

IMPACT OF KINSHIP NAVIGATOR PROGRAM ON RURAL KIN CAREGIVER  
WELLBEING

by

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## DEDICATION

First and foremost, I dedicate this thesis to God Almighty, your divine guidance has sustained me throughout this journey.

To my beloved husband, your endless encouragement and unconditional love, and support have been my anchor during the most challenging times.

To my amazing parents, your sacrifices and praise have been a pillar of support. Thank you for raising me right.

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## ABSTRACT

More than 2.6 million children live in kinship families without their parents. Kinship caregivers provide care for children whose parents are unable to care for them, yet often face significant challenges that can impact their wellbeing and the caregiving situation. In line with the passing of the Family First Prevention Services Act in 2018, Kinship Navigator Programs are required to submit for evaluation in the Title IV-E Prevention Services Clearinghouse to seek federal reimbursement. This study evaluated the efficacy of the Montana Kinship Navigator Program in improving caregiver wellbeing through its intervention (Enhanced Case Management) compared to a service-as-usual control (Information and Referral only). The quasi-experimental design compared caregivers in the intervention group (n=59) to the control group (n=33) across measures of wellbeing, services accessed, and navigator assistance at case closure. Data was collected through surveys and program records. The preliminary findings support wider implementation of enhanced case management services. Analysis showed significantly higher wellbeing in the intervention group across domains of coping, enjoying life, and average wellbeing compared to controls. Navigator assistance was significantly higher for the intervention group and positively correlated with multiple wellbeing domains across all participants. Financial and health service accessed showed positive associations with improved health wellbeing across participants. Financial resources emerged as particularly important for improving wellbeing for rural kinship caregivers. White non-Hispanic caregivers were more likely to access more services and navigator support compared to Black, Indigenous, and other People of Color, who in turn were more likely report higher stress. This demonstrates the need for training and culturally informed navigator support to promote equitable access. Implementing enhanced intervention could better address the complex needs of kinship families, particularly in underserved rural communities where resources are limited. MTKNP's recognition by the Clearinghouse and state legislators can result in a more sustainably funded program and positive wellbeing outcomes for kin caregivers and their kin children.



## INTRODUCTION

In the US, over 7.6 million kids live a home where someone other than the parent is the head of the household; more than 2.6 million of these children live with kinship families without their parents (The Annie E. Casey Foundation, 2022; U.S. Census Bureau, 2022). Approximately 9.2% of children in Montana live in a home where a relative is the head of the household (Grandfamilies.org, 2021; U.S. Department of Health and Human Services et al., 2021). Kinship care as a favored placement option has been growing over the years. Montana has witnessed about 67% increase in children within kinship care living arrangements from 2017 through 2019 to 2020 through 2022 (The Annie E. Casey Foundation Kids Count Data Center, 2023). This demonstrates the increased implementation of kinship care as a primary assignment option for children who are removed from the home. Kinship care may result from a report of abuse or neglect, parental economic instability, incarceration, substance use disorder, domestic violence, military deployment, illness, or death of a parent (The Annie E. Casey Foundation, 2012).

Kinship caregivers raise a relative or fictive kin child when the biological parents are unable to provide care. This could be formal—initiated by the Child and Family Services (CFS) division in the state— or informal, where the kin caregiver steps into the protective caregiving role without government intervention. Kids separated from parents have been primarily entered into the formal foster care system as a ward of the government. Due to the unexpected nature of kinship care, caregivers often require assistance in service navigation. Both formal and informal caregivers can benefit from services that provide supports for themselves and their kin child (Wheeler & Vollet, 2017). Therefore, there is need to evaluate and enhance the Kinship Navigator Programs (KNPs) which are designed to help kin caregivers.

Kinship Navigator Programs are a social service program developed with efforts aimed at assisting relative or fictive caregivers in navigating government and private resources within the community (Littlewood et al., 2020). KNP help relative caregivers succeed in their caregiving roles. This could be in the form of providing information, referral, concrete goods, legal, finance, housing and healthcare assistance for kin children and caregivers. Support in KNPs may also include training, or education to improve family wellbeing, use of support groups and referrals to other social, behavioral, or health-related services as well as helping kin caregivers access government services (like Social Security Income, Temporary Assistance for Needy Families, Medicare, Medicaid, etc.) which are often a challenge for these families (Littlewood et al., 2020; Wilson et al., 2019). Many caregivers taking on the responsibility of raising relative children are often unaware of government assistance that may be available to them (The Annie E. Casey Foundation, 2012). Research has shown that both caregiver and child can achieve positive wellbeing when provided with the proper support tools and services (The Annie E. Casey Foundation, 2012).

The separation of children from their parents can result in emotional and psychological trauma for the child and family members involved (Strozier, 2012). There is a need to help kin children and their caregiver families in adjusting to this major life transition. KNPs may improve kin placement outcomes for kin children and caregiver family. Appropriately supporting families through this change can potentially influence short-term and long-term outcomes such as wellbeing, safety within the home environment, stability of the child's living situation, and the achievement of a permanent placement (Strozier, 2012).

## Literature Review

### Wellbeing of Kinship Caregiver and Child

Wellbeing is a multidimensional quality of life concept which may be subjective (kin caregiver and family perspectives of their wellbeing) or objective (measured by social factors like income, education, health, housing). The World Health Organization (WHO) defines wellbeing as elements comprising quality of life and the ability for people to contribute to community and make sense of meaning and purpose in life. Wellbeing is a resource needed for all to thrive in daily affairs as is relevant to both caregiver and child outcomes (Harding et al., 2020).

Kin caregivers often experience both rewards and challenges related to their wellbeing when providing care. Kin caregivers report higher satisfaction with providing care but higher levels of stress and more mental wellbeing issues as compared to their foster caregiver counterparts (Harding et al. (2020). Similarly, comparing kin to non-kin caregivers, kin caregivers were found to be more prone to be depressed or persist in a depressed state. (Garcia et al., 2015). Despite the challenges, there are benefits involved with kinship care.

There is evidence of positive influences of kinship care provision on caregiver wellbeing. Hilbrand et al. (2017) found that custodial grandparents had a reduced mortality when compared to non-helper groups—such as non-caregiving grandparents or non-grandparents—after accounting for covariates including demographics and health. Some other rewarding impacts include building family resilience when going through adversity, a sense of fulfillment and contribution to the family (Wu et al., 2023). Caregivers are an important asset in the child

welfare system (Bramlett et al., 2017) and ensuring their wellbeing is of utmost importance to also ensuring wellbeing of the children they support.

Children in kinship care also benefit from relative placement arrangement. Some of the advantages potentially include fewer behavioral disruptions, maintained sibling relationships, continued cultural connections as well as higher levels of safety, stability and permanence (The Annie E. Casey Foundation, 2012; Wheeler & Vollet, 2017). Additionally, child behavioral outcomes are correlated with caregiver wellbeing and functioning. Garcia et al. (2015) found that youth placed with relatives often had improved social, emotional, and behavioral outcomes compared to a non-relative foster care group despite caregivers reporting depression. These outcomes were mostly improved for youth whose caregiver's depression reduced over time. A multifaceted, coordinated intervention targeting all levels of the caregiver's environment could potentially promote kin caregiver wellbeing which may lead to positive outcomes for the child. Hence, while placing kids with kin proves beneficial, it is important to provide adequate resources and guidance to caregivers.

