ACF-OGM SF-PPR

FINAL EVALUATION REPORT

Submitted to: Children's Bureau, Administration for Children and Families
US Department of Health and Human Services

Funding Recipient: The Children's Home Society of New Jersey
Grant #: 90CF0022

Program Name: Kinship Cares
City and State: Trenton, New Jersey

Reporting Period: September 30, 2009 to September 29, 2012

EXECUTIVE SUMMARY

I. Executive Summary

Overview

Our federally-funded ACF Children's Bureau Kinship Cares Program assisted relative caregivers in raising their kin children in a permanent, safe and nurturing way. The program staff worked more intensively with these caregivers to improve caregiver and child wellbeing and prevent child maltreatment and placement disruption leading to re-placement in the State foster care system. Older kin caregivers, and those with health, financial or other personal problems – now raising a second family – often cannot get enough community and emotional support services and may be more at risk of asking the State to take their kin children into placement, disrupting young lives and family constellations, and imposing an increased financial burden on the State.

The Kinship Cares Program augmented and expanded our ten-year old state-funded Kinship Navigator program with six new ombudsmen who provided services that are more intensive. They also ran parent support and education groups, and a children's group. The ombudsmen worked to provide families with solutions to everyday problems as well as resolve crisis situations with a hands-on connection to needed community resources. Comparison families in a traditional services group received the standard Kinship Navigator services, essentially, an annual stipend of $500[1] and brief information and referral services. Based on our field experience over the last eleven years, we know the current funding and structure of the New Jersey Kinship Navigator program is not structured to allow for work that is more intensive and follow-up with Kinship families when the need arises. Kinship Navigator receives requests for more services, but minimal in person follow-up is possible and comprehensive assessments of need cannot be completed.

The Children's Home Society of New Jersey (CHS of NJ) rigorously evaluated the Kinship Cares program processes and the outcomes against a control group receiving traditional navigator service by using a randomized control group design. CHS of NJ also developed a caregiver and kin profile. The profile describes who was served and what their priority needs were in order to make recommendations to the State for improving New Jersey Kinship Navigator services to achieve optimized support for kin caregivers.

Changes in the following outcomes were measured: wellbeing in terms of caregiver stress level, caregiver perceived level of social support, caregiver capacity to provide for their children's needs, caregiver's and child's health status, and caregiver reports of child adjustment in the home. Child safety was measured in terms of referrals to the State's child welfare agency; permanency, measured by caregiver's intent to maintain a long-term home for child and/or seek legal guardianship.

Grantee organization

Founded in 1894, The Children's Home Society of New Jersey (CHS of NJ) is a not-for-profit statewide, child welfare organization, with proven experience and leadership in developing family and children's services, neighborhood-based networks and inter-disciplinary partnerships to promote the welfare of infants, children, youth and their families. CHS of NJ has been meeting the needs of extended kin families since 2001 with its Kinship Service Navigator program in Central New Jersey.

[1] As of 7/1/2010. In the prior period, the stipend had been $1,000 annually.

Project location

Two of seven New Jersey counties receiving Kinship Navigator services provided by CHS of NJ were focused on in our federal evaluation grant. We utilized two contrasting counties – Mercer and Ocean. These two counties accounted for more than 38 percent of all CHS of NJ Kinship Navigator program referrals in 2009. Mercer Kinship families are primarily located in Trenton. Trenton is an ethnically diverse city and evidences all of the urban ills in its neighborhoods and schools. The second county chosen, Ocean County is comprised of 33 small communities. Ocean communities brought a suburban/rural caseload to the CHS of NJ project. Ocean County cases are spread throughout the large geography– a 40-mile stretch. This difference in the clustering of cases impacted support group and advisory board participation and lengthened the amount of time workers spent driving to visit families.

Project Goals and Objectives

Goal #1: Create a group of professional ombudsmen who will advocate for kin caregivers, especially grandparents, and the kinship children that they are caring for to get the help and services that are needed. This intensive kinship navigator system will: a) assist these families in identifying the barriers they face; and b) finding the solutions for the jointly identified needs in order to achieve better child outcomes for safety, permanency and child well-being (prevent dissolution of kin families and/or return of child to foster care).

