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## **Edgewood's Kinship Support Network: Program Model and Client Characteristics**

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## Abstract

### Edgewood's Kinship Support Network: Program Model and Client Characteristics

This article describes the development of the Kinship Support Network (KSN), focusing on the Case-managed Unit of the KSN program model. KSN provides community-based, case-managed, supportive services to kinship caregivers, filling gaps in public social services. The article discusses strengths and weaknesses of privatizing public services and presents demographic data, needs and health information describing kin caregivers and relative children in their homes. Future research directions are suggested.

## Introduction

Kinship care is growing dramatically, as children entering the foster care system are placed with relatives, particularly grandparents in the African American community (Berrick et al.. 1994; Dubowitz et al.. 1993; Minkler et al.. 1992; Thornton 1991). In New York, 42 percent of the 45,500 children in foster care stay in kinship homes, and in Illinois, 8,000 of approximately 18,000 children in foster care live with relatives (Goerge et al. 1994; Killackey 1992). In California, two-thirds of the foster care growth from 1984 to 1992 can be accounted for by the rise in kinship care (Barth et al. 1994). According to a 1991 San Francisco Department of Human Services' (SFDHS) Annual Statistical Report, at the end of 1991, 55% (or 1,575) of all children who became dependents of San Francisco's juvenile court because of documented abuse or neglect (n = 2,864), were removed from the abusive setting and placed in the home of a relative.

Though a growing proportion of children is becoming the full-time responsibility of kinship caregivers (usually grandparents), the public system has not focused on these caregivers' needs. A review of 32 states' policies for kinship care strongly indicates that the government's response to this phenomenon has been reactive, "influenced more by the increasing demand for placement services and the decreasing number of available foster homes than it has by a societal commitment to the importance of relatives in the lives of abused, neglected and dependent children" (Gleeson & Craig 1994: 26). Recent research shows that dependent children in kinship care receive less frequent monitoring than children

in other family foster homes, and that 91% of kinship caregivers had undergone no training in the previous year (Scannapieco et al. 1997; Gebel, 1996; Hegar & Scannapieco 1995; Berrick et al. 1994).

Blending the informal with the formal systems continues to challenge policy makers (Gleeson & Craig 1994). Their efforts have produced a variety of funding approaches and service program models nationally (Berrick 1998; Gleeson et al. 1997; Danzy & Jackson 1997; Testa 1997; Harden et al. 1997; Scannapieco & Jackson 1996; Scannapieco and Hegar 1995; Hegar and Scannapieco & Hegar 1995). Financial reimbursement policies are one method of influencing kinship outcomes, higher pay rates being associated with longer stays in placement, as reported by Courtney and Needell (1997). Increasingly, therefore, states are experimenting with different formulas to reimburse relative caregivers (Testa 1997; Gleeson 1996; Hegar & Scannapieco 1995). Modifying the service delivery program model can also affect kinship placement outcomes. Communities have responded with a variety of program models, ranging from diversion outside the protective services system (McLean & Thomas 1996), to private contracts for recruitment, training and supervision of homes (Zimmerman et al. 1998). Other models ally themselves more closely with the formal public system (Jackson 1996; Scannapieco & Hegar 1995), some including wraparound case management programs (Mills & Usher 1996).

Demographic shifts in the past decade show that while the number of children in out-of-home care has increased, the number of non-related foster family

homes has decreased (Courtney & Needell 1997; Berrick 1997; Danzy & Jackson 1997). Like other urban centers, substance abuse, homelessness, and high rates of mental illness trouble San Francisco. Skyrocketing real estate values have squeezed out middle-income families, a number of whom are from African American communities, and have contributed to a widening gap between the affluent and the impoverished. Thus, San Francisco's middle-class population, from which foster family homes have traditionally been recruited, has shrunk, making recruitment of foster families (especially from the African American community) challenging. SFDHS has responded to the situation with a competitive bidding process, awarding contracts to private agencies to serve a proportion of the City's family foster homes, including a growing number of kinship care homes.

### **The Kinship Support Network**

Since its founding in 1851, Edgewood Center for Children and Families (Edgewood), a private non-profit agency, has been meeting children's and families' needs. In the past thirty years, Edgewood has focused primarily on serving seriously emotionally disturbed children and their families, providing residential treatment with the goal of returning children home. As the Bay Area population has grown and the needs of families have changed, Edgewood has evolved, filling gaps in San Francisco's family and children's services system. Over the past ten years, the agency has increased its outreach into the community and now serves families through school-based and community-based programs, mental health consultation to other agencies and community advocacy for children's rights.

### *Program Development*

One example of Edgewood's outreach efforts is the Kinship Support Network (KSN), which grew out of its relationship with an organization known as Grandparents Who Care (GWC). GWC was founded in 1989 to provide support groups for grandparents stressed by the responsibility of caring for their grandchildren. Edgewood's relationship with GWC spawned KSN, and has matured into a unique and productive collaboration. In the spring of 1992, as part of its community outreach effort, Edgewood offered to act as GWC's fiscal agent and provide in-kind support to GWC, including office space, administrative support, telephone service and supplies. GWC moved its offices to the Edgewood campus in mid-1993. The Boards of Directors of GWC and Edgewood then decided to consolidate their efforts, and in early 1995, GWC became a community program of Edgewood's while maintaining its own director.

In early 1992, Edgewood's Director of Program Development (DPD) began attending GWC support group meetings. Over the course of a year she gathered information based on the discussions of these predominantly African American kinship caregivers. The DPD refined this qualitative data into three predominant themes expressing needs for: 1) Respite from caregiving responsibilities, 2) Recreational activities for children, and 3) Respect for the caregivers from agency caseworkers. In March 1993, the Director of Edgewood's Institute for the Study of Community-Based Services (ISCBS) conducted a formal needs assessment of GWC kinship caregivers using an instrument based on the Family Needs Scale (Dunst et

al. 1988). Caregivers expressed needs related to the following: 1) Respite needs, 2) Monetary needs, 3) Needs for peer support, 4) Their grandchildren are challenging behavioral problems, 5) Confusion about the public agencies' bureaucracies, 6) Confusion at having two or three caseworkers from the same agency responsible for the grandchildren in their care, 7) Their desire to get to know their caseworkers, who now just "run in and out", and 8) Their children's drug use.

