

NEGLECTED CHILDREN IN INTERGENERATIONAL KINSHIP CARE PROJECT HEALTHY GRANDPARENTS

I. Introduction

The following report will present the methodology, process and outcome findings related to Neglected Children in Intergenerational Kinship Care: Project Healthy Grandparents. Project Healthy Grandparents (PHG) was supported with a \$750,000 five year demonstration grant from the Office of Child Abuse and Neglect, in response to a critical need identified by Dr. Susan J. Kelley through her extensive work with abused and neglected children. In twenty years of research and service to this population, Dr. Kelley recognized that many grandparents assume parental responsibility of their grandchildren when the biological parents are absent, often due to substance abuse, incarceration, or death. The stress of raising children at this stage in life takes its toll – physically, financially, and emotionally on many grandparents. Sponsored in part by Georgia State University, the mission of PHG is to support the permanency and stability of families in which grandparents and great-grandparents are raising grandchildren in parent-absent households. PHG is designed to strengthen intergenerational families by providing grandparents and grandchildren with comprehensive services and improved access to community resources.

A. Background information

Description of the Problem

According to published reports, the number of abused and neglected children increased nearly 135% between 1983 and 1993 (Goerge, Wulczyn, & Hareden, 1996). When Project Healthy Grandparents was implemented in 1995, there was an increase in the number of neglected, abused and abandoned children in the foster care system. Moreover, children placed with grandparents represented 50-75% of the children in kinship care (Allen Harden, University of Chicago, personal communication). Despite this growing phenomenon, there were few programs that addressed the specific needs of intergenerational caregivers. Based on the findings of a pilot study in the Atlanta area, the need for family support incorporating multiple professional services specific to intergenerational families was critical, but absent from the local health and social welfare arena.

Rationale and Assumptions

The rationale for the development and implementation of this cost-effective multi-service model was to provide resources that empower and support intergenerational families impacted by child abuse and neglect, and to reduce the likelihood of further abuse and neglect of children. There were a number of underlying assumptions to support the rationale of the project. First, neglected children placed in the care of their grandparents remain at increased risk since many grandparents do not have adequate financial and supportive resources to raise their grandchildren. Additionally, undertaking full-time

parenting responsibilities for grandchildren leads to increased physical, psychological, and economic vulnerability of grandparents, rendering them less capable of meeting the physical and emotional needs of their grandchildren. Placing children who are abused and neglected by their biological parents with grandparents is preferred over foster care because cultural and ethnic practices are sustained, family attachments are maintained, and family ties are supported. Preserving family structures reduces the need to isolate children from their families through the foster care system. Since the PHG multi-service model operates from a family empowerment philosophy, it supports and promotes the autonomy of the caregivers served.

Expected Impact of the Project on Participants

The project was expected to impact grandparent headed households by improving access to community resources and services that address the unique healthcare, financial and legal needs of their families, thereby decreasing the likelihood that the grandchildren would be neglected and placed in non-relative, foster homes. The research component contributes to the literature and ultimately will impact policy decisions that effect inter-generational families caring for children who have been abused and neglected. Finally, it was expected that the grandchildren would experience improved outcomes related to emotional health, risk for neglect, juvenile delinquency and school performance.

B. Program Model

Target Population

The target population was grandparents who reside in metropolitan Atlanta and who are the primary caregivers of their grandchildren under the age of 16 who have been abused or neglected by their biological parents.

Service Components of the Project Model

The core service components offered by Project Healthy Grandparents, as stated in the original proposal, include: mental health, physical health, legal assistance, educational support, and financial benefits assistance. Upon enrollment in the project participants have access to these core service components for twelve months. The core components are described below. Support group meetings and parenting classes serve as a link to maintain connection with caregivers who have completed the twelve-month intervention. Transportation is provided to parenting classes and support group meetings during the first twelve months only.

- a. **Mental Health:** As a part of the initial data collection process data collectors administer standardized mental health measures to the grandparent caregivers and their grandchildren. Participants scoring in the clinical range on these assessments are offered referrals to a mental health professional. In addition any families or individual family members who have experienced traumatic events known to

- increase psychological problems, such as severe abuse or neglect, recent death of a parent, or witnessing violence are also referred for services.
- b. **Social Support:** Through the development of the grandparent support group, participants meet monthly with other grandparent caregivers to discuss topics and issues related to parenting their grandchildren. Parenting education classes were designed to enhance the parenting skills of grandparent caregivers. Both of these groups were available beyond the 12-month intervention.
 - c. **Physical Health:** Each family is assigned a registered nurse who makes monthly visits to perform health assessments, provide health education, monitor health status and screen the children for potential developmental delay.
 - d. **Legal Services:** Legal assistance is offered to achieve an optimal custodial arrangement if the legal status regarding child custody is not satisfactory to the grandparent.
 - e. **Educational Support Services:** The educational component of the program is tailored to the specific needs of the family and the child requiring assistance. The services offered by the family social worker are based on the child's developmental assessment, school performance, concerns expressed by grandparents, and feedback from teachers. Graduate and undergraduate students at Georgia State University provide tutoring and mentoring for grandchildren when appropriate. Referrals to community based agencies e.g., head-start, early intervention, after-school and summer programs are made for grandchildren whose needs require such services.
 - f. **Financial Benefits/Social Work Case Management:** Similar to the nursing staff, each family is assigned a social worker who visits monthly and provides case management services and referrals to community-based resources. Case management services include: counseling to enhance family stability, consultation on financial benefits, referral for housing, and legal assistance.
 - g. **Substance Abuse Referrals:** While providing direct services to substance abusing biological parents is beyond the scope of the project, social work staff make appropriate referrals to substance abuse treatment programs for biological parents seeking help. The social workers also work closely with the grandparents on issues of co-dependency and substance abuse education.

C. Collaborative Efforts

Collaborative partners that have worked with PHG are those agencies that have an active and ongoing working relationship with the families in the project. Many of these agencies have also served as referral sources and resources for the families. For example, The Atlanta Legal Aid Society (ALAS) initially approached the project to offer assistance

with an adoption assistance program to grandparents who were raising their grandchildren. This partnership resulted in many families being referred to ALAS and eventually adopting their grandchildren. The adoptions resulted in a more stable home for the children, assurance for the grandparents that their children would not be taken from them, and stipends for each child. In addition, ALAS attorneys present information about adoption at the grandparent meetings several times a year.

It is the goal of PHG to work with local programs and agencies on behalf of the families served. PHG staff recognizes that it is important to partner as much as possible with agencies in the community so that the families in the program have access to a full complement of resources. Please see Appendix A for a listing of agencies that PHG collaborates with and Appendix B for a listing of the resource and referral base.

D. Special Issues – Cultural Issues

There were no eligibility requirements as it relates to race or ethnicity, however the project did target a geographic area that contained a large African-American population. In addition, many of the initial referral agencies serve predominantly African-American families. In an effort to be sensitive to cultural issues related to the clients and community served, there was a deliberate attempt to recruit staff and a community advisory board whose members who are predominantly African-American. Appendix C contains a list of current Advisory Board members

E. Funding Information – Funding Initiative

In addition to the five-year federal demonstration grant, the project receives funding from Georgia State University, Georgia Department of Human Resources (DHR), United Way, and numerous foundations. Georgia State University also provides in-kind contributions of office space, utilities and other overhead expenses.

PHG leadership has worked diligently to diversify its funding sources and cultivate support from local and national foundations. The program has developed a successful track record for raising funds and hopes to continue to build relationships with the various individuals, corporations and private foundations that have supported PHG. See Appendix D for total project funding.

F. Evaluation Information

All evaluation efforts were coordinated under the direction of Dr. Theresa Ann Sipe. Dr. Sipe is an Assistant Professor at Georgia State University. She is the Statistician/Methodologist for the College of Health and Human Sciences where she consults with faculty who are conducting research. She is the Evaluator for Project Healthy Grandparents and is responsible for data entry, data management and data analysis. Dr. Sipe has been an integral member of the PHG team and meets on a regular basis with the Project Director and Data Manager of the project. She supervises five graduate research assistants who enter data for the project. In addition, Dr. Sipe is the

Project Director for the Georgia Fatherhood Program Evaluation. She holds an MPH from Emory University and a PhD from Georgia State University in Research, Measurement, and Statistics in Education.

II. Process Evaluation

A. Proposed Implementation Objectives

1. Objectives and description of planned services for each activity

The comprehensive service model is designed to offer twelve months of home-based nursing interventions and social work services to grandparents who are raising their grand or great-grandchildren. The duration and intensity of activities are dictated by the individual needs of the families served.

- a. The project will serve 25 families per year and a total of 100 families over the 4-year service period.**

Recruitment of subjects will be from multiple agencies serving low-income African-American families residing in Fulton and DeKalb counties. The referral agencies will include but not be limited to: Grady Health System, the public hospital in Atlanta; Southside Community Healthcare Center, an agency that serves over 800 children a year in their well child clinic; and Gate City Day Care Centers, community day-care centers located in public housing developments.

- b. The project will provide bi-weekly (twice monthly) nursing visits for each family enrolled in the project.**

Each family will be assigned a registered nurse to monitor blood pressure, weight and cholesterol on a bi-weekly basis or more often as needed. The RN will also provide health education/counseling.

- c. Each family will receive at least one monthly home visit from their assigned social worker during the twelve months they are enrolled in the program.**

Each family will have a social worker assigned to visit their home at least one time per month. The social worker will provide social support, information regarding community resources, financial benefits counseling, housing assistance, substance abuse referrals for biological parents and other assistance as deemed necessary.

- d. The project will provide an opportunity for participants to attend 12 support group meetings per year.**

Monthly support groups will be offered for participants to receive peer support and information on topics they find of interest. Transportation and childcare will be made available. Ultimately support groups will be organized and led by grandparent caregivers to ensure that groups continue after the demonstration project is completed.

e. Each family enrolled in the project will have at least one legal consultation to review and explore child custody issues.

An assessment will be conducted on the legal status of each child in the family. Legal assistance will be provided for any participant requesting help with custodial issues.

f. Project staff will provide educational support to each family that requests assistance.

Grandparent caregivers who express concerns and needs related to their grandchildren's formal education will receive guidance, support and advocacy services from their social worker. Grandchildren will also receive tutoring and mentoring from graduate and undergraduate students working with the project.

2. Planned staffing arrangements and qualifications/characteristics of staff

The project was staffed with two full-time social workers, approximately 10 part-time registered nurses, two work-study students, and several graduate research assistants. The social workers and nurses assigned to each family are masters or bachelors-prepared professionals. Every effort was made to hire staff that reflected the ethnic and cultural characteristics of the population served. Social workers performed all case management duties for families. Registered nurses made monthly visits to perform health assessments, provide health education, monitor health status and screen the children for potential developmental delay. One doctoral-level RN supervised and trained all nursing staff on project protocols and data collection. Two graduate students were hired and trained to obtain informed consent and administer the standardized measures to be used as data collection tools. All staff participated in an orientation that reviewed issues related to safe home visiting, cultural competence, ethics in research and working with human subjects.

3. Target population and description of efforts to recruit

The target population for the project is grandparents raising grandchildren who have been abused or neglected by their biological parents. Recruitment was conducted at sites that target low-income African-American families. The primary sites were pediatric clinics, day care centers and the major public hospital in the metropolitan Atlanta area.

4. Plans for collaborating with other agencies and organizations

There were no formal collaborations specified in the original grant proposal. However, the project worked with a variety of community agencies and organizations to execute the full compliment of services needed by families (e.g., daycares, legal assistance, healthcare agencies, etc.).

