



## Kinship Support Network Intervention Study

By

Institute for the Study of Community-Based Services: Don Cohon, Lisa Hines, Wendy Packman, and Elizabeth Siggins (Edgewood Center for Children and Families), October 1999

### TABLE OF CONTENTS

<b>I. INTRODUCTION .....</b>	<b>5</b>
A. PROGRAM HISTORY .....	5
B. THE RESEARCH INSTITUTE.....	5
C. THE PROBLEM.....	5
1. <i>Child Outcomes</i>	
2. <i>Social Service Privatization</i>	
D. INTERVENTION .....	6
1. <i>KSN Service Intervention</i>	
2. <i>DHS Service Intervention</i>	
<b>II. STUDY OBJECTIVE .....</b>	<b>7</b>
<b>III. STUDY POPULATION .....</b>	<b>8</b>
A. THE URBAN CONTEXT .....	8
<b>IV. STUDY DESIGN AND METHODS .....</b>	<b>9</b>
A. OUTCOME MEASUREMENT .....	9
B. OUTCOMES AND HYPOTHESES .....	9
C. RESEARCH DESIGN.....	10
D. SCHEDULE OF MEASUREMENT.....	10
E. DURATION OF THE STUDY.....	10

<b>V. MEASUREMENTS .....</b>	<b>11</b>
A. CAREGIVER MEASURES .....	11
B. CHILD SELF-REPORT MEASURES .....	11
C. OTHER COVARIATES/VARIABLES .....	12
D. CASE RECORD REVIEW .....	12
<b>VI. STUDY PROCEDURES.....</b>	<b>13</b>
A. NUMBER OF SUBJECTS .....	13
B. SELECTION CRITERIA.....	13
C. REFERRAL PROCESS.....	15
D. RANDOMIZATION .....	16
E. INTERVIEW PROCEDURE .....	18
F. CASE RECORD REVIEW PROCEDURE .....	20
<b>VII..... DATA MANAGEMENT</b>	<b>21</b>
A. DATA EDITING AND DATA REDUCTION .....	21
B. DATA SOURCES .....	21
<b>VIII..... STATISTICAL ANALYSIS</b>	<b>22</b>
<b>IX. OBLIGATIONS OF THE INVESTIGATOR .....</b>	<b>22</b>
A. INSTITUTIONAL REVIEW BOARD (IRB).....	22
B. INFORMED CONSENT AND ASSENT .....	22
C. CONFIDENTIALITY.....	23
D. RETENTION OF DATA .....	23
E. WITHDRAWAL OF SUBJECTS .....	23
<b>X. ASSESSMENT TECHNIQUES .....</b>	<b>23</b>
A. THE INTERVIEW .....	23
1. <i>Scheduling the Interview</i>	
2. <i>Introductory Comments for the Interview</i>	
3. <i>Provisions for Youth and Caregivers Experiencing Problems</i>	
B. ADMINISTRATION OF QUESTIONS FOR CAREGIVERS .....	25
1. <i>General Considerations</i>	
2. <i>Order of Presentation of Materials</i>	
3. <i>Introductory Comments for the Caregiver</i>	
C. ADMINISTRATION OF QUESTIONS FOR CHILDREN .....	28
1. <i>General Considerations:</i>	
2. <i>Order of Presentation of Materials</i>	
3. <i>Introductory Comments for the Child</i>	
<b>XI. REFERENCES.....</b>	<b>33</b>
<b>XII..... APPENDICES</b>	<b>38</b>

**APPENDICES**

## A. Study Forms

- Evaluation Protocol
- Informed Consent
- Informed Assent
- Request for Signed Minute Order
- Minute Order for Consent to Receive Services

## B. Protocol: Administration of Measures

## 1. Caregiver Measures

- Questions for caregivers (eight questions about family background)
- Perceived Self-Efficacy and Grandparenting Scale: six-item subscale (King and Elder, 1998)
- Parent Self-Efficacy Scale: twelve-item subscale (Bandura et al., 1996)
- Child Health Questionnaire PF-50 (Landgraf, 1996)
- Child Behavior Checklist 4/18 (Achenbach, 1991)

## 2. Child Self-Report Measures

- Child's Perceived Self-Efficacy Scale : 37-item subscale (Bandura, Barbaranelli, Caprara and Pastorelli, 1996)
- Child Quality of Life (Andelman, 1999)
- My Exposure to Violence (My ETV) (Buka, Selner-O'Hagan, Kindlon, & Earls, 1997)

## C. Sample Study Forms

- Interview Log
- Case Record Review Form
- System for Quantifying Child Protective Service Records Subtype Definitions and Severity Scales (Barnett, Manly, & Cicchetti, 1993)

## SYNOPSIS

- Title:** Kinship Support Network Intervention Study.
- Objectives:** The objective of the David and Lucile Packard/California Endowment Project is to compare outcomes for four groups of children and youth, two of them receiving private contract services from Edgewood's Kinship Support Network (KSN), and two receiving services from the public sector. In addition to the children, kin caregivers and primary caregiving foster parents will also be interviewed.
- Study Design:** Pretest-posttest, nonequivalent group design with one between subjects factor, and a within subjects factor with three levels.
- Comparison Groups:** KSN case-managed children will be compared to KSN non-case managed children, DHS case-managed children in kinship homes, and DHS case-managed children in foster homes.
- Duration of Participation:** Accrual will take place over a three-year period. Participation in the study will require assessing each participant at baseline and twice more. Each interview will take approximately one and one-half hours.
- Subjects:** Children between the ages of 7 and 14.
- Statistical Analysis:** For continuous variables measured at each time point, the method of analysis is doubly multivariate repeated measures analysis of variance. Dichotomous variables will be analyzed using chi-square methods.

## **I. INTRODUCTION**

### **A. Program History**

Edgewood Center for Children and Families has been serving the Bay Area's most at-risk children for 147 years. Originally a refuge for orphans of the Gold Rush era, Edgewood has evolved into a nonprofit residential and day treatment facility for severely emotionally disturbed and learning disabled children, ages five to fourteen, most of whom have been abused or neglected. The agency has longstanding collaborative linkages with San Francisco's public sector, including the Department of Human Services (DHS), Youth Guidance Center (YGC), San Francisco Unified School District (SFUSD) and Community Mental Health Services (CMHS). In the late 1980's, Edgewood developed a broad range of community outreach programs such as the Kinship Support Network (KSN) to prevent at-risk children from needing our most intensive services.

### **B. The Research Institute**

The Institute for the Study of Community-Based Services (Institute) is the research arm of Edgewood. The goal of the Institute is to make use of Edgewood's numerous clinical settings to conduct evaluative research of program effects and provide useful data to the Edgewood program staff and a variety of audiences including families, community leaders, professionals, policy makers, and administrators.

### **C. The Problem**

Slightly more than one million children were identified as victims of substantiated abuse or neglect in 1997 (Wang & Daro 1998; U. S. Department of Health & Human Services [DHHS] 1998). National studies show increases in the incidence of substantiated child maltreatment in the past decade (Sedlak & Broadhurst 1996; Barth 1996). The General Accounting Office reports that this increase, as well as the greater service needs of these children, has led to a crisis in the nation's child welfare system (US/GAO 1995). One way the system has adapted to this crisis is by placing more children with relatives, particularly grandparents in the African-American community (Wilson & Chipungu 1996; Berrick, Barth & Needell 1994; Dubowitz, Feigelman & Zuravin 1993; Minkler, Roe & Price 1992). In California, two-thirds of the foster care growth from 1984 to 1992 is accounted for by the rise in kinship care (Barth, Courtney, Berrick & Albert 1994). California's Department of Social Services Foster Care Information System reports that, as of August 1998, 46 percent of children in the foster care system statewide reside in relative placements (California Department of Social Services [CDSS] 1998).