These kin caregivers who take up the responsibility of raising a relative's child frequently confront difficulties accessing basic resources for them and their family (Riley-Behringer & Cage, 2014) and barriers to resources may be impacting their wellbeing and that of their family. Informal kin caregivers also report higher levels of insufficiency for financial support than non-kin caregivers, (Rushovich et al., 2017). We also know that poorer caregiver health, fewer support systems and high financial burden may negatively impact kinship care outcomes (Foluso et al., 2024). Therefore, there is need to recognize effective strategies KNP's can implement to mitigate kinship caregiver burnout and meet the needs of diverse caregivers and kin children in

their care. While many studies explore the impacts of KNPs on child wellbeing outcomes, there exists research gaps regarding the influence of navigator supports on kin caregiver wellbeing.

### Rural Kinship Care

Supporting kinship caregivers in rural communities is important and presents unique challenges. It is recognized that in frontier rural states families often encounter even more difficulty in accessing basic amenities like food, housing, and healthcare (Scott & Koller, 2019). Characterized by less dense population, high poverty rates, lower wages, with limited availability and/or long distances to basic amenities and community infrastructures, rural dwelling when compared to urban living is more likely to result in poorer physical and mental health (Scott & Koller, 2019).

Kinship caregivers are also demographically different from parent caregivers. They are often older, and from lower socioeconomic status (The Annie E. Casey Foundation, 2012). Some minority populations (such as Native Americans) have a higher percentage of their total population dwelling in rural areas and are often understudied in research (Foluso et al., 2024; USDA, 2020). These sociodemographic characteristics intersected with rural living could lead to even greater disparities for this population.

KNP delivery in rural states also faces difficulties such as fewer resources, limited access to kinship navigators, long distances, and lack of public transit in rural areas. As there are currently no rated KNPs targeting rural populations, it is even more imperative to evaluate these programs for effectiveness in rural context. There are research gaps around marginalized groups like wellbeing of rural caregivers, grandparents, and racial/ethnic minority kin caregivers which may account for varying caregiving experiences (Foluso et al., 2024). To address this gap in

programming, the MTKNP has been adapted specifically for delivery throughout rural states. An evidence-based evaluation of KNP in rural communities could potentially support service to rural audiences across the United States.

### History of Kinship Navigator Programs

Prior to Family First Prevention Services Act of 2017 (FFPSA), federal child welfare funding priorities had centered on foster care placement rather than prevention contributing to an overburdened foster system and separation of families (Annie E. Casey Foundation, 2019). With research highlighting the benefit of kin-first placement of children in the welfare system compared to non-relative foster care of children (Strozier & Krisman, 2007), The Family First Prevention Services Act was passed in 2018 in recognition of the increased role of kinship families in caring for children unable to remain with their parents (115th Congress, 2018). The objectives of the FFPSA of 2017 include helping states provide substance abuse and mental health prevention and treatment services, in-home parenting programs and kinship navigator services to children at risk for removal from the home (115th Congress, 2018). This provides sustainable funding under parts B and E of the Title IV of the Social Security Act for enhanced prevention plans from entry into foster care systems. Reimbursement for these services is based on their evidence-based impact review by a federal Clearinghouse.

To ensure that kids are placed in family-like settings that would encourage them and their caregivers thrive, KNP services are currently being revised in many states across the country in line with passing of the FFPSA of 2017 (Wilson et al., 2019). As stated by the FFPSA of 2017, the Child and Family Services Division (CFSD) in every state is required to create a foster care prevention plan in the event of a report of abuse or neglect, and one of these is kin placement.

Out of home non-kin placements are considered when there is no way for the child to safely remain in-home or live short term with a kin caregiver as well as when reunification with parents or permanency with a relative caregiver is unattainable. KNPs across the country are trying to help kinship caregivers navigate new caregiver challenges, with some showing success, particularly in the safety and permanence of children in kin care (Wheeler & Vollet, 2017). The overall goal of KNPs is to provide resource navigation for kinship families and help them ultimately achieve outcomes like child safety, stability, permanence, optimum child and caregiver wellbeing outcomes and family satisfaction with services (Wilson et al., 2019).

Before the FFPSA of 2017, kinship programs in many states were semi-formal and often only serving high need areas due to resource constraint. KNPs are required to submit their service model for evaluation in the Title IV-E Prevention Services Clearinghouse if they would like to be federally reimbursed. Programs that meet the criteria for causal evidence can be rated as promising, supported, well-supported and are then eligible to receive federal funds. KNPs are often challenging to evaluate in accordance with Clearinghouse guidelines because they must meet rigorous standards for design and execution that may be difficult to achieve or ethically concerning in communities of service by taking away services, they may have already had access to in order to randomize participants for program evaluation. By following the standard procedures outlined by Title IV-E Prevention Services Clearinghouse, MTKNP can build evidence to support eligibility for federal dollars and fill the programming gap demanded by the FFPSA of 2017.

At the time of legislative approval, there were no kinship program evaluated by the Clearinghouse (Title IV-E Prevention Services Clearinghouse, n.d.). Out of nine kinship

navigator associated programs and services reviewed by 2024, five currently meet the minimum acceptable criteria: *Ohio's Kinship Supports Intervention/ProtectOHIO* and *Foster Kinship Navigator Program* are rated promising, *Colorado Kinnected Kinship Navigator Program* and *Arizona Kinship Support Services* are rated as supported and only *30 Days to Family*® a non-state specific Child Welfare Agency administered program is rated well-supported (Title IV-E Prevention Services Clearinghouse, n.d.). None of these programs have evaluated their KNP services specifically meeting the needs of rural formal and informal kin caregivers.

### Current Study

This multi-site community-based program with a quasi-experimental design (QED) was delivered in an alliance between two rural frontier states - the Montana Kinship Navigator Program (MTKNP) and the Kinship Connections of Wyoming (KCW). This study specifically explores preliminary data from MTKNP and was conducted to evaluate outcomes of a collaboratively designed Kinship Navigator Program Model. The overarching goal of the current study is to examine the relative efficacy of the intervention (enhanced case management services) compared to service as usual control (information and referral services) in improving wellbeing outcomes for caregivers and kinship families in rural communities. Evaluating these KNPs would help identify helpful program interventions for kinship caregivers in rural communities, ensure sustainable funding for this research-informed program, and determine if service utilization predicts caregiver wellbeing.



### Research Questions

- 1) Does the intervention (enhanced case management services) significantly improve caregiver wellbeing compared to the control (information and referral services) at case closure?
  - a. Is there a significantly higher mean score (i) wellbeing average and sub-domains (coping wellbeing, less stressed wellbeing, improved health wellbeing and enjoying life wellbeing); (ii) navigator support and (iii) services accessed at case closure for intervention group compared to the control?
- 2) Does accessed services correlate positively with navigator assistance.
  - a. Is there a significant correlation by sub-domains of services (financial, health)?
  - b. Do high needs at enrollment correlate significantly with services accessed?
- 3) Is there significant correlation between services accessed, navigator assistance and caregiver wellbeing?
- 4) Is there a significant association between navigator assistance, caregiver wellbeing and sociodemographic characteristics?

CHAPTER TWO

IMPACT OF KINSHIP NAVIGATOR PROGRAM ON RURAL  
KIN CAREGIVER WELLBEING

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## Abstract

### Background

Kinship caregivers often face significant challenges that can impact their wellbeing and the caregiving situation. In line with the passing of the Family First Prevention Services Act in 2018, Kinship Navigator Programs are required to submit for evaluation in the Title IV-E Prevention Services Clearinghouse to seek federal reimbursement.

### Objectives

This study assessed the efficacy of the Montana Kinship Navigator Program (MTKNP) in improving caregiver wellbeing through its intervention services (Enhanced Case Management) compared to a service-as-usual control (Information and Referral only).

