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Connecting older grandmothers raising grandchildren with community resources improves family resiliency, social support, and caregiver self-efficacy

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ABSTRACT

Custodial grandparenting can be especially challenging for older grandmothers facing age specific issues. Kinship navigator programs are social service delivery programs intended to inform grandparents and other relatives raising children about available resources and services, provide information specific to their individual needs, and help families navigate service systems. Our study utilizes self-report data from one kinship navigator federal demonstration project, which used a randomized control trial, to examine demographic characteristics for grandmothers under and over 55 years of age, whether grandmother caregivers (≥55 years) improve family resilience, social support, and caregiver self-efficacy, and which interventions improved outcomes for grandmothers (≥55 years). Each participant was randomly assigned to one of four groups: Usual Care (traditional child welfare services), Standard Care (family support and case management), Peer-to-Peer Care Only, and Full Kin Tech Care (peer navigators with computer access and interdisciplinary team). Thirty-nine percent of grandmothers (55-75 years) were mostly living in poverty, predominantly Caucasian, with 36% identifying as African American/Black, with at least one to two children at home. Repeated-measures ANOVAs for each subscale showed statistically significant within- and between-group differences for Family Functioning, Social Supports, Concrete Supports, Child Development, and Nurturing and Attachment, with the exception of Usual Care, which showed a decline in protective factors consistently across subscales. Future research with kinship families could qualitatively examine the experiences for older women in navigator programs and replication of kinship navigator programs could build capacity in data collection and maintenance systems to gain better perspective about how systems of care impact families.

KEYWORDS

Grandparents raising grandchildren; kinship care; kinship navigator; protective factors; randomized control trial; resiliency; social support

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Introduction

Many circumstances result in the decision of nonparental relatives, mostly older women, caring for their younger kin. Child maltreatment, parental substance abuse, incarceration, 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. This type of care is referred to as *kinship care*, or the full-time care, nurturing, and protection of children by their relatives, fictive kin, or member of tribes or clans (Child Welfare League of America, 2000).

Custody options exist for kinship families based on the family's relationship with the child welfare system, including formal and informal types of care. Formal kinship care, or public kinship care, often involves families whose children are placed with relatives by a child welfare agency because of child abuse, neglect, or abandonment. Formal kinship care can depend on how caregivers are publically supported and the way they are monitored by a child welfare agency. Informal or private kinship care is usually a relationship initiated by the family because of a crisis or other family problem (Strozier & Krisman, 2007).

About 2.6 million children are being raised in kinship care with no birth parents in the home (3.5% of all children in the United States) (Kids Count Data Center, n.d.). Many of the estimates available on kinship care are based on data available from administrative records from the child welfare system, which often only include children who have been placed in the home of a relative due to child maltreatment. For every child in foster care with relatives, there are 20 children being raised by grandparents or other relatives outside the foster care system (Kids Count Data Center, n.d.). Children who are raised by grandparents outside of the foster care system have more difficulty connecting to needed resources and support compared to children involved in the child welfare system (Annie E Casey Foundation, 2012). This discrepancy can be concerning, since kinship care has been on the rise for the past decade, and this growth is most dramatic among families headed by older women with the least amount of financial resources and the highest social service needs (Gleeson, 2007).

Regardless of available resources, custodial grandparenting can be especially challenging for older grandmothers facing age-specific issues, such as 55-and-older living communities' restrictions of including children on the property and physical and mobility issues associated with caregiving. Peterson (2017) explored specific challenges for older grandparent caregivers with a mean age of 65. Peterson's study reported that before assuming the primary caregiver role, older grandparents described their physical health as

good, filled with physical activity, and reasonably free of health conditions. After entering the primary caregiving role, older grandparents of adolescents described functional restrictions and visible changes in physical health requiring intensive medical interventions, and they also experienced anxiety, worry, depression, sadness, and frustrations.

Besides support groups and educational programs (Kelley, Whitley, & Campos, 2013; Littlewood, 2014), few studies have specifically examined how other programs could improve the lives of kinship caregivers, especially for older women. Furthermore, few studies have focused on custodial grandparents' strengths, which serve as protective factors to build strong resilient kinship families. Researchers are now increasingly thinking about protective factors that can reduce risks, build family capacity, and foster resilience. These are the things that could shed light on the dynamics of survival in high-risk volatile settings and help us better understand what happens to familial relationships as they are exposed to a wide variety of biopsychosocial and economic factors. This study offers a unique opportunity to examine how a kinship navigator program could improve various protective factors for families headed by older custodial grandmothers.