## **1. Child Outcomes**

As the number of kinship placements in the foster care population continues to grow, many unanswered questions warrant investigation. The early-to-mid 1990s has seen increasing research on grandparent caregivers, but more effort needs to focus on the children in these relative placements (Fuller-Thomson, Minkler & Driver 1997). One recent study of kinship care provides basic demographics of caregivers and includes children as well as their service needs (McLean & Thomas 1996). Other studies have examined outcomes for children with regard to their permanency status (Link 1996), health care and health needs (Feigelman, Zuravin, Dubowitz, Harrington, Starr & Tepper 1997), or looked at the adult functioning of children who lived in kin versus non-relative family foster homes (Benedict, Zuravin & Stallings 1996). A recent study comparing quality of care in kinship and foster family homes found little difference between them, but noted areas for improving emergency procedures and providing first aid materials and fire extinguishers to the kin homes (Berrick 1997). Several investigators have indicated a need for further research of children in kinship placements (Fuller-Thomson, Minkler & Driver 1997; Wilson & Chipungu 1996; Berrick, 1997; Berrick et al.1994; Minkler et al. 1992).

## **2. Social Service Privatization**

The recent implementation of Welfare Reform has challenged policymakers to create programs that cut costs and address new service demands imposed by the kinship placement phenomenon (Gleeson 1996). States and localities contract out social services for a variety of reasons, but these decisions are based primarily on the belief that higher quality services can be delivered more cost-effectively by private providers. "Privatization is commonly defined as any process aimed at shifting functions and responsibilities, in whole or in part, from the government to the private sector" (U.S. General Accounting Office [GAO] 1997a). The GAO (1997b) cites results from a Child Welfare League of America survey that found thirty-one states planning or already implementing managed care approaches in the management and delivery of child welfare services. This transition is likely to continue, as Congress has shown greater interest in privatizing social services programs, even though there have been few empirical studies comparing the quality of publicly and privately provided services (GAO 1997b).

## **D. Intervention**

### **1. KSN Service Intervention**

The KSN case-managed and non case-managed programs and service components have been described in detail (Cohon & Cooper, 1999). Clients receiving case-managed services are assigned a Community Worker (CW), receive a thorough assessment of their needs, a

written case plan, direct intervention including monthly home visits (at minimum), weekly phone contact and collateral visits.

In comparison, the non-case-managed program does not assign a CW to clients nor does the program offer direct services or home visits. Participation in either program gives families access to the same variety of caregiver self-help support groups, recreation and respite activities, training workshops, tutoring/mentoring, health support, and transportation services. To ensure treatment fidelity the KSN case files for all study participants are reviewed and the frequency and type of services provided (e.g. direct home, direct office, ancillary with medical, ancillary with school, ancillary with specified other, direct telephone, ancillary telephone with specified other) are noted. Past and concurrent interventions from other service providers are also recorded.

## **2. DHS Service Intervention**

The California Manual of Policies and Procedures, State of California Health & Welfare Agency Department of Social Services specifies child welfare services in Division 31, Chapters 31-000 through 31-500 (CDSS 1993). This manual provides detailed requirements to public agency Child Welfare Workers (CWW) for minimum services to families. CDSS has historically questioned San Francisco DHS's compliance with minimum standards. Rather than assuming compliance with these regulations, we will review the DHS case files of study participants, noting the frequency and type of services provided.

## **II. STUDY OBJECTIVE**

The David and Lucile Packard/California Endowment Project addresses two important public policy areas. First, it examines selected outcomes for children placed in kinship homes. We are comparing outcomes (e.g., health status, permanency) for four groups of children and youth, two of them receiving private contract services from Edgewood's Kinship Support Network (KSN), and two receiving services from the public sector. Second, it evaluates the trend towards privatizing the delivery of social services, comparing the quality of publicly and privately provided services and their effects on children.

We intend to use the findings of this study to educate policy makers and practitioners. We expect to inform stakeholders regarding the effects of a community-based intervention from a private, non-profit organization on children living in kinship placements in comparison with the effects on children receiving a public sector intervention.

### III. STUDY POPULATION

#### A. The Urban Context

The population is drawn from two sources: Kinship families referred to the KSN program and DHS kinship families and foster families not referred to KSN. KSN and DHS both serve the same groups of San Francisco City/County families. The average age for children in both programs is nine; their gender is evenly divided, and African Americans make up the majority of cases (KSN children are 87 percent and DHS are 72 percent African American). KSN and DHS families reside in the following neighborhoods.

The Bayview Hunters Point (94124) is a predominantly African-American neighborhood with 27,239 residents. There is a large concentration of youths in the neighborhood with almost 30 percent (7,924) of the population under the age of eighteen. There are many health needs in the Bayview area with 18 percent (107) of total births being to adolescents and 12 percent (72) of live births reported as low birth weight. A significant number of these infants are drug-exposed and reside with kin families.

Visitacion Valley/Portola (94134) is home to 34,635 residents with almost 26 percent (9,049) being under age eighteen. Over 24 percent of these youth live below the poverty line. This neighborhood is also predominantly African American .

The Western Addition (94115) has 28,859 residents and 11% of them are children under 18. This area is ethnically diverse with significant populations of African Americans, Asian Americans, Latinos and Whites. A significant number of residents in this neighborhood (12% -17%), and 27.6% of children under 18, live below the poverty line.

The Inner Mission (94110) is the most populated neighborhood in San Francisco with 70,770 residents, primarily Latino, with over 20 percent (15,213) of the community being youth under the age of eighteen. There is a high adolescent birth rate with 11 percent (147) of the total births.

South of Market (94103) is the location of Edgewood's Family Center and the KSN project. This is a poor neighborhood with a median household income of \$18,114 and 30 percent of the children under eighteen living below the poverty line (San Francisco Mayor's Office of Children Youth and Families [MOCYF] 1998).

## IV. STUDY DESIGN AND METHODS

### A. Outcome Measurement

The study will yield information comparing privately and publicly delivered child welfare services. These are defined as: 1) Child Outcomes: Health and mental health, behavioral functioning, perceived self-efficacy, school attendance and performance, and life satisfaction; and 2) Service Outcomes: Child protection (e.g. safety, including exposure to maltreatment) and permanence as demonstrated by placement stability, reunification, adoption and legal guardianship (Berrick 1998; Testa 1997; Gleeson, O'Donnell & Bonecutter 1997).

### B. Outcomes and Hypotheses

The study examines the following outcomes:

1. Number of children reunified with biological parent(s);
2. Number of family members' choosing adoption or legal guardianship;
3. Number of children who experience recidivism (e.g. movement of children from relative placements back into foster care system) and the reasons for recidivism (e.g. maltreatment);
4. Number of and reasons for placement disruptions, not including recidivism (e.g. other relative placement);
5. Number of and reasons for use of more restrictive placements;
6. Number of referrals for out-of-county placements;
7. Status change to the juvenile justice system (e.g. from W&I 300 to W&I 600) and type and frequency of juvenile offenses committed;
8. Length of stay in placement before achieving permanence;
9. Child health and mental health status as measured by the Child Health Questionnaire-PF50 (Landgraf et al 1996);
10. Child behavioral functioning as measured by the Child Behavior Checklist 4/18 (Achenbach 1993);
11. Child school attendance and behavioral performance (e.g. suspensions, expulsions);
12. Child perceived self-efficacy in domains of academic, social and self-regulatory efficacy measured with a 37 item scale developed by Bandura, Barbaranelli, Caprara, and Pastorelli (1996); and
13. Child life satisfaction using a scale developed by Andelman specifically for foster children.

Hypotheses: Our primary hypothesis is that children receiving the private agency KSN case-managed intervention will do better than children in the three other study groups.

- We expect them to be better in the areas of health and mental health (CHQ-PF50).

- We expect them to show better behavioral functioning than children in all other groups (CBCL 4/18).
- We expect them to show higher perceptions of self-efficacy in three domains: academic, social and self-regulatory (37-item efficacy scale).
- We expect them to show better school attendance and behavioral performance than children in all other groups as measured by data extracted from review of school records.

We will also examine individual variables for these children, comparing the children on the following outcomes:

- We expect KSN case-managed children to experience fewer instances of replacement into regular foster care as measured by data extracted from case files.
- We expect them to experience fewer other placement disruptions as measured by data extracted from case files.
- We expect them to have lower rates of juvenile delinquency after beginning the program than children in all other groups as measured by data extracted from case files.

### **C. Research Design**

The quasi-experimental design that best describes the study is the pretest-posttest, nonequivalent group design (Campbell & Stanley 1966). There is one between subjects factor, and a within subjects factor, which is time, with three levels. The between subjects factor is intervention type with four levels:

KSN case-managed kinship care;  
 KSN non-case-managed kinship care;  
 DHS case-managed kinship care; and  
 DHS case-managed foster care.