Following the analysis of GWC members' qualitative and quantitative needs, and discussions with the SFDHS and San Francisco Community Mental Health Services (SFCMHS), Edgewood established KSN. The KSN model is an example of a contractual, community-based service approach with the public DHS acting as a "managed care" agency by monitoring services. KSN's primary mission is to provide a comprehensive, private-sector response and to offer case-managed services that fill gaps in public social services. This privatized model delivers services at the community level without evident participation in a public sector program, which caregivers had indicated they found stigmatizing. At the same time, the KSN model also gives the public agencies (in this case, SFDHS and SFCMHS) sufficient oversight and controls to ensure that mandated policies are observed.

KSN clients may be assigned to either the Case-managed or non Case-managed programs. KSN offers case-managed services to address needs expressed by caregivers who want a more active and direct intervention than GWC's non-Case-managed support services. Clients receiving Case-managed services are assigned a Community Worker (CW), receive a thorough assessment of their needs,

a written case plan, direct intervention including minimum monthly home visits, weekly phone contact and collateral visits. In comparison, the non-Case-managed program neither assigns a CW to clients nor offers direct services or home visits. Participation in either program gives families access to the same variety of caregiver self-help support groups, recreation and respite activities, training workshops, tutoring/mentoring, health support, and transportation services.

This paper outlines KSN's theoretical foundation, describes the KSN model and presents descriptive demographic data on kin families who received case-managed services between July 1993 and March 1998. The paper also discusses the results of a Family Needs Scale and a health assessment given to caregivers in the Case-managed program at intake.

*Theoretical Foundation:*

Almost 90% of caregivers attending the GWC support groups were African American. Therefore, when developing KSN Edgewood decided it was important to implement case-managed services in ways that fit the cultural patterns and preferences of this population. Luckey (1994) argues that the African Americans' informal kinship support network for the elder generation follows the principle of substitution, where aging parents rely on their daughters and sons. Because of their educational attainment and increased interaction with mainstream society, second and third generation African American kin (e.g. children and grandchildren) often have functioned as supports to the first generation by "linking elderly family members with formal systems, monitoring interactions with these

systems, and providing advice regarding help-seeking and services” (Luckey 1994: 85). KSN families, however, do not follow this pattern. The immediate kin support of daughters and sons and/or grandchildren is not available because of problems experienced by the second and/or third generations (e.g., substance abuse, mental illness, AIDS). These very conditions put grandparents into caregiving roles. As traditional networks of support erode, families become more isolated, often having to rely on public bureaucracies rather than informal family supports for assistance. But Edgewood’s needs assessments had shown that unfamiliarity with and mistrust of the formal public service system inhibit kin caregivers from seeking this assistance. High caseloads at public agencies and lack of culturally informed staff inhibit outreach efforts to the kin caregiver community. To bridge this gap, KSN decided to hire elderly African American and Latino grandparents from the communities where kinship caregivers live. With training and supervision these paraprofessional Community Workers (CW) effectively link, monitor, and provide advice to caregiver clients, assuming the roles of the second and third generations in the informal extended family support system.

Edgewood’s staff drew primarily upon two theories to formulate KSN’s Case-managed service approach: 1) Social Learning Theory, and more specifically the extension of this theory to explain behavioral change in terms of self-efficacy (Bandura 1997, Bandura 1977a; 1977b; Bandura & Adams 1977) and 2) Ecological Theory (Bronfenbrenner 1972).

1) *Social Learning Theory*: According to Bandura (1997, 1977a), self-efficacy refers to an individual's perceptions of confidence in his/her capabilities to organize and execute actions required to complete a specific task or behavior successfully. Bandura (1997, 1977a, 1982) and others (Mowat & Laschinger 1994; Friedman et al., 1994) describe four principal sources of information upon which these perceptions of confidence (e.g. self-efficacy) are based: (1) enactive attainments involving actual mastery experiences; (2) vicarious experiences or modeling and observational learning of others' achievements; (3) verbal persuasion by others, including other types of social influences that encourage a belief that one can achieve what one wants and (4) monitoring one's physical and affective state. Bandura discusses varying dimensions of self-efficacy perceptions, and cites research demonstrating that generalization about one's perceptions of efficacy requires cognitive discrimination. Not only do personal cognitions play an important role in mediating efficacy beliefs, but multiple interactions between numerous external and internal factors, including emotional states, make the process highly complex.

Because of the theory's complex nature, staff focused very concretely on three of the four information sources when applying self-efficacy theory to KSN. CWs develop a case plan with achievable goals, which build on client strengths, so that caregivers are more likely to experience successes (e.g. mastery). Bandura (1997) notes that mastery is the most powerful of these factors, so KSN supervisors work closely with CWs to define goals that are likely to produce early positive results as

clients begin implementing their case plan. Because they share common circumstances and have confronted similar experiences as clients, CWs act as models of successful caregiving and coping (e.g. vicarious experience through observational learning). Third, in their direct contacts with families, CWs encourage (e.g. persuade) caregivers to work towards achieving the goals outlined by case plans, often basing such verbal support on their own successes. Thus, the clinical intervention with kin families is designed to reinforce and strengthen caregivers' skills by encouraging caregivers to master goals, by providing positive models and encouragement. This combination of strategies aims to enhance caregivers' confidence in their abilities to meet their own and their child(ren)'s needs.

2) *Ecological Theory*: Ecological theories of development acknowledge the complex relationships among different parts of a child's environment and emphasize that not only does the family unit affect a child, but the larger systems with which the family interacts also play a significant influential role (Bronfenbrenner 1972). Therefore, in addition to families, other agencies and institutions in a community must be included when considering interventions. To this end, CWs coordinate services not only with DHS but also with the San Francisco Unified School District (SFUSD), SFCMHS, Department of Public Health, Juvenile Probation, Legal Services for Children, and local churches and youth organizations. In collaboration with these groups, CWs offer both home-based and center-based services to caregivers. By providing case-managed services that use goal attainment, modeling

and verbal reinforcement and by offering supportive services, recreation and respite, and including the web of agencies and organizations involved with families, the KSN model intervenes both clinically and structurally.