B. Statement of Questions Related to Assessing Implementation Objectives

1. How successful was the project in recruiting the 25 families per year into the project? What were the policies and practices implemented to attain this objective? What were the barriers and facilitators? What changes were made with respect to this objective and why?
2. How successful was the project in providing bi-weekly nursing services for each family in the project? What were the policies and practices implemented to attain this objective? What were the barriers and facilitators? What changes were made with respect to this objective and why?
3. How successful was the project in providing monthly home visits for each family from the assigned social worker? What were the policies and practices implemented to attain this objective? What were the barriers and facilitators? What changes were made with respect to this objective and why?
4. How successful was the project in providing access to monthly grandparent led support groups? What were the policies and practices implemented to attain this objective? What were the barriers and facilitators? What changes were made with respect to this objective and why?
5. How successful was the project in ensuring that every family had at least one legal consultation to review custody issues? What were the policies and practices implemented to attain this objective? What were the barriers and facilitators? What changes were made with respect to this objective and why?
6. How successful was the project in providing educational support services for families requesting assistance? What were the policies and practices implemented to attain this objective? What were the barriers and facilitators? What changes were made with respect to this objective and why?

C. Brief Descriptions of Types of Data Collected, Data Collection Methods and Data Analysis Procedures.

1. How successful was the project in recruiting 25 families per year into the project?

Data Collected:

- Number of families recruited by outreach/partnership with community health resources
- Number of families recruited by community agencies
- Number of families recruited by media coverage
- Number of families recruited by grandparent participants

Method of Data Collection:

- Referral sheets

Sampling Procedure:

- Record review

Data Analysis:

- Descriptive statistics

2. How successful was the project in providing bi-weekly nursing services for each family in the project?

Data collected:

- Number of nurses available to provide monthly services
- Number of in-home family contacts each family received
- Participant perception of RN monthly service

Method of Data Collection:

- RN progress notes
- Focus group of grandparents who completed the program

Sampling procedure:

- Record review
- Random selection for focus group

Data Analysis:

- Descriptive statistics
- Focus group content analysis

3. How successful was the project in providing monthly home visits for each family from the assigned social worker?

Data Collected:

- Number of in-home social work visits
- Number of social workers available to provide service
- Participant perception of social work contacts

Method of Data Collection:

- Review of SW progress notes

- Focus group with grandparents who completed the program

Sampling Procedures:

- Record review
- Random selection for focus group

Data Analysis:

- Descriptive statistics
- Content analysis of focus group

4. How successful was the project in providing access to monthly grandparent led support groups?

Data Collected:

- Number of support group meetings held annually
- Number of times transportation was provided to support group meetings
- Number of participants attending meetings via PHG transportation
- Participant perception of support groups

Method of Data Collection:

- Transportation logs
- Sign in sheets
- Focus group with grandparents who completed the program

Sampling Procedures:

- Random selection for focus group

Data Analysis:

- Descriptive statistics
- Content analysis of focus group

5. How successful was the project in providing one legal consultation to review and explore child custody issues?

Data Collected:

- Number of legal consultations
- Number of referrals to legal aid

Method of Data Collection:

- Review of case record progress notes

Sampling Procedure:

- Record review

Data Analysis:

- Descriptive statistics

6. How successful was the project in providing educational support services for families requesting assistance?

Data Collected:

- Number of children participating in tutor/mentor activities (Years I and II only)

- Number of children participating in the Saturday Youth Academy (Years III and IV only)
- Participant perception of service

Method of Data Collection:

- Review of case record progress notes
- Focus group with grandparents who completed the program

Sampling Procedures:

- Random selection for focus group

Data Analysis:

- Descriptive statistics
- Content analysis of focus group

D. Findings for Implementation-Related Questions

The findings presented below are based on 104 families recruited to participate in the study between 1996 and 2001.

1. How successful was the project in recruiting 25 families per year into the project?

Description

The project was successful in meeting the goal of recruiting 25 families per year for a total of 100 families over the four years of the federally funded demonstration project. One hundred-and-four grandparent caregivers enrolled in the study and completed pretest data collection. Table 1 lists the number of families enrolled each year. Of the 104 families that enrolled in the program, 92 remained active in the project and completed posttest data collection. Thus, most data analyses were conducted on the final sample of 92 grandparent caregivers. Of the 12 families not included in the final sample, five participants completed 12 months of the intervention but were unavailable for posttest data collection; three participants completed the enrollment process but were unable to continue due to physical or mental illness; two grandparents returned their grandchildren to their biological parents; one participant died from a prolonged illness; and one participant was terminated by the project staff due to refusal to participate in program activities. Overall the project was able to complete 12 months of service for 88% of the families enrolled.

As stated in the original proposal, families were recruited from local community agencies. In addition, after the project secured additional funding from the Georgia Department of Human Resources, the recruitment pool expanded to include families that had contact with the local Department of Family and Children Service (DFACS). During the first year, the project received local media coverage that increased public awareness and generated a multitude of referrals to the program. In subsequent years additional media coverage, both locally and nationally, increased the exposure of the project. Grandparent caregivers were also a significant source of referrals; this was an unexpected referral source.

2. How successful was the project in providing bi-weekly nursing services for each family in the project?

Service Description

Each family enrolled in the project was assigned a registered nurse to implement the health services component of the project. The nurse provided initial blood pressure, cholesterol, and glucose screenings and ongoing monitoring of blood pressure and glucose levels. The home visit also presented an opportunity for the nurse to offer teaching, make medical referrals, and support the grandparents in their efforts to improve their physical and psychological health. Nurses made a total of 932 home visits during the four years of service implementation. Most families received nine or more nurse visits during the 12 months they were in the project. Nurses made additional phone contact as needed by the families.

Nurses also assisted grandparents with making and attending medical appointments. Many times the RN role involved advocating for medical care, clarifying treatment plans and educating grandparents on newly diagnosed health problems and the treatment of those problems. For grandparents with health issues that required a daily monitoring of weight, blood pressure or glucose levels, the nurses ensured that appropriate equipment – scales, blood pressure monitors and glucometers – were available for use in the home.

Grandparent caregivers would often forgo their own physical and medical concerns to ensure that the grandchildren's needs were being met. In an effort to assist grandparents with their vision and prescription needs, an emergency fund was established in Year III to provide assistance with obtaining eyeglasses and medications. A local eye-care establishment, Hunter Eye-care, offered a 20% discount on eye exams and glasses for all Project Healthy Grandparent participants. Any participant unable to pay for their medication could request financial assistance from the project. For participants experiencing difficulty obtaining their prescriptions, the RN and social worker explored available resources to implement a plan that would ensure the participant would be able to obtain their required medication.

Staffing

The project employed 26 graduate nursing students, who were practicing RNs, during the four years of service implementation. Caseloads ranged from 2-7 families per nurse depending on family size and needs. In addition, two full-time RNs were hired. One full-time RN served as the nursing services coordinator and carried out all administrative and personnel duties of the health services component. The other full-time RN served as the high-risk nurse and provided intensive case management services to participants with more acute health needs. The high-risk nurse position was supported with foundation funding.

Changes to the Proposed Services

The initial design of the health services component proposed bi-weekly home visits for the program participants. However, over the course of the first year it was determined that not all families required or wanted two visits per month. Thus, home visits were reduced to once per month for most families. Grandparents with health problems that required more intervention received additional home visits and/or phone calls throughout the month.

Challenges of Providing Services

Employment of graduate nursing students was an efficient and cost effective method to provide health services. However, graduate students were limited to 10 – 20 hours of work per week, which often restricted their scheduling of appointments at convenient times for the grandparents. Another issue, the turnover of the nursing staff as they graduated from the university, resulted in a change in nursing staff for some families.

Participants who were employed presented the greatest challenge to home visitation. Twenty-seven percent of the participants in the program were employed outside of the home. In some cases, participants were not comfortable with home visitation due to the physical condition of their homes or the lack of trust with an outsider. These barriers resulted in fewer intervention visits for some families.

Facilitators of Providing Services

There were several factors that facilitated success of nursing services. The nurses were highly committed to the project and possessed clinical expertise in many areas. For example, the nurses offered specialized care and education on issues related to health promotion, hypertension, diabetes, renal disease, cardiovascular disease, oncology, and other health problems.

Utilizing a home visitation model also facilitated providing services that met the needs of our participants. Home visitation offers the participant access to information on resources and community services and health education in the convenience of their home. Providing these services in the familiarity and comfort of their homes also facilitated the establishment of a open trusting relationship between the nurse and the participant. This arrangement gave the grandparent an opportunity to openly discuss issues such as personal relationships, hygiene, and cultural practices that may have been in conflict with their particular medical treatment plan

For many of the grandparent caregivers, barriers such as lack of transportation, traveling with very small children, and physical impairments prevented them from accessing health care. Providing information and services to them through home visitation and offering transportation to medical appointments enhanced their access to health care.

Focus group participants expressed a high level of satisfaction with nursing home visits, citing examples of nursing services that they claimed literally “changed their lives.” One participant shared that her nurse had identified an error in her medication dosage (she was incorrectly taking double the dosage). After consulting with her doctor and discontinuing the second dose the participant experienced increased energy and stated that she felt like “a new person.”

3. How successful was the project in providing monthly home visits for each family from the assigned social worker?

Service Description

The social work staff completed 1068 home visits over the four years of service implementation. Each family was assigned a social worker to provide case management services using the strengths-based approach. This approach includes problem identification, recognition of current support systems, and identification of community resources that impact family challenges. Social work services also included advocacy, financial benefits eligibility assessment, housing assistance, legal referrals, educational support, and referrals.

Fifty-two percent of the grandchildren in PHG are living with their grandparents as a result of parental substance abuse. While the project was not intended to provide substance abuse treatment, social workers were available to assist family members with locating treatment resources.

Staffing

Two full-time social workers provided direct services and served as project administrators in Years I and II. Their responsibilities included monthly home visits with families and management of all administrative duties of the project. During Year III new funding was secured and an additional full-time social worker and administrative assistant were hired. The social workers each managed a caseload of 12 – 13 families.

In Years II through IV, social work interns from the School of Social Work were selected to complete their practicum experience with the project. Social work students paired with a full-time staff member for supervision and to ensure continuity of service for the families they served.

Changes to Proposed Services

In the original grant proposal, educational support, legal referrals, housing assistance, substance abuse referrals, benefits counseling, mental health services, and social support were included as service offerings, but not specified as components of social work case management. When the project was implemented, these services were included as social worker responsibilities.

Challenges of Providing Services

Challenges faced by the social workers in providing monthly visits were the same as those described in the nursing section. The greatest challenges arose with participants who worked or had extensive commitments outside of the home. After the initial assessment and home visit, social workers communicated regularly with these caregivers by phone.

Another challenge developed in educating participants that the goal of the project was to empower them to be more self-sufficient. Oftentimes the participants expected a more paternalistic role of the social work and nursing staff. This was most evident with transportation services. The provision of transportation improved access to many community and medical resources. Nonetheless, grandparents had to be educated and encouraged to access other means of transportation in preparation for self-sufficiency upon completion of the program.

Facilitators of Providing Services

Using the home visitation/multi-service model was a key factor in delivering services to participants. Home visitation is advantageous for families that do not have access to professionals who can assist with resource identification. As a result of using a home visitation model, our target population was able to minimize barriers related to illness, lack of transportation or childcare, and physical disability.

The intervention was designed to empower grandparents so that they will confidently make decisions regarding their grandchildren. Both the social work and nursing components sought to influence this outcome by using a strengths-based case management approach. Problem resolution, using this approach, permits clients to take an active role in identifying the source of their own problems, assume greater responsibility in defining the issues, assess their personal and environmental resources and take ownership of the final resolution and eventual outcome. Moreover, the strengths-based approach encouraged grandparents to identify and prioritize their perceived needs. The validation of their perceived needs also facilitated the establishment of a trusting relationship between both parties.