### **D. Schedule of Measurement**

An assessment of each participant in the KSN group is conducted when they enter the KSN program (Baseline) and twice more. The second assessment (T2) will occur either at graduation/closing or the nine-month anniversary of enrollment into KSN. The time-three data point (T3) will occur at fifteen months after the time-one baseline assessment.

Time 1/Baseline	Time 2/Follow-up	Time 3/Follow-up
Enrollment In KSN	Graduation/Closing, or 9 Months	15 Months

### **E. Duration of the Study**

It is anticipated that subject accrual will take place over a 3-year period.

## V. MEASUREMENTS

### A. Caregiver Measures

**Child Health Questionnaire-PF50** (CHQ-PF50) (Landgraf et al 1996) is appropriate for children ages 5 to 18 and will be completed by caregivers. The CHQ-PF50 is a multi-item scale measuring the primary caregiver's perceptions of the following child health concepts: 1) Physical Functioning; 2) Bodily Pain; 3) Role/Social limitations-Physical; 4) General Health Perceptions; 5) Role/Social-Emotional; 6) Role/Social-Behavioral; 7) Mental Health; 8) General Health, and 9) Self-Esteem. The measure includes four additional scales. The Emotional Impact and Time Impact scales measure the burden of the child's health on the caregiver; and, The Family Activities and Family Cohesion scales measure the impact of the child's health on family activities and the degree of a family's "getting along".

**Child Behavior Checklist/4-18** (CBCL)(Achenbach, 1991) is appropriate for children ages 4-18 and will be completed by caregivers. The caregiver-completed CBCL is a widely employed measure for assessing children's behavioral and social competencies. The CBCL uses caregiver reports and yields scores for three broadband scales (Social Competence, Internalizing, Externalizing) and a total behavior problem score (total problems). The measure also yields eight narrow-band scores: Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior and Aggressive Behavior.

### B. Child Self-Report Measures

**Child's Perceived Self-efficacy** (Bandura, Barbaranelli, Caprara and Pastorelli, 1996) This 37-item scale represents seven domains of functioning of which we will examine three principal factors. The three factors of interest in this study include: 1) perceived academic self-efficacy; 2) perceived social self-efficacy; and, 3) perceived self-regulatory efficacy. Reliability of these three factors is acceptable, reported as .87 for academic self-efficacy, .75 for social self-efficacy and .80 for self-regulatory efficacy (Bandura et al 1996).

**Child quality of life (QOL)**(Andelman, 1999). We are collaborating with Dr. Ross Andelman of the University of California, San Francisco to develop an empirically derived life satisfaction measure for foster children. Dr. Andelman has conducted separate kin caregiver and child focus groups to derive items relevant to a foster care population.

**My Exposure to Violence** (My ETV) (Buka, Selner-O'Hagan, Kindlon, & Earls, 1997). My ETV has been used with a longitudinal study called the Project on Human Development in Chicago Neighborhoods. The instrument was developed to try to gauge the types of violence to which children and their caregivers may have been exposed, that is, violence that they, themselves, may have experienced or have seen, in real life. The questions all relate to specific types of verbal and physical violence. For each type of violence, it asks if the youth

has ever been exposed at any point in her/his lifetime. It also asks about age of first exposure, number of times of exposure of violence over the last 12 months, frequency and location of exposure, and questions about identity of the victim and perpetrator. In the Packard Project we will use the child self-report version of this measure.

### **C. Other Covariates/Variables**

We will collect and investigate other areas as potential influences on outcome measures:

1. **Perceived Self-Efficacy and Grandparenting Scale** as measured by a six-item subscale (King and Elder, 1998).
2. **Parent Self-Efficacy Scale** (caregiver academic efficacy) as measured by a twelve-item subscale selected from the multidimensional scales of perceived parenting efficacy and used by Bandura et al. (1996).
3. **Child abuse/neglect.** Child abuse/neglect as scored using Barnett, Manly, & Cicchetti's (1993) system for quantifying child protective service records based on data extracted from case files with the Case Record Review.
4. **Frequency of Contact.** Child frequency of contact with biological parent(s) as measured by contacts reported in case files using Case Record Review and interviews with kin and foster caregivers.
5. **School Functioning.** Child school attendance and behavioral performance (e.g. suspensions, expulsions); Review of school records and consultation with the truancy office at San Francisco Unified School District.
6. **Caregiver Educational Level.** Kin or foster home SES and primary caregiver educational level obtained by caregiver interview, zip code/census tract and review of case files.

### **D. Case Record Review**

For extracting data from case files, we will use the KSN Case Record Review, based upon a structured form specifically designed to extract information from child welfare files (Fanshel, Finch, and Gundy, 1990). This form allows Institute staff to systematically record information about abuse and neglect history, frequency and reasons for court appearances, rates of recidivism or replacement, use of more restrictive placements, length of stay in placement, frequency of agency-monitored child's contacts with biological parents; status change to juvenile delinquency, out-of-county placement, and use of adoption or legal guardianship to achieve permanence. We will also collect information for enrollment in special education programs, in other human service programs (e.g., mental health, specialty medical clinics, community clubs, etc.), and of contacts with the juvenile justice system. This

will allow us to examine the effects of these other interventions and influences by themselves on our outcome measures, as well as allow us to examine them for confounding (interactive) effects with KSN placement.

## VI. STUDY PROCEDURES

### A. Number of Subjects

*Study Sample Groups:* The comparison of outcomes for four groups of children and youth will be made. Two of the groups receiving private contract services KSN, and two receiving services from the public sector. The two private sector groups are 1) KSN children in kinship placements receiving the KSN case-managed intervention and 2) a second group of KSN children receiving the non-case-managed intervention (supportive services only). The two public sector sample groups are 1) DHS children in kinship placements NOT receiving the KSN intervention, but receiving DHS case management services, and 2) DHS children in typical foster family home placements, also receiving DHS case management. In addition to the children, we will also interview their kin caregivers or foster parents.

These groups are as follows:

GROUP	COMPOSITION	ESTIMATED SAMPLE N
Group 1	KSN case-managed children	N = 70-80
Group 2	KSN non-case-managed children	N = 60-70
Group 3	DHS case-managed children in kinship homes	N = 70-80
Group 4	DHS case-managed children in foster homes	N = 70-80

### B. Selection Criteria

#### 1. Inclusion Criteria

Subjects eligible for this study:

- a) Children ages seven through fourteen at the time of interview
- b) Children and caregiver speak English fluently
- c) San Francisco resident
- d) Length of time in program
  - KSN: KSN client must be new to the program or for the non-case managed group clients who have been most recently assigned to that program

- DHS: No minimum length of time is required for receiving services from DHS

## 2. Exclusion Criteria

Subjects excluded from this study:

- a) Duplicated cases (receive both case-managed and non-case managed service interventions)
- b) Former clients of the KSN program
- c) Children who are identified with a disability (e.g. hearing impaired, severely developmentally disabled).

All new referrals to the KSN program will be recruited to obtain the samples for the research between July 1, 1999 and October 30, 2000. The annual referral rate of kin families to KSN has fluctuated, with an average rate of eighty-one referrals yearly for case-managed services. Annual referral rates for non case-managed services average forty-seven. Eighteen percent of all KSN referrals are duplicated cases, and receive both case-managed and non-case-managed service interventions at different times. We will not include these duplicated cases in the study sample. To calculate an accurate sample size we estimate a 20 percent duplication rate for all KSN referrals.

With expectable non-participation and attrition, we anticipate approximately one year and a half to recruit a sample group of seventy to eighty non-duplicated KSN case-managed, sixty to seventy non-case-managed families, seventy to eighty case managed DHS children living with relatives and children living in foster care. We also anticipate that if we are unable to recruit a sufficient sample size within this time period we will extend the recruitment period six months to fill the sample. We began enrolling the study children in July, 1999.

Because the median age for the 725 KSN children served between 1993 and March 1998 is nine (Cohon & Cooper, 1999) and because there has been little research on latency-aged children in the foster care system, we plan to limit our sample to children ages seven to fourteen. To insure statistical independence between children in the samples, only a single child in the seven to fourteen age range will be chosen at random as the focus child from each family.

