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Article

Cross-State Validation of a Tool Supporting Implementation of Rural Kinship Navigator Programs

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Abstract: While kinship care is prevalent and preferred over out-of-family care, there are relatively few measurement tools validated for use with this audience. The Title IV-E Clearinghouse, used to rate Families First Prevention Services such as Kinship Navigator Programs, requires valid tools. Such families face a myriad of needs in supporting children in their care. Previous research has established the significant challenges faced by rural families. Accurate assessment of these needs, particularly for rural families, is an essential component of kinship navigation services. In this study, we examined the face validity of the Family Needs Scale for use with kinship caregivers in rural programs. Methods: The evaluation teams with each respective kinship program conducted four virtual focus groups comprising kinship caregivers (n = 18) in three rural states. Participants were recruited from outside an ongoing Kinship Navigator Program Evaluation sample but had previously received program support as kinship caregivers. All states received IRB approval from their respective universities. Verbal consent was obtained at the time of the focus group. Focus groups lasted approximately 60–90 min and participants received a gift card incentive. Data were transcribed and qualitatively coded by question set and individual questions to identify phenomenological trends. Findings: Across four focus groups, we found four themes: (1) Broad agreement regarding the face validity of most assessment items; (2) Lack of clarity and shared understanding of several terms used within the tool, (3) Responses change with Ages and Stages of kinship family, and (4) Perspective considerations varying when completing the assessment. Discussion: Findings indicate that most assessment items had strong face validity, where there are a few opportunities to clarify key concepts relevant to rural kinship families and assess additional needs to understand the situational scope of the kinship experience. Overall, the needs assessment tool appears to have validity in assessing current kinship needs and outcomes within Kinship Navigator program evaluation.

Keywords: kinship; rural; resource

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1. Introduction

As of 2023, there were 2.4 million children in the U.S. who were receiving kinship care from a relative or fictive kin (i.e., someone who has a relative-like relationship with the child(ren) in care) [1]. These families, referred to as kinship families, or "grandfamilies", are formed due to a variety of factors such as the death of one's parent(s), substance use disorder, military deployment, mental health disorders, and incarceration [2]. At times, this care can be formal, arrangements facilitated by-, or informal, arranged outside of-, the state child welfare entity [3].

A number of studies have demonstrated the benefits of kinship care and this research indicates that children living with either formal or informal kinship caregivers have better safety, stability, and well-being outcomes, compared to those placed in non-kinship care [4–6]. Recognizing the importance of support for families, including kinship families, the Federal government enacted the Families First Prevention Services Act (FFPSA; 2018) to enhance support services for families to safely keep children in family homes. FFPSA includes financial support to states for the development and/or implementation of evidence-based strategies effective in supporting children living with relative kin whenever possible. Since the implementation of this Act, child welfare agencies have prioritized placing children with kinship caregivers and have provided support services to these kinship families [7].

Despite the strengths of kinship care, children in this care setting also navigate a myriad of well-being challenges. For example, kinship care families are more likely to experience poverty compared to their counterparts raised by non-kinship, foster families [8]. While youth in kinship care may fare better than those in non-kinship placements with respect to behavioral development and mental health [4], these youths are still likely to experience mental health and behavioral challenges and those responsible for their care may face difficulty accessing the care and support needed to address these challenges [9–11]. There are several reasons why kinship caregivers may experience difficulty accessing resources. For example, they may experience sudden parenting needs due to unexpected care transitions resulting in the need to care for children who often have experienced traumatic or abusive parent-living situations [12]. Families who care for kin children may also not self-identify as kinship families. If they do, they may also be unlikely to seek out services or supports when needed [13]. This help-seeking may be hindered by kinship caregivers' limited experience navigating the physical, mental, or behavioral health needs of their kinship children [14]. If kinship caregivers can identify and seek out these services, they often indicate social services are fragmented, cumbersome, or unresponsive. These access barriers are also compounded by fear or mistrust of the systems that are meant to serve them [15].

In addition to navigating new parenting needs and resources, kinship caregivers face unique stressors potentially impacting their own well-being. Research has consistently identified parenting stress as negatively impacting kinship caregivers' psychosocial quality of life [16]. While a wide range of kinship types step in to provide care for children, importantly, a substantial portion of these kinship caregivers are grandparents. Together, they raised approximately 1 million children in the U.S. in 2022 [17]. As grandparent kinship caregivers are often older, taking on the role of primary caregiver and associated stressors, they are more likely to have declines to their own physical and mental health care needs [18,19]. These grandparents were also more likely to report working full-time, being married, and completing at least some college [20]. Higher rates of working may be related to unexpected financial needs [8,18] and difficulties with employment [21] that are broadly experienced by kinship caregivers across the U.S. compared to their parental caregiver counterparts. Additionally, grandparents from minoritized racial and ethnic groups are more likely to be in a kinship caregiver role, potentially compounding intersectionality in accessing resources and disparate health outcomes [22]. Although this body of research will grow as Kinship Navigator evaluations are published, limited research currently explores kinship caregiver well-being beyond grandparent kinship caregivers.

