Positive Impacts on Health Disparities for Kinship Caregivers Using Technologies New to Them: Lessons Learned about Virtual Peer Support Services Compelled by COVID-19
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1 Overview
Kinship caregivers are persons with widely varying characteristics and their diverse, often changing, relationships to those for whom they provide care makes them a group difficult to define succinctly. For present purposes of discussing kinship caregivers in New York State, a kinship caregiver is a grandparent, other non-parent relative, or anyone with a prior positive relationship to the family who cares full-time for a minor child in the absence of a biological parent. Many kinship caregivers identify as Black or Hispanic, members of minority groups long documented to suffer burdensome health disparities, including challenges in behavioral health. The COVID-19 pandemic and its associated community lockdowns initially exacerbated suffering for many people in New York State and the suspension of in-person peer support services negatively impacted kinship caregivers by cutting-off a key source of social support. Using technology that was new to them, many kinship caregivers sought virtual support. For this study, kinship caregivers and professional staff attached to five New York supportive services agencies were interviewed to learn about the health impacts of pandemic-induced virtual peer support services. The thematic evidence that emerged showed kinship caregivers experienced, and professional staff observed, positive effects of virtual peer support services on kinship caregiver behavioral health and other health-related aspects of their lives.

2 Kinship Caregivers
While public child welfare systems differ state to state, child welfare professionals today regularly first seek out kinship caregivers to care for a minor child in out-of-home care who cannot return safely to live with a parent (Testa 2017; Child Welfare Information Gateway 2021a; Annie E. Casey Foundation 2021b). Studies suggest that children placed with kinship caregivers (whether relatives of common ancestry or fictive kin) experience comparable or better placement stability than children placed with non-kin by better supporting a child’s behavioral health and maintaining their connections with members of the birth family, community, and cultural group (Johnson-Reid 2003; Hegar and Rosenthal 2009; Koh 2010; Fox, Levitt and Nelson 2010; Fuller at al. 2017).

Relatives may become caregivers for one or more children under a wide variety of circumstances ranging from those planned well ahead of time to those dictated by emergency circumstances (Child Welfare Information Gateway 2021b). The varying scenarios in which kin become caregivers, in turn, is reflected in their wide-ranging custodial circumstances (e.g., private care with or without legal recognition of the caregiver’s status, guardianship, foster care, and adoption) and also by the reality that kinship caregivers may provide care in the same

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home for multiple children under different custodial arrangements (Lee et al. 2017; Annie E. Casey Foundation 2021a).

Tracking the numbers of kinship caregivers and children in their care is not easy given the diverse processes through which their relationships are formed, the manners in which a kinship caregiver’s role may change over time, the various ways kinship caregivers may self-identify or be identified by others, and differences in the counting methods of public and private agencies (Testa 2017). Current, accurate, comprehensive, national figures on kinship caregivers appear lacking in the literature, but the average number of children served by kinship caregivers outside the formal foster care system in the U.S. for each year between 2018 and 2020 has been estimated at almost 2.7 million (Annie E. Casey Foundation 2021b). In New York approximately 95% of kinship caregivers provide care to children outside the formal foster care system. At the time of writing, there were an estimated 179,000 kinship caregivers in New York (New York State Kinship Navigator 2021).

2.1 Using Social Determinants of Health to Frame New York State Kinship Caregiver Barriers to Health and Other Supportive Services

Using a social determinants of health framework can provide a general outline of the socio-economic context within which many New York State kinship caregivers live, and from which a subset of the participants in this study likely originated. The U.S. Department of Health and Human Services (hereafter, DHHS) (2022) recognizes social determinants of health as “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks,” including racism, age discrimination, limited education and low incomes (p. 1).