Kinship navigator programs

Kinship navigator programs are social service delivery programs intended to inform grandparents and other relatives raising children about available resources and services, provide information specific to their individual needs, and help families navigate service systems (Woodruff, Murray, & Rushovich, 2014). These programs were named "Kinship Navigator Programs" because their purpose is to connect caregivers with available resources. Kinship navigator programs were established in the late 1990s in two states, Ohio and New Jersey, prior to the passage of the 2008 Fostering Connections Act, to meet the informational needs of kinship caregivers and link them with available resources (Letiecq, Bailey, & Porterfield, 2008). In 2009, the U.S. Children's Bureau funded six kinship navigator demonstration programs and seven in 2012. This current study uses data from one of the seven kinship navigator programs funded in 2012.

Kinship navigator programs are customizable and differ in program design, scope, and outcomes. For example, states with state-administered child welfare systems often use a statewide kinship navigator approach that includes information and referral with a connection to local community partners to follow up with service recommendations (for example, New York kinship navigator). States with county-administered child welfare systems often select a more localized approach to kinship navigation and include home visits, case management, and wrap-around services (for example, Children's Home Network Kinship Navigator in Florida).

An evaluation of one of the kinship navigator (KN) programs in Washington State found statistically significant improvements in 11 of 31 areas of need (e.g., understanding government agencies, help with social services, assistance with public assistance, legal assistance, and access to kinship support groups) from intake to the three-month follow-up period; however, no comparison group was available, so results could not be attributed to the KN program (TriWest Group, 2005). In Baltimore, Maryland, program goals were to increase informal kinship providers' access to information, support, and services and to improve the safety, well-being, and stability of children residing in informal kinship homes (Woodruff et al., 2014).

No rigorous, peer-reviewed studies about the effectiveness of KN programs have been published. The California Evidence-Based Child Welfare Information Clearinghouse notes that a scientific rating of KN programs is not yet possible. There are no rigorous, peer-reviewed articles examining the efficacy of these programs (The California Evidence-Based Clearinghouse for Child Welfare, n.d.). This study includes data from one of the first randomized control trials to test the kinship navigator program model.

Our study uses data from the pragmatic randomized controlled trial (RCT) designed to test the effects of a kinship navigator program that included several unique features of the KN model: one-e-application (online service portal site to apply for eligible benefits and services and administered in the home of a relative with a laptop computer), peer-to-peer support (hiring grandparents and other relatives who have lived the caregiving experience and can mentor and coach kinship caregivers), and an interdisciplinary team (a cadre of interdisciplinary professionals who unite to help kinship caregivers problem-solve complex issues).

This article will examine the following research questions:

RQ1: Using all participants' data from one kinship navigator program, are there statistically significant relationships between demographic characteristics for grandmother caregivers who are age 55 and older?

RQ2: Did grandmother caregivers age 55 or older improve family resilience, social support, and caregiver self-efficacy?

RQ3: Which interventions improved outcomes for grandmothers 55 years of age or older?

Methods

Recruitment

Flyers, Web sites, social media, community events, and public service announcements were used. Recruitment occurred through strong, well-

established community partnerships, including schools, local area agencies on aging, and other organizations who have served grandparents and other relatives raising children. All participants contacted a central intake telephone line and self-reported information, which was verified by the State Safety Information Database. Once enrolled in the study, each caller was randomly assigned into groups using a decision-tree and extensive front-end training. Due to local match funding requirements, once enrolled in the study, participants were stratified by (a) county and (b) involvement with the child welfare system. Participants were randomly assigned to one of four groups:

(1) Usual Care: Traditional child welfare services;
(2) Standard Care: A family support and case management community-based program;
(3) Peer-to-Peer Care Only: Grandparents raising grandchildren hired and trained as "peer navigators" by a local community agency; and
(4) Full KIN Tech Care: A community based program using peer navigators providing assistance with program eligibility and enrollment with a laptop in grandmother's home and access to an interdisciplinary team.

