



2010

Albany County, NY System of Care Final Evaluation Report

The final evaluation report of the Albany County Family Partnerships for Change is submitted pursuant to Grant No. 5U79SM056284-06 under the direction of the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services.

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March 11, 2011

Dear Friend,

Over the last several years, we have had the privilege of working on the Albany County Family Partnerships for Change initiative, funded by the United States Department of Health and Human Services.

As part of this initiative, the Albany County Department for Children, Youth and Families worked closely with Families Together in New York State (FTNYS) and Families United Network (FUN) to improve access to mental health services for youth and their families. As a result, three community-based family resource centers were established in rural, urban and suburban communities.

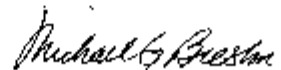
There were many lessons learned from this initiative that are valuable to our ongoing efforts to improve access to children's mental health services. This experience is essential to our ongoing development in care for children, youth and young adults with emotional behavioral and social challenges. This initiative also enabled Albany County to learn many things about our ability to meet the needs of these communities, directly and indirectly related to children's mental health services.

The suburban family resource center in Colonie served a high volume of clients, established strong relationships with the school districts, and as a result of aggressive outreach, will continue to serve clients. It is through the rural site in the hilltowns of Albany County that we established a location for additional County departments to offer on-site information and enrollment sessions for Food Stamps, Medicaid and other benefit programs. Through the urban site in the city of Albany, we learned successful and unsuccessful approaches to delivering the system of care. One significant accomplishment was the implementation of the Safe Schools Healthy Students grant through the Albany City School District.

I want to thank all of those involved in this initiative including, DCYF, FTNYS and FUN staff, our dedicated parent partners, and most importantly the children and their families who were an essential part of this learning process. It is because of the Substance Abuse and Mental Health Services Administration (SAMHSA) that we were given the opportunity to explore the system of care philosophy in serving this important population.

I hope that you find valuable information about our efforts in the enclosed Final Evaluation Report completed by the Center for Human Services Research, University of Albany, State University of New York.

Sincerely,


Michael G. Breslin



About the Center

The Center for Human Services Research (CHSR) is a research department within the School of Social Welfare at the University at Albany. CHSR has nearly 20 years of experience conducting evaluation research and designing information systems for a broad spectrum of agencies serving vulnerable populations. CHSR research studies cover a wide range of topics including children's mental health, child welfare, child health and development, early childhood education, substance abuse, and service collaboration. What characterizes all these studies is CHSR's focus on rigorous methods, strong stakeholder involvement, and the dissemination of timely, accurate and non-partisan information to guide best practices in service delivery. For more about the Center please visit www.albany.edu/chsr.

The Evaluation Team

The evaluation team was led by LuAnn L. McCormick, PhD, MSW. Family interviews were conducted by Corinne Noble, Elizabeth Cataldo, and Jennifer Rickert. Data analysis and project support were provided by Matt Vogel, Rose Greene, Lynn Warner, and Man-Chun Chang. The local Management Information System was developed and managed by Dorothy Baum, Jeffrey Luks, and Jay Robohn.

Acknowledgments

The evaluation team would like to thank the youth and families who participated in the study and shared their personal stories with us. We would also like to thank the Parent Partners as well as county and agency staff who assisted the evaluation team in recording valuable data for the evaluation.

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Albany County System of Care Final Report

BACKGROUND AND PROJECT OVERVIEW

History of the Children's Mental Health Initiative

In 1992 Congress passed legislation creating the Comprehensive Community Mental Health Services for Children and their Families Program, or *Child Mental Health Initiative*, to develop a comprehensive array of community-based services and supports. These services were guided by a system of care philosophy that emphasizes individualized, strength-based services planning, intensive care management, partnerships with families, and cultural and linguistic competence (tapartnership.org). Known as *systems of care*, the Substance Abuse and Mental Health Services Administration (SAMHSA) has entered into cooperative agreements with 173 communities since 1993.

Description of the Albany County, NY System of Care

In 2004, Albany County joined the national system of care initiative. Coined *Families Together in Albany County*,¹ this initiative was a partnership between the Albany County Department for Children, Youth and Families (DCYF), under the direction of the County Executive's office, and the parent-governed, non-profit Families Together in New York State, Inc. (FTNYS).

DCYF was created in 2001 to integrate all children's services into one department – Child Welfare Services; Children's Mental Health Services; Single Point of Access (SPOA) for high-needs, seriously emotionally disturbed (SED) youth; Children with Special Needs Program; and the Youth Bureau. At the time of the grant award, DCYF integrated most intakes, assessments, and referrals through a centralized unit. This process continued as an option throughout the course of the grant and is referred to as the "traditional portal of entry."

One of the primary goals of the Albany County system of care (SOC) was to facilitate access to mental health services for youth and their families. To provide an alternative to the traditional portals, community-based Family Resource Centers (FRCs) were established in rural, urban, and suburban communities in the county. The FRCs were, at the beginning, entirely parent-run. Parent Partners – parents or family members with experience raising a child with social, emotional, or behavioral challenges – were hired to welcome families into the centers, perform intakes, and assist families to navigate through the multiple systems with which their children were involved.

There were three new Family Resource Centers established under this initiative. Each was staffed by Parent Partners and was under the direction of the initiative's family co-project director. The first FRC to open in early 2006 was located in a rural area of the county known as the Hilltowns. The next to open in the Spring of 2006 was the suburban FRC in the Town of Colonie. The third FRC was established in the Albany city limits in 2008. Families United Network (FUN) was a pre-existing parent support network affiliated with a large child-serving organization and continued serving families throughout the initiative as they had for many years.

Among the Family Resource Centers, the Colonie FRC had the highest volume of clients. The centralized, visible, and accessible location of this FRC contributed to the number of families and youth served at this site. This FRC established and maintained a strong relationship with the school

¹ The original name was "Albany Partnerships for Change."

districts in its catchment area. Additionally, this FRC engaged in aggressive outreach, including targeted efforts into the small city of Cohoes once the need for services in that area was identified early in the initiative. Ongoing outreach resulted in continued partnerships with local schools and agencies, shared space in the community, and satellite clinical services through the psychiatric hospital, the Capital District Psychiatric Center (CDPC). The Colonie FRC remained the most active FRC throughout the initiative and is the only site that may sustain beyond the grant period.

The rural Hilltowns FRC was challenged with being located in a community with a range of needs that went well beyond the scope of the SAMHSA-defined system of care initiative. However, in an attempt to meet community needs while remaining within the parameters of the Cooperative Agreement, the Hilltowns FRC established partnerships with county departments to offer regular, on-site information and enrollment sessions for Food Stamps, Medicaid, and other benefits programs.

Relatively few youth and families presented for services at the Albany site relative to the population of the city of Albany. Some of this may be due to the rotation of Parent Partners from the Albany site to collocate at the Children's Mental Health Unit (CMHU). That is, Albany families would present for intake at CMHU and then be transferred to the Albany FRC for services. In the last year of the initiative, two Parent Partners at the Albany FRC were transferred out of the FRC to another project so service capacity was reduced. Finally, while the internal space at the Albany FRC was inviting, it was in a building offset from the street in a location that would not be considered a high-traffic area for families with children.

Families United Network (FUN) is a longstanding family support program of Parsons Child and Family Center, one of the region's largest and oldest family service organizations. FUN remained an underutilized resource throughout the initiative, serving less than ten percent of all families enrolled into the Albany system of care. Rather than building on the existing history, experience, and connections of FUN and its parent organization, new Family Resource Centers were developed and staffed and new relationships had to be established throughout the county.

The community-based Family Resource Centers were predicated on families and youth making the first step to cross the threshold to request assistance. This can be a very difficult step to take for many families who face both external stigma associated with mental illness as well as internal shame or embarrassment to admit their child may have serious emotional issues. To address this, Parent Partners were collocated at the Albany County Children's Mental Health Clinic to help engage families during the intake process. During a pilot period in 2009, Parent Partners also actively collaborated with the county Probation Department to engage families in the initial conferencing process. At both sites there was a demonstrated improvement in engagement of families when a Parent Partner was involved. At CMHU, the appointment success rate (meetings scheduled and kept) was significantly higher for families with a Parent Partner compared with families without a Parent Partner. The Probation Department experienced a zero no-show rate for initial conference meetings during the pilot collaboration project period.

