Kinship Support Services in California: An Evaluation of California's Kinship Support Services Program (KSSP)

Aron Shlonsky, MSW, MPH, Ph.D.
William C. Dawson, MSW
Young Choi, MSW
Wendy Piccus, BA
Patricia Cardona

Barbara Needell, MSW, Ph.D
Principal Investigator

University of California at Berkeley
Center for Social Services Research

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INTRODUCTION

Kinship or relative care has become one of the most successful and highly utilized forms of foster care for maltreated children. When compared to nonrelated foster care, this age-old formula for the protection and care of children whose parents are unable to provide for them tends to result in fewer placement moves, fewer reentries to foster care after family reunification has occurred (Needell, B., Webster, D., Cuccaro-Alamin, S., Armijo, M., Lee, S., Brookhart, A., 2003), and a greater likelihood that siblings will be placed together in the same family home (Needell et al., 2003; Shlonsky, Webster & Needell, in press). Children in relative care are no more likely to be reabused while in care (Needell et al., 2003; Zuravin, Benedict, & Somerfield, 1993), are able to maintain a sense of family and ethnic identity (Schwartz, 2002), and are often able to remain in their community of origin when placed into care (Needell et al., 2003). More recently, kinship caregivers have been increasingly embracing adoption and subsidized legal guardianship (Needell et al., 2003; Shlonsky, 2002; Testa, 2002), moving toward out-of-home care that is both stable and legally permanent.

Yet, like any other foster care provider, kinship caregivers face the challenge of raising some of the most disadvantaged and vulnerable children, sometimes requiring additional assistance to meet their formidable needs. Children entering out-of home care tend to have elevated levels of medical (Bilaver, Jaudes, Koepke, & Goerge, 1999; Halfon & Klee, 1987; Schneiderman, 2003), psychosocial (Bilaver et al., 1999; Dubowitz, 1994), and educational problems (Benedict, Zuravin, & Stallings, 1996; Berrick, Barth, & Needell, 1994; Fox & Arcuri, 1980; Heath, Colton, & Aldgate, 1994; Sawyer & Dubowitz, 1994), and the child welfare system often attempts to meet these challenges through access to specialized services. Although these services are clearly important, many informal kinship caregivers are ineligible for assistance.

Kin may also experience difficulties contending with parents who are both family members and potential threats to their children, sometimes prompting conflict and significant role changes within the family (Crumbley & Little, 1997). While the commitment of long-term caregiving is difficult in the best of circumstances, kinship caregivers are often grandparents living on a fixed or limited income (Berrick, Barth, & Needell, 1994), making the challenge of raising children that much more difficult.

In order to support the well-being of children in formal kinship placements and to prevent the entry of children in informal kinship care into the child welfare system, the State of California established the Kinship Support Services Program (KSSP), a unique grants-in-aid program allowing various counties to develop and fund specialized, community-based kinship support services. This report highlights findings from the ongoing evaluation of the program and contains information related to program participation, services utilization, and client satisfaction.

Background

The removal of a child from their parents and their placement in non-related foster care has broad psychological and moral implications for both the child and the extended family to which they belong. Not only is the relationship between parent and child interrupted, but the child may also experience psychological hardship due to the loss of treasured relationships with grandparents, aunts and uncles, siblings, cousins, and extended family members, perhaps promoting or perpetuating attachment and other psychosocial difficulties. Rather than removing children from the very institution of family that the state is trying to support, kinship care uses natural or informal caregivers (suitable family members who wish to care for their relative children) to preserve familial identity while maintaining child safety and security.

The formal use of relatives as a foster care resource in California and across the nation has steadily increased since the mid 1980's. While this form of out-of-home care represents an advance in child welfare services, it is by no means a new or unusual strategy to care for children whose parents are unable to raise them. Countless instances of kinship care have been documented over the centuries, and extended family care has been a common practice in the African-American community dating back at least as far as the time of legal slavery in this country (Jimenez, 2002; Stack, 1978). According to the 2000 U.S. Census, over 6 million children (about 8.3 percent of all children in the U.S.) are living in households headed by relatives in the United States and a substantial portion of them (2.4 million) live alone with their grandparents (i.e., the child's parent does not reside in the home). In California, more than 0.9 million children (about 10 percent of the child population) are living with relatives and 295,000 children live alone with grandparents (U.S. Census Bureau, 2002). These children are being cared for by their relatives for a number of reasons ranging from the death of a parent(s) to parental absence or incapacity.

Yet, despite the voluntary efforts of a many relative caregivers to pick up where parents left off, the many instances of parental maltreatment that are brought to the attention of child welfare authorities has also led to an increase in the formal use of relatives as a foster care resource. The mid-1980s through the 1990s saw a rapid growth in the number of children being maintained nationwide in the child welfare system. From 1985 to 1990, the national foster care population rose 53 percent from an estimated 280,000 at the end of 1986 to an estimated 429,000 at the end of 1991 (Tatara, 1994). In California, the midyear caseload rose from just over 52,000 children in 1988 to over 100,000 in 1997. This unprecedented rise in caseload came at a time when fewer nonrelated foster homes were available (Chamberlain, Moreland, & Reid, 1992), the

public came to view kin as an important resource for children (Child Welfare League of America, 1994), and states introduced foster care payments to kinship caregivers (Courtney & Needell, 1997). Due to reporting inconsistencies, the exact number of kinship foster placements in the United States is difficult to ascertain, though efforts are being made in this area. The Adoptions and Foster Care Analysis and Reporting System (AFCARS) estimates that about 25 percent of the 556,000 children in foster care nationally reside with their relatives (U.S. Department of Health and Human Services Administration for Children and Families, 2003). The latest midyear figures from California show a decline in both the absolute number of children in care and the percentage of children in formal kinship care. On January 1, 2000, 45 percent of the 104,612 youth in child welfare supervised foster care in California resided with relative caregivers while on January 1, 2002, 38 percent of the 89,168 children in child welfare supervised foster care resided with kin. The decline in both overall census and kinship care census is at least partially attributable to the large numbers of children in kinship care who exited the child welfare system into legal permanence when their kinship caregivers became their legal guardians through the Kinship Guardianship Assistance Payment (KinGAP) program. Between January 1, 2000 and February 8, 2002, an estimated 8,231 children exited child welfare supervised foster care through the KinGAP program (Shlonsky, 2002). Comparing these largely overlapping time periods, KinGAP accounted for 53 percent of the decrease in the overall child welfare supervised census and 65 percent of the decrease in the kinship care census.

The inherent stability of kinship care placements is seen as a benefit for children in out-of-home care. While the foster care system has historically been criticized for the frequent placement moves experienced by children who are removed from their parents (Fanshel & Shinn, 1978; Maas & Engler, 1958), kinship care consistently has the greatest placement stability of all

forms of out of home care. Figures I and II detail the number of placements experienced by children in their first spell (continuous period of time) in out-of-home care among children who entered care in 1998 and who were still in care after 24 and 36 months for children in kin and non-kin. For children in kinship care, 38 percent were still in their first placement and 70 percent had 2 or fewer placements. In stark contrast, for children in nonrelated foster care, only 17 percent of children were in their first placement and 44 percent had experienced 2 or fewer placements.

Figure I:

1998 Entries: Number of Placements in First Spell for Children Still in Care After 24 Months

At the 36 month mark, differences remained large with 60 percent of children in kinship care having 2 or fewer placements and children in 33 percent of children in nonrelated foster care

experiencing 2 or fewer placements. Children in nonrelated foster care who stayed in care for at least 36 months were far more likely to have experienced 5 or more placements (34 percent) than children in kinship care (12 percent).

Figure II:

1998 Entries: Number of Placements in First Spell for Children Still in Care After 36 Months

Although children in kinship care are less likely than children in nonrelated foster care to be reunified with their biological parent within the first 6 months of removal, they are almost as likely to be reunified within 2 years (45% v. 51%) and 3 years (53% v. 57%) and tend to be less likely to reenter care once they have reunified (Needell et al., 2003; Westat & Chapin Hall Center for Children, 2001).

Despite the tangible benefits of kinship care and a set of identified service needs (see below), services for both formal and informal kinship caregivers have been slow to materialize.

In 1996, a Kinship Care Policy Summit sponsored by CDSS, CWDA and the California Partnership for Children, attended by state foster care administrators, county child welfare leaders, university-based analysts, and child advocates was convened and resulted in an action plan for the State of California. As a result of this collaborative process, legislation was passed in 1997 (Shelley, Chapter 794, Statutes of 1997; amended WIC Section 16605) establishing the Kinship Support Services Program (KSSP). This grants-in-aid program allowed eligible counties to facilitate the creation of community-based kinship support programs designed to provide services to relatives caring for abused and neglected children and those at risk of entering foster care (Appendix I - KSSP Fact Sheet). Although an evaluation component was not originally part of the KSSP legislation, in July 2001 CDSS asked the Center for Social Services Research at UC Berkeley to conduct an outcome evaluation as an addendum to its ongoing contract (California Children's Services Archive) with CDSS. This report presents findings from the beginning of the KSSP evaluation, October 1, 2001, through January 31, 2003.

Kinship Care Policy Review[1]

The rise of formal kinship care can be seen as an attempt to meld traditional family responsibilities (moral support and actual caregiving) with state intervention (supervision and monetary compensation). The laws establishing the formalization of kinship care have their roots in Title IV of the Social Security Act, which made grandparents, siblings, stepsiblings, aunts, and uncles eligible to receive AFDC grants for the care of dependent children (Gleeson & Craig, 1994).[2] While this law enabled non-licensed relatives to receive some financial

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[1] Parts of this section are contained in Shlonsky & Berrick (2001).
[2] The definition of kin was later expanded as a result of the Adoption & Safe Families Act of 1997 to include more distant kin.

compensation for providing care, the amount was substantially less than foster care payments to nonrelated caregivers. In 1979, the landmark Miller v. Youakim decision made it illegal for states to continue paying relative caregivers at a lesser rate if the child qualified for federal foster care funds and the home met licensing standards. Thus the court, and by extension the state, further recognized and solidified state sanctioned aid for placing abused children with kin, intimating that family responsibility did not extend to financial responsibility for a dependent child. The line between nonrelated foster care and kinship care began to be blurred.

Three other significant laws established preference for the use of kin in foster care placement during the 1980s and 1990s. The Adoption Assistance and Child Welfare Act of 1980 (PL 96-272) began the establishment of much needed general foster care guidelines and mandates. The law's aim was to end foster care drift through facilitating permanency and requiring reasonable family reunification efforts (Pine, 1986). However, the act also specified that children should be placed in the least restrictive, most family-like environment available, which began to be interpreted as a legal preference for kinship placements (Gleeson & Craig, 1994). The Indian Child Welfare Act of 1978 (ICWA), which called for the preservation of Indian tribes through the recognition of first nation status, may also be interpreted as a preference for maintaining "family" or "tribal" ties through the use of kinship placements (Kusserow, 1992; McLean & Thomas, 1996). Finally, the recent Adoptions and Safe Families Act of 1997 (ASFA) established a national preferential policy for kinship placements whenever possible. Thus, the sanctity of the family and promoting family responsibility were acknowledged through funding and placement preferences for kin.

Placement preferences and financial support for kin have been instrumental in the marked increase in kinship placements during the 1980's and 1990's, the implications of which are

profound. By taking fiscal responsibility, the state maintains the ultimate responsibility for assuring quality in kinship homes. In essence, if the child is detained by the state and placed in a home, regardless of relative status, the state is responsible for insuring a level of quality (including safety) commensurate with state requirements. Whereas the 1980s and early '90s saw a convergence of foster and nonrelated care, the latter part of this decade has seen a redefinition of kinship care which diverges from nonrelated foster care by recognizing kin's financial need, their sense of family obligation, and their ability to provide informal care for their relatives. However, this redefinition may not coincide with the requirements of ASFA, which has been interpreted to insist that relatives must meet the same licensing/approval standards as nonrelative homes in order to be eligible for federal (Title IV-E) foster care funding. The introduction of California's KSSP program signals a belief in the necessity and inherent value of kinship care as well as an acknowledgement that relatives face a unique set of caregiving challenges and could benefit from a set of targeted services, and that these services are best provided by community-based agencies.

Development Of KSSP Policy And Services

The 1996 Summit Work Groups and subsequent Action Plan called for the description and development of service delivery systems that are essential and/or beneficial to kinship caregivers and their relative children. These included post-permanency community-based support services.

The partnership between CDSS, counties, and community-based service providers aims at assisting relatives who provide care for their relative children when the parents are unable to do so. Relatives, most often grandparents, may be aging or in poor health, and may be socially

isolated or emotionally unprepared to assume the responsibility for young children. The children, often abused or neglected, may have physical or behavioral problems that require professional help as well as the nurturing attention of the relative caregiver (CDSS fact sheet).

AB 1193 appropriated $1,500,000 for KSSP, and counties were eligible to apply for KSSP funding if at least 40 percent of the children in child welfare supervised foster care in their county were placed in relative care. In September 2000, the Governor signed SB 1946 (Chapter 866, Statutes of 2000) to maintain the eligibility of those counties that met the eligibility requirements in January 1998 when the program was established, but whose proportion of relative placements were reduced by foster care exits (largely as a result of California's Kinship Guardianship Assistance Program (KinGAP) implementation). There are currently 11 counties receiving KSSP funding in 20 sites located throughout the state (Appendix I – KSSP Fact Sheet).

Services To Kinship Caregivers

Similar to nonrelated foster parents, kinship caregivers face a formidable set of challenges to raising children who can no longer be cared for by their parents. However kinship caregivers, by virtue of their relative status and general demographic characteristics, may have a unique set of challenges and corresponding service needs. While prevalent among all ethnic groups, African-Americans are more likely to be providers of both formal and voluntary kinship care (Ehrle & Geen, 2001), and most of children in kinship care (about 69 percent) are being cared for by a grandparent, usually a grandmother (Geen et al., 2001; Harden, Clark, & Maguire, 1997). Kinship caregivers are more likely to live in poverty, tend to receive more public benefits, and generally experience more economic hardship than the general parent caregiver population (Ehrle & Geen, 2002b; Ehrle et al., 2001; Harden et al., 1997; Minkler & Roe, 1993; Minkler &

Roe, 1996; Minkler, Roe, & Price, 1992; U.S. Department of Health and Human Services, 2000). Kinship caregivers may also struggle with newly conferred roles within their families, often creating conflict or role confusion among family members (Crumbley, 1997). In addition, like nonrelated foster parents, formal kinship caregivers and a proportion of informal kinship caregivers have to contend with the many emotional, behavioral, and health problems experienced by children who have been maltreated. The combination of these factors establishes the call for a unique set of services tailored to the needs of kinship families.

Financial Needs. Previous research indicates that many children and caregivers in kinship care often face financial difficulties (Berrick et al., 1994; Ehrle & Geen, 2002a; Geen et al., 2001). For example, Ehrle and Geen (2002a) found that sixty-four percent of children in all kinship care arrangements (61 percent in private and 76 percent in public kinship care) live in homes with incomes below 200 percent of the poverty line and 31 percent live in homes below the poverty line while only thirteen percent of children in nonrelative foster care live in poverty and about twenty percent of all children in the United States experience poverty. Accordingly, a substantial number of families in public kinship care (51 percent) and private kinship care (43 percent) experience food insecurity.

Interviews with kinship caregivers find that financial assistance is a primary concern. Burton's (1992) qualitative study of African American grandparent caregivers found that over 70 percent of caregivers in her sample indicated that they needed economic assistance more than any other services. Though both kinship and nonrelated foster parents face severe economic challenges (Chamberlain et al., 1992), Berrick and her colleagues (1994) found that thirty-five percent of formal kinship caregivers compared to twenty-five percent of nonrelative foster

caregivers indicated that a foster care subsidy was the most helpful service to them in providing care for children.

Health, Mental Health, and Emotional Needs. Because many caregivers are likely to be older, kinship care families may face physical health challenges that have the potential to interfere with their ability to care for children (Ehrle & Geen, 2002a, 2002b; Minkler et al., 1992; Musil & Ahmad, 2002). According to Ehrle and Geen's (2002b) research, about 70 percent of voluntary kinship caregivers and 42 percent of kinship foster caregivers are over 50 years old in comparison to only 26 percent of nonrelative foster caregivers. Berrick, Barth, and Needell (1994) reported that one in five female and one in four male kinship caregivers characterized their health status as "poor" or "fair" in comparison to seven percent of female and six percent of male nonrelative caregivers. Other studies appear to show the same trend. Minkler et al. (1992) found that 34 percent of her sample of grandmothers raising grandchildren reported that their physical health had worsened when compared with their health before caregiving began, and 28 percent of grandmothers indicated that their health had become worse in the past year. Musli and Ahmad (2002) also found that caregivers who had primary responsibility for raising their grandchildren reported worse self-assessed health status and more physical health problems than caregivers who had no responsibility for raising the grandchildren.

Kinship caregivers may also need a great deal of emotional support since they may experience stress surrounding the unexpected and often long-term care of their relatives (Burton, 1992; Ehrle & Geen, 2002b; Kelley et al., 2000; Minkler et al., 1992; Musil & Ahmad, 2002). As with any parent or caregiver, their mental and emotional functioning is an important element of providing continued, high quality care. The psychological distress of a role change (e.g., from

involved grandparent to primary grandparent caregiver), while understandable, prompts a call for support services to mitigate its toll on kinship families.

Most caregivers also have great concern about their children's health status. The health care needs of children in foster care have been well-documented (Halfon & Klee, 1987; Schneiderman, 2003), and these extend to children in kinship care (Dubowitz, 1994). These health issues include high rates of diabetes and dental problems (Dubowitz et al., 1994) as well as developmental concerns (Simms, 1989). Caregivers often must contend with children's multiple health problems or, at the very least, make up for the insufficient care children received while they resided with their parents. Although children in foster care have medical insurance, this coverage is often inadequate for the severe problems they may face, records are often missing or incomplete, and there is a lack of continuity of care with a single, community-based health care provider (Simms & Halfon, 1994).

Children in kinship care may also need help with trauma, educational, or behavioral problems that result from their new living situation, separation from the birth parents, and prior abuse or neglect (Geen et al., 2001). Dubowitz et al. (1994) point out that the behavior problems of the children living in kinship care are significantly higher than the general population, and Sawyer and Dubowitz (1994) find that children in kinship care are in need of more attention by school personnel than many of their peers. Despite similarities in health, behavioral, and educational problems among children in kin and nonkin care, the unique family relationship, financial, and health challenges faced by kinship caregivers may require a set of services that more adequately contextualizes the family's situation and takes steps to optimally respond to children's needs. In particular, services that specialize in developing caregiving capacity for older parents (e.g., in-home caregiving assistance, transportation to medical care, and

contingency planning in the event of caregiving difficulty) and educational support services may be necessary.