Although participants were randomly assigned into groups, sample sizes for each group differed because participants were stratified based on county of residence and relationship with the child welfare system. Additionally, only grandmothers aged 55 or older were included in the sample. When responses to these variables differed, they resulted in unequal sample sizes among groups. Table 1 provides additional description of the group and sample sizes.

Table 1. Description of the study groups.

Name	Description	*n*
(1) Usual Care	Traditional child welfare services as provided by local providers with state oversight	134
(2) Standard Care	A family support and case management community-based program available for informal and formal kinship caregivers and administered by local community agency.	61
(3) Peer-to-Peer Care Only	Grandparents raising grandchildren are hired and trained as "peer navigators" by a local community agency to provide in-home social support and connection to available family resources.	123
(4) Full Kin Tech Care	A community-based program using peer navigators (above) providing assistance with program eligibility and enrollment with a laptop in grandmother's home and access to an interdisciplinary team, including community leaders in several systems of care such as education, child welfare, addictions, legal, health, mental health, child care, and others.	188

Sample

The entire kinship navigator program enrolled 1,551 participants. The current study selected cases based on age, gender, and relationship of the caregiver. Caregivers were included in this study if they reported that they were 55 years of age or older, female, and a grandparent providing full-time care to a child. The evaluation was approved by the institutional review board of the Juvenile Welfare Board (IRB #00009403). Inclusionary criteria included all participants who contacted the central intake line who indicated being a full-time caregiver for a relative child when a parent was unable or unwilling to provide care and lived in eligible counties. Participants were excluded if the participant lived outside the county or did not provide full-time care for a relative's child.

Participant characteristics

To illuminate the differences grandmother caregivers experience based on age, Table 2 compares demographic characteristics for the entire kinship navigator program by grandmothers who are under and over 55 years of age. Thirty-nine percent of grandmothers were between 55 and 75 years of age, mostly living in poverty, and were predominantly Caucasian, with 36% identifying as African American/Black, with at least one to two children at home. Thirty percent were unemployed, 19% reporting income <$10K, and 40% had private medical insurance coverage. Participants were providing care to mostly school-age children, and 30% were providing caregiving for more than six years.

Measures

This study used the Protective Factors Survey (PFS) (Counts, Buffington, Chang-Rios, Rasmussen, & Preacher, 2010; FRIENDS National Center for Community-Based Child Abuse Prevention [CBCAP], n.d.) to assess protective factors at pretest at enrollment, posttest at three to six months, and 12-month follow-up. The PFS is a pre/post evaluation tool for use with caregivers receiving child maltreatment prevention services. It is a self-administered survey that measures protective factors in five areas: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development. The Protective Factors Survey is a measure that is internally consistent, with a factorially sound set of items that remain stable over time (see Table 3 for Internal Reliability Statistics). The PFS negatively predicts risk factors for child abuse and neglect (stress and depression) and positively predicts caregiver health (Counts et al., 2010). This was used to provide a snapshot of the kinship

Table 2. Comparison of participant demographic characteristics for grandmothers under and over 55 years of age.