The disparities experienced by kinship caregivers may be further compounded when living in rural communities. According to the Far and Remote (FAR) area code classification system, 18.0 to 33.6% of the populations in these three participating states, Maine, Montana, and Wyoming, fall into the two highest FAR categories. This indicates the highest degree of remoteness and difficulty in accessing many types of goods and services including "lower order" goods like groceries, gas stations and basic health care compared to their less remote rural counterparts. The majority of land in each of these states is also considered frontier and rural [23]. In addition, rural residents tend to have higher rates of poverty [24]. Child

welfare services in rural communities at times seem to exist in a "goldfish bowl" with service providers who may have an increased awareness or access to resources, but also a more intimate connection to the families they serve [25]. Alternatively, caregivers in rural communities may experience a higher sense of community cohesion compared to their urban counterparts, particularly related to more willingness to help, a perceived close-knit community, and trust between neighbors [24]. This community's social cohesion can be a protective factor during times of stress.

As laid out in the FFPSA legislation, Kinship Navigator Programs (KNP) should aim to remove barriers to accessing services for kinship caregivers and the children they support. To receive federal reimbursement, KNP services need to coordinate across state and local agencies to avoid duplicate efforts, consult with key kinship stakeholders, and services must be clearly defined and replicable. Navigator services provide families with a connection and referral to resources, provide information and education, and serve as formal or informal support assisting in navigating the complexities of kinship care [13,26,27]. Some navigation programs include a case management component for more intensive engagement with families that includes goal setting and even home-based follow-up [28]. A growing research body indicated KNP services can meet FFPSA criteria of reducing self-reported service needs and increased access to services by kinship caregivers, greater caregiver well-being, more permanency, and a reduction in subsequent child welfare involvement after kinship placement [26,28,29].

Additionally, to receive sustainable and reimbursable FFPSA funding, the KNP must demonstrate to a Federal Clearinghouse review that there is evaluation evidence these services are "promising", "supported", or "well supported" in helping kinship families meet these specific criteria. At FFSPA inception, there were no KNP programs meeting any level of Clearinghouse criteria for evidence-based evaluation and promising dissemination. By May 2023, four KNPs had been successfully identified by the Clearinghouse as "promising" or "supported". To conduct a program evaluation with reliable and rigorous outcomes, KNP programs must also use valid and reliable measurement tools. While there are many tools researchers and evaluators use to assess needs and program outcomes, this rapid growth in kinship research has highlighted the limited number of tools previously validated with kinship or rural caregiver populations.

A core component of many navigation programs is an assessment of family needs, whether formally or informally, by staff. A needs assessment tool that proves accurate for this population is critical to the success of KNPs. One such tool that is often cited in the literature is the Family Needs Scale or Family Resource Scale. This measure was originally developed by Dunst and colleagues [30] with a sample of preschooler families with low household incomes. The measure is comprised of 41 items which are rated on a 5-point response scale from 1 ("Almost Never") to 5 ("Almost Always") with the additional choice of "Not Applicable", which indicates no need. The measure was validated in more than one study [30,31]. The tool was then adopted for use as a common measure shared by KNP demonstration projects which were funded by the Children's Bureau in 2012. This tool has since been used to guide family needs assessments in KNPs across the U.S. including programs in South Carolina [27], Washington [28], Florida [32], and New York [33]. Lee and colleagues [33] also tested the psychometric properties and construct validity of the Family Needs Scale in a sample of 303 informal kinship families as part of a demonstration project. This validation supported the promising application of this tool, and Lee et al. noted further research was needed to support the use of the Family Needs Scale for kinship families, particularly among diverse kinship caregiving experiences not represented in their sample [33]. A collaboration of rural KNPs further adapted the tool to understand needs and track changes in resource access for both formal and informal kinship caregivers within the rural context.

The purpose of this study was to provide evidence of construct face validity and reliability of the adapted Family Needs Scale with kinship caregivers from three rural states. In particular, we explored scale characteristics of understanding, clarity, and relevance of

items and responses [34]. Focus groups were employed to gain experiential knowledge of kinship caregivers and assess the extent to which the adapted Family Needs Scale items clearly and accurately reflect rural kinship caregivers' experiences and understanding of needs. With further evidence of validity, this tool may be used to promote effective program delivery and an understanding of KNP impact on kinship caregivers in rural states. Additionally, we examined item responses from baseline assessments of 41 kinship caregivers taking part in a navigation intervention evaluation in one of the rural states to demonstrate preliminary internal consistency and reliability of the measure in a similar population.

2. Materials and Methods

To explore the content face validity and reliability of this tool in assessing the needs of kinship caregivers in rural communities, a qualitative content analysis of focus groups was conducted. The key informants were recruited from current or former kinship caregivers who had taken part in kinship program services before the new KNP model implementation evaluation. These informants were recruited to provide depth of experience and the team attempted to achieve an optimal size of attendees at each focus group (5–8 participants) [35].

To supplement these validity findings with rural kinship caregivers, the study team conducted a preliminary analysis of the adapted Family Needs Scale with data collected from case-management program evaluation participants. Program evaluation participants were recruited through organizational partner warm hand-off or direct participant interest. At the beginning of case-management services, the enrolled kinship caregiver participants, individually or with the support of the Kinship Navigator, completed the adapted Family Needs Scale to inform services and provide a family baseline to measure service impact. This baseline assessment from 41 kinship caregivers in one state provides a preliminary data set for scale reliability in a comparable sample to the focus group participants.