In summary, the KSN offers case-managed services staffed by paraprofessionals and grounded in psychological and cultural anthropological theories consistent with recommendations that outreach services should be provided by indigenous workers collaborating with community organizations (churches, recreational centers), offering transportation, and coordinating multiple service needs to meet demands on clients' lives (Finnegan & Kandall 1992).

#### *Kinship Support Network Case-managed Program Model*

Service delivery models describe the dynamics and skills used in a helping process from the opening to the closing of a case for an identified population (Jackson 1996:585). The KSN Case-managed program is made up of Intake, Carrying, and Mental Health units, problem-focused intervention teams, and a broad array of supportive services (See Figure 1).

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**Insert Figure 1 About Here**

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*Intake & Case Plan:* As case managers, CWs not only provide direct intervention services and coordinate a variety of supportive services to client families but also assess the functioning of client families and develop a case plan. Intake and development of the initial case plan are the foundation for KSN services to families. There are two types of intake referrals for KSN Case-managed services:

1) Referrals for short-term assessment and placement decision, which may be graduated, closed or transferred on for case-managed services and 2) Referrals solely for case-managed services that are made independently.

In the first situation, cases are referred to KSN's Intake unit by DHS Child Protective Services (CPS) when there is a question about the safety or well being of a child or when a kin family is being assessed as a potential placement for a child. This referral type usually involves rapid response for assessment and a short-term intervention to determine if this relative caregiver is willing and able to provide care in a manner that ensures the safety of the child. Following a referral from CPS, the Intake Worker (IW) contacts the potential kin placement within 48-72 hours to assess the home environment, assesses the willingness and capability of the caregiver to adequately care for the child(ren), and informs the caregiver of his/her rights. A Family Needs Scale (FNS) is completed and a preliminary case plan developed. The IW then contacts CPS and informs them of the assessment findings and recommendations. The CPS Child Welfare Worker (CWW) has the final authority in determining the viability of a placement. The case is then assigned to a CW who meets the client to finalize the case plan based on the FNS and any other information the client shares. Upon completion of this intake case plan, there are three possible outcomes for a family: a) Graduation from intake, b) Transfer to either the Case-managed Unit's Carrying or Mental Health teams for services, or c) Closure for any of the following reasons: 1) Client request; 2) Placement failure; 3) Request of the referring agency. If the family is transferred for

case-managed services, they go through another intake process as described in the following paragraph.

In this second referral situation, the Intake unit (described above) may refer a client, or more typically, a DHS CWW makes a decision that a kinship family in their existing caseload requires additional services. For these cases, DHS has already assessed that kin placement is appropriate for the child(ren). There are no specific criteria that determine when a DHS CWW makes referrals to KSN for case-managed services. This decision is based on the individual CWW's assessment of a family's need for case-managed supportive services. Other referrals for case-managed services may come from hospitals, community mental health services, schools, juvenile probation, private agencies, public health nurses, probate court, jails, kin families themselves or KSN's non Case-managed program unit. When a referral is received, an IW contacts the caregiver and sets up an appointment at the client's home. During the visit, the worker uses the Family Needs Scale (FNS) and other information and observations to assess strengths and needs of kin family members (e.g. caregivers, child(ren) and birth parent(s)). This assessment is the basis for the initial case plan. IWs are trained to: 1) Evaluate the safety of the kin housing; 2) Observe evidence of prior or current substance abuse by caregivers; 3) Coordinate with DHS to check caregivers' prior criminal history; 4) Observe caregivers' physical or mental functioning; 5) Determine the availability of a supportive extended family system; 6) Assess willingness and ability of the caregiver to implement changes as indicated by the case plan; and 7) Inquire of

their willingness and ability to meet the special needs of the child(ren) in their home. Depending on the intake assessment, cases accepted to KSN are placed in either the Carrying or Mental Health Team for assignment to a CW, who will carry the case until graduation or closing.

*Case-managed & Supportive Services:* Case management and provision of supportive services are the central components of KSN's service model. A full-time CW carries a caseload of 20 families. CWs have direct contact with clients, visiting their homes at minimum monthly and making at least weekly phone calls to kin caregivers. Phone calls and home visits occur more often during difficult times. CWs accompany clients to collateral meetings with the schools or other agencies, provide transportation for purchasing groceries or to attend doctor appointments, and offer general support in times of need. KSN's Volunteer Coordinator may become involved with a family for needs related to housing, or obtaining clothes, furniture, food, etc.). As part of case management, CWs meet regularly with their supervisors to review and modify the case plan and to assess the kin caregiver families to ensure that the child(ren) is/are safe and in a stable, nurturing environment. Regular contact is maintained with the referring DHS CWW, who monitors the family's progress towards achieving goals.

These support services are primarily provided at Edgewood's Family Center, where KSN staff are based. The Family Center site was selected because of its proximity to several major city bus lines. The facility has offices, meeting rooms and a large kitchen where food for holiday celebrations or luncheons is prepared,

sometimes with client assistance. Caregivers in the Case-managed program may choose to attend self-help support groups under the auspices of GWC or participate in recreation and respite activities such as sewing classes, workshops, self-improvement groups, special outings, luncheons, and picnics. Children's supportive services include educational tutoring, sports activities, summer camp, outings and parties. KSN has received donations and outfitted a computer room, library and play area with toys and games. An *Independent Living Skills* program for high school students provides tutoring, computer training, life skills and career guidance. The *Junior Enrichment* program for children ages 8-12 provides safe recreational opportunities, tutoring and a forum for these children to discuss their fears and anger about what is going on in their lives. A Tiny Tots program for infants and very young children operates at the Family Center every other weekend providing group play activities.

Service components of the KSN model have developed in response to expressed client needs and to inquiries from the community as others learn of KSN services. For example, KSN added a Mental Health unit for both children and caregivers funded through SFCMHS. Physical health needs of all family members are also significant, and in 1997 KSN received a grant from the National Center on Child Abuse and Neglect (NCCAN) for a Registered Nurse and a Senior Developmental Specialist. These new workers along with a Health Supervisor and a LVN make up a Health Team that serves children and caregivers. After noting increasing referrals of children for school related problems, KSN has several CWs

stationed at various schools for part of each week to address problems that arise and to act as liaisons between school staff and kin caregivers.