A primary component of the KSSP program is to provide health services and/or referrals for caregivers with health concerns. Many centers have established relationships with local health care providers and some sites have on-site nurses available to conduct a health assessment. For those without health insurance, KSSP centers can also help caregivers apply for Medi-Cal for themselves and their children. Additional information and resources can also be found at the California Department of Health Services website at http://www.dhs.cahwnet.gov/home/hsites/ and links to county Public Health offices can be found at http://www.dhs.cahwnet.gov/home/hsites/hdlinks.htm.

Other Service Needs. Similar to nonrelated foster parents, other service needs for caregivers and children in kinship care arrangements have been identified including child and respite care (Berrick et al., 1994; Geen et al., 2001; McLean & Thomas, 1996), legal assistance for permanency planning (Burton, 1992; Geen et al., 2001), and parenting education and training programs (Berrick et al., 1994; Burton, 1992; McLean & Thomas, 1996). Yet, despite the similarity in many identified services needs between related and nonrelated caregivers, there are key differences. First, many kinship caregivers are informal providers and are not eligible for the range of services offered to formal care providers. Examples include day care and specialized emancipation services. Further, even for formal kinship caregivers, the scope and quality of such services may be different. For example, parenting education and training is typically offered to nonrelated caregivers before they assume caregiving responsibilities for a child. Kinship caregivers, on the other hand, often become caregivers unexpectedly. They may be asked to monitor or even prohibit visits between their children and their grandchildren. In

short, the challenges faced by kinship caregivers stem from a combination of factors, some similar to foster parents, some quite different, resulting in a unique set of service needs.

Findings from Prior Evaluations

Edgewood Children's Services. While it makes logical and intuitive sense that support services provided to kinship caregivers would be linked to positive child and caregiver outcomes (e.g., placement stability, child well-being), little research has been conducted in this area. Much of the early research that does exist has been conducted by San Francisco's Edgewood Center for Children and Families, the State of California's model agency for the implementation of KSSP. Based on a formal needs assessment of kinship caregivers conducted in 1993, Edgewood identified a number of services that might assist relatives in their caregiving endeavor. These included: (1) respite care; (2) monetary assistance; (3) peer support; (4) assistance with child behavior problems; (5) assistance with public agency bureaucracies; (6) assistance with child welfare agencies; (7) assistance with their child's drug use (Cohon & Cooper, 1999). Later research with this population of San Francisco caregivers indicated that the health status of older caregivers was improved or maintained, satisfaction with social supports increased, caregivers were satisfied with the scope and type of services received, and caregivers who received kinship support services had reduced levels of expressed need but that many of these services were still necessary over time (Cohon, Hines, Cooper, Packman, & Siggins, 2000). In addition, the center has documented gains in child and youth health and mental health among certain sub-populations seen at their kinship support network (Cohon, Brown, Wheeler, & Cooper, 2001).

Post Adoptive Services. Edgewood's research is supported by findings from studies of adoptive parents, a group of caregivers most resembling kinship homes in terms of permanency.

Following the Adoptions Assistance and Child Welfare Act of 1980, adoption research increasingly focused on services needed for adoptive families and the potential effect that services would have on adoption outcomes (Rosenthal, Groze, & Morgan, 1995). Many preliminary studies were done to evaluate service need and most found that when adoptive families asked for assistance, few agencies existed or that, when adoptive families reached out to agencies for help, few resources were available to them (Fales, 1985).

The increasing number of kinship adoptions also provides information about the support needs of relatives choosing a more permanent plan. Using survey and administrative methods, Festinger (2001) examined adoption disruption as well as service provision and service needs for a randomly drawn sample of 450 parents. These parents had adopted a child welfare supervised child in 1996 in New York, about half of whom (49 percent) were kin. Only 3.3 percent of children reentered foster care for a spell within 5 years of adoption, indicating a high level of permanence for this group. Drawing from an extensive list of possible services, Festinger found that of an average of 13 self-reported needed services, only 4 (32 percent) were provided over the course of the 5-year period. Services tended to cluster into the following areas: after-school services, informational services, educational services, home assistance, clinical services, housing assistance, vocational services, and legal assistance (not adoption).

Barth and Berry (1988) evaluated the effectiveness of post-adoption services in preventing adoption disruption, finding that participation in self-help or peer support groups was uncommon, but appeared to provide some buffering of disruption risk. Reports by social workers or families indicated that 18% of the total sample of 120 families participated in support groups during the placement process, and that while some of the stable placements were those that used groups, none of the families that disrupted used either the self-help or peer support

groups. From their evaluation, Barth and Berry concluded that while some post-placement services correlated positively with the stability of adoption placements, most of the services as they existed then were few and usually inadequate to the task of preventing disruption.

Rosenthal et al. (1996) examined the types of services and perceived effectiveness of a sample of adoptive families (n=562). They found that the most important services to families were "hard services" (e.g., medical, dental, financial support), and that subsidies emerged as the key post-adoptive service or support. Sixty-two percent of those receiving financial subsidies evaluated them as "essential," and 29% as "important." Only 3% of those evaluated regarded financial subsidies as "not important." Medical subsidies were also key supports to those evaluated in the study: 65% of families called them "essential," 25% as "important," 6% as "somewhat important," and 4% as "not important." The study also found that counseling and help on adoption issues, child development, and planning for the child's future were all evaluated as "very helpful" by more than 60% in the full sample. Furthermore, counseling and help on parenting skills, family counseling and individual counseling for the child were evaluated as very helpful by about one-half of respondents in the full sample, and tutoring was evaluated as being very helpful by almost three-quarters of respondents.

In one of the first large-scale studies of post-adoptive services, Smith and Howard (1994) identified the presence of what they called "family stressors," or conditions that increased family stress level and decreased their resources for coping with difficulties relating to adoptions, and their significance in raising dissolution. These stress factors included financial problems, child care problems, job problems, addition or loss of a family member, marital problems, recent disabilities of a family member, death of a family member, reduced family support, physical illness, job loss, divorce/separation, a recent move, or parent mental illness. Four of these stress

factors were also associated with a greater frequency of parents' raising adoption dissolution as an option. These included childcare problems, job loss, marital problems, and the physical illness of the parent. Smith and Howard also identified services and techniques used by adoptive families to deal with the family stressors. Of the services introduced by the families, the most commonly used were individual counseling for the child (66%), stricter discipline (64%), help from extended family (44%), family counseling (39%) and individual counseling for the parent (32%). Parent support groups, although infrequently used in the past by those receiving services (17%), were rated as the most helpful type of service used, as were child support groups. Individual counseling for the child and the parent was also thought to be helpful.

Child day care is one of the fundamental support services that helps promote stability in intact families (Roditti, 1995), and this should apply to kinship caregivers as well. As a family support service, day care offers both a preventive tool for dealing with caregiver stress and serves as a practical caregiving tool for such concerns as being able to go to work. Child day care centers also provide parenting programs, education on child development, and respite care for caregivers. Without this foundation of social support, Roditti argues, caregivers may be less able to cope with stress, more prone to crises, and could be at greater risk of abusing or neglecting their children.

Description of KSSP Sites

Since KSSP is a relatively new program, each site was asked to prepare a brief description of their agency and these have been updated for this report. Although there are similarities in the types of services provided at various sites, community partnerships ensure that there are differences in their focus, scope, and intensity.

Alameda North and South. The Kinship Support Services Programs in Alameda County understand that Kin Care offers a positive and stable placement alternative for many children who are unable to be raised by their biological parents. The program has been designed to support both the relative caregivers and the kin children they are raising by offering services at drop-in resource centers in Oakland and Hayward and at various sites in the surrounding communities. Services include: social service information, referral and advocacy; case management; education and training; caregiver and teen support groups; child activity groups; group and emergency respite care; legal services; assistance with basic needs; and warm-line (telephone) assistance.

Contra Costa West Central, Central, and East. In Contra Costa Counties, the Kinship Support Services Program's primary goal is to meet the needs of kinship caregivers so that they can effectively raise the relative child(ren) in their care. The program focuses on supporting, strengthening, enhancing, and assisting relative caregivers who are working to protect and strengthen the children in their care. They provide an array of services including case management, advocacy, in-home support, information and referral, informational workshops, recreation, family activities, an after school program, an independent living skills program, (limited) legal assistance, and assistance with basic needs.

Monterey East and West. Family Ties, Monterey County's Kinship Support Services Program, provides services to assist relative caregivers to protect and promote the safety, permanency and well being of children in kinship families. Services include support groups for caregivers, counseling for self-esteem building, peer support, empowerment for children, groups for children, recreational events for families to enjoy together, case management, legal assistance for legal guardianship and permanency planning, information and referral, advocacy, and parent

education in an effort to provide a comprehensive system of support to caregivers and their relative children and help address difficult parenting issues. Family Ties seeks to increase the chances for children's success by building the capacity of kin caregivers to meet their health, financial, social, emotional, and child rearing challenges.

Riverside. Grandparents, aunts, uncles, siblings, even cousins in some cases are taking in children from family members, and giving them stable, loving homes. The California Family Life Center (CFLC) was recently granted the Riverside County KSSP (or Kinship Support Services Program) contract to support these families. The program provides assistance to relative caregivers with help in navigating the social services system, the school system, and local services, as well as establishing support groups and recreational activities for both the children and their relative caregivers.

San Bernardino. The San Bernardino County Kinship Support Services Program, the Kinship Family Center, opened April 2002. The Kinship Support Services Program (KSSP) helps strengthen families of individuals who are raising children of their extended family by providing them with information, community resources, education, weekly support groups in the mornings and evenings, free monthly classes to help caregivers learn about each unique situation they are going through, monthly events, and other services relating to their needs. Through kinship placements, families are maintained, traditions are upheld, children move less and experience fewer behavioral, educational and/or health problems. San Bernadino also has a Kinship Advisory Council that meets monthly and is contributing to the developments of this exciting program. Members of the council include relative caregivers, representatives from the County and City schools, and various government agencies. As a group, they are committed to

addressing and resolving kinship issues in the community. KSSP is dedicated to provide the support those relative caregivers and the children in their care.

San Diego North Central, Central, East, North Inland, South, and North Coastal Regions. San Diego County Kinship Support Services Programs are private, non-profit agencies that receive County, State, and Federal funds as well as private donations to assist and support relative caregivers. KSSP in San Diego County is divided between New Alternative programs and YMCA programs. The New Alternative programs are located in the Central, East County, North Central, and North Inland regions. Central Region serves the inter-city population of families caring for relatives either placed through San Diego County Juvenile Courts or who are voluntarily caregivers. The program's main goal is to create long-term permanency placement for the children. East Region serves their families through case management, caregiver and teen support groups, tutoring and mentoring, exercising, arts and crafts, bingo and respite, etc. North Central Region provides a wrap-around approach to serving the entire family through one location. North Inland Region's main goal is to promote stability in families, leading to long-term permanency for the children. The YMCA programs are located in the South and North Coastal regions. The YMCA Kinship Support Services programs have developed services around the need of the population in that region. Their strengths are: information on permanency planning, assisting with legal guardianship paperwork, assisting families in court especially monolingual Spanish relative caregivers, advocacy, monthly family outings, and most important all these services are offered in both English and Spanish. In general, the programs offer many similar services to both relative caregivers and the child(ren) for whom they are providing care.

San Francisco and San Mateo (Edgewood). San Francisco (the model state program) and San Mateo County's Kinship Support Services Program focuses on nurturing children,

empowering caregivers, and strengthening families. The program is a comprehensive public/private collaboration designed to fill the gaps in public social services to relative caregivers and the children they are raising. KSSP works towards strengthening the family's ability to maintain a supportive and stable environment as a preferred alternative to out-of-home placement. The array of services provided include information and referral, advocacy, training and workshops for caregivers, transportation, recreational activities, long-term planning for children, housing assistance, mental health assessment and support, special events celebrations, summer camp programs, tutoring for children, and case management.

Santa Clara. Santa Clara County's Kinship Support Services Program, known as the Grandparent Caregiver Resource Center, provides many services based on the premise that kinship placements are much more likely to be successful if the caregivers receive support services. Their mission is to strengthen and support grandparent and other relative-headed families in Santa Clara County so that they can provide safe and secure homes for the children in their care. The program offers case management, support groups, an information and referral phone line, a resource library, recreation and respite, advocacy, housing assistance, legal services, counseling, transportation, and a full-time nurse.

Stanislaus. Stanislaus County's Kinship Support Services Program aims at helping relatives do the best job they can so that children can remain connected to their families. More than 40% of Stanislaus County's 675 children in foster care are placed with kin, the preferred strategy for children who are not able to remain with their biological parents. In order to encourage and support families assuming responsibility for minor kin, and to promote the success of those arrangements, the Stanislaus County Community Service Agency (CSA), Families First, Inc. (a not for profit social services agency) and the Stanislaus County Behavioral

Health and Recovery Services (BHRS) piloted this kinship support service program which opened its doors as the Apron Strings Kinship Center on June 1, 2001. Additional services offered are support groups and educational workshops for the caregivers, tutoring services, youth support groups, mental health services, cultural recreation/respite activities, linkages to existing resources in their communities, transportation, emergency food, housing and clothing assistance, and most importantly translation.

KSSP Evaluation

In July 2001, CDSS contracted with Center for Social Services Research at UC Berkeley to evaluate California's KSSP program, which was already serving children and families at 20 sites located throughout the State. These community-based[3] agencies work with both formal (current or previous involvement with the child welfare system) and informal (no history of child welfare involvement) kinship caregivers, some of whom are KinGAP recipients. Although KSSP funding did not include an evaluation component, key California stakeholders identified the need for such an evaluation if effective services and practices were to be identified and funding for the program was to be continued. Unfortunately, the data management system originally distributed to KSSP sites, though originally designed to meet state reporting requirements, was unable to provide the necessary information for individual-level data analysis and was not designed to function as a case management system. Many KSSP sites were unable to use the system and, among those who were able, many important data fields remained incomplete. Reports to the state were limited to hand-entered, summary data, possibly containing many duplicate entries. Faced with little data upon which to make an informed decision about whether to pursue increased funding for the program, state representatives asked

UC Berkeley to incorporate an evaluation of KSSP into their existing contract to analyze state administrative data.

Due to the need for an expedited evaluation for a program that was already underway and the fact that most kinship caregivers served by KSSP are not and have never been in the foster care system (therefore, not in the State's child welfare data system), UC Berkeley evaluators designed and have been conducting an evaluation incorporating survey and administrative data obtained during the course of service provision at each of the sites. Although Goerge, Wulczyn, & Fanshel (1994) describe the combination of administrative and survey data sources as promising, the challenge of obtaining county and service provider cooperation while adhering to an expedited timetable was formidable. Data collection had to be both relatively simple and complete, and a system for identifying and obtaining missing data was essential. KSSP agencies had differing levels of technological expertise, requiring the evaluation team to find a way to gather data that required little or no technical proficiency. Experience gathered from another California study (Dawson, Shlonsky, Tomy & Embry, in review; Hines, Embry, Ferguson, & Shlonsky, 2000; Shlonsky, Ferguson, & Hines, 2001) and anecdotal evidence led the research team to believe that providers' non-compliance with data requests are often the result of what are perceived as unreasonable demands on the part of evaluators. Providers are often overwhelmed with service provision and tend to have a high turnover of staff, resulting in time shortages and a lack of adequately trained employees.

Therefore, it was decided that the evaluation team would create straightforward paper forms that could be faxed directly to the evaluators and processed using Teleform™ automated forms processing software. This procedure allows service providers to submit uniform data to the evaluation team with a minimal level of technological sophistication (basically, a fax

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[3] Los Angeles County KSSP is not currently a community-based partnership.

machine and an organizational system to obtain the data). Although the data are faxed to the evaluators, Teleform™ allows the information to be verified on-screen (i.e., data entry is virtually eliminated) and exported directly to a database. Immediate entry to the database also allows the evaluators to continuously monitor the quality of the data and to generate reports detailing missing, incomplete, or out-of-parameter values. These reports are sent to the appropriate providers and can be sorted according to agency specifications (e.g., by site / by case manager / by client). Research assistants conduct intensive telephone follow-up to obtain or correct these missing and odd data, dramatically increasing the reliability of the data received.

During the course of this evaluation, Edgewood Children's Services has continued to develop and test a site-level case management system that promises to be more "user-friendly," have greater stability, and have the necessary flexibility to generate comprehensive individual-level reports. This new case management system will hopefully replace the more cumbersome fax system over time, with sites sending information electronically to the evaluation team. UCB and Edgewood will work together to "backfill" the data sent to UCB into this new case management system, allowing sites to utilize the information as part of their ongoing management and reporting procedures. Sites that continued to use the old case management system (TAG)[4] can have their data "bridged" to the new system. Edgewood Children's Services

no longer has a technical contract with CDSS, but is still offering the new case management system software to sites. Individual sites can choose to obtain technical assistance, including

bridging the data from the old system to the new and training on the new system, though there will be a cost for such services.

METHODS

Sample and Instrumentation

Agencies were asked to provide information on all caregivers receiving services during the month of October 2001 and all new entries coming into the programs after October 1, 2001. This recording has continued to date. Records include basic demographic and referral information for relative caregivers, basic demographic and legal status for all relative children living in the home, monthly reports on the frequency and types of services received, and, for those relative caregivers who have received services six or more months, caregiver satisfaction with services (Appendix II – Data Collection Instruments). These data will be integrated with the existing child welfare database in the California Children's Services Archive (CWS/CMS) in order to analyze rates of documented child maltreatment, entry and reentry into the foster care system, and participation of caregivers in the KinGAP program. However, due to the limitations of cross-sectional data (Gambrill & Shlonsky, 2000; Simpson, Imrey, Geling, & Butkus, 2000; Webster, Barth, & Needell, 2000), the use of child welfare archival data will largely be limited to families who began receiving KSSP services after the start of data collection in October 2001 (i.e., length of exposure to KSSP services can be controlled for in the analysis), and sufficient time has not passed to begin looking at these data. Thus, outcomes from the integration of administrative and survey data (e.g., documented rates of child maltreatment, child welfare history, and rates of reentry to foster care) will become part of an ongoing evaluation of KSSP

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[4] Edgewood Center for Children and Families initially developed a case management system (called TAG) to document their services to kin. After becoming the state's lead agency for KSSP development, this older system

services and will not be included in this report. This report will broadly summarize the types of caregivers and children served by KSSP for a 16-month period between October 1, 2001 and January 31, 2003, the frequency and types of services received by families during the course of these same months. This report will also provide the first results from the KSSP Satisfaction Questionnaire (Appendix II), which measured the levels of satisfaction with KSSP services for those caregivers who began receiving KSSP services before August 1, 2002.[5]

Data Gathering and Missing Data Collection Strategies

UC Berkeley generates monthly reports of required and missing data, and sends these to sites. For example, as demographic information is sent to UC Berkeley, a new caregiver record is entered into the database and a prompt for services data is made every month until such a time that the site informs UCB that the family is no longer receiving services. Also, if any fields are incomplete on the form or if a subsequent monthly services tracking form is not received, a missing data report is generated and sent to the site. Missing demographic and services data are identified by site, community worker (if one is assigned), and caregiver, and missing fields within forms are detailed. Follow-up phone calls are then made for a three-month period or until such a time as the site indicates it cannot gather the requested information. For satisfaction measures, UC Berkeley informs sites monthly about caregivers who become eligible to complete a satisfaction measure (at least six months have passed from KSSP study entry), sends them a pre-printed form and postage paid envelope, and asks sites to give the forms to caregivers. If caregivers do not mail the satisfaction forms to UC Berkeley, follow-up phone calls are made to caregivers and their alternate contacts (if permission was granted by the caregiver). Most

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was installed at most KSSP sites.

caregivers who did consent to have data forwarded to CDSS (82 percent) also consented to let UC Berkeley contact them if a satisfaction form is not received (88 percent), which has increased the response rate for this portion of the evaluation. In general, this system worked well, with most contacted caregivers granting permission for data transmission and follow-up procedures.