The kinship caregiver literature reveals that many kinship caregivers suffer from social determinants of health outcomes, such as poor behavioral and physical health, from these same social determinants (i.e., minority status, advanced age, limited educational opportunities, low incomes, and lack of access to public financial support and services) (Sakai, Lin and Flores 2011; Hayslip et al. 2015; Xu et al. 2020; Gleeson et al. 2016; Generations United 2021). On a national basis, for example, Lee, Clarkson-Hendrix, and Lee (2016) found that nearly one-third of kinship caregivers identified as a member of a minority group, with 31.8% identified as Black or Hispanic.² Compared to birth and foster parents in different parts of the U.S., kinship caregivers also experience an increased need for behavioral health care (for stress, anxiety, feelings of isolation, depression) and other supports (information about benefits and financial support, transport, childcare, respite, legal aid) (Billing, Ehrle and Kortenkamp 2002; Baker and Mutchler 2010; Kelley et al. 2013; Denby et al. 2015; Denby 2016; Garcia et al. 2015). These needs may be due in part to the fact that many kinship caregivers are older adults who have entered their role in response to a family crisis (Coakley et al. 2007) and grandparent kinship caregivers often attended fewer years of school and low household incomes (Bryson and Casper 1999; Rapoport et al. 2020).

While the literature on kinship caregivers in New York State appears to be limited, available information highlights that the state’s kinship caregivers are at-risk of experiencing

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² Twenty-five (25) percent of children living with grandparent kinship caregivers in the U.S. are Black (Generations United 2021a).
health disparities. Sources suggest that 77% of the approximately 179,000 New York State kinship caregivers are persons identifying as Black, a statistic underscoring potential financial vulnerabilities because 20% of Black persons in New York State live below the federal poverty line, more than twice the rate of white individuals (9.1%) in the state (Lee, Clarkson-Hendrix and Lee 2016; New York State Kinship Navigator 2021; AARP 2021; New York 2020 2021). Additional age-related vulnerabilities come to light with the knowledge that 77% of New York State kinship caregivers are grandparents (Lee, Clarkson-Hendrix and Lee 2016).

Unsurprisingly these disparities also may be augmented by a lack of support services. Some kinship caregivers across the nation receive financial and other resource assistance and others receive none but, as a whole, kinship caregivers often receive fewer public services compared to non-kin certified foster parents (Dubowitz, Feigelman and Zuravin 1993; Berrick, Barth and Needell 1994; Geen 2004). While foster care is the most comprehensively funded system accessible to kinship caregivers it is not the only one, but other funding resources are sparse (National Conference of State Legislatures 2019). In New York State the Office of Children and Family Services (OCFS) funds kinship caregiver services through (a) an organization known as the New York State Kinship Navigator (hereafter, Kinship Navigator) that provides information, referral, and education services, and (b) local kinship caregiver supportive services agencies (n = 14 at the time of writing) that offer local peer support (4) and other services (e.g., case management, respite) (see www.nysnavigator.org). In addition to OCFS funds, the federal National Family Caregiver Support Program is designed to support kinship caregivers by funding local Area Agencies on Aging in New York State to offer peer support groups and related services to kinship caregivers who are grandparents and other relatives over 55 years of age (see https://aging.ny.gov/national-family-caregiver-support-program). Additionally, the Families First Prevention Services Act of 2018 sought to shift federal funding priority from foster care to family-based care, but eligibility requirements have proven unattainable thus far for state kinship navigator programs in New York and across the nation to receive these funds.

While the researchers in this study did not systematically collect detailed socio-economic or health data from participants, comments about behavioral health challenges associated with primary effects of disease (e.g., anxiety, depression) and as Clay and Rogus (2021) describe them “secondary effects (e.g., economic depression, loneliness, social isolation)” surfaced during the focus groups and interview conducted with kinship caregivers and supportive services agency professionals (p. 2). A limited literature on the effects of pandemics provides evidence that they can negatively impact behavioral health and this study sought to explore the impact of one means to counter this impact through supportive services agency provision of kinship caregiver peer support groups (Nelson et al. 2020; Clay & Rogus 2021).