*Training & Supervision:* This is a very important component of the KSN model and includes not only didactic presentations but also clinical case supervision for paraprofessional staff. CWs receive regular training about programs in the public sector in order to provide clients up-to-date guidance and education about welfare, legal, school, and health matters. With this knowledge, CWs instruct and link caregivers with public agencies, guiding and encouraging clients to obtain appropriate assistance from social services, education, and health institutions.

Mindful of the need to protect the child(ren) in kinship homes, CWs receive regular training and supervision in assessment techniques. Assessment of kin homes begins at intake and continues throughout the life of a case. CWs discuss their assessment findings in supervision meetings and may meet with the DHS CWW to present recommendations about a specific kin family deemed at risk. Because many CWs are themselves grandmothers raising kin, it is sometimes difficult for them to assume an authority role that is critical of a client's parenting. Decisions about the safety and appropriateness of a kin placement are challenging, but when risks to KSN children have been identified, CWs have referred their kin caregiver clients to DHS Child Protective Services (CPS) for alternative placements. Supervision of CWs takes place weekly or more frequently if there is a crisis.

*Level 1 and Level 2, Graduation and Closing:* Because of the close rapport that develops between CWs and kin caregiver clients, termination of cases poses

challenges for both parties. For this reason, once the goals of the case plan have been completed, CWs may recommend transferring a case from the regular status (Level 1) to a less active status (Level 2). The CW's supervisor must approve this decision. A client transferred to Level 2 status no longer sees the CW and receives only a monthly phone call, but no other case-managed services. Other KSN supportive services such as respite and recreation remain available to clients. This "stepping down" to a less intense service level assists clients and CWs to prepare for graduating the case.

Before a family graduates, CWs consult with their supervisors, their caregiver client and the DHS CWW. The case plan is reviewed and a collaborative determination made as to whether the goals and objectives were met. Only after a consensus is reached among staff and caregivers does a family graduate, indicating successful completion of their case plan. Clients who graduate from Case-managed services may be referred to non Case-managed services and remain eligible to participate in any supportive services they wish. If/when other needs emerge, a graduated case can be reopened.

Children placed with relatives tend to stay there, are not usually adopted, and are less likely to be reunified (Courtney & Needell 1997). KSN Case-managed families have been caring for child(ren) a median of four and one-half years. Because of minimal or no involvement of birth parents, reunification for many of these children is often no longer a possibility. In these cases the issue of permanency revolves around the willingness and ability (including financial) of the

kin caregiver to continue in that role. CWs discuss with each caregiver the implications of permanently caring for the child(ren) and consider pros and cons of various long-term options for each child and family unit (e.g. adoption, legal guardianship, long term placement). KSN collaborates closely with Legal Services for Children to pursue legal guardianship for caregivers who express interest, but as of March 1998 only a small number of KSN clients had elected this option.

Lastly, not all clients successfully complete their case plan. KSN cases may be closed at any time if: 1) Client is deceased. 2) Client moves out of San Francisco City/County. 3) Client refuses services or is non-compliant. 4) Child is reunified with biological parent(s). 5) Request of DHS CWW.

### **Descriptive Findings**

Because kinship care has only recently attracted the attention of social scientists, little systematic study exists as to its scope and nature (Scannapieco et al. 1997; Berrick 1997; Wilson & Chipungu 1996; Burton 1992; Berrick & Barth 1994). KSN provides an opportunity to systematically collect demographic information about kin caregiver families, many of whom are part of the foster care system in San Francisco. The Stuart Foundations of San Francisco awarded a multiyear grant to Edgewood to look in more detail at these kin caregivers. Demographic data have been collected since the inception of KSN services in July 1993. The families described in this paper have received case-managed services and supportive services. None of the families described here were recipients of only non case-managed services. As of March 1998, KSN had provided case-managed services to

a total of 340 cases/families of which 179 are considered dependent and 162 non-dependent (A family having one child or more involved with DHS Child Protective Services who is a dependent of the San Francisco Juvenile Court is considered a dependent case even though there may be non-dependent kin children residing in the same home.) Descriptive data are reported below.

### *Caregivers*

One hundred seventeen of these 340 families were active KSN cases in March 1998 and 223 had graduated or closed. For the 117 active cases 59 of these were dependent and 58 non-dependent. Of the 223 inactive cases, fifty-nine percent (n = 132) had successfully graduated, 11 percent (n = 24) were closed at client request, seven percent (n = 15) were judged non-compliant, six percent (n = 14) moved out of San Francisco, five percent (n=12) had the children removed, four percent (n = 10) were closed at KSN's request and the remainder were due to caregiver's death or other reason. Only 2% (n = 4) cases were closed because the children were reunified with their biological parents. Ninety-five percent of the primary caregivers in these families are women (n = 326) with only twelve males. Eighty-two percent (n = 281) of the caregivers were African American; 6% (n = 21) Latino; 1% (n = 3) Native American; 4% (n = 14) Caucasian; 1% (n = 3) Other/MultiRacial, and 5% (n = 17) Unknown or Unspecified. This group of kinship caregivers has a median age of 54, ranging from 20 to 91. Age was related to caregivers' kin relationship. We separated caregivers into the following groupings: 1) Non-grandparents, median age 37 (n = 62); 2) Grandparents, median age of 55 (n = 253); and 3) Great- or Great-great

grandparents, median age of 68 (n = 26). We examined familial relationships of kin with an unduplicated count, we found that 57% (191) are maternal grandmothers; 2% (6) are maternal grandfathers; 11% (38) are paternal grandmothers; 1% (2) are paternal grandfathers; 10% (35) are maternal aunts; 6% (19) are maternal great-grandmothers. Interestingly, 18% (60) have two kin relationships with the children in their care (e.g. maternal grandmother, maternal aunt); 2% (5) caregivers have three kin relationships; and 1% (3) caregivers have four types of kin relationship with the 17 children in their care (e.g. maternal grandmother, maternal aunt, paternal grandmother, paternal aunt).