### Method

The quasi-experimental design compared caregivers in the intervention group (n=59) to the control group (n=33) on measures of wellbeing, services accessed, navigator assistance and sociodemographic characteristics at case closure. Data was collected through satisfaction surveys and program records.

### Results

The intervention group showed significantly higher wellbeing across domains like coping, enjoying life, and average wellbeing versus controls. Navigator assistance was significantly higher for the intervention group and positively linked to multiple wellbeing domains. Financial and health services accessed were associated with improved health and

wellbeing. White non-Hispanic caregivers accessed more services and navigator assistance while BIPOC caregivers reported higher stress.

### Implications

The preliminary findings support wider implementation of enhanced case management services. Highlighting financial resources as particularly important in rural kinship care. The observed disparities demonstrate the need for culturally informed navigator support. MTKNP's recognition by the Clearinghouse and state legislators can result in sustainable funding for beneficial kin caregiver/child outcomes.

*Keywords:* kinship, navigator, evaluation, rural, caregiver, wellbeing

### Impact of Kinship Navigator Program on Rural Kin Caregiver Wellbeing

In the U.S., over 7.6 million children live in a home where someone other than a parent is the head of the household, with more than 2.6 million specifically living in kinship families without their parents. Approximately 9.2% of children in Montana, live in a home where a relative is the head of the household (Grandfamilies.org, 2021; U.S. Department of Health and Human Services et al., 2021). Kinship care as a favored placement option has been growing, with Montana witnessing an increase of about 67% in the number of children in kinship care living arrangements from 2017-2019 to 2020-2022 (The Annie E. Casey Foundation, 2022; U.S. Census Bureau, 2022). This demonstrates the increased implementation of kinship care as a primary assignment option for children removed from the home.

Kinship care may result from abuse or neglect, parental economic instability, incarceration, substance use disorder, domestic violence, military deployment, illness, or death of

a parent (The Annie E. Casey Foundation, 2012). Kinship caregivers raise a relative or fictive kin child when the biological parents are unable to provide care, either formally through Child and Family Services or informally without government intervention. Compared to non-relative foster care, research indicates that kin-first placement can be more beneficial to the child's immediate and long-term wellbeing, potentially including improved wellbeing, safety within the home environment, stability of the child's living situation, and the achievement of a permanent placement.

Due to the unexpected nature of kinship care, caregivers often require assistance in service navigation. Therefore, there is a need to evaluate and enhance Kinship Navigator Programs (KNPs), which are designed to help kin caregivers succeed in their roles by providing information, referrals, concrete goods, legal, finance, housing, healthcare assistance, training, education, support groups, and access to government services. Many caregivers lack awareness of available resources, and research has shown that kinship families can achieve positive results when provided with proper support tools and services (The Annie E. Casey Foundation, 2012).

The separation of children from their parents can result in emotional and psychological trauma for the child and family members involved. KNPs may improve kin placement outcomes for kin children and caregiver families by helping them adjust to this major life transition. Appropriately supporting families through this change can potentially influence outcomes positively. Therefore, evaluating and enhancing KNPs is crucial to ensuring the wellbeing of kinship families.

The Family First Prevention Services Act (FFPSA) of 2017 recognized the crucial role of kinship families in caring for children unable to remain with their parents, emphasizing the need

for prevention services and kinship navigator programs (Wilson et al., 2019). The FFPSA provides an opportunity for federal funding reimbursement for evidence-based models that support families and reduce the risk of child welfare system involvement. Rigorous evaluation of kinship navigator programs is necessary to meet the Clearinghouse criteria and ensure eligibility for this funding stream. Programs like the Montana Kinship Navigator Program (MTKNP) aim to build robust evidence through ongoing evaluation, highlighting the potential benefits of enhanced interventions for improving caregiver wellbeing and access to services.

Kinship caregivers face significant challenges, including financial strain, legal issues, and physical and emotional stress, which can negatively impact their wellbeing and the stability of the caregiving situation. Caregiver wellbeing is important, as it not only impacts the caregivers themselves but also influences the overall family dynamics and the development of the children in their care. However, there are gaps in evaluated kinship navigator programs, particularly none tailored to rural communities. Recognizing the importance of supporting these families, this study evaluates the efficacy of a Kinship Navigator Program in fostering positive wellbeing outcomes for kinship caregivers.

### Current Study

The study utilized a quasi-experimental design to evaluate the relative effectiveness of Enhanced Case Management (intervention group) and Information and Referral (control group). The intervention involved three to four goal-oriented sessions with a Kinship Navigator over 6 months, providing tailored support, tangible goods, financial assistance, and referrals based on the caregiver's needs. In contrast, the control group received minimal services— information and referral only— and a standardized packet with general state resources. The broader aim of the

study is to evaluate if enhanced case management significantly improved caregiver wellbeing versus information and referral at case closure. More specifically our objectives are (1) To determine if the intervention group has significantly higher mean wellbeing scores, navigator assistance and services accessed at case closure compared to the control group (2) To assess the correlation between services accessed and navigator assistance and determine if access of sub-domains of services (financial, health) are associated; (3) To determine if high needs at enrollment are associated with services accessed; (4) To assess the relationship between services accessed, navigator assistance and caregiver wellbeing, and (5) To assess the association between navigator assistance, caregiver wellbeing and sociodemographic characteristics (race/ethnicity and SNAP benefit eligibility).

## Methods

### Research Design

Montana State University Extension has been serving formal and informal kinship families caring for a relative's child since 2002. To facilitate positive rating by the Clearinghouse, a collaboratively adapted and designed program, MTNKP, and its evaluation model was adapted to serve relative caregivers in rural Montana. This study was approved by the Montana State University Institutional Review Board (DK113021-EX). The quasi-experimental research methodology was designed by a large collaborative consisting of experts, advisory council members and stakeholders with lived experience contributing to key program components and program direction. Both programs in this partnership combined evaluation data to reduce the intervention period and limited resources that would otherwise be required to reach the recommended sample size of 250 participants for the Clearinghouse. This combination allows for



increased power to detect statistically significant differences between the two interventions in a timely manner. This design was also selected due to real world difficulties associated with a randomized control trial such as providing equal availability of intervention, limited staffing, and resources (Schweizer et al., 2016). The model was also examined for fidelity to delivery of services to ensure the program was being implemented as intended and consistent across participants. Child welfare services could not be used as the control condition because many kin caregivers often take up informal caregiving roles without involvement from child protective services, (Bramlett et al., 2017), we opted to use service-as-usual (Information and Referral only) as our control condition.

To be considered for moderate causal evidence rating, the Prevention Services Clearinghouse requires KNPs to ensure similarity between control and intervention groups (Wilson et al., 2019). By achieving baseline equivalence, or statistically controlling baseline differences, a quasi-experimental study design can prevent substantially different characteristics confound (Wilson et al., 2019). To improve potential similarity between groups, the evaluation team selected the intervention and control groups by counties as shown in Table 1. We first considered some components of case management services such as support groups that were already underway in some counties in Montana. We ensured information and referral participants still had access to support groups by creating new groups physically or virtually available to control counties. To avoid withdrawing services, additional intervention counties were picked because they were within two hours of an existing Navigator or Extension Agent active in local kinship support. We also looked for equal dispersion of urban versus rural, and tribal counties between groups and split between more resource-heavy western and less resource-rich eastern

Montana and proximity to current kinship support groups. More control counties were selected to account for differences in size and population density between the two groups. Due to challenges associated with rural programming, virtual contact methods were utilized to facilitate program delivery.

Table 1. Intervention and Control Counties.