Variable	Response	Under 55	55 and over	Total	Chi-square ***$p < .001$
Age	<30	106 (13.9)	X	108 (8.5)	749.10***
	31–34	69	X	69 (5.6)	
	35–39	68	X	68 (5.5)	
	40–44	130	X	130 (10.5)	
	45–49	190	X	190 (15.3)	
	50–54	199	X	199 (16.0)	
	55–59	X		212 (17.1)	
	60–64	X		126 (10.1)	
	65–69	X		72 (5.8)	
	70–74	X		37 (3.0)	
	75–80	X		18 (1.4)	
	80+	X		15 (1.2)	
Marital status	Single	268 (36.3)	68 (14.3)	336 (27.7)	141.30***
	Cohabitation	47 (6.4)	13 (2.7)	60 (4.9)	
	Married	231 (31.3)	172 (36.1)	403 (33.2)	
	Separated	56 (7.6)	31 (6.5)	87 (7.2)	
	Divorced	115 (15.6)	109 (22.9)	224 (18.5)	
	Widowed	21 (2.8)	83 (17.4)	104 (8.6)	
Race/ethnicity	African American/Black	357 (49.4)	169 (36.3)	526 (44.3)	33.70***
	Caucasian/White	295 (40.9)	264 (56.8)	559 (47.1)	
	Hispanic/Latino	20 (2.8)	9 (1.9)	39 (2.4)	
	Asian	3 (0.4)	2 (0.4)	5 (0.4)	
	Native American	4 (0.6)	0 (0.0)	4 (0.3)	
	Hawaii/PI	2 (0.3)	0 (0.0)	2 (0.2)	
	Two or More	0 (0.0)	1 (0.2)	1 (0.1)	
	Don't know	1 (0.1)	1 (0.1)	2 (0.2)	
	Refused	40 (5.5)	19 (4.1)	59 (5.0)	
Number of grandchildren in care	1	356 (48.4)	221 (47.6)	577 (48.1)	13.18
	2	178 (24.2)	141 (30.3)	319 (26.6)	
	3	118 (16.1)	51 (11.0)	169 (14.1)	
	4	52 (7.1)	35 (7.5)	87 (7.3)	
	5	14 (1.9)	9 (1.9)	23 (1.9)	
	6	11 (1.5)	5 (1.1)	16 (1.3)	
	7	3 (0.4)	0 (0.0)	3 (0.3)	
	8	1 (0.1)	1 (0.2)	2 (0.2)	
	9	2 (0.3)	2 (0.4)	4 (0.3)	
Employment	Employed Full Time	284 (38.0)	113 (23.7)	397 (32.4)	180.17***
	Employed Part Time	77 (10.3)	31 (6.5)	108 (8.8)	
	Full-Time Caregiver	50 (6.7)	19 (4.0)	69 (5.6)	
	Unemployed, looking for work	105 (14.0)	48 (10.1)	153 (12.5)	
	Unemployed, disabled	155 (20.7)	141 (29.6)	296 (24.2)	
	Unemployed, volunteer work	11 (1.5)	5 (1.0)	16 (1.3)	
	Retired	14 (1.9)	108 (22.6)	122 (10.0)	
	Unemployed, not looking for work	17 (2.3)	7 (1.5)	24 (2.0)	
	Student	15 (2.0)	1 (0.2)	16 (1.3)	
	Other	20 (2.7)	4 (0.8)	24 (2.0)	
Education	1st–4th grade	22 (3.0)	9 (1.9)	31 (2.6)	12.82
	5th–8th grade	36 (4.9)	35 (7.4)	71 (5.9)	
	9th–11th grade	122 (16.5)	78 (16.5)	200 (16.5)	
	High School Graduate	188 (25.4)	107 (22.7)	295 (24.3)	

(*Continued*)

Table 2. (Continued).

Variable	Response	Under 55	55 and over	Total	Chi-square ***$p < .001$
	Some college, no degree	211 (28.5)	137 (29.0)	348 (28.7)	
	Associates Degree	61 (8.2)	31 (6.6)	92 (7.6)	
	Bachelor's Degree	46 (6.2)	38 (8.1)	84 (6.9)	
	Master's Degree	14 (1.9)	10 (2.1)	24 (2.0)	
	Professional Degree	11 (1.5)	9 (1.9)	20 (1.6)	
	Doctoral Degree	2 (0.3)	4 (0.8)	6 (0.5)	
	Don't know	2 (0.3)	1 (0.2)	3 (0.2)	
	Refused	4 (0.5)	0 (0.0)	4 (0.3)	
	Other	22 (3.0)	13 (2.8)	35 (2.9)	
Household income	under $10,000	158 (21.6)	88 (18.8)	246 (20.5)	15.38
	$10,000–$19,999	156 (21.4)	119 (25.4)	275 (23.0)	
	$20,000–$29,999	124 (17.0)	82 (17.5)	206 (17.2)	
	$30,000–$39,999	103 (14.1)	73 (15.6)	176 (14.7)	
	$40,000–$49,999	48 (6.6)	20 (4.3)	68 (5.7)	
	$50,000–$59,999	41 (5.6)	39 (8.3)	80 (6.7)	
	Over $60,000	61 (8.4)	29 (6.2)	90 (7.5)	
	Don't know	31 (4.2)	17 (3.6)	48 (4.0)	
	Refused	8 (1.1)	1 (0.2)	1 (0.8)	
Length of caregiving	> six months	367 (52.1)	193 (42.6)	560 (48.4)	55.41***
	7–11 months	54 (7.7)	30 (6.6)	84 (7.3)	
	1 year	51 (7.2)	17 (3.8)	68 (5.9)	
	2 years	51 (7.2)	24 (5.3)	75 (6.5)	
	3 years	41 (5.8)	16 (3.5)	57 (4.9)	
	4 years	24 (3.4)	17 (3.8)	41 (3.5)	
	5 years	22 (3.1)	19 (4.2)	41 (3.5)	
	6 or more years	95 (13.5)	137 (30.2)	232 (20.0)	
Caregiver health coverage	Private Insurance	146 (38.5)	99 (39.8)	245 (39.0)	42.47***
	Medicaid	121 (31.9)	46 (18.5)	167 (26.6)	
	Medicare	40 (10.6)	71 (28.5)	111 (17.7)	
	No Insurance	52 (13.7)	28 (11.2)	80 (12.7)	
	Other	20 (5.3)	5 (0.2)	25 (4.0)	
Child health coverage	Private Insurance	62 (16.3)	31 (12.4)	93 (14.7)	15.46***
	Medicaid	257 (67.5)	170 (67.7)	427 (67.6)	
	Medicare	7 (1.8)	19 (7.6)	26 (4.1)	
	No Insurance	45 (11.8)	22 (8.8)	67 (10.6)	
	Other	10 (2.6)	9 (3.6)	19 (3.0)	