4. How successful was the project in providing access to monthly grandparent led support groups?

Service Description

Forty-eight grandparent support group meetings were conducted for PHG participants over the four years of service implementation. Meetings were held on the second Tuesday of each month from 10:30 am to 12:30 pm to ensure participants were returned home prior to dismissal of children from school. Support group meetings were open to all current and past participants; however, transportation was provided only for active participants. Eighty-five percent of those attending a support group meeting utilized

transportation provided by the project. Support groups were designed to facilitate discussion among grandparents. The grandparents planned the meeting agendas with no formal agenda stipulated by project staff. If the grandparents requested a formal presentation from a speaker outside of the project, the project staff arranged the presentation. This process allowed the grandparents to share their stories and develop a support network.

Grandparent facilitators presented on topics in which they were knowledgeable. For example, one grandparent, a retired New York City school principal, led a meeting on negotiating school systems and knowing grandparent rights as the primary caregiver. Another grandparent made a presentation on teaching grandchildren about entrepreneurship.

An average of 15 grandparents attended each support group meeting. The meetings were an integral part of involvement with the project and the participants valued the support network established by attending the meetings. One focus group respondent stated,

“It (support group) gives you an opportunity to know that you are not the only one that is in this...you feel love, you feel like we are sisters in Christ, a lot of us get to know each other and we feel close to each other.”

It was evident that spirituality was valued by participants and supported in the programming of support group meetings. Many participants reported that their faith was a significant source of support. One participant stated,

“You can’t just say I’m going to handle it and let God handle it. Sometimes you have to reach beyond. I have to ask you for help.”

Staffing

The support group meetings were coordinated and facilitated by a masters-prepared social worker, supported by funding from the Georgia Department of Human Resources. All project staff encouraged participants on their caseload to attend support group meetings. Two part-time staff were hired to coordinate and provide transportation to meetings.

Changes to the proposed services

Two additional support mechanisms, parenting education classes and a leadership team evolved from support group meetings. The parenting education group was initiated after participants expressed conflict over the difference in their past parenting practices and current views on parenting. Parenting education groups were held monthly at the same location as the support group meetings. Transportation was provided. The parenting education group presented a forum for meaningful and practical parenting tools to be explored and discussed. See Appendix E for list of topics.

A leadership team was formed with participants who completed the program. This group meets monthly to discuss issues that have been raised by other grandparents and assist in planning upcoming social events. The leadership team is responsible for notifying current and past PHG participants of scheduled events.

Challenges to Providing Service

Participants who worked outside of the home during the day found it difficult to attend support group meetings. An evening support group was initiated, but due to poor attendance was discontinued.

Meeting locations changed several times. Meetings were initially held at the DeKalb Addiction Center, a community substance abuse treatment program with a component targeted to substance abusing women and their children. This location supported our approach to holding meetings in the community and also provided childcare. Unfortunately this facility was sold in 1998 and was no longer available. No other community-based centers with childcare accommodations were located. Subsequently, meetings were located on the campus of Georgia State University in the new state-of-the-art student center and at the Georgia State University Recreation Lodge. Both locations are within one block of public transportation.

In the first two years of the project, on-site childcare was provided. This required transportation of children as well as the grandparents, which limited the number of grandparents that could be transported. During the final two years of the project, the Georgia State locations were suitable for conducting meetings but were not conducive to offering childcare. The absence of childcare resulted in a decrease in support group attendance for those with preschool children and during the summer hours.

Facilitators to Providing Service

The consistency of the regular monthly schedule of support group meetings allowed grandparents to plan around the meeting dates. Project provided transportation, as well as meeting locations within access of public transportation, facilitated attendance.

Throughout the four years of service implementation, the project was able to provide transportation to every support group meeting and parenting education class. Prior to the acquisition of two PHG owned 15 passenger vans, transportation was facilitated through rentals and contract service with transportation companies.

5. How successful was the project in providing a minimum of one legal consultation to review and explore child custody issues?

Service Description

The initial proposal stated that legal status of each child would be assessed. All families received a legal assessment within the first month of enrollment. Thirty-four percent of the caregivers did not have legal custody of the grandchildren they are raising. Failure to establish a legal relationship can result in barriers to school registration and access to health care. Furthermore, lack of custody may cause emotional distress to the grandparents and grandchildren who may fear that the children can be removed at any time. The former associate director, who is an attorney, law students and social work staff collaborated to provide education on custody options available, as well as assist with completing and filing necessary paperwork and referral for legal services.

Thirty grandparents desired adoption of their grandchildren and were referred to Atlanta Legal Aid. The Atlanta Legal Aid - Senior Citizen Law Project partnered with a local law firm, Kilpatrick and Stockton, to offer pro bono legal services for adoption of grandchildren. Adoption is a solution that offers social, economic and psychological benefits to the adoptive children and adoptive grandparents. Nine of the thirty grandparents adopted their grandchildren.

Grandparents who adopted their grandchildren were eligible for financial assistance under the Adoption Assistance and Child Welfare Act of 1980. Under the Adoption Assistance Act each adopted child in the family is eligible to receive between \$387.81 and \$433.43 per month, depending on their age, as opposed to a descending schedule of benefits under TANF (see Table 2).

Staffing

In Year I, under the supervision of the associate project director, three-second year law students from Georgia State University conducted the custody assessments. In Years II-IV the social work staff assumed this duty after training from the associate project director. This change occurred because it was more efficient to reassign the task to the social worker who had regular contact with the grandparent. This also decreased the number of individuals coming into the participants' home

Changes to Proposed Services

There were no changes to this service component

Challenges to Providing Service

There were no challenges to service provision.

Facilitators to Providing Services

Home visits provided convenient access to legal consultations. Transportation to probate court facilitated the process of initiating legal services.

6. How successful was the project in providing educational support services for families requesting assistance?

Service Description

The educational support component was designed to offer guidance to grandparents who were experiencing academic challenges with their grandchildren. Many grandparents requested assistance related to maladaptive behavior in school that prevented children from functioning at the appropriate academic level. Considering that various dynamics influence a child's ability to function appropriately in a school setting, the social worker made appropriate referrals to identify and address the source of the academic problem. Social workers were instrumental in arranging conferences with school counselors, teachers, mental health professionals and grandparents to foster a team approach in working with the child. Preschool children who screened suspect for a developmental delay were referred to Babies Can't Wait, an early intervention program.

Graduate students arranged home visitation with the grandparents to develop a plan for tutoring and mentoring the grandchildren. In Years I and II, the graduate students worked with over 75 of the school-age children in the program. In addition to the tutoring and mentoring they also provided cultural outings and field trips. Outings included local community centers and libraries, cultural events within the city, a tour of a local radio station and other areas of interest to the children.

Changes to Proposed Services

In December of 1999 the Gouizeta Foundation and the Hasbro Children's Foundation provided additional funding to develop comprehensive mental health support services. This funding permitted the development of the Saturday Youth Academy (SYA). The SYA provided mental health support services to grandchildren in the mornings and activities centered on entrepreneurship skills and cultural enhancement. Fifty to sixty grandchildren attended each 10-week session. With the implementation of the SYA, individual tutoring and mentoring was phased out; however children who still needed academic tutoring were referred to resources within their community

The objectives of the SYA are to (1) provide a setting where grandchildren can be supported and made to feel safe while freely expressing their feelings and emotions; (2) help the grandchildren recognize their strengths and use them to address the challenges they face at home, school and in their communities; and (3) reduce the grandchildren's sense of isolation by providing activities that permit socialization with other children being raised by their grandparents.

The SYA provided an opportunity, through the field trips to museums, art galleries and local businesses, for the children to extend beyond the geographical boundaries of their local communities. In addition grandparent caregivers have remarked that the children who have participated in the youth academy established better social networks.

Staffing

During Years I and II graduate students from various colleges and disciplines within Georgia State University were hired to provide individual tutoring and mentoring. During Years III and IV, with the inception of the SYA, twenty-five graduate students, nine MSW social workers, and two mental health professionals conducted three 10-week sessions per year. The mental health professionals included a doctoral-prepared psychologist and a masters-prepared licensed professional counselor.

Facilitators to Providing Service

As with other aspects of the service model, home visits facilitated the implementation of the educational support component. The graduate students were able to work with the children within their own communities. Transportation provided to the children ensured their attendance at the SYA.

Challenges to Providing Services

Prior to the establishment of the SYA, the project attempted to serve as many school-age children as possible in a year. With one hundred to one-hundred-fifty children per year, and a staff of five to six graduate students, the project sought to identify creative ways to serve all families that requested tutoring and mentoring services.

While many of the children had academic problems, few were receptive to tutoring by the graduate students. This became a source of frustration for the graduate students and the children. Some incentives were offered to the children in the way of field trips on the weekends for spending time working on academics during the week. Tutoring sessions were held individually and sometimes as a group. The group sessions were conducted at local community centers that also offered recreation opportunities such as arts and crafts, basketball, and pool tables. The children were given time to play after completing their schoolwork. Transportation for the tutoring sessions was provided by PHG, however due to the large number of children in the project and the travel logistics, it became prohibitive to transport more than five or six children at a time.

III. Outcome Evaluation

A. Proposed Outcome Objectives

1) Identify the negative effects of prior neglect and provide resources tailored to the individualized special needs of the children.

Grandchildren in intergenerational families will experience improved child outcomes, including an increase or stabilizing effect on child growth and development, and physical health, as well as a decrease in emotional and behavioral problems.

Hypothesis 1a. Grandchildren in intergenerational families will demonstrate a statistically significant decrease in the emotional and behavioral problems as measured by the Child Behavior Check List (CBCL).

Hypothesis 1b. Grandchildren in intergenerational families will demonstrate a statistically significant increase in child well being as measured by the Child Well Being Scale (CWS).

Hypothesis 1c. Grandchildren will experience improved physical health based upon established standards for growth and development.

2) Prevent subsequent neglect of children while they are in intergenerational kinship care.

Hypothesis 2a. Grandchildren in intergenerational families will demonstrate no statistically significant difference in type and severity of child neglect as measured by the Child Neglect Index (CNI).

Hypothesis 2b. Grandparents will report a statistically significant increase in family resources (e.g., physical shelter, nutrition, financial support, child care, employment, etc.) as measured by the Family Resource Scale (FRS).

Hypothesis 2c. Grandparents will report a statistically significant increase in their sense of empowerment to affect change within their families as measured by the Family Empowerment Scale (FES).

3) Decrease social isolation of grandparent caregivers.

Intergenerational families will experience a variety of forms of social support such as support groups and home visitation.

Hypothesis 3a. Grandmothers will demonstrate a statistically significant increase in social support as measured by the Family Support Scale (FSS).

4) Maximize the quality of life for grandparent caregivers.

Grandparents will report improvement in their physical and psychological functioning since their participation in PHG.

Hypothesis 4a. Grandparents will report a statistically significant increase in physical and behavioral health as measured by the Short Form – 36 (SF36) and the Health Risk Appraisal (HRA).

Hypothesis 4b. Grandparents will report a statistically significant increase in psychological health as measured by the Brief Symptom Inventory (BSI).

B. Questions Related to Outcome Objectives

1a. How effective is the program in decreasing emotional and behavioral problems in grandchildren?

- a. Expectations: After participation in PHG, grandparents will report a statistically significant decrease in child behavior problems.
- b. Definitions: Child behavior problems are defined according to the internalizing and externalizing syndrome scales of the Child Behavior Check List. The internalizing scales include the following syndromes: withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, and attention problems. The externalizing scales incorporate the following syndromes: delinquent behavior, aggressive behavior, and other behavior problems involving destructive physical behavior to self or others.

1b. How effective is the program in increasing child well-being in intergenerational families?

- a. Expectations: A statistically significant increase in the well-being of the grandchildren is expected to occur following family participation in the program.
- b. Definitions: Child well-being relates to the social, physical and environmental conditions that support the growth and development of a child.