Table 1 shows descriptive data for primary caregivers seen in the Case-managed Unit between KSN's 1993 opening and March 1998:

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Caregivers' educational level showed that 4% (14) had completed elementary/middle school; 12% (42) had some high school; 32%(107) had a high school diploma; 14% (49) had some college; and 3% (10) had a college degree. The educational level of 35% (118) was unknown or unspecified. Caregivers' had a median educational level of 12 years (e.g. high school graduate). Two hundred ninety-one caregivers reported that they had been raising their kin for several months to as long as 17 years, with a median of five and one half years of active caregiving. The number of kin living with each caregiver ranged from one to eight, with a median of two children per family.

### *Children*

The total number of children in these KSN Case-managed families was 725 of whom 48% (345) were dependents of the court and 52% (380) were non-dependents; 49% (357) were Female. Children's racial identification was 87% (633) African American; 6% (40) Latino; .03% (2) Native American; 1% (7) Caucasian; .03% (2) Asian/Pacific Islander (Filipino); 1% (9) Other/MultiRacial and 4% (32) Unknown/Unspecified. Children's ages were as follows: 2% (13) were aged 0 through 1; 5% (38) ages 2 or 3; 33% (237) ages 4 through 8; 29% (214) ages 9 through 12; 26% (190) ages 13 through 18; 4% (29) ages 19 through 21; and 1% (4) unknown. Less than 1% (2) of the children were reported by their caregivers to be involved with the juvenile court as delinquents. Within the calendar year prior to their KSN intake date, 11% of children (80) had received Special Education services, and 46% (337) had received a physical examination. As reported by caregivers, children's primary sources of income show that 44% (317) are foster care recipients; 31% (227) receive AFDC; 4% (28) qualify for SSI and 3% (24) were receiving Social Security (e.g. for a deceased parent). Children may have multiple sources of income.

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**Insert Table 2 About Here**

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### *Services*

For 175 graduated or closed cases receiving Case-managed KSN services, ten percent (n = 17) were closed within three months; 37 percent (n = 64) were closed

between three and 13 months; 22 percent (n = 39) were closed between 13 months and 20 months; 26 percent (n = 46) closed between 20 and 36 months, and the last five percent (n = 9) remained active between 36 and 50 months. The median number of months receiving case-managed services for this population is 14 months.

Supportive services are offered to caregivers and their kin children enrolled in either the Case-managed or non-Case-managed components of KSN. Figures reported are only for clients receiving Case-managed KSN services. Direct Case-managed contacts such as monthly visits, weekly phone calls or the accompanying of caregivers to school or medical appointments are not included here.

For 215 caregivers who received case-managed services between August 1993 and March 1998, there were a total of 7,448 hours of supportive services provided, with a median number of 9.5 hours per caregiver during the time a case was active. It is important to note that the distribution of services is highly skewed, ranging from 1 to 292 hours of service. Analysis of the services shows that most clients receive a few hours of service and that a small number of clients receive a very high number of supportive services.

#### *SF-36 Health Survey (SF-36)*

Studies have found that assumption of the caregiving role does negatively effect caregivers' health and that kin caregivers rate their health as poor when compared with regular foster parents (Minkler & Roe 1993; Berrick et al. 1994). The instrument used to measure general health and mental health of kin caregivers

for the Stuart Foundations project was chosen so as not to overly burden respondents. The SF-36 Health Survey (Ware 1993; Ware & Sherbourne 1992; McHorney et al. 1994) is a 36-item standardized measure of eight general health concepts: physical functioning (PF); role limitations due to physical health problems (RP); bodily pain ((BP); general health (GH); vitality (VT); social functioning (SF); role limitations due to emotional problems (RE); and mental health (MH).

Estimates of score reliability and validity of this survey scale lie within acceptable standards as reported by Ware (1993). A recent study found missing data problems among minority populations using the SF-36 (McHorney et al. 1994). KSN CWs' experiences confirm this finding. When materials are left with elderly kinship caregivers to complete, the return rate is poor. Tactful questioning of KSN's caregiver clients has revealed that problems of literacy and poor vision probably contribute to lower completion rates. To address this, KSN's Research Associate helps clients complete this measure, which is administered very soon after intake.

One hundred-eighteen kinship caregivers in the Case-managed program completed the SF-36 soon after intake. Because increased age is typically associated with poorer health and role limitations, we created two caregiver groups for analysis: 1) Grandmothers, Great Grandmothers, and Great-Great Grandmothers (n=91) and 2) Non-Grandparents younger than 45 (n=20). Of the 118 cases, seven clients were not included (e.g. a Great Aunt older than 45). Because the median age of KSN grandparents is 55, means for females in the SF-36 normative age groupings 45-54 (sample n = 193) and 55-64 (sample n = 164) were combined to

produce norm means for females ages 45-64 for comparative purposes. Transformed KSN mean scores on a scale of 0 to 100 for 91 grandmothers, great grandmothers, and great-great grandmothers compared with the normative sample grouping revealed statistically significant lower scores on all eight subscales of the SF-36 as shown in Table 3:

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For non-grandparents under age 45, we used SF-36 normative mean scores for females ages 35-44 (n-264) for comparison. This analysis showed that the KSN group of younger, non-grandparent females were healthier on every subscale of the SF-36 than the normative comparison group mean scores as shown in Table 4.

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### *Client Needs*

Because perceived needs play a central role in establishing client goals, a needs assessment based on Dunst et al.. Family Needs Scale (1988) (previously used with GWC clients) was modified for use with KSN caregivers. The revised measure is an important element in KSN's intake process, as it forms the basis for developing the family case plan. The KSN IW completes the Family Needs Scale (FNS) at the initial intake meeting. This instrument asks, "How often do you have

need for the following types of help?” The measure initially contained 39 items such as: “Having money to buy necessities and pay bills;” “Having enough food daily for two meals for my family;” and “Transporting my child places including appointments.” Respondents are given three choices: “Never,” “Sometimes,” or “Almost Always.” After nine months of use with clients, the needs assessment questionnaires were analyzed for frequency of response, and eight items were eliminated to minimize burdening the respondents, resulting in a 31 item scale.