Governance and Project Management

The Albany County System of Care was unique in its strong emphasis on the family-driven principle in service delivery. The Family Resource Centers were staffed by parents, the co-project director was a parent, and the umbrella organization for the FRCs was the statewide, parent-governed organization, Families Together in NYS, Inc. As a chapter of the National Federation of Families for Children's Mental Health, FTNYS has a strong history as a children's advocacy organization. As its first major foray into providing direct services, Families Together faced a steep learning curve and spent a significant amount of time during the early years of the initiative establishing the new FRCs,

developing forms and procedures, and training new staff. These efforts were essential but delayed focusing on sustainability early in the initiative.

The initiative started under a co-director model. One co-director was a parent employed by FTNYS, and the other co-director was a clinical supervisor from the county children's mental health clinic. This model proved to be confusing to staff in terms of lines of communication and authority, and was challenging to the co-directors themselves. Later in the project, when the roles of the co-directors were more clearly delineated, challenges remained. In the last 18 months of the initiative, a program manager was hired to handle the daily operations of the FRCs, including staff supervision.

The expectations for Parent Partners were unrealistic given their experience. The primary requirement for Parent Partners was personal experience as a parent or family member of a child with social, emotional, or behavioral issues. While all Parent Partners were deeply committed to their roles and their assigned families, most had little or no experience with the functions they were expected to perform in their family support roles. Further, there was no clinical staff on site at the FRCs for most of the first year of service. This put an additional burden on the Parent Partners. Preparing them for their job functions required a significant amount of training and supervision. Much of the first year and beyond was spent getting parent partners to a level of comfort and competence to serve youth and families with complex needs.

The officially-designated governance body for the initiative was the Coordinated Children's Services Initiative (CCSI) Tier II Committee, a county-led body with representation from county departments and family support organizations. This committee served as a reporting mechanism for the project co-directors and was not actively engaged in the fiscal or project oversight of the initiative. Serving in this latter capacity was the Executive Committee comprised of the DCYF Commissioner, FTNYS Executive Director, the Project Co-Directors, a representative from the County Executive's office, and the Lead Evaluator as a source for data relevant to the discussions. This committee was, for all intents and purposes, responsible for the execution of the Cooperative Agreement. The Executive Committee was dissolved in May 2009 to open the possibility for FTAC to apply for county contracts and for the county to avoid any conflicts of interest. Responsibility for project oversight was to have transferred to Tier II, but this was never fully enacted.

The family-driven principle that was so strongly emphasized in the provision of services and support through Family Resource Centers was not mirrored in the governance of the initiative, nor was it youth-guided. This was primarily a staff-driven initiative. While there were family-run FRCs, a vibrant youth program, and a family member as a project co-director, recipients of SOC services were not active members of governance bodies. The community was not actively or regularly engaged in the governance of the initiative. While the Project Workgroup was active in the first several years of the initiative, the few parents that attended were not service recipients. One youth attended several Tier II meetings in 2009-10 but was never fully integrated into the group. The youth joined the armed forces and was not replaced on the committee.

BRIEF OVERVIEW OF THE EVALUATION DESIGN

This report presents data from two studies comprised of different samples:

- The Descriptive Study (N=1,497) collected data pertaining to demographic characteristics, social and functional characteristics, mental health diagnoses, and presenting problems on all children and youth who presented for services through the system of care.
- The Longitudinal Child and Family Outcome Study (N=236) used a combination of questionnaires and standardized instruments to collect data regarding: children's emotional

and behavioral status, strengths, educational performance, criminal justice system involvement, living environments, caregiver strain, family functioning, service utilization, and child and family satisfaction with services.

The reporting period for this report is from January 1, 2006 to September 30, 2009. While 236 families were enrolled in the longitudinal study, not every family completed every interview in the prescribed 6-month intervals for the entire 36-month enrollment period. In order to run analyses on a stable sample, outcomes are reported on the 128 families who completed the intake, 6-month follow-up, and 12-month follow-up interviews.

The focus of this report is on outcomes achieved from SOC services as captured in the longitudinal evaluation. There were other evaluation measures of the Albany SOC that are not included in this report. Please refer to www.albany.edu/chsr for previous evaluation reports.

ENTERING THE SYSTEM OF CARE

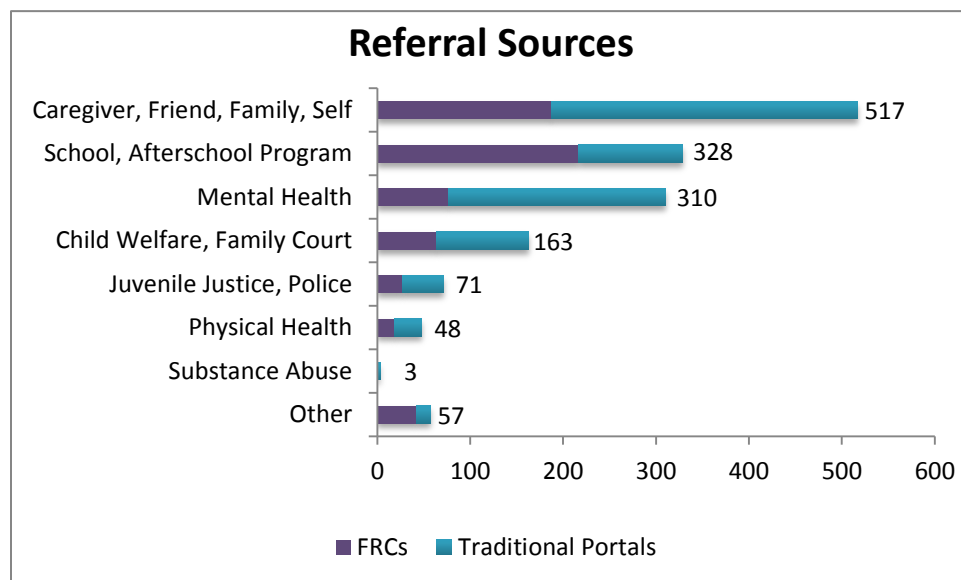
Intakes by Portal of Entry

There were a total of 1,497 referrals of youth and their families into the Albany system of care over the course of the initiative. More than half (58%) of the referrals to the system of care were to the county's traditional portals. The remainder of referrals (42%) were to the Family Resource Centers (FRCs). The rural Hilltowns site received 156 referrals (10.4% of all referrals); the suburban Colonie FRC received 331 referrals (22%); and the Albany FRC received 113 referrals (7.5%).

Referral Sources

The most common referral source across sites was family, friends, or the youth themselves (Figure 1). Schools and mental health providers also referred large numbers of families to the system of care. Indicating a strong connection between school districts and FRCs, schools were the most common referral source to FRCs. There were fewer referrals from other systems such as juvenile justice, physical health care, or substance abuse; a total of only eight percent of all referrals came from these sources.