***$p < .001$.

families, changes in protective factors, and areas where staff can focus on increasing individual family protective factors. This survey was completed over the phone at pretest (at central intake), six months (postintervention), and 12-month follow-up.

Items on the Protective Factors Survey are self-reported by the participant to either a peer navigator, family support coordinator, or child welfare professional assigned to assist the family. Responses are subject to social desirability bias because respondents may answer the questions to please the person asking the question. In some circumstances, their responses could also be influenced by feelings of guilt and shame related to their caregiving experiences. These sources of bias may limit the utility of the results of this

Table 3. Protective factors survey subscales (Counts et al., 2010; FRIENDS National Center, n.d.).

Protective factors	Internal consistency of subscale	Definition
Family Functioning/ Resiliency (5 items)	α = .89	Having adaptive skills and strategies to persevere in times of crisis. Family's ability to openly share positive and negative experiences and mobilize to accept, solve, and manage problems.
Social Support (3 items)	α = .89	Perceived informal support (from family, friends, and neighbors) that helps provide for emotional needs.
Concrete Support (3 items)	α = .76	Perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.
Child Development/ Knowledge of Parenting (5 items)	NA*	Understanding and utilizing effective child management techniques and having age-appropriate expectations for children's abilities.
Nurturing and Attachment (4 items)	α = .81	The emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

*The KOP/CD items are not expected to correlate with one another—that is, there is no theoretical reason for the items to conform to a factor structure (Bollen & Lennox, 1991).

study. Furthermore, the administration of posttest assessments was not completed prior to the second-to-last home visit with the caregiver to allow appropriate time for relationship closure and to lessen the influence of response bias toward the end of service delivery. We've noticed that some caregivers respond to items less favorably close to the end of the program in anticipation of ending the relationship with the program. Although an attempt was made to lessen this bias, the timing of survey administration may still impact validity of responses in this regard.

Data analysis

All data were entered into an IBM SPSS (v21) database and double entered to reduce error. To determine the mean differences between and within each of the four groups at three points in time (pretest, posttest, and 12-month follow-up), repeated-measures ANOVAs were run and reported in Table 4. Outcomes measures were found to be significant if between- and within-group differences were noted with a p value of .05 or lower, as indicated in the last column of the table.

Results

Results of the repeated-measures ANOVAs for each subscale showed statistically significant within- and between-group differences. Table 4 reports the mean scores for Family Functioning, Social Supports, Concrete Supports, Child Development, and Nurturing and Attachment. Each subscale showed

Table 4. Comparison of groups on socioemotional outcomes at pre-, post-, and follow-up assessment.

