	2	3	4	5
28. Money to buy things for yourself.	N/A	1	2	3	4	5
29. Money for family entertainment.	N/A	1	2	3	4	5
30. Money to save.	N/A	1	2	3	4	5
31. Time and money for travel/vacation.	N/A	1	2	3	4	5

H. General Health Questionnaire (GHQ-SF12)

GHQ-SF12 Items

1. In general, would you say your health is
 - A. Excellent
 - B. Very Good
 - C. Good
 - D. Fair
 - E. Poor

- 2A. Does your health now limit you from moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?
 - A. Yes, limited a lot
 - B. Yes, limited a little
 - C. No, not limited at all

- 2B. Does your health now limit you from climbing several flights of stairs?
 - A. Yes, limited a lot
 - B. Yes, limited a little
 - C. No, not limited at all

- 3A. During the past 4 weeks, how much of the time have you accomplished less than you would like as a result of your physical health?
 - A. All of the time
 - B. Most of the time
 - C. Some of the time
 - D. A little of the time
 - E. None of the time

- 3B. During the past 4 weeks, how much of the time were you limited in the kind of work or other activities as a result of your physical health?
 - A. All of the time
 - B. Most of the time
 - C. Some of the time
 - D. A little of the time
 - E. None of the time

4A. During the past 4 weeks, how much of the time have you accomplished less than you would like as a result of any emotional problems (such as feeling depressed or anxious)?

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time

4B. During the past 4 weeks, how much of the time did you work on other activities less carefully than usual as a result of any emotional problems (such as feeling depressed or anxious)?

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- A. Not at all
- B. A little bit
- C. Moderately
- D. Quite a bit
- E. Extremely

6A. How often have you felt calm and peaceful in the past 4 weeks?

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time

6B. How often did you have a lot of energy in the past 4 weeks?

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time

6C. How often have you felt downhearted and depressed in the past 4 weeks?

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time

7. During the past 4 weeks, how much of your time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc)?

- A. All of the time
- B. Most of the time
- C. Some of the time
- D. A little of the time
- E. None of the time

I. Curriculum Vitae

Kerry Anne Littlewood (Krisman)
14137 Thacher Avenue
Largo, FL 33774
727.771.3766

krisman@unc.edu or klittlew@cas.usf.edu

Areas of Special Interest: Social intervention research; management and community practice; aging; kinship care policy, practice, and research; child maltreatment; and intergenerational issues.

Educational Experience

8/01-present	The University of North Carolina at Chapel Hill Doctoral Student, Social Work (Doctoral Candidate, 2004)
8/01- 5/03	The University of North Carolina at Chapel Hill Masters of Social Work, Aging Concentration Management and Community Practice
8/97-5/00	North Carolina State University Bachelor of Social Work, Summa Cum Laude 4.0 Grade Point Average (on 4.00 scale)

Paid Employment History

8/2004-present	The University of South Florida School of Social Work. Visiting Faculty. Teach graduate level social work courses in macro practice, psychodynamic theory, and policy. Teach undergraduate course in research and statistics.
8/2004-present	Florida Kinship Center. The University of South Florida School of Social Work. Research Coordinator. Design and implement evaluation for Center Programs. Analyze FKC data, develop reports to State and other funding sources, prepare manuscripts for publications.
8/2005-present	Kinship Services Network of Pinellas. Senior Evaluator. Design and implement evaluation for the Kinship Services Network of Pinellas, includes Children's Home Inc., Big Brothers Big Sisters, and Catholic Charities.

Analyze data, develop reports to Juvenile Welfare Board, prepare manuscripts for publications.

1/2006-present

National Institute on Health, Hillsborough County Sheriff's Office and University of South Florida St. Petersburg. Research Coordinator.

Coordinate research in the Hillsborough County Orient Road Jail. Supervise social workers in Orient Road Jail in recruitment, data collection, and qualitative interviews.

5/2004-5/2005

Florida Kinship Center. University of South Florida School of Social Work. Informal Kinship Care Study. Dissertation Research Fellow.

Design and implement study on the informal kinship care family, including relative caregiver, biological parent, and child. Identify the strengths, resources, and service needs of relatives who care for children who cannot be cared for by their biological parents, and describe how these may change over time.

8/2003-8/2004

Frank Porter Graham Child Development Institute. University of North Carolina, Chapel Hill. Child Maltreatment in Child Care Settings Study.