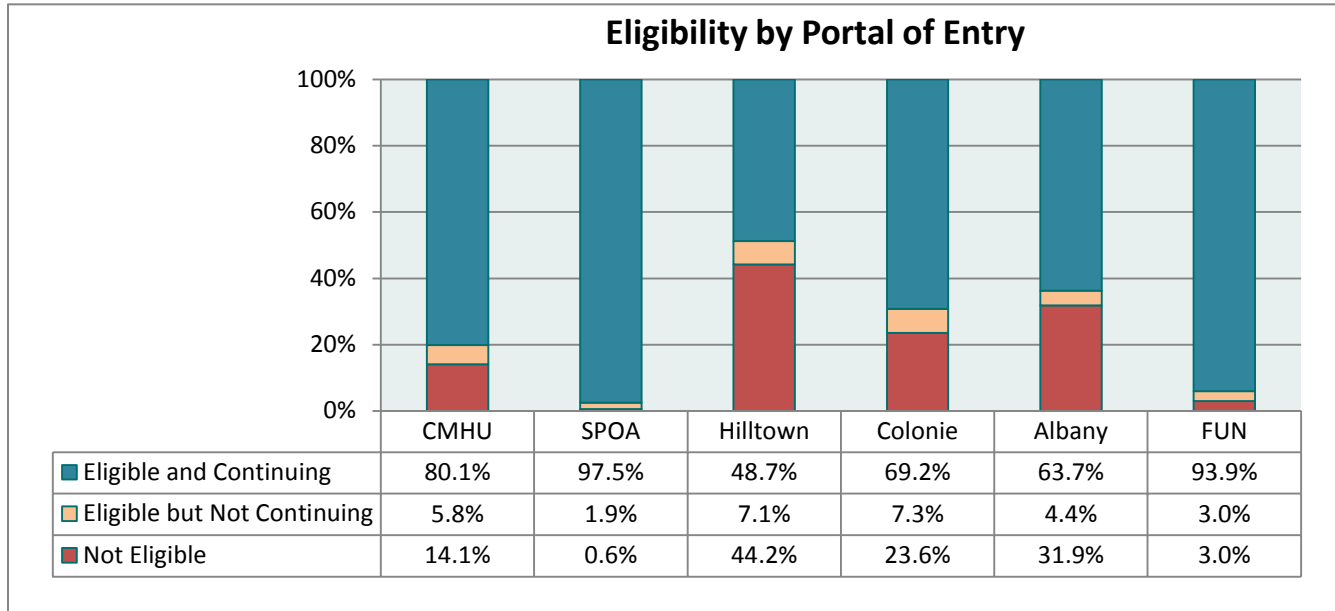
Figure 1



Eligibility by Portal

Figure 2 represents the proportion of youth who presented for SOC services through one of the portals by their eligibility status. The traditional portals – CMHU and SPOA – had the highest proportions of eligible intakes in comparison to the three FRCs. The relatively higher proportion of youth who were considered not eligible for continuing SOC services in the three FRCs may be partly attributed to outreach and social marketing that was not sufficiently focused on the identified populations of focus – families with children with serious emotional difficulties and involvement with multiple systems. In the case of the rural Hilltowns FRC, we learned through focus groups and interviews that this was also a reflection of a level and range of needs in that community that went well beyond the scope of the SAMHSA-defined system of care initiative.

Figure 2



Percentages may not sum to 100% due to rounding.

DESCRIPTION OF YOUTH AND FAMILIES

The FRCs and traditional sites served very similar populations of youth in terms of gender and age, and this is consistent with national data (Table 1). The number of Hispanic youth served increased modestly over the life of the project. There was little change, however, in the racial distribution of youth served throughout the project. Proportionally more African American and fewer White youth were served by the system of care than the county Census would suggest (17.9% of Albany County's youth (under 18) population is African American; 70.4% is White). Furthermore, traditional portals served proportionally more African American youth; FRCs served proportionally more White youth.

Table 1
Demographic Characteristics of Eligible Children Served

	FRC	Traditional	Albany SOC (Total)	National
Gender	N=576	N=551	N=1,127	N=18,966
Male	61.8%	59.9%	60.9%	62.9%
Female	38.2%	40.1%	39.1%	37.1%
Average Age at Intake	N=576	N=551	N=1,127	N=18,966
Average Age	11.18 years	11.99 years	11.58 years	11.5 years
Age Range	2 - 21 years	4 - 19 years	2 - 21 years	Birth - 21 years
Age Group	N=576	N=551	N=1,127	N=18,885
Birth to 3 years	1.9%	0.0%	1.0%	5.8%
4 to 6 years	13.0%	8.0%	10.6%	10.3%
7 to 11 years	33.5%	34.5%	34.0%	26.4%
12 to 14 years	25.5%	29.0%	27.2%	27.0%
15 to 18 years	25.2%	27.8%	26.4%	29.4%
19 to 21 years	0.9%	0.7%	0.8%	1.1%
Race/Ethnicity	N=570	N=547	N=1,117	N=18,698
American Indian, Alaskan Native only	0.2%	0.4%	0.3%	4.2%
Asian only	0.0%	0.9%	0.4%	1.3%
Black or African American only	20.4%	42.0%	31.0%	24.9%
Native Hawaiian, Other Pac. Islander	0.0%	0.0%	0.0%	1.7%
White only	65.1%	39.1%	52.4%	38.2%
Hispanic/Latino	8.9%	11.5%	10.2%	26.1%
Multi-Racial	5.4%	5.5%	5.5%	3.2%
Other	0.0%	0.5%	0.3%	0.3%

Source questionnaire: EDIF. Local data are from final Macro aggregate data set, 01/01/06-09/30/09. National data are aggregates from communities funded in 2002, 2003, and 2004 as reported in the April 2010 Data Profile Report (DPR). Race/Ethnicity categories are mutually exclusive as calculated by ICF Macro. N's may be different due to missing data. Percentages may not sum to 100% due to rounding.

Income and Employment²

Across sites, nearly half (45.2%) of primary caregivers were not employed in the six months prior to intake. This is consistent with the employment rate of the national evaluation sample. There was some variation between sites in poverty levels (Figure 3). Most youth (84.8%) served through traditional sites lived near or below the poverty level.³ More than a third of FRC-served families (39.2%) were above the poverty level, which is notably higher than families served through traditional sites as well as the national sample.

Figure 3

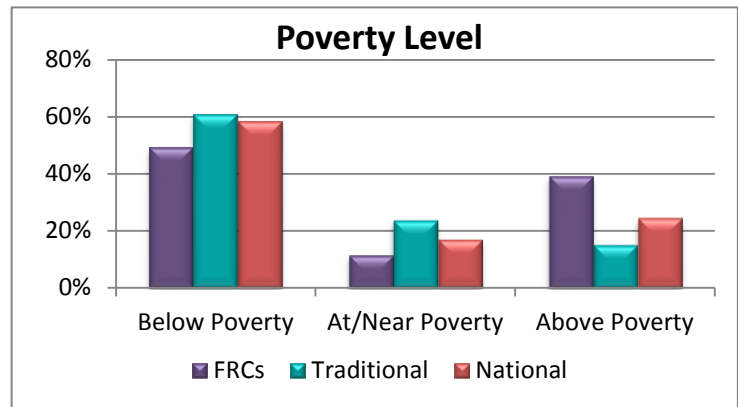
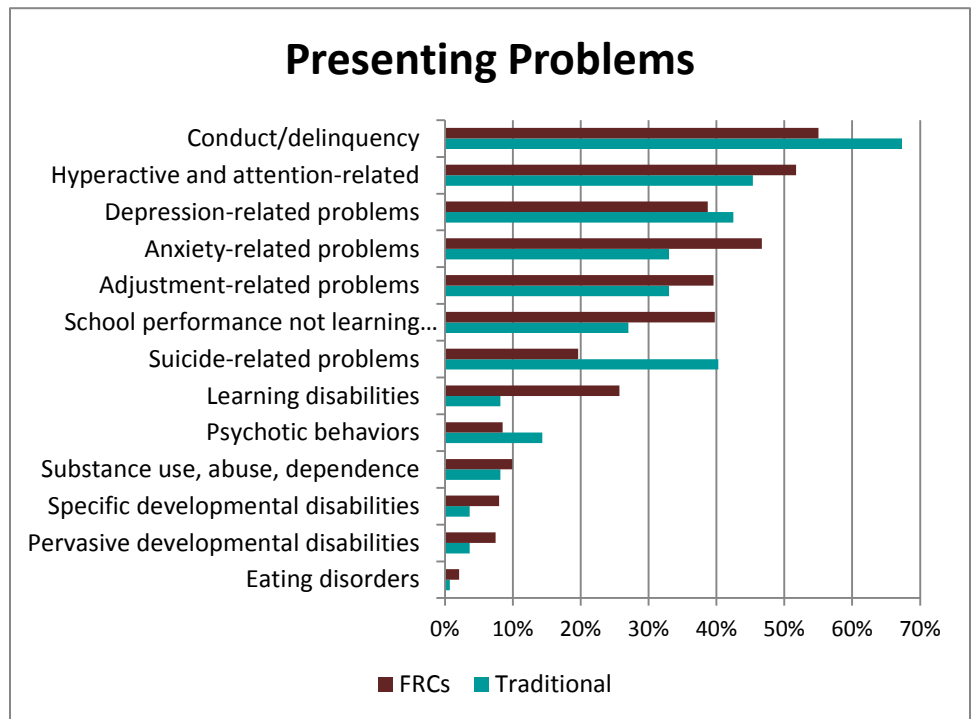


Figure 4

Presenting Problems

On average, youth entered the Albany SOC with 3 or 4 co-occurring issues. The most common presenting problems were conduct/delinquency, and hyperactive and attention-related (Figure 4). Proportionally more youth who presented for services at FRCs had hyperactivity, anxiety, adjustment, learning disabilities, and school-related problems compared to youth who entered at traditional portals. More of the youth presenting at traditional portals had conduct/delinquency problems, psychotic behaviors, and suicide-related problems than youth at the FRCs.