Intervention Counties	Control Counties
Mineral, Missoula, Lake, Ravalli, Granite, Powell, Glacier, Pondera, Teton, Cascade, Toole, Liberty, Chouteau, Hill, Blaine, Philips, Valley, Garfield, Rosebud, Treasure, Daniels, Sheridan, Roosevelt, Richland, McCone, Dawson, Prairie, Wibaux, Fallon, Custer, Powder River, and Carter	Yellowstone, Silver Bow, Deer Lodge, Beaverhead, Madison, Jefferson, Broadwater, Meagher, Wheatland, Golden Valley, Musselshell, Petroleum, Fergus, Judith Basin, Big Horn, Carbon, Stillwater, Sweet Grass, Park, Gallatin, Lewis and Clark, Flathead, Lincoln, Sanders.

Allocation Allocation to the intervention condition (i.e., enhanced case management services- CM) or the control condition (i.e., provision of information and referrals- IR) occurred at the individual participant level and was determined by county of residence. Participants residing in counties designated for the intervention were screened for eligibility criteria for the intervention condition. Those reporting two or more basic needs (e.g., housing, healthcare) or one complex need (e.g., legal services) and expressing interest in receiving case management services were considered eligible to participate in the enhanced case management service. Caregivers residing in intervention counties were ineligible if contacted by the Navigator, met eligibility criteria for the intervention, but declined to receive the enhanced case management services.

All eligible caregivers, regardless of county designation, were notified about the study and provided the opportunity to participate. Participants were assigned to the control condition if they met one of the following criteria: (1) resided in a county designated for the control condition; (2) resided in an intervention county but did not meet eligibility criteria for case management services; or (3) resided in an intervention county, met eligibility criteria, were placed on the waitlist for intervention services, but due to program capacity limitations, opted out of receiving the enhanced case management intervention.

Study Eligibility At the time of enrollment into the program, eligible participants are enrolled into the study. All caregivers could access navigator services irrespective of eligibility. To be included in the evaluation they had to meet the following inclusion criteria: (1) Presently serving as a kin 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, (5) The caregiver is reaching out about a new kinship caregiving need. Cases were excluded if they did not meet the following criteria: (1) They had an open or current case with MTKNP prior to starting the evaluation consent process, (2) Did not meet the minimum requirement of 80% fidelity to service.

### Program Components

Kinship Navigator Programs are grounded in theory to inform their design and approach. The current study utilized a quasi-experimental design to assess the relative efficacy of Enhanced Case Management (intervention group) to Information and Referral (control group) in improving caregiver wellbeing outcomes. The essential program components were determined by a multi-state collaborative of rural states across the US. Due to multifaceted factors impacting child and

caregiver, it is essential to utilize a suitable model that accounts for the complexities for factors and interactions. Bronfenbrenner (1986) ecological systems theory has been identified as an appropriate framework to address dynamic social issues in the context of kinship care (Hong et al., 2011).

This perspective emphasizes the constant interaction between the developing child and their immediate microsystem environment (which may include kin caregiver/family, birth parents, teachers), the mesosystems (which involve the interacting microsystems), the exosystems (like social supports, community resources, schools), the macrosystems (culture, economics, policies) and the chrono systems (life transitions like parenteral separation, or historical happenings, like the COVID-19 pandemic) that exert sometimes indirect yet profound impacts (Hong et al., 2011). KNPs serve to connect caregivers and children to needed support services across ecological systems. Through relationships with organizational partners operating within the exosystems, KNPs can facilitate referrals tailored to the family and child developmental chronosystem ages and stages. By also functioning at the macrosystem level through policy interactions that enable the provision of these enhanced services, KNPs dynamically address the evolving needs and multidimensional factors influencing wellbeing of kinship caregivers and the children in their care.

Enhanced Case Management (Intervention) The intervention consisted of at least three to four goal-oriented, enhanced case management sessions with a kin caregiver and Navigator. These included at least an initial visit, follow-up visits at 3 weeks, 3 months, and potentially 6 months post-baseline. Goals are informed by client's needs assessment, discussion, requests and/or location specific needs. Clients could receive comfort cases, tangible goods, financial

support and referral to services based on the specific goals set by the Navigator. In addition, they get a standardized packet with general state resources, county-specific forms and Grandfamilies facts. Resource types include legal aid, self-care, housing assistance, and nutrition information. During the intervention, Navigators are available for unlimited additional contact. Needs and goals are re-evaluated by the Navigator during the 3-month visit. For example, the Navigator could work with the client with a goal of securing SNAP benefits within the next month. If successfully completed and no new goals identified, the Navigator closed the case. However, if goals are incomplete or new needs/objectives surfaced, services are continued, and an additional 6-month visit conducted. During this visit, goals are reexamined, and the case is closed. This flexible approach allowed for responsiveness to emerging needs over the intervention duration. Clients can also contact the navigator between regularly scheduled visits with questions or for support.

Information and Referral Only (Control) When they reach out to the KNP, participants in the control condition receive minimal follow-up information and referral services. All communication with service-as-usual participants occurs via phone, text, or email, depending on the participant's preference. They get a standardized packet with general state resources, county-specific forms and Grandfamilies facts. Resource types include legal aid, self-care, financial and housing assistance, and nutrition information. Although control participants can initiate contact with Kinship Navigators (via the website or outreach materials) to request more resources, no additional outreach or case management to navigate resources is provided unless by specific participant request. Also, the Navigators do not offer these families tangible goods. The Navigators are available for unlimited contacts or questions as long as they are initiated by the

participant. All control cases stay open for 4-6 weeks after the last participant contact. If 4 weeks pass with no contact, the case is closed. Cases still open at the 6-month mark due to ongoing participant contact are automatically closed and given a post evaluation. Clients who have reached 6-month post-closure (beyond evaluation timeframe) are able to request additional services. Clients can also contact the navigator between regularly scheduled visits with questions or for supports.

### Recruitment

Kinship caregiver participants were recruited utilizing mixed outreach strategies. Both caregiver groups were reached via organizational or professional partnerships also serving these families like, schools, childcare scholarship locations, children's hospitals, extension staff, district judges, 211 and the Department of Child and Family Services. Additionally, caregivers could reach out via the website and a toll-free line. The intervention participants were able to contact the program after a direct outreach, warm handed-off from partner organizations to facilitate contact, this was not implemented for the control counties who primarily contacted the program because they had seen marketing materials such as the webpage, flyers, community tabling events etc. Once a caregiver reached out or partner organization referred, the KNP reached back out to share more about the study, check eligibility, provide services, and consent participants if willing and eligible. Enrollment into the evaluation was promoted by providing similar gift card incentives to all participants whose data was collected for inclusion in the study. To encourage retention, incentives at 6-month post-closure evaluation were higher. Study participants in both groups could be contacted via in-person or virtual (phone, email, text)

meetings based on clients' preferred method of follow-up. Study enrollment commenced in February of 2022.

### Data Collection

The cases in the intervention groups were contacted at a 3week, 3month, case closure and 6-month post-closure. While the control groups were only followed up at case closure and 6-month post-closure. The same measures were used for data collection in both groups and time points, except for the baseline measures used in case counties to determine eligibility for and potential service needs. Navigators administered satisfaction surveys at case closure via telephone, email, or online survey. At 6-month post-closure, the evaluation team collected the follow-up evaluation measure through telephone or electronic survey methods. Data collection was facilitated by use of Montana State University Qualtrics (<https://www.qualtrics.com>) for online surveys and Titanium® (client relationship and data management software).