Outcomes		Usual Care	Standard Care	KIN Tech Full	Peer-to-Peer Only	*F*	*p* value
n		*134*	*61*	*188*	*123*	Df (3)	
Family Functioning	Pre	4.45	4.16	4.33	4.23	50.41	<.001
	Post	4.63	4.32	4.52	4.7		
	12 mo	3.8	4.8	4.73	4.95		
Social Supports	Pre	4.63	3.91	4.51	4.37	71.14	<.001
	Post	3.78	4.32	4.98	5.32		
	12 mo	4.34	4.66	5.65	4.91		
Concrete Supports	Pre	3.92	4.68	3.77	4.5	85.19	<.001
	Post	4.12	4.39	4.83	5.23		
	12 mo	3.43	5.44	5.26	5.29		
Child Development/ Knowledge	Pre	3.27	3.96	3.14	3.26	37.75	<.001
	Post	3.99	4.12	3.48	3.59		
	12 mo	3.11	4.87	4.42	4.14		
Nurturing and Attachment	Pre	4.55	4.58	4.15	4.47	49.91	<.001
	Post	4.23	4.97	3.84	4.89		
	12 mo	3.87	5.14	5.23	5.09		

an improvement by the 12-month follow-up from pretest, with the exception of Usual Care, which showed a decline in protective factors consistently across subscales. Figure 1 illustrates the pretest, posttest, and 12-month follow-up mean scores for each subscale.

For each subscale, the Usual Care group (traditional child welfare service) showed a decline in protective factor at the 12-month follow-up. Mean differences in protective factors from pretest to 12-month follow-up for

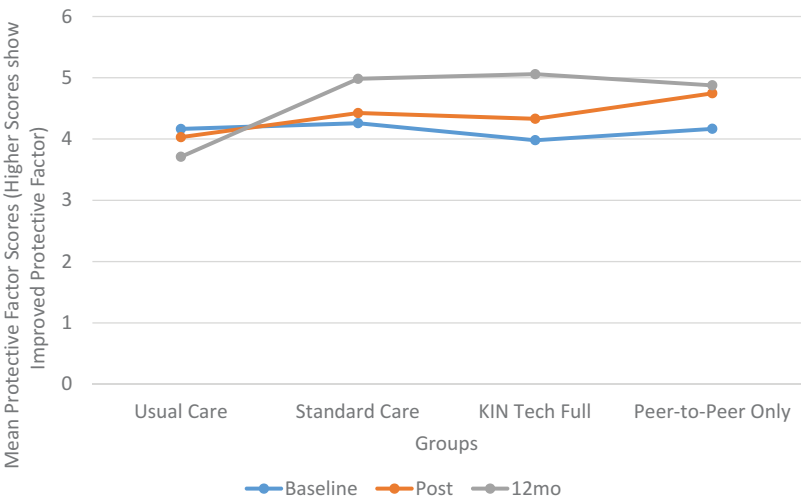

Figure 1. Mean scores for each group at pretest, posttest, and 12-month follow-up.

this usual care group ranged from 0.16 (Child Development/Knowledge) to 0.68 (Nurturing and Attachment). All other groups increased their mean protective factors score, with the exception of the Peer-to-Peer-Only group, which showed a 0.41 decline in social support between posttest and 12-month follow-up. However, the 12-month follow-up mean score was still improved compared to the pretest (4.37 pretest to 4.91 12-month follow-up).

Discussion

Older custodial grandparents who are involved with traditional child welfare services (the Usual Care group) showed a decline in protective factor at the 12-month follow-up. Because child welfare services have historically served the needs of parents and foster parents, these results suggest that these traditional services may need to be culturally tailored to better meet the nuanced needs of relative caregivers, especially older caregivers. Future research could better identify the needs of older grandmothers providing care within the child welfare system.

The largest decline in the Nurturing and Attachment protective factor for this Usual Care group could illuminate some limitations child welfare service systems have in engaging with older relatives, who may experience more limitations, especially with younger children who require more current and up-to-date parenting practice recommendations, such as safe infant sleep practices and immunizations. This finding could help promote specialized training for child welfare workers to improve their practice engaging older grandparent caregivers. This training could be used as an opportunity to engage interdisciplinary collaboration with local area agencies on aging and other experts in working with aging people in the community.

Although all other groups increased their mean protective factors score, the Peer-to-Peer-Only group showed a 0.41 decline in social support between posttest and 12-month follow-up. However, the 12-month follow-up mean score showed improvement compared to pretest (4.37 pretest to 4.91 for the 12-month follow-up). Perhaps at the time of case closure, the grandmother could perceive a loss of social support when the peer ends the professional relationship. It is unclear whether or not this impacted the results, given the limitations of the data. More information on how peers and/or community health workers promote protective factors and encouragement after case closure with older grandparent caregivers is needed.