1c. How effective is the program in improving the physical health of grandchildren?

Expectations: All grandchildren participating in PHG will have access to a medical service provider for necessary child health services.

Definitions: A medical service provider is defined as a health care resource where grandchildren receive medical care (e.g., private physicians, hospital outpatient clinic, community health center, or other health care resource). Child health services is defined as services performed by health care professionals for the purpose of promoting, maintaining or restoring health (e.g., immunizations, monitoring of child growth (i.e., height/weight measurements), and annual physical examinations).

2a. How effective is the program in preventing subsequent child neglect within grandparent households?

- a. Expectations: No new incidences of child neglect are expected while families are participating in PHG.

Definitions: The definition of child neglect is derived from Dubowitz, Black, Starr, & Zuvarin (1993), that “neglect occurs when basic needs of children are not met, regardless of cause.” Basic needs include adequate shelter, food, health care, clothes, education, protection, and nurturance.

2b. How effective is the program in increasing family resources in grandparent households?

- b. Expectations: Grandparents will report an increase in family resources available to them as a result of their participation in PHG.

Definitions: Family resources are defined as goods and services perceived by the caregiver to be necessary to support the family including financial support, child care, employment, shelter, health care, and food.

2c. How effective is the program in enhancing grandparents’ sense of empowerment?

- c. Expectations: It is expected that the grandparents’ general sense of empowerment will increase after receiving services from the program.

Definitions: The definition of empowerment is based on the concept by Lorraine Gutierrez (1994), “... the process of increasing personal, interpersonal, or political power so that individuals, families, and communities can take action to improve their situation.” Within the context of families, empowerment is a process by which family members access knowledge, skills, and resources that allow them to gain control over their lives and improve the quality of their life-styles.

3a. How effective is the program in affecting social support systems of grandparent caregivers?

- a. Expectations: Grandparents will experience a positive perception of social support that will lead to an increase in their reported support systems.
- b. Definitions: Social support is defined as the perceived helpfulness of various social systems, including assistance from immediate family members, social organizations, specialized community services, formal and informal kinship care resources.

4a. How effective is the program in maximizing the quality of life for grandparent caregivers?

- 1a. Expectations: Grandparents will have improved physical health and functioning, and execute healthy lifestyle behaviors as a result of their participation in PHG.
- 1b. Definitions: Physical health indices are based upon standard medical measurements for hypertension, diabetes, cholesterol and obesity. Healthy lifestyle behaviors consider the physical and social functioning of grandparents, as well as any risky health behaviors that could potentially lead to negative health outcomes.

4b. How effective is the program in reducing psychological distress in grandparents?

- 2a. Expectations: Grandparents participating in the program will report a reduction in psychological distress resulting from the receipt of multiple mental health interventions provided by the program, which will result in improved psychological functioning.
- 2b. Definitions: Psychological distress is defined as stress that often is high enough to warrant mental health intervention. Factors that potentially contribute to psychological distress include financial burdens, social isolation, and lack of accessibility to necessary community resources. Mental health interventions include social support groups, parent education classes, and referrals for mental health counseling.

C. Methods To Answer Outcome-related Questions

Both quantitative and qualitative data were used to address the outcome-related questions. Unless noted differently, all quantitative measures were collected at two time points – prior to the grandparent and family members receiving services from Project Healthy Grandparents (pretest) and upon exiting the program after one full year of service intervention (posttest). All data were collected within 15-30 days of intake. The specific quantitative measures are noted in the next section corresponding to each outcome-related question.

Data collectors for the project were trained graduate research assistants from Georgia State University. A total of 11 data collectors were hired and trained over the course of the grant. The data collection training sessions included a review of the various questionnaires and observation measures, an overview of interviewing techniques, and mock interview/observation activities. The data collection process varied during the initial two years of the program to accommodate the needs of the data collectors, as well as the families. During Year I, data were collected by the nurses and social workers assigned to each family; nurses collected the health related data; social workers collected the psychosocial data. This practice raised concerns about bias entering the process when family workers also served as the data collectors for posttest data. By the end of Year I, an administrative decision was made to categorize the data collection process into three groups: Graduate research assistants with nursing backgrounds collected all health related data (Denver, SF-36, HOME, Health Risk Appraisal, physical assessments of grandparents and grandchildren); a second group of graduate research assistants gathered all psychosocial data (Brief Symptom Inventory, Child Behavior Check List, Grandparent Interview IA, Family Empowerment Scale, Family Support Scale, Family Resource Scale); finally, the assigned family social worker collected two observational measures – Child Well-being Scale and the Child Neglect Index. Use of graduate nursing students for collection of health information proved to be unsatisfactory since the nursing students had difficulty scheduling home visits due to their school commitments. As a result data were not collected in a timely manner. In Year II, a part-time nurse data collector was hired to gather all health related data; the psychosocial data continued to be collected by graduate research assistants, and the two observational measures were collected by the family social workers.

The qualitative data were derived from three focus groups conducted as part of the formative evaluation process. Each focus group consisted of a random sample of 6-8 grandparents who received services for one year and had exited the program within 4-6 months. The aim of the focus group was to obtain the grandparent's perceived satisfaction with program services including the intake process and how the program services enhanced their support system. The focus group also allowed grandparents to discuss how the program altered their feelings about parenting their grandchildren. The focus group discussions add richness to the outcome data.

An outside consultant hired by Project Healthy Grandparents conducted the focus groups. A group facilitator who was not a service provider of the program encouraged

grandparents to speak openly about positives and negatives of the program. The focus group sessions were held on the campus of Georgia State University, and transportation was available to grandparents upon request. Open-ended questions were used to generate discussions on program services and effects. All sessions were tape recorded and transcribed by the consultant. The transcribed interviews were categorized into the following topical themes: program satisfaction, support system enhancement, and parenting experiences. An executive summary was prepared that highlighted the major themes of the group. All tapes and transcriptions remain the property of Project Healthy Grandparents and are maintained in secure storage facilities.

1a. How effective is the program in decreasing emotional and behavioral problems in grandchildren?

- a. Method of assessment: Child behavior problems were reported by grandparents using a standardized measure on child behavior. Graduate research assistants obtained these data during a home visit. The Teacher's Report Form was proposed to obtain information about the grandchild's behavior in the classroom setting, but it was discontinued as discussed below.
- b. Data collected: The Child Behavior Checklist (CBCL) (Achenbach, 1991) was completed by grandparents at pretest and posttest. The CBCL is a self-report measure for assessing behavioral and social competence in children ages 2-16 years. The grandparents rated each of their grandchildren in terms of presence and intensity of behaviors, which have been factor analyzed into two broad dimensions – externalizing and internalizing. Externalizing behaviors are viewed as likely to impede peer relationships and task completions; internalizing behaviors impact the grandchild's affective state.
- c. Data analysis: Descriptive statistics, repeated measures analysis of variance for the CBCL total score, and multivariate analysis of variance for the CBCL Internal and External Scale scores.
- d. Discussion: The Teacher's Report Form was initially proposed to measure the grandchild's academic performance and school behavior. It was discontinued during Year I of the program because of difficulties with getting teachers to return completed forms. Several methods for obtaining information from teachers were attempted, such as direct contact of the teacher by the family social worker and grandchild's tutor. One reason for not completing the data instrument cited by the teachers was the time investment necessary to complete the TRF. None of the attempted strategies were effective in collecting completed information in a timely manner, thus the TRF was discontinued. Although teacher input on the behavior of the grandchild in the classroom setting would have been a valuable piece of information, it was not deemed a critical element in understanding the child's behavior problems. The grandparents served as a

conduit of information on the grandchild's school performance and behavior as reported to them by teachers. This information was then passed on to the social workers where it was considered in the overall assessment of the grandchild's behavior.

1b. How effective is the program in increasing child well-being in intergenerational families?

- a. Method of assessment: A standardized questionnaire on child well-being was completed by the social workers during a home visit.
- b. Data collected: The Child Well-being Scale (CWS) consists of 43 behavior rating subscales that are multidimensional measures of potential child maltreatment situations. According to Lyons, Doueck, et al (1999), the items reflect four dimensions of child well-being: parenting role performance, familial capacities, child role performance, and child capacities. The types of situations included in the scales refer to provision of basic necessities (e.g., food, clothing, shelter), parental relations, access to community resources, and parental support toward the child. Relative to the grandchildren types of conditions reflected in the measure relate to adequacy of education, school performance, child conduct, and child disabilities. Each item has four or five indicator categories, which are weighted based on seriousness of the condition. The data from the CWS were obtained at pretest and posttest.
- c. Data analysis: Descriptive statistics; repeated measures analysis of variance of the Child Well-being total score.
- d. Discussion: The Child Well-being Scale was introduced as an outcome variable at the beginning of Year II of the program; as a result only three years of data were obtained using this measure.

1c. How effective is the program in improving the physical health of grandchildren?

- a. Method of assessment: Information collected by nurse and psychosocial data collectors included grandchildren's health history, early child development screening, and physical health assessments on each child. An early child development screening was used to assess the developmental status of children between the ages of 0 and 5 years. Portable weight/height scales were used to obtain child height and weight measurements. Using a health information survey, grandparents reported their access to a primary care physician, medical transportation, and other health information.

- d. Data collected: The Denver II (Frankenburg, 1992) was used to screen for developmental competence in four domains: personal-social, fine motor-adaptive, language, and gross motor skills. Height and weight data were obtained on each grandchild at pretest only. The Grandparent Interview IA, developed by the authors, is a survey containing questions about health care resources available to the family, including primary care physicians/pediatricians, hospitalizations, immunization records, and previous visits to a physician.
- e. Data analysis: Descriptive statistics on all measurements were obtained.

2a. How effective is the program in preventing subsequent child neglect within grandparent households?

- a. Method of assessment: The social workers and nurse data collector completed two standardized observational measures on child neglect during a home visit.
- b. Data collected: The home environments of participating families were observed by social workers using the Child Neglect Index (Trocme, 1996) and the Home Observation of the Environment (HOME) (Caldwell & Bradley, 1984). The CNI is an observational measure that assesses risks attributed to neglect within the home environment. The social worker observing the home considers six items relative to risk of neglect. Items such as access to medical care, adequacy of basic necessities, e.g., food, clothing and shelter, and methods of discipline, and availability of adequate educational resources are rated by the social worker. The HOME is administered by having the data collector observe interactions with the grandparent and child. The objective is to observe environmental characteristics that foster child development, including stability of adult contact, emotional climate, and home characteristics indicative of parental concern with achievement. A portion of the data is based on parental report. These observations were completed at pretest and posttest.
- c. Data analysis: Descriptive statistics, McNemar test of change for the categorical measure of substantiated neglect versus no neglect; repeated measures analysis of variance of the Child Neglect Index and HOME total scores.
- d. Discussion: Collection of the HOME at the time of posttest was very difficult because each child was required to be present in the home at the time of data collection. Consequently the number of children with a completed posttest was diminished.

2b. How effective is the program in increasing family resources in grandparent households?

- a. Method of assessment: Grandparents reported the adequacy of family resources to meet their primary needs to graduate research assistants during a home visit.
- b. Data collected: Grandparents were administered the Family Resource Scale (FRS) (Dunst and Leet, 1988) at pretest and posttest. The FRS is a 31-item self-report Likert type scale and is derived from a conceptual framework that predicts inadequacy of resources that will negatively impact child well-being and parental commitment. Items refer to specific resources and are rated on a 5-point scale from (1) does not apply to (5) almost always adequate. The total score is obtained by adding the score or each item, with higher scores indicating more resources.

Grandparents were interviewed using a survey developed by the authors, Grandparent Interview IA, which identifies access to and use of a variety of community resources necessary for family functioning. This information will be used to complement the data from the FRS.

