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A Study of New York State's Family Resource Center Network

A Report Submitted to
New York State Office of Children and Family Services
Bureau of Program and Community Development
Children and Family Trust Fund
New York State Family Resource Center Trust Fund

July 2006

Prepared by the
Center for Human Services Research
University at Albany
State University of New York



**A Study of
New York State's
Family Resource Center Network**

*Center for Human Services Research
University at Albany
Albany, New York*

This report was prepared by a team of researchers and analysts at the Center for Human Services Research led by Ann-Margret Foley and comprised of Manrong Chen, Nina Esaki, Rose Greene, Eunju Lee, Jeff Luks, and LuAnn McCormick. The report benefited by the thoughtful feedback of NYSOCFS staff including Judy Richards, Lisa Gordon, Cheryl Cannon, Maria Rosado, and Kathleen Chu. We would like to acknowledge the efforts of Dikla Madera and Nancy Chiarella for formatting and editing the report.

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Executive Summary

This report was prepared by the Center for Human Services Research (CHSR) of the University at Albany as part of an evaluation of NYS Family Resource Centers (FRC) supported by the NYS Office of Children and Family Services (NYSOCFS).

Section I provides the background and history of the family support movement and offers a basic description of the NYS Family Resource Center Network. The NYS FRC Network was initiated by the NYS Trust Fund, established in 1984 to assist in the prevention of all forms of family violence. In 1986, the Trust Fund first provided funding for the Webster Avenue FRC in Rochester (NYS, 2003). During the 1990's, additional resource centers were funded through federal funds administered by NYSOCFS. In 1996 a Request for Proposals was solicited by NYS to establish 12 centers in high need communities.

NYS Family Resource Centers are voluntary programs that offer universal access and culturally competent services and support for all families living within a designated area, with an emphasis on young children. NYS FRC's are primarily located in rural communities or in modestly populated areas across NYS, with several located in more densely populated urban areas.

Section II presents data from two sources: an administrative survey completed in the Spring of 2005 and data from the 2005 NYS FRC Management Information System. The analysis found that as a whole, FRCs offered many services and activities that would be expected to influence intermediate outcomes: enhancing child-parent interaction, increasing knowledge of child development, and promoting positive parenting. The analysis also found there was great variation among the sites regarding the populations served, the intensity of services delivered, and the nature of the program offerings. Patterns were discovered regarding participant household income and service utilization.

Section III describes current and future trends to evaluate FRCs and the increasing emphasis for designs that measure program effectiveness. Much of the research that has been conducted consists of implementation studies that report on the types and amounts of services provided. In 2006-2007 the Center for Human Services Research will conduct an outcome evaluation of one of the FRC component services – formal parenting education.

Based upon the wealth of information collected from document reviews, FRC Management Information System, FRC Administrative Questionnaire and FRC Surveys, the following **recommendations** have been made for the NYS FRC Network:

- **Target Vulnerable Families** – particularly low-income families who are in greater need for services and are at the highest risk for poor child outcomes.
- **Reexamine Hours of Operation** – to consider expanding program offerings to more evening hours and weekends. This would reach a broader mix of families such as parents trying to comply with welfare-to-work requirements.

- **Extend Outreach to Subsidized Legally-Exempt Child Care Providers and Child Care Centers** – to reach family, friend and neighbor care, an increasing form of child care. These providers could benefit from FRC programs and services. Some innovative models across the country have partnered FRCs with child care centers.
- **Reexamine Program Offerings** – to provide more evidence-based practices should be among the program offerings. Also, it may be necessary to increase the intensity of services to produce desired outcomes. Comprehensive family assessments would allow for better meeting family needs.
- **Increase Collaboration and Coordination of Services** – to include partnerships with child welfare agencies, early intervention, mental health, substance abuse treatment and domestic violence services.
- **Develop Staffing Guidelines** – that include standards such as full-time coordinators, backgrounds in early childhood education, and screening and background checks for staff and volunteers.