² Source questionnaire: CIQ-I. Local data are from final Macro aggregate data set, 01/01/06-09/30/09 for all intake interviews (not just those who completed baseline through 12-months). National data are aggregates from communities funded in 2002, 2003, and 2004 as reported in the April 2010 Data Profile Report (DPR). N's may be different due to missing data.

³ Poverty categories are based on the U.S. Department of Health and Human Services poverty guidelines, which are available for the 50 States. The categories take into account calendar year, State, family income, and household size. Specifically, if family income is less than the relevant poverty threshold, they are "below poverty", if income is 1 to 1.5 times the threshold, they are "at/near poverty", and if income is more than 1.5 times the threshold, they are "above poverty." In 2009, the poverty threshold for a family of four residing in the 48 contiguous states was \$22,050. Poverty level data are provided by ICF Macro.

In fact, across all sites, nearly 1 in 3 youth presented with suicide-related problems. Upon closer examination of youth in the longitudinal study, more youth in Albany County had attempted suicide compared with the national sample (17.8% and 13.3%, respectively). In 2009, project leadership addressed the issue of teen suicide by forming the county-wide Suicide Prevention and Education Committee and provided several community educational opportunities and clinical trainings. This effort continues.

Multi-System Involvement

On average, youth enrolled into the Albany SOC were engaged in 2.63 service systems, ranging from 1 to 8. More than half of youth (56.6%) were actively being served through the schools and mental health system at the time of intake. More than a third (37.7%) of youth engaged with multiple systems were being served by the schools, mental health, and at least one other agency, most often child welfare.

Living Environments

At intake into the system of care, the majority of youth in the study lived at home (95.2%) with their biological family (82.6%). Many youth lived in high-risk environments. Consistent with the national sample, about half had ever lived with someone with a substance abuse problem or had witnessed domestic violence, and a third had lived with someone who had been convicted of a crime. More youth in the Albany SOC lived with someone with depression or other mental illness as compared with youth in the national study. More youth served through FRCs experienced physical or sexual abuse or had run away compared with youth served through traditional portals. Physical and sexual abuse among FRC-served youth was higher than the national cohort as well.

Summary

Overall, the Albany System of Care served a very needy population in terms of poverty and employment levels, living situations, and presenting problems. While this whole descriptive picture is fairly consistent with the national evaluation sample, there were some differences in the profiles of youth and families served by traditional portals vs. Family Resource Centers.

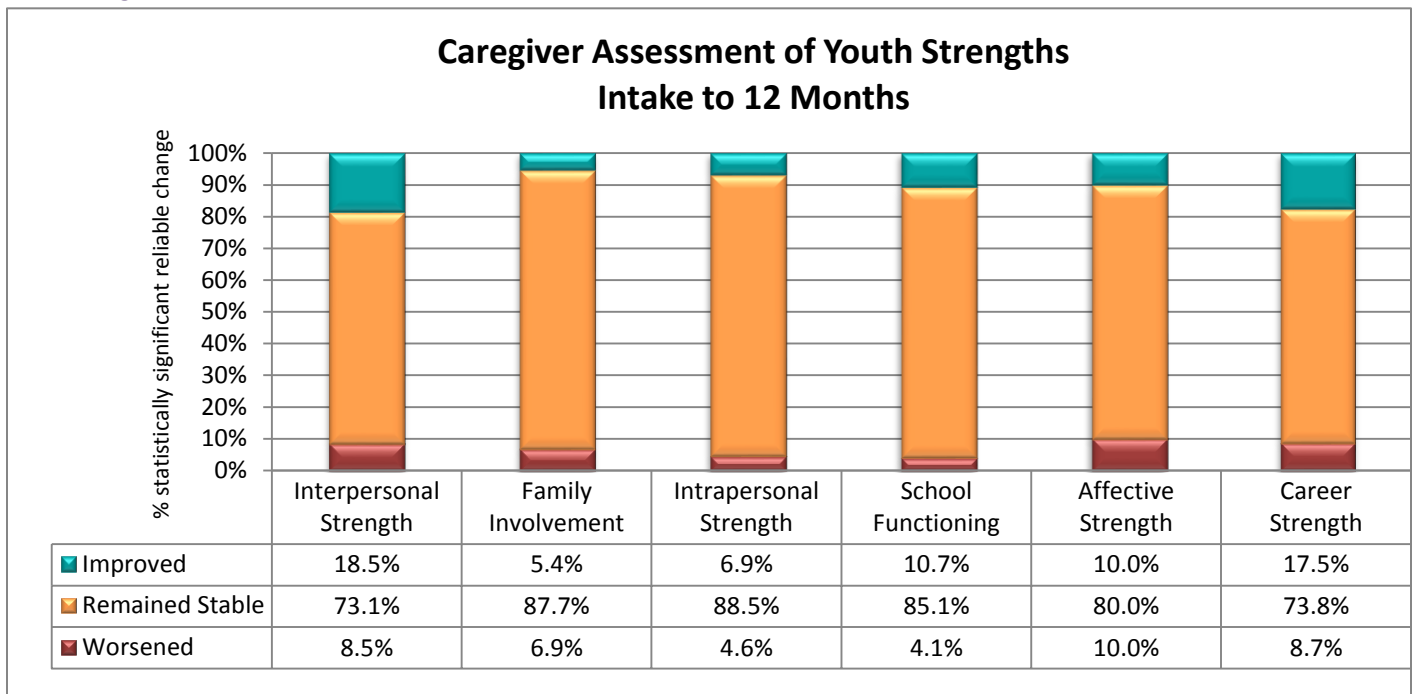
FINDINGS: CHANGES OVER TIME

Systems of care are built on the core principles of family-driven, youth-guided, strength-based, and culturally competent coordinated care to improve youth clinical functioning and behavior and family functioning. Changes in these areas are presented in the following section. In addition, the availability of multiple entries into the system of care allowed for comparisons of outcomes between families served through traditional portals and those served through the newly established Family Resource Centers.

Strengths

Using the Behavioral and Emotional Rating Scale (BERS), caregivers were asked to rate their children's strengths in six areas: interpersonal strength, family involvement, intrapersonal strength, school functioning, affective strength, and career strength. Figure 5 displays changes from intake to 12-months (Figure 5). The majority of caregivers reported their children remained stable across all areas. More improvement than worsening was reported for interpersonal and intrapersonal strengths, school functioning, and career strength. Slightly more families reported that family involvement worsened (6.9%) than reported it improved (5.4%), and equal percentages of families reported that affective strength improved and worsened (10%).

Figure 5



Percentages may not sum to 100% due to rounding.

Clinical Outcomes

Improvements in clinical functioning have been observed across several measures in the national sample. Results are mixed for the Albany SOC sample as a whole. Table 2 presents the percentage of youth scoring in the clinical range of impairment, anxiety, and depression, as well as average scores on behavior scales. There were no statistically significant differences in clinical outcomes between FRC and traditionally served youth.

As reported by caregivers on the Columbia Impairment Scale (CIS), the majority of Albany youth remained in the clinical range of dysfunction and experienced little change over time. For reference, the findings from the national evaluation have shown a 10 percent improvement in CIS scores over time.

Youths' self-report of anxiety and depression were mixed between FRCS and traditional portals. The proportion of FRC youth reporting anxiety in the clinical range remained unchanged during the first six months of service but dropped dramatically through 12-months. Improvements were not sustained for traditionally-served youth, where the percentage of youth reporting anxiety dropped from 26% to 17% in the first 6 months, but returned to 26% at 12-months. Findings from the national evaluation demonstrate modest and steady improvements over time.

The proportion of FRC-served youth who scored in the clinical range for self-reported depression increased from baseline through 12-months. The proportion of traditionally-served youth in the clinical range declined from baseline to 6-months but increased slightly at 12-months.

Reflecting the severity of dysfunction among Albany system of care youth, all youth at baseline scored in the clinical range on internalizing behaviors, (e.g., anxious/depressed, withdrawn, thought problems) and externalizing behaviors (e.g., rule breaking, aggression).⁴ Despite some modest improvements, all remained in the clinical range through 12-months. A comparison on the subscales of the CBCL found that youth served by FRCS were more likely to experience increased social problems and attention problems from baseline to 12-months relative to those served by traditional sites.