2.1. Participants

In each of the three frontier rural states, ~15–20 potential participants who had previously engaged with state KNP services as grandparents, other extended family members, or unrelated adults raising a child were identified. Participant inclusion criteria included no previous involvement in the current intervention evaluation, being over 18, living in three recruiting states, and being currently or had previously been a kinship caregiver to a child. A member of the evaluation team from two of the states attempted to reach potential participants at least three times by phone to invite them to attend one of the scheduled session times of their preference. In the third state, recruitment was conducted by Kinship Navigators who forwarded recruitment language via email to eligible participants. During each telephone call or sent email, the study was introduced, the purpose explained, times for focus group sessions provided, an invitation to participate was offered, and an opportunity to ask questions was given. Of these, all kinship caregivers willing and able to join a focus group time were provided login information for a focus group session of their preference. In addition, all participants received a copy of the adapted Family Needs Scale before the focus group meeting. Those who attended a focus group were provided gift card incentives for their participation. The study was further explained and continued participation implied voluntary informed consent.

In one of these rural states, a sample of 41 kinship caregivers completed the adapted Family Needs Scale during their initial Kinship Navigator case management experience and consented to data collection as a part of a larger evaluation effort. Participants were screened for similar eligible inclusion criteria: (1) Presently serving as a kinship caregiver for a child(ren) under 18 years old, (2) Currently living in Montana, (3) Ability to communicate in English, (4) Ability to provide informed consent, and (5) The caregiver is reaching out about a new kinship caregiving need. Kinship caregivers who enrolled in the program evaluation were provided gift card incentives at each point of survey data collection.

2.2. Study Design

The semi-structured focus group protocols were conducted virtually by four members of the evaluation team, with one serving as a facilitator and the other a note-taker in each session. Four group sessions were conducted during the summer of 2023. Upon agreeing to participate, a link to a confidential electronic evaluation of the Family Needs Scale was provided to study participants to review before the focus group. Each live focus group session lasted 60–90 min. They were scheduled for different times of day and days of the week to accommodate a variety of schedules.

Immediately before the commencing of each focus group session, the purpose and nature of the study were re-explained, an opportunity to ask questions was once again provided, and participants were informed that further participation implied consent. Group members were invited to respond verbally or in the chat. Interviewers noted verbal and non-verbal affirmation to questions or statements made by others. Sessions were recorded via a university video conferencing platform for future transcription. The note taker and facilitator documented a debrief discussion at the end of each focus group as well to support analysis. Protocols were reviewed and approved by IRBs at the three respective universities which were conducting focus groups, the associated quasi-experimental program evaluation, and managing participant data.

In addition to the focus group participants, kinship caregiver responses to the needs assessment as a part of a larger program evaluation study were used for reliability analysis. These caregivers were from the quasi-experimental KNP Evaluation and included only participants residing in case counties at the time of initial service. At intake in their initial visit, the adapted version of the Family Needs Scale was administered individually or electronically by the admitting Kinship Navigator either in-person or electronically taking approximately 5 min to complete. The survey is used to help guide referral to resources and to support understanding of program impacts. Preliminary intake responses were collected from Enhanced Case Management (Case) participants between February 2023–November 2024. The KNP Evaluation process and protocols were also reviewed and approved separately by IRBs at respective universities.

2.3. Measures

Prior to commencing both the evaluation and focus group studies, a multi-state collaborative of rural kinship stakeholders reviewed and modified the Family Needs Scale, building on prior adaptations [33]. The goal for further adapting the Family Needs Scale was to better reflect the experiences of rural kinship caregivers. For example, language on some needs was adapted to be more kinship specific: "paying for special needs of my child" was changed to "legal assistance related to being a kinship caregiver (for example, adoption, legal custody, guardianship)". Specific items captured separate needs of both kinship children and caregivers related to health care and transportation. Items further expanded understanding of basic needs that may have higher access challenges in rural communities like housing and nutrition. In total, 46 items were included across 8 domains, financial and legal, nutrition, housing, caregiver employment and self-care, transportation, health care, childcare/daycare, and children's education resources. The 5-point response scale to the adequacy of item resources for both kinship caregiver and their child(ren) was maintained, from 1 ("Almost Never") to 5 ("Almost Always") with the additional choice of "Not Applicable", which indicates no need.

The research team created a focus group protocol to further consider cultural differences in conceptualization and operationalization of tool items [36]. The protocol comprised questions aimed at assessing the content's meaning and relevance to rural kinship caregivers. Specifically, we identified items that were acceptable to the group, items needing modification for better clarity or relevance, and items that did not capture concepts important to kinship caregivers. Each of the eight domains of the Family Needs Scale was presented visually, and items were read aloud by the facilitator. Participants were encouraged to discuss any concerns about clarity, understandability, or relevance of the items to

their experiences as kinship caregivers. "Is there any language in these items you think would be more straightforward?", "Could this item concept be asked about in a more understandable way?", and "Please tell us a little about why this item didn't feel relevant to you?" Follow-up questions included asking about language difficulties, the intended meaning of items, and suggestions for improvement in clarity and relevance, such as "What language did you find was difficult to understand?" and "What do you think this item is trying to ask about?" We also evaluated the assessment instructions and response scale to ensure they were clear and understandable. Additionally, participants were invited to share any kinship caregiving needs not addressed by the tool and to identify any potentially offensive or insensitive language used.