- c. Data analysis: Descriptive statistics and analysis of variance to compare the total Family Resource mean score from pre and posttest.

2c. How effective is the program in enhancing grandparents' sense of empowerment?

- a. Method of assessment: Using a standardize questionnaire, grandparents were interviewed by graduate research assistants to assess their confidence and competence in seeking resources to meet family needs. In addition, the questionnaire addressed the grandparents' ability to advocate for necessary changes within their communities in response to family needs.
- b. Data collected: Grandparents were administered the Family Empowerment Scale (FES) (Koren, DeChillo, & Friesen, 1992). The scale consists of four factors of family empowerment: Knowledge, competency, systems advocacy and self-efficacy. The scale was developed to measure empowerment in families with children who have emotional, behavioral, or mental disorders. The FES is a 34-item scale. Each item is rated on a 5-point Likert type scale from (1) not true at all to (5) very true, with higher scores reflecting greater empowerment.
- c. Data analysis: Descriptive statistics and a repeated measure analysis of variance on subscales; an analysis to compare the mean scores between

pretest and posttest for statistically significant differences on the four constructs that compose the scale.

- d. Discussion: A central objective of the proposed program was to empower the grandparents so that they may have a greater sense of control over their lives and the lives of their grandchildren. Although the original proposal did not include a measure of 'empowerment', the Family Empowerment Scale was added to the measurement list during the middle of Year II.

3a. How effective is the program in affecting social support systems of grandparent caregivers?

- a. Method of assessment: Quantitative data on support systems were obtained from grandparents during a home visit using two surveys: A standard questionnaire on family social support and a survey that allows grandparents to describe the level of support within the household. Qualitative data were obtained during a focus group session where a randomly selected group of grandparents discussed their support networks.
- b. Data collected: Grandparents were administered the Family Support Scale (FSS) (Dunst, Trivette & Jenkins, 1988) which measures the helpfulness of support sources to families raising children. The scales consists of six factors: Informal Kinship, Social Organizations, Formal Kinship, Immediate Family, Specialized Professional Services and Generic Professional Services. The FSS includes 18 items that are rated on a 5-point scale from (1) not at all helpful to (5) extremely helpful. A total score is obtained by adding the score for each item. In addition, questions from the focus groups also provide information about the type and quality of emotional and social support grandparents have while raising their grandchildren.
- c. Data analysis: Descriptive statistics and a repeated measures analysis of variance to compare the mean scores between pre and posttest. Focus group content data was analyzed according to the basic theme of social support, specifically reviewing the comments for similarity in types and number of support, expression regarding satisfaction with support systems, and characterizations of formal vs. informal support.
- d. Discussion: There were no issues that affected the data collection or data analysis for this question.

4a. How effective is the program in maximizing the quality of life for grandparent caregivers?

- a. Method of assessment: Registered nurses obtained blood pressure measurements, weight, cholesterol and glucose levels on all grandparents. Two standardized questionnaires were used by nurses to assess the physical and functional levels of the grandparents. A definition of high blood pressure was based on a diastolic reading of ≥ 90 mg Hg; a high cholesterol level was based on a read of ≥ 200 mg/dl.
- b. Data collected: The Health Risk Appraisal (Hutchins, et al, 1991) and the SF-36 (Ware & Sherbourne, 1992) are two standardized measures on health outcomes that were administered to grandparents at pretest and posttest by nurse data collectors. The Health Risk Appraisal (HRA) is a self-assessment of risky health behaviors in four general areas – physiologic measures, behavioral factors, motor vehicle risk factors, and women’s preventive health behaviors. The HRA is commonly used to report specific modifiable risk factors that are associated with premature death or serious illness. The SF-36 measures eight health attributes using multi-item scales. The scales are physical functioning, bodily pain, role limitations resulting from physical health problems, general mental health, role limitations due to emotional problems, social functioning, vitality, and general health perceptions. All physical health measurements obtained by nurses were recorded onto standard data forms for data entry.
- c. Data analysis: Descriptive statistics, and a repeated measure of analysis of variance.
- d. Discussion: There were no issues that affected the data collection process or data analysis for this question.

4b. How effective is the program in reducing psychological distress in grandparents?

- a. Method of assessment: Self-report of mental health status by grandparents by the psychosocial data collectors.
- b. Data collected: Brief Symptom Inventory (BSI), (Derogatis, 1993) was used to assess psychological distress in participants. The scale is scored and evaluated in terms of eight primary symptom dimensions: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, and Paranoid Ideation. The Global Severity Index combines information about numbers of symptoms and intensity of distress and is considered the best summary

score for psychological distress. Each item on the BSI is rated on a 5-point scale of distress, ranging from “not at all” (0) to “extremely” (4).

- c. Data analysis: Descriptive statistics; repeated measures analysis of variance for the Global Severity Index; MANOVA to test statistical significant differences between pre and post-test measures the BSI subscales.
- d. Discussion: The Brief Symptom Inventory is a substitute for the Symptom Checklist-90-R, the measure that was listed in the original proposal. In order to minimize fatigue by the grandparents who had to answer multiple questionnaires in the study, the BSI was used in place of the Symptom Checklist 90-R. Previous studies have confirmed that reduction in the length of the Symptom Checklist 90-R dimensions does not have a significant effect on validity. Correlations between the BSI and the Symptom Checklist 90-R on a sample of 565 outpatients show very high correlation on all nine dimensions.

D. Findings For Outcome-related Questions

The findings presented below are based on 92 grandparents (unless noted otherwise) who participated in Project Healthy Grandparents between 1996 and 2001. Table 3 presents the general characteristics of families served in the program. Grandmothers are the primary caregivers for their grandchildren; other intergenerational relatives include grandfathers and great-aunts. Although not a requirement, a majority of the participating families were African-American and low income. Grandparents were as young as 38 years of age and as old as 78, with an average age of 57 years. Grandparent caregivers were raising between one and seven children, with an average of 2.41 grandchildren per family. Most grandparents were separated/divorced or widowed and most grandparents had less than a high school education. The specific research questions that guided the service delivery for families are addressed below.

Table 4 presents the characteristics of the 222 grandchildren. The grandchildren ranged in age from less than one year to 16 years, with an average age of 8 years. In the majority of families the grandparent has legal custody of the grandchildren; child protective services has custody of the children in 5% of the families. On average, the grandchildren have been living with their grandparents for 5.5 years. Substance abuse is the primary reason the grandparents are parenting their grandchildren.

1a. How effective is the program in decreasing emotional and behavioral problems in grandchildren?

Statistically significant findings: Table 5 presents the finding from the CBCL. Grandchildren scored lower on the CBCL External subscale ($F = 49.1, df = 2, 192, p = .000$) and Internal subscale ($F = 71.6, df = 2, 192, p = .000$) after the year-long intervention. Univariate analyses indicate that both the External and

Internal scores are statistically significantly different. Grandchildren also scored lower on the Total CBCL score ($F = 70.2, df = 1, 193, p = .000$)

Other findings: Based on a review of case management documentation by social workers on the families, none of the grandchildren were referred for to institutions for behavioral problems while participating in PHG.

Discussion of results: The findings clearly indicate that grandchildren's behavior improved during the course of the year. What is encouraging about this finding is the fact that grandchildren improved in both their externalizing and internalizing attributes. The CBCL pretest score was used by the social workers, with other known information about the family, to support the intervention with families. In consultation with a doctoral-candidate in clinical psychology, who had extensive experience using the measure, social workers discussed the results of the CBCL with each family. This process was important to develop the most appropriate case management service for each family. Further, the CBCL was used to identify grandchildren who were appropriate for interventions (e.g., tutor/mentoring, Saturday Youth Academy, referral to community agencies).

1b. How effective is the program in increasing child well-being in intergenerational families?

Statistically Significant findings: The grandparent and grandchildren behavior dimensions scores demonstrate an improvement on the critical factors attributed to child well-being. Findings from the Child Well-being observational measures, Table 6, relative to grandparents were statistically significant ($F = 5.0, df = 1,64, p = .03$); findings relative to the grandchildren were also statistically significant ($F = 13.0, df = 1,159, p = .000$).

Implication of data collection/analyses: Since the Child Well-being scale was initiated in Year II, the sample size was 65 grandparents rather than 92 grandparents for the four-year service implementation. The total sample of grandchildren observed under the Child Well-being scale is 160 rather 222 grandchildren for the four-year service implementation.

Discussion of results: The statistically significant total scores on the grandparent and grandchildren behavior dimensions demonstrate reduced risk for child neglect. The findings from the CWS indicate that by the end of the program year, grandchildren were in a far less threatening environment for child abuse and neglect than when families first entered the program. In particular, items related to provision of basic necessities were improved during the course of the year.

Interpretation of results: The individual scores on each of the scale items have practicality as an indicator for family social workers to monitor specific conditions that are a serious threat to the well-being of the grandchild. Used in combination with other information derived from the case management process,

social workers are able to give specific attention to the critical needs of the families for better services and outcome.

1c. How effective is the program in improving the physical health of grandchildren?

Other types of findings: The Child Health Data inquires about the health status of the grandchildren, as reported by the grandparents. Noteworthy is the fact that 28% of the grandchildren were drug exposed at birth, 21% have asthma, 17% have learning problems, and 10% have a known developmental delay. Relative to preventive health measures, 99% of the grandchildren are up to date on their immunizations.

The scores on the Denver II indicate that 20 of the 65 grandchildren less than 6 years of age were suspect for developmental delays. All grandchildren who scored suspect were referred to appropriate community services for early intervention or school-based special education programs. Moreover, thirty-five of the 65 grandchildren under 6 years of age scored in the low percentile range for height and weight at the time of pretest data collection. Since 85% of the grandparents reported that their grandchildren had a primary care provider and were on Medicaid, these children were under medical care. The remaining grandchildren were referred for medical assistance and primary health care.

Implication of data collection/analysis: Although nurses obtained weight and height measurements on the grandchildren at the time of pretest, the same measures were not obtained at the end of the program year. As a result, these data are not available to determine changes in growth according to anthropometric norms.

Discussion of results: Based on the findings, grandparents appear to have adequate access to primary medical care for their grandchildren. Children who required additional resources to enhance their physical well-being such as mental health, early intervention, or services specifically designed for chronic health conditions were referred to the appropriate provider.

2a. How effective is the program in preventing subsequent child neglect within grandparent households?

Statistically Significant Findings: Tables 7 and 8 present the findings from the Child Neglect Index. There was no statistically significant difference from pretest to posttest on the Child Neglect Index total score in the repeated measures analysis. The McNemar test of change indicated no significant differences in the proportion of grandchildren living in risk environments from pretest to posttest. Similarly, there was no statistically significant difference from pretest to posttest on the HOME.

Other findings: Although the Child Neglect Index was not statistically significant, there are some important findings that need to be discussed further. At the time of pretest, four grandchildren were living in environments with risks considered as “Substantiated Neglect” according to the CNI. Two of these grandchildren moved to the category of “No Neglect” because of improvement in their home environments. The remaining two grandchildren were from the same family and continued in the category of ‘Substantiated Neglect’ because the mental health needs of the grandchildren were not being met. The grandparents had religious beliefs that conflicted with the mental health treatment protocol. On the other hand, six grandchildren, representing three separate families, showed no neglect on pretest and were categorized as living in environments with risks considered as “Substantiated Neglect” on posttest. In each of these cases the grandchild’s emotional or educational needs were not being met. Interventions were provided through the project, which positively impacted each situation. However, the families required additional intervention beyond the project time period.

Discussion of results: The finding of no statistical significance indicates that the goal of the program, that there would be no further neglect for grandchildren under the care of grandparents, had been met. The majority of children live in homes that are not at risk for neglect. Relative to the homes where the CNI results indicated the grandchildren were at risk for neglect, in some cases, forces external to the home environment (e.g., school system and religious beliefs of the caregiver) were the factors that contributed to the outcome.