Measures The following measures were utilized in this study: (1) Sociodemographic, (2) Family Needs Assessment, (3) Access to Services and (4) Caregiver Wellbeing.

*Sociodemographic* Sociodemographic variables were collected during intake to confirm equivalence between groups include age of caregiver, sex of caregiver (male or female), race/ethnicity (which was dichotomized as 0=White, non-Hispanic and 1= Black, Indigenous, and other People of Color) and self-reported SNAP (Supplemental Nutrition Assistance Program) benefits 0=No, 1= Yes suggested by the Clearinghouse (Wilson et al., 2019) an indication of socioeconomic status.

*Family Needs Assessment* The study utilized a 46-item Family Needs Assessment measure adapted from the Family Needs Scale.(Lee et al., 2016) This measure is used for caregivers residing in intervention counties and is a pre-only measure. The measure evaluates the adequacy of specific social, educational, nutritional legal, and financial resources for kinship caregivers and the children in their care. The items assessed the degree to which the caregiver perceived their access to various support resources as sufficient to meet their family's needs while providing kinship care. The adapted measure was validated via focus group interviews with kinship caregivers coordinated by three rural states within the Kinship Navigator Collaborative in July 2023.

Caregivers were asked to rate each resource on a 5-point Likert scale: 1) Almost Always Adequate 2) Usually Adequate, 3) Sometimes Adequate, 4) Seldom Adequate, or 5) Not at all Adequate. Participants also had the option to indicate "Does Not Apply" (0) for any given item, which was interpreted as no need similar to Lee et al. (2016). For analysis, this measure was recoded into a dichotomous variable with 0, 1, 2 responses recoded into 0 indicating low needs and 3, 4, 5 responses recoded into 1 indicating high needs at the time of assessment. This was done to simplify and improve interpretability of the measure (Shentu & Xie, 2010). Total number of needs were computed as a sum of the count for all survey items a high need was indicated.

*Access to Services* Access is defined as a kinship caregiver's ability to obtain and use resources supporting their family's social, educational, health, legal, or financial needs (Wilson et al., 2019). Access to services is a post only measure administered to both the intervention and control groups at case closure and 6-month post-closure. This 19-item measure was modified from the Washington State Kinship Navigator satisfaction survey (Fowler et al., 2023) by



reducing the number of items and response options from the original scale to gather a quick snapshot of services accessed and navigator supports. Participants indicated if they had accessed each listed resource in the prior 6 months. Response options were "Yes," "No," or "I did not need this" coded as 1, 0 and 3 respectively. Those answering "Yes" were asked if the kinship navigator facilitated access, with responses of "Yes," "No," or "I did not ask the navigator for help." The adapted measure's validity and reliability was established by Lee et al. (2016) through interviews with informal caregivers with Cronbach's alpha greater than 0.6, and has been used in kinship caregivers in rural setting (Fowler et al., 2023) reaching acceptable reliable standards ( $\alpha = 0.6$ ).

To facilitate analysis, sum scores capturing the total number of times the navigator was helpful in accessing services was computed. The total number of services accessed was computed as a domain by taking the sum of all responses to "yes" for each survey item. Subdomains were computed into finance and health categories. Finance category included response to the questions: Did you use this service or resource? (in the last 6 months) (1) Public assistance to help meet the needs of your kin child(ren) (for example, Medicaid, SSI, TANF), (2) Financial support for necessities (for example, rent/mortgage, utilities, phone, internet, transportation), (3) Concrete goods (for example, bedding, furniture, clothing), (4) Enough food for 2 meals daily for you and your kin child(ren). Health category included response to the questions: Did you use this service or resource? (in the last 6 months) (1) Medical care for yourself (2) Medical care for your kin child(ren) (3) Dental care for yourself (4) Dental care for your kin child(ren) (5) Professional mental health counseling for your kin child(ren), (6) Professional mental health counseling for yourself.

*Caregiver Wellbeing* Caregiver wellbeing was a post-only measure, collected at case closure and 6-month post-closure for both intervention and control conditions. Caregiver wellbeing is a comprehensive outcome for kinship caregivers that includes physical, mental, and emotional health, parenting practices, substance use patterns, economic and housing stability, and overall family functioning. The wellbeing scale was adapted from the Washington State Kinship Navigator satisfaction survey (Fowler et al., 2023). The survey items were: 1) "I now feel better able to cope with caring for the child compared to before kinship care services"; 2) "I do not feel as stressed as before participating in kinship care services"; 3) "My overall health and wellbeing have improved since kinship care services"; and 4) "I am enjoying life more now since kinship care services." Responses to these four items were rated on a 7-point Likert scale: "Strongly Agree= 1, Agree= 2, Somewhat Agree= 3, Neither Agree or Disagree= 4, Somewhat Disagree= 5, Disagree= 6, Strongly Disagree= 7, ". The face validity and reliability (Cronbach's  $\alpha = 0.85$ ) of this tool has been established in similar rural population (Fowler et al., 2023). Each item of the measure was recoded into a dichotomized wellbeing variable generating the following categories "Coping wellbeing, Less stressed wellbeing, Improved health wellbeing, Enjoying life wellbeing" with 1, 2, 3, = 1 indicating more positive wellbeing and 4, 5, 6, 7 = 0 indicating more negative wellbeing. The mean scores of the above categories were computed to provide the average wellbeing variable.

### Data Analysis

To analyze the data, a combination of descriptive and inferential statistical techniques was used to address the research objectives. The choice of methods was guided by the type of variables and the specific research questions being investigated. General descriptive statistics

were calculated, such as mean, frequencies, standard deviation, and range (measures of central tendency and measures of variability) to explore the overall characteristics of the data and provide insights on the variables of interest.

To evaluate whether the means of the dependent variables (wellbeing scores across sub-domains: coping, less stressed, improved health, enjoying life and the average wellbeing scores) differed significantly between the intervention and control groups, independent samples t-tests were employed. This parametric test is an appropriate tool for comparing the means of a continuous variable across two independent groups. The Levene's test for equality of variances was conducted to assess the homogeneity of variance assumption, and the appropriate t-statistic (either assuming equal or unequal variances) was selected based on the results of this test. Independent samples t-tests were also used to investigate statistically significant differences between the intervention and control groups for services accessed and navigator assistance. This analysis allowed for determining if services access and navigator support varied across intervention and control condition.

Pearson's bivariate correlation analysis was employed to assess the strength and direction of the relationships between various continuous variables, including services accessed, caregiver wellbeing, navigator assistance, SNAP benefit eligibility, and caregiver race/ethnicity. This correlation analysis helped identify potential associations between these factors and provided insights into the interplay among them which are relevant to practice and policy.

All statistical analyses were conducted using the Statistical Package for the Social Sciences (IBM SPSS version 29.0.2.0 (20)), a widely used software package for quantitative data analysis. The chosen analytical methods were regarded suitable for the research objectives, as

they allowed for hypothesis testing, effect size estimation, and investigation of relationships between variables.

## Results

The study aimed to evaluate the effectiveness of an enhanced case management intervention in improving caregiver wellbeing compared to standard information and referral services. The primary objective was to determine if the intervention group experienced significantly higher mean wellbeing scores, navigator assistance, and accessed more services at case closure compared to the control group. Additionally, the study sought to assess the correlations between services accessed, navigator assistance, and caregiver wellbeing, as well as the potential associations between these factors, caregiver needs at enrollment and race/ethnicity. Despite variations in caregiver demographics, both the intervention and control groups reported meaningful outcomes after participating in the KNP, with the enhanced case management participants indicating substantial services accessed, higher navigator supports and higher wellbeing outcomes. The following sections present the findings related to these objectives.