Goal #2: Develop and implement kin caregivers/grandparent support groups with a focus on parenting skills that are designed to: a) increase successful parenting ability; b) increase child development knowledge; and c) increase awareness of resources and strategies needed to raise successfully kin/grandchildren.

Goal #3: Develop the methodology and implement a procedure to profile and document the characteristics and needs of Kinship families in order to enhance existing and future Kinship programming that will promote enhanced positive outcomes for these families.

Goal #4: Conduct an evaluation of the impact of the additional intensive support provided by the ombudsmen along with kin participation in kin support/learning groups as these may be two necessary design features all funders need to consider in future Kinship Navigator program design.

Service Model

In the project, caregivers eligible for Navigator services were randomly assigned to either the enhanced services or traditional services group in each county.

If assigned to traditional services, the field worker goes out to do a home visit/eligibility verification and brief needs assessment. The caregiver will receive all regular Kinship Navigator services. The worker gives information and referral advice as needed. Service is then completed for that year. Telephone information and referral (I&R) can continue throughout the year.

If assigned to the enhanced services caseload, the project supervisor determines which of six ombudsmen immediately gets the case. The selected ombudsman makes an initial home visit to verify eligibility, does an in-depth assessment of needs, administers pre-intervention questionnaires, jointly develops a Family Service Plan based on what the caregiver says she wants and needs, offers ongoing follow-up visits and active, hands-on, linkage to resources, and encouragement to participate in support group activities. At close of the case, the ombudsman administers post-intervention questionnaires. Additionally, it was hoped that there would be a gain in perceived

social support and knowledge through the scheduled activity and education groups facilitated by the ombudspersons. A concurrent children's group was added as an inducement to increase adult participation.

Families were offered as much help by ombudsmen as they needed within a four to six-month service window. In some cases, a family could request additional help through a "booster shot" after the case was closed. Caregivers were also eligible for renewed Kinship Navigator financial support of $500 each calendar year.

Staff

There were 2 ½ Kinship Navigator ombudsmen in Ocean County and 3 ½ ombudsmen in Mercer County; at least one ombudsman in each county was Spanish speaking. There was a project supervisor to coordinate and supervise the six ombudsmen. There was a half-time administrative assistant to serve the record keeping and reporting needs of the project. Finally, there was part-time research assistant assigned to the principal researcher. She assisted staff and the principal researcher in collecting and coordinating data and providing quality control. She also assisted in the follow-up phone calls to caregivers regarding consumer satisfaction.

Six ombudspersons were hired and trained as per the work plan. They receive regular in-service training, including feedback about interpreting and using the survey data that is collected. The project supervisor monitors the ombudsperson's work. She meets individually with each worker to review case progress and goals. Staff turnover included the supervisor and two ombudspersons. In the last six months of the grant, staff was reduced to four as the project moved towards its completion, and closed new intake.

The ombudspersons implemented their work with caregivers as specified. They conducted family assessments, developed family service plans (with kin taking the lead) and worked with the caregivers to implement each plan. Workers averaged about 11 activities directly with or on behalf of the client during the case life. Cases were open an average of 6.2 months vs. 1.2 months for traditional Navigator-only control group families.

Kinship Advisory Council

Project staff established an advisory council in each county to provide stakeholder feedback about the operation of the project. Participants invited included kin caregivers, collaborating churches, family success centers or United Ways and other community members. The meetings were chaired by the project supervisor. The periodic meetings was used to assess how the project was being implemented, review and add kin needs, suggest outreach strategies, vet public relations materials, hear ongoing evaluation reports, and give input to the project supervisor for any mid-course corrections.

Evaluation Methodology

The evaluation: 1) assessed the implementation of the project and 2) measured whether the caregivers and kin children receiving enhanced services had better outcomes than families who only received traditional Kinship Navigator services.

Process Evaluation –determined whether the project was conducted in a manner consistent with its implementation plan. Briefly, the process evaluation questions were:

1. Did the project staff develop a profile of the characteristics and needs of each of the Kinship families?
2. Did the project Ombudsman more intensely advocate for caregivers and their kin and ensure better linkages to community services and subsidies for which they were eligible?
3. Did the project develop and implement caregiver support and education groups? Were these groups well received?