2b. How effective is the program in increasing family resources in grandparent households?

Statistical significant findings: Table 9 presents the findings from the Family Resource Scale. Repeated measures analysis of variance showed a statistically significant gain in family resources, ($F = 16.2$, $df = 1,88$, $p = .000$). The pretest and posttest means score were 101.3 and 108.9 for respectively.

Other findings: Findings from the Grandparent Interview I obtained at intake identifies the variety of support services grandparents use to meet their needs. The most common support services used by grandparents were in the public welfare sector. The services include TANF, food stamps, Medicaid, Medicare, WIC, and SSI Disability (see Table 10). As seen in Appendix B, families received referrals to numerous community-based programs.

Discussion of results: Although most grandparents readily accessed public welfare sector resources, social work and nursing case management services provided under the project were essential in assisting families to identify and access private sector resources such as daycare, legal services, and academic services. In addition, grandparents were “coached” concerning how to become advocates for themselves and their grandchildren.

2c. How effective is the program in enhancing grandparents' sense of empowerment?

Statistically significant findings: Table 11 presents the results of the Family Empowerment Scale. Based on a sample of 56 grandparents, the Family Empowerment Scale total score demonstrated a statistically significant increase from pretest to posttest ($F = 3.94, df = 1, 52, p = .05$). Results from the multivariate repeated measures analysis of the empowerment subscales indicated a statistically significant increase ($F = 2.65, df = 1, 52, p = .043$). Univariate analyses indicate two subscales (system advocacy and knowledge) showed statistically significant difference between pretest and posttest scores. The pretest and posttest mean scores for system advocacy were 32.4 and 35.2 respectively ($F = 7.38, df = 1, 52, p = .01$); and the pretest and post test mean scores for knowledge were 45.0 and 47.4 respectively ($F = 5.58, df = 1, 52, p = .02$). Comparison of the mean scores for competence and self-efficacy at pretest and post-test were not statistically significant.

Other findings: Discussions from the focus groups indicated that grandparents often had feelings of incompetence in raising their grandchildren. Several recognized the differences in parenting their grandchildren in present day society versus parenting their own children. In particular, the grandparents noted the influence of media and other children on the behavior of their grandchildren. Grandparents expressed concern that the level of respect held by children towards their elders is dramatically lower than in previous generations. As stated by one grandparent,

“... Now in my time, you do what you are supposed to do. Now other children will take your children away from you.”

But in spite of feelings of uncertainty or lack of competence about parenting their grandchildren, grandparents spoke about how their self-esteem was enhanced since participating in the program; that they had become empowered to facilitate change in their lives. As one grandparent stated,

“...To me I feel as though I took over the ship. In order for something to work, if I'm a part of it, I have to be a part of making it work...”

Discussion of results: The focus group discussions and the quantitative data results indicate that grandparents have experienced a positive change. In working with families, nursing and social work staffs use a strengths-based case management approach to help individuals reconnect to their inner strengths. Families are encouraged to recognize internal resources that can be used to address family needs. The success of this approach is measured in the expanded

choices and opportunities the grandparents believe they have acquired. As aptly stated by one grandparent, getting “control of the ship” is the essential outcome that any case management approach attempts to achieve and was an ultimate goal of PHG.

3a. How effective is the program in affecting social support systems of grandparent caregivers?

Statistically significant findings: Table 9 presents the Family Support Scale results. Repeated measures analysis of variance demonstrated a statistically significant increase in the social support score ($F = 6.61, df = 1, 88, p = .01$), demonstrating that grandparents had an increase in social support.

Other findings: Based on the Grandparent Interview, 39 (42.4%) of the grandparents reported they have help within the household to assist in caring for the grandchildren. Adult caregiver support included spouses (15.2%), sisters (1.1%), daughters (14.1%), and sons (12.0%). Other adult caregivers include a stepfather, friends, significant others, and older grandchildren.

In the focus groups, grandparents repeatedly spoke of the emotional support they received from staff and peers. One grandparent remarked:

“I was going against a blocked wall, and then all of a sudden I could call this person and say, ‘look, this is what is happening in school, who do I need to talk to?’ ...It really helped me to feel much better...”

Another grandparent remarked:

“It helped me to know that I wasn’t the only one with problems, because I had feelings of incompetence, and then I’d listen to some of the other grandparents, and I’d say, I was feeling the same thing.”

Participants in the focus groups acknowledged the importance of faith as a source of support for them. For example, one grandparent stated,

“I would say things are getting better. I’m trusting God. It’s all just falling together.”

Discussion of results: The results demonstrate that grandparents’ perception of social support was positively enhanced since their participation in the program. The PHG support group played a major role in bringing about this outcome. Despite the fact that many grandparents have child care support from family members or significant others, such assistance did not provide the emotional support that grandparents received from the group meetings. The majority of

grandparents does not have adult support in the household and are attempting to manage the care and nurturance of their grandchildren on their own. The monthly support group meetings provide a venue where grandparents meet with peers and share experiences with one another. The meetings allowed grandparents to express concerns, share stories and learn about new resources in the community.

4a. How effective is the program in maximizing the quality of life for grandparent caregivers?

Statistically significant findings: Repeated measures analysis of the SF-36 indicated no statistical differences from pretest to posttest (See Table 12). Repeated measures analysis indicated no statistical difference in pretest and posttest on the BMI scores.

Other findings: Based on the Health Risk Appraisal, the major health conditions/behaviors that were of concern related to high blood pressure, diabetes and obesity.

Weight Gain/Loss: Body Mass Index (BMI) was calculated for each grandparent at pretest and posttest (see Table 13).

Diabetes: A total of 19 (21.3%) grandparents reported having a diagnosis of diabetes prior to their participation in the program. One grandparent was newly diagnosed with diabetes while participating in the program.

Smoking: Based on 89 grandparents, 2 stopped smoking during the time they were participating in the program; and one grandparent who reported she was a past smoker, resumed smoking by the time she exited the program.

Hypertension: Thirty (34.1%) of 88 grandparents tested had high blood pressure at intake, of which 13 (43.3%) had normal blood pressure levels at the end of their participation in the program. Four grandparents were taking medication to control their blood pressure prior to their participation in the program, but were no longer required to take medication at the time of program completion. Of the 58 grandparents who reported not having high blood pressure at the time they entered the program, 11 (19%) were newly diagnosed with high blood pressure during the course of the program.

Cholesterol: Thirty-six (55%) of 66 grandparents tested had high cholesterol levels, of which 17 (47.2%) had lowered cholesterol levels during their participation in PHG. Eleven grandparents had normal cholesterol levels when they began the program, but their levels had increased to at least 200 mg/dl at the time of program completion.

Discussion of results: The data from the HRA indicates the necessity to continue health education and close monitoring of grandparents' health. The identification of newly diagnosed cases of diabetes and hypertension is important to note in view of the fact that these medical conditions often go undiagnosed and untreated in the African-American population. The need for continued health education and health promotion activities is evident considering that the numbers of grandparents who gained or lost weight were similar. A concern is the fact that eleven grandparents had an increase in cholesterol levels despite the health promotion aspects of the program.

Interpretation of results: The initial expectation was that grandparents would experience improved physical healthy/functioning as a result of their participation in the program. Based on the SF-36 findings the grandparents' physical functioning did not improve, however, it did not deteriorate either. This result is not surprising given the age and physical condition of the grandparents when they entered the program.

4b. How effective is the program in reducing psychological distress in grandparents?

Statistical significant findings: The Global Severity Index of the BSI was statistically significant ($F = 13.54, df = 1, 82, p = .00$). The MANOVA conducted on all subscale mean scores was statistically significant different from pretest to posttest (See Table 14). Univariate F tests indicate that each the subscales, with the exception of somatization demonstrated a statistically significant decline from pretest to posttest.

Implications of data collection/analyses: Implications include that nine grandparents had an invalid BSI because they reported no problems with any of the items. This decreased the number of grandparents in the data analysis.

Discussion of results: Based on the results of the data, the grandparents experienced a significant decline in psychological distress during the time they participated in the program. Assistance provided by the home visiting staff (nurses and social workers), and in particular, the social support group meetings were instrumental in providing grandparents with the necessary emotional support to facilitate a reduction in psychological stress.

E. Lessons Learned

Policies, Practices, and Procedures To Be Maintained

Case Management Practice – The strengths-based approach to case management supported the goals of PHG and provided the staff with a common framework for working with families. The nursing and social work staff used the strengths-based approach to reinforce principles that guided participants toward self-reliance.

Interdisciplinary Array of Services. The combination of social work, nursing and legal services combined with support groups and the Saturday Youth Academy addressed family issues and provided a holistic approach to serving intergenerational families.

Community Advisory Board – The program was able to focus on issues most important to grandparents since grandparent caregivers served as members of the community advisory board. Two of the grandparent advisory board members were also members of the grandparent leadership team. These two board members served as liaisons between the advisory board and the leadership team. Moreover, communication between project administration and the collective body of grandparents was enhanced by this arrangement.

Documentation – Clear policies and procedures regarding documentation, staff communication and reports were essential. A central file containing all documentation on the family provided an up-to-the-minute record of services and resources that the participants had received or were seeking. All staff had access to the central file. Program staff are exploring the feasibility of using Web CT, an electronic method of documentation that will allow staff to access files from their personal computers.

Transportation – Transportation is an essential service for project-sponsored events such as support groups, parenting education classes and the Saturday Youth Academy. This service boosted attendance at these events. Wheelchair-accessible vans or vans with platforms will facilitate boarding of the vans for grandparents who are physically challenged.

Potential Changes To Policies, Practices and Procedures

Project Staffing – Ideally, full-time professionals are needed to provide the essential core services of the project. Students are a wonderful resource and can be used to augment core services. Graduate student staff was cost effective, however, school commitments often limited their availability and eventually they graduated, causing a need for new staff. This staffing change often meant a break in continuity of nursing services for families or delays in collection of pre and posttest data. In addition, a full-time project manager, responsible for supervising

day-to-day operations of all project components, is essential for efficient delivery of services.

Child Care – Providing child-care at support group meetings and parenting education classes increased the number of participants who attended meetings. Two challenges to providing child-care were lack of an appropriate space at the meeting sites and limited seating on the vans for children. A possible alternative to providing childcare is to reimburse the grandparents for childcare expenses incurred while attending meetings.

Data Collection – PHG collected many standardized measures and demographic data on each family. Although the grandparents did not complain about the amount of time spent to collect the data, the process could be burdensome for large families. Specifically, the observational data was problematic in that children were often unavailable or too fatigued to complete the process. Depending on the number of children in the family, the data collection session ranged from four to six hours. The session was usually divided into two separate days and two data collectors administered the measures.

Utilizing part-time staff dedicated to collecting data is preferable to graduate students. Additionally, reducing the number of data collection instruments to a minimum would impact the number of complete datasets collected.

While grandparents made themselves available for the pretest data collection because it was a prerequisite to accessing services, posttest data were often more difficult to collect. The grandparents' reluctance to transition from the project might also account for their avoidance of posttest data collection.

Home Visits – As previously mentioned, the number of home visits for PHG participants was dictated by the families' needs rather than by program protocol. Families were found to have varying needs that did not fit into a prescribed protocol.

Recruitment – While grandparents are often anxious to join the program, unanticipated circumstances may make it difficult for them to participate. Due to attrition, it is best to recruit at least 10-15% more participants than required.

IV. Relationship Between Program Implementation and Participant Outcome Evaluation Results

There are several program implementation processes that contributed to the effectiveness of PHG. A central goal of Project Healthy Grandparents is to develop a model of services that empowers caregivers impacted by child neglect. Strengths-based case management promotes grandparents to be actively involved in resolving their problems and to celebrate their accomplishments. This perspective permeates all aspects of service

delivery – social work, nursing, legal support, parent education, and youth activities. As a result, grandparents learn how to “get control of the ship” again.