### Sample Description

The study included a total of 92 kinship caregivers from a variety of backgrounds. As shown in Table 2, the majority of the study participants were female which is consistent with findings across rural kinship caregivers (Denby & Bowmer, 2013; Foluso et al., 2024). The average age of all study participants is 52.7(13.2), with similar distribution across the intervention 51.9 (13.2) and control group 54.2 (13.1).

Table 2. Kinship Caregiver Demographics for all Participants.

Characteristic	Total (n = 92)		Control (n = 33)		Intervention (n = 59)	
	n	Mean (SD) / %	n	Mean (SD) / %	n	Mean (SD) / %
Caregiver Sex	91		32		59	
Female	84	92.3	28	87.5	56	94.9
Male	7	7.7	4	12.5	3	5.1
Caregiver Race/Ethnicity	92		33		59	
White	55	59.8	23	69.7	32	52.3
American Indian/Alaskan Native	34	37	8	24.2	26	44.1
Native Hawaiian/Pacific Islander	2	2.2	1	3	1	1.7
Black/African American	2	2.2	0	0	2	3.4
Asian	1	1.1	0	0	1	3.4
Unknown/Unable to Determine Race	2	2.2	2	6.1	0	0
Hispanic	3	3.3	2	6.1	1	3.4
SNAP Benefit Eligibility	92		33		59	
Yes	24	26.1	7	21.2	17	28.8
No	68	73.9	26	78.8	42	71.2

Note: Race/Ethnicity does not add to 100% as participants may select more than one category.

In the intervention group there is a slightly higher representation of American Indian/Alaskan Native participants, with White participants accounting for over half of the

participants across groups which is consistent with rural Montana. SNAP benefit eligibility as reported by participants is also similar across groups.

#### Mean Differences in Wellbeing Measures, Services Accessed, and Navigator Assistance

To determine if the intervention group has significantly higher mean wellbeing scores at case closure compared to the control group, independent samples t test was conducted to compare both group means for the wellbeing score average across all categories (coping, less stressed, improved health, enjoying life) as well as the means of each individual wellbeing category.

Results indicate that the participants in the intervention group ( $M = .93, SD = .25$ ) compared to the control group ( $M = .55, SD = .51$ ) demonstrated significantly higher coping wellbeing scores  $t(29) = 3.284, p = .001$  with an effect size of Cohen's  $d = 0.38$ . The moderate-to-small effect size suggests that the intervention had a relatively modest impact on wellbeing scores. This means after participating in intervention services the caregivers felt better in their ability to cope with caring for their kin child(ren) than before their involvement with the MTKNP when compared to the information and referral only group.

Participants in the intervention group ( $M = .77, SD = .53$ ) compared to the control group ( $M = .41, SD = .50$ ) demonstrated significantly higher enjoying life wellbeing scores  $t(41) = 2.69, p = .005$ . with an effect size of Cohen's  $d = 0.46$ . The moderate effect size suggests that the intervention had a substantial impact on the wellbeing scores. Kinship caregivers in the intervention group have higher wellbeing scores in the sub-domain: enjoying life more now since participating in kinship care services and activities when compared to information and referral only.

Participants in the intervention group ( $M = .70, SD = .47$ ) versus the control group ( $M = .50, SD = .51$ ) demonstrated less stress in wellbeing with an effect size of Cohen's  $d = 0.49$ . However, this difference was not statistically significant but approaching significance  $t(43) = 1.45, p = .08$ . Similarly, participants in the intervention group ( $M = .73, SD = .45$ ) compared to the control group ( $M = .57, SD = .51$ ) demonstrated higher improved health wellbeing scores with an effect size of Cohen's  $d = 0.47$ . Likewise, this difference was not statistically significant  $t(29) = 1.18, p = .124$ .

The average wellbeing scores of participants in the intervention group ( $M = .79, SD = .29$ ) compared to the control group ( $M = .50, SD = .44$ ) demonstrated significantly higher means  $t(34) = 2.73, p = .005$  with an effect size of Cohen's  $d = 0.36$ . The medium-to-small effect size suggests that the intervention had a somewhat moderate impact on average wellbeing scores. This means the caregivers participating in intervention services when compared to the information and referral only group overall fared better in all sub-domains of wellbeing before their enrollment in the MTKNP.

Cases in intervention and control were also compared to determine if there were significant variations in services accessed as well as in navigator assistance. Participants in the intervention group ( $M = 3.14, SD = 5.40$ ) compared to the control group ( $M = 1.39, SD = 2.74$ ) demonstrated significantly higher navigator assistance  $t(89) = 2.05, p = .022$  with large effect size of Cohen's  $d = 4.63$ . This shows that enhanced case management participants indicated they received assistance from the navigator in accessing services at a level significantly higher than the control condition. The intervention group ( $M = 3.27, SD = 3.99$ ) also had higher means for total number of services accessed when compared to information and referral only group ( $M =$

2.88,  $SD = 3.69$ ) including the sub-domains of finance and health. However, these differences were not statistically significant but may have possible practical significance.



Table 3. Correlations between Services Accessed, Navigator Assistance, and Caregiver Wellbeing in Control Group (IR).

	Variables	1	2	3	4	5	6	7	8	9	10	11	12
1	Total no of services accessed												
2	Total no of finance services accessed	.844**											
3	Total no of health services accessed	.953**	.774**										
4	Total no of Nav Assistance	.710**	.626**	.670**									
5	Coping wellbeing	.067	.137	.122	.235								
6	Less stressed wellbeing	.262	.268	.359	.237	.730**							
7	Improved health wellbeing	.391*	.300	.511**	.224	.417*	.716**						
8	Enjoying life wellbeing	.081	.213	.119	.246	.760**	.647**	.556**					
9	Average wellbeing	.244	.282	.331	.277	.856**	.906**	.790**	.867**				
10	Total of high needs (at enrollment)	.312	.397	.217	-.350	.397	.397	.397	.397	.397			
11	SNAP eligibility	.058	.054	.107	.199	.194	.236	.175	.327	.276	-.993		
12	Race/Ethnicity	.129	.298*	.035	.263	-.267	-.365*	-.330	-.017	-.268	-.993*	.224	

Note: \* p < .05. \*\* p < .01.

Table 4. Correlations between Services Accessed, Navigator Assistance, and Caregiver Wellbeing in Intervention Group (CM).

	Variables	1	2	3	4	5	6	7	8	9	10	11	12
1	Total no of services accessed												
2	Total no of finance services accessed	.885**											
3	Total no of health services accessed	.919**	.737**										
4	Total no of Nav Assistance	.738**	.747**	.657**									
5	Coping wellbeing	-.133	-.202	-.036	.225								
6	Less stressed wellbeing	-.006	-.114	.059	.018	.408*							
7	Improved health wellbeing	-.013	.136	.006	.446**	.443**	.263						
8	Enjoying life wellbeing	-.159	.064	-.143	.375	.169	.155						
9	Average wellbeing	-.065	-.017	-.023	.357*	.632**	.677**	.824**	.710**				
10	Total of high needs (at enrollment)	-.258	-.340	-.179	-.156	-.119	.010	-.221	-.034	-.145			
11	SNAP eligibility	.270*	.268*	.232*	.277*	.203	-.106	-.167	-.234	-.112	-.278		
12	Race/Ethnicity	.346**	.377**	.315**	.311**	-.218	-.386	-.185	.032	-.302	.515**	.123	

Note: \* p < .05. \*\* p < .01.

Table 5. Correlations between Services Accessed, Navigator Assistance, and Caregiver Wellbeing across all Participants.