After 33 months of actual direct services (3 month start-up), the program had served 437 caregivers. There were slightly more caregivers (227 vs. 210) in the traditional Navigator services (control) group. An additional 127 caregivers were referred for more intensive services but did not participate due to caregiver refusal or ineligibility. It was anticipated that by September 29, 2012, the program would have served at least 650 clients; a shortfall of 162 caregivers (33 percent).

The program consistently met its activity milestones. Staff were hired, trained and in the field by January 2010. Group work began in March 2010. A children's group facilitator was hired. The program newsletter was published monthly and two Parent Advisory Councils – one in each county – were established and met periodically.

Caregivers

The caregivers were primarily grandmothers (67 percent), average age 52 (10 percent over 65). There was a second caregiver in 30 percent of the homes. There were few Hispanic families (7 percent). Caregiver race was primarily African American in Mercer County and Caucasian in Ocean County. The median annual household income was $27,368 with almost 43 percent of the families having earnings below the federal poverty level. The great majority of caregivers (73 percent) were single, separated, widowed or divorced.

The highest priority needs as scored on the Family Needs Scale at the initiation of service included:

- Having money to buy necessities and pay bills
- Paying for the special needs of my child
- Information about where to get help
- Getting furniture, clothing, toys
- Exploring future educational options for my child
- Expanding my education, skills and interests
- Getting a mentor (big brother/sister) for my child
- Traveling/vacationing with my child
- Getting a job
- Getting counseling for my child

Groups began in March 2010 as specified in the work plan. There were 119 support group/educational meetings (61 Mercer/58 Ocean). Each group was facilitated by two ombudspersons. In addition, 41 children's activity groups were held. Feedback about the groups was very positive. Attendance increased over the course of the project, averaging nine persons (up to 21) per session in Mercer County. Attendance averaged five persons in Ocean County (up to 11). The program staff helped reduce barriers to attendance by providing transportation, child activity groups and holding day and evening sessions.

Caregivers rated the ombudspersons very highly in follow-up telephone interviews. The workers were described as extremely helpful and supportive to the caregivers, e.g., "A has been my rock..." "B was patient with me and kept revisiting the goals that our family made for ourselves..." "D was there to answer my questions…"

In order of frequency: service planning, information giving, assessment, referral for services and advocacy were the primary service activities used to address the caregiver's needs.

Biological Parents

A significant percentage of the birthparents are involved in the lives of their children who are being raised by kin. Seventy-three percent have face-to-face contact with their children; many on a frequent basis. Ten percent of the parents visit daily, thirty-three percent of the parents visit at least weekly and another 33 percent visit at least monthly. Including them in service planning and co-parenting activities may be beneficial for all involved. Research suggests a positive relationship between parental visits and child well being[2].

Outcome Evaluation – was designed to demonstrate the linkage between more intensive service provision and improved outcomes for the caregiver and kin child. The evaluation questions included:

1. Were the expressed needs (Family Needs Scale) of the enhanced services group more likely to be met than for the traditional services group at Time 2 (done at the end of service)?
2. Did the caregivers report the satisfactory achievement of goals in their family service plan?
3. Did caregivers have lower levels of stress from parenting concerns at Time 2 when compared to the traditional services group?
4. Did perceived levels of caregiver social support increase at Time 2 when compared to the control group?
5. Did child behavior improve as reported by the caregiver at Time 2 when compared to the traditional services group?
6. Were the enhanced services kin children less likely than the control group children to be referred to child protective services or less likely to experience an out-of-home placement under state supervision?

On the Parent Stress Index (PSI), the Total stress score was slightly lower (i.e. more favorable) for the Enhanced services group as compared to the control group. The finding was not statistically significant. However, when considering families where Time 1 subscale scores were of clinical

[2] Green, Y. R. and Goodman, C. C (2010). Understanding birthparent involvement in kinship families: Influencing factors and the importance of placement arrangement. *Children and Youth Services Review*, 32, 1357-1364.

concern, there were statistically significant findings favoring the Enhanced Services group. On the Stress Index for Parents of Adolescents (SIPA), total stress scores at Time 2 were identical. However, the percentage of families with improved total stress scores was higher for the Enhanced Services families though not statistically significant.

There was no difference between the Time 2 scores of the Enhanced and Control group caregivers on the measure of social support. In both groups, the supports kin said were most needed were for emotional/informational support and tangible (concrete) support.