FNS items sorted by Means for 275 KSN caregivers assessed at intake show a combination of personal, tangible, and child-focused needs. Using the three point scale (1=Never and 3=Almost Always), the ten needs receiving the highest ratings were personal: “respite care” (M=2.11) was followed by “having time for myself” (M=2.04). Next came needs for money and tangible goods: “having money for necessities” (M=1.94) and “getting furniture, clothes and toys” (M=1.87). Caregivers then expressed several child-focused needs: “getting special services for my child” (M=1.86) and “transporting my child” (M=1.78). These highest-ranking needs were followed by a combination of personal and child focused needs: “Participating in parent groups or clubs” (M=1.77); “getting places I need to go for myself” (M=1.76); “having emergency childcare” (M=1.74) and “having a person to talk to about me” (M=1.73).

## **Discussion**

Kinship placement as an alternative to foster family care has grown substantially within the public welfare system over the last decade. It utilizes a

historically informal extended family system, especially among people of color (McFadden 1996). Practitioners and policy makers continue to debate how best to integrate the informal with the formal systems. Apart from changing reimbursement formulas for kinship homes, there are essentially two basic approaches to altering the service delivery system for kin families: 1) Change the formal system, and 2) Contract with private service providers.

Many professionals acknowledge the need for the public system to become more educated about and responsive to kinship care, specifically to African American cultural and familial strengths (Danzy & Jackson 1997; Testa 1997; Scannapieco & Jackson 1996; Burnette 1997; Gleeson 1996). Jackson (1996) and Scannapieco and Jackson (1996) propose adopting a “kinship triad model” within the public system. This model views kinship care as family preservation rather than foster family care, and focuses on developing culturally sensitive services, working with the children, biological parent(s), and relative caregivers while avoiding overly intrusive responses. Their recommendations resemble those of Link (1996), who calls not only for increasing financial supports to relative caregivers but also for minimizing intrusion into kin families. These proposals highlight some of the tensions created when attempting to alter the formal system governed by federal, state, and local statutes to fit the needs of children and caregivers who comprise an informal extended family tradition (Gleeson & Craig 1994). Public agencies are mandated to protect the best interests of the child; ensuring that caregiving families meet specific criteria. However, enforcing compliance with standards is

often perceived as intrusive, culturally insensitive and offensive to kin caregivers, undermining the possibility of a collaborative relationship between agency workers and family members.

An alternative to changing the public welfare system's service model and improving the staff's cultural sensitivity is to contract with community-based agencies using paraprofessionals. Edgewood's KSN Case-managed program serves as an example of this trend towards privatization of public social services (GAO/HHS 1997). Following a competitive bidding process, SFDHS now contracts with Edgewood to have KSN serve a portion of the public sector's kinship caseload, while SFDHS monitors KSN's performance and continues to serve the rest. The advantages of this approach include a flexible program which can respond quickly to emerging needs, ease of collaboration with other community-based programs serving these families, and cultural and ethnic matching of paraprofessional staff with clients.

Using CWs from the same neighborhoods as clients also has challenges associated with it. KSN CWs sometimes over-identify with clients, in part to avoid being seen as part of the public system whose mandates they now enforce. Wasik (1997) describes this as straddling two cultures—the one of the community and the other of the hiring agency. Ongoing skills training and close supervision are essential to help paraprofessional CWs balance their roles and responsibilities to families and to the public sector (Wasik 1993). Supervisors play a critical role in assisting the KSN CWs to carry out their jobs effectively, although supervisors also

must straddle multiple roles of administrators, teachers, and therapists (Wisik 1993). One other challenge in privatizing services is determining how the public sector should monitor private contractors' performance (GAO/HEHS 1997).

Edgewood's ISC-BS regularly assesses client satisfaction with KSN services and collects other client outcome data, providing quarterly reports to SFDHS.

Periodically, SFDHS contract compliance staff randomly review KSN case records.

KSN caregivers share much in common with the subjects of previous studies. KSN kin caregivers are predominantly African American female grandparents with a high school education. They have been caring for both dependent and non-dependent grandchildren for at least five years. The high number of African American caregivers probably reflects the demographics of urban America (Harden et al 1997). McLean and Thomas (1996) and Gebel (1996) also report high African American representation in their urban samples. The preliminary findings about this group indicate areas for intervention that may improve the caregivers' situations and thereby improve outcomes for the children in their care. The age demographics of these families, the majority of children are younger than age 12 and the majority of their caregivers are over age 50, in addition to caregivers' expressed needs, strongly support the importance of providing respite services. Moreover, the preponderance of female caregivers in single parent households (only 18% are married) raising families that are equally divided between male and female children points to the need for male role models.

The majority of KSN caregivers' self-assessment of health status is significantly below the national female norms on every subscale of the SF-36 Health Survey (e.g. poorer health), indicating that it is essential to address health care and mental health needs when serving this population. Low scores for the grandparent group may have to do with our strategy for analyzing the data. We divided the KSN sample into two groups based on their relationship to the children in care—the grandparent and great grandparent group is older and had significantly poorer health ratings, while the younger group below age 45 rated their health similar to the normative population. This finding is similar to Berrick et al. (1994), who noted that 80% of the kinship parents with a mean age of 48 (e.g. younger) reported good or excellent health. Of course these scores, which show older persons having more health problems, are to be expected. However, it is not known if assumption of the caregiving role has contributed to increased health problems for the older KSN group, although other studies support this view (Minkler & Roe, 1993; Berrick et al. 1994; Shore & Hayslip 1994). On a measure such as the SF-36 there may be systematic under- or overreporting. In previous studies of grandparent caregivers, Minkler et al. (1994) issued a warning against this possibility, suggesting that underreporting may be expected from grandparents afraid to lose their grandchildren to the public foster care system if they describe themselves as having health problems. However, because the older group of KSN caregivers fall significantly below the national norms in all SF-36 subscales, underreporting of health problems was not an issue in this group.

As with the kin caregivers, there were many similarities between KSN children, and those described in other studies (McLean and Thomas 1996; Scannapieco et al. 1997; Berrick 1997). The children in KSN families are predominantly African American, latency-aged boys and girls. Nine percent (n = 64) of KSN children receive special education services, similar to the California rate of 9.34% (California Department of Education 1996). Very few children (n = 2) are reported by caregivers to be delinquents with juvenile court, although the literature suggests an association between documented abuse/neglect experiences and risk for delinquency involvement with the juvenile justice system (Widom In press; Maxfield & Widom 1996). If caregiver reporting is accurate, these figures may indicate the importance of placing these youngsters with extended family members. On the other hand, this number may also reflect underreporting by caregivers, who do not want to appear inadequate to caring for their kin.