	Variables	1	2	3	4	5	6	7	8	9	10	11	12
1	Total no of services accessed												
2	Total no of finance services accessed	.865**											
3	Total no of health services accessed	.930**	.734**										
4	Total no of Nav Assistance	.707**	.727**	.629**									
5	Coping wellbeing	.120	.162	.129	.320*								
6	Less stressed wellbeing	.170	.105	.223	.144	.599**							
7	Improved health wellbeing	.210	.238*	.251*	.391**	.438**	.488*						
8	Enjoying life wellbeing	.064	.246*	.045	.404**	.599**	.431**	.660**					
9	Average wellbeing	.200	.245*	.214	.387**	.815**	.794**	.795**	.821**				
10	Total of high needs (at enrollment)	-.109	-.247	-.024	-.119	-.170	-.003	-.183	-.058	-.149			
11	SNAP eligibility	.206*	.219*	.192*	.264**	.248*	.067	.000	.067	.137	-.225		
12	Race/Ethnicity	.277**	.359*	.219*	.306**	-.141	-.335**	-.223	.061	-.200	.462**	.165	

Note: \* p < .05. \*\* p < .01.

### Relationship between Services Accessed, Navigator Assistance with Caregiver Wellbeing

In the intervention group, navigator assistance also showed significant moderate positive relationship with improved health wellbeing sub-domain and average of wellbeing ( $r=0.446$ ,  $r=0.357$ ), whereas the control group had weak non-significant correlations. Remarkably, when the groups were combined, there were even more positive associations with wellbeing, with significant moderate positive correlation between the average wellbeing ( $r=0.387$ ), its sub-domains (coping wellbeing ( $r=0.320$ ), improved health wellbeing( $r=0.391$ ), enjoying life wellbeing ( $r=0.404$ ) and navigator assistance across all participants, with only less stressed wellbeing sub-domain having weak non-significant correlation. This indicates that for enhanced case management participants, navigator support is associated with improved health wellbeing and average wellbeing, different from the control group which has weak non-significant relationships. Although, across both groups there is overall positive relationships when receiving navigator assistance with feeling better to cope with caring for kin child(ren), an improved sense health, enjoying life better and improved overall wellbeing.

We found that across all groups, the total services accessed, and services accessed in the finances and health subdomain were significantly positively correlated with navigator support. Compared to information and referral, there were higher strong positive correlations for total services accessed and finance services accessed in the intervention group ( $r=0.738$ ,  $r=0.747$  respectively) than control group. Across board, as participants received assistance from the navigator, they were more likely to use services with a stronger relationship observed in the enhanced case management group.

A weak positive correlation ( $r=0.238$ ) between finance services accessed and improved health wellbeing scores were seen collectively across intervention and control caregivers when combined. When looked at separately, intervention and control groups had positive correlations which were not statistically significant but may have practical significance. Likewise, the correlation between health services accessed and improved health wellbeing scores was significantly positively associated ( $r=0.251$ ) across both groups combined. However, when looked at by groups, only the information and referral cases remained statistically significant. This indicates that at case closure, as more finance and health services were accessed caregivers across both intervention and control were more likely to have an improved sense of health and wellbeing, with finance being more indicative for enhanced case management participants.

There were no statistically significant findings for the correlation between total high needs at enrollment and services accessed. However, there were very weak negative correlations which may indicate real life significance, that higher needs may not necessarily correspond to services accessed and navigation support may be more beneficial in directing services accessed.

#### Relationship with Sociodemographic Characteristics

Across both groups, White non-Hispanic caregivers were weakly positively correlated with navigator assistance ( $r=0.306$ ), total services accessed ( $r=0.277$ ) and the sub-domains of finance and health services accessed ( $r=0.359$ ,  $r=0.219$  respectively) with statistical significance. While Black, Indigenous, and other People of Color (BIPOC) was significantly weakly negatively correlated ( $r=0.251$ ) with less stressed wellbeing sub-domain. This indicates that caregivers identifying as White were more likely to access services and receive navigation assistance in accessing those services. However, caregivers identifying as BIPOC were more

likely to be associated with lower wellbeing scores on reduced stress outcomes. SNAP benefit eligibility showed a weak positive correlation ( $r=0.248$ ) with coping wellbeing. Indicating that SNAP benefit eligibility is slightly positively related with ability to cope for need of kin child(ren).

### Discussion

Providing support to kinship caregivers, who have taken on the responsibility of caring for relatives' children, is crucial for promoting their wellbeing and ensuring they can access the necessary resources needed to care for themselves and their kin children. This study found mixed effects of enhanced case management services versus information and referral only services on wellbeing of kinship caregivers in the Montana Kinship Navigator Program at case closure. In addition, these findings highlight potential disparities and associations related to sociodemographic characteristics.

#### Mean Differences in Caregiver Wellbeing Measures, Services Accessed and Navigator Assistance

Wellbeing is an important aspect of kinship caregiving, as these caregivers often face significant challenges and stress related to their caregiving responsibilities. The intervention group had significantly higher coping wellbeing scores compared to the control group. This finding suggests that the enhanced case management intervention had a modest but positive impact on caregivers' ability to cope with caring for their kin child(ren) compared to the information and referral-only group. Participants in the intervention group felt better equipped to manage the challenges of kinship caring for their kin child after receiving the intervention services.

The intervention group also had significantly higher "enjoying life" wellbeing subdomain compared to the control group. This means that enhanced services received by caregivers led to a significant improvement in their ability to enjoy their life, compared to those who received information and referrals only. The intervention group had significantly higher average wellbeing across all subdomains compared to the control group. These findings suggest the intervention led to a positive impact on overall caregiver wellbeing. These findings support other kinship programs that have found positive association when investigating coping wellbeing domain and enjoying life wellbeing in enhanced intervention services (Day et al., 2024).

The enhanced case management group versus control group demonstrated a significantly higher navigator assistance. These findings align with an ecological approach as proposed by Hong et al. (2011). The increased navigation support provided within the micro, meso, and chrono systems of the environment (rurality, culture, family ties, social support, socioeconomic factors) resulted in improved wellbeing outcomes. Previous studies indicate that barriers such as inadequate access to services, financial and health burden may impact caregiver outcomes (Foluso et al., 2024; Riley-Behringer & Cage, 2014). By bridging that gap in kinship care provision via boosted services, this program resulted in better caregiver wellbeing.

#### Relationship between Navigator Assistance, Services Accessed and Caregiver Wellbeing

The findings revealed important relationships between services accessed, navigator assistance, and caregiver wellbeing. Understanding these associations is crucial for developing effective interventions and support systems that can improve outcomes for kinship caregivers. For the intervention group, navigator assistance showed significant moderate positive relationships with improved health wellbeing and average wellbeing while the control condition

showed no significant relationships in the control condition. Across all participants, significant moderate positive correlations were found between navigator assistance and various wellbeing subdomains (coping, improved health, enjoying life, and average wellbeing). This suggests that navigator assistance plays a crucial role in enhancing caregiver wellbeing, particularly in areas such as coping, health, and overall wellbeing. The support provided by navigators particularly in the enhanced services appears to be associated with improved outcomes for caregivers.

Across both groups, accessing finance and health services was positively associated with improved health wellbeing scores, with finance services being more indicative for the enhanced case management participants. This implies that navigators may play a crucial role in connecting caregivers with economic resources and accessing financial and health-related services may contribute to improved perceptions of health and wellbeing among caregivers, with financial services potentially playing a more significant role for those in the enhanced case management group. These findings are similar to research outcomes in a comparable rural KNP showing improved caregiver wellbeing and services utilization after participation in enhanced intervention services (Day et al., 2024).