A large number of goals established in the family service plan were resolved (83 percent). The Time 2 Family Needs Scale reflected a significant drop in the intensity of needs for the Enhanced Services families relative to the Control group families. This finding was statistically significant inferring more enhanced interventions could make a positive difference in better outcomes.

No differences were found between the two groups on measures of caregiver or child health. There was no significant difference on the child behavior dimensions of the PSI and SIPA between the groups. However, when only families with elevated scores at intake were considered, the enhanced services group had some lower scores than the traditional services group at Time 2.

Child Welfare System Involvement

At the time of acceptance into the project, not surprisingly, 441 (73 percent) of 603 children have had a Division of Child Protection and Permanency (DCP&P) open case. Of those children having a case history, 51 percent were control group cases and 49 percent were enhanced services cases. The difference was not statistically significant. The kin children with a DCP&P history were more likely to reside in Mercer County than in Ocean County (60 vs. 40 percent).

The majority of those identified as having a DCP&P open case (98 Percent) were known to the child welfare agency prior to involvement with Kinship Cares (these DCP&P cases were closed prior to Kinship program involvement). Fifteen children had a DCP&P service opening after Kinship Cares services were completed. Nine of those 15 were control group cases; six were enhanced services cases. The DCP&P cases were opened an average of 6 months after Kinship services completion.

Referrals to Child Welfare – Two types of referrals can be made to DCP&P, namely, child protective services (CPS) and child welfare services (CWS). CPS involves a traditional child protective investigation and a determination of whether reported maltreatment is substantiated or not. CWS is an alternative response to lower-risk referrals and generally involves assessing the family's strengths and needs and offering services to meet the family's needs as well as support positive parenting.

While referrals and even multiple referrals may be indicative of family difficulties or children at risk of harm, the referral itself may not necessarily lead to the opening of a DCP&P case. For this group of children the mean number of referrals was 2.8. The number of referrals ranged from one up to 22 in one case. DCP&P SACWIS data reported that 107 CPS referrals (unduplicated by ID and date of report) were made after the kinship case was closed. Of these, 48 percent were for enhanced services cases and 52 percent were for the control group families. Six reports were substantiated; five of these were enhanced services cases. Of 31 CWS referrals, 31 percent were for enhanced services.

Placements – Prior to kinship services, 125 of the 603 (21 percent) children experienced out of home placement. Six children had a placement event at some point after kinship services were completed.

The average time until placement was 1.1 years. The quickest placement occurred 65 days after services ended. Five of these placements were for control group cases and one was an enhanced services case. All of the control group placements were adolescents. The enhanced services child was under eight years old and was cared for by an elderly grandparent, approaching 80 years of age. Again, enhanced services may be reducing the need for further state placements.

Consumer Feedback

Caregivers were extremely pleased with their ombudsperson and the work he or she did on behalf of the caregiver and her family. The relationship was characterized as excellent or good 99 percent of the time. The caregivers also reported a rate of problem resolution of 78 percent. They identified the following needs as likely to be unresolved and seemingly difficult to solve:

- Financial assistance;
- Housing or housing repair;
- Support groups;
- Transportation; and
- Educational advocacy

Conclusions and Recommendations

Project staff all reported that working with the kinship population is a rewarding and positive experience. The grandparents, aunts and uncles, siblings and others who act as caregivers to kin children are dedicated to these children and provide long-term stable homes. They are a valuable placement resource when the biological parents are unable to provide appropriate care for their children and are often a better permanency resource than a non-relative placement in foster care. These caregivers are in need of significant family and external supports to aid them in their long-term child caring role. They have been very grateful for all supports and services provided.

Any program serving this population should be prepared to give more than a financial stipend and needs to respond to concrete, emotional/behavioral, and health needs of both the caregiver and the child(ren). Kin program service design needs to provide help with the unpredictable crises that are likely to occur, exacerbated by limited resources, caregiver age and a possibly unresponsive external system. Some type of transportation aid should be built into the program budget. Linkage with a state's Kinship Navigator program can make a critical design difference that will enhance outcomes. A cost-effective strategy to address on-going caregiver issues might operate from a grand family drop-in center (in New Jersey we call them Family Success Centers) that has staff skilled in crisis intervention. The development of an updated local resource manual for use by all staff should be a priority.