⁴ As reported by caregivers on the Child Behavior Checklist (CBCL).

Table 2
Youth Scoring in the Clinical Range of Impairment, Anxiety, and Depression

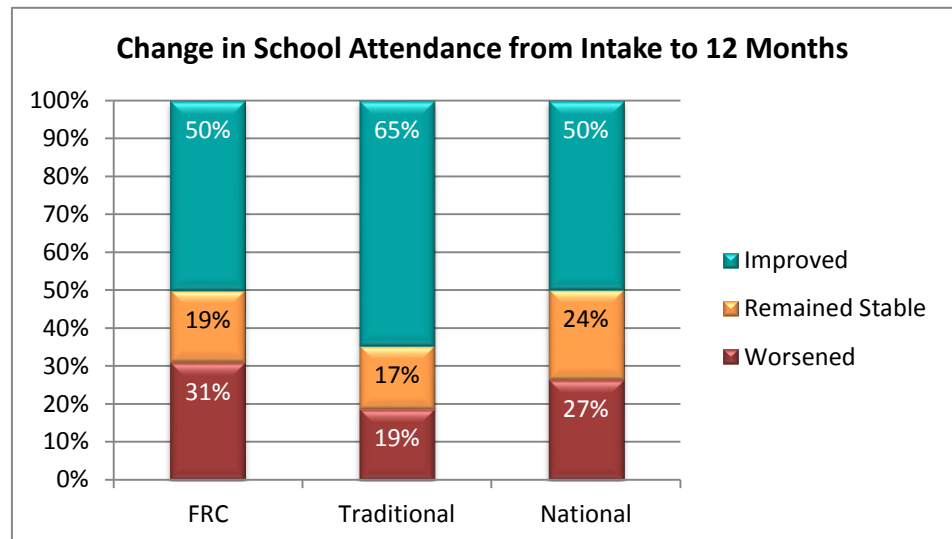
	Family Resource Centers			Traditional Portals		
	Baseline	6 Months	12 Months	Baseline	6 Months	12 Months
% Scoring At or Above Clinical Range for Impairment ⁵	82%	80%	83%	85%	81%	81%
% Scoring At or Above Clinical Range for Anxiety ⁶	32%	32%	21%	26%	17%	26%
% Scoring At or Above Clinical Range for Depression ⁷	11%	16%	21%	17%	9%	13%
Average CBCL Internalizing Behaviors Score ⁸	69.1	67.1	65.9	68.7	66.9	65.9
Average CBCL Externalizing Behaviors Score ⁷	71.2	70.3	69.1	71.4	70.4	69.0

School Attendance and Performance

Across the Albany system of care as a whole, youth improved their school attendance from intake to 12-months at a rate higher than the national rate (Figure 6). This was not the case for school performance where

Albany SOC youth improved at rates lower than the national cohort (Figure 7). When comparing service sites, more youth served through traditional services improved in both school attendance and performance as compared to youth served through FRCs. These differences are not statistically significant.

Figure 6



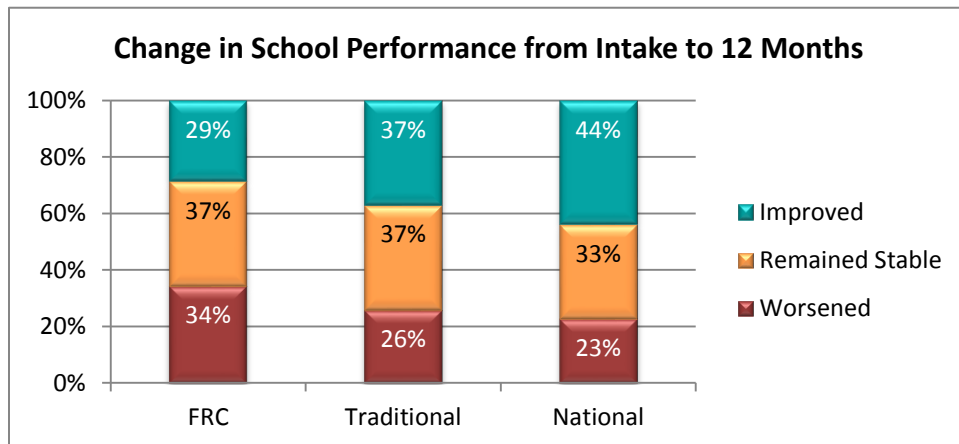
⁵ Columbia Impairment Scale, Caregiver report.

⁶ Revised Children's Manifest Anxiety Scale, Second Edition, Youth report.

⁷ Reynold's Adolescent Depression Scale, Second Edition, Youth report.

⁸ Child Behavior Checklist, Caregiver report; problem scores of 64 or above are in the clinical range.

Figure 7



Other measures of school functioning did significantly differ between youth served by FRCs and by traditional sites. Caregiver reports of school functioning revealed that youth served by FRCs were significantly more likely to experience decreased school functioning⁹ between baseline and 12-months than were youths served by the traditional service sites (Table 3). Additionally, youth served through traditional sites experienced a steady improvement in suspensions and expulsions (Figure 8). Youth served through FRCs remained stable in this area.

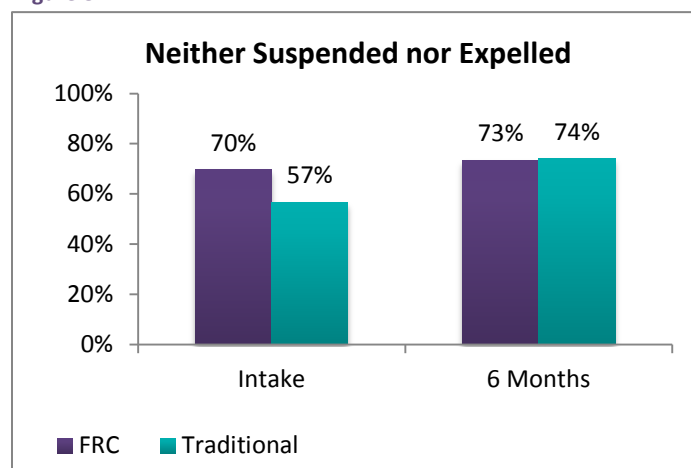
Table 3
School Functioning from Baseline through 12-Months

	Family Resource Centers N=55	Traditional Portals N=54
Improved or remained same	54.5%	75.9%
Worsened	45.5%*	24.1%

* Chi-square=5.49, df=1, p=.027.

Data source: Behavioral and Emotional Rating Scale (BERS) School Functioning Subscale, caregiver report.

Figure 8



⁹ The BERS School Functioning Subscale is comprised of 7 items regarding studying and note-taking habits, school task and homework completion, attention in class, performance in math and reading, and attendance.

Youth served through traditional sites experienced declines in all areas of delinquent behavior (Table 4). Youth served through FRCs also experienced declines in bullying, fighting, stealing and running away, but had increases in their arrest and probation rates.

Table 4
Youth Contact with Police and Juvenile Justice System

<i>In the past 6 months...</i>	Family Resource Centers				Traditional Sites			
	Baseline	6 Months	12 Months	Change from Baseline*	Baseline	6 Months	12 Months	Change from Baseline*
Been arrested	6%	6%	11%	↑	18%	11%	9%	↓
Been on probation	17%	21%	23%	↑	15%	15%	14%	↓
Been a bully or threatened without a weapon	20%	26%	17%	↓	29%	27%	18%	↓
Hit someone/got in physical fight	40%	34%	21%	↓	56%	43%	38%	↓
Taken something from store w/o paying	13%	4%	9%	↓	21%	15%	14%	↓
Been in trouble w/ police for running away	15%	11%	7%	↓	16%	11%	8%	↓

*Changes are not statistically significant.