2.4. Data Analysis

The focus groups were transcribed verbatim initially by the video conferencing software with revisions for accuracy made by the evaluation team. The transcripts were anonymized to remove any names or potentially identifiable information disclosed by participants and aggregate data were shared across evaluation team members from all three sites for comparison of focus group data. Data were explored by five members of study team (i.e., B.R., A.F., D.W., J.C., J.J.) using content analysis to categorize responses and identify themes explaining item validity [37]. Five evaluation team members familiarized themselves with transcripts and videos. They then rated each participant's response as support, neutral, or disagreement on each domain or item clarity, understandability, and relevance and discussed to come to consensus. Quoted discussion of any item that had a disagreement as well as some supportive discussion was also coded to clarity, understandability, and relevance to kinship experience. While participants were asked about and responded to items in each domain, 29 individual items had no coded remarks discussing confusion or variation with respondents otherwise indicating those domains were clear, understandable, and relevant. Thus, these items were assumed to confirm face validity without the need for updates. The evaluation team identified preliminary validity themes with specific survey item suggestions for any item that may not have had universal face validity having one or more comments of disagreement across focus groups. These themes and item revisions were discussed with the programming team to identify commonalities or wording modifications they may have experienced in practice. Further, quantitative data were reviewed, cleaned, and subjected to reliability analyses using SPSS version 29. Cronbach's alpha was employed to examine reliability using the scale reliability analysis for 41 kinship caregivers from the KNP Evaluation intake survey across the three participating states [38].

3. Results

3.1. Focus Group Descriptive Results

A total of 18 caregivers and key informants participated in the study as seen in Table 1. These individuals represented three states and spanned representation of a variety of rural kinship caregiver demographics. This allowed for a range of perspectives to be represented, including rural communities, kinship type, and care situations. Additional voices such as an Indigenous voice, homeowners and renters, currently working and retired, and both formal and informal care arrangements were represented by participants' explanations of item relevance. It is of note that grandmothers were the primary respondents, but this is the primary population accessing Kinship navigator services within these states as well. Each of the focus group participants were unaffiliated with each state's kinship navigator demonstration projects.

Table 1. Focus Group Participant Characteristics (n = 18 kinship caregivers and n = 25 children).

Characteristics	Range (Average)/Percentage of Total (%)
STATE	
Mountain West Rural State 1	27.8
Mountain West Rural State 2	27.8
Northeast Rural State 3	44.4
SELF-IDENTIFIED RELATION TO KIN	
Grandmother	50.0
Grandfather	16.8
Great-grandmother	5.6
Aunt	16.8
Fictive	11.1
KINSHIP CHILD AGE at the START OF CARE	4–16 (9.4)
KINSHIP CHILD GENDER	
Male	36%
Female	64%

3.2. Focus Group Qualitative Results

Findings from qualitative analysis of the Family Needs Scale support clarity, understanding, and relevance of items for rural kinship caregivers. During the focus groups, some kinship caregivers spoke broadly of the experience and perceptions of caregivers while others shared individual experiences to elaborate on their responses. Four themes were identified from the kinship caregivers' discussions and personal considerations on clarity, understandability, and relevance of items. The first theme highlights broad agreement of the tool's validity to kinship caregivers like themselves. A total of seven items (15% of total) were discussed for minor clarification or relevance by multiple focus groups and fourteen additional items were mentioned once across the four focus groups. Themes from these discussions are highlighted in themes 2 through 4 below. These themes included the broad validity of the items, the defining concepts within some items, the considering ages and stages of the kinship family when responding to items, and the considering the perspective of the child vs. the caregiver when responding to an item.

3.2.1. Broad Validity

Among the focus groups conducted, participants indicated that most items in the tool were clear, understandable, and relevant, not requiring further modification to assess needs of rural kinship caregivers. Of the 46 items, 29 items (63%) received little discussion (1 or less follow-up discussions) beyond positive validity across all 4 focus groups. Some participants provided additional personal examples to support the validity of items by sharing how they were relevant to their specific situations, further supporting the validity of these items within this population. One grandparent caregiver noted the benefits of community support:

> "Some of the things we're dealing with now compared to when my kids were growing up is social media and peer pressure and drugs and alcohol and the ability for me to access help around parenting (support) because, obviously, it's changed considerably."

Another grandparent caregiver highlighted the need for kinship caregiver connection to resources:

> "We ended up connected with (youth support program), but it took me a long time to try and access them and fill out all the forms. We were literally in crisis, it took me months before I even knew who to contact to try and get help".

The focus group respondents in those states voiced how much they would have appreciated being asked about the particular resource needs that were included in the measure when they were first kinship caregivers. For example, one kinship caregiver

mentioned that she did not always know what resources she needed or might be available to her through the KNP when her child first arrived at their home. The Family Needs Scale was newly implemented within KNPs in two of the three states, potentially contributing to this discussion.

3.2.2. Defining Concepts

When reviewing the item with participants, there were multiple discussions among focus group participants regarding concept clarity or shared understanding or wording. Seven items were discussed related to clarity or shared understanding, with four resources discussed in multiple focus groups, including "the ability to complete home repairs or improvements", "ability to do things myself", "babysitting for your kin child(ren)", and "payment for special needs of your kin child(ren)".