Researcher.

Conduct six state survey on practice and policy on child maltreatment in child care settings. Analyzed data from NC Division of Child Development. Reported results and recommendations for task force to change policy and procedure in NC.

5/2002-5/2004.

University of South Florida School of Social Work, Florida Kinship Center.

Research Coordinator.

Developed research protocol and conduct analyses for the Kinship Care Warmline, Kinship Care Connection, Toolkit, Kin as Teachers, and other programs administered by the Florida Kinship Center.

8/2001-6/2003

University of North Carolina at Chapel Hill School of Social Work Title IV-E Waiver Evaluation Project Team

Researcher.

Conduct evaluation for Title IV-E Waiver Demonstration Project as a member of Process Evaluation Team for

North Carolina Assistant Guardianship Program.
Assisted in analyzing data from longitudinal databases.

1/2000-8/2001 University of South Florida School of Social Work, Florida Kinship Center.
Program Coordinator.
Responsible for operating a statewide toll-free support telephone line for kinship caregivers in Florida, support group facilitation and development, grant writing, curriculum development, training, and research in kinship care.

01/99-07/99 North Carolina State University Social Work Department.
Research Assistant.
Worked primarily on the Family Group Conferencing Cultural Competency Grant. Responsible for research for African American, Hispanic/Latino, and Cherokee Focus Groups. Transcriber for focus group tapes and flip charts.

09/98-01/99 North Carolina State University Social Work Department.
Research Assistant.
Researched and organized literature on children, adolescents, and youth violence and aggression, specifically among Hispanics and Latinos.

Clinical Experience

8/01-6/02 Duke University Hospital Department of Psychiatry, Duke Addictions Program Substance Abuse and Mental Health Services Administration: Rural Integrated Service Project for Triple Diagnosis Clients (AIDS/HIV, MH, and SA).
MSW Field Placement.
Provided individualized interventions to triple diagnosis clients. Co-facilitated a bi-weekly abstinence support group for triple diagnosis clients. Participated in weekly Social Work Colloquium at the Duke University Hospital Department of Social Work.

8/99-8/01 Tampa Bay Regional Planning Council Area Agency on Aging Senior Victim Advocate Program.
BSW Field Placement.

Made home visits to elderly victims of crime and assisted them through the criminal justice system. Accompanied senior victims to court and provided court orientation. Assessed senior crime victims.

1/99-6/99

University of North Carolina at Chapel Hill Memorial Hospital. Crisis Emergency Services Department of Psychiatry.

Student Intern.

Interviewed patients with mental illnesses, substance abuse, and HIV/AIDS in Emergency Department and Walk-In Clinic. Gained experience in assessments, interventions, social/medical histories, mental status exams, medications, referrals, interdisciplinary approaches, and follow-ups in a hospital environment. Attended weekly social work seminars in hospital.

8/98-12/98

Mount Vernon Redirectional Middle School.

Student Intern.

Facilitated Problem Solving Groups. Led bi-weekly counseling sessions with Hispanic sixth and seventh graders. Gave classroom presentations. Specifically focused on anger/violence management among females.

8/97-12/97

National Association of Social Workers, North Carolina Chapter. BSW Intern.

Attended advocacy meetings regarding mental health, legislative, and juvenile justice issues. Assisted in the creation of a program unit on aging.

Teaching

Spring, 2005- Fall, 2007. SOWO 3401 Research and Statistics Course. Instructor.

The purpose of this course is: to familiarize the student with research as it is practiced in the profession, learn statistical software packages, and to equip the student with those theoretical understandings necessary to be a critical consumer and designer of social work research.

Summer, 2005. SOWO 6375 Macro Practice Seminar. MSW Concentration Macro Practice course. Instructor: Grant seminar. Faculty advisor: Marsha Marley.

The course prepares students to use professional knowledge, values, and skills in advanced practice with organizations

and communities. The grant seminar prepares students to develop grants and design innovative programs and services.

- Spring, 2005. SOWO 6235 Foundations of Social Welfare Policy. MSW Foundation Policy course. Instructor.
The course provides first year graduate social work students with an introduction to social welfare problems, policies, and programs.
- Fall, 2004. SOWO 6114. Individual Growth and Development Theory. MSW Concentration Theory course. Instructor.
This course is designed to enhance students' abilities to apply biopsychosocial theoretical constructs to clinical practice with individuals, groups, families and communities.
- Fall, 2002. SOWO 239. Organizational and Community Behavior. MSW Concentration HBSE course. Faculty advisor: Walter Farrell, PhD.
This course explores theories and models for understanding the behavior of human service organizations and local communities.