#### Relationship with Sociodemographic Characteristics

Kinship caregivers come from diverse backgrounds, and it is essential to consider the potential impact of these characteristics on their experiences and outcomes (Foluso et al., 2024). Identifying any disparities or specific needs related to sociodemographic characteristics can inform more equitable and culturally responsive service delivery and support strategies. This study explored the associations between navigator assistance, services accessed, caregiver wellbeing, and sociodemographic variables, such as race/ethnicity and SNAP benefit eligibility.



SNAP benefit eligibility was weakly positively associated with coping wellbeing scores. This implies that access to financial assistance programs like SNAP may play a role in supporting caregivers' ability to cope with the demands of kinship caregiving.

White non-Hispanic caregivers were more likely to receive navigator assistance and access services, including finance and health-related services, compared to caregivers of other racial/ethnic backgrounds. This implies potential disparities in services accessed and navigator support based on race/ethnicity. Conversely, caregivers identifying as BIPOC were more likely to report lower levels of wellbeing in the "less stressed" sub-domain. This signals that BIPOC caregivers may face additional challenges or barriers that contribute to higher stress levels compared to their White non-Hispanic counterparts. Caregivers are often unaware of resources available to them but can achieve positive outcomes if given assistance (The Annie E. Casey Foundation, 2012) which may result in overall positive outcomes. White non-Hispanic caregivers may have had better access to, or awareness of available services and navigator assistance compared to their counterparts from other racial/ethnic backgrounds. Perhaps, barriers like systemic racism and lack of trust in the child welfare system may be discouraging BIPOC caregivers from seeking support and services. There is a need to promote a more culturally informed approach in program delivery.

The findings of this study provide valuable understandings of the impact of an enhanced case management intervention on caregiver wellbeing, service utilization, and the role of navigator assistance for kinship caregivers. The intervention group demonstrated significant positive findings for wellbeing, services accessed, and navigator assistance. This research identified potential disparities and associations related to sociodemographic characteristics.

While these findings contribute to our knowledge of effective interventions and support for kinship caregivers, there are still areas that require further exploration. There is need to investigate specific pathways through which navigator assistance and services accessed influence caregiver wellbeing as this could inform the improvement of KNP intervention. Sub-domains of services can also be explored to determine which is most relevant across all participants. Future studies should examine the reasons behind the observed disparities and develop strategies to promote equitable access to services.

Additionally, when interpreting the findings of this study, the limitations should be considered. There may have been selection bias as participants were not randomized into groups. However, this was addressed by ensuring similar sociodemographic across both intervention and control cases. The study also relied on self-report of measures which may be subject to response bias (Wetzel et al., 2016). The small sample size ( $n=92$ ) compared to Clearinghouse recommendation ( $n=250$ ) may reduce the ability to detect statistically significant differences and increase the likelihood of Type II errors (Wilson et al., 2019). As the analyses may have been underpowered, making it difficult to identify differences across intervention and control condition and the small sample size may limit the precision of the effect size estimate (Althubaiti, 2023).

Another limitation to the interpretation of these findings is the limited exploration of the assumption of normality for the statistical tests performed. Parametric tests, such as the independent samples t-test, rely on the assumption of normality. Violation of this assumption can lead to inaccurate or biased results. While Levene's test for homogeneity of variance was conducted, the study did not report any tests for normality. Future research should examine the

normality assumption to ensure the appropriate use of parametric tests or consider non-parametric alternatives if necessary.

### Implications for Practice and Policy

Caregivers in the program who received enhanced case management services reported better wellbeing across multiple domains, including coping, lower stress, health improvement, and enjoyment of life, compared to their counterparts in the information and referral-only group. By improving the wellbeing of relative caregivers who provide social capital in the child welfare system, we can safeguard the safety, stability, and wellbeing of kin children. This also supports the potential value of implementing enhanced case management interventions for all kinship caregivers, as they may improve caregiver wellbeing and service utilization. Training and support for navigators should focus on strategies to connect caregivers with appropriate financial and health-related resources, as these services may have profound impact on caregiver wellbeing. Strategies could be implemented to address potential barriers and challenges faced by diverse caregivers, such as trauma-informed program delivery. Programming efforts to promote access to public assistance programs (like SNAP, Medicaid, SSI, TANF) may contribute to improved abilities to cope with kinship caregiving.

The role of navigators in facilitating access to financial and health-related services is particularly crucial in rural areas, where these resources may be scarce or geographically dispersed. The significant associations between navigator assistance and improved wellbeing domains, such as coping and enjoying life, are especially significant for rural kinship caregivers. These caregivers may experience higher levels of isolation, limited social support networks, and increased stress due to the challenges of caregiving in rural environments. The provision of

enhanced case management services, including dedicated navigator support, could potentially alleviate some of these burdens and promote better overall wellbeing among rural caregivers.

Finally, obtaining positive ratings from the Prevention Services Clearinghouse could result in reimbursement for MTKNP services utilizing Title IV-E funds leading to a more sustainably funded program. Nonetheless, if the program does not receive good Clearinghouse ratings, the positive associations and trends observed across all caregiver groups suggest that the services provided are indeed helpful and beneficial to some extent. Policymakers and legislators should consider continuing to fund and support this program, as well as allocating resources for its continued development and evaluation to promote better wellbeing outcomes for these kin families and the children in their care.

## CHAPTER FIVE

## CONCLUSION

The preliminary findings from the evaluation of the Montana Kinship Navigator Program (MTKNP) emphasize the benefits of an enhanced case management intervention for improving caregiver wellbeing and access to service. The findings offer important implications for supporting kinship caregivers, particularly those residing in rural areas. For rural kinship caregivers, who often encounter significant barriers to accessing resources and support systems, the implementation of enhanced case management programs with dedicated navigator assistance could be particularly impactful. The geographical isolation, limited-service availability, and cultural factors that characterize many rural communities underscore the importance of tailored interventions that address the specific needs of rural caregivers.

The positive associations between the enhanced case management intervention, increased navigator assistance, and improved wellbeing outcomes suggest that this model of service delivery can effectively address the unique challenges faced by kinship caregivers. The role of navigators in facilitating access to financial and health-related services, as well as promoting better coping strategies and overall enjoyment of life, highlights the value of providing comprehensive and tailored support to this population. While these preliminary findings are promising, it is important to acknowledge their limitations and the need for further research.

The study's sample size restricts the generalizability of the results, and the observed findings are primarily applicable to the participants in this specific study. Continuing data collection efforts to reach the Clearinghouse target of 250 participants will strengthen the robustness and external validity of the findings. Future analyses will also explore the 6-month

post-closure measures to investigate potential differences in program outcomes over time. Longitudinal data will provide valuable information regarding the long-term impact of the enhanced case management intervention on caregiver wellbeing and service utilization, as well as the sustainability of the observed effects.

Additionally, further research is still needed to understand the underlying path contributing to the observed disparities in service access and wellbeing outcomes based on race/ethnicity. Developing culturally responsive strategies and addressing potential barriers to equitable access will be vital for ensuring that all kinship caregivers, regardless of their racial or ethnic background, can benefit from the support services offered.

As the MTKNP continues to collect data and refine its interventions, the findings from this study serve as a foundation for future program development, efforts, and evidence-based practice in the field of kinship caregiving. By prioritizing the wellbeing of caregivers and providing individualized support through enhanced case management models, policymakers and service providers can contribute to improving outcomes for kinship families and promoting the healthy development of the children in their care.

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