RESULTS

The following demographic, services, and satisfaction summaries are based on an unduplicated count of KSSP families and their unduplicated, discrete service histories. However, the numbers reported here are a substantial underestimation of both the number of families served and the services they were provided. Since data had to be linked to individuals for this and subsequent evaluations, identifying information was required of individual service recipients. As such, caregivers had to consent to submit this information to CDSS for use in an evaluation (Caregiver Demographic Form - Appendix II). Some caregivers did not consent, others could not be located, and still others did not have their consent information recorded in the data system.

In addition, despite the development and implementation of an intensive set of procedures for collecting missing data, there is a considerable amount of missing or underreported data. This is likely due to the time commitment required to gather and send these data. Community service providers are often short-staffed, under-funded, and have many competing demands, not the least of which is providing services to children and families. Given

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[5] Caregivers who began receiving services after August 1, 2002 are excluded since they would not have had an opportunity to receive KSSP services for 6 months.

such time constraints and the delay in implementing an automated case management system, response has been better than expected, but not optimal.

Another reason these data are an undercount is that individual-level data from Los Angeles County are not included. Los Angeles has a very unique model of KSSP service provision and is the only site that does not employ a community-based agency as its primary service provider. Instead, Los Angeles County mainly provides services using a small number of dedicated Children's Social Workers from the Department of Children and Family Services. Individual-level data collection has not yet been fully implemented and, even if it had, the difference in approach between LA and the rest of the KSSP sites is large enough that it is unadvisable to mix these data. Therefore, only aggregate referral data from Los Angeles County are included in this report. Later reports may include more LA data as the program evolves.

KSSP Population by Site

From October 2001 to January 2003, KSSP providers served a total of 2,169 caregivers and 3,923 relative children for a total of 6,092 unduplicated service recipients who consented to have their data released to CDSS (Table 1).[6] San Diego County, with a total of 6 sites and two providers, served the most caregivers (n=746) and children (n=1,363) for a total of 2,109 service recipients, followed by Contra Costa County with 308 caregivers and 612 children for a total of 920 service recipients. The largest single site was Santa Clara with 237 caregivers and 400 relative children for a total of 637 service recipients, followed by East Monterey County with 240 caregivers and 371 relative children for a total of 611 service recipients. Thus, each kinship

caregiver involved with the KSSP program had an average of almost 2 relative children who were also receiving services. Of caregivers who received KSSP services during this evaluation period (and for whom an enrollment date could be determined) (n=1,840), 2 percent (25 caregivers) received services for the first time prior to 1997 when the KSSP program was established (Table 2),[7] 14 percent (253 caregivers) received services for the first time from 1997 to 1999, and 84 percent (1,548 caregivers) received services for the first time from 2000 to 2002. About one percent (14 caregivers) began receiving services in the first month of 2003.

Caregiver Demographics

The KSSP caregiver population (n=2,169) appeared to be similar to the general kinship care population, with kinship caregivers tending to be single, female grandparents. KSSP caregivers were overwhelmingly (86 percent) female (Table 3) and the bulk of caregivers (58 percent) fell between the ages of 40 and 59 years (Table 4). Only 5 percent of caregivers were under the age of 30 and about 27 percent were 60 years of age or older. Although the largest single marital category was married (42 percent), most caregivers (57 percent) reported they were single parents (i.e., they listed themselves as single, divorced, separated, or widow/widower) (Table 5). The presence of other caregivers in the home was also quite limited. Only 17 percent of caregivers reporting on this measure indicated that they have another adult caregiver residing in the home (Table 6).

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[6] Data were collected from October 1, 2001 through December 31, 2002. However, a small number of records that were received in January 2003 are included in this report since tables were generated shortly after the first of the month. The number of caregivers and children served is an undercount since it reflects only those caregivers and children who were approached and agreed to have their information sent to UC Berkeley. Some sites were more inclusive than others. For example, Edgewood Center for Children and Families reports sending information on only 28 percent of their active clients for inclusion in the study (Powell, 2003).

[7] These caregivers were receiving services from Edgewood Center for Children and Families, which began their kinship program in 1993.

Caregivers were most often people of color, and the largest single category of caregiver race/ethnicity was "Black / African American" representing 34 percent of the KSSP service recipients. The next largest group was "White / Caucasian" (30 percent), followed by "Latino / Hispanic" (28 percent), "Asian / Pacific Islander" (3 percent), "Native American" (1 percent), and (3 percent) "multi-ethnic" (Table 7). Most caregivers listed their primary language as English (82 percent), though a substantial number (17 percent) spoke Spanish as a primary language (Table 8). Even so, the vast majority of caregivers (91 percent) were able to communicate in English. However, 9 percent of caregivers indicated they could not speak English and, therefore, were likely to require specialized services in their native language. In terms of education, 72 percent of KSSP caregivers had at least a high school education or the equivalent, and 42 percent had attended or graduated from post high-school education programs (Table 9).

Total household monthly income was calculated for caregivers who chose to respond to this question (81 percent).[8] Caregivers were asked to include any foster care, TANF, or SSI payments as well as personal income from social security, wages, alimony, child care payments, and other sources (Appendix II – Caregiver Demographic Form). A number of caregivers reported total household earnings of less than $1000 per month (21 percent), more than half (59 percent) reported income of less than $2000 per month, and the vast majority (80 percent) reported earning less than $3000 per month (Table 10). Considering the cost of living in California, these figures indicate a population that is financially strained. Among caregivers who opted to disclose specific income sources (approximately 96 percent), 42 percent (n=825) reported income from wages, 35 percent reported income from TANF / CalWORKS (n=697), 13

percent (n=249) reported income from foster care, 12 percent (n=230) reported income from SSI (caregiver), and 21 percent (n=419) reported income from social security (Table 11).

Most caregivers (52 percent) maintained two or more relative children in their home (Table 12). While a substantial number of caregivers had only one relative child in the home (48 percent), almost one quarter (23 percent) had 3 or more relative children in their home and 8 percent had 4 or more relative children living in the home. But these relative children were not the sole caregiving responsibility for this group of kin (Table 13). Many had their own children to care for (25 percent), were caring for other children who were not relatives (4 percent), or were caring for adults living in the home (6 percent). The caregiving burden was often exacerbated by health concerns. Caregivers themselves or their case managers noted a health concern in 37 percent of KSSP caregivers, however 32 percent of caregivers noted that they do not have health insurance (Table 14).

Caregivers were referred to KSSP from a variety of sources ranging from child welfare services to clergy (Table 15). By far, the most common source of referral was Child Welfare Services (32 percent) and the least common was Probation Services (less than 1 percent). Common sources of non-child welfare referrals included self-referrals (i.e., kinship caregiver discovered KSSP and contacted one of the agencies), which occurred eleven percent of the time, neighbors/friends (11 percent), schools (6 percent), relatives or family members (5 percent), and health professionals (5 percent). The "other" category, which made up 17 percent of responses, contained referral sources such as the media, Red Cross, housing assistance organizations,

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[8] Although this question initially raised concerns among sites that caregivers would not be comfortable disclosing this information, KSSP sites were apparently diligent in their efforts and caregivers may have been less apprehensive than was anticipated. However, there is still considerable concern about the reliability of this question.

various community-based agencies, the YMCA (a San Diego provider), legal aid, WIC, and KSSP outreach.

Child Demographics

The 3,923 children receiving KSSP services were fairly evenly split in terms of gender (Table 16), though there were slightly more females (51 percent) than males (49 percent). Race/ethnicity of children was slightly different than the proportions seen with relative caregivers (Table 17). The single largest group of children was still "Black / African-American" (37 percent). However, the next largest group was "Latino / Hispanic" (28 percent) rather than "White / Caucasian" (23 percent). "Asian / Pacific Islander" comprised 2 percent of the child sample and "Native American" 1 percent, and there were proportionately more "multi-ethnic" children at 7 percent of the sample than there were caregivers (3 percent) in the same category. The histogram in Chart 1 details the current age of children by year, and the brackets categorize each year into age groupings with percentage of children in each grouping. Children were somewhat normally distributed in terms of their age, with only about one percent of children currently less than one year of age and only seven percent age 16 or older. At the two ends of the age spectrum, children receiving KSSP services were teenagers (age 13+) about 25 percent of the time and were young children (age 0-5) about 23 percent of the time.

Children served by the KSSP programs tended to have lived with their kinship caregiver for long periods of time (Table 18). Over two-thirds of the children (69 percent) had lived with their current caregiver for at least one year over the course of their lifetime, and 44 percent had lived with their caregiver for 3 or more years. Children also tended to have resided with their

current caregiver continuously, with 96 percent (n=3,512) having stayed with their caregiver since coming to live with them. Thus, the total number of years residing with a kinship caregiver largely resembled the number of years residing with this kinship caregiver during the current "event" (defined as continuous length of stay with the current caregiver).

Most children resided with a maternal relative (73 percent), though a sizeable minority were related to their caregiver through paternal lineage (27 percent). Three-quarters of children (73 percent) were living with a grandparent and 2 percent were living with a great-grandparent (Table 19). Nineteen percent were living with an aunt or uncle (including great aunts and uncles) and the remaining 6 percent were living with siblings, cousins, extended family, or other relatives.

A large proportion (44 percent) of the children receiving KSSP services were in "informal" care settings with their kin, meaning their kin were voluntary caregivers who were uninvolved with the Child Protective Services system (Table 20). Of these voluntary placements, 56 percent of caregivers were receiving TANF funds for their relative children and 44 percent were not. About 16 percent of children were in formal foster care (either in long-term foster care or pre-permanency stages of care), and these children were almost entirely child welfare cases (99 percent) rather than probation cases (1 percent). A large proportion (35 percent) of children were residing with kin who were their permanent caregivers. About 4 percent of children resided with their adoptive relative and 31 percent resided with their legal guardian (5 percent of whom had exited formal foster care into the Kinship Guardianship Assistance Payment Program). At this time, it is unknown what proportion of adoptive and Non-KinGAP guardianships were established through the Child Welfare System, though the proportion is likely to be quite high. Future analyses will link these data with CWS/CMS data to

more accurately determine the number of KSSP children who are currently involved with or had been previously involved with the child welfare system on a more formal basis.

Caregivers or their KSSP representatives often indicated educational, behavioral, and medical concerns for this group of children (Table 21). Twenty-seven percent of children had an educational concern, 29 percent had a behavioral concern, and 20 percent had a medical concern. Although the severity of these issues is beyond the scope of this report, these concerns were considered important enough to list on the intake sheets and, presumably, would be part of the service needs addressed during the course of involvement in KSSP.

Services to Caregivers and Children

A total of 91,385 individual services were documented as delivered by KSSP agencies between October 2001 and January 2003 (Table 22). These numbers reflect actual services performed by the agencies (described in Appendix II) and include referrals to outside service providers. Sites tended to deliver more services to caregivers (63 percent) than to children (34 percent), and referred families to services they did not offer about 3 percent of the time. Among caregiver services, Central Contra Costa County had the greatest proportion of service recipients (18 percent), followed by San Diego South Region (13 percent), and West Contra Costa County (10 percent). For services to children, Central Contra Costa County was again the largest service provider (23 percent) followed by San Francisco (14 percent), and San Diego South Region (13 percent). For referrals, East Monterey County was clearly the largest provider (33 percent), followed by San Diego East Region (19 percent), San Diego Central Region (17 percent) and West Contra Costa County (11 percent). Overall numbers are similar, with Central Contra Costa County accounting for 19 percent of services provided, San Diego South Region accounting for

12 percent, and West Contra Cost County accounting for 10 percent of all services rendered and documented.

Although the number of services delivered is quite large, it is a considerable underestimate. Only services that were documented and submitted to UC Berkeley were included in this report. An unknown number of caregivers received services at each of the sites, but did not consent to have their information submitted to UC Berkeley. The number of caregivers and children served is an undercount since it reflects only those caregivers and children who were approached and agreed to have their information sent to UC Berkeley. Some sites were more inclusive than others. For example, Edgewood Center for Children and Families reports that only 38 percent of the services provided to KSSP clients was sent to UC Berkeley for inclusion in the study (Powell, 2003). In addition, there is likely a large number of services delivered that were not documented due to time constraints and the difficulty of keeping track of all services provided in a community agency setting. Possibly, some sites are more adept than others at documenting services. Also, despite concerted efforts to track service recipients on a monthly basis, many service histories are incomplete and it is assumed that some proportion of caregivers with incomplete histories were receiving services without proper documentation. Of course, there also exists the possibility that the number of services provided is being exaggerated in order to obtain a more favorable evaluation. This, however, is unlikely given the time intensive nature of the documentation process and the perpetual shortage of personnel at each site.

For every month of caregiver involvement in KSSP, sites were asked to submit a services tracking form documenting the monthly service usage of each caregiver and child(ren). Table 23 details service history by matching the number of caregivers with their expected number of

service reports. For instance, column 2 / row 1 lists the number of caregivers with only one expected report (n=30). Column 2 / row 2 lists the number of caregivers with 2 expected reports (n=37). Using this method of calculating what amounts to a monthly response rate on services tracking forms, fifty-five percent of all expected reports were received yet only 9 percent of individuals in the database have complete service histories. There are several reasons for incomplete service histories. First, as can be seen in the table, caregivers with more data collection points tended to have fewer instances of complete data. Caregivers with 16 expected reports illustrate this point. Although the overall response rate for this large group is among the highest (61 percent), no caregiver in this group (n=818) currently has a complete service history. Over time, sites have a greater risk of missing a data collection point if there are more data collection points to miss. Second, although there is a way to inform UC Berkeley when a caregiver is no longer receiving KSSP services, the evaluation team has found that this information is sometimes not transmitted to the evaluation team, resulting in an overestimation of missing data. Third, many caregivers begin KSSP services as case managed clients. Over time, they may move from more intensive, formal involvement to a more informal, "drop-in" status. While such clients are actively involved in the program, they are far less likely to be actively monitored and service receipt may be undocumented by the agency. If a family is not receiving case management services, their presence for various services (such as support groups and recreational activities) may go unnoticed or at least undocumented. Even among case managed services, it seems reasonable to assume that some proportion of services provided were not documented and are not reflected in the following tables. Last and somewhat related to the previous point, in light of the current fiscal crisis facing California and its various agencies, sites may be even more hard-pressed to take the time to monitor and document client activity due to

staff shortages and increasing demands. Therefore, these numbers should be considered an estimate of the lower bound, or absolute minimum, of the total number of services provided to KSSP caregivers and children.

Total received services have been detailed by type of service provided for caregivers, children, and out-of-agency referrals. Of the 57,527 documented services provided to caregivers (Table 24), information and referral (I and R) were the most common (31 percent) service provided, followed by caregiver assessments (18 percent), support groups (7 percent), household needs / family necessities (5 percent), recreation (4 percent), and transportation (4 percent). In general, service reporting has tapered off during the latter part of 2001, which again may be a result of UC Berkeley having fewer months to pursue missing data, an increasing number of KSSP clients moving from case managed to informal services, decreasing KSSP site ability to meet data collection demands, or some combination of these factors.

Of the 30,923 documented services provided to children (Table 25), 16 were recreational services, 15 percent involved child care, 14 were transportation related, and 13 percent were tutorial services. Other large categories of service provision for children were assessment (7 percent), information (7 percent), mentor services (7 percent), household needs, family necessities (5 percent), and education assistance (5 percent).

Of the 2,935 documented instances of out-of-program referrals (Table 26), 12 percent were for information services, 8 percent were for tutorial services, 8 percent were for recreational services, 6 percent were for household needs / family necessities, 6 percent were for assessment, 6 percent for mental health assessment / counseling, 6 percent for emancipation/independent living services (ILS), and 6 percent were for legal services.

Referrals for Services – Aggregate level

During the planning stages for the evaluation, KSSP sites expressed a concern that they sometimes provided referrals to community members over the phone or by mail, that these community members were not necessarily receiving KSSP services, and sites do not have individual level data (caregiver / child demographic forms) for these services recipients. For instance, a caregiver in the community that is otherwise unknown to the KSSP site might call and ask for advice or for a referral, but chooses not to become involved with KSSP services. The site would serve this caregiver, but would not complete a caregiver or child demographic form. Similarly, if the caregiver lived too far from a site, they might be referred to local providers. With input from the sites, the evaluation team developed a "Referral Tally" form, which allows sites to document such referrals without submitting individual level data. These data should not be confused with referrals to services where the client is known and individual-level data are available (see previous section).

Despite KSSP site support for the development of such a measure, about half of the sites did not submit referral tally data during the evaluation period. This is likely due to organizational limitations. That is, the organizational capacity needed to document such services systematically may not exist at all sites. Thus the numbers presented here are, again, a fairly substantial undercount. Between October 2001 and January 2003, 25,901 referrals were made among the eleven sites submitting such information (Table 27). Most referrals were for caregivers (74 percent), though referrals for children were common events (26 percent). By far, the site with the most referrals was San Diego East Region with over 13,000 referrals (n=13,314), almost all of them (80 percent) to caregivers rather than children. Los Angeles

County documented 8,598 referrals to services, but was far more evenly split between caregiver and child referrals. South Alameda County was also quite active in this area, providing 1,084 referrals.

Community referrals[9] differed somewhat from client referrals (Table 28). The largest single category of these types of referrals consisted of Newsletters/informational mailings, which were sent out almost 7000 times and comprised 27 percent of the total community referrals. Similar to direct client services, information was given out quite often (20 percent), as were assessments[10] (presumably for KSSP or other services). Referrals for recreational activities (10 percent) and support groups (5 percent) were also fairly common.

Caregiver Satisfaction with KSSP Services

Scale Measures. Satisfaction surveys were distributed to 1,533 caregivers meeting the following inclusion criteria: (1) caregiver first receipt of KSSP services occurred at least six months prior to January 2000; (2) caregiver was not receiving services at the San Francisco site; (3) caregiver indicated language proficiency in either English or Spanish. The six-month time frame was considered necessary in order for caregivers to have sufficient time to experience a range of KSSP services and form an opinion about them. Caregivers from San Francisco were excluded since caregivers were not administered the UC Berkeley satisfaction measure. San Francisco is the state model agency and conducts frequent research with its clients and one of its

[9] Referrals made to clients who did not regularly receive KSSP services and for whom no demographic material was available.