The median length of service time for 340 KSN cases seen between 1993 and March 1998 was 14 months (Cohon & Cooper, 1999). Because of this, we believe that a minimum of 75 percent of KSN children who meet our age criteria will be active cases for longer than nine months. We will check on the effect of graduation/closing that occurs before nine months by reanalyzing the data without these cases. We will make efforts to enroll the DHS, public-sector comparison groups so that we collect DHS data at similar times. Research staff will maintain contact by telephone and mail with children in these groups.

### C. Referral Process

The sample for the private sector groups (KSN case-managed clients and non-case managed clients) is obtained from the new referrals to the KSN program and the sample for the public sector groups (DHS kinship families and foster families) is identified from a list of DHS clients. The DHS list is comprehensive and contains the names of all clients receiving services from the department including current Kinship Support Network clients. The process for identifying participants for the study is as follows:

*Kinship Support Network case-managed and non-case managed referrals:*

The Kinship Program Assistant (KPA) enters the data for all new intakes received from the intake workers. Immediately following the data entry of the information into the database the KPA informs the RA of the new intake. Once a week the Research Associate (RA) obtains this intake information from the KPA.

The KPA generates a client and child face sheet from the database for each new case and a copy is given to the RA. When the RA receives the copy of the face sheets this indicates that the new intake has been assigned to the *case-managed* program of the Kinship Support Network.

At the beginning of each month the RA is also given a list of all new clients who entered the program in the previous month. This list is entitled “Cases that became open in Period” and is generated by the KPA. The RA identifies clients who have been assigned to the *non-case managed* program from this monthly list. To identify clients who are assigned to the *non-case managed* program the RA reviews the list for client’s who do not have an assigned community worker. Because of the low number of non case-managed cases, we will select the most recently opened case to interview.

Potential participants are identified for the study from this intake information and selected based on the research criteria. Clients are contacted as soon as possible after the initial intake date and asked to voluntarily participate in the research study.

The RA can also periodically obtain intake information directly from the intake workers or the director of the *non-case managed program*. This informal inquiry is made by the RA in order to identify potential participants for the research study as soon as possible after the referral is made and to abide by the timeline for the research protocol.

*DHS kinship and foster family placement referrals:*

Quarterly, the Research Associate (RA) requests a database list from DHS of children living with relatives and a list of children in foster home placements. Because the DHS list includes children who are dependents of the Family Court, there must be permission from the court for the child to participate in the research study. The RA reviews the list and identifies potential participants based on the research criteria. The RA then requests permission from the Family Court via a minute order for consent to include the child in the research study. The signed minute order must be received from the Family Court prior to including the child in the research study.

*Procedure for obtaining a Minute Order:*

A request for a signed minute order is made to the supervising judge of the family court. The court must receive an original request form by mail and generally responds by fax within one week of receiving the request. Several requests for a minute order are submitted simultaneously to minimize the administrative process for the court. The minute order must be on file prior to the RA interviewing the dependent of the court. (Request forms are found in the research files.)

**D. Random Subject Selection**

A random selection of participants is conducted in order to identify the study sample. A random selection of subjects assures that every one in the population has an equal chance at being selected to participate in the research. This process is also used to prevent biases from influencing the selection. (See below for a brief outline of the selection process and table.)

**1. Selection Process**

Participants are selected based on the randomized list of numbers generated by the Institute statistician. The Program Manager uses this list to randomly sort the names of the participants. This number list is matched with the names of participants identified for the study. The randomized list of names is sorted by a chronological family order number and includes the assigned random order number and contact information for the family. The RA is responsible for selecting the families from this list. (See sample table below for randomized list.)

The selection of subjects for the study is based on family size and child order. In order to determine which child is interviewed, the Research Associate first identifies the number of children in the family that are eligible to participate then selects the child based on the order number identified in the randomization list.

Randomization list:

ORDER	FAMILY	LAST NAME	FIRST NAME	PHONE
1	98	Sharp	Sandra	555-1213
2	14			
3	25			
4	77			
5	16			

Once a family is chosen, the child participant is selected based on the number identified in the table of random numbers for selecting study child. (See below for sample of this table.)

For example, if FAMSIZE = 3 and CHILD = 3, choose the oldest of the three eligible children.

Use these numbers in the NFAM order, cross off after using.

FAMSIZE=3	
NFAM	CHILD
1	3
2	3
3	2
4	3
5	3
6	1
7	2

The NFAM shown in the above list is specific to families with 3 children. There is an identical numbering for families with one to ten children in a family.

General Note on Random Selection:Random selection of families:

All new clients to the Kinship program are eligible to participate to ( i.e.Kinship families assigned to either case-managed or non-case managed program) in the study sample for groups one and two. However, a random selection of families is used for comparison groups three and four (i.e. DHS case-managed relative and foster families).

Random selection of children:

All children who are potential study participants are selected using a random selection.

If the caregiver refuses to give consent for the child to participate in the study and the reason for refusal is consistent with the exclusion criteria (e.g. if the child is language impaired etc.) another child may be selected. The new child selected should be chosen from

the randomized family list for the number in the family excluding the ineligible child. On the other hand, if the caregiver's reason for refusal is arbitrary, the family is then excluded from the study.

For example, if the number of children in the family eligible to participate is three, but one child is ineligible for a reason that is consistent with the exclusion criteria the next child is chosen using the number in family list for two children in a family. The child is then selected based on the order number for the child identified in the table of random numbers for selecting study child.

## E. Interview Procedure

- 1) Initial (T1) interviews are conducted within two weeks or as soon as possible after the intake process. Participants from the comparison group are interviewed within two weeks of the KSN clients. As noted above, if the research involves interviewing a child who is a dependent of the court the RA must receive permission from the court, via a minute order to include the child in the research. This process is only applicable to children selected for the comparison group. Dependent children of KSN clients do not need to have a minute order to participate.

- 2) Contacting families –

Participants are contacted by telephone and asked to voluntarily participate in a research interview. In those instances where a family is not reachable by phone, the following procedure is suggested:

### For KSN clients:

- a) Ask the KSN community worker to assist in contacting the client and requesting their participation in the study,

### For DHS clients:

- b) Call the DHS caseworker for current information (i.e., phone numbers and address) on family,
- c) Use DHS terminal at Edgewood to search for current information on the family, and check the telephone book for family's number,

### For Follow-up interviews:

- d) Send registered letter to family requesting that they call the research team at Edgewood,
- e) Visit the family's residence and leave a business card and a note requesting that the family call the research team.

Participants are informed of the purpose of the research project and given general information regarding the interview. They are also asked if their child can be included in the interview. Interviews are conducted at the participant's home or at any location that is convenient for them and they are compensated \$30.00 for their participation.

- 3) If the family agrees to participate they are given specific information about the subject areas and questions included in the interview, how long the interview will take and the fee that they will be paid for their participation. At the end of the call the participant is asked if they have any further questions and told that a call will be placed to them the day before the scheduled interview to confirm the appointment.
- 4) The RA maintains a record of all the names of participants and their children selected for the research. This record includes contact information and comments indicating whether the interview was completed. (See Appendix for sample of Interview Log)
- 5) At least one day prior to the interview a request for the \$30.00 fee paid to the participant is made to the KSN Site Manager by completing a check request form. The check is written in the name of the client. If the interview is not completed with the client the check is returned to the KSN Site Manager.
- 6) Also prior to the interview the intake worker is informed that an interview has been scheduled with the new KSN client. The KSN intake worker is given a *Research Interview Form* which includes the name of the client, the date of the interview and the name of the RA who will be conducting the interview. This form is in the research files. If the client is new to the *non-case managed program* the Director of *this* program is similarly informed of the scheduled interview. If the intake worker informs the RA that the client has already been assigned to a KSN community worker the Social Work Supervisor is then informed of the interview and is responsible for communicating the information to the KSN community worker. (See Appendix for a sample of the Research Interview Form)
- 7) At the interview the participant is again informed of the purpose of the study and given information about how the interview will progress. The participant is initially asked to sign a consent form confirming their agreement to participate. Also, the child being interviewed is given the same information and a verbal explanation of the assent form they are asked to sign. The RA then gives an overview of the areas that are included in the interview, an explanation of the options for responses to the questions and assures the participant that their interview responses will be kept confidential.
- 8) At the end of the interview the participant is given a copy of the consent form and asked to sign a payment receipt confirming that they were paid for their participation. They are also informed that the RA will be calling them at a later date to conduct a follow-up interview. The RA makes a copy of the original receipt and gives the original to the KSN Site Manager and files the copy in the research files.