Although 48% (323) of these children have received a physical exam within the past year, 52% have not, and this is of concern. Scannapieco et al. (1997) note that the physical health status of children varied with the source of assessment, some studies reporting high levels of medical problems (Dubowitz et al. 1994) and others finding caregiver report of children to be generally healthy (Berrick et al. 1994). KSN's data indicates only whether a child had an exam within the past year. (A minimum standard suggested by state health agencies [State of California 1992] and also the federal Early and Periodic Screening, Diagnosis and Treatment Program.) KSN's NCCAN-funded Health Team promotes greater understanding

among caregivers of the preventive nature of regular well-child medical and dental exams and assists in taking children for these check-ups.

Needs reported by clients to KSN are generally similar to those cited in the literature. They involve tangible items as well as caregiver and child-focused needs for respite, recreation, and supportive services, including education about the public systems (Davidson; 1997; McLean and Thomas 1996; Feigelman et al. 1995). KSN CWs identified the most important services they provide as: 1) emotional support and encouragement in the form of regular contact; 2) modeling advocacy techniques when accompanying clients to meetings with outside agency staff; 3) respite and recreation and 4) tangible support in the form of transportation or obtaining housing, food, furniture, and toys for the children. Most importantly, CWs share a supportive, non-professional relationship with their clients. It is culturally appropriate to maintain and sustain relationships of this type for longer than more traditional professional-client relationships. In the present era of managed care this is particularly relevant. Public agencies increasingly operate in an environment of cost-consciousness and may impose limits on length of service provision, disrupting the bond that develops between clients and staff. This has the potential of undermining KSN services and the supportive client-CW relationships that exist under the auspices of SFDHS.

## **Conclusion**

KSN's Case-managed program reduces gaps in a public system confronting a crisis of rising caseloads, reduced funding, bureaucratic paperwork requirements,

and the need to carry out new legislative mandates. The model presented here exemplifies the privatization of a public human service program, using paraprofessional CWs to facilitate service delivery to relative caregivers. It seems important for this predominantly African American client population that the service staff are largely persons of color, mostly African American. Using indigenous staff to educate about and advocate with agencies, this community-based model serves as a bridge between the informal kinship system and the highly bureaucratized public government system. Privatization of social services is predicted to continue (GAO/HEHS 1997), and in an era of free-markets it seems likely that different contractual models designed to address unique local circumstances will appear. Studies of these private models are needed, especially comparing service outcomes for families with those who are served by the public sector.

This descriptive analysis of kinship caregivers and children receiving KSN's Case-managed services provides some interesting and meaningful findings and points to areas that are worth further study. KSN case outcomes vary, with 59% of clients successfully graduating, and 28% closed for reasons that warrant investigation to understand why families do not graduate. It is critical to look at the children's functioning in kinship placements more closely. The report by these caregivers that only two children out of 725 are formally involved as delinquents is intriguing. It is unclear whether this low number is specific to this sample, or whether it is placement of these children with extended family that buffers youth

from becoming delinquents. Further study of this possibility is critically important. Future studies should also involve an examination of outcomes longitudinally with respect to children's general health and mental health status, behavioral and school functioning, reunification with parents, participation in community activities, and the utilization of other community services such as special education, mental health and juvenile offender programs.

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Figure 1.