Participants felt that some concepts warranted being asked as specific items to reflect the kinship experience. For example, one participant indicated a preference for a specific item reflecting the need for "access to guardianship supports" rather than a broad category of "legal assistance related to being a kinship caregiver (for example, adoption, legal custody, guardianship)". While other participants called out the importance of guardianship support, they felt it was adequately addressed in the list of examples. One aunt providing formal kinship foster care shared how access to adaptive equipment like a car seat at different time points might impact her response to "the ability to transport kin",

> "In my particular circumstance when I got the two children, one was a two-year-old and I didn't have a car seat. . . the (CPS) Department gave us a car seat but then we had to go out and buy one the next day".

There were also discussions across all four focus groups with participants sharing varying examples of how they might interpret items. Ultimately, most of these discussions resulted in participants saying they could adequately see their particular examples or circumstances reflected within the item broadly as written. While many items in the measure already included examples in parentheses to help support a similar understanding of item possibilities, findings suggested that additional examples could be beneficial to support personal relevance. More common examples were discussed related to home repairs, self-care, and babysitting items, with kinship caregivers building on or connecting to each other's experiences.

When considering what home-repair might mean, a variety of perspectives and personal scenarios were shared. Echoing a sentiment expressed in at least two other focus groups, one grandfather caregiver asked if the "ability to complete home repairs or improvements" should reference the impact on the child or the kinship caregiver. "Say my underground sprinklers aren't working, you know, that's not necessary. So maybe just basic essential housework like things that are relatively easier to complete on your own or that pertains to being a caregiver?" Alternatively, an Indigenous grandmother caregiver shared how this item felt relevant to her as a renter though,

> "We have to tell them what's wrong and then if they think it works in their schedule then they will come and fix it. Otherwise, they don't and we're not allowed to do it ourselves unless it comes out of our pocket. Don't come off for rent or anything. I've been looking for a new place, for what, eight months now, and I'm still in the same place because there's nobody on rent. And he owns like 3/4 of the town".

Additionally, across three focus groups, there was discussion considering the definition of babysitting. Some focus group participants indicated that babysitting would be defined by paid care, while other participants suggested it could include unpaid support. There was also discussion of whether the length or regularity of care indicated that a need was related to "babysitting" or better represented by "daycare". Interestingly, this item was one of the adapted items as the initial review team determined that "babysitting" would be a clearer term than "respite care" which was included in the Family Needs Scale that was

previously tested with kinship caregivers [33]. One female caregiver noted the challenges for all in finding adequate child care: "I don't really know if there's any other questions that you could put for this because I mean just daycare in general is hard to find these days". Another fictive kinship caregiver noted challenges in considering access as well: "The ability to get respite care, for like an hour and go actually get the food can be a challenge". Additionally, she noted that "a lot of times with kinship, you're like the only person that these kids have".

Similarly, participants in all four focus groups asked whether the ability to "do things for myself" was about essential self-care or things they considered to be more optional self-care if resources allowed. One formal kinship caregiver (aunt) questioned, "Could I wash my dishes and make my bed, or are you asking, can I get my nails done and go get a haircut?" Another aunt caring for her nephew shared her uncertainty with "ability" when considering self-care, stating, "It's been a challenge because I get judged like I'm some young mom with the kid". These considerations indicated some possible variations in response determined by ways in which focus group participants defined these terms.

3.2.3. Consider Ages and Stages

Another common topic across focus groups addressed ways in which items may indicate different needs depending on the age and life stage of household members. Seven additional items were discussed related to how responses may be different depending on the kinship caregiver or child's age and life stage at the time of care. Three resources were discussed in multiple focus groups, with items including "a job that will support my household", "ability to transport your kin child(ren) to places, including appointments", and the "ability to plan for a future job for your kin child(ren)".

Kinship caregivers discussed the relevance of certain resources potentially changing depending on their own life stage or that of the child/children in their care. For example, the item addressing a "job that will support my household" did not feel relevant to some caregivers. One grandparent caregiver shared, "I am self-employed and my husband is of retirement age. So I don't work, I don't have a job that I go to punch a time clock". Another kinship caregiver of an older child who was bullied and had challenges in school noted a resource they would have found helpful for school-aged kinship caregivers: "I think finding someone to mediate at the schools would be very helpful". Several other kinship caregivers expressed difficulty related to considering future educational or job options for very young children in their care, However, they expressed that it was easier to consider future educational and job options for an older kin child. One grandmother kinship caregiver of a young child pondered:

> "I was thinking who knows what the future is going to bring? Second off, I was thinking if there is a family history of a problem that you could say you know that probably has a high likelihood of happening. And then third, could that be access to insurance to help cover whatever comes up in the future?"

Another kinship caregiver in the same interview expressed that the whole assessment should be age-dependent for more clarity, "for people with older children and then people with younger children".

Further, kinship caregivers discussed that the relevance of particular resources may vary by age and developmental needs of the kin child as well as changes in resources over time. For example, a fictive (teacher) kinship caregiver noted when considering routine childcare, "I'm glad it was good that we only had them (in the summer) because I don't know what I would have done when my work started back up because I'm a teacher and so in the Fall, I don't know how that would have worked". Another grandmother kinship caregiver noted the changing circumstances over time, particularly impacted by rurality:

> "Initially I could afford the gas to be able to take him everywhere. But it was me driving 30 miles twice a day to get him in for community service work, for court

hearings, and appointments. It got very expensive when you're all of a sudden driving, any budget that you have is out the window".