[10] Assessments in this referral category are limited to Los Angeles County and are a product of a function Los Angeles KSSP performs in conjunction with the Los Angeles County Community and Senior Services Department, Area Agency on Aging. This related agency offers kinship support services through various community-based agencies. Los Angeles County KSSP staff screen applicants and follow up with both caregivers and the contracted service provider.

standard measures is a satisfaction instrument that resembles, but is not the same, as the UC Berkeley instrument (Appendix II – Data Collection Measures).[11]

The UC Berkeley Satisfaction Measure was translated into Spanish and the evaluation team employs a Spanish-speaking survey worker for follow-up phone calls. Unfortunately, resource restrictions prohibited the evaluation from developing forms in other languages and employing survey workers with different language proficiencies. However the lack of instruments in other languages probably did not drastically affect the response rate since most respondents (84%) indicated they could speak English and an additional 8 percent were monolingual Spanish speakers. Thus 92 percent of caregivers who granted permission to have data sent to UC Berkeley were provided satisfaction measures in a language in which they were proficient. It remains unknown whether monolingual clients speaking a language other than Spanish were systematically excluded from the sample.

Of the 1,533 surveys administered, 806 usable surveys were returned or caregivers were later contacted by telephone for a response rate of 53 percent. Follow-up procedures (sending duplicate surveys and contacting caregivers by telephone) brought the response rate up considerably, raising it almost two-fold. About half of the responses (n= 409) were initially received by mail after being distributed by the sites. Of the remaining 1,124 caregivers, 559 consented to have UC Berkeley contact them by telephone and 71 percent of these (n=397) were administered the survey over the phone by trained UC Berkeley research staff. Characteristics of non-respondents were not investigated for this report.

The satisfaction measure used a mixed response category design. The first third of the

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[11] Creation of the UC Berkeley satisfaction survey actually involved using elements of the Edgewood form as an initial building block. Unfortunately, the differences between the two measures are substantial, time frames for administration differ, and the San Francisco form is not administered independent of the site being evaluated.

instrument utilized a simple A-F grading scheme, similar to the one used by most educational institutions. The second third used a 5 item, Likert-type response set ranging from "Strongly Agree" to "Strongly Disagree." The third section contained two open-ended questions (see below). For the most part, caregivers rated KSSP services very highly.

When asked to rate the overall quality of KSSP services, 88 percent of responding caregivers choose A: Highest (64 percent) or B: High (24 percent) grades (Table 29).[12] Another overall measure of satisfaction is the extent to which people will recommend a service or product to another person. When asked if they would recommend kinship services to other caregivers who face similar problems, caregivers almost always agreed that they would (92 percent), with 65 percent strongly agreeing and 28 percent agreeing. Timeliness of service provision was ascertained by asking caregivers the speed with which services were provided to them. Caregivers also tended to rate sites very highly in this respect, with 82 percent choosing A: Highest (58 percent) or B: High (24 percent) grades for this question.

Several questions attempted to ascertain caregiver perception about whether KSSP services helped them maintain their family. When asked whether kinship services were effective in reducing their worries and concerns as concerns as a caregiver, most respondents indicated that they had (79 percent), with 54 percent assigning A: Highest and 25 percent assigning B: High grades. Caregivers were also asked whether kinship services helped them keep their family together. Of those caregivers who felt the question applied to them (78 percent of respondents), an overwhelming proportion (84 percent) strongly agreed (39 percent) or agreed (45 percent). Along these same lines, caregivers were asked whether kinship services helped them take care of their relative children. Among those who felt that this question applied to them (87 percent of

[12] Percentages reported in the text portion of this section are calculated by excluding "missing" or "not applicable" (N/A) responses. However the corresponding tables include percentage of "missing" or "N/A" responses.

respondents), 85 percent of respondents either strongly agreed (40 percent) or agreed (46 percent). Somewhat related, caregivers were asked whether kinship services helped kin take care of themselves. Of those who felt the question applied to them (78 percent of respondents), 79 percent strongly agreed (37 percent) or agreed (42 percent). Caregivers also tended to feel that kinship services benefited them personally. Among respondents who felt the question applied to them (91 percent of respondents), most (88 percent) strongly agreed (44 percent) or agreed (44 percent) that kinship services made a positive difference in their lives.

The satisfaction measure also attempted to gauge the extent to which caregivers felt that KSSP services benefited their relative children. Caregivers were asked to rate the help they received for their relative child's behavior. Among caregivers who felt this question applied to them (67 percent of respondents), 83 percent rated these services very highly, with 55 percent giving an A: Highest grade and 28 percent giving a B: High grade. Caregivers were also asked to rate the kinship services they received that were focused on helping them with their relative child's educational needs. Among caregivers who felt this question applied to them (62 percent of respondents), 80 percent rated such services very highly with 56 percent giving an A: Highest grade and 24 percent giving a B: High grade. When asked whether they felt that kinship services made a positive difference in the lives of their relative children, caregivers who felt the question applied to them (88 percent of respondents) tended to either strongly agree (43 percent) or agree (43 percent).

Open-ended Responses. While closed ended-responses to satisfaction questions are useful for measuring standardized responses to key programmatic concepts, they do not allow respondents to freely express their opinion. In an effort to ascertain caregiver opinion about what they felt was most salient about KSSP services, caregivers were asked to: (1) briefly

describe the most helpful part of Kinship Services; and (2) briefly tell us what KSSP can do to improve. Of the 806 caregivers who completed a satisfaction form, 730 provided a response to the first statement (most helpful) and 643 provided a response to the second statement (needs improvement). Answers received in Spanish (n=61) were translated into English and are included in this analysis. These more qualitative, open-ended responses were added to the database, each statement was separated into one or more thematic codes, and these were then grouped into larger categories for ease of presentation. The smaller themes (e.g., "Acknowledgement and Communication") were constructed by coding each caregiver's response into discrete themes until the entirety of each individual statement seemed to be represented (each response could contain several themes). Although no formal structure was imposed on the coding of statements, the range of known services provided by KSSP sites (Appendix II) was considered as a beginning framework for categorizing responses into larger themes. After statements were coded for the entire sample, these were organized into broader categories. Since the nature of this type of thematic coding is somewhat subjective, all responses are presented in Tables 30-32 within their broader categorical groupings. In order to enhance the qualitative aspect of this section, caregiver quotes are included within each section when a suitable quote was provided.

Most helpful.

> The fact that there is a service, or rather support group, for the situation of taking care of young children at a time in one's life that you believed all of that is behind you.
>
> Female, African-American Caregiver, Age 54. Three Children, ages 6, 7 and 7.

Of the 806 caregivers who completed a survey, 730 replied to this statement for a total of 1,508 responses (each caregiver's statement could contain more than one theme). The largest category of KSSP services that caregivers found most helpful was "Social Support", with more than half (55 percent) of caregivers making statements falling into this category. Social support consisted of a combination of a concrete service, attending a support group (19 percent), and more qualitative statements such as "someone to turn to" (19 percent) and "being with others in similar circumstances" (5 percent). Caregivers were clearly expressing how important it was for them to speak with people, both other caregivers and staff, about their experiences as relative caregivers. Even if this category is separated into its smaller components, references to the importance of the support group and "someone to turn to" were the two largest single themes that were identified, and "being with others in similar circumstances" (5 percent) was also one of the top 10 themes.

> They treat me and my children like family and not like its just part of their jobs. And the children love being with the staff. Other children feel the same.
>
> Female, African American Caregiver, Age 53. Three Children, ages 10, 12 and 12

Related to the social support cluster, a staff support category emerged. Caregivers made a series of statements (18 percent) complimenting both overall site staff as well as extolling the virtues of specific staff members. Caregivers seemed to notice and acknowledge when staff members went out of their way to help families. Many statements reflected the sentiment that staff were able to act as advocates for services and also functioned as knowledgeable listeners.

> During the summer the grandchildren got to go a lot of places I couldn't have taken them. They are wonderful - friendly, courteous. I have nothing but good things to say about them.
>
> Female, Caucasian Caregiver, Age 53. Three Children, ages 4, 9 and 13

Caregivers also seemed to appreciate the recreational activities provided by KSSP sites. Responses were sometimes unclear as to whether they referred to activities for children (8 percent), caregivers, or families (1 percent), forcing the creation of an unspecified recreation category (6 percent). Taken together, these responses account for 15 percent of caregivers in the sample. Nevertheless, caregivers expressed that they sometimes found it difficult to provide such opportunities for their children due to financial, physical, or other constraints, and that KSSP provided the ready structure and resources needed to give children and families a range of recreational activities.

> Giving out positive information, which can better secure your needs.
>
> Female, Hispanic Caregiver, Age 46. Three Children, ages 3, 4 and 9

Information and referrals, a service often provided by the sites (see above services analysis) was also valued by caregivers. Although specific types of referrals were not detailed, caregivers apparently had needs that went beyond the services provided by individual KSSP agencies. These included legal, medical, and educational services. About 15 percent of caregivers cited information (8 percent) and referrals (7 percent) as helpful.

Not surprisingly, child care / respite care was also valued by kinship caregivers (13 percent). Respite care is not often offered for foster care providers (including kin) in the Child Welfare System, yet 8 percent of kinship caregivers in this sample cited respite care as helpful.

Child care was also cited as helpful about 5 percent of the time, though it is unclear whether childcare was provided on site or caregivers were referred to outside vendors.

> If I need food or run short on paying bills, I call them and they help me. It's a wonderful program.
>
> Female, African American Caregiver, Age 68. Two Children, ages 14 and 15

Another cluster of themes emerged around direct assistance to caregivers and families with financial and household needs (10 percent). Although financial assistance by KSSP sites tends to be somewhat limited, emergency assistance is often provided as are referrals to community and governmental agencies with access to funds. Three percent of caregivers cited financial aid / counseling as helpful while 6 percent of caregivers cited household needs / family necessities as key.

> At the most critical period in my life they helped me to stay afloat.
>
> Female, African American Caregiver, Age 54. Three Children, ages 7, 12 and 13

Somewhat related to this category, caregivers sometimes endorsed emergency assistance (1 percent), which likely means short-term financial aid for housing, utilities, or food. Although this percentage is somewhat low, the assistance provided could determine whether a child would continue to reside with their kinship caregiver and, most likely, is not a service most KSSP sites can afford to give to everyone.

> In my family we seemed to have a saying, "good things come to those that wait;" and if it wasn't for Family Ties coming to our home and taking action with medical, legal advice, we wouldn't have a family. I am now the legal guardian of my blood granddaughter.
>
> Female, Hispanic Caregiver, Age 48. One Child, age 8

One of the main purposes for the inception of KSSP services was to ensure and promote permanence for children residing with relatives. Accordingly, permanency planning was another particularly helpful set of services mentioned by caregivers (8 percent). These services were mostly comprised of guardianship (4 percent) and legal services (3 percent), which may actually overlap since there was no way to determine whether legal services were in the pursuit of guardianship. In any case, it appears as though KSSP services helped a number of caregivers to move from either long-term foster care or informal kinship care to more legally permanent placements or residences by moving them through the guardianship process.

> We used another agency for [child's] behavior with no progress. Kinship services has been a god send for me!
>
> Female, Caucasian Caregiver, Age 80. One Child, age 16

Mental health services were also perceived as particularly helpful for kinship caregivers. About 8 percent of caregivers described counseling (5 percent) or other forms of family or group therapy (3 percent) as making a difference for them in raising their relative children, though it is somewhat unclear as to whether they meant individual counseling for themselves or counseling services for children. There is some indication that caregivers distinguished some of the counseling services as being focused on their children, including child counseling in this category (1 percent) and help with child behavioral problems in the child behavior category (1 percent), yet the level of use deemed helpful for individual caregivers remains unknown.

> When I lost my husband I found out that I was not alone, everybody called me and visited me, like a part of my family.
>
> Female, Hispanic Caregiver, Age 70. Three Children, ages 7, 10 and 14

Other categories that seemed to be helpful for caregivers were home support services (8 percent) – including home visits / phone calls, educational services for children (7 percent) - including tutoring (5 percent), and general children's services (7 percent).

> The kinship program helped my grandson from special education classes to regular classes going into the second grade.
>
> Male, African American Caregiver, Age 60. Two Children, ages 9 and 10

There were a number of responses that did not seem to fit into any single category but were mentioned with relative frequency. Last, KSSP sites also offer training on various topics from HIV/AIDS awareness prevention to parenting skills training, and about 5 percent of caregivers cited this service as helpful.

Needs Improvement. Of the 643 caregivers who completed this section, responses seemed to fall into two overall categories: (1) Program enhancement (73 percent), which refers to caregiver sentiment that the services, while beneficial, needed to be expanded or made more available and (2) Program improvement (28 percent), which refers to elements of KSSP services that caregivers did not like, had a bad experience with, or found lacking.

Program enhancement. The largest single category in this grouping was "No needed improvement," with close to half (44percent) of caregivers reporting that "nothing" needed to be improved (27 percent), "Great job" (13 percent), or "no needed improvement (4 percent). These comments are different than simply the absence of a comment since the caregiver took the time

to reinforce the site with their comments. In this respect, these types of answers more closely approximate an overall complement to the agency rather than a critique of agency practice. In addition, 104 respondents answered the first open-ended question (Greatest benefit of KSSP) but did not answer the second probe for areas of improvement. Some proportion of these 104 caregivers likely felt, or at least wanted to express, only positive thoughts about their KSSP experience.

> More funding so that nobody has to be in line for some of the services. Have more child development professionals, for all of the children's needs and problems. If some of the counselors could come to the home, because I am blind and it's hard to go out.
>
> Female, Hispanic Caregiver, Age 65. Two Children, ages 4 and 10

Over half (53 percent) of the remaining responses were statements asking for increases in specific services (30 percent). These were mostly comprised of standard KSSP services and included such categories as “more respite services (5 percent), “more recreational activities” (3 percent), and “more transportation” (3 percent). Some caregivers also suggested “more funding” (4 percent) – which generally referred to enhancing current services or maintaining current services.

> Just please, don’t change. Hire more people of the same type of warm hearted feelings and concerns for others. And please never close down. Thanks!
>
> Female, African American Caregiver, Age 53. Four Children, ages 9, 11, 12 and 15

> Get the word out more - please do whatever to keep this service online and well. It is so needed and necessary - a life saver for some.
>
> Female, Caucasian Caregiver. Age 61. One Child, age 17

Related to funding, about five percent of the responses were categorized under the heading of "program stability," which refers to a concern among some caregivers about the survival of KSSP services. Caregivers sometimes appeared worried that KSSP services would be diminished or entirely lost due to ever-present funding concerns. This theme also runs through another category, "Agency Growth," which 5 percent of caregivers cited as an area that sites needed to focus more attention. Caregivers were concerned that many other kinship caregivers were struggling with similar issues, yet were not aware that kinship services were available to them. As with the previous category, kinship caregivers appeared to be concerned about agency survival, sometimes suggesting advertising as a means to increased program funding.

> Make other info more available - on housing, public assistance, education benefits.
>
> Female, African American Caregiver, Age 52. One Child, age unknown

Information and referrals, while the top service provision category (see above), was also one of the areas that some caregivers felt could be expanded. About 6 percent of caregivers described wanting more information about available services (3 percent), two percent described wanting general information, and one percent described wanting more referrals.

Program Improvement. Notwithstanding all the positive comments made by caregivers, some respondents indicated that certain elements of the program did not meet their expectations and could be improved (Table 32). The largest theme emerging from this part of the second open-ended question (10 percent) seemed to involve communication difficulties between the various sites and caregivers seeking services ("Improve communication").

> I am disappointed because they never called back when they were called for help in children's custody battle.
>
> Female, Filipino Caregiver, Age 60. Three Children, ages 3, 6 and 9

These types of negative interactions mostly seemed to revolve around issues of staff turnover (4 percent), responding to caregivers by returning phone calls (1 percent) and increasing contact with caregivers (2 percent), and providing "more caring" staff (2 percent). Caregivers also expressed concern that certain events or services were held at inconvenient or otherwise unmanageable times (5 percent). Certain activities were apparently difficult for some caregivers to take advantage of if they were not held on the weekend (2 percent), and some caregivers found it difficult to attend support groups (1 percent) and recreational activities (1 percent). Somewhat related, caregivers sometimes complained that the facilities housing KSSP agencies were inconveniently located or were inadequate in other ways. About five percent of caregivers felt this way, with two percent describing agency, support group, or activity locations as inconvenient, and about two percent describing accessibility or space issues at the site. Although not reflected in the tables, some monolingual Spanish-speaking caregivers stated that monolingual English-speaking agency staff were unable to assist them. For these caregivers, services may have been underutilized or rendered ineffective due to these language differences.

Experience with the KSSP Evaluation

The outcomes obtained from program evaluations are often influenced by agency and environmental contexts (Lipsey & Cordray, 2000). In an effort to gauge the extent of such influences and, in particular, to investigate the reasons for the fairly substantial amount of missing services data (Table 23), an investigation of each site's experience with the program

evaluation was undertaken. Research staff at UC Berkeley contacted KSSP Program Coordinators by telephone and asked them a series of process oriented questions about the difficulties and successes that site staff encountered while trying to collect and submit data to UC Berkeley (Appendix IV). Responses were thematically coded and were then categorized by whether sites were relatively up to date with their data submissions (high levels of complete data) or were struggling with data submissions (high levels of incomplete data). Results are presented in summary form.

Completeness of data. For the most part, sites were accurate in their perceived level of reporting. That is, most of the sites that reported high levels of data completion tended to have fairly complete caregiver and child data, and also tended to have a higher percentage of complete services data. Sites reporting difficulties in this area did, indeed, have higher levels of missing data.

Collecting personal information. One of the major challenges that sites faced when trying to collect and send data was the fact that caregivers were sometimes reluctant to provide personal data. Many site coordinators stated that caregivers responded negatively to being asked for personal information such as income and Social Security numbers. Sites that were up to date with their data submission used one or all of the following strategies to overcome these feelings: (a) took information at enrollment when caregivers were more eager to cooperate; (b) explained the nature of the UC Berkeley evaluation and the reason personal information was being asked of them; and (c) slowly built trust with caregivers, collecting more information as caregivers and site staff became more acquainted with each other.

Prioritizing data collection and paperwork days. Sites that were caught up on data collection tended to place a high priority on data collection and submission and used various

techniques to mobilize staff. One of the most popular methods was to designate certain days of the week or month as “Paperwork Days.” On these days, all or some of the staff spent the entire day filing out and sending UC Berkeley data collection forms and, at certain sites, these “Paperwork Days” were accompanied by pizza to make the task more enjoyable. Only one of the sites that was behind on data collection employed such a strategy. Though useful, this strategy may be of limited use to sites suffering from severe staff shortages. Of the six sites that were behind in data submission, four also mentioned that they needed an increase in staff and in funding to bring themselves up to date. Thus, a major difference between sites that were caught up and those that were not was the number and availability of staff to submit data to UCB.