- 9) The RA gives the completed protocol to the data entry clerk who enters all the responses into the database. The hard copies are sorted by client ID number and filed in the research files. The RA also records the date of the completed interview in the research record.
- 10) At the end of the interview both the child and the caregiver are informed that they will be asked to participate in a follow-up interview in which they will be asked the same questions in order to test whether their responses change over time.

### Follow-Up Interviews

A follow-up interview is conducted with the clients twice after the initial interview. The first follow-up interview (T2) will occur at closing/graduation or ninth months after the initial interview. The second follow-up interview (T3) will occur fifteen months after the initial interview. The process for the follow-up interview is the same as described above.

## **F. Case Record Review Procedure**

After the Time 2 interview with participants, a case record review will be conducted. This form is used to summarize information about a child's experience from the time an abuse/neglect petition was filed to the current date. Since many of the youth in the study have documented histories of abuse or neglect and are adjudicated 300s (or wards of the court), the San Francisco Family Court has a file of dependency information about each child. The information from these files is used as supplemental information to quantitative measures.

The Case Record Review Form is organized into several sections. These include Focus Child Information, Abuse/Neglect Information, Placement History and Reasons for Filing the Dependency Petition, Parental Contact with Child Since Dependency, Requirements for Reunification with Parents, and Parents' History. (See the Appendix for a copy of the Case Record Review form.)

Following completion of the case record review, we will calculate an abuse/neglect severity rating for each participant. The abuse/neglect petition counts from each child's dependency file will be rated using the System for Quantifying Child Protective Service Records Subtype Definitions and Severity Scales. This scale was developed by Barnett, Manly and Cicchetti with the goal of standardizing the assessment and quantification of child maltreatment (D. Barnett, J. T. Manly & D. Cicchetti, 1993). This scale uses six categories of abuse/neglect; Physical Abuse, Sexual Abuse, Failure to Provide, Lack of Supervision, Emotional Maltreatment, and Moral/Legal/Educational Maltreatment. Within each category, there are five severity-rating choices, with 1 being the least severe and 5 being the most severe.

## VII. DATA MANAGEMENT

### A. Data Editing and Data Reduction

We will examine initial frequency distributions for all variables to determine illegal values, poor variation, and other distribution characteristics. Where several variables measure the same general dimension, principal component analysis will be used to create summary scales.

### B. Data Sources

Through a Memorandum of Understanding, we have access to both DHS and YGC databases. Institute staff experience comparing database information with case files has shown a 30 percent data-entry error rate (e.g. misspelling, typographical errors). Rather than relying solely on these database sources, we believe that analysis of the actual case file will produce fewer errors. This is particularly the case for DHS, which in October of 1997 began using a new statewide data system, Child Welfare Services Computer Management System (CWSCMS). San Francisco DHS staff is receiving ongoing training in using this new system, but the potential for error when using a new system is significant, as glitches are expectable during the first year or two of implementation.

The specific data sources that will provide outcome measures are listed below:

1. Number of children reunified with biological parent(s); Case file information using Case Record Review.
2. Number of family members choosing adoption or legal guardianship; Case file information using Case Record Review.
3. Number of children who move from relative placements back into the foster care system and the reasons for moving (e.g. maltreatment); Case file information using Case Record Review.
4. Number of and reasons for placement disruptions, not including recidivism (e.g. other relative placement); Case file information with Case Record Review.
5. Number of and reasons for use of more restrictive placements; Case file information with Case Record Review.
6. Number of referrals for out-of-county placements; Case file information using Case Record Review
7. Status changes to the juvenile justice system (e.g. from W&I 300 to W&I 600) and types and frequency of juvenile offenses committed. Case file information using Case Record Review.
8. Length of stay in placement before permanence achieved; Case file information using Case Record Review.
9. Child health and mental health status.

## **VIII. STATISTICAL ANALYSIS**

For continuous variables measured at each time point (T1, T2, and T3) the method of analysis will be doubly multivariate repeated measures analysis of variance (ANOVA). All subscales of an instrument such as the CBCL are analyzed simultaneously across the three times. This combination of multiple measures at multiple times has been termed a doubly multivariate design. The design will include a between subjects factor with four levels corresponding to the four study groups. Significant overall multivariate tests will be required before proceeding to analyses of individual scales. This requirement helps to control the Type I error rate.

Hypotheses with respect to the superiority of a particular group, such as the KSN case-managed children, will be tested with a planned comparison of that group against all other groups. The variable, length of stay in placement before permanence, is the only outcome variable that represents an amount of time. We will analyze this variable using survival analysis methods.

Variables one through seven listed in Data Sources are all one-time, dichotomous variables. That is, each individual is classified Yes or No on some dimension over the course of the study. These variables will be analyzed using chi-square methods. Again, focused tests of KSN case-managed children versus the other groups can be constructed by partitioning the overall chi-square using a planned comparison.

We will also look at associations of individual variables such as gender and ethnicity with all outcome variables. Where we find significant relationships, we will attempt to control for these variables in the analyses of the main hypotheses by including them as blocking factors.

## **IX. OBLIGATIONS OF THE INVESTIGATOR**

### **A. Institutional Review Board (IRB)**

Prior to enrollment of subjects into this study, the original informed consent, informed assent, and minute orders were reviewed by the IRB at Edgewood. (Copies of these documents are included in the Appendix.)

### **B. Informed Consent and Assent**

All children and their legally authorized representative or family member must sign informed consent and assent forms before entering the study. By signing the informed consent/assent forms, subjects agree that they will complete all evaluations required by the study, unless they withdraw voluntarily or are terminated from the study for any reason.

### **C. Confidentiality**

The study protocol, documentation, data and all other information generated will be held in strict confidence.

### **D. Retention of Data**

The investigator will maintain all records pertaining to this study for a minimum of two years.

### **E. Withdrawal of Subjects**

The attrition rate will be monitored and clients who drop out of the program are followed-up with telephone calls, or, when possible, face-to-face visits. Interviews are conducted with these caregivers and children to determine their reasons for leaving, without encouraging or influencing them to return. This group will be compared with persons who remain in the program. Also, any subject may choose to withdraw from the study for any reason and at any time. The investigator will withdraw any subject from the study if it is not in the subject's best interest to continue.

## **X. ASSESSMENT TECHNIQUES**

### **A. The Interview**

#### **1. Scheduling the Interview**

Rather than the administrative personnel scheduling assessment sessions, the interviewer schedules them in order to reduce confusion and to build and maintain rapport with each caregiver. When calling to schedule a home visit, the interviewer tells the caregiver: 1) who the interviewer is, 2) what agency is being represented, 3) what kind of information is needed for the session being scheduled, 4) approximately how much time to allow for the session; and, 5) whether the child (children) are directly involved in testing.

#### **2. Introductory Comments for the Interview**

When administering the protocol the interviewer begins by first introducing themselves. The caregiver is then informed of how the interview will proceed and given a brief explanation of the assessment measures. The interviewer presents as follows:

“We want to talk to you and your child in order to help programs like ours improve services to children and caregivers.” This interview will include two sets of questionnaires; both are questions regarding your child. I will first ask questions to you and then interview your child.”

“This interview is voluntary and your responses will be kept confidential. The information collected is identified with a number, and your responses to the questions are grouped with other caregivers answers. You may ask me to repeat a question if you don’t understand what I’ve asked or tell me if you don’t know the answer to a question. You should also know that the questions are of a personal nature and you may decline to answer or end the interview at any time if you have any concerns or feel uncomfortable.” Before we begin I also want to explain to you what will happen in the interview with your child.

“Prior to the interview your child will be given the same information I gave you and they will be asked to sign a consent form agreeing to participate. They have the same options in response to the questions (i.e. they may refuse to answer) because their questions are also of a personal nature, particularly the violence questionnaire. This includes questions related to your child’s level and amount of exposure to violence. Please take a moment to read the following information which has samples of the questions and let me know if you give your consent to interview your child.” [Give copy of My ETV explanation sheet to caregiver. A copy of this form is in the Child Measures section of the Appendices].