2.2 Peer Support Groups as a Key Supportive Service for Kinship Caregivers
Prior to the start of the pandemic, numerous studies found peer support for kinship caregivers to be a worthwhile addition for improving behavior health outcomes along with access toother supportive services, such as case management (Burnette 1998; Strozier et al. 2005). Other researchers found that support groups may decrease depressive symptoms and foster feelings of empowerment among kinship caregivers (McCallion et al. 2004). Support group attendance also has been shown to lessen feelings of social isolation and increase perceived levels of
community support, even beyond the impact of case management alone, demonstrating the independent benefit of the support group itself (Kelley et al. 2001; Strozier 2012). Within the peer support model, kinship caregiver peer mentor facilitation of meetings has been demonstrated to be particularly effective and kinship caregiver meeting participants report a high level of satisfaction (Denby 2011). McCallion, Janicki, and Kolomer (2004) demonstrated that grandparent kinship caregivers participating in support groups facilitated by peer mentors experienced a decrease in symptoms of depression and an increase in their sense of empowerment and mastery of parenting skills for children with special needs. Despite these benefits, kinship caregivers across the nation are four times less likely to receive peer support services than formal foster caregivers (Sakai, Lin and Flores 2011).

3 Impetus for the Study
In October 2018 Kinship Navigator implemented the three-year New York State Kinship Navigator System of Care Project. At that time University at Albany researchers from the Center for Human Services Research (CHSR) began evaluating whether the project was achieving its intended service goals via a quasi-experimental mixed methods study. One of the service types under evaluation was in-person peer support groups. In January 2020 there were five agencies included in the evaluation serving diverse populations in seven counties across New York State: Broome, Dutchess, Erie, Queens, Kings (“Brooklyn”), Oswego, and Tioga. These agencies were holding in-person, kinship caregiver peer-led support meetings comprised of both caregivers who were enrolled in and surveyed as part of the evaluation and those who were not. In March 2020, with the onset of the COVID-19 pandemic and enactment of New York State on Pause, all non-essential businesses closed and certain gatherings were banned. Coupled with the additional pressures imposed by the COVID-19 pandemic, kinship caregivers’ vulnerability and pressures on kinship family supportive services agencies increased (Generations United 2020). While more information is coming to light on the effects of the COVID-19 pandemic on kinship caregivers, there is an emerging literature on how the pandemic deepened existing vulnerabilities caused by age, ethnicity, and socio-economic status in New York State communities. University at Albany researchers argue that the disparity in COVID-19 deaths by ethnicity was stark for residents of New York State where reported deaths per 100,000 population were “four times greater for Black residents (109) and more than 3.5 times greater for Hispanic residents (99) than white residents (27)” (University at Albany, SUNY, NYS COVID-19 Minority Health Disparities Team July 2020, p. 4). Additionally, Clay and Rogus (2021) found 3.5 greater odds that a Black survey respondent knew “a friend or family member infected with COVID-19 compared to white respondents” (p. 6).

The many existing challenges faced by New York State kinship caregivers, in tandem with the disproportionate primary and secondary health threats imposed on them by the pandemic, underscored why seeking a solution to suspended in-person peer support groups became a priority for both kinship caregivers and supportive services agency professionals who served them. The five agencies’ staff realized that the kinship caregiver peer-led support meetings all previously conducted in-person had to be quickly transitioned to an online format. This change forced already burdened participating kinship caregivers to learn how to connect with their peers through technologies new to them, such as Zoom® and Facebook Chat®.
By September 2020 the researchers were learning of anecdotal evidence provided by agency leaders suggesting that despite some initial challenges these meetings were changing in positive ways. For most of the agencies, the meetings were increasing in the numbers of participants and frequency of occurrence. To begin learning how this technological change in service delivery impacted kinship caregivers’ access to and benefits from online peer support meetings, the researchers initiated an exploratory study. The researchers conducted focus groups and interviews with kinship caregivers and agency staff to understand the relationship between a pandemic-driven technological change in family services delivery and how this necessitated change shaped some kinship caregivers’ access to and benefits from peer support meetings.

4 Study Methods

4.1 Study Procedure
To investigate the accessibility and efficacy of online kinship caregiver peer-led support groups, researchers conducted eleven focus groups and one individual interview with staff and kinship caregivers associated with five supportive service agencies between November 2020 and March 2021.