Special Skills or Attributes

Computer skills: web site design and maintenance in html, ftp, or MS Front Page; basic computer networking; basic computer troubleshooting; manage and maintain multiple databases; multiple database searches; and publishing and formatting skills for reports, newsletters, and web sites.

Computer program knowledge: Unix Systems; Windows 3.1, 95, 98SE, ME and 2000 Pro; most Adobe software; Microsoft Office 97 and 2000; Corel Office 2000; Corel Print Office; FrontPage 97, 98, and 2000; Atlas ti; SYSTAT; HLM; ENVIVO; SPSS; AMOS, other statistical software.

Research experience: research and intervention design, multilevel modeling, multivariate methods, and other data analyses; grant writing, report development, and curriculum development; and qualitative methodologies, focus group and semi-structured interviews.

Honors and Awards

Dissertation Research Fellow, Florida Kinship Center

Transatlantic Scholar, Transatlantic Consortium on Early Childhood Intervention
Recipient of the NC Swedish Women's Association 2003 Scholarship
Recipient of the North Carolina Chapter National Association of Social Workers Toby Brown Scholarship.
Deans list, all semesters at NC State with 4.0 grade point average.
Co-President, Student Social Work Association
Phi Alpha National Honor Society
Golden Key National Honor Society
Secretary, Students for Gov. Tommy Thompson
Delegate, Model Organization of American States General Assembly, Washington, D.C.
Certified Youth Campaign Coordinator, Leadership Institute, Washington, D.C.

Professional Affiliations

National Association of Social Workers-Florida Chapter
Kinship Care Advisory Committee
Hillsborough County Comprehensive Child Welfare Planning Committee
Hillsborough County Grants Collaborative
Pinellas County Victim Rights Coalition
Pinellas County TRIAD
Phi Alpha National Honor Society
Golden Key National Honor Society
University of South Florida School of Social Work Kinship Research Center Team
State Contact National Teleconference for Grandparents Raising Grandparents: Legal and Policy Issues

Publications

- Littlewood, K. & Strozier, A. (2008). Learning about Leaders: Exploring and measuring leadership qualities in grandparents and other relatives raising children. Manuscript submitted for publication to *The Journal of Intergenerational Relationships*.
- Strozier, A., & Krisman, K. (2007).. Capturing caregiver data: An examination of kinship care custodial arrangements. *Children and Youth Services Review*, 29(2), 226-246.
- Strozier, A., McGrew, L., Krisman, K., & Smith, A. (2005). Kinship Care Connection: The analysis of a school-based intervention for kinship caregivers, the children in their care, and the schools. *Children and Youth Services Review*, 27, 1011-1029.
- .Smith, A., Krisman, K., Strozier, A., Marley, M. (2004). Breaking through the bars: Exploring the experiences of addicted incarcerated parents whose children are cared for by relatives. *Families in Society*, 85, 187-196.

Paper Presentations at Conferences

- May, 2007. Assessing dialogues between incarcerated mothers and custodial maternal grandmothers about child problems. Paper presented at the meetings of the American Psychological Society, Washington, D.C. Littlewood, K., Baker, J., Elliston, D., Strozier, A., Cecil, D. & McHale, J.
- April, 2007. Incarcerated mothers' descriptions of co-caregiving alliances. Paper presented at the Society for Research in Child Development.. Boston, MA Skuza, S., Sieber, Z, Krisman, K., Strozier, A., Cecil, D., and McHale, J.
- .June 15, 2005. Linking kinship families to community supports: The role of Geographic Information Systems (GIS) to inform service delivery. Hawaii International Conference on Social Sciences. Waikiki Beach, Hawaii. Co-Presenters: Robin Ersing & Anne Strozier.
- June 3, 2005. Florida Kinship Center statewide initiative: Creating a family of families. AARP National Grandparent Outreach Training. St. Pete Beach, Fl. Co-Presenters: Anne Strozier, Tracie Merrit, & Amy Caparratto.