3.2.4. Perspective

With slightly less discussion across focus groups, kinship caregivers discussed four individual items for which they were uncertain if they should consider resource access from their personal perspective or for their kinship child(ren). Additionally, while instructions state that participants should consider "to what extent are the following resources adequate for you and your kin child(ren)?", findings indicate participants may not always feel confident in their assessment of both themselves and their kinship children at the same time when responding to items. No individual item was discussed related to perspective across multiple focus groups, indicating this was a less common challenge for respondents.

For the individual items related to this theme, participants noted their responses may vary when considering their own needs versus those of their kinship children. One grandmother kinship caregiver noted about "access to fruits and vegetables", "The way I eat is not how he needs to eat, luckily WIC. . . has this thing where you get $25 extra fruits and vegetables and (my grandson) love it. . . that made a difference in our life". A Maine participant with several kinship children discussed how phone access may be impacted by perspectives and ages and stages:

> "I think the only thing that really wasn't completely clear to me was the telephone access. I wasn't sure if it was access that us as kinship providers had to have or if it was access to the children. Because like nowadays, obviously everybody has cell phones. . . most of the children, unless they're like teenagers and they have a phone, don't typically have access to a phone".

3.3. Measure Reliability

The intake reliability sample was similar from diverse kinship caregiving life circumstances as seen in Table 2. Notably, the reliability analysis had a smaller representation of grandfathers, but larger representation of uncles and sibling caregivers compared to the focus group sample. The high representation of Native American families aligns with the state's demographics, particularly for kinship caregivers. A Scale reliability analysis including all 46 survey items across 39 participants at KNP intake in one rural state indicated a strong, statistically significant Cronbach's alpha of 0.906. This suggests a strong level of internal consistency among program participants in their responses.

Table 2. Reliability Participant Characteristics from Mountain West Rural State 1; (n = 39 Kinship caregivers and n = 86 children).

Characteristics	Range (Average)/Percentage of Total (%)
KINSHIP CAREGIVER AGE	25–71 (52.5)
KINSHIP CHILD AGE	0–18 (9.3)
KINSHIP CHILD GENDER	
Male	46.5
Female	52.3
Other	1.2
SELF-IDENTIFIED RELATION TO KIN	
Grandmother	56.4
Grandfather	0
Great-grandmother	2.6
Aunt/Uncle	23.1
Sibling/Cousin	7.7
Fictive	10.3
RACE/ETHNICITY of KINSHIP CAREGIVER	
White	51.3
Native American/American Indian	33.6
Black/African American	5.1
Native Hawaiian/Pacific Islander	5.1
Asian	2.6

4. Discussion

KNPs are designed to meet kinship caregivers and relative children's needs to promote their well-being and safe, stable living environments. A key component of enhanced case management within the Kinship Navigator model is connecting kinship caregivers with family-centered services and resources. The assessment of family needs and goal setting based on identified family needs is central to employing this family-centered service approach. Program staff (kinship navigators) and researchers must be able to trust that the tool they are using reasonably captures these unique needs. Results from the focus groups, conducted with diverse kinship caregivers from rural communities in this study, provide support for the clarity, understanding, and relevance of items in the Family Needs Scale.

Furthermore, the population sampled provided a deeper contextual understanding of family needs across a diverse group of rural kinship caregivers. Previous studies largely recruited formal kinship caregivers who likely had more connection to family and social services [33]. Our sample population includes both formal and informal kinship caregiver representation along with caregivers from rural community experiences. While participants described various examples for improving clarity or relevance to their particular life circumstances, very few participants described items as difficult to understand and still felt they could respond with relative accuracy. Even with varying experiences and potential considerations of need, items were broad enough that participants indicated they would respond accurately to indicate a need. The KNPs could further explore individualized circumstances within case management clientele to help best understand these unique considerations and address individualized needs.

To provide further clarity and efficiency of kinship navigator supports and services, the following item updates may be considered and tested. Additional examples in parentheses may be included for items that sparked more kinship caregiver discussion on home repairs, self-care, and babysitting. Considering placement of examples within the questions may help to further clarify and connect to kinship caregivers' experiences, especially for the items on legal assistance. Some questions may benefit from including a time-bound prompt or examples of relevance across ages and life stages to help all respondents to see themselves in the item. Examples might include assessing "income or financial support" instead of "job support" to capture retired caregivers, including accessibility and affordability of transport resources, or only asking about "future educational options (e.g., college)" and "vocational training" if your kid is within 5 years of graduating high school. Additionally, findings indicate participants may benefit from being regularly reminded to consider their present resource adequacy for both caregiver and kinship youth when responding to items of need. Future updates could strengthen understanding of specific kinship caregiver needs, referral to resources, and documentation of change, but all suggested updates should be further validated with the kinship caregiver audience before use.