4.2 Participants
A total of 46 unique individuals were interviewed or participated in a focus group for this study, comprised of kinship caregivers (28), agency-based peer mentors who are experienced kinship caregivers with meeting moderation skills and who may or may not have completed state accreditation at the time of this study (7), agency leadership (5), and case managers (6). While none of the participants were approached to participate in a second individual interview, six peer mentors and one case manager also participated in a kinship caregiver focus group, bringing the total number of participants across all data collection sessions to 53. These participants were conveniently recruited from the five agencies participating in the evaluation that conducted peer support meetings. Due to funding changes, one agency ceased conducting peer support meetings at the end of August 2020.

From January 2019 through September 2020 there were 43 kinship caregivers enrolled in the evaluation and taking part in peer support meetings. The data collected from the 28 kinship caregivers described herein were provided anonymously and it is unknown whether all of the 28 caregivers interviewed were among these 43 evaluation enrollees. However, the demographic data collected at enrollment from these 43 caregivers provides a general overview of kinship caregivers in New York State seeking services from the five agencies under evaluation. These 43 caregivers had a median age of 57 years, with ages ranging from 32 to 73 years old. Females made up 95% of the pool. Participants self-identified as Black (62%), white (31%), Hispanic (5%), and “other” (2%). Forty-two percent of participants reported they were in poor or fair health. The highest level of education caregivers reached was fairly evenly divided between participants, with 42% having some schooling or completing high school, and 46% having attended some college or completing college. A majority of participants were not employed, with 30% retired, 19% unable to work, 14% describing themselves as a homemaker, and 14% unemployed. Participants also were asked to indicate their income sources and only 33% received any employment income and 70% received at least some Social Security income.
and/or Temporary Assistance for Needy Families benefits. These demographics depict the vulnerability of the kinship caregivers participating in the peer support groups and mirror the situation of other kinship caregiver populations described in the literature.

All peer mentors, agency leadership, and case manager participants initially were invited to participate over email by the second author, with follow-up emails and/or phone calls conducted by the first author. All kinship caregivers were invited to participate by their peer mentors and/or case managers. The first author conducted 9 focus groups and the one interview. A CHSR research scientist conducted 2 focus groups. The first author and the research scientist had exchanged evaluation-related emails with several agency leaders and/or conducted focus groups with them prior to this round of research, but otherwise did not know the participants. At the time of the research, the first author was a white female in her 50s and a senior research scientist with a Ph.D. in cultural anthropology. She had more than 25 years of experience conducting research among vulnerable community members, including those experiencing structural racism, socioeconomic, and physical and behavioral disparities. The first author was employed by both the University at Albany and Case Western Reserve University. The research scientist was an Asian American female doctoral candidate in her 30s with a MS in Educational Psychology and Methodology. She had 10 years of experience in program evaluation, collecting and analyzing qualitative data, and was employed by the University at Albany. The focus group/interview guide was iteratively developed over the course of several weeks by members of the CHSR Kinship Navigator evaluation team. The focus groups and interview lasted from approximately 30 to 60 minutes. Nine of the focus groups and the interview were audio recorded. During the two focus groups that were not audio-recorded, the interviewer took extensive notes. All interviews occurred virtually, either over the telephone or videoconference (e.g., Zoom®, Facebook Chat®). Recorded interviews were transcribed verbatim and transcript accuracy was checked against the recordings. None of the transcripts were returned to participants for comment. Participants were asked not to reveal proper names during the interviews and any names on the recordings were removed from the transcripts.