- June 2, 2005. The anatomy of a Warmline. AARP National Grandparent Outreach Training. St. Pete Beach, Florida. Co-Presenter: Amy Caparratto.
- May 13, 2005. Outcomes and lessons learned for polling voters about the voting experience. 60th Annual Conference American Association for Public Opinion Research: Improving Survey Quality. Miami Beach, FL. Co-Presenters: Votewatch and Aguaire International members.
- April 23, 2005. Child maltreatment in child care settings: Experiences in North Carolina. 15th National Conference on Child Abuse and Neglect. Boston, MA. U.S. Administration on Children and Families. Co-Presenter: Teresa Derrik.
- April 22, 2005. Assessing kinship caregiver's physical and emotional health: An analysis of coping skills and support group effectiveness. 15th National Conference on Child Abuse and Neglect. Boston, MA. U.S. Administration on Children and Families. Co-Presenter: Teresa Derrik.
- September 27, 2004. Kinship Care Connection: A comprehensive school-based intervention connecting caregivers, children and schools. 2004 National Conference: Raising Kin: The Psychosocial well-being of Substance-affected Children in Relative Care. Chicago, Illinois. National Abandoned Infants Assistance Resource Center. Co-Presenters: LaSandra McGrew, MSW.
- July 30, 2003 A theory of change in community practice to promote integrated support for kinship caregiving families. 4th Annual National Kinship Care Conference, Philadelphia, Pennsylvania. Child Welfare League of America. Co-Presenters: Anne Strozier, Ph.D. & Aaron Smith, Ph.D.
- April 4, 2003. Kinship care connection: Design and evaluation of a school-based intervention project. National Conference on Child Abuse and Neglect. St. Louis, Missouri. National Association on Prevent Child Abuse. Co-Presenters: Anne Strozier, Ph.D. & LaSandra McGrew, MSW.
- October 30, 2002. Aging adults raising children: A theory of change in North Carolina. North Carolina Conference on Aging. Greensboro, NC. University of North Carolina Institute on Aging.

- June 12-14, 2002. The No Contact Lens Model: A qualitative analysis on addictions, incarceration, and kinship care. National Association of Social Work, Florida Chapter. Orlando, FL. Co-presenter: Aaron Smith, Ph.D., MSW, MPH.
- February 23-27, 2002. Analyzing addictions, incarceration, and kinship care linkages. Council for Social Work Education Annual Program Meeting. Nashville, TN. Council for Social Work Education. Co-Presenters: Aaron Smith, Ph.D., MSW, MPH & Anne Strozier, Ph.D., MSW.
- July 24-27, 2001. Kinship care connection: An innovative school-based intervention project for kinship care families. 3rd Annual National Kinship Care Conference. Chicago, IL. Child Welfare League of America. Co-presenters: Anne Stozier, Ph.D, MSW, Aaron Smith, Ph.D., MSW, MPH, & LaSandra McGrew, MSW
- June 16, 2001 Responding to changing families: Meeting the health care needs of grandparents and other relatives and the children in their care. National Association of Social Work, Florida Chapter. Fort Lauderdale, FL. Co-presenters: Aaron Smith, Ph.D., MSW, MPH, Anne Strozier, Ph.D., MSW.
- November 16, 2000. *Kinship Care: Other State's Experiences* in Kinship care in Massachusetts: Fostering policy solutions consensus panel assembly. Boston, MA. Heller Graduate School, Brandeis University and Raising Our Children's Children, Inc.
- .October 13, 2000. Supporting grandparents and other relatives raising children: Kinship care in the school system. Hillsborough County, FL. Hillsborough County School System Social Work. Co-presenter: LaSandra McGrew, MSW.
- August 27, 2000. Empowering children, youth, and families: Kinship care and relatives raising children. Gainesville, FL. The University of Florida-Gainesville, Extension Center. Co-presenter: Anne Strozier, Ph.D., MSW.
- June 26, 2000 Kinship care practice in the child welfare system: A day of training. Hillsborough County, FL. Hillsborough Partners, Inc and Family Enrichment Center. Co-presenters: Aaron Smith, Ph.D, MSW, MPH. and Anne Strozier, Ph.D., MSW.

February, 2000. Kinship care in Hillsborough County. Tampa, FL. Children's Board of Hillsborough County. Co-presenters: Aaron Smith, Ph.D., MSW, MPH. & Anne Strozier, Ph.D., MSW

March, 1999. Social work advocacy: Encouraging social work policy practice. Raleigh, NC. North Carolina State Undergraduate Research Symposium. Faculty sponsor: Cheryl Waites, Ph.D., MSW.

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