Designated staff for data collection. Related to the idea of making data submission a priority, many of the sites with high data completion rates also had one or two people that were primarily responsible for submitting data to UCB. These people fell into two categories; either they were administrative staff who were solely charged with the task of making sure that the lengthy faxes were monitored, or they were supervisory staff that both pushed caseworkers to collect data and reviewed the reliability of the data prior to submission to UCB. Regardless of whether staff members were administrative or supervisory, many sites stated that it was important to designate responsibility for data gathering and monitoring to one or two peers who could encourage and instruct staff. Only one of the six sites that were behind in data collection mentioned this as an effective strategy for catching up with data collection. Again, this could be a result of staffing shortages.

TAG and UC Berkeley database issues. Many sites postulated that challenges and strategies for current and future data collection were directly linked to problems with the old TAG database and with the implementation of a newer case management system. Among sites

that experienced difficulties submitting data (either prior or current difficulties), many linked their problems to the instability and/or complexity of the old TAG database (the original KSSP case management software). Some sites mentioned that the database crashed a lot, others mentioned that it was too difficult to understand and use, and still others mentioned that it took too long to train staff in its use. Sites that were behind in data submission more often had more severe problems with the TAG database, making their transition to the UC Berkeley forms database that much more difficult. Some of the problems with the UC Berkeley data collection procedures included difficulties with fax machines (due to poor quality machines at the sites, limited access to fax machines, and/or the large quantity of pages that had to be faxed), the absence of a viable database with which to track client services, and fatal crashes of the old TAG database resulting in major losses of data. Despite the fact that some sites mentioned that the old database created additional difficulties for staff, almost all sites also felt hopeful that the new Edgewood database would help them manage the competing demands of service provision and data collection, and also felt that data submission would be far easier with the new system.

Organizational factors. Many of the sites expressed that the amount of data that needed to be collected hampered efforts and diminished enthusiasm for data collection, and is likely one of the reasons certain sites fell behind. The large number of caregivers and children being served translated into a great many demographic forms, and keeping up with services tracking for each family was almost impossible to contend with for some sites. Staff at sites with large caseloads that were somehow able to maintain timely data submissions often stated that a primary reason for such success had to do with the ability of the agency to maintain organization in the face of competing demands of staff time.

Staff turnover. One of the most important differences between sites that were caught up and those that were not was the amount of staff turnover experienced during the previous year. Sites that were caught up in data submission experienced few (if any) changes in staff, while sites that were behind in data submission experienced many staff changes. Of the sites that were behind in their data submission, three experienced leadership crises brought on by the resignation, death or illness of a Program Coordinator.

UC Berkeley missing data collection procedures. Despite being a helpful tool, some site coordinators also mentioned that the UCB missing data reports created anxiety and, perhaps, resentment on the part of agency staff. Especially when caseloads were high, coordinators conveyed that staff felt that, despite all of their hard work, the only feedback that they got from UCB were reports of missing data. This discouraged some staff, made data collection feel overwhelming, and may have caused some caseworkers to give up completely. All sites also relayed that they experienced increased activity and demands on their time during holidays and summer periods, and asked that staff at UCB make fewer demands of them during these peak periods.

DISCUSSION

Kinship care is now being recognized as one of the most stable, permanent forms of out-of-home care yet kin often have a set of service needs unique to their familial circumstances (e.g., raising grandchildren as their own) and generally shared demographic characteristics (older, single females with relatively low income levels). The Kinship Support Services Program is one of the few programs in the country offering extensive services to the large number of kinship caregiving families that are formally involved with the child welfare system, and is one of the only programs offering services to the even larger number of kinship caregiving

families that are not formally involved with the child welfare system. This analysis of the KSSP program is also one of the few independent evaluations of kinship services that extends beyond administrative data to provide an unduplicated count of caregivers and children receiving services, individual-level service history, and satisfaction measures. Information gathered thus far offers a fairly detailed view of the characteristics of caregivers and children making use of this program, the types of services they are likely to receive, and their satisfaction with the services rendered.

The demographic characteristics of kinship caregivers receiving KSSP services resemble the characteristics of kinship caregivers formally providing care for children in the child welfare system, indicating that the child welfare target population is being reached. Caregivers tended to be single, female grandparents of color struggling to make ends meet on an income that is often inadequate. The addition of a relative child to the household, while sometimes providing additional funds, may add to caregiver emotional and financial stress. The demographic trend seen in the overall population, namely that the fastest growing family group in poverty is comprised of single, female-headed households, looms large in this subpopulation. The largest single source of referrals to KSSP was from Child Welfare agencies. It seems likely that local Child Welfare agencies are aware of some of the problems faced by kinship caregivers and were using KSSP programs to provide caregiver services that were otherwise unavailable.

Many children had resided with their relative caregivers for extended, continuous periods of time, a large number since birth, again indicating the stability and permanence of these placements. Yet the stresses faced by caregivers were considerable. In addition to a number of caregivers indicating they had their own health challenges and often did not have health insurance, a substantial portion of children appeared to have health, educational, and/or

behavioral concerns. Although the severity of these issues is beyond the scope of this report, these concerns were considered important enough to list on the intake sheets and, presumably, would be part of the service needs addressed during the course of involvement with KSSP. By definition, some of these children have been maltreated, putting them at risk for a myriad of problems as they grow up. More than half of the caregivers in this sample looked after at least two relative children and sometimes resided with other children or adults for whom they provide care. Since a large proportion of caregivers are between the ages of 50-59, they may be faced with providing care to their children, their children's children, and their own parents. Similar to adoptive families, services designed to address the unique challenges faced by these caregivers and children are vital if we are to prevent entry or reentry into the foster care system, maintain permanency, and enhance the quality of out-of-home care for all children, both formal and informal, who live with their relatives.

The number and type of documented services evaluated in this study indicate that KSSP providers are successfully offering kinship caregivers a series of supportive services designed to facilitate their caregiving role and attend to their special needs. Remarkably, over 120,000 discrete services were provided to caregivers during a 16 month period (including aggregate referrals). Even more telling, this number is likely an enormous undercount resulting from high rates of missing data that can at least be partially attributed to the difficulties faced by small, community-based agencies to track, organize, and submit services data. Unless they take drastic steps to incorporate data collection into their daily approach to service provision, agencies find it increasingly difficult to maintain a high level of reporting. Nonetheless, the State's grants-in-aid partnership with counties and community-based providers may be yielding a set of services that

is both greater in scope and more sensitive to community needs than would otherwise be possible.

Caregiver satisfaction with KSSP services was overwhelmingly positive, with almost all caregivers (between 75 and 90 percent) indicating high or very high levels of satisfaction. Questions designed to gauge the extent to which caregivers perceived KSSP services aided them in maintaining their relative children in the home were equally positive, with the vast majority of caregivers indicating that such services improved their ability to care for their relative children. Open-ended response categories offered both testimonials and descriptions of which services caregivers found most helpful. Similar to studies of adoptive parents, support services that allowed kin to interact with people in similar circumstances (e.g., support groups) were seen quite favorably. Staff, recreational activities, information and referrals, and child/respite care were also viewed as important. Caregivers also suggested several improvements, including providing more of the same services, expanded hours, and maintaining the sites on a long-term basis. Still, a smaller number of caregivers expressed some level of dissatisfaction with services, most of which revolved around communication difficulties between site staff and caregivers, staff turnover, and organizational issues.

Limitations

Although this study assumes that the prevention of entry or reentry to foster care over time is likely improved through the provision of high quality services specifically tailored to kinship caregivers and their relative children, this study is not a rigorous evaluation of the effectiveness of these services. Short of random clinical trial or some other design employing a non-equivalent comparison group, the tracking service history, satisfaction with services, and

future reports longitudinally modeling dependency history and reentries for this sample are the best sources of information.

The biggest non-design limitation in this study is the fairly large amount of missing services data. The data collection measures used in this study were designed as a temporary solution to obtain individual-level data in the absence of a viable management information system. Edgewood Center for Children and Families, with evaluation measure input from UC Berkeley, has now developed a preliminary version of a new case management system that promises to be able to track and submit these data to UC Berkeley as time goes on. Although the new system will require staff training and a period of adjustment, it should allow sites to save a considerable amount of time now being spent completing paper forms faxing them to UC Berkeley.

Last, although the satisfaction measure response rate was fairly high (53%), it remains unknown whether the remaining 47 percent would have answered the questions differently. However, given the extremely positive responses contained in the forms that were received, a large number of non-respondents would have to be quite dissatisfied with services to substantially change the findings presented here.

The new case management software

If all goes well with the new Edgewood Center for Children and Families case management system, data collection should become less burdensome for sites. The original evaluation design called for a gradual switch from UC Berkeley paper forms to electronic submissions using the new case management system. Although submission of hardcopy forms to UC Berkeley has been proceeding fairly well, sites are more likely to update and maintain an in-

house system and all of the information would be centralized (i.e., different people providing services to the same family could document services more easily by simply entering it into the computer). The new database is in MS Access, the same program used by the UC Berkeley evaluation team. During their development process, Edgewood received the UC Berkeley evaluation tables and have now integrated these into the new system. Thus, the information coming from the new system will parallel information needed for the evaluation.

With the new case management system, sites will also have the opportunity to use their site-specific information to manage their cases (i.e., track service history, generate mailings, etc.) and use the data to write and obtain grants. This is especially important given the current fiscal crisis in California. In order to continue to provide and expand these key services, sites must generate new funds and must have a data system both to obtain the grants and to provide reports to their funders. UC Berkeley will continue to work with Edgewood Center for Children and Families to implement this new system.

Future directions

Over time, analyses could expand so that individual families could be linked to discrete service events, providing a more detailed view of the type and scope of service utilization, patterns of service utilization, and satisfaction with services. Also, entering cohorts of KSSP recipients could be analyzed for child welfare and probation history, as well as further involvement and/or reentry into the foster care system. The link to administrative-level data, slated for upcoming reports, must be done very carefully since there exists no direct comparison group for recurrence of maltreatment and reentry to foster care. This population consists of caregivers who are, by their very involvement with KSSP, acknowledging a service need. The

population of kinship caregivers, both formal and informal, who do not use this service (where it is available) may be quite different from the KSSP population. Direct comparisons should not be made. Rather, within group comparisons of services used and outcomes found should be employed to guide and improve the program, alerting key stakeholders to the strengths and weaknesses of the services provided and targeting resources as needed.

The KSSP evaluation staff at the UC Berkeley Center for Social Services Research would like to thank the California Department of Social Services for the opportunity to conduct this very important work. The department's commitment to serving children in out-of- home care is made apparent by their investment in the KSSP program, and this commitment is enhanced by their sponsorship of an evaluation study investigating the scope and quality of the program. The commitment of the individual KSSP sites to their clients and to the evaluation has also been tremendous. In addition to the valuable work they perform with kinship caregivers and their children, sites spent valuable time and resources to provide UC Berkeley with data that were not always easily obtained. The endless UC Berkeley requests for missing or corrected data were always met with gracious professionalism, and we thank them for their efforts and expertise. Lastly, we would like to thank the kinship caregivers receiving KSSP services who agreed to participate in this study. The most rewarding part of this evaluative work comes from hearing the voices of kin struggling to meet the needs of their children on a daily basis, and succeeding.

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Appendix I – Kinship Support Services Program

California Department of Social Services, 2001

Background

- The Kinship Support Service Program (KSSP) is aimed at assisting relatives who provide care for their grandchildren and/or relative children when the parents are unable to do so. The goal for KSSP is to assist relatives with the numerous challenges they face when they become the caregivers for their grandchildren and/or relative children. Relatives are often grandparents, in aging or poor health, socially isolated or emotionally unprepared to assume the responsibility for young children, despite how much they love them. The children, often abused or neglected, may have physical or behavioral problems that require professional help as well as the nurturing attention of the relative caregiver.

- The KSSP was established in 1997 with Assembly Bill 1193 (Shelley, Chapter 794, Statutes of 1997; amended WIC Section 16605). This created a grants-in-aid program that allows eligible counties to establish community-based support programs that provide needed services to relatives caring for abused and neglected children and those at risk of becoming dependent children.

- The bill appropriated $1,500,000 for KSSP. Eligible counties could access KSSP funds through a funding application process. Counties were eligible to apply for KSSP funding if at least 40% of the children in foster care in their county were placed in relative care. In September 2000, the Governor signed SB 1946, Chapter 866, Statutes of 2000, to maintain the eligibility of those counties which met the eligibility requirements in January 1998 when the program was established but whose relative placements were reduced by foster care exits.

- The CDSS views the KSSP an essential element for kinship care in general. As of January 2001, 43% of California's foster care population is placed with relative caregivers. CDSS recognizes the value of relative care and the contribution relatives make to providing safe, stable and permanent placements to children within the dependency system. Further, CDSS recognizes that by providing support services to relative caregivers we are diverting first entries and/or returns into the foster care system.

- The Edgewood Center for Children & Families, who founded the kinship care model program, was identified in statute to serve as the State's consultant to provide technical assistance to all eligible counties and their service providers to facilitate effective replication of their program.

- In the 1997 funding cycle, 14 counties were eligible to apply. The eight counties that applied and received funding to establish programs were:

  - Contra Costa (3 sites)
  - Los Angeles (2 sites)
  - Monterey (2 sites)
  - Santa Clara
  - San Diego (6 sites)
  - San Francisco
  - San Mateo (2 sites)
  - Riverside

Current Status

- In September 2000, three more counties applied and received State funding to establish KSSP centers. Thus, in addition to the eight counties named on the reverse, the following counties were funded for KSSP and will have sites opening by May 2001:
  - Alameda (2 sites)
  - Stanislaus
  - San Bernardino (start-up)

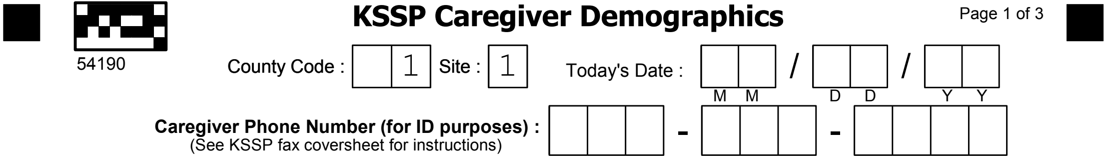
- These KSSP sites provide community based services to relatives caring for abused and neglected children. Services provided to these caregivers and their children include:
  - ♥ respite
  - ♥ support groups
  - ♥ recreation
  - ♥ mental health and legal services
  - ♥ tutoring services
  - ♥ training
  - ♥ transportation
  - ♥ emergency food
  - ♥ housing and clothing assistance
  - ♥ mentoring services
  - ♥ assistance with accessing and negotiating the educational system (understanding children's Individual Education Plans);
  - ♥ linkages to existing resources in the community, including medical, housing
  - ♥ adolescent services including preparation for emancipation

- The KSSP sites must have sufficient space to deliver the required services (noted above) and be located in an area that is easily accessible to the target population. The KSSP sites are to be: in a safe area; zoned for this type of service; and have: access to public transportation and public parking; indoor space for large and small group activities, a welcoming reception area that is comfortable for families and children, kitchen, storage and space for clothes and food closets and library (if possible), outdoor space or access to park/play areas; and they must meet ADA requirements.

- The CDSS estimates that it costs a minimum of $500,000 per county annually to maintain an effective KSSP. The average State-fund allocation is approximately $135,000 per county. This means that the counties and their community-based partners contribute an average of $365,000 in county and community funding to support the KSSP centers in their county. Many counties are utilizing excess Temporary Aid to Needy Families (TANF) dollars to expand their services. (State funding remains at $1.5 million dollars as originally established in 1997.)

- Over the past four years, the 11 participating counties have partnered with 14 different non-profit agencies to develop over 20 KSSP sites currently in operation. During 2000/01 fiscal year, these sites are estimated to served over 5000 children and over 3100 relative families.

Appendix II – Data Collection Instruments



KSSP Caregiver Demographics

54190

Page 1 of 3

County Code : 1 Site : 1 Today's Date : __ __ / __ __ / __ __ (M M / D D / Y Y)

Caregiver Phone Number (for ID purposes) : ___ - ___ - ____
(See KSSP fax coversheet for instructions)

CAREGIVER INFORMATION

☐ **Yes** ☐ **No** **Caregiver consents** to KSSP forms being submitted to California Department of Social Services.

☐ **Yes** ☐ **No** **Caregiver consents** to be contacted by UC Berkeley regarding satisfaction form.

☐ **Yes** ☐ **No** **Caregiver consents** to UCB contacting alternate contact (below), if necessary.

1. Is client
- ☐ Continuing (received Kinship services last month)
- ☐ Returning (absent for 1 or more months)
- ☐ New (never received Kinship services before current month)

\>>

2. If Continuing or Returning, month and year first received services : __ __ / __ __ (M M / Y Y)

3. Caregiver Last Name :

4. Caregiver First Name : **M.I.**

5. Gender : ☐ Female ☐ Male

6. Date of Birth : (If given) __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)

Age : (If no DOB given)

Age Range : (If no DOB or Age provided)

(Ask for age range: If no age range provided, have community worker estimate)

☐ 18-24 ☐ 25-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60-69 ☐ 70-79 ☐ 80-89 ☐ 90+

As provided by Caregiver ☐ **As estimated by Community Worker** ☐

7. Primary Referral Source : (How did you find out about us?) (Choose only one)

- ○ Child Welfare Services
- ○ School
- ○ Clergy
- ○ Other Kinship Caregiver
- ○ Day Care
- ○ Child Advocate/CASA
- ○ TANF/CalWorks/Welfare
- ○ Probation Services
- ○ Counselor/Therapist
- ○ Relative/Family member
- ○ Health Professional
- ○ Neighbor/Friend
- ○ Self
- ○ Other, Specify Category (e.g., CBO, Jail):

CONTACT INFORMATION

8. Current Address

Caregiver Street Number, Street Name (Current Address) : **Apt. / Suite Number :**

City : **State :** **Zip code :**

Caregiver Phone Number : ___ - ___ - ____

9. Alternate Contact

Alternate Contact: Somebody who will know how to contact the caregiver in the event of a move. The Alternate Contact should not be a member of the caregiver's household and should have a different phone number than the caregiver.

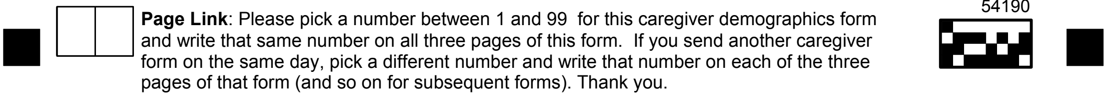
☐ Mr. ☐ Ms. **Alternate Contact Last Name :** **Alternate Contact First Name :** **M.I.**

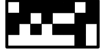
Alternate Phone Number : ___ - ___ - ____

Alternate Contact relationship to Caregiver :
☐ Family ☐ Friend ☐ Neighbor ☐ Service Provider ☐ Other

Page Link: Please pick a number between 1 and 99 for this caregiver demographics form and write that same number on all three pages of this form. If you send another caregiver form on the same day, pick a different number and write that number on each of the three pages of that form (and so on for subsequent forms). Thank you.