This article presents the results specific to older grandmothers from one of the only randomized control trials on the kinship care navigator intervention. Although the peers in the Peer-to-Peer-Only group were grandparents raising grandchildren who had varying levels of education and experience in helping others, they were more effective in improving protective factors than the other groups. This is consistent with previous research, which has

highlighted the importance of using peers because they have close ties to the communities they serve, and they are able to deliver cost-effective health education and health promotion and prevention services in a more culturally appropriate manner (Cohon & Cooper, 1999; Kelly et al., 1991; Rhodes, 1994; Viswanathan et al., 2009). Furthermore, more information is needed to better understand the cultural differences between peers who share a lived experience and traditional community health workers to reach populations that are inaccessible via conventional methods, improve provider–client communication, and increase the impact of outreach efforts through ongoing contact (Kelly et al., 1991; Rhodes, 1994; Viswanathan et al., 2009).

Limitations

Although many comparisons were statistically significant, the differences between groups were small and possibly of little practical significance. Although multiple tests of significance were conducted, we did not control for overall study-wise statistical significance, which may include a false significant finding as the number of tests increase. An additional limitation of this study includes the reliance on kinship caregivers' self-report data, which can be highly influenced by response bias. This can be a threat to the generalizability of the results. Additionally, this study was conducted in two large urban counties in the southeastern United States. Kinship programs have been supported in these two counties for over 15 years. These strong community-based partnerships could influence the positive results experienced in this setting. Other programs should be cautious about implementing a community-based collaborative kinship program and expecting similar results without broad-based interdisciplinary support from multiple systems.

Recommendations for furthering practice and research of relevance to older women

Practice

Results highlight the importance of implementing alternative community-based strategies, like the kinship navigator, to better meet the needs of these families. Usual care or traditional services may not meet the dynamic needs of these families that often take a multidisciplinary approach informed by knowledge about services and supports available in the community (Child Information Gateway, 2014). For example, a custodial grandmother who is struggling with enrolling a grandchild in school faces a multitude of barriers (Strozier, McGrew, Krisman, & Smith, 2005). While the grandmother does not have custodial rights, she may also be unable to vaccinate the child as a requirement for enrollment and unable to purchase school supplies. This grandmother will also need to

rearrange work schedules and accommodate transportation and after-school care for children. A multidisciplinary approach will convene school administrators, legal aid, a local health department, a local area agency on aging, TANF or child welfare or financial assistance offices, and other community-based agencies to coordinate and meet these complex needs. Usual care, which is traditional child welfare services, may be unequipped or underresourced to spend the time and resources to pursue these multisystem challenges.

This research highlights the importance of using peer support and including peers in service delivery models tailored to meet the needs of multigenerational families. As shown in this study, grandparents raising grandchildren have a multitude of protective factors and the capacity to provide leadership and peer support when needed. These strengths need to be built on through public health and aging program development. Older caregivers have a wealth of experience and knowledge to share with program developers, but they are not often asked to participate due to ageism or other discriminatory practices. Efforts to promote widespread adoption of peer support require top-down and bottom-up approaches to encourage transformational changes to improve the lives of kinship families. Future policy work will need to use the results of kinship navigator demonstration projects to support design, implementation, and evaluation of these programs to provide community-based services and supports for both informal and formal families.

Research

Future research should replicate and test components of the KIN Tech Kinship Navigator Model, specifically the one-e-application, peer-to-peer navigation, and interdisciplinary team intervention for older caregivers. This could include the development and testing of an assessment specifically designed to measure the severity of the need for kinship caregivers and the children in their care. This measure will help triage at intake and expeditiously assign a family to a service that meets the severity or acuity of their needs.

Future research with kinship families could qualitatively examine the experience for these older women in navigator programs. Furthermore, replication of kinship navigator programs could build capacity in data collection and maintenance systems to gain a more complete picture about how systems of care impact the family. A good way to promote cross-system collaboration in practice is to implement data-sharing agreements with state, local, private, and public agencies and organizations serving kinship caregiving families. In many areas, child welfare, public health, aging and elder affairs, education, and juvenile justice data are not shared or easily accessed across systems. This can be a barrier for practice and can discourage system collaboration.

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