If your child should become upset during the interview I will stop the interview and consult with you regarding what has happened. Keep in mind that children rarely become upset or uncomfortable by the interview but Edgewood has a procedure that I will follow and discuss with you if this should happen.

You should also know that I am a mandated reporter which means that I am required by law to report to Child Protective Services if your child tells me that they have been abused in any way. I will also inform you before I report the incident. Do you have any questions regarding what I have said?

### **3. Provisions for Youth and Caregivers Experiencing Problems**

If a child or caregiver participant becomes visibly upset at any point during the interview, the interview is stopped and the following steps are taken:

(KSN groups 1 and 2)

- The interviewer first discusses the situation with the caregiver and determines if the problem requires a follow-up with a therapist .
- If it is decided that the child needs to see a therapist the interviewer asks the caregiver if the family or the child has one and asks the caregiver for permission to contact that therapist.
- If the child or caregiver does not have a therapist, he or she will be referred to the Supervisor of the KSN Mental Health Unit. The child’s community worker is also informed of the nature of the problem and the referral.
- A note is placed in the case file.

If the interviewer believes that the child or caregiver may have been upset, but not shown visible signs of this, the interviewer discusses the situation with the KSN Community Worker and ask them to follow-up with the client to provide a chance for the participants to discuss any reactions that they may have had to the interview process.

(DHS groups 2 and 3)

- The interviewer first discusses the situation with the caregiver and determines if the problem requires follow-up with a therapist .
- If it is decided that the child needs to see a therapist the interviewer asks the caregiver if the family or the child has a therapist.
- If the family already has a therapist the interviewer then asks the caregiver for permission to contact the DHS Child Welfare Worker to make a referral to the assigned therapist.
- If the child does not have a therapist, the interviewer will ask the caregiver for permission to contact the DHS Child Welfare Worker to discuss the situation and request a referral and follow-up with a therapist.
- If the person conducting the interview believes that the child or caregiver may have been upset, but not shown visible signs of this, the interviewer will address their impressions or concerns with the caregiver and provide a chance for these participants to discuss any reactions that they may have had to the interview process.

## **B. Administration of Questions for Caregivers**

### **1. General Considerations**

Caregivers are not required to answer the questionnaires. If they decline to participate, they are told that their participation is voluntary and they can decide to end the interview.

Emphasize that all caregiver/children's responses are kept confidential. Point out that their names are not linked with their answers but the results will be identified by a number and compiled with other caregiver responses.

In order to maintain consistency in test administration, all caregiver questionnaires are read aloud to the caregiver and responses recorded by the interviewer.

Data and school information will also be gathered from teachers and schools using the mail and a telephone follow up.

### **2. Order of Presentation of Materials**

1. Caregiver informed consent (general consent and school consent forms; children's informed assent)
2. Questions for caregivers (questions about family background)
3. Child Health Questionnaire PF-50 (Landgraf, 1996)
4. Parent Self-Efficacy Scale: twelve-item subscale (Bandura et al., 1996)
5. Perceived Self-Efficacy and Grandparenting Scale as measured by a six-item subscale (King and Elder, 1998)
6. Child Behavior Checklist 4/18 (Blue form) (Achenbach, 1991)

### 3. Comments for the Caregiver

“The interview will begin with some questions about your family background and the rest of the questions are about your child. Please let me know if you don't understand the question, or if you don't know the answer to a question. There are no right or wrong answers. You should also know that some of the questions are of a personal nature and you may decline to answer or end the interview at any time if you feel uncomfortable or have any concerns. Do you have any questions before we begin?”

The interviewer presents as follows:

➤ Administration of the family origin questions.

“First, I want to ask you some questions about your family background. We are collecting this information so that we can include in our research report some general information about the population we provide services to.”

➤ Administration of the Child Health Questionnaire (CHQ-PF 50)

The following script is used to introduce the CHQ-PF50.

“The Child Health Questionnaire was designed to provide reliable information about the everyday functioning and well-being of children in ways that matter most to them and their families. The questionnaire asks questions about your child's physical wellness, his/her feelings, behavior, and activities at school and with family and friends. The questionnaire contains questions that ask how you feel. There are no right or wrong answers.”

The interviewer hands the caregiver a copy of the Child Health Questionnaire (CHQ-PF 50) to use as a visual cue and administers the measure by recording their verbal responses on another copy.

*Note: The use of the Response Card instead of a copy of the measure may be used as a visual cue.*

The interviewer says, “there are different response options for each section, please listen to all the possible responses before responding with an answer to the question.”

- Administration of the Perceived Parent Self-Efficacy Scale twelve-item subscale (Bandura et al.,1996) and Self-Efficacy and Grandparenting six-item subscale (King and Elder, 1998) and

The interviewer presents as follows:

“These questionnaires are designed to help us gain a better understanding of the kinds of things that make it difficult for caregivers to influence their children’s school activities and behaviors. First, I will read a few situations where caregivers may or may not have influence over their children. We are interested in how much you think you can help your child in the following situations.

The interviewer hands the caregiver a copy of the twelve-item Parent Self-Efficacy Scale and the six-item Perceived Self-Efficacy and Grandparenting scale to use as a visual cue and administers the measures by recording their verbal responses on another copy.

*Note: The use of the Response Card instead of a copy of the measure may be used as a visual cue.*

The interviewer says, “ The responses for these questionnaires asks you to indicate an appropriate number on a scale identifying the level of influence you feel you have over your child. Please indicate your opinions about each of these statements by saying the appropriate number.”

- Administration of the Child Behavior Checklist (CBCL/4-18)

The interviewer presents as follows:

The first part of the Child Behavior Checklist asks parents to report on the amount and quality of their child’s participation in sports, hobbies, games, activities, jobs and chores, and friendships; how well the child get along with others and plays and works alone; and school functioning. The second part focuses on how often a child is observed exhibiting a specific behavior.

- The interviewer hands the caregiver a copy of the Child Behavior Checklist (CBCL/4-18) to use as a visual cue and administers the measures by recording their verbal responses on another copy.

*Note: The use of the Response Card instead of a copy of the measure may be used as a visual cue.*

The interviewer says, I will first ask you some general questions about (child’s name) and record your answers. Then, I will read a list of items that describe children. For each item that describes your child, now or within the past six months, please respond with the

appropriate response of ‘Very True’ or ‘Often True’, ‘Somewhat’ or ‘Sometimes or if not true (as far as you know) of (child’s name) at all, simply state ‘Not True.’”

### Caregiver Questionnaire Administration Do’s and Don’ts

**Do** request and encourage the caregiver to answer

**Do not force** or command the caregiver to answer

**Do** read and repeat a question **verbatim** for the caregiver

**Do not interpret** a question

**Do** tell the caregiver to answer a question based on what they think the question means

**Do not accept** an incomplete questionnaire without first encouraging the caregiver to provide responses to unanswered questions

**Do** have the caregiver answer the questions **by themselves**

**Do not** allow spouses or family members to help the caregiver answer the questions

**Do** encourage the caregiver to complete all questions

**Do not** force or command the caregiver to complete a particular question

## C. Administration of Questions for Children

### 1. General Considerations:

Children are not required to answer the questionnaires. If they decline to participate, tell them that their participation is voluntary.

Emphasize that all children’s responses are kept confidential. Point out that their names are not linked with their answers but the results will be identified by a number and compiled with other children’s responses.

### 2. Order of Presentation of Materials

1. Children’s informed assent
2. Child’s Perceived Self-Efficacy Scale as measured by a 37-item subscale (Bandura, Barbaranelli, Caprara and Pastorelli, 1996)
3. Child Quality of Life (Andelman, 1999)

4. My Exposure to Violence (My ETV) (Buka, Selner-O'Hagan, Kindlon, & Earls, 1997).

### 3. Introductory Comments for the Child

We are talking to young people about their lives. We are interested in better understanding what's important in young people's lives, especially for young people living with relatives. "This interview is voluntary, your responses will be kept confidential and you will not be identified by name. Please let me know if you don't understand the question or a word that is used in a question, or if you don't know the answer to a question. There are no right or wrong answers. You should also know that the questions are of a personal nature and you may decline to answer or end the interview at any time if you feel uncomfortable or have any concerns. Also, I will not discuss your answers with your caregiver without talking to you first." Do you have any questions before we begin?