Access to program services is critical to the overall effectiveness of the program. It is important to develop services that are home-based, eliminating the need for grandparents to travel to service providers. This is especially important for grandparents who have physical limitations that preclude them from traveling, do not have accessible transportation or do not have access to childcare. Over the course of program operation, less than 1% of the families served refused participation in the program because they did not want a PHG provider to come to their homes.

Access to group meetings is also critical in helping grandparents achieve their desired goals. Transportation was provided to the monthly support group meetings and the parent education classes. As a result, grandparents had the opportunity to express their emotions about parenting their grandchildren, learn about parenting techniques, and establish a support network with other caregivers. Based on the results from quantitative measures (e.g., Family Support Scale, Family Resource Scale) and the focus group content, the grandparents experienced positive emotional effects as a result of the various group meetings.

The majority of the grandparents and grandchildren served by PHG were African-American. It is important to be certain that the staff reflect the racial status of the families, not only the direct service staff but also the administrative and community advisory board members. This practice promoted a rapport between the service providers and grandparents. Moreover, a racially/culturally diverse staff was especially important when providing youth services and promoting the benefits of diversity. Many of the grandchildren have little exposure to positive role models in their communities. Consequently, the grandchildren often looked upon the staff as role models.

V. Recommendations

The following recommendations are based on our experiences in designing and implementing, and evaluating this five-year demonstration project.

1. Public policy must address the financial needs of grandparents who are raising grandchildren.

Policy makers need to recognize grandparents raising grandchildren as a legitimate family unit regardless of their formal legal relationships. There are very few financial resources available to grandparents raising grandchildren. National policies that address families need to consider the impact on grandparent-headed households. In some states, time limits for TANF benefits also apply to grandparent caregivers who are not the target of the welfare reform policy. Moreover, TANF benefits are inadequate.

The policy of excluding grandparents in informal foster care arrangements from foster care stipends is contrary to the promotion of family preservation. Our experience

indicates that most grandparents will forgo foster care stipends since it requires that the grandparent must relinquish custody of the grandchildren to the state. States have a great deal of latitude in defining eligibility for benefits. A national policy that recognizes the contribution of informal kinship care to family preservation is critical and will influence state policy.

2. Coordination of comprehensive services is needed for intergenerational families.

Grandparents raising grandchildren are often confronted by inadequate resources for raising children. Many are retired, on fixed incomes, or have been forced to leave gainful employment because of added childcare responsibilities. Results of this demonstration project indicate that the resources needed by grandparents include health care, adequate housing, child care, respite care, and legal services related to child custody, guardianship, and adoption. Although these resources exist, there are no case management services available to coordinate services for grandparents raising children.

Children raised by grandparents often have specialized needs that require professional intervention. Results of our demonstration project indicate that most grandchildren were neglected, abused or abandoned by their birth parents; many were born exposed to drugs. These factors place them at risk for emotional problems, developmental delays, and health problems. Addressing the mental health needs of children raised by grandparents can be achieved with psycho-educational group therapy, mentoring, and referrals for individual therapy. Grandchildren under the care of grandparents need case management to coordinate services offered by health, mental health, education and juvenile justice systems.

3. Transportation is critical when planning interventions for grandparents raising grandchildren.

Accessing resources is a major challenge for grandparents raising grandchildren. Many do not own cars and public transportation is often difficult to use because of health problems. The use of a home visitation model for social workers and nurses greatly enhanced the successful delivery of services in this demonstration project. Likewise, provision of transportation to support groups, parenting classes, and children's activities was essential in accessing these services.

4. Professionals who intervene with families in which grandparents are raising grandchildren require the appropriate education regarding the special needs of these families.

Professionals are often unaware of the myriad challenges that confront grandparents raising grandchildren. Thus, information on the unique needs of this population should be disseminated to various groups including social service and health care providers, child protective workers, educators, and mental health specialists. Appendix F contains a list of project dissemination to date.

5. An increase in appropriations to fund demonstration projects of intergenerational families is needed.

A limitation of the current study is the narrow scope of the sample, which was low income, African-American and living in urban communities. Funding is needed to further test the PHG model with different populations in other communities. In addition, support is needed for longitudinal research studies of these families to determine if the PHG intervention has an impact beyond one year. An experimental design with random selection, random assignment, and one or more comparison groups is a stronger methodology for testing the PHG model.

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Appendix A

Project Healthy Grandparents Community Partners

Atlanta Legal Aid Society (ALAS): Legal assistance is provided to grandparent-headed households through their Grandparent Project and other relevant aspects of their program. Project Healthy Grandparents (PHG) works closely with the attorneys on adoptions for families and assists in the training of attorneys. ALAS attorneys present information at the Grandparent Education Classes on adoption and education.

Big Brothers Big Sisters of Metro Atlanta: PHG is in the beginning stages of forging a relationship. A Memorandum of Understanding is in the process of being developed. Currently, social workers in PHG make referrals and interface with the staff to insure the children are enrolled in the program.

Capitol City Opera Company: Programs for the children and adults are offered throughout the year. In addition, the Capitol City Opera Company has provided funding for PHG's annual events for grandparents: Holiday Party in November 2000 and the Grandparent's Day Celebration in September 2001.

City of Atlanta Bureau of Cultural Affairs: During the summer of 2000, the Bureau of Cultural Affairs provided funding to a quilting teacher so that the grandparents could learn to quilt. The grandparents and teacher worked on the quilt every week during the summer and then presented the quilt to PHG. In addition, a storyteller gathered the stories of the grandparents and grandchildren, and a photographer taught the children in the Saturday Youth Academy photography. An exhibit of the grandparents' quilt, the children's photographs, and the stories were on display at the Holiday Luncheon in 2000 at the Holiday Inn - Atlanta.

DeKalb Addiction Clinic: For the first several years of PHG, the grandparent support groups and parent education classes were held at the DeKalb Addiction Clinic. The space was offered free of charge. The clinic also provided childcare and childcare workers so that the grandchildren were cared for while the grandparents met. Eventually, the clinic was closed and moved to another building and the meeting place was changed to Georgia State University.

DeKalb County Department of Family & Childrens Services: Referrals, mutual in service training, and collaboration on behalf of families are ongoing with the department.

Fairburn Town Homes: As a result of a request for housing on the part of one of the families, a relationship has been established with this facility. We are actively pursuing mutual in service training and an opportunity for clients to have some priority for housing.

Family Links: Respite care for grandparents has been offered through this program for many years. Referrals are made and the social workers and agency staff work together on behalf of families. In an emergency situation, when the grandparent has no one to care for the children, PHG works closely with the agency to insure that care will be provided.

Fulton County Department of Family & Children Services: Referrals, mutual in service training, and collaboration on behalf of families are ongoing with the department.

Grady Child and Adolescent Psychiatric Clinic: Children are referred to the clinic for counseling services. The clinic and PHG work closely together on behalf of families.

Kilpatrick Stockton, Attorneys at Law: Attorneys provide pro bono legal services to families in the program. When the law firm offers training on adoption with the Atlanta Legal Aid Society, PHG participates. More recently, grandparents who have adopted their grandchildren also participate in the training.

Marcus Institute: Grandchildren who have been prenatally exposed to drugs and/or alcohol are assessed at this agency. Through a formal agreement, two slots per month are set aside for PHG children. The Early Intervention Specialist from PHG works closely with the Marcus Institute to refer families, provide support, and assist with the implementation of the Marcus Institute recommendations.

Seventh Day Adventist Church, Decatur: Food baskets are provided to families who are in need. PHG and two Seventh Day Adventist Churches work together to identify the most needy families. The churches provide the food and PHG delivers the baskets.

Appendix B

Project Healthy Grandparents Referrals and Resources 1996 - 2001

African-American Studies Program/Heritage Awards, Georgia State University
Arts For All

Atlanta Center for Home Ownership

Atlanta Regional Commission

Atlanta Legal Aid Society

Babies Can't Wait

Big Brothers Big Sisters of Metro Atlanta

Boys & Girls Club of America Career Exploration, Broader Horizons

Brightside Youth & Family Intervention Program

Capitol City Opera Company

ChAMPS (Child and Adolescent Multi disciplinary Program System of Care)

Chris Homes

City of Atlanta Bureau of Cultural Affairs

Communities in Schools, Project Grad

Computer Lab, Georgia State University

Decatur Food Co-op

DeKalb Addiction Clinic

DeKalb County Department of Family & Childrens Services

Fairburn Town Homes

Families First

Family Friends

Family Links

Family Support Services

Frazer Center

Fulton County Department of Family & Childrens Services

Fulton County Juvenile Court

Gate City Day Nursery

Georgia Council on Child Abuse

Georgia Regional Hospital

Grady Child and Adolescent Psychiatric Clinic

Grady Memorial Hospital

Grady Memorial Hospital Senior Services Program

Good Samaritan Health Center

Hughes Spalding Childrens Hospital

Indian Creek Recreational Site, Georgia State University

Junior Achievement

Kilpatrick Stockton, Attorneys at Law

Kirkwood Mental Health
Marcus Institute
Morehouse School of Medicine
Moving in the Spirit
Office of Community Service Learning
Parents Educating Parents and Professionals
Pediatric Clinic at Southside Health Center
Project Prevent
Project Read
Providence Headstart Program
Prenatal Substance Abuse Program, Grady Memorial Hospital
Psychology Clinic, Georgia State University

Quality Living Services
Seventh Day Adventist Church, Decatur
South Side Community Health Center
St. Vincent de Paul
The Atlanta Project
The Grandparent Information Center, AARP
Tilson Elementary School
United Way
Whitefoord Community Program

Appendix C

Project Healthy Grandparents Community Advisory Board Members

The PHG Community Advisory Board is comprised of individuals who are uniquely qualified to advise on the needs of intergenerational families. This diverse group of people represents both the population served and the key service providers. The Board is 75% female and 83% African-American.

General responsibilities of Advisory Board members include:

- Sharing resources that will benefit the grandparents and grandchildren
- Counseling staff on PHG operations and delivery of services
- Participating in planning sessions to assist in the strategic development of PHG

Roles of Individual Board Members:

Louise Alexander – Project Healthy Grandparents Alumna, board member 1996-1998

Provided the grandparents' perspective and represented the needs of families.

Billie Astin - Project Healthy Grandparents Alumna, board member 1996-1998

Provided the grandparents' perspective and represented the needs of families.

Alma Blackmon – Community Volunteer, board member since 2001

Serves as advocate for kinship care based on personal experience.

Geneva Boykin - Project Healthy Grandparents Alumna, board member 1996-1998

Provided the grandparents' perspective and represented the needs of families.

Joan Burton - Project Healthy Grandparents Alumna, board member since 1998

Provides the grandparents' perspective and represents the needs of families

Janet Carthon – Community Volunteer and Activist, Salvation Crisis Center, board member 1996 - 1998

Served as advocate for kinship care.

Doris J. Dickens, LMSW – Director, Social Services, Gate City Day Nursery, board member since 1996

Referred initial clients to PHG and advises on community resources.

Delores Ewing - Community Volunteer, board member 1996, deceased 1996

Advocated for parenting training for grandparents raising grandchildren.

Barbara Friday - Project Healthy Grandparents Alumna, board member 1996-1998

Provided the grandparents' perspective and represented the needs of families.

Leonard Jenkins – President, Elite Staffing, board member since 1999
Offers a corporate perspective that connects PHG the business community.

Brenda Jones - Project Healthy Grandparents Alumna, board member since 1998
Provides the grandparents' perspective and represents the needs of families.