This study does represent an incremental step in the generation of a family needs assessment that is valid for kinship families, but it is not without limitations. While other types of validity may provide alternative insights on the measure, previous assessments have not explored these aspects of validity with rural kinship caregivers. By exploring the construct, face validity, our study helps understand what the scale measures on the surface as well as assessing whether or not the construct are represented for respondents. Furthermore, face validity is often considered from the perspective of researchers and health care and social service professionals, as was included in developing the adapted version, but often limited input is sought from service users [39]. It is the service users who experience needs that are addressed by Kinship Navigator models and whose outcomes are examined to determine the empirical and clinical value of these intervention models. This study supports and adds to the Lee et al. [33] findings with further depth of validity with rural formal and informal kinship caregivers. Further psychometric analysis in a representative sample of kinship caregivers should be conducted to understand the breadth of reliability. Some response variation may be attributed to the fact that some participants were not currently providing kinship care if their wards were older than 18 years old or

were in the care of their parents at the time of focus group administration. Future efforts should explore the impacts of modifying wording or adding examples to select items towards improving the impact and efficacy of Kinship Navigator service delivery.

Minor suggestions to improve validity could all be viewed as improvements to increase response reliability across rural kinship caregivers. There were not any items identified for removal and even in explaining for clarity, many participants still indicated they felt their examples and counter-examples were at least broadly represented within the item presented and often explained their considerations with individual experiences. Kinship navigators may need to be flexible in understanding needs and inquire further to address families' circumstances. The preliminary quantitative analysis of the adapted kinship Family Needs Scale produced a Cronbach's alpha indicating strong internal consistency of the items together. Thus, while some item improvements could be beneficial to impactful programming, these findings largely indicate that the current adapted Family Needs Scale is valid in measuring family needs for KNPs assessing the needs and outcomes of the rural kinship caregivers they intend to serve.

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References

1. Annie, E.; Casey Foundation. Children in Kinship Care. 2024. Available online: https://datacenter.aecf.org/data/tables/10455-children-in-kinship-care (accessed on 12 July 2024).
2. Generations United. Kinship/Grandfamilies Families: Strengths and Challenges. 2022. Available online: https://www.gksnetwork.org/wp-content/uploads/2022/07/General-Grandfamilies-Fact-Sheet-2022-FINAL-UPDATE.pdf (accessed on 14 May 2024).
3. Annie, E. Casey Foundation. What is Kinship Care? 2023. Available online: https://www.aecf.org/blog/what-is-kinship-care (accessed on 14 May 2024).
4. Winokur, M.; Holtan, A.; Batchelder, K.E. Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment. *Cochrane Database Syst. Rev.* **2014**, *1*, CD006546.
5. Child Welfare Information Gateway. Family Engagement: Partnering with Families to Improve Child Welfare Outcomes. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. 2021. Available online: https://www.childwelfare.gov/pubs/f-fam-engagement/ (accessed on 4 September 2024).
6. O'Brien, V. The benefits and challenges of kinship care. *Child Care Pract.* **2012**, *18*, 127–146. [CrossRef]
7. Xu, Y.; Jedwab, M.; Lee, K.A.; Levkoff, S.E. The negative effects of adverse childhood experiences (ACEs) on behavioral problems of children in kinship care: The protective role of kinship caregivers' mental health. *J. Emot. Behav. Disord.* **2023**, *31*, 41–53. [CrossRef]