4.3 Data Analysis
The focus groups and interview provided opportunities to explore “rich points” or experiences, behaviors, observations and opinions of the participants that were offered in participants’ own words and were outside the authors’ knowledge of virtual peer support group meetings (Agar 1980, 2; Flynn and Hoffer, 2019). Transcribed focus group and interview texts were analyzed by the first author using systematic text condensation to derive key themes (Malterud 2012). The first author began by reading all the transcripts to gain an overview of early themes associated with participants’ virtual peer support meeting-related experiences and viewpoints. The first author then read the transcripts a second time to identify various meaning units related to the participants’ peer support group descriptions. The first author created code groups by categorizing and grouping units in relation to the preliminary and subsequently emerging themes and then split or joined code groups to report more precisely distinct phenomena. Finally, the first author separated the meaning units from the broader context of the focus groups and interviews into consistent statements about the participant’s behaviors, beliefs, and/or social interactions. Both authors discussed the general findings, and
the first author’s interpretations were crosschecked by the second author. The findings are presented in the study participants’ own words, with some edits for clarity and brevity, selected on the basis that they best illustrate one or more key points. The authors followed the consolidated criteria for reporting qualitative research (COREQ) (Tong, Sainsbury, & Craig 2007).

4.4 Findings
While the weight of the thematic evidence that emerged from this study leans toward positive impacts on primary and secondary behavioral health disparities for kinship caregivers using technology that was new to them, some evidence shows that some caregivers could not or did not benefit from this use of technology. For example, there were concerns expressed by agency leaders that transitioning to virtual meetings with the onset of the pandemic would present insurmountable hurdles, including (a) that kinship caregivers would be unwilling to attend online support groups, (b) would not have the technology to access—or struggle with the technology required to access—online videoconference platforms, and (c) would find virtual meetings less beneficial than in-person ones. According to agency leaders, other agency staff, and kinship caregivers, these and other obstacles arose. For instance, staff members representing four of the five agencies expressed their initial concern after losing at least one peer support group participant due to the switch to a virtual platform (the fifth agency saw only an increase in meeting participation after going virtual because they had experienced a lapse in providing peer support meetings pre-pandemic due to a lack of staff). Importantly, some staff emphasized that a small number of caregivers stopped attending peer support meetings once they went virtual because they did not have a smartphone or tablet and were unable to get one. Another agency leader recognized that poor countywide online connectivity limited the accessibility of some kinship caregivers living in rural areas to Zoom® participation via a phone call without video. One staff member described another case involving a primarily Spanish-speaking kinship caregiver who had previously attended in-person peer support meetings but did not attend virtual ones because Zoom® added too much to the language barrier. Other participants observed that some new kinship caregivers enrolled in services after peer support meetings had already gone virtual declined to participate and speculated that this may have been due to their not having initial, in-person opportunities to build rapport and trust with the pre-existing support group members. Additionally, some caregivers explicitly stated their preference for in-person meeting perks (e.g., face-to-face interaction, snacks or meals, on-site childcare, time away from children). These examples all comprise challenging barriers for agencies providing supportive kinship caregiver services in New York.

Yet other obstacles have been easier to overcome. For example, a peer mentor described the social hesitancy some kinship caregivers expressed about engaging over Zoom® from home because of their and/or their home’s appearance. The peer mentor observed they “didn’t want people to see them in their rollers [or] see their house. When they come in person, they got up, got dressed, did hair, made themselves presentable so they were okay seeing each other in person.” Yet after several weeks of transitional phone-based meetings and ongoing encouragement, the peer mentor was able to make the switch to holding the meeting via Zoom®.

Other participants acknowledged that technological delays in caregiver participation in virtual meetings were lessened as the contemporaneous change to remote schooling forced
caregivers to learn how to teleconference using their existing phones, tablets, and computers in ways they had not done so before. As one agency lead explained,

They [kinship caregivers] sort of transitioned at different speeds from [in-person to] phone to Zoom®, kind of based on what it was going to take to bring everybody along. But ... only one dropped off [the support group] ... and that was not [due to] a technology barrier.

Another agency lead expressed, “We were so pleasantly surprised that the technology piece, they were able to figure it out, if it was just enough to click that link and get in.” This agency lead continued, “I’ve been very surprised that for the age group we’re working with that the technology really hasn’t been an issue.”