Reverend George Lanier – Associate Pastor, Cascade United Methodist Church, board member since 2001
Serves as a liaison between the church and the community, including outreach to grandparent- headed families.

Reverend Caroline Leach – Pastor, Oakhurst Presbyterian Church, board member since 1998
Provides counseling and support for grandchildren and grandparents in the community.

Lovell O. Lemons, M.Ed. – Director, Community Service, Georgia State University, board member since 1996
Facilitates involvement of GSU students and links PHG families to resources.

Phyllis Miller, LCSW – Social Worker/Administrative Director, Hughes Spalding Children's Hospital, board member since 1996
Provides referrals and advice on children's health and social services.

Dr. Richard Owens – Pastor, Trinity United Methodist Church, board member 1998–2001, deceased 2001
Pastored grandparent-headed households in the community.

Gretchen Patton – Community Volunteer, board member since 1999
Supports children's issues through volunteer leadership. Recognizes the importance of grandparents in grandchildren's lives.

Barbara Rouse - Project Healthy Grandparents Alumna, board member 1996–1998
Provided the grandparents' perspective and represented the needs of families.

Debra Sabree, LCSW – Social Worker, Hughes Spalding Hospital, board member since 1997
Provides referrals and advice on children's health and social services.

Merle Smith – Project Healthy Grandparents Alumna, board member since 1997
Provides the grandparents' perspective and represents the needs of families.

Verna White, MSW – Director, New Visions, DeKalb Addiction Clinic, board member since 1996
Collaborates with PHG staff and provides client referrals. Provided PHG meeting space and childcare for the first several years of the project.

**Appendix D
Total Project Funding**

Funding Source	FY2002	FY2001	FY2000	FY1999	FY1998	FY1997
Federal	95,511	83,315	179,958	172,028	164,474	149,964
State	186,503	390,004	170,000	150,000	150,000	95,000
Private*	196,775	202,775	248,550	0	10,000	10,000
GSU	291,558	282,179	185,551	0	0	0
Total Funding To- Date	\$770,347	\$958,273	\$784,059	\$322,028	\$324,474	\$254,964
*Private Grant Funding						
Harland	10,000	0	10,000	0	0	10,000
GA Health Foundation	25,000	0	25,000	0	10,000	0
Hasbro	0	0	100,000	0	0	0
Dunn	10,000	10,000	10,000	0	0	0
Williams Foundation	0	11,000	11,000	0	0	0
Goizueta	108,775	108,775	92,550	0	0	0
Shallenberger Fund	0	25,000	0	0	0	0
United Way Community Foundation	25,000	23,000	0	0	0	0
	18,000	25,000	0	0	0	0
	\$	\$	\$			
Total Private	196,775	202,775	248,550	\$ -	\$10,000	\$10,000

APPENDIX E

Project Healthy Grandparents Topics for Parent Education Classes

Adopting Your Grandchild
Anticipating the Holiday
Big Brothers Big Sisters
Budgeting
Children's Health Issues
Coping with September 11
Counseling
Department and Family Children Services/Presentation by DFCS Administrators
Discipline
Education
Effects and Signs of Drugs
Family Reunification
Free Medication
Grady Hospital's Senior Services Program
Grandparent/Grandchild Relationships
Health and Recreation
High Blood Pressure
Home Ownership
Menopause
Money Management
Negotiating the Educational System
Nutrition
Parents Rights in Education
Preparing Your Grandchild for a Successful School Year
Stress Management
Supporting Behavior Change in Your Grandchildren
Time Management
Voter Education
Voter Registration
West Nile Virus
Who Do You Put First?
Words of Encouragement

Appendix F

Project Healthy Grandparents Dissemination Activities 1996 - 2001

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International Outreach

Deborah Whitley, PhD, Associate Director, and a team of GSU faculty, visited several universities in South Africa and Botswana in October 2000 following a request to help develop community models that would impact the AIDS crisis. Project Healthy Grandparents is a model that is being considered with some modifications. Further work is in progress between those African institutions and GSU.

Program Replication

The Department of Human Resources is currently funding three sites in Georgia to replicate Project Healthy Grandparents: University of Georgia in Athens, Valdosta State University in Valdosta, and Medical College of Georgia in Augusta.

Table 1
Number of Families Enrolled By Year

Time Period of Enrollment	Number of Families
1. October 1996 – September 1997	28
2. October 1997 – September 1998	25
3. October 1998 – September 1999	22
4. October 1999 – September 2000	29
Total	104

Table 2
Comparison of TANF Benefits vs. Adoption Assistance Benefits

TANF		Adoption Assistance	
Number of Children	Monthly Stipend	Age of Child	Monthly Stipend
First child	\$155	0-5 years	\$387.81
Second child	\$ 80	6-12 years	\$410.63
Third child	\$ 45	13 and over	\$433.43
Fourth child	\$ 30		

Table 3
Demographic and Background Information (n=92)

Family Relationship	
Grandmother	84 (91.3%)
Grandfather	2 (2.2%)
Great Grandmother	5 (5.4%)
Great Aunt	1 (1.1%)
Age	
Mean (SD)	57.1 (9.3)
Range	38 – 78 years
Race	
African-American	89 (97.8 %)
Caucasian	1 (1.1 %)
Native American	1 (1.1 %)
Missing	1 (1.1 %)
Marital Status	
Married	20 (21.7%)
Separated/divorced	39 (42.4%)
Widowed	23 (25.0%)
Living with partner	2 (2.2%)
Single, never married	8 (8.7%)
Educational Attainment	
Mean (SD)	11.5 (3.0)
Range	0 – 20 years
≤ 8 th grade	15 (16.5%)
9 – 12 th grade	54 (58.7%)
Some college	19 (20.6%)
College/technical school	2 (2.2%)
Employment Status	
Employed outside home	25 (27.2%)
Not employed outside home	47 (51.1%)
Retired	20 (21.7%)
Financial Support	
TANF	57 (62.0%)
Food Stamps	
Grandparent	34 (37.0%)
Grandchildren	42 (47.0%)
WIC	13 (14.1%)
SSI Disability	
Grandparent	28 (30.4%)
Grandchild	18 (19.6%)
RSDI/Retirement	17 (18.5%)

Table 4
Grandchildren: General Characteristics (*n* = 222)

Gender	
Male	112 (50.5%)
Female	110 (49.5%)
Age of grandchildren	0-16
Mean age of grandchildren	8.35 years (<i>SD</i> = 4.18)
Race	
African-American	213 (95.9%)
Caucasian	7 (3.2%)
Asian	1 (.5%)
Biracial	1 (.5%)
Legal Custody of Grandchildren	
Grandparent	147 (66.2%)
Biological Parent	38 (17.1%)
Child Protective Services	12 (5.4%)
Mean length of time living with grandparent	66.75 months (<i>SD</i> = 49.91)
Mean age of biological mother	30.9 years (<i>SD</i> = 5.47)
Mean age of biological father	33.6 years (<i>SD</i> = 7.21)
Primary reasons grandparent is raising grandchildren	
Parent drug abuse	49.5%
Parent abandonment	39.6%
Alcohol abuse	22.5%
Deceased	20.3%
Incarceration	15.8%
Removal by child protective services	10.8%
Number of Grandchildren per Family	
Range	1-7
Mean	2.4

Table 5
Child Behavior Check List (*n* = 194)

Attribute Scores	<i>n</i>	Pretest		Posttest		Univariate		
		<i>M</i>	(<i>SD</i>)	<i>M</i>	(<i>SD</i>)	<i>F</i>	<i>df</i>	<i>p</i> value
CBCL External T score	194	53.3	(12.6)	48.4	(11.8)	49.1	1,193	.000
CBCL Internal T score	194	48.2	(11.3)	42.4	(9.4)	71.6	1,193	.000
CBCL Total Score	194	51.2	(13.0)	45.4	(12.3)	70.16	1,193	.000

Table 6
Comparison Child Well-being Scale Scores

	Range of Scores	Mean Score	<i>SD</i>	<i>F</i>	<i>df</i>	<i>p</i>
Grandparents (<i>n</i> = 65)						
Pretest	70.3 – 96.4	88.3	6.4			
Posttest	62.5 – 100.0	90.6	7.4	5.0	1,64	.03
Grandchildren (<i>n</i> = 161)						
Pretest	40.4 – 87.2	69.8	10.9			
Posttest	30.7 – 88.2	72.8	9.8	13.0	1,159	.00

Table 7
Child Neglect Index (*n* = 188)

	<i>n</i>	Pretest		Posttest		<i>F</i>	<i>df</i>	<i>p</i> value
		<i>M</i>	(<i>SD</i>)	<i>M</i>	(<i>SD</i>)			
CNI Total Score	188	13.25	(13.31)	14.84	(14.62)	2.17	1,187	.142

Table 8
Child Neglect Index Categories at Pretest and Posttest ($n = 188$)

		Posttest		
		No Neglect	Substantiated Neglect	Total
Pretest	No Neglect	178	6	184
	Substantiated Neglect	2	8	4
	Total	180	8	188

McNemar test ($p=.289$)

Table 9
Family Social Support and Family Resources (*n* = 92)

<i>Variable</i>	<i>n</i>	<i>Pretest</i>		<i>Posttest</i>		<i>F</i>	<i>df</i>	<i>p value</i>
		<i>M</i>	<i>(SD)</i>	<i>M</i>	<i>(SD)</i>			
Social Support	92	27.41	(9.90)	29.67	(10.71)	4.02	1,91	.048
Family Resources	92	101.28	(18.62)	108.87	(15.49)	16.67	1,91	.000

Table10
Support Services used by Grandparents (*n* = 92)

Support Service	<i>n</i>	%
Medicaid	79	86%
TANF	66	72%
Food Stamps	42	46%
Medicare	32	35%
SSI Disability for grandchildren	18	20%
WIC	13	14%

Table 11
Family Empowerment ($n = 56$)

Variable	n	Pretest $M (SD)$	Posttest $M (SD)$	F	df	p value
Knowledge	53	45.0 (6.1)	47.4 (6.7)	5.6	1, 52	.02
System Advocacy	53	32.4 (7.0)	35.2 (6.6)	7.4	1, 52	.01
Self-efficacy	53	27.6 (2.8)	28.1 (2.4)	1.4	1, 52	.24
Competence	53	37.6 (3.2)	37.7 (3.2)	.03	1, 52	.90
Total Scale	53	142.8 (15.8)	148.1 (16.6)	3.94	1, 52	.05

Table 12
Body Mass Index ($n = 91$)

BMI Category	Pretest		Posttest	
	<i>n</i>	%	<i>n</i>	%
Normal weight	13	14%	15	16%
Overweight	25	27%	22	24%
Obese	53	58%	52	57%
Missing	1	1%	3	3%

Table 13
Brief Symptom Inventory (*n*=83)

Subscales	Pretest		Posttest		Univariate		
	<i>M</i>	(<i>SD</i>)	<i>M</i>	(<i>SD</i>)	<i>F</i>	<i>df</i>	<i>p</i> value
Somatization	55.27	(11.3)	53.1	(9.8)	3.7	1, 82	.060
Obsessive/Compulsive	54.1	(10.5)	50.7	(10.1)	8.1	1, 82	.006
Interpersonal Sensitivity	50.8	(9.9)	48.1	(9.1)	6.3	1, 82	.014
Depression	52.5	(10.1)	49.0	(8.2)	11.5	1, 82	.001
Anxiety	50.9	(11.5)	46.8	(9.8)	9.6	1, 82	.003
Hostility	51.9	(11.4)	47.9	(9.4)	10.7	1, 82	.002
Phobic Anxiety	52.7	(9.4)	50.4	(8.5)	6.3	1, 82	.014
Paranoid Ideation	57.9	(10.2)	55.0	(9.5)	7.3	1, 82	.008