8. Berrick, J.D.; Boyd, R. Financial well-being in family-based foster care: Exploring variation in income supports for kin and non-kin caregivers in California. *Child. Youth Serv. Rev.* **2016**, *69*, 166–173. [CrossRef]
9. Wellard, S.; Meakings, S.; Farmer, E.; Hunt, J. Growing Up in Kinship Care: Experiences as Adolescents and Outcomes in Young Adulthood. Grandparents Plus. 2017. Available online: https://www.academia.edu/66697153/Growing_Up_in_Kinship_Care_Experiences_as_Adolescents_and_Outcomes_in_Young_Adulthood (accessed on 30 August 2024).
10. Fergeus, J.; Humphreys, C.; Harvey, C.; Herrman, H. Supporting foster and kinship carers to promote the mental health of children. *Child Fam. Soc. Work* **2019**, *24*, 77–83. [CrossRef]
11. Schneiderman, J.U.; Smith, C.; Palinkas, L.A. The caregiver as gatekeeper for accessing health care for children in foster care: A qualitative study of kinship and unrelated caregivers. *Child. Youth Serv. Rev.* **2012**, *34*, 2123–2130. [CrossRef]
12. Gleeson, J.P.; Wesley, J.M.; Ellis, R.; Seryak, C.; Talley, G.W.; Robinson, J. Becoming involved in raising a relative's child: Reasons, caregiver motivations and pathways to informal kinship care. *Child Fam. Soc. Work* **2009**, *14*, 300–310. [CrossRef]
13. Rushovich, B.; McKlindon, A.; Vandivere, S. Strategies to build evidence for kinship navigator programs under the Family First Act. *Child Trends* **2021**, *12*, 1–12.
14. Koh, E.; Daughtery, L.; Ware, A. Informal kinship caregivers' parenting experience. *Child. Youth Serv. Rev.* **2022**, *133*, 106360. [CrossRef]
15. Matovu, S.N.; Whitley, D.M.; Young, H.M. A Global Perspective on Intersecting Social and Systemic Barriers Experienced by Grandparent-Caregivers: A Qualitative Systematic Review. *GrandFam. Contemp. J. Res. Pract. Policy* **2024**, *7*, 6.
16. Sharda, E.A.; Sutherby, C.G.; Cavanaugh, D.L.; Hughes, A.K.; Woodward, A.T. Parenting stress, well-being, and social support among kinship caregivers. *Child. Youth Serv. Rev.* **2019**, *99*, 74–80. [CrossRef]
17. Grandfamilies and Kinship Support Network. Kinship Data. Generations United. Available online: https://www.gksnetwork.org/kinship-data/ (accessed on 14 May 2024).
18. Wu, Q.; Zhu, Y.; Brevard, K.; Wu, S.; Krysik, J. Risk and protective factors for African American kinship caregiving: A scoping review. *Child. Youth Serv. Rev.* **2024**, *156*, 107279. [CrossRef] [PubMed]
19. Letiecq, B.L.; Bailey, S.J.; Kurtz, M.A. Depression among rural Native American and European American grandparents rearing their grandchildren. *J. Fam. Issues* **2008**, *29*, 334–356. [CrossRef]
20. Anderson, L.R.; Buck, C.; Hayward, G.M. *Grandparents and Their Coresident Grandchildren: 2021*; Current Population Reports, P20-588; U.S. Census Bureau: Suitland, MD, USA, 2024.
21. Smithgall, C.; Yang, D.H.; Weiner, D. Unmet mental health service needs in kinship care: The importance of assessing and supporting caregivers. *J. Fam. Soc. Work* **2013**, *16*, 463–479. [CrossRef]
22. Kiraly, M.; Hoadley, D.; Humphreys, C. The nature and prevalence of kinship care: Focus on young kinship carers. *Child Fam. Soc. Work* **2021**, *26*, 144–152. [CrossRef]
23. Cromartie, J. Frontier and Remote Area Codes. U.S. Department of Agriculture, Economic Research Service. 2024. Available online: https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes/ (accessed on 14 May 2024).
24. Avery, E.E.; Hermsen, J.M.; Kuhl, D.C. Toward a better understanding of perceptions of neighborhood social cohesion in rural and urban places. *Soc. Indic. Res.* **2021**, *157*, 523–541. [CrossRef]
25. Day, A. Foster Care Stigma and Ethical Boundary Violations in the Rural Child Welfare Workplace. *Rural Child Welf. Pract. Stories Field* **2018**, *16*, 174–209.
26. Lee, D.H.J.; Huerta, C.; Farmer, E.M. Kinship navigation: Facilitating permanency and equity for youth in child welfare. *Child. Youth Serv. Rev.* **2021**, *131*, 106251. [CrossRef]
27. Sutphin, S.T. Using kinship navigators to assess the needs of kinship caregivers. *GrandFam. Contemp. J. Res. Pract. Policy* **2015**, *2*, 3.
28. Day, A.; Barton, E.; Cross, S.; Miller, C.; Gonzales, J. Experiences and service utilization of American Indian/Alaskan Native kinship caregivers in kinship navigator programs across Washington state. *Fam. Soc. J. Contemp. Soc. Serv.* **2024**, *105*, 19–36. [CrossRef]
29. Schmidt, M.C.; Treinen, J. Using kinship navigation services to support the family resource needs, caregiver self-efficacy, and placement stability of children in informal and formal kinship care. *Child Welf.* **2017**, *95*, 6990.
30. Dunst, C.J.; Cooper, C.S.; Weeldreyer, J.C.; Snyder, K.D.; Chase, J.H. Family needs scale. In *Enabling and Empowering Families: Principles and Guidelines for Practice*; Brookline Books: Brookline, MA, USA, 1988; pp. 149–151.
31. Hanley, B.; Tassé, M.J.; Aman, M.G.; Pace, P. Psychometric properties and norms of the Family Needs Scale. *J. Child Fam. Stud.* **2003**, *12*, 41–48. [CrossRef]
32. Littlewood, K. Kinship services network program: Five year evaluation of family support and case management for informal kinship families. *Child. Youth Serv. Rev.* **2015**, *52*, 184–191. [CrossRef]
33. Lee, E.; Choi, M.J.; Clarkson-Henderix, M. Examining needs of informal kinship families: Validating the family needs scale. *Child. Youth Serv. Rev.* **2016**, *62*, 97–104. [CrossRef]
34. Fowler, F.J. *Improving Survey Questions: Design and Evaluation*; Sage: Thousand Oaks, CA, USA, 1995.
35. Krueger, R.A.; Casey, M.A. *Focus Groups: A Practical Guide for Applied Research*; Sage Publications: Thousand Oaks, CA, USA, 2009.
36. Sidani, S.; Guruge, S.; Miranda, J.; Ford-Gilboe, M.; Varcoe, C. Cultural adaptation and translation of measures: An integrated method. *Res. Nurs. Health* **2010**, *33*, 133–143. [CrossRef]

37. Castel, L.D.; Williams, K.A.; Bosworth, H.B.; Eisen, S.V.; Hahn, E.A.; Irwin, D.E.; Kelly, M.A.; Morse, J.; Stover, A.; DeWalt, D.A.; et al. Content validity in the PROMIS social-health domain: A qualitative analysis of focus-group data. *Qual. Life Res.* **2008**, *17*, 737–749. [CrossRef]
38. Tavakol, M.; Dennick, R. Making sense of Cronbach's alpha. *Int. J. Med. Educ.* **2011**, *2*, 53–55. [CrossRef]
39. Wiering, B.; de Boer, D.; Delnoij, D. Patient involvement in the development of patient-reported outcome measures: A scoping review. *Health Expect.* **2017**, *20*, 11–23. [CrossRef]

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