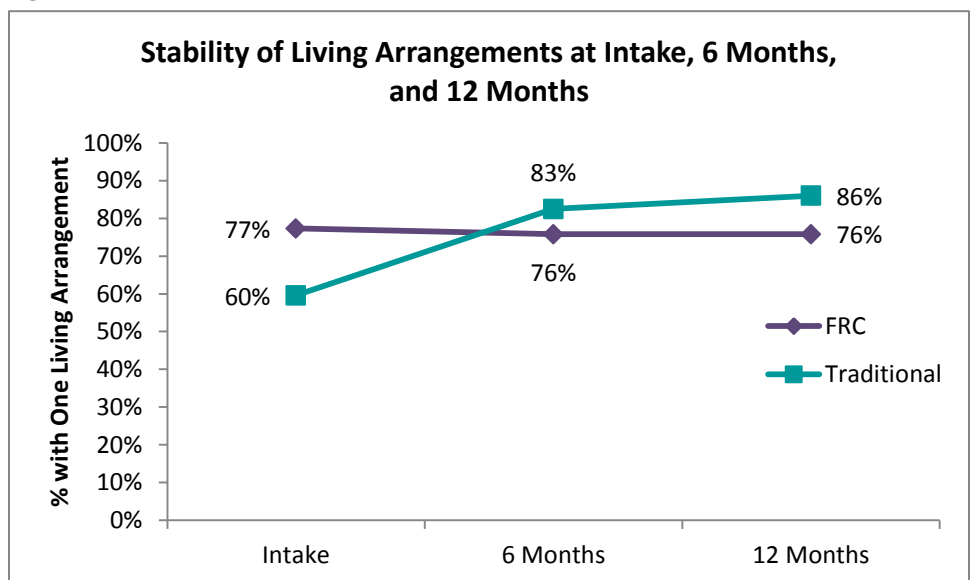
Alcohol, Tobacco, and Other Drug Use

Consistent with national data, there was minimal change in alcohol, tobacco, or marijuana use across the Albany system of care over time.

Living Arrangements

Three-quarters of youth served through FRCs remained stable in their living arrangements from intake to 12-months (Figure 9). More youth served through traditional portals as compared with youth served through FRCs transitioned to a stable living arrangement. Specifically, among youth served through traditional services, there was a 26-point increase in the proportion who had one living arrangement from intake to 12-months. There was virtually no change in housing stability for FRC-served youth.

Figure 9



Caregiver Strain

Caregivers can be affected by the special demands associated with caring for a child with emotional and behavioral problems. Caregiver strain was measured in a questionnaire comprised of three

subscales: *Subjective Internalized Strain* refers to the negative feelings that the caregiver may experience such as worry, guilt, or fatigue. *Subjective Externalized Strain* refers to negative feelings about the child such as anger, resentment, or embarrassment. *Objective Strain* refers to observable disruptions in family and community life (e.g., interruption of personal time, financial strain, or lost work time).

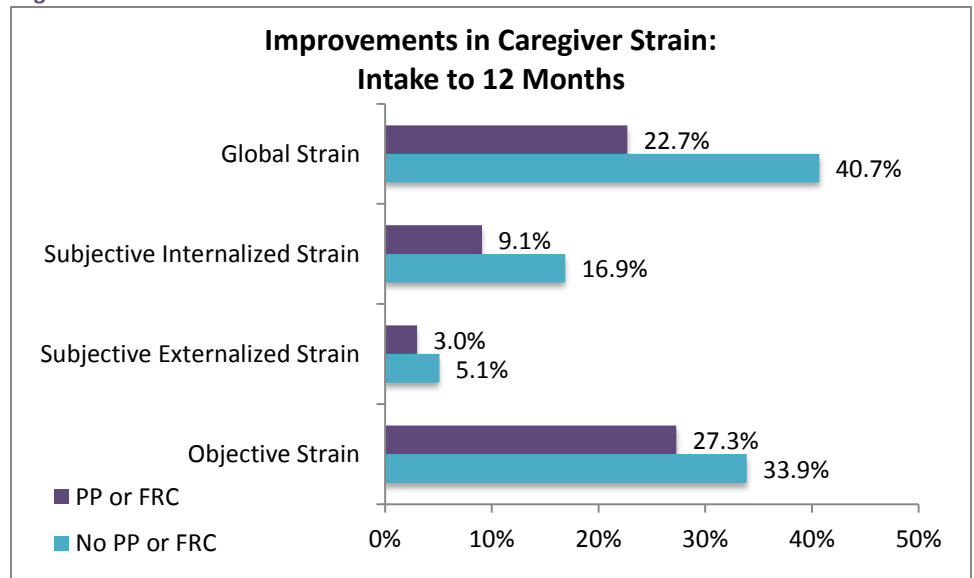
One of the core tenets of peer-to-peer family support is the sharing of knowledge and coping tools based on one's own experience. One area to expect a positive influence is caregiver strain. That is, a parent who has "been there" would share de-escalation and de-stressing techniques with parents new to the experience of caring for a child with complex needs. The data did not support this hypothesis. There were no significant differences in caregiver strain over time between caregivers who had a Parent Partner

or visited an FRC compared with caregivers served through traditional sites without a Parent Partner (Figure 10). There were also no significant reductions in caregiver strain from baseline to 12-months within service sites.

While the difference is not statistically significant, it is notable that more caregivers who did not have a Parent

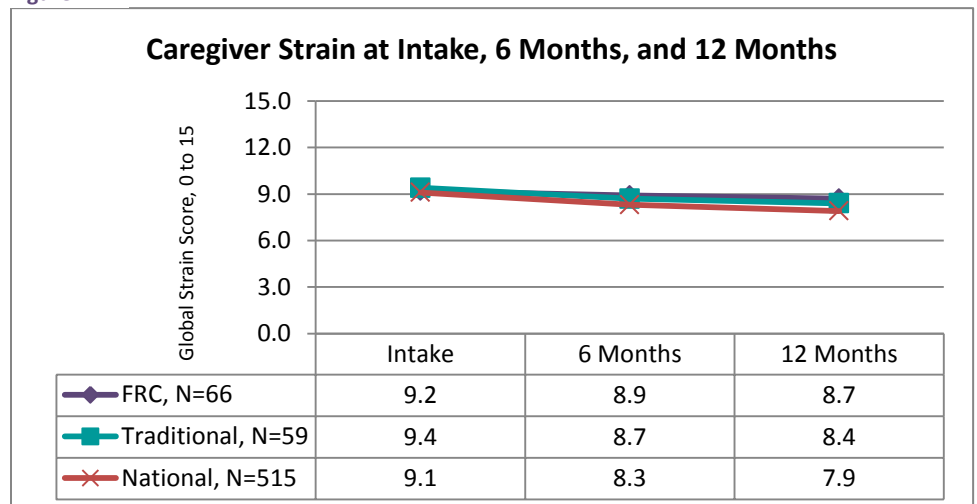
Partner or visit an FRC improved on all strain scales (Figure 10). For example, the Global Strain scores improved for 40.7% of traditionally-served caregivers, compared with 22.7% of caregivers served through Family Resource Centers.

Figure 10



We also did not find statistically significant reductions in caregiver strain on any of the subscales or global strain for those served through the FRCs. Remaining stable could be considered a relatively positive outcome, however global strain scores were in the mid to high range at intake and declined only moderately over time (Figure 11). There was not a significant difference in the reduction of caregiver strain between those who had a Parent Partner and those who did not. While not statistically significant, it is worth noting that caregivers served through traditional sites started at a slightly higher level of strain (9.4) and were at a lower level of strain (8.4) at 12-months as compared to caregivers served through FRCs (9.2 and 8.7, respectively).

Figure 11



In terms of missed work due to child's problems, a proxy measure of caregiver strain, caregivers reported missing an average of 13 days of work in a 6-month period due to their child's problems. Of those not working, 36% said they would have a job if not for their child's problems. Caregivers served by traditional sites were significantly more likely to experience reductions in the number of days of work missed between baseline and 12-months relative to those served by the FRCs.

Family Life

Quality of family life was measured using the Family Life Questionnaire (FLQ) which assesses family communication, decision-making, and support and bonding. The FLQ consists of 10 statements describing positive family interactions. Using a 5-point scale from never (1) to always (5), caregivers are asked to rate how often each interaction occurs in their family. Table 5 displays the average scores on the rating scale for families served by FRCs and traditional sites. While ratings of positive interactions were significantly different between FRC-served and traditionally-served families at baseline and 6-months, there was virtually no change in positive interactions experienced by either set of families served by FRCs or traditional portals over 12-months.