I

Introduction

Overview

This report was prepared by the Center for Human Services Research (CHSR) of the University at Albany as part of an evaluation of New York State Family Resource Centers (FRC) supported by the New York State Office of Children and Family Services (NYSOCFS). Beginning in the summer of 2001, NYSOCFS established a contractual agreement with CHSR to develop and manage a database for the NYSOCFS Family Resource Center network and to assist with its evaluation plans. Since that time, CHSR has conducted a number of activities including modifying and enhancing the database, conducting annual participant telephone surveys, interviewing FRC staff, developing a NYS FRC logic model and convening participant focus groups.

This report synthesizes the wealth of data that has been compiled on NYS' FRCs. It describes FRC participants and activities, analyzes related programs and trends in other parts of the country, and offers recommendations for future practice. The data for this report came from a number of sources:

- Document Review: including FRC peer reviews, FRC annual reports and contracts, scholarly literature, websites and national reports
- FRC Management Information System: data collected on adult and child participants and the activities they engaged in at local FRC sites
- FRC Administrative Questionnaire: data gathered by telephone interviews with FRC program coordinators and other FRC staff at each site
- FRC Surveys: data collected by telephone interviews and focus groups with participants

The report is organized into three sections. In Section I, we provide a brief background of the family support movement in the country as well as in New York State and offer a basic description of the NYS FRC network. Section II includes data analysis from two sources: an FRC administrative survey and the NYS FRC Management Information System. Section III concludes with a description of current and future trends in evaluating family support programs, several noteworthy national models, and recommendations for future practice.

Family Support and Family Resource Centers

History

Family Resource Centers are part of today's growing Family Support Movement which has its roots in a number of social programs that have evolved over the past 100 years. The Settlement House Movement is attributed with the origins of the family support philosophy – a rejection of a deficit orientation, an emphasis on community and preventive interventions, an acknowledgement of the importance of providing social support, and the acceptance of advocacy as a service function (Kagan & Weissbourd, 1994). Family Support Programs also borrowed ideas from the War on Poverty and the Head Start Program. Head Start Programs involved parents in the development, implementation, and delivery of services. Unlike other traditional hierarchical social service programs that exercise authority through the provision of services, the Head Start Program emphasized collaboration among paraprofessionals, professionals, and lay persons through the entire service delivery process (Manalo & Meezan, 2000).

Family Support Programs were started in the late 1960's and early 1970's by community-based groups of parents and those who sought to help them and their children (FSA, 2002). They all shared a common goal: to enhance the ability of families to successfully nurture their children. These community-based groups believed that involving and engaging parents as partners would lead to future successful parents, children, and communities. By the early 1980's, the family support momentum was growing. In 1981, in Chicago, an organization was conceived by family support pioneer Bernice Weissbourd and was given the name Family Resource Coalition.

In 1993, The Omnibus Budget Reconciliation Act of 1993 (P.L.103-66), was passed and provided federal support to family support programs. The program gave states wide latitude in designing programs to meet families' needs within their community. In 2000, The Family Resource Coalition changed its name to Family Support America (FSA, 2002).¹

Principles of Family Support Practice

There have been a number of attempts to characterize the programs that are part of the family support movement. Generally, it has been recognized that what distinguishes family support programs are the underlying principles of practice. As articulated by Family Support America (2002) these principles include the following:

- 1) Staff and families work together in relationships based on equality and respect
- 2) Staff enhance families' capacity to support the growth and development of all members- adults, youth and children

¹ At the time of writing this report, Family Support America closed its doors due to a lack of funding.

- 3) Families are resources to their own members, to other families, to programs, and to communities
- 4) Programs affirm and strengthen families' cultural, racial, and linguistic identities and enhance their ability to function in a multicultural society
- 5) Programs are embedded in their communities and contribute to the community-building process
- 6) Programs advocate with families for services and systems that are fair, responsive, and accountable to the families served
- 7) Practitioners work with families to mobilize formal and informal resources to support family development
- 8) Programs are flexible and continually responsive to emerging family and community issues
- 9) Principles of family support are modeled

Typology of Family Resource Centers

Family Resource Centers are sometimes called family support centers, family centers, parent-child resource centers, family resource schools, or parent education centers. Each family resource center works with community members to develop specific services that meet the needs of the people who use the center and the community that surrounds it. Participants of the center, as well as community members, are involved in the design, implementation, and evaluation of the center (U.S. Department of Health and Human Services [DHHS], 2005).