# Edgewood Center for Children & Families

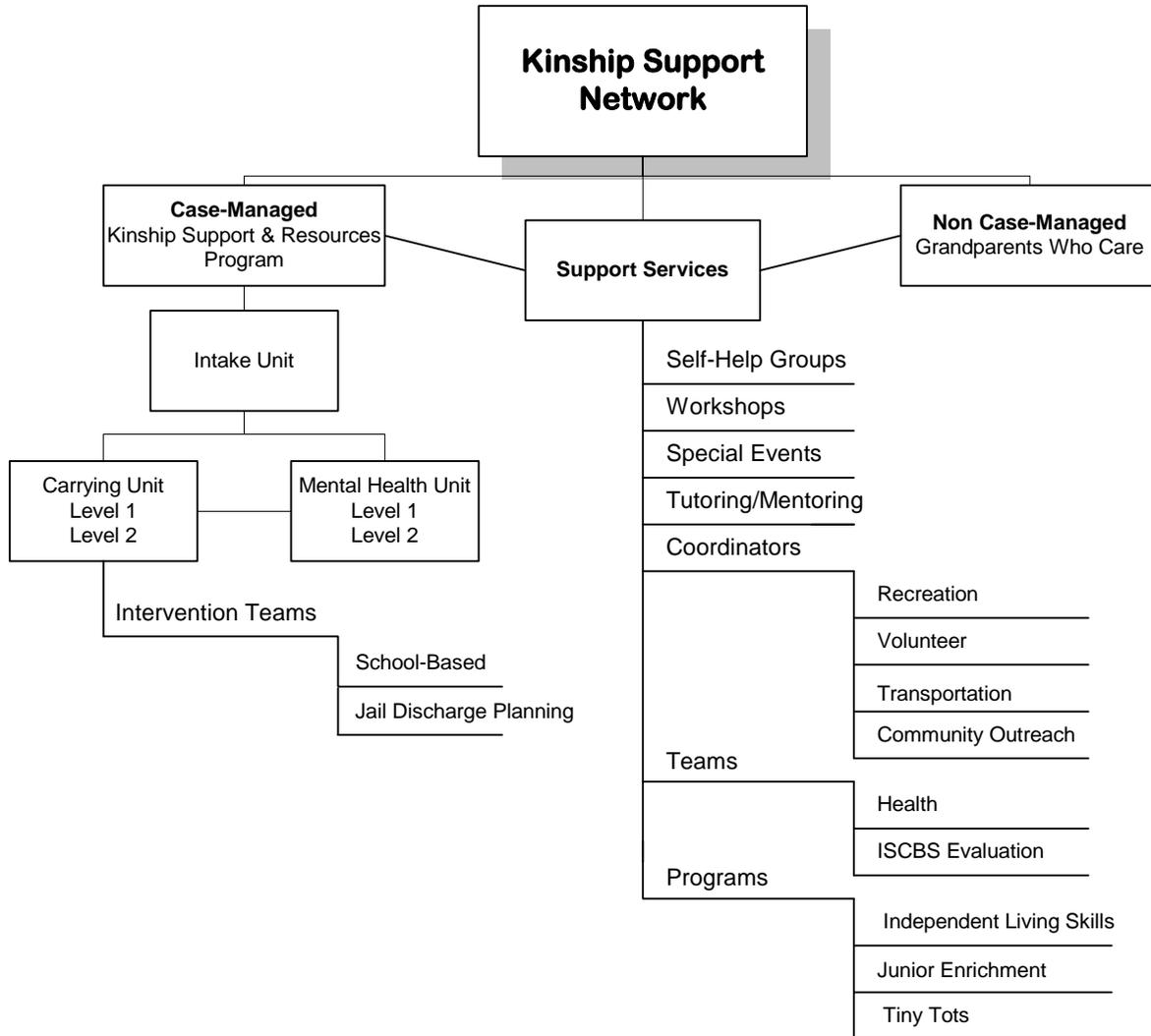


Table 1

Table 1. Caregivers' Demographic Variables				
Variable	Active (117)	InActive (223)	Missing	Total (340)
Dependent Caregivers	59 (33%)	121 (67%)		180
Non-Dependent Caregivers	58 (36%)	102 (64%)		160
Males	2 (17%)	10 (83%)		12
Females	115 (35%)	211 (65%)		326
Gender Unidentified			2 (100%)	2
African American	98 (35%)	184 (65%)		281
Latino	11 (52%)	10 (48%)		21
Filipino		1 (100%)		1
Native American	0	3 (100%)		3
Caucasian/White	4 (29%)	10 (71%)		14
Other/ Bi- MultiRacial	1 (33%)	2 (67%)		3
Ethnicity Unknown/Unidentified	3 (18%)	14 (82%)	17	17
Median Age (All Caregivers)	54	54		n/a
Median Age, Non-Grandparents (n=62)	37	37		n/a
Median Age, Grandparents (n=252)	55	55		n/a
Median Age, Great and Great-Great GP (n=26)	68	68		n/a
Median Number of Years of Education	12	12		n/a
Median Number of Years of Caregiving	5.7 (0-17)	4.8 (0-17)		n/a
Median Number of Children in Home	2	2		n/a

Table 2

Table 2. Children's Demographic Variables by Caregiver Classification*					
Variable	Active Depend.	InActive Depend.	Active Non-Dep	InActive Non-Dep	Total
Number of Children	138/19%	291/40%	112/16%	184/25%	725
Number of Depend. Children	108/31%	233/68%	1	3	345
Number of Non-Dep Children	30/8%	58/15%	111/29%	181/48%	380
Males	67/18%	150/41%	53/14%	98/27%	368
Females	71/20%	141/39%	59/17%	86/24%	357
Age 0 through 1	2/15%	0	4/31%	7/54%	13
Age 2 through 3	8/21%	9/24%	8/21%	13/34%	38
Age 4 through 8	45/19%	89/38%	39/16%	64/27%	237
Age 9 through 12	40/19%	92/43%	32/15%	49/23%	213
Ages 13 through 18	38/20%	88/46%	25/13%	39/21%	190
Age 19 through 21	4/14%	11/38%	3/10%	11/38%	29
Age Missing	1/25%	2/50%	1/25%	0	4
African American	126/15%	272/36%	92/18%	140/31%	630
Asian/Pacific Islander	0	2/100%	0	0	2
Latino	8/20%	7/18%	13/32%	12/30%	40
Native American	0	0	0	2/100%	2
Caucasian/White	0	4/57%	0	3/43%	7
Other	0	1/12%	4/44%	4/44%	9
Race Unknown/Unspecified					35
Receiving Special Education	9/8%	43/47%	11/14%	17/31%	64
Involved with Juvenile Court	0	2/100%	0	0	2
Physical Exam in Last Year	70/21%	138/41%	50/15%	79/23%	337

\* Caregivers are classified by Activity Status of Active or Inactive and as Dependent or Non-Dependent depending on whether they have children living with them who are dependents of San Francisco Juvenile Court. Any caregiver caring for a dependent child is classified as Dependent. Caregivers classified as Dependent may have Non-Dependent children living with them. Four families had dependent children who were removed or closed and these cases were re-classified as Non-Dependent. One of these families was re-activated.

Table 3

Table 3. 91 KSN Female Grandmothers, Great Grandmothers and Great-Great Grandmothers Compared to Norm Group Females, ages 45-64, on SF-36 Scales								
Short-Form 36 General Health Survey Scales**								
FEMALES	Phys. Funct	Role-Phys.	Bodily Pain	Gen. Health	Vitality	Social Funct	Role-Emot	Ment. Health
KSN Means	60.9	49.7	52.5	55.5	48	67.6	52.7	64
KSN SDs	29.86	43.54	32.17	25.40	24.35	32.70	41	23.73
Norm Means (Ages 45-64)	78.0	75.8	69.4	66.7	59.4	81.1	81.7	73.9
t-statistic	-4.94 *	-4.99 *	-4.83 *	-4.22 *	-4.17	-3.79 *	-6.28 *	-4.0 *
* $p < .001$ , 90 <i>df</i> , two-tailed.			**Lower scores mean poorer health					

Table 4

Table 4. 20 KSN Female Non-Grandmothers Younger than age 45 Compared to Norm Group Females, ages 35-44, on SF-36 Scales								
Short-Form 36 General Health Survey Scales								
FEMALES	Phys. Funct	Role-Phys.	Bodily Pain	Gen. Health	Vitality	Social Funct	Role-Emot	Ment. Health
KSN Means	89.3	83.8	81.5	80.7	61	87.5	83.3	73.7
KSN SDs	12.1	29.6	22.2	15.9	16.4	18.6	31.5	12.6
Norm Means (Ages 35-44)	88.1	83.7	74.9	74.3	59.4	83.1	80.1	73.3
<i>t</i> -statistic	0.46	0.02	1.34	1.81	0.43	1.07	0.46	0.12
NS, 19 <i>df</i> , two-tailed.								