Table 5
Family Life Mean Scores

MEAN FLQ: Baseline, 6-months and 12-months FRC vs. Traditional			
	FRC	Traditional	Overall
Baseline	3.32**	3.59	3.45
6-months*	3.36 ^t	3.57	3.46
12-months	3.33	3.45	3.39
N	65	59	125

*N for 6-month = 124, one respondent served by FRCs didn't fill out FLQ in 6-month follow-up

**difference between FRC and Traditional significant at $p < 0.05$;

^t difference between FRC and Traditional significant at $p < 0.1$

A feature of parent-to-parent support is modeling parenting and communication skills and support for positive family interactions. As such, we would expect improvements in these areas among families who had the support of a Parent Partner. Table 6 shows improvements from intake to 12-months in only 3 of the 10 areas, declines in 6 areas, and no change in 1 area.

Table 6
Family Life Questionnaire*

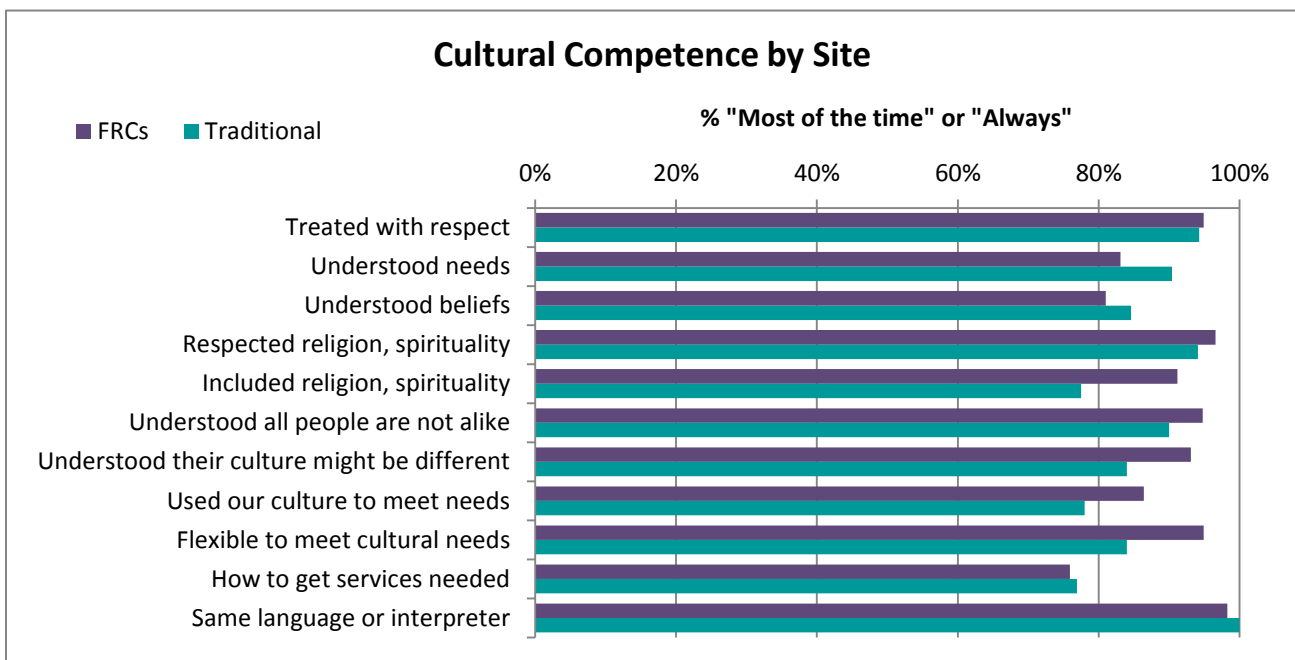
Our family...	Intake	6 Months	12 Months	Change Intake to 12M
Talks about fun things and things that make us laugh	55.4%	55.4%	55.4%	--
Spends time together as a family	58.5%	58.5%	55.4%	↓
Does things together outside of our home	41.5%	40.0%	47.7%	↑
Agrees about things like what to watch on TV or what to eat for dinner	40.0%	40.0%	29.2%	↓
Talks about our problems and troubles	40.0%	44.6%	38.5%	↓
Talks about things that make us angry without fighting	24.6%	21.5%	18.5%	↓
Relies on each other when problems arise	64.6%	63.1%	67.7%	↑
Can solve problems our child has when they happen	30.8%	32.3%	27.7%	↓
Deals with crises or major problems without fighting	44.6%	41.5%	32.3%	↓
Our child talks with members of our family about things that make him/her happy, sad, or upset	33.8%	35.4%	43.1%	↑

*% who responded "most of the time" or "always." Changes were not statistically significant.

Culturally Competent Services

Overall, respondents indicated that their culture and belief systems were respected. There were some differences between sites as well as between White respondents and respondents of other races. Figure 12 shows that caregivers served through FRCs experienced a bit more understanding of their culture and religion or spirituality, as well as flexibility in Family Partners using their culture to meet their families' needs. Slightly more caregivers served through traditional sites than FRCs reported that their needs and beliefs were understood.