Staff Training

Workers hired for this type of support program should have training in child development, child behavioral issues, child trauma, conflict resolution, separation and loss counseling, family impact of substance abuse and group work, including family group conferencing. Training should include an emphasis on rapport and trust building as well as strengths based approach. It often takes time for caregivers to reveal the "real issues." Workers should be prepared to engage and work with not only the caregiver and child(ren), but also the biological parents since many of them have a continuing role

with their children. This is especially important when the relationship between the caregiver and parent is considered dysfunctional.

Parent Involvement

A form of family group meetings might be one vehicle to plan more inclusive involvement of parents and emotional support for children in kinship care as biological parents remain involved in the lives of their children. Sibling contact should also be emphasized and strongly encouraged. Each family should be viewed within an extended family structure that could provide needed supports. Workers should be trained in conducting family group conferences and following up with the family to ensure that goals are met. In addition to family supports, a major component of any program should be the scheduling of education and support groups during the day and evening. A concurrent children's group should be run in the evening to provide both respite for the caregivers and fun for the children.

Kinship caregivers provide a valuable and stable resource for children that cannot live with their biological parents, preventing their placement in the "formal" child welfare system. However, the great majority of these families have had historical involvement with the child protective agency. We recommend a coordinated kinship services model. A multi-faceted, cost-effective approach is recommended to support these families in order to ensure child safety, permanency and child well-being and prevent non-relative foster placement.

Recommended Model

The optimum elements of caregiver support still need demonstration and testing. One model approach might include: 1) means tested financial support, perhaps through IVE funds with the state encouraged to help all caregivers meet the conditions for foster care licensure. Currently, in New Jersey, there is a bifurcated system where some caregivers get board payments while others receive nothing or a small annual supplement. Financial support should also include the funding of an emergency crisis fund to prevent evictions and utility shut offs, etc. 2) the development of a grand family/kin resource/drop-in center, uniquely for caregivers and their kin children. The center would offer daily activities, regular support, and educational group meetings. Children could receive after-school help with homework or meet up with a mentor. Crisis workers would be available on-site to assist families with immediate needs. 3) Non-emergent family needs could be addressed by staff advocates who would also offer the opportunity for family group conferences as method to build extended family support for the caregiver. 4) Kinship navigator services should be co-located at the same grand family drop-in center.

The literature supports the benefits of maintaining children with extended family members when their parents are unable to care for them. There is a growing population of kin providers in the US and these kinship families are often in need of various long-term supports to provide care for their kin children. The national trend according to Children's Bureau statistics is that 40% of all closed state/county child welfare cases are those with a kin placement as the permanency plan. One of the issues for the field is to determine if attempts at reunification with biological parents – when appropriate – should be a higher priority in these families. If so, can the intervention of the extended family help achieve this end while providing supports to both the caregiver and biological parents?

This would require workers with the clinical skills to balance competing needs of biological parents, extended family, and the children; each party brings their own issue to the table: conflicted loyalties, guilt of the grandparent for 'failing' their child, resentments between parents and children (in both parent-child dyads). There is ample research in family therapy, post-adoption counseling, and foster

care work to apply to Kinship families that would insure more stability and avoid disruption of these placements.

The field needs to publicize the value of kinship caregivers and their presence in all income strata of the population. It is important ensure that these providers of care have the supports necessary to carry out their parenting responsibilities and to recognize that they are neither unique nor alone. Curricula in MSW programs should have content related to kinship caregivers and the general public should also be educated about the role these selfless individuals play in society through PSAs or other means such as the dissemination of findings from projects such as those funded by the Children's Bureau.

With the termination of this grant-funded program, the CHS of NJ strategy is to utilize its state funded Navigator Wraparound program, its foundation funded Grand Family Center and its federally funded Family Group Decision Making project to serve kinship families at one co-located site in Mercer County, New Jersey. A cost-effective approach to services is based on offering group support and wraparound (as eligible) to all families that come to the Center. The Family Group Decision Making project is providing intensive kinship support services by workers, one-on-one, along with the opportunity to participate in a voluntary Family Success Conference with the extended family to solve viable short term and long term plans to help grandparents and kin to more successfully raise their children. .