54190





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County Code : 1 Site : 1

SOCIOECONOMIC STATUS

10. Current Status : (Choose one that applies)
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow / Widower ☐ Domestic Partner

11. Total Household Monthly Income : (Approx.) $ ___ , ___

Please categorize your sources of income :

☐ Social Security	$ ___ , ___	☐ Foster Care	$ ___ , ___
☐ Wages	$ ___ , ___	☐ SSI Caregiver	$ ___ , ___
☐ KinGap	$ ___ , ___	☐ SSI Child	$ ___ , ___
☐ TANF/CalWorks	$ ___ , ___	☐ AAP (Adoption Assistance Program)	$ ___ , ___
☐ Child Support	$ ___ , ___	☐ Private Pension	$ ___ , ___
		☐ Others	$ ___ , ___

☐ **Caregiver declined** to provide information regarding income.

12. Highest Education Level Completed : (Choose one)
☐ No Formal Education ☐ Elementary/Middle ☐ Some High School ☐ High School Graduate / GED
☐ Some College / Professional / Trade ☐ 4 Year College Degree ☐ Graduate Degree

ETHNICITY and LANGUAGE

13. Ethnicity : (Choose 1 or 2 you most closely identify with)
☐ Black/African-American ☐ Latino/Hispanic ☐ White/Caucasian ☐ Native American
☐ Pacific Islander ☐ Asian ☐ Filipino

☐ Unknown ☐ Other ___

14. What is your primary language?
☐ English ☐ Spanish ☐ Other, Specify: ___

English speaking? ☐ Yes ☐ No

CAREGIVING

15. Has a health concern been identified? ☐ Yes ☐ No

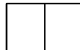
16. Do you have personal health insurance? ☐ Yes ☐ No

17. Why did you originally come to Kinship support services?

___

___

___



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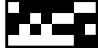

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County Code : 1 Site : 1

Children You Care For

18. How many relative children living with you (21 yrs or younger) do you provide care for ?
(i.e., Those children for whom you will complete child demographics forms.)

19. Do you provide care for any of your own children (21 yrs or younger) living with you? ☐ Yes ☐ No
If YES, how many?

20. Do you provide care for any other children (21 yrs or younger) living with you? ☐ Yes ☐ No
(e.g. non-related foster children)
If YES, how many?

Adults You Care For

21. Do you also provide care for any adults (over age 21) living with you? ☐ Yes ☐ No
(e.g. adults with D.D., health problems, etc.)
If YES, how many?

Adults Who Help With Caregiving

22. Do you receive informal caregiving assistance from anyone (living in your home or living outside your home; e.g., spouse, adult child, other relative, neighbor, friend, etc.)? ☐ Yes ☐ No
If YES, considering all caregiving responsibilities, how many hours/week would you estimate you receive assistance with caregiving?
Total hours /week from all informal sources

Community Worker Information

Please provide information about the person who completed this form :

23. Last Name :

24. First Name :

25. Phone Number : - - Ext.

26. Is this person the caregiver's assigned Community Worker ? ☐ Yes ☐ No **If YES, stop here.**
If NO, does caregiver have an assigned Community Worker? ☐ Yes ☐ No **If NO, stop here.**

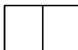
If YES, please provide information about Community Worker :

27. Community Worker Last Name :

28. Community Worker First Name :

29. Community Worker Phone Number : - - Ext.

54190



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56989

KSSP Child/Youth Demographics

(One page per child/youth)

County Code : ____ Site : ____ Today's Date : __ __ / __ __ / __ __
M M D D Y Y

Caregiver Phone Number (for ID purposes) :
(Must match caregiver phone number on KSSP Caregiver Demographics Form) ___ - ___ - ____

1. Child/Youth Last Name : ____ **2. Child/Youth First Name :** ____ **M.I. :** ____

3. Date of Birth: __ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

4. Gender : ☐ Female ☐ Male

5. SSN : ___ - __ - ____

6. Ethnicity: (Choose 1 or 2 you most closely identify with)

☐ Black/African-American ☐ Latino/Hispanic ☐ White/Caucasian ☐ Native American
☐ Pacific Islander ☐ Asian ☐ Filipino

☐ Unknown ☐ Other ____

CHILD/YOUTH's RELATIONSHIP TO CAREGIVER

7. Date this child first came to live with you (relative caregiver) : Month/Year __ __ / __ __ __ __

(If month/year not available) Year : ____ **(If year not available) Please estimate Number of Years ago:** __

8. Has this child lived with you (relative caregiver) continuously since that time? ☐ Yes ☐ No

If NO, a) how long has this child been with you (relative caregiver) THIS TIME? __ **Years** __ **Months**

b) Please estimate the TOTAL number of __ **Years** __ **Months this child has lived with you in her/his life.**

9. Current Legal Status (of this child) **:**

☐ Foster Child - Child Welfare ☐ Guardian (Non KinGAP) ☐ Voluntary (Informal) - TANF
☐ Foster Child - Probation ☐ Guardian (KinGAP) ☐ Voluntary (Informal) - Non-TANF
☐ Adopted By Caregiver

☐ Other, Specify : ____

10. Child's Relationship to Caregiver : ☐ Maternal / ☐ Paternal

☐ Great Grandchild ☐ Grandchild ☐ Niece / Nephew
☐ Cousin ☐ Sibling ☐ Non-related Kin

☐ Other, Specify
(e.g., Step-grandchild, God-child, etc.) : ____

11. Has an educational concern been identified? ☐ Yes ☐ No
12. Has a behavioral concern been identified? ☐ Yes ☐ No
13. Has a health concern been identified? ☐ Yes ☐ No

56989

KSSP Services Tracking Form

60345

County Code : Site : Reporting for : Month / Year

Caregiver Last Name: Caregiver First Name: M.I.

Caregiver Phone Number (for ID purposes)* : - -

Case Closing Date (Month/Year) : /
(If applicable)

Case Managed ? ☐ Yes ☐ No
(If Case Managed for any part of report month, indicate Case Managed)

SERVICE TYPE	CAREGIVER Number of times service provided this month	CHILDREN / YOUTH Total number of times service provided to all relative children in the household this month	# REF (see instructions)
1. Assessment (Intake/Ongoing)	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
2. Child Care (Days)	Not Applicable	1 2 3 4 5 6 7 8 If > 8 Specify	
3. Education Assistance	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
4. Employment Assessment / Counseling	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
5. Financial Aid / Counseling	1 2 3 4 5 6 7 8 If > 8 Specify	Not Applicable	
6. Health Care Assessment / Referral	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
7. Household Needs / Family Necessities	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
8. Housing Assistance	1 2 3 4 5 6 7 8 If > 8 Specify	Not Applicable	
9. Emancipation Services / ILS	Not Applicable	1 2 3 4 5 6 7 8 If > 8 Specify	
10. Transitional Housing	Not Applicable	1 2 3 4 5 6 7 8 If > 8 Specify	
11. Information	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
12. In-Home Supportive Services	1 2 3 4 5 6 7 8 If > 8 Specify	Not Applicable	
13. Legal Services	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
14. Mental Health Assessment / Counseling	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
15. Mentor Services	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
16. Tutorial Services	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
17. Permanency Planning Counseling / Assessment	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
18. Recreation	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
19. Respite	1 2 3 4 5 6 7 8 If > 8 Specify	Not Applicable	
20. Support Groups	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
21. Training (i.e. Caregiver)	1 2 3 4 5 6 7 8 If > 8 Specify	Not Applicable	
22. Translation / Interpretation Services	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	
23. Transportation	1 2 3 4 5 6 7 8 If > 8 Specify	1 2 3 4 5 6 7 8 If > 8 Specify	

* Must match caregiver phone number (for ID purposes) on the caregiver demographics form.

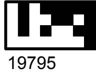
41126

KSSP Referral Tally

County Code : Site : Reporting for: Month / Year

Please use this form to report the number of referrals your site made to each service type. Only include referral-only clients (i.e., those clients without a UCB demographics form). Thank you.

SERVICE TYPE	CAREGIVERS Number of caregivers referred to service this month	CHILDREN / YOUTH Number of children/youth referred to services this month
1. Assessment (Intake/Ongoing)	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
2. Child Care	*Not Applicable*	1 2 3 4 5 If > 5 Specify
3. Education Assistance	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
4. Employment Assessment / Counseling	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
5. Financial Aid / Counseling	1 2 3 4 5 If > 5 Specify	*Not Applicable*
6. Health Care Assessment / Referral	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
7. Household Needs / Family Necessities	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
8. Housing Assistance	1 2 3 4 5 If > 5 Specify	*Not Applicable*
9. Emancipation Services / ILS	*Not Applicable*	1 2 3 4 5 If > 5 Specify
10. Transitional Housing	*Not Applicable*	1 2 3 4 5 If > 5 Specify
11a. Newsletter/Informational Mailing	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
11b. Information	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
12. In-Home Supportive Services	1 2 3 4 5 If > 5 Specify	*Not Applicable*
13. Legal Services	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
14. Mental Health Assessment / Counseling	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
15. Mentor Services	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
16. Tutorial Services	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
17. Permanency Planning Counseling / Assessment	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
18. Recreation	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
19. Respite	1 2 3 4 5 If > 5 Specify	*Not Applicable*
20. Support Groups	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
21. Training (i.e. Caregiver)	1 2 3 4 5 If > 5 Specify	*Not Applicable*
22. Translation / Interpretation Services	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify
23. Transportation	1 2 3 4 5 If > 5 Specify	1 2 3 4 5 If > 5 Specify



19795

KSSP Satisfaction Form

County Code ☐☐ Site ☐ Today's Date ☐☐ / ☐☐ / ☐☐
M M D D Y Y

Introduction: Thank you for taking the time to complete this short survey! We would like to hear your opinions about the kinship support services you've received and whether they are making a difference in your family's life. We hope to **use this information to maintain and improve the program. All information will be kept confidential.**

Your Last Name ______________ Your First Name: ______________ M.I ___

Your Phone Number (for ID purposes) : ___ - ___ - ____

Please grade us on how we're doing by circling the following **:**
A= highest grade possible, F= lowest grade possible.
If a statement does not apply, please mark **"NA" (Not Applicable).**

	A Highest Grade	B High Grade	C Medium Grade	D Low Grade	F Lowest Grade	NA Not Applicable
1. Overall quality of services you received.	A	B	C	D	F	NA
2. How quickly services were provided to you.	A	B	C	D	F	NA
3. The effectiveness of **Kinship Services** in reducing your worries and concerns as a caregiver.	A	B	C	D	F	NA
4. Rate the help you received for your relative child(ren)'s behavior.	A	B	C	D	F	NA
5. Rate the help you received for your relative child(ren)'s educational needs.	A	B	C	D	F	NA

(circle one)

Please tell us whether you **Strongly Agree (SA), Agree (A), Neutral (N), Disagree (D), Strongly Disagree (SD)** with the following statements. If a statement does not apply to you, please mark **Not Applicable (NA).**

	SA Strongly Agree	A Agree	N Neutral	D Disagree	SD Strongly Disagree	NA Not Applicable
6. Overall, **Kinship Services** helped me keep my family together.	SA	A	N	D	SD	NA
7. **Kinship Services** made a positive difference in my life.	SA	A	N	D	SD	NA
8. **Kinship Services** made a positive difference in my relative child(ren)'s life.	SA	A	N	D	SD	NA
9. **Kinship Services** helped me take care of myself.	SA	A	N	D	SD	NA
10. Overall, **Kinship Services** helped me take care of my relative child(ren).	SA	A	N	D	SD	NA
11. If I had the opportunity, I would recommend **Kinship Services** to other caregivers who face similar challenges.	SA	A	N	D	SD	NA

(circle one)

Please Comment : 1) Briefly describe the most helpful part of Kinship Services :

____

____

2) Briefly tell us what we can do to improve :

____

____

Appendix III – Services Provided by Kinship Support Service Programs

Assessment/Intake

Assessment may involve evaluation of the service needs of the relative caregiver and child(ren), the development of a case plan (may be in collaboration with the relative family, the public agency, and/or another CBO). It may also involve monitoring the case plan, progressing toward goals, and providing encouragement and emotional support.

Child care

Child care involves the provision of adult supervision of child(ren) in the relative caregiver's home or at the KSSP site, or provided by a licensed childcare program paid for or subsidized by the KSSP.

Education Assistance

This may involve assisting the relative caregiver(s) with the school system, including accompanying a relative caregiver to parent/teacher conferences, explaining Individual Education Plans (IEPs), counseling on college and/or vocational education, etc. Assisting the relative caregiver and KSSP child(ren) to understand the importance of completion of homework and study habits, and/or sharing successes and problems with tutorial programs (including adult tutorials).

Employment Assessment/Counseling

This may involve assessment of job skills, assistance with the preparation of resumes and for job interviews, counseling to help match skills and available job opportunities, and referring to job placement agencies.

Financial Aid/Counseling

This may include the provision of family financial and budget counseling, information about public benefits (e.g. TANF, AAP, KinGAP, SSI, WIC, Food Stamps), advocacy for relative caregivers when they are applying for or denied public benefits.

Health Care Assessment/Referral

This may include encouraging relative caregivers to make appointments for and/or referral to health care providers for assessments/treatments including mental health for relative caregivers and children; referral to County Health Department Program for health assessments/immunizations for children.

Household Needs/Family Necessities

This may include the provision of durable goods for relative families, including items such as: furniture, kitchen, and other household supplies/equipment, food, clothing, school uniforms and school supplies.

Housing Assistance

This may involve the provision of information on availability and location of affordable/low income housing and assistance with relocation of households.

Emancipation/Independent Living Skills Services

This may include the provision of (or referral for) services to enable high school age youth (both dependent and non-dependent) to achieve self-sufficiency prior to leaving their relative caregiver's home or the foster care support system. Providing ILS/Emancipation assessments, training, services, and a written transitional independent living plan for each participating youth.

Transitional Housing

Transitional housing refers to housing services (usually supervised) provided to youth who are emancipating from foster care.

Information

This may include the provision of oral and/or written information needed by a family member.

In-home Supportive Services

These services are to support the activities of daily living, such as: cooking, cleaning, bathing, dressing, errands, etc. Services are intended to support the relative family when a family member is temporarily unable to perform such activities due to illness or disability.

Legal Services

This may involve assisting the relative caregiver to find appropriate legal counsel for assistance with legal guardianship, adoption, juvenile court, estate planning and other legal issues facing KSSP families.

Mental Health Assessment/Counseling

This may include the provision of mental health assessment of relative caregiver and/or child(ren) by a licensed or licensed-eligible KSSP mental health staff member; and/or individual, family or group counseling by a licensed social worker or family counselor, paid for by KSSP, in areas such as: parent-child relationships and group conflict.

Mentor Services

Tutorial Services

Permanency Planning Counseling/Assessment

This may include discussion with the relative caregiver promoting possible permanency options, such as: reunification with parents, legal guardianship, adoption, and including a change in placement plan in the event of illness or death of relative caregiver.

Recreation Services

This may involve provision of recreational activities for the child(ren) and/or relative caregiver such as: individual or group outings, sports, arts and crafts days, computer projects, etc.

Respite Services

This may involve provision of any services that provides "time off" for the relative caregiver from their child care responsibilities.

Support Group Services

This may include the provision of support through regularly scheduled meetings with other relative caregivers and trained facilitators to discuss feelings, situations, concerns, and shared problems facing relative caregivers.

Training Services

This may include the provision of workshops by qualified personnel for relative caregivers on topics of concern to them, such as: issues regarding at-risk youth, Parenting Skills, health care issues, problem solving within the family, etc.

Translation/Interpretation Services

This may include assistance in the translation of documents and/or interpretation for the relative caregiver and/or child(ren) for whom English is their second language.

Transportation Services

This may include provision of transportation by KSSP staff, or paid for by KSSP, for relative caregivers and/or children to get to medical appointments, recreational and educational activities, center-based programs, relative family emergencies, etc.

Linkages to existing resources & services including:

Medical
Housing
Mental Health
Legal

KSSP creates an essential support system for relatives caring for abused and neglected children, allowing them to provide optimum care. In doing so, relatives can become or remain independent of the child welfare system. It facilitates the most fundamental family philosophy, which is to create systems that support families.

Appendix IV - Questions for KSSP Sites

February 24, 2003

Difficulties and Successes

Hello ______________.

As you know, we here at KSSP are drafting a report to send to the state. We will be reporting on the caregiver and child demographic data that you have been sending as well as the service and satisfaction data that we have been collecting. We will also be reporting on missing data from the sites. As a part of this, we want to include a section that will detail some of the difficulties and successes that sites experienced when trying to collect and send data. To help us draft this portion of the state report, would you mind answering a few questions about the data collection process?

1. Do you feel that at this point, that your site is pretty much caught up in data collection and only needs to send monthly service reports?
    a. If so, when did you reach this point? Was it hard to get caught up with data collection? What strategies did you employ to get to this point? Who was involved?
    b. If not, what is the hardest part about catching up with data collection? Do you think that you will eventually be caught up? What would make data collection easier? Is there anything that we can do on this end to help you?
2. Was there anything that made data collection easy to do? Anything that made it difficult?
3. Were the Monthly Missing Data Reports helpful to your site?
    a. If so, what was most helpful about these reports? What can be improved?
    b. If not, what made the Missing Data Reports unhelpful? What can be improved?
4. If you were asked to give advice to a site that was falling behind, what would you tell them? What are some good ways to get caught up when you are very far behind?
5. Do you feel like the amount of paperwork that we ask you to fill out creates an unbearable burden? Are there too many forms for the amount of time that you have to fill them out?
6. Is the paperwork that we ask you to submit confusing? Is it hard to understand what we asking for?
7. Do you feel like you have an organizational structure at your site that helps with the data submission process?
    a. If so, how are things organized? How does this organization help with data submission?
    b. If not, what are some of the problems? Is there enough staff? Do caseworkers work outside of the agency? Is there anything that we can do to help with these problems?
8. Are there certain times in the year when you feel that the workload becomes overwhelming? What can we do to assist you during these times?
9. Do you feel that there were special circumstances this last year that made data submission especially difficult? Did your site undergo management changes? A change in location? Were the staff at UC Berkeley helpful during these times?