Family Support Centers, since their inception over twenty-five years ago, have evolved into a variety of models and there have been various attempts to create organizing frameworks or program typologies. Despite their shared philosophies, principles, and practices, family support programs do not fit into “neat, clean categories” (Kagan et al., 1994).

Family Support America organizes support centers into the following five categories:

1. **Family Support Centers.** Most family support centers in the United States and Canada are small, serving an average of 300 families per year through a set of formal and informal program components, generally decided upon with input from local families. These centers, located in the community, are places where families can gather or turn to for assistance, to share knowledge and experience, and to contribute to their community.

2. **Family support programs nested within larger organizations.** Family support is also emerging in the form of family-serving programs within larger efforts, organizations, or institutions. Increasingly, family support programs are located in schools, health settings, Boys and Girls Clubs, libraries, and a variety of other settings. These programs may be developed as family support centers within institutions or as discrete services and supports delivered in a variety of non-center settings.
3. **Organizations that adopt and work from the principles of family support practice.** This model derives from organizations choosing to apply the principles of family support to their entire body of work including staff policies. Recently, providers of services such as health care, mental health care, child protection, child welfare, and family counseling have adapted family support practices.
4. **Community-level systems of family support.** Systems reform at the community level may result not in a single center base for family support, but rather in a more diffuse, less centralized, but nonetheless family support-based model of collaboration on behalf of families.
5. **Comprehensive community collaborative structures for family support.** Several states, including Georgia, Michigan, Minnesota, Washington, and West Virginia, have local collaborative bodies that are community-based efforts to improve the conditions of well-being for children and families. In contrast to other models of family support, these collaborative bodies do not typically deliver direct services to families. The uniqueness of this model is its role in bringing parents and other community leaders together to shape and design integrated services and supports.

The NYS Family Resource Center network can best be characterized by the first two categories. Like the Family Support Center category, the NYS FRCs offer formal and informal programs that solicit input from local families, are located in the community, and are places where families can gather to share knowledge and experience and contribute to their community. Further, as described in the second category, the NYS FRCs are typically located within larger organizations and institutions.

New York State Family Resource Center Network

Background

The NYS Trust Fund was established in 1984 to assist in the prevention of all forms of family violence (NYS, 2003). The Trust Fund is administered by NYSOCFS, under the Division of Development and Prevention Services. In 1992, the Fund was renamed to honor one of its creators, the late Assemblyman William B. Hoyt of Buffalo, and today is one of 52 Trust Funds in the nation dedicated to the prevention of child abuse (NYS, 2003). The Trust Fund provides support to community-based programs that

are deemed worthy based on competitive responses to a Request for Proposals (RFP) (NYS, 2003).

In 1986, The Trust Fund first provided funding for the Webster Avenue Family Resource Center, which became a model child abuse prevention program, and part of a network of five family resource centers in the Rochester Family Resource Network (NYS, 2003). During the 1990's, additional resource centers were funded through federal funds administered by New York State Office of Children and Family Services, under the Community-Based Family Resource Program (CBFRP) , which were used to establish 12 resource center programs in high need communities across New York State, selected through a 1996 Request for Proposals.

The purpose of the CBFRP was to assist states to establish and expand statewide networks of prevention-focused community-based family resource programs. The legislation required interagency coordination and collaboration in the planning and implementation of family resource programs providing 5 specific core services (parent education and support, early developmental screening, outreach, community referral, and follow-up) and a variety of optional services (e.g., early care and education, respite, job readiness, education and literacy, and referral for health services).

In 1997, amendments to the Child Abuse Prevention and Treatment Act (CAPTA) created the Community-Based Family Resource and Support (CBFRS) grant program. The purpose of the new CBFRS program was (1) to support State efforts to develop, operate, expand and enhance a network of community-based, prevention-focused, family resource and support programs that coordinate resources from existing public and private organizations, and (2) to foster understanding and knowledge of diverse populations in an effort to effectively prevent and treat child abuse and neglect.

In 2003, amendments to CAPTA resulted in the renaming the Community-Based Family Resource and Support Program to the Community-Based Child Abuse Prevention (CBCAP) program. The purposes of the CBCAP program are to support community-based efforts to develop, operate, expand, enhance, and where appropriate, to network initiatives aimed at the prevention of child abuse and neglect.