Not only have many caregivers been successful connecting with online technologies new to them, they also described some benefits of the virtual meetings and the ways they supported kinship caregivers’ behavioral health and helped them circumvent other caregiving challenges during the pandemic. In response to the focus group moderator’s prompt, “I would like to learn how the pandemic has impacted your lives and caregiving,” several caregivers mentioned problems with their behavioral health. For instance, one caregiver expressed sadness and fear when she said, “I just felt like since the pandemic, and I got the baby, there’s been so much. Like, I just don’t know. Every time I talk to somebody they have COVID.” Another said, “It’s got me down. I can’t go out.” Some caregivers emphasized other medical concerns. For example one explained, “If I get the COVID, it would kill me. All the breathing issues, Asthma, COPD, and with my heart and kidneys, they’ve suggested me to stay home, fully remote.” An additional caregiver explained, “Since the pandemic started, I have a problem with getting outdoors to get the groceries. I have asthma and stuff and it’s hard to get around.”

Participants noted that virtual meetings held important and positive benefits for their behavioral health. Some expressed that the virtual meetings often were perceived to be less intimidating and caregivers described feeling less emotionally exposed than in in-person meetings. Caregivers also noted increased personal comfort in sharing problems with and seeking support from people often previously unknown to them. One peer mentor, remarked,

I almost feel like the groups have gotten so much deeper than they did face-to-face because people can be in their homes. Comfortable. In a quiet place.... Maybe in a way it is easier to share some of these thoughts virtually. I don’t know. I do think there’s a difference here with the depth of our groups from when we were in-person.

One kinship caregiver explained, “I think it is because I am so emotional that I don’t want to break down and cry in front of someone in-person. But if I do here, I could just walk off the screen. It’s great.” And another caregiver followed-up by saying, “And you’re not walking, you're not driving home a crying mess, you know.”

In response to a focus group moderator’s prompt, “How do you think these [virtual] meetings could be improved?” a caregiver said the meetings help her feel less isolated. “I think they’re good,” the caregiver explained. “I mean, we’re gonna talk about everything that we’re thinking and feeling. I mean, it really helped me especially bearing this pandemic. Just to be
able to have people to talk to, understand what I'm going through.” Other caregivers in the focus group immediately concurred by saying, “I think this is better also for everyone,” “Nobody’s judging you. We can all relate,” and “Everybody’s got a dangerous situation but we all stick together.”

One caregiver described the close, comforting friendship she developed with another peer support group caregiver:

“[X] and I have gotten extremely close. And I thank God every day that I do have her to fall back on, when I'm emotional and know just everything that we've been going through. And she's been like a godsend to me, because I don't know, I just, I really connected with [her].”

A kinship caregiver in another focus group responded to a similar prompt be explaining her sense of personal growth as a virtual peer support group member. “I've been in this kinship group a little over a year,” she said.

And I think within this year, it has helped me grow not only as a parent, but as a civilized human, too, because it's basically grounded me and showed me that, you know, you need self-care. You need, you know, to take care of yourself first or else you're not gonna be able to help anybody. So I think I've grown a lot in the year I've been with kinship.

Many expressed that virtual meetings suit them well in terms of meeting availability, and help with significant transportation and/or childcare cost savings. For instance, many caregivers were pleased by the growing meeting attendance that has led some agencies to add more meetings each month. A case manager noted that in-person meetings previously were held “at a different location every month, so most people only came to one a month…. Since it’s online now, they can come to more.” As caregivers confirmed, this increase in meeting frequency has been beneficial by the scheduling flexibility provided. “I know for me,” said one, “I would not be able to participate before [in the one monthly in-person meeting] because my boys' schedules dominate everything.” Another caregiver noted, “This is just so convenient, because you don't have to go out and then it doesn't get canceled because it's snowing.”

Agency staff highlighted that they witnessed comparable benefits for caregivers. A peer mentor observed that virtual meetings appear to be simply easier for caregivers because, “they don’t have to worry about leaving a group early to pick up a kid that was getting off the bus.” Another peer mentor explained that virtual meeting attendance is up over in-person ones because, “It’s just a little bit easier for people not traveling and they don’t have to worry about baby care.” Some caregivers’ personal comfort levels also appear to have risen, especially for those living in one particularly rural county. “They’re a lot more inclined,” observed an agency lead, to want to take care of themselves. They were very, very cautious about asking for assistance [when meetings were in-person]…It was really hard to get people involved. The good news is once we went virtual … we told the kinship caregivers in [the rural]
county ... just go online and join the support groups. And that made it much easier for our [rural] county kinship caregivers.... The silver lining of COVID [is] that we’re finally able to get our [rural] county kinship caregivers involved.