- Administration of the Child's Perceived Self-Efficacy Scale (Bandura, Barbaranelli, Caprara and Pastorelli, 1996)

*Interviewer note:* There may be certain difficulties studying self-efficacy in younger children (younger than 12). Accordingly, following consultation with Bandura, we rephrased the wording of 11 items in the Child's Perceived Self-Efficacy scale. When asking questions to children 11 years or younger, use the phrase to the right of the "/" on item numbers 2,4,5,7,17,20,22,24,25,28,32 that are marked with an asterisk (\*). If the child is 12 years or older, use the phrase to the left of the "/" on these items.

The interviewer presents as follows:

"This questionnaire is designed to help us get a better understanding of the kinds of things that are difficult for students. Please indicate your opinions about each of the statements by saying the appropriate number.

Response cards should be explained and provided to the children as a visual cue.

- Administration of the Child Quality of Life measure (Andelman, 1999)

For the Child Quality of Life measure, it is suggested that the interviewer read the statements to younger children (< 12 years old) and have older children independently complete the QOL measure. Response card should be explained and provided to the children as a visual cue. Interviewer should also verbally review the example on the QOL measure.

The interviewer presents as follows:

"We would like to know how you feel about different things in your life. Think back recently or over the last four weeks.

[younger children] listen to each statement and say which word or phrase that tells best how often you have had that thought or feeling. **Or** [older children] Read each statement and circle the one word or phrase that tells best how often you have had that thought or feeling.

- Administration of My Exposure to Violence (My ETV) (Buka, Selner-O'Hagan, Kindlon, & Earls, 1997).

For My ETV, we expect to achieve greater accuracy in completion by having interviewers read the statements to the children and record their answers. Response cards for this measure are optional.

The interviewer presents as follows:

“The next set of questions are about different violent things that may have happened to you or that you may have seen. In order for us to really understand what it’s like to grow up in San Francisco, it is very important that the kids we interview tell us about their experiences. Some of the questions ask about things that have happened that might be difficult for you to think about. When I ask whether different things have happened to you or that you have seen, do not include things that you have seen on TV. It’s important for you to tell me experiences that may have happened to you in real life... not on television or in the movies. Also, I want you to know that I will not discuss your answers with your caregiver without talking to you first.

### **Child Questionnaire Administration Do’s and Don’ts**

<b>Do</b> request and encourage the child to answer all the questions	<b>Do not force</b> or command the child to answer questions
<b>Do</b> read and repeat a question <b>verbatim</b> for the child	<b>Do not interpret</b> a question
<b>Do</b> tell the child to answer a question based on what <b>he/she thinks</b> the question means	<b>Do not accept</b> an incomplete questionnaire without first encouraging the child to provide responses to unanswered questions
<b>Do</b> have the children answer the questions <b>by themselves</b>	<b>Do not allow</b> family members to help the child answer the questions

## My ETV – Helpful Hints and Common Questions

- When administering this interview, it is very important that the interviewer remain neutral and as unaffected as possible. These are experiences that characterize many youth's day-to-day life. Some will report these incidents in a very matter-of-fact manner, while others will display more distress at their experiences. It is very important that the interviewer maintain a professional, objective and relatively detached demeanor. If the respondent becomes distressed, the interviewer should be as empathic as possible. Any concerns regarding the respondent's well-being should be discussed with a supervisor as soon as possible after the interview.
- If the subject reports circumstances that suggest that he or she has been the victim or perpetrator of abuse, the interviewer should discuss this with his or her supervisor as soon as possible and complete all necessary paperwork to document this.
- In order to minimize the repetitive nature of this interview (the same questions are asked numerous times about different types of violence), please review the following points:
  1. If you are using the response card, make sure that you review the card clearly at the beginning of the interview and walk the respondent through it carefully the first time it is used. It is critical that the respondent is familiar with all response choices.
  2. Be very familiar with the general format of this interview. Following the hierarchies closely (Go To, etc.) will help keep the time of this interview down.
  3. Make sure that you are clearly differentiating questions regarding what the subjects *have seen* from *what has happened to them*.
  4. Make sure you are clearly differentiating questions regarding lifetime frequency from those regarding past year. These words are underlined and in BOLD to help make sure you emphasize them.
- Remember that you will be prompting for a specific number of times ONLY if the subject reports that the event has occurred more than 10 times. Keep in mind that you can record only ONE number in this data entry box. If the subject provides a range, you must encourage him/her to select one number, stating "I can only write down one number".
- If the subject gives any location outside the **current** neighborhood, code this as "outside the neighborhood". For example, if they said the event occurred "in Mississippi", this would be coded as outside the neighborhood.

### Addressing Problems and Questions

- What to do if the caregiver or child doesn't want to complete a questionnaire.

A caregiver or child is not required to answer the questionnaire. If the caregiver or child declines to participate, tell them that their participation is voluntary. Tell them that they are being asked to complete the questionnaire so that we can better understand the problems of children. Tell them that responses are needed so that a complete picture of the child may be obtained. If the caregiver still declines, record the reason for the decline and go on to the next measure.

- What to do if the caregivers or children are concerned that someone will look at their answers.

Emphasize that all responses to the questionnaires are to be kept confidential. Point out that their names do not appear anywhere on the questionnaire, so that their results will be linked with an ID number and not their name. Explain that their answers to the questionnaire will be pooled with other grandparents and children's answers and that they will be analyzed as a group rather than as individuals.

- What to do if the caregiver or child asks you the meaning of an item.

Some caregivers or children might ask the meaning of specific items so that they can better understand the response. If this happens, you can assist them by rereading the question for them verbatim. If they ask you to interpret the meaning of an item, do not try to explain it, but suggest that he/she use his/her own interpretation of the question. All participants should answer the question based on what they think the questions mean. They should be encouraged to answer all of the questions.

Sometimes caregivers or children may have trouble with the response choices. They may say "I don't know" or something different than what is stated in the questionnaire. In this circumstance, gently guide them to respond in one of the pre-set categories by saying something like:

"I know that it may be hard for you to think this way, but which of these responses most closely expresses what you are thinking or feeling?"

If the caregiver or child does not like a question, or thinks it is unnecessary or inappropriate, state that they may refuse to answer any item(s).

Rewording items, paraphrasing or interpreting items for the caregiver or child can bias results. Thus, it is important that differences in answers due to rewording of items be minimized.

If the caregiver has difficulty completing the questionnaires and you feel you cannot address their concerns adequately with the instructions and guidance provided, thank them, and discontinue the measure and record the difficulty on a blank sheet of paper.

- What to do if the caregiver wants to know the meaning of their answers.

If a caregiver asks you to interpret responses or asks for a “score” on the CHQ, tell him/her that you are not trained in interpreting or scoring the information. Emphasize that their responses are to be kept confidential. Tell caregivers that their answers to the questionnaire will be pooled with other caregivers’ answers and that they will be analyzed as a group rather than as individuals.

- What to do if the caregivers asks why they have to complete the questionnaires additional times

Explain to the caregiver that they must complete the questionnaires at different times to test whether their responses change. This will give a more complete representation of the child over the course of time.

*Note: Interviewer may refer to the supplemental information on each measure for more techniques on administering the measures. (Manuals and information are kept in research files.).*

## XI. REFERENCES

Achenbach, T.M. (1991). Manual for the Child Behavior Checklist/4-18 and 1991 Profile. Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T.M. (1993). Empirically based taxonomy: How to use syndromes and profile types derived from the CBCL/4-18, TRF, and YSR. Burlington, VT: University of Vermont Dept. of Psychiatry.

Bandura, A., Barbaranelli, C., Caprara, G. V., & Pastorelli, C. (1996). Multifaceted impact of self-efficacy beliefs on academic functioning. *Child Development*, 67, 1206-1222.

Barnett, D., Manly, J.T. & Cicchetti, D. (1993). Defining child maltreatment: The Interface between policy and research. In D. Cicchetti and S. Toth (Eds.). *Child Abuse, Child Development and Social Policy*. Norwood: NJ. 7-73.

Barth, R.P. (1996). The Juvenile Court and Dependency Cases. *The Future of Children*, Packard Foundation, The Juvenile Court. Vol. 6, No. 3, 100-110.