Appendix V – Map of California Kinship Support Centers

Table 1

Total KSSP Caregivers and Children: Oct. 2001 – Jan. 2003			
Site Name	**Caregivers**	**Relative Children**	**TOTAL**
Alameda - North County	69	115	184
Alameda - South County	77	125	202
Contra Costa - West Central County	140	301	441
Contra Costa - Central County	117	222	339
Contra Costa - East County	51	89	140
Monterey - West County	58	106	164
Monterey - East County	240	371	611
Riverside County	95	185	280
San Diego - North Central Region	81	104	185
San Diego - Central Region	158	337	495
San Diego - East Region	196	345	541
San Diego - North Inland Region	66	102	168
San Diego - South Region	150	307	457
San Diego - North Coastal Region	95	168	263
San Francisco County	110	204	314
San Mateo County	111	195	306
Santa Clara County	237	400	637
Stanislaus County	83	165	248
San Bernardino County	35	82	117
TOTAL	2,169	3,923	6,092

Table 2

Caregiver Enrollment Date: Year				
Year	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	329	.	.	.
1990~1995	17	0.9	17	0.9
1996	8	0.4	25	1.4
1997	15	0.8	40	2.2
1998	45	2.4	85	4.6
1999	193	10.5	278	15.1
2000	229	12.4	507	27.6
2001	535	29.1	1,042	56.6
2002	784	42.6	1,826	99.2
2003	14	0.8	1,840	100.0

Table 3

Caregiver Gender				
Gender	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	38	.	.	.
Male	294	13.8	294	13.8
Female	1,837	86.2	2,131	100.0

Table 4

Caregiver Age Range				
Age	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	75	.	.	.
18-24	45	2.2	45	2.2
25-29	64	3.1	109	5.2
30-39	219	10.5	328	15.7
40-49	501	23.9	829	39.6
50-59	710	33.9	1,539	73.5
60-69	414	19.8	1,953	93.3
70-79	127	6.1	2,080	99.3
80-89	14	0.7	2,094	100.0

Table 5

Marital Status				
Marital Status	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Missing	140	.	.	.
Single	470	23.2	470	23.2
Married	858	42.3	1,328	65.5
Divorced	337	16.6	1,665	82.1
Separated	102	5.0	1,767	87.1
Widow/Widower	245	12.1	2,012	99.2
Domestic Partner	17	0.8	2,029	100.0

Table 6

Other Caregiver				
Other Caregiver	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Missing	297	.	.	.
No	1,545	82.5	1,545	82.5
Yes	327	17.5	1,872	100.0

Table 7

Categorized Ethnicity/Race				
Ethnicity/Race	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Missing	88	.	.	.
Asian/Pacific Islander	51	2.5	51	2.5
Black/African American	711	34.2	762	36.6
Latino/Hispanic	581	27.9	1,343	64.5
Multi-Ethnic	58	2.8	1,401	67.3
Native American	19	0.9	1,420	68.2
White/Caucasian	628	30.2	2,048	98.4
Unknown	13	0.6	2,061	99.0
Other	20	1.0	2,081	100.0

Table 8

Primary Language				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Missing	159	.	.	.
English	1,638	81.5	1,638	81.5
Spanish	346	17.2	1,984	98.7
Other	26	1.3	2,010	100.0

Can speak English				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Missing	171	.	.	.
No	171	8.6	171	8.6
Yes	1,827	91.4	1,998	100.0

Table 9

Highest Education Level				
Education level	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	204	.	.	.
No Formal Education	34	1.7	34	1.7
Elementary/Middle	202	10.3	236	12.0
Some High School	323	16.4	559	28.5
High School Graduate/GED	583	29.7	1,142	58.1
Some College/Professional/Trade	644	32.8	1,786	90.9
4 Year College Degree	128	6.5	1,914	97.4
Graduate Degree	51	2.6	1,965	100.0

Table 10

Total Household Monthly Income				
Income	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Missing	410	.	.	.
<$500	64	3.64	64	3.64
$500-$999	298	16.94	362	20.58
$1,000-$1,999	677	38.49	1039	59.07
$2,000-$2,999	361	20.52	1400	79.59
$3,000-$3,999	187	10.63	1587	90.22
$4,000-$4,999	75	4.26	1662	94.49
$5,000-$5,999	43	2.44	1705	96.93
$6,000-$6,999	27	1.53	1732	98.47
$7,000-$7,999	10	0.57	1742	99.03
$8,000-$8,999	10	0.57	1752	99.60
$9,000-$9,999	1	0.06	1753	99.66
$10,000+	6	0.34	1759	100.00

Table 11

Sources of Income		
Source	**Freq**	**Percent**
Social Security	419	21.4
Wages	825	42.0
KinGap	25	1.3
TANF/CalWorks	697	35.5
Child Support	32	1.6
Foster Care	249	12.7
Caregiver SSI	230	11.7
Child SSI	82	4.2
AAP	38	1.9
Private Pension	117	6.0
Others	282	14.4

* Categories are not mutually exclusive

Table 12

Relative Children (Number)				
Children	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	128	.	.	.
1	985	48.3	985	48.3
2	587	28.8	1,572	77.0
3	303	14.9	1,875	91.9
4	136	6.7	2,011	98.5
5+	30	1.5	2,041	100.0

Table 13

Own Children				
Own Child	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	176	.	.	.
No	1,499	75.2	1,499	75.2
Yes	494	24.8	1,993	100.0

Other Children				
Other Child	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	180	.	.	.
No	1,902	95.6	1,902	95.6
Yes	87	4.4	1,989	100.0

Provide care for any adults				
Other Adult	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	180	.	.	.
No	1,867	93.9	1,867	93.9
Yes	122	6.1	1,989	100.0

Table 14

Health Concern?				
Concern	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	125	.	.	.
No	1,282	62.7	1,282	62.7
Yes	762	37.3	2,044	100.0

Health Insurance?				
Insurance	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	176	.	.	.
No	645	32.4	645	32.4
Yes	1,348	67.6	1,993	100.0

Table 15

Referral Source				
Source	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Missing	71	.	.	.
Child Welfare Services	665	31.7	665	31.7
Other Kinship Caregiver	82	3.9	747	35.6
Counselor/Therapist	69	3.3	816	38.9
Self	231	11.0	1,047	49.9
Day Care	22	1.1	1,069	51.0
Other	362	17.3	1,431	68.2
Child Advocate/CASA	17	0.8	1,448	69.0
Relative/Family member	101	4.8	1,549	73.8
School	131	6.2	1,680	80.1
TANF/CalWorks/Welfare	77	3.7	1,757	83.8
Health Professional	99	4.7	1,856	88.5
Clergy	13	0.6	1,869	89.1
Probation Services	9	0.4	1,878	89.5
Neighbor/Friend	220	10.5	2,098	100.0

Table 16

Child Gender				
Gender	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	42	.	.	.
Male	1,900	49.0	1,900	49.0
Female	1,981	51.0	3,881	100.0

Table 17

Categorized: Child Ethnicity/Race				
Child Ethnicity/Race	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	62	.	.	.
Asian/Pacific Islander	67	1.7	67	1.7
Black/African American	1,412	36.6	1,479	38.3
Latino/Hispanic	1,066	27.6	2,545	65.9
Multi-Ethnic	275	7.1	2,820	73.0
Native American	23	0.6	2,843	73.6
White/Caucasian	879	22.8	3,722	96.4
Unknown	49	1.3	3,771	97.7
Other	90	2.3	3,861	100.0

Chart 1

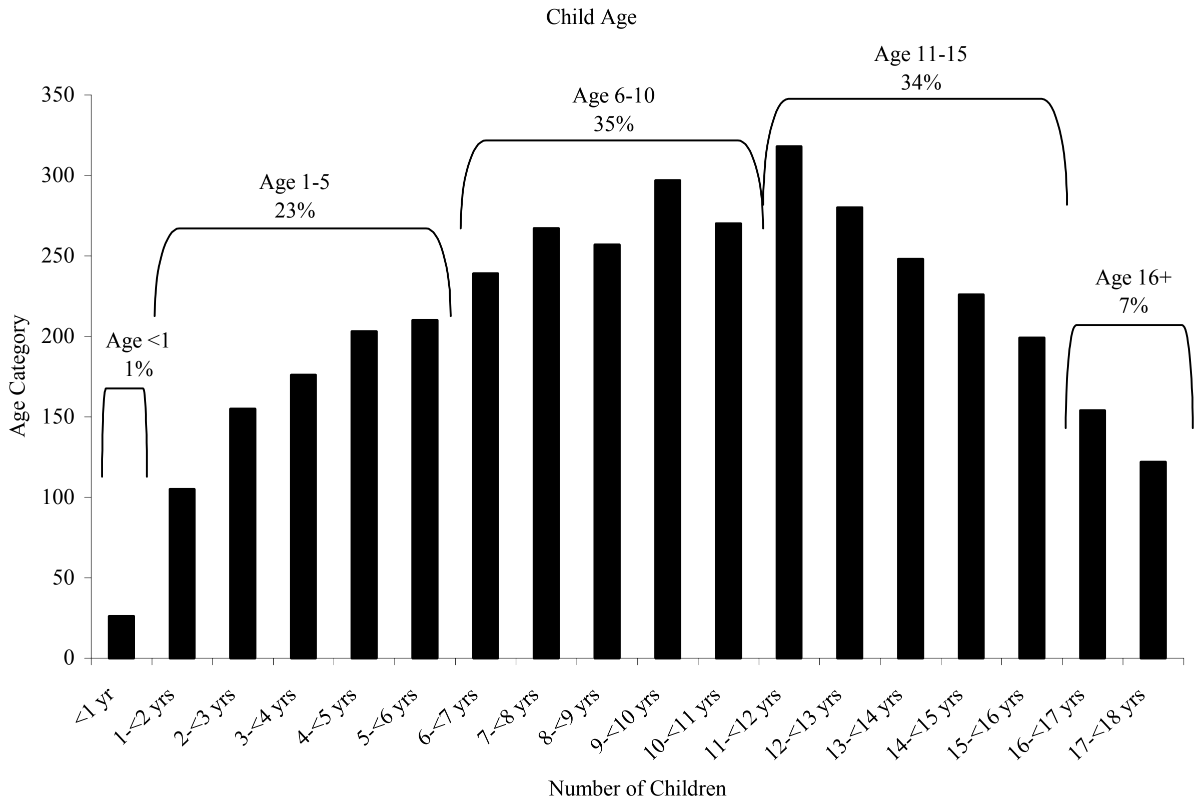


Table 18

Categorized: How long has child been with caregiver this time? (Number of Years)				
Years	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	308	.	.	.
<1	1,150	31.8	1,150	31.8
1-<2	475	13.1	1,625	45.0
2-<3	415	11.5	2,040	56.4
3-<5	472	13.1	2,512	69.5
5 +	1,103	30.5	3,615	100.0

Has child lived with caregiver continuously since that time?				
	Frequency	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	281	.	.	.
No	130	3.6	130	3.6
Yes	3,512	96.4	3,642	100.0

Categorized: Total estimated number of YEARS child has lived with caregiver in her/his life				
Years	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	289	.	.	.
<1	1,122	30.9	1,122	30.9
1-<2	478	13.2	1,600	44.0
2-<3	417	11.5	2,017	55.5
3-<5	473	13.0	2,490	68.5
5 +	1,144	31.5	3,634	100.0

Table 19

Relationship to Caregiver (Maternal or Paternal)				
Lineage	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	250	.	.	.
Maternal	2,686	73.1	2,686	73.1
Paternal	987	26.9	3,673	100.0

Relationship to Caregiver				
Relationship	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	44	.	.	.
Great Grandchild	86	2.2	86	2.2
Grandchild	2,850	72.6	2,936	74.8
Niece/Nephew	737	18.8	3,673	93.6
Cousin	58	1.5	3,731	95.1
Sibling	63	1.6	3,794	96.7
Non-related Kin	21	0.5	3,815	97.2
Other	110	2.8	3,925	100.0

Table 20

Child Legal Status				
Legal Status	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	94	.	.	.
Voluntary (Informal) - TANF	943	24.6	943	24.6
Voluntary (Informal) - Non-TANF	743	19.4	1,686	44.0
Foster Child - Child Welfare	607	15.9	2,293	59.9
Foster Child - Probation	8	0.2	2,301	60.1
Adopted by Caregiver	150	3.9	2,451	64.0
Guardian (KinGAP)	195	5.1	2,646	69.1
Guardian (Non-KinGAP)	999	26.1	3,645	95.2
Other	184	4.8	3,829	100.0

Table 21

Education Concern				
Education	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	123	.	.	.
No	2,767	72.8	2,767	72.8
Yes	1,033	27.2	3,800	100.0

Behavior Concern				
Behavior	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	411	.	.	.
No	2,502	71.2	2,502	71.2
Yes	1,010	28.8	3,512	100.0

Medical Concern				
Medical	**Frequency**	**Percent**	**Cumulative Frequency**	**Cumulative Percent**
Missing	133	.	.	.
No	3,017	79.6	3,017	79.6
Yes	773	20.4	3,790	100.0

Table 22

Number of Services Provided (by Site)

Site Name	CGR	%	Child	%	Refer	%	Overall	%
Alameda – North County	1,306	2.3	597	1.9	0	0.0	1,903	2.1
Alameda – South County	1,032	1.8	652	2.1	111	3.8	1,795	2.0
Contra Costa – West Central County	5,869	10.2	2,864	9.3	334	11.4	9,067	9.9
Contra Costa – Central County	10,369	18.0	7,034	22.7	0	0.0	17,403	19.0
Contra Costa – East County	3,302	5.7	1,616	5.2	26	0.9	4,944	5.4
Monterey – West County	804	1.4	551	1.8	184	6.3	1,539	1.7
Monterey – East County	3,382	5.9	848	2.7	958	32.6	5,188	5.7
Riverside County	2,003	3.5	2,073	6.7	125	4.3	4,201	4.6
San Bernardino County	521	0.9	50	0.2	0	0.0	571	0.6
San Diego – North Central Region	502	0.9	151	0.5	13	0.4	666	0.7
San Diego – Central Region	3,753	6.5	699	2.3	508	17.3	4,960	5.4
San Diego – East Region	4,280	7.4	2,141	6.9	554	18.9	6,975	7.6
San Diego – North Inland Region	780	1.4	412	1.3	2	0.1	1,194	1.3
San Diego – South Region	7,342	12.8	3,950	12.8	1	0.0	11,293	12.4
San Diego – North Coastal Region	1,814	3.2	1,345	4.3	8	0.3	3,167	3.5
San Francisco County	3,475	6.0	4,238	13.7	0	0.0	7,713	8.4
San Mateo County	775	1.3	596	1.9	0	0.0	1,371	1.5
Santa Clara County	5,411	9.4	914	3.0	60	2.0	6,385	7.0
Stanislaus County	807	1.4	192	0.6	51	1.7	1,050	1.1
Total	**57,527**	**100.0**	**30,923**	**100.0**	**2,935**	**100.0**	**91,385**	**100.0**

Table 23

Service History Completeness Report (Caregivers): 10/2001- 01/2003

Received Service Reports (by number expected)

# of Expected Reports	N (# cgrs)	Total # Expected Reports	Total # Received	Total % Received	# Complete Service Histories	% Complete Service Histories
1	30	30	16	53.3	16	53.3
2	37	74	53	71.6	20	54.1
3	66	198	110	55.6	18	27.3
4	85	340	207	60.9	26	30.6
5	83	415	177	42.7	11	13.3
6	95	570	303	53.2	16	16.8
7	105	735	429	58.4	12	11.4
8	90	720	366	50.8	14	15.6
9	100	900	383	42.6	12	12.0
10	116	1,160	590	50.9	15	12.9
11	113	1,243	650	52.3	15	13.3
12	83	996	519	52.1	13	15.7
13	114	1,482	676	45.6	9	7.9
14	164	2,296	915	39.9	2	1.2
15	70	1,050	581	55.3	1	1.4
16	818	13,088	7,943	60.7	0	0.0
Total	**2,169**	**25,297**	**13,918**	**55.0**	**200**	**9.2**

Table 24

SERVICE TRACKING - CAREGIVER

Service	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	TOTAL	%
Expected (N)	1042	1110	1185	1287	1339	1343	1445	1632	1700	1783	1833	1874	1907	1933	1953	1931	25297	
Reported (N)	794	894	982	1042	1082	1004	1092	1055	1112	1063	1063	956	722	526	525	6	13918	
Missing (N)	248	216	203	245	257	339	353	577	588	720	770	918	1185	1407	1428	1925	11379	
Percent Reported	76.2%	80.5%	82.9%	81.0%	80.8%	74.8%	75.6%	64.6%	65.4%	59.6%	58.0%	51.0%	37.9%	27.2%	26.9%	0.3%	55.0%	
CGR Assessment	442	609	656	846	879	747	948	838	739	728	835	646	581	469	465	0	10428	18.1%
CGR Education Assistance	55	62	36	93	62	64	42	77	32	15	139	44	41	30	10	2	804	1.4%
CGR Employment Assessment / Counseling	13	15	17	14	4	8	10	9	5	8	12	4	8	5	2	0	134	0.2%
CGR Financial Aid / Counselling	50	54	45	45	38	62	65	45	66	32	158	27	42	43	6	0	778	1.4%
CGR Health Care Assessment / Referral	70	53	78	131	95	55	54	61	33	40	62	40	53	20	5	0	850	1.5%
CGR Household Needs / Family Necessities	109	193	586	129	123	134	169	107	119	82	178	89	174	197	202	0	2591	4.5%
CGR Housing Assistance	52	59	43	63	57	56	73	43	38	19	19	28	27	18	13	1	609	1.1%
CGR Information	851	1177	1149	1471	1400	1402	1506	1545	1272	1267	1551	1098	977	804	523	3	17996	31.3%
CGR In-Home Supportive Services	89	63	50	52	31	39	65	60	42	44	34	51	45	17	12	0	694	1.2%
CGR Legal Services	107	113	79	131	89	83	90	125	72	86	182	104	85	89	29	0	1464	2.5%
CGR Mental Health Assessment / Counseling	53	47	35	58	56	56	58	58	54	73	98	75	86	29	23	0	859	1.5%
CGR Mentor Services	40	39	27	39	52	11	16	12	32	29	28	19	13	5	1	0	363	0.6%
CGR Tutorial Services	26	5	7	23	8	8	8	10	15	2	9	49	33	0	0	0	203	0.4%
CGR Permanency Planning Counseling	69	78	45	68	52	91	59	87	63	62	140	66	44	15	7	0	946	1.6%
CGR Recreation	232	125	325	69	111	169	170	210	151	168	151	149	138	134	142	0	2444	4.2%
CGR Respite	290	352	355	612	772	425	572	515	445	553	574	423	594	344	181	0	7007	12.2%
CGR Support Groups	359	303	300	397	360	287	258	300	239	236	302	323	275	163	116	0	4218	7.3%
CGR Training	54	64	56	73	87	109	98	134	39	34	61	45	76	63	3	0	996	1.7%
CGR Translation / Interpretation Services	96	170	258	176	114	80	143	140	44	26	248	32	119	192	8	0	1846	3.2%
CGR Transportation	124	111	91	104	92	171	123	377	358	143	147	127	162	99	68	0	2297	4.0%
TOTAL	3181	3692	4238	4594	4482	4057	4527	4753	3858	3647	4928	3439	3573	2736	1816	6	57527	100.0%
%	5.5%	6.4%	7.4%	8.0%	7.8%	7.1%	7.9%	8.3%	6.7%	6.3%	8.6%	6.0%	6.2%	4.8%	3.2%	0.0%	100.0%	