All five agency leads interviewed conveyed the message that this pandemic-induced technological change in kinship caregiver peer support will likely have a lasting transformative effect post-pandemic on the delivery of supportive services, perhaps in a hybrid in-person/virtual form. While the majority of caregivers expressed contentment with virtual meetings, some also missed the in-person format. Said one caregiver who continued to feel isolation in spite of the virtual meetings, “Even for myself, like seeing my kinship group [at the agency] in face-to-face, is a lot different than doing Zoom.” Yet the amelioration of some of the stress, anxiety, depression and feelings of isolation together with other meeting scheduling/attendance benefits and financial savings, bolster kinship caregivers’ and agency staff members’ support for at least offering some virtual meetings—or even combined in-person/virtual meetings—going forward. One caregiver concluded her thoughts by saying,

I think both [virtual and in-person meeting offerings] sounds good to me, because then if I can’t get out for whatever reason, the car breaks down or whatever, then I still have the opportunity to engage in Zoom. So, even if even if they had a meeting where everybody was together, perhaps, people could still join through Zoom.

In summing-up pandemic peer support lessons learned, one agency lead asserted, “moving forward, a hybrid model is going to allow us to help more people.”

5 Discussion and Conclusions
Limitations should be noted when interpreting the findings. For example, because this study used a small convenience sample to collect data from five social services agencies serving seven counties, the generalizability of findings is restricted, especially across a large state of 62 counties with the urban/rural variability and cultural diversity of New York State. Additionally, the study was done amid the COVID-19 pandemic and findings may differ post-pandemic. This study is missing the perspectives of kinship caregivers who did not transition from in-person to online peer support group. For those who were unable to participate in virtual meetings due to lack of access to smartphones, tablets or other required technical supports, understanding their experiences and challenges is vital to providing fully inclusive future supportive services to all who would like to participate. For those who are hesitant to engage virtually for any number of possible reasons, it is important to learn of these reasons and whether or not such hesitancy could be eliminated (Patton 1999; Creswell 2012).

With these limitations in mind, this study has significant implications for supportive service agencies positively impacting the behavioral health of New York State kinship caregivers via virtual peer support meetings. As surfaced through the interview and focus groups, many kinship caregivers found online platforms accessible and beneficial, presaging a permanent transformation in family support service delivery. For these reasons, hybrid and/or virtual peer support meetings for kinship caregivers deserve further research. Future studies could not only include a larger participant pool, inclusive of those caregivers who opted-out during the
pandemic or declined post-pandemic to participate in online peer support meetings, but also comprise interviews/focus groups conducted over several timepoints to track changes in caregivers’ peer support meeting experiences. For those kinship caregivers who chose not to participate in virtual peer support meetings because they felt Zoom® fatigue after a long day of supporting their child’s/ren’s Zoom® school lessons, future studies could shed light post-pandemic on whether such reluctance of caregivers to logon remained when children were back in school for the day. Future inquiry also could shed light on the degree to which it is beneficial to have participated in a kinship caregiver peer support meeting in-person prior to moving to a hybrid or virtual platform. None of the participants included in this study were approached to provide feedback on the findings but doing so may prove a productive line of further research. Additionally, because attention has been paid only recently to children who live with kin outside of foster care, fewer supportive services and other resources have been allocated to this population to help sustain families in need. Further studies could drive the creation of robust federal- and state-funded service system to support the housing, financial, behavioral health, legal, transport, and childcare needs of these children and lead to increased stability, increase the likelihood of permanency, and reduce stress in the household. These and other such studies are warranted to determine how best to provide supportive services to kinship caregivers and most empathetically, impactfully, and sustainably eliminate any health and other disparities they experience.

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