- Barth, R. P., Courtney, M., Berrick, J. D., & Albert, V. (1994). Pathways to permanence. Hawthorne, NY: Aldine de Gruyter.
- Benedict, M., Zuravin, S. & Stallings, R. (1996), Adult functioning of children who lived in kin versus nonrelative family foster homes. *Child Welfare*, 75, #5, 529-549.
- Berrick, J. D. & Barth, R. P. (1994). Research on kinship foster care: What do we know? Where do we go from here? *Children and Youth Services Review*, 16, ( 2), 1-5.
- Berrick, J. D., Barth, R. P., & Needell, B. (1994). A comparison of kinship foster homes and foster family homes: Implications for kinship foster care as family preservation. *Children and Youth Services Review*, 16, ( 2), 33-63.
- Berrick, J. D. (1997). Assessing quality of care in kinship and foster family care. *Family Relations*, 46(3), 273-280.
- Berrick, J. D. (1998). When children cannot remain home: Foster family care and kinship care. *The Future of Children: Protecting Children from Abuse and Neglect*, 8(1), 72-87.
- Buka, S. & Birdthistle, I. (1997). Exposure to violence: extending the research frontier. *The Chicago Project News*. Vol. 3, Issue 1, 1-4.
- California Department of Social Services Foster Care Information System (1998). Characteristics of children in foster care August 1998 <http://www.dss.cahwmet.gov/isb/docs/reports>(20 Nov. 1998)
- California Department of Social Services. (1993). *Child Welfare Services Manual of Policies and Procedures*, Division 31, Manual letter No. CWS-93-01. Sacramento CA: Health and Welfare Agency.
- Campbell, D. T., & Stanley, J. C. (1966). *Experimental and Quasi-Experimental Designs for Research*. Chicago: Rand McNally.
- Cohon, D., and Cooper, A., (1999) Edgewood's kinship support network: Program model and client characteristics", *Children and Youth Services Review*, Vol 21, No. 4, 311-338.
- Dubowitz, H., Feigelman, S., & Zuravin, S. (1993). A profile of kinship care. *Child Welfare*, 72, 153-169.
- Fanshel, D., Finch, S. J. & Grundy, J. F. (1990). *Foster Children in a Life Course Perspective*. New York. Columbia University Press.

- Feigelman, s., Zuravin, S., Dubowitz, H., Harrington, Starr, R.H. & Tepper, V. (1995). Sources of health care and health needs among children in kinship care. *Archives of Pediatric Adolescent Medicine*. Vol. 149, 882-886.
- Fuller-Thomson, E., Minkler, M., & Driver, D. (1997). A profile of grandparents raising grandchildren in the United States. *The Gerontologist*. Vol. 37, No. 3, 406-411.
- George, R.M., Wulczyn, F.H. & Harden, A. W. (1994). A Report from the Multistate Foster Care Data Archive. Chicago, IL: Chapin Hall Center for Children at the University of Chicago.
- Gleeson, J.P. (1996). Kinship care as a child welfare service: the policy debate in an era of welfare reform. *Child Welfare*, 75, #5, 419-450.
- Gleeson, J. P., O'Donnell, J., & Bonecutter, F. J. (1997). Understanding the Complexity of Practice in Kinship Foster Care. *Child Welfare*, 76(6), 801-827.
- Henry, G. T. & Rog, D. J. (1998). A realist theory and analysis of utilization. *New Directions for Evaluation*, No. 78, 89-102.
- Ingram, C. (1996). Kinship care: from last resort to first choice. *Child Welfare*. 75, #5, 550-566.
- Jackson, S. (1996). The kinship triad: a service delivery model. *Child Welfare*. 75, #5, 583-599.
- Killackey, E. (1992). Kinship foster care. *Family Law Quarterly*, 26, 211-220.
- Landgraf, J.M., Abetz, L., & Ware, J.E. (1996). *The CHQ User's Manual*. First Edition. Boston, MA: The Health Institute, New England Medical Center.
- Link, M.J. (1996). Permanency outcomes in kinship care: a study of children placed in kinship care in Erie County, New York. *Child Welfare*, 75, #5, 509-528.
- McLean, B & Thomas, R. (1996). Informal and formal kinship care populations: a study in contrasts. *Child Welfare*. 75, #5, 489-508.
- Mills, C.S. & Usher, D. (1996). A kinship care case management approach. *Child Welfare*. 75, #5. 600-618.
- Minkler, M., Roe, K. M. & Price, M. (1992). The physical and emotional health of grandmothers raising grandchildren in the crack cocaine epidemic. *Gerontologist*, 32, 752-761.

- Rog, D. (1998). Creating change with evaluation: Ripples that make a difference. Keynote address at 21<sup>st</sup> Annual Conference of the Eastern Evaluation Research Society. April 27, Cape May.
- San Francisco Mayor's Office of Children Youth and Families (1998). Neighborhood Research Reports. ( HYPERLINK <http://www.mocyf.org/home/html/research> (23 Nov. 1998).
- Sedlak, A. & Broadhurst, D. (1996). Third national incidence study of child abuse and neglect: Final report. U. S. Department of Health and Human Services. Washington, DC: U. S. Government Printing Office.
- Selner-O'Hagen, M. B., Buka, S., Kindlon, D., Raudenbush, S., & Earls, F. J. (1998). Assessing exposure to violence in urban youth. *Journal of Child Psychology and Psychiatry and Allied Disciplines*. 39 (2), 215-224.
- Spiker, D., Kraemer, H.C., Constantine, N. A. & Bryant, D. (1992). Reliability and Validity of Behavior Problem Checklists as Measures of Stable Traits in Low Birth Weight, Premature Preschoolers. *Child Development*, 63, 1481-1496.
- Testa, M. (1997). Kinship care in Illinois. In Berrick, J. D., et al., (Eds.), *Child Welfare Research Review*, Volume 2, New York, N.Y., Columbia University Press, (pp. 101-129).
- U.S. Department of Health and Human Services, Children's Bureau. (1998) *Child maltreatment 1996: Reports from the states to the national child abuse and neglect data system*. Washington, DC: U.S. Government Printing Office.
- United States General Accounting Office, Health, Education and Human Services Division. (1995). *Child Welfare: Complex Needs Strain Capacity to Provide Services*, Washington, D.C: GAO/HEHS-95-208.
- United States General Accounting Office (1997a). *Privatization: Lessons Learned by State and Local Governments*. Report to the Chairman, House Republican Task Force on Privatization. Washington, D.C. GAO/GGD-97-48.
- United States General Accounting Office (1997b). *Social Service Privatization, Expansion Poses Challenges in Ensuring Accountability for Program Results*. Report to the Chairman, Subcommittee on Human Resources, Committee on Government Reform and Oversight, House of Representatives. Washington D.C. GAO/HEHS-98-6.
- Wang, C. T. & Daro, D. (1998). *Current trends in child abuse reporting and fatalities: The results of the 1997 annual fifty state survey*. Chicago, IL: National Committee to Prevent Child Abuse.

Weiss, C. H. (1998). Have we learned anything new about the use of evaluation? *American Journal of Evaluation*, Vol. 9, No. 1, 21-33.

Wilson, D. B. & Chipungu, S. S., Eds. (1996) Special Issue Kinship Care. *Child Welfare*, 75, #5, September/October.

## **XII. APPENDICES**

### A. Study Forms

- Evaluation Protocol
- Informed Consent
- Informed Assent
- Request for Signed Minute Order
- Minute Order for Consent to Receive Services

### B. Protocol: Administration of Measures

#### 1. Caregiver Measures

- Questions for caregivers (eight questions about family background)
- Perceived Self-Efficacy and Grandparenting Scale: six-item subscale (King and Elder, 1998)
- Parent Self-Efficacy Scale: twelve-item subscale (Bandura et al., 1996)
- Child Health Questionnaire PF-50 (Landgraf, 1996)
- Child Behavior Checklist 4/18 (Achenbach, 1991)

#### 2. Child Self-Report Measures

- Child's Perceived Self-Efficacy Scale : 37-item subscale (Bandura, Barbaranelli, Caprara and Pastorelli, 1996)
- Child Quality of Life (Andelman, 1999)
- My Exposure to Violence (My ETV) (Buka, Selner-O'Hagan, Kindlon, & Earls, 1997)

### C. Sample Study Forms

- Interview Log
- Case Record Review Form
- System for Quantifying Child Protective Service Records Subtype Definitions and Severity Scales (Barnett, Manly, & Cicchetti, 1993)