The Trust Fund depends primarily on an annual appropriation from the State Legislature and Federal CBCAP program funds. Any public agency or not-for-profit corporation may apply for a Trust Fund grant. Priorities are determined by NYSOCFS administration with recommendations made by an Advisory Board of thirteen members who are appointed by the Governor with recommendations from the Legislature. Family Resource Centers must set forth anticipated outcomes, specify how they will accomplish them, and show how they intend to continue their program once the Trust Fund's four year commitment expires (NYS, 2003). As of July 2006, the Trust Fund supports 22 Family Resource Center Programs located in 15 counties statewide.

NYS FRC Model

NYS Family Resource Centers are voluntary programs that offer universal access and culturally competent services and support for all families living within a designated area, with an emphasis on families with young children. The program design is based on local needs assessments that incorporate broad-based stakeholder participation, including parents, local providers, social services, local government, and schools. The Centers seek to promote positive parenting, healthy child development and family self-sufficiency. FRCs are based upon the principles of family support and emphasize building family strengths and abilities in order to maximize the capacity of families to take care of themselves, raise healthy children and contribute to their community.

In 2006, CHSR researchers worked with State leaders and local program managers to develop a NYS FRC logic model (see Figure 1). Logic models link outcomes (both intermediate and long-term) with activities and specify the guiding principles of programs. NYS FRCs defined four long term outcomes:

- Prevent child abuse and neglect
- Improve parenting practices that minimize risk factors and promote healthy child development
- Improve child development and school readiness
- Reduce child welfare involvement and prevent out-of-home placements

The long term outcomes are reached through the attainment of the following intermediate outcomes categorized into three areas:

- Family Support and Education: increase parents' knowledge of child development and use of positive parenting techniques; increase positive interactions between parents and children; establish sustainable connections between parents; identify developmental disabilities earlier; and increase enrollment in health insurance, referrals to health care, and immunization rates
- Community Support and Education: reduce social isolation, improve availability of and access to community resources to meet families' basic needs, and raise awareness of family health and safety through community education
- Advocacy: increase parent leadership roles, increase parents' sense of confidence and empowerment in their parental role, and foster parent engagement in community activities

Figure 1: The New York State Family Resource Center Network

The New York State Family Resource Center Network offers early and comprehensive support for parents/caregivers of young children. Culturally competent services emphasize education in informal settings that promote positive parenting, healthy child development and family self-sufficiency. Using community needs assessments and peer reviews, each Family Resource Center (FRC) is customized to meet its community's needs. FRC programs emphasize building family strengths and abilities in order to maximize the capacity of families to take care of themselves, raise healthy children and contribute to their community. Provision of support before families become high-risk or abusive is both potent and cost effective.

Societal Expectations

Research has identified three key societal expectations of parents:

- To provide for basic needs and keep children physically and psychologically safe,
- To guide children's physical and psychological development,
- To advocate on children's behalf within the wider community.

Underlying Conditions

Regardless of socio-economic status, all families experience risk factors or circumstances that diminish their capacity to meet these expectations. These factors are compounded for families experiencing geographic or social isolation, economic challenges, limited education or employment opportunities, inexperience with positive parenting techniques, or physical or mental health issues.

Target Populations

While the NYS Family Resource Center Network targets all families, special emphasis is placed on:

- Young children, ages 0-5.
- Families involved with the child welfare system.
- Families at-risk for child abuse or neglect.

Activities

Family Support & Education

- Information and referral
- Adult education classes
- Job readiness programs
- Life skills education
- ESL/citizenship services and supports
- Basic needs, food/clothing pantries
- Literacy services, lending library
- Child care during adult activities
- Respite child care services
- Health and developmental screenings, including Early Intervention
- Drop-in play, play groups
- Preschool/early childhood education
- Parenting education
- Family support and counseling
- Group support (adult & child)
- Home visits

Community Support & Education

- Trainings for providers
- Interagency collaboration
- Supervised visitation
- Family social/recreational programs
- Transportation to/from FRC or other community services
- Youth development groups and clubs
- Public awareness campaigns and community presentations

Advocacy & Empowerment

- Active intervention or liaison services on behalf of family
- Parent leadership, peer learning and employment opportunities within FRCs
- Parent participation on FRC boards
- Peer reviews and family engagement
- Advocacy training for parents

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Long-Term Outcomes:

- ✓ Prevent child abuse and neglect.
- ✓ Improve parenting practices that minimize risk factors and promote healthy child development.
- ✓ Improve child development and school readiness.
- ✓ Reduce child welfare involvement and prevent out-of-home placements.
- ✓ Empower families to help build strong neighborhoods and interconnected communities.

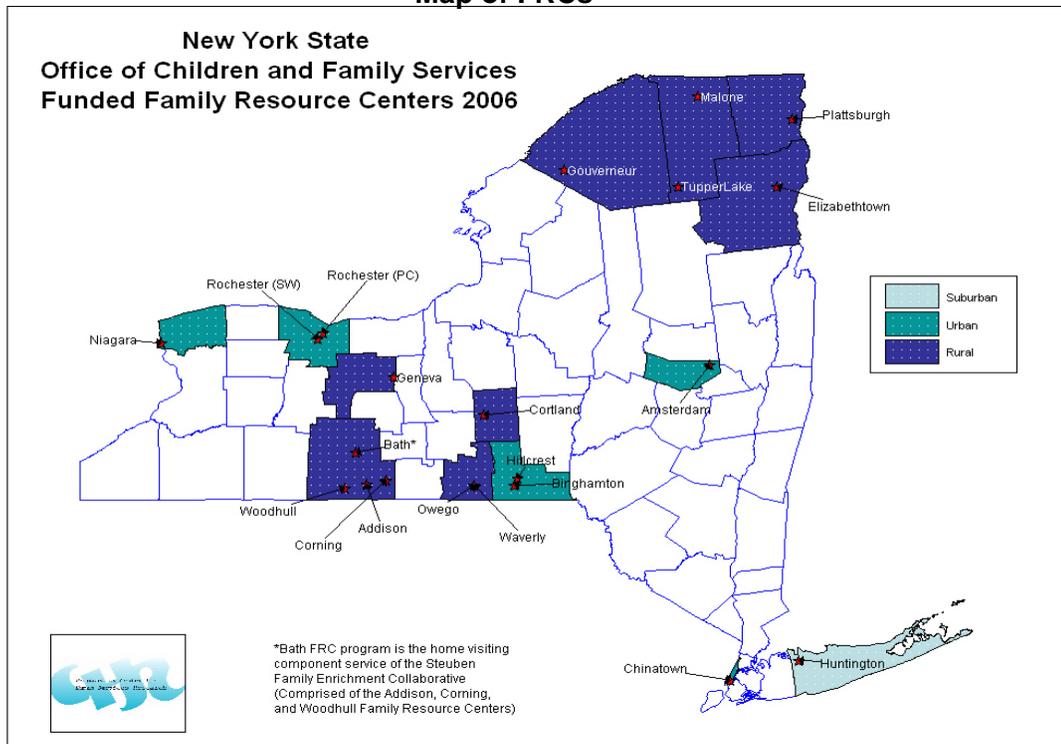
Core Values: Strength-Based / Social Support / Cultural Competence / Empowerment

The outcomes are to be achieved by delivering a set of core services and complementary services. The core services include informal and formal parenting education and support, referral to needed services, outreach and follow-up. The complementary services include preschool and early childhood education, health programs, home visits, ESL, life skills, adult education, job readiness, family social and recreational activities, supervised visitation, support groups, family support counseling, counseling (therapeutic), library, basic needs, respite care, advocacy, and transportation.

The NYS FRCs are primarily located in rural communities or in modestly populated areas across New York State. (See Figure 2 for a map of FRCs). There are presently five programs in the state's northern Adirondack region (Malone, Gouverneur, Tupper Lake, Plattsburgh, and Elizabethtown). There are ten programs in the Southern Tier and Finger Lakes regions (Geneva, Cortland, Owego, Waverly, Hillcrest, Binghamton, Addison, Woodhull, Corning and Bath²). One FRC is located in Western New York (Niagara) which serves participants from the City of Niagara Falls and neighboring towns and villages within Niagara County; another FRC is located in the city of Amsterdam, which also serves participants from towns and villages within Fulton County.

The remaining FRCs are located in more densely populated urban areas. Two are in the city of Rochester (Peter Castle and Southwest), and two are located downstate – in New York City (Chinatown) and Long Island (Huntington).

Figure 2
Map of FRCs



² Addison, Woodhull and Corning comprise the Steuben Family Enrichment Collaborative. Bath is the home visiting component of the collaborative.

II

Data Analysis

Introduction

This section presents data from two sources. First, we describe an administrative survey that collected information on organizational factors such as staffing and funding. The second data source is from the NYS FRC Management Information System (MIS) that collected information on adult and child participants and the activities they engaged in.

Administrative Survey

Description

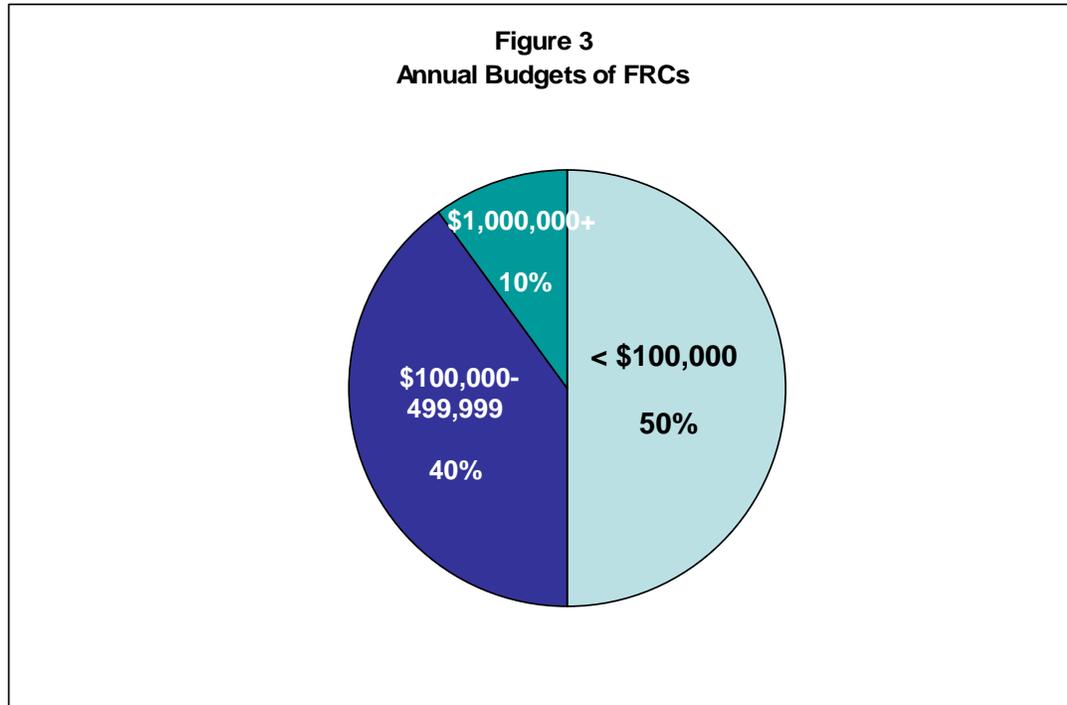
In order to better understand the operations of NYS FRCs, an administrative survey was conducted in the Spring of 2005. Phone calls were made to Program Coordinators, and in some cases higher level management, to collect the information. Copies of the interview guide were provided in advance of the phone call to facilitate the interviews. A summary of the findings is provided below.

Settings

The NYS programs can best be characterized as commonly nested within larger organizations. Typically FRCs are sponsored by community-based children and family service organizations such as child care coordinating councils, cooperative extensions, local school districts, and community action programs. All of the programs are collocated with other agencies. About 40% of the FRCs are collocated with their sponsoring organization.

Funding

The Trust Fund supports a proportion of the annual budgets of the FRCs. Budgets from all sources range from \$27,000 to \$1,800,000. Ten centers have a budget less than \$100,000, eight have a budget between \$100,000 and \$499,000 and the remaining two centers have budgets that equal or exceed \$1,000,000 (See Figure 3). The annual budgets vary depending upon the Center's geographical location, scope of services, and fundraising ability.

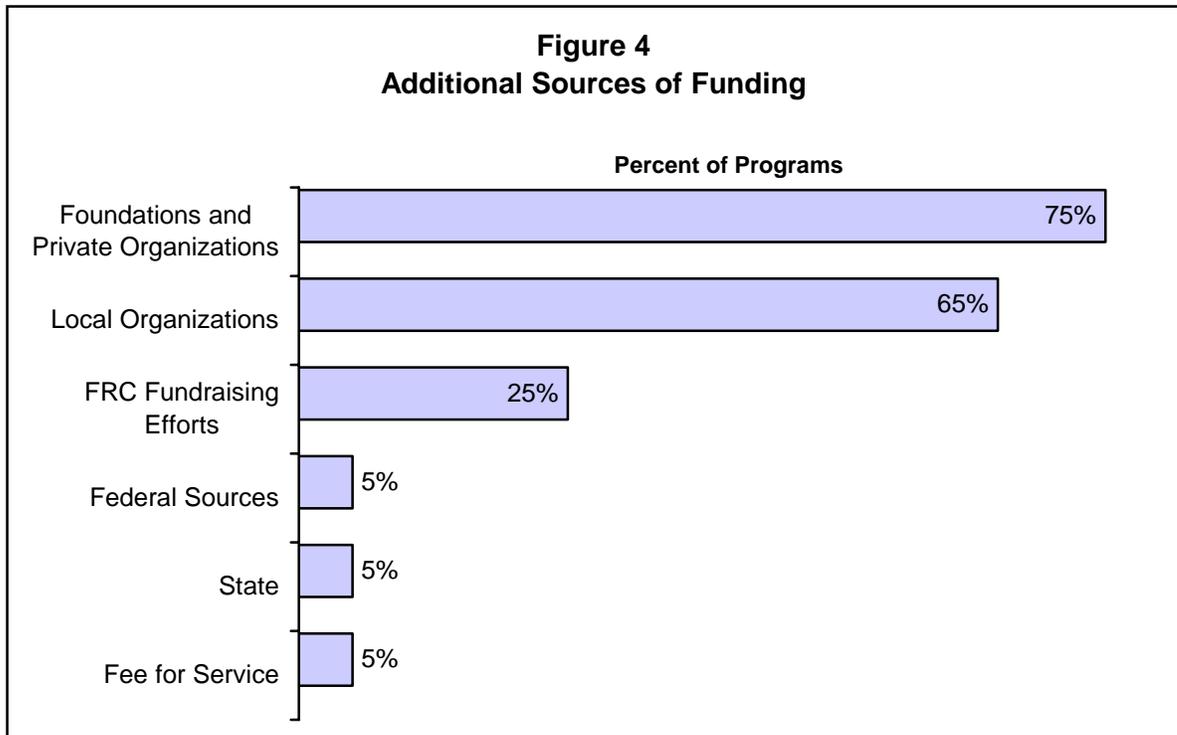


The Trust Fund contributes between 3% and 89% of the total budgets of FRCs, averaging nearly 50%. The actual dollar range of the Trust Fund contribution ranged from \$9,344 to \$103,000, with an average of \$40,163 annually. Of the total budget dollars for FRCs, 18% of the total dollars are contributed by the Trust Fund.

As indicated in Figure 4, 75% of the programs received additional funding from foundations and businesses including the Brookdale Foundation, Foundation for Literacy, Ametek Foundation, Wyckoff Foundation, Verizon, and United Way. About 65% of the programs received additional funds generated by local organizations including Youth Bureaus, local government, county agencies, housing authorities, and Catholic Charities. Approximately 40% of the programs received additional funds from FRC fundraising efforts, federal and state support, and minimal fees associated with services.

Programs are generally funded for four years to enable adequate development and procurement of funding for continuation of the center (NYS, 2004). The amount of funding from the Trust Fund decreases over time. In years 1 and 2 the funding remains the same, in year 3 funding is at 75% of the original allocation and in year 4 funding is at 50% of the original allocation³. FRCs may submit additional proposals under the Request for Proposal (RFP) competitive bid process following the completion of the four year funding cycle. Presently, NYSOCFS has provided continuation funding to support the program's operational costs for all existing Centers that completed their 4 year cycle as they have met program standards and specified outcomes.

³ For the