Table 25

Service	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	TOTAL	%
Expected (N)	1042	1110	1185	1287	1339	1343	1445	1632	1700	1783	1833	1874	1907	1933	1953	1931	25297	
Reported (N)	794	894	982	1042	1082	1004	1092	1055	1112	1063	1063	956	722	526	525	6	13918	
Missing (N)	248	216	203	245	257	339	353	577	588	720	770	918	1185	1407	1428	1925	11379	
Percent Reported	76.2%	80.5%	82.9%	81.0%	80.8%	74.8%	75.6%	64.6%	65.4%	59.6%	58.0%	51.0%	37.9%	27.2%	26.9%	0.3%	55.0%	
CHILD Assessment	87	119	71	142	241	150	252	153	197	175	129	147	120	90	69	0	2142	6.9%
CHILD Child Care (Days)	292	324	339	364	499	299	420	337	233	300	280	296	278	281	101	0	4643	15.0%
CHILD Education Assistance	94	152	128	160	150	116	100	132	74	20	74	144	127	179	31	1	1682	5.4%
CHILD Employment Assessment / Counseling	1	7	14	2	4	3	4	0	0	8	3	4	0	1	1	0	52	0.2%
CHILD Health Care Assessment / Referral	9	4	17	10	16	17	11	9	2	3	13	15	26	4	0	0	156	0.5%
CHILD Household Needs / Family Necessities	50	35	457	106	35	55	31	56	30	26	114	26	175	200	262	0	1658	5.4%
CHILD Emancipation Services / ILS	32	51	29	56	80	71	80	65	66	73	39	76	78	9	20	0	825	2.7%
CHILD Transitional Housing	0	0	0	3	1	1	1	0	1	0	0	0	0	0	0	0	7	0.0%
CHILD Information	87	182	79	124	82	207	200	167	93	196	191	164	138	106	83	0	2099	6.8%
CHILD Legal Services	9	17	2	30	6	8	11	13	10	11	36	26	8	2	1	0	190	0.6%
CHILD Mental Health Assessment / Counseling	84	41	43	59	33	48	43	43	41	68	87	74	78	12	4	0	758	2.5%
CHILD Mentor Services	95	138	157	128	190	130	145	187	78	81	95	118	226	184	51	0	2003	6.5%
CHILD Tutorial Services	345	290	239	314	348	289	317	285	116	105	50	451	648	153	197	0	4147	13.4%
CHILD Permanency Planning Counseling	17	18	26	5	13	19	21	33	13	26	46	36	44	5	1	0	323	1.0%
CHILD Recreation	351	211	492	268	279	277	294	264	347	573	610	204	403	233	173	0	4979	16.1%
CHILD Support Groups	102	94	90	58	71	34	40	42	22	23	11	15	70	42	1	0	715	2.3%
CHILD Translation / Interpretation Services	11	59	52	12	0	4	0	4	12	2	8	14	17	24	0	0	219	0.7%
CHILD Transportation	407	162	190	258	273	251	275	508	457	212	175	313	545	163	136	0	4325	14.0%
TOTAL	2073	1904	2425	2099	2321	1979	2245	2298	1792	1902	1961	2123	2981	1688	1131	1	30923	100.0%
%	6.7%	6.2%	7.8%	6.8%	7.5%	6.4%	7.3%	7.4%	5.8%	6.2%	6.3%	6.9%	9.6%	5.5%	3.7%	0.0%	100.0%	

Table 26

SERVICE TRACKING - REFERRAL

Service	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	TOTAL	%
Expected (N)	1042	1110	1185	1287	1339	1343	1445	1632	1700	1783	1833	1874	1907	1933	1953	1931	25297	
Reported (N)	794	894	982	1042	1082	1004	1092	1055	1112	1063	1063	956	722	526	525	6	13918	
Missing (N)	248	216	203	245	257	339	353	577	588	720	770	918	1185	1407	1428	1925	11379	
Percent Reported	76.2%	80.5%	82.9%	81.0%	80.8%	74.8%	75.6%	64.6%	65.4%	59.6%	58.0%	51.0%	37.9%	27.2%	26.9%	0.3%	55.0%	
REF Assessment	1	2	2	102	32	3	11	3	14	0	0	2	4	3	3	0	182	6.2%
REF Child Care (Days)	0	1	2	44	16	3	21	4	16	1	14	1	11	0	1	0	135	4.6%
REF Education Assistance	0	1	1	41	12	0	12	2	13	2	3	1	2	1	1	0	92	3.1%
REF Employment Assessment / Counseling	0	0	2	114	3	0	3	0	0	0	1	1	2	0	0	0	126	4.3%
REF Financial Aid / Counseling	0	2	2	68	0	1	1	3	2	0	11	0	3	0	1	0	94	3.2%
REF Health Care Assessment / Referral	0	1	19	25	9	2	11	2	2	9	0	2	4	0	0	0	86	2.9%
REF Household Needs / Family Necessities	2	10	35	27	15	15	12	12	16	3	14	8	11	4	4	0	188	6.4%
REF Housing Assistance	0	0	5	31	38	3	16	2	4	3	5	1	1	0	1	0	110	3.7%
REF Emancipation Services / ILS	0	0	24	31	77	0	11	0	11	0	11	0	0	0	1	0	166	5.7%
REF Transitional Housing	0	0	2	23	0	0	12	0	0	0	0	11	1	0	0	0	49	1.7%
REF Information	12	23	30	46	45	18	16	17	35	50	7	20	24	6	6	0	355	12.1%
REF In-Home Supportive Services	0	0	1	11	1	2	15	9	3	10	6	5	7	0	0	0	70	2.4%
REF Legal Services	0	2	8	33	10	9	11	11	18	8	9	13	14	11	7	0	164	5.6%
REF Mental Health Assessment / Counseling	3	3	10	33	11	10	18	28	9	17	4	10	16	4	5	0	181	6.2%
REF Mentor Services	0	0	12	33	3	4	14	3	21	0	0	10	12	0	1	0	113	3.9%
REF Tutorial Services	0	27	2	31	36	7	11	8	14	1	1	10	84	10	0	0	242	8.2%
REF Permanency Planning Counseling	0	1	2	13	7	0	0	1	2	1	0	0	3	0	0	0	30	1.0%
REF Recreation	2	4	25	16	15	13	12	22	35	32	8	22	1	0	12	0	219	7.5%
REF Respite	0	2	14	18	3	5	12	3	0	0	1	2	2	0	0	0	62	2.1%
REF Support Groups	0	4	10	30	31	0	11	0	9	7	10	3	8	0	0	0	123	4.2%
REF Training	0	1	4	8	1	1	9	1	13	0	0	0	0	0	0	0	38	1.3%
REF Translation / Interpretation Services	0	0	3	36	0	0	11	0	11	0	11	1	1	0	0	0	74	2.5%
REF Transportation	0	2	11	2	3	2	2	1	0	1	1	0	1	0	10	0	36	1.2%
TOTAL	20	86	226	816	368	98	252	132	248	145	117	123	212	39	53	0	2935	100.0%
%	0.7%	2.9%	7.7%	27.8%	12.5%	3.3%	8.6%	4.5%	8.4%	4.9%	4.0%	4.2%	7.2%	1.3%	1.8%	0.0%	100.0%	

Table 27

Total Number of Referrals by Site			
Site Name	**Caregiver**	**Child**	**Total**
Alameda - North County	0	0	**0**
Alameda - South County	1,083	1	**1,084**
Contra Costa - West Central County	21	9	**30**
Contra Costa - Central County	0	0	**0**
Contra Costa - East County	116	41	**157**
Los Angeles - South Central and Central Regions	1,631	2,299	**3,930**
Los Angeles - East and Southeast Regions	2,950	1,186	**4,136**
Los Angeles - Kinship Care Liaisons (began 11/02)	257	275	**532**
Monterey - West County	0	0	**0**
Monterey - East County	0	0	**0**
Riverside County	1	0	**1**
San Bernadino County	0	0	**0**
San Diego - North Central Region	0	0	**0**
San Diego - Central Region	0	0	**0**
San Diego - East Region	10,688	2,626	**13,314**
San Diego - North Inland Region	2	1	**3**
San Diego - South Region	0	0	**0**
San Diego - North Coastal Region	4	0	**4**
San Francisco County	0	0	**0**
San Mateo County	0	0	**0**
Santa Clara County	2,410	300	**2,710**
Stanislaus County	0	0	**0**
Total	**19,163**	**6,738**	**25,901**

Table 28

Number of Referral by Service Type				
	Caregivers	**Children**	**Total**	**%**
1. Assessment(Intake/Ongoing)	1,511	1,360	**2,871**	11.1
2. Child Care		336	**336**	1.3
3. Education Assistance	127	185	**312**	1.2
4. Employment Assessment/Counseling	68	23	**91**	0.4
5. Financial Aid/Counseling	479		**479**	1.8
6. Health Care Assessment.Referral	226	171	**397**	1.5
7. Household Needs.Family Necessities	608	372	**980**	3.8
8. Housing Assistance	147		**147**	0.6
9. Emancipation Services / ILS		54	**54**	0.2
10. Transitional Housing		13	**13**	0.1
11a. Newsletter/Informational Mailing	6,903	0	**6,903**	26.7
11b. Information	4,133	1,149	**5,282**	20.4
12. In-Home Supportive Services	294		**294**	1.1
13. Legal Services	393	157	**550**	2.1
14. Mental Health Assessment/Counseling	319	211	**530**	2.0
15. Mentor Services	176	169	**345**	1.3
16. Tutorial Services	175	207	**382**	1.5
17. Permanency Planning Counseling / Assessment	554	347	**901**	3.5
18. Recreation	892	1,604	**2,496**	9.6
19. Respite	529		**529**	2.0
20. Support Groups	1,022	167	**1,189**	4.6
21. Training	366		**366**	1.4
22. Translation/Interpretation Services	73	16	**89**	0.3
23. Transportation	168	197	**365**	1.4
TOTAL	**19,163**	**6,738**	**25,901**	100.0

Table 29

Caregiver Satisfaction with KSSP Services

		Highest Grade					
Satisfaction	N	%A	%B	%C	%D	%F	%NA
Overall	803	63.5	24.3	7.1	1.7	0.5	2.9
Speed	801	57.8	24.3	8.0	3.3	0.8	5.9
Worries and Concerns	800	53.9	25.4	8.5	2.1	1.8	8.4
Child behavior	801	37.1	18.7	7.9	1.5	1.8	33.1
Child Education	798	34.6	14.8	8.4	2.0	1.8	38.5
	N	%SA	%A	%N	%D	%SD	%NA
Keep Family Together	798	30.6	35.6	7.3	3.6	1.3	21.7
Positive Difference for CGR	802	39.8	39.5	7.0	3.2	1.3	9.2
Positive Difference for Child	799	37.4	37.7	7.6	4.0	1.0	12.3
Take Care of Self	797	29.1	32.5	9.5	4.6	2.0	22.2
Take Care of Child	798	34.6	39.9	6.8	4.5	1.6	12.7
Recommend to Others	794	64.7	27.7	1.9	1.3	1.1	3.3

Table 30

Briefly describe the most helpful part of Kinship Services:

Categories	Frequency	% Caregivers
Emergency assistance	**14**	**1.9**
Emergency assistance	8	1.1
Support during illness	6	0.8
Other	**230**	**31.5%**
Holiday assistance	16	2.2
Childcare	34	4.7
Quick response	18	2.5
Outreach	0	0.0
Health care assessment/referral	12	1.6
Mentor services	14	1.9
Respite	59	8.1
Training	39	5.3
Transportation	14	1.9
Housing assistance	1	0.1
Case management	9	1.2
Other	14	1.9
Child Care / Respite	**93**	**12.7**
Childcare	34	4.7
Respite	59	8.1
Everything Helpful	**62**	**8.5**
Everything	35	4.8
No service provision/wasn't helpful	27	3.7
Home Support	**58**	**7.9**
Home visits/phone calls	52	7.1
In-home supportive services	6	0.8
Educational Services	**49**	**6.7**
Educational assistance	2	0.3
Tutorial services	34	4.7
Educational assistance for child	13	1.8
Financial / Household Needs	**69**	**9.5**
Financial aid/counseling	23	3.2
Household needs/family necessities	46	6.3
Information and Referrals	**108**	**14.8**
Information	55	7.5
Referrals	53	7.3
Recreation	**112**	**15.3**
Recreation for children	60	8.2
Recreation for families	9	1.2

Recreation	43	5.9
Social Support	**402**	**55.1**
Support group	141	19.3
Acknowledgement and communication	8	1.1
Being with others in similar circumstances	38	5.2
Companionship	7	1.0
Emotional support	13	1.8
Ideas/information from other caregivers	5	0.7
Someone to listen	11	1.5
Someone to talk to	30	4.1
Someone to turn to	137	18.8
Stress relief/helps cope	12	1.6
Permanency Planning	**57**	**7.8**
Adoption	4	0.5
Guardianship	30	4.1
Legal services	23	3.2
Mental Health	**57**	**7.8**
Mental health assessment/counseling	3	0.4
Counseling	33	4.5
Therapy	5	0.7
Group therapy	1	0.1
Family counseling	4	0.5
Family therapy	1	0.1
Child counseling	10	1.4
Child Behavior	**10**	**1.4**
Help with child behavioral problems	8	1.1
Help child's self esteem	2	0.3
Support for children	0	0.0
General Children's Services	**50**	**6.8**
Make children leaders	1	0.1
Good/safe environment for children	6	0.8
Children being around others with similar circumstances	11	1.5
Emancipation services/ILS	4	0.5
Services for children	28	3.8
Staff Support	**129**	**17.7**
Assessment	2	0.3
Direction	11	1.5
Guidance	14	1.9
Staff	102	14.0
Family Unity	**8**	**1.1**
Keeping family together	4	0.5
Family unity	4	0.5
Total Number of Responses to this question	1,508	

Total Number of Responders to this question 730

Note: Because caregivers may have responded more than once, the total of frequencies and percentages will sum to greater than 730 (100%).

Table 31

Briefly tell us what we can do to improve:

Program Enhancement

Categories	Frequency	% Caregivers
Increase Specific Services	**190**	**29.5**
Adoption assistance	3	0.5
Child care	14	2.2
Legal/governmental advocacy	6	0.9
More funding	23	3.6
More meetings for support group	17	2.6
More housing assistance	8	1.2
More legal assistance	11	1.7
More recreational activities	21	3.3
More respite	29	4.5
More transportation	21	3.3
Holiday assistance	1	0.2
Emergency response/assistance	1	0.2
Employment assistance	3	0.5
More medical assistance	2	0.3
More informed guest speakers	19	3.0
More adult services	8	1.2
More counseling	1	0.2
More mentorship	2	0.3
Educational Support	**25**	**3.9**
More educational support	10	1.6
More tutoring/tutorial services	9	1.4
More afterschool activities	6	0.9
In-home Services	**20**	**3.1**
Home visits/phone calls	17	2.6
In-home support/services	3	0.5
Information and Referrals	**39**	**6.1**
Information on services available	20	3.1
Information	10	1.6
More referrals	5	0.8
More research	4	0.6
Training	**18**	**2.8**
More training and workshops	12	1.9
Training for dealing with teens	0	0.0
More mental health workshops	1	0.2
Parenting classes	5	0.8

Agency Growth	**33**	**5.1**
More advertising/outreach	26	4.0
More families/involvement	7	1.1
Services for Children	**19**	**3.0**
Support for teens	11	1.7
Employment assistance for teens	8	1.2
Services for young children	6	0.9
Mentoring for children	2	0.3
Financial / Household Needs	**26**	**4.0**
Financial assistance	21	3.3
More household needs/family necessities	5	0.8
Special Needs Support	**18**	**2.8**
Help with behavior problems	2	0.3
Services for special needs children	4	0.6
Information on special needs children	5	0.8
More mental health services	4	0.6
More counseling for children	3	0.5
More Intense Services	**22**	**3.4**
More individualized services (per family)	9	1.4
More guidance	3	0.5
More one-on-one	4	0.6
More time with children	3	0.5
Closer relationships	3	0.5
No Improvement Needed	**282**	**43.9**
No needed improvement	23	3.6
Great job	86	13.4
Nothing	173	26.9
Program Stability	**34**	**5.3**
Continuity of services	6	0.9
Continuity	28	4.4
Unknown / No Service Provided	**31**	**4.8**
Don't know	21	3.3
No service provision	10	1.6
Total Number of Responses: Program Enhancement	757	72.5
Total Number of Responses to this question	1,044	
Total Number of Responders to this question	**643**	

Note: Because caregivers may have responded more than once, the total of frequencies and percentages will sum to greater than 643 (100%).

Table 32

Briefly tell us what we can do to improve:

Program Improvement

Categories	Frequency	% Caregivers
Various Improvements	**127**	**19.8**
More organization	11	1.7
More services/programs	15	2.3
More staff	28	4.4
Quicker response	13	2.0
Cheaper services	1	0.2
Bilingual services	2	0.3
Other	57	8.9
Improve Specific Services	**19**	**3.0**
Better referrals	2	0.3
Improve childcare	1	0.2
Improve mentorship program	3	0.5
Prolong mental health services	4	0.6
Improve adoption assistance	3	0.5
Improve transportation	2	0.3
Improve tutoring program	2	0.3
Improve recreational activies	2	0.3
Service Times	**32**	**5.0**
Times of services	10	1.6
Time of group meetings	5	0.8
Time of recreational activities	4	0.6
Activities on weekends	10	1.6
More open hours	3	0.5
Access for All	**5**	**0.8**
Activities accessible to all children		0.0
More programs open to children that are not wards of court		0.0
Services should be open to everyone		0.0
Services for all children		0.0
Activities that families can do together	5	0.8
Location / facility	**30**	**4.7**
Accessibility	6	0.9
Location of facility	12	1.9
Locations of group meetings	1	0.2
Location of recreational activities	1	0.2
Offices in more locations	5	0.8
Size of facility	5	0.8

Improve Communication	**63**	**9.8**
Communication with caregivers	7	1.1
Keep in touch	3	0.5
Hard to contact	2	0.3
More caring staff	12	1.9
Return phone calls	6	0.9
Maintain more contact with families	3	0.5
Improve on making people feel welcome	2	0.3
No favoritism	1	0.2
Open-mindedness - don't judge, no prejudice	1	0.2
Reduce staff turnover	14	2.2
Continuity of relationships	12	1.9
Professionalism	**11**	**1.7**
Caseworker involvement	1	0.2
Case management	1	0.2
Review/revise case plans	3	0.5
Follow-up on promises	3	0.5
Follow-up on referrals	3	0.5
Total Number of Responses: Needs Improvement	287	27.5
Total Number of Responses to this question	1,044	
Total Number of Responders to this question	**643**	

Note: Because caregivers may have responded more than once, the total of frequencies and percentages will sum to greater than 643 (100%).