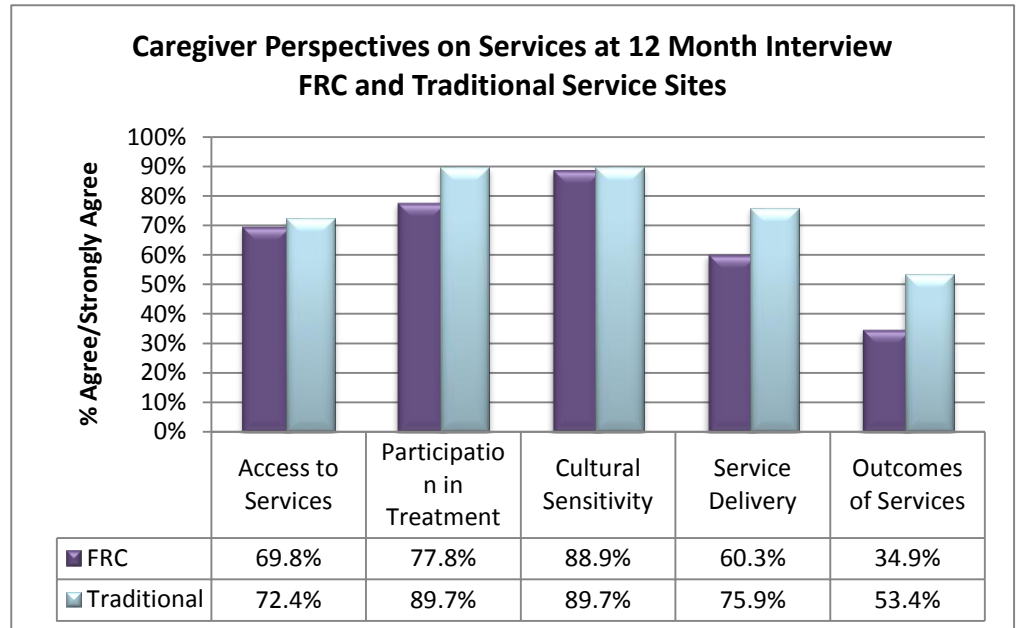
Figure 12



Satisfaction with Services

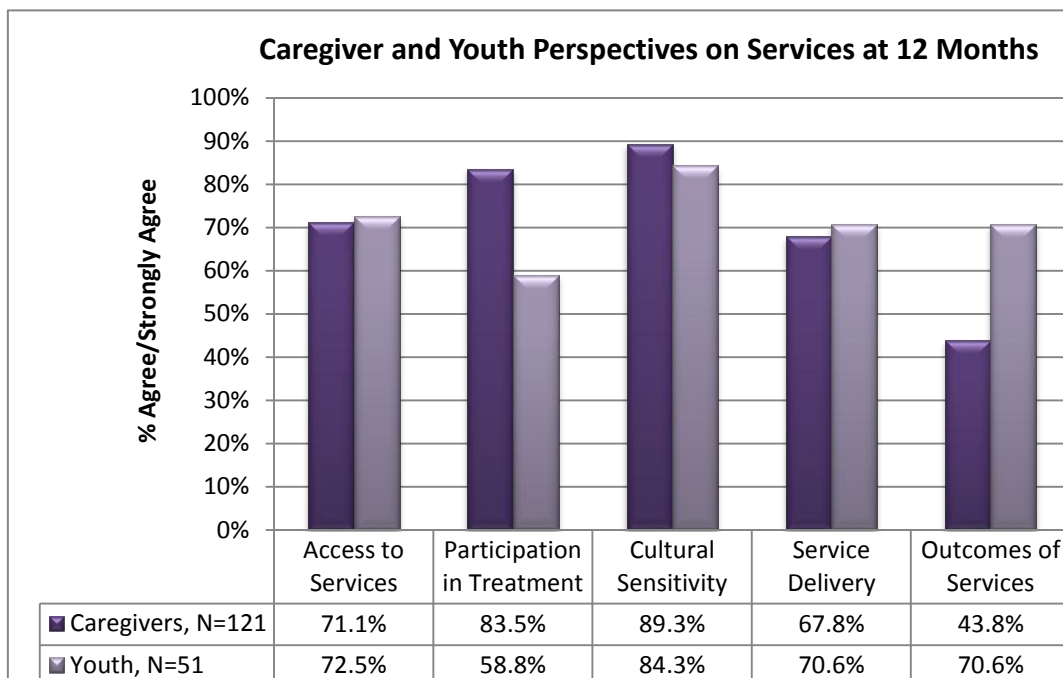
Respondents were asked a series of questions about their satisfaction with the services they received and the outcomes of those services. The majority of caregivers were satisfied with access to services, participation in treatment, cultural sensitivity, and service delivery (Figure 13). Caregivers served through traditional sites had higher rates of satisfaction across all five satisfaction subscales as compared to those served through FRCs. Only 35% of those served through FRCs and 53% through traditional portals were satisfied with the outcome of services.

Figure 13



Youth and caregivers were fairly equally satisfied with access to services, cultural sensitivity, and service delivery. More youth than caregivers were satisfied with the outcomes of their services (Figure 14). Of note, while more than 80% of caregivers were satisfied with their level of participation in treatment, less than two-thirds of youth were satisfied. This is an indication that work remains to be done in the area of ensuring that the system of care is youth-guided.

Figure 14



SUMMARY AND RECOMMENDATIONS

Findings of the evaluation revealed that, in and of itself, family support did not lead to better outcomes, more satisfaction with services, or less caregiver strain. There were some dimensions on which the traditional way of serving families was better than FRCs, and some on which there was no difference. There are lessons learned from the evaluation that can assist Albany County in continuing to develop the system of care, as well as lessons for other communities embarking on system transformation for children, youth and young adults with emotional, behavioral and social challenges, and their families.

Clarify Job Functions and Provide Ongoing Training

The scope of work for Parent Partners was unrealistic given their experience and the range and complexity of needs with which youth and families presented. Family support positions require a skill set and some level of experience to which one's personal experience as a parent or family member adds value. Many of these skills can be learned and nurtured with the appropriate training, supervision, and procedures in place. Job roles and supervision were complicated by the co-director model. Staff reported confusion on the lines of communication, authority, and personnel management.

- A well-developed training curriculum and clear expectations need to be developed prior to rolling out services to families.
- Parent Partners need to be fully trained and closely supervised before working directly with families and youth with complex needs.
- Identify one project director and clearly delineate the scope of responsibilities. A program manager to handle supervision, training, and day-to-day FRC operations is a model worth exploring further.

Balance Family Support and Clinical Intervention

A strong partnership and balance between clinical services and family support is needed throughout the continuum of services. One cannot, and should not, replace the other.

- Consider focusing family support on engagement and retention of families in services, with the understanding that clinical outcomes are best left to clinical providers.

Draw on Parent Partner Strengths in Engaging Families

There is some evidence that family support is effective in engaging youth and families at the start of their journey into services and that is where the Parent Partners' strengths lay. Consideration should be given to drawing on this strength and utilizing the skills of Parent Partners during this important stage of initiating services.

- Collocate Parent Partners at the Children's Mental Health Clinic to improve engagement of families and youth into services.
- Continue the collaboration with the Probation Department; pursue the possibility of collocating Parent Partners to help with family engagement.

Go to the Family

The community-based Family Resource Centers were predicated on families and youth making the first step to cross the threshold to request assistance. This can be a very difficult step to take for many families who face both external stigma associated with mental illness as well as internal shame or embarrassment to admit their child may have serious emotional issues.

- Establish outreach strategies for engaging families in the community and in their natural settings rather than expecting them to come into a facility to seek services.

Build on Existing Experience and Resources

The Albany System of Care did not achieve full integration of family support into the array of existing services. Rather, a parallel tier for family support was created into which families and youth were referred. Collocating parent partners in existing agencies, rather than creating new portals (the Family Resource Centers), may have been a better investment of resources early in the initiative and may have had a more positive and significant effect on family and youth outcomes. Building on these partnerships might have strengthened the foundation upon which FRCs and the infusion of family support could then be built. Furthermore, this approach might also have garnered wider and stronger community support which could have contributed to the long-term sustainability of the model.

The umbrella family organization has a strong history in children's mental health advocacy. This was its first major foray into providing large scale direct services. A more experienced service-providing organization may have been more efficient in getting the FRCs up and running, training Parent Partners, and focusing on sustainability earlier in the initiative.

- Build upon existing resources in the community rather than building a model from scratch.
- As a first step, consider offering family support in existing agencies, e.g., collocate parent partners in agencies, and use data and social marketing strategies to demonstrate the value of family support.
- Conduct a careful community needs assessment to gauge the need for free-standing centers prior to establishing them.
- Use the relationships built throughout the grant initiative to demonstrate the value of Family Resource Centers as community resources. Adapt to community needs.

Start Planning for Sustainability Early in the Initiative

As we know from multiple resources and publications,¹⁰ efforts regarding sustainability must start early and receive continued attention throughout the initiative. We also know that this is not a job for one person. It requires a collaborative effort. Unfortunately, sustainability was one of many tasks on the family project co-directors' plate, and the once-formed sustainability workgroup was not, itself, sustained. At the time of this report, none of the parent-run Family Resource Centers has been sustained beyond the grant period. The physical establishments simply proved too costly to sustain. And, despite some positive effects of Parent Partners on engagement into services, the family support model still has yet to be fully integrated throughout the service system in Albany County. Recently, in an effort to promote the family support model, DCYF developed a new requirement for family support in their latest round of Requests for Proposals for prevention services. This came too late in the initiative to effect sustainability. And, while this is a positive, forward step, more work needs to be done to infuse SOC principles into services and through the Albany County community as a whole.

¹⁰See <http://www.tapartnership.org/SOC/SOCsustainabilityPlanning.php?id=topic1> and <http://www.cmhi-library.org/> for resources.

- Begin planning for sustainability as early in the initiative as possible.
- Establish a workgroup of committed partners whose primary focus is sustaining the system of care values, principles, and services beyond the grant period.
- Continue efforts to infuse family support throughout the service system for children, youth, and families.

Engage the Community

This was primarily a staff-driven initiative. Community members and SOC service recipients were not actively or regularly engaged in the governance of the initiative. Furthermore, there was no overarching, unified, collaborative oversight body for the initiative. CCSI received reports but was not actively engaged in the fiscal management or project oversight of the initiative. These duties were left to the Executive Committee, a 5-person committee of paid staff with no community representation or involvement. If engaged properly, the community at large can be a valuable resource of experience, expertise, creativity, and decision making to help implement and sustain a large transformation initiative like a system of care.

- Assertive and sustained efforts to engage the community, as well as families and youth who are recipients of services, in the decision-making process are needed. Attention to the time and location of meetings is warranted.
- Fiscal and programmatic oversight of the initiative must come from a unified governance body representative of families and youth being served, service providers, agency administrators, and the community at large.

Use Social Marketing Effectively

Social marketing is vital to the success of any transformation initiative.¹¹ A primary goal of systems of care is to increase community awareness of children's mental health and reduce stigma. While the FRCs were marketed successfully, there was not the same focus placed on changing the broader community's knowledge and attitudes towards children's mental health. There was little focus on identifying and reducing stigma. Engaging the community and garnering support for the model is a critical goal for social marketing and can have significant effects on the sustainability of the initiative. The importance of social marketing on community engagement and sustainability cannot be overstated.

- Hire an experienced social marketing coordinator, preferably at full-time status, to fulfill the broad scope of work entailed in large-scale, system transforming social marketing campaigns.

¹¹ See www.vancomm.com and www.tapartnership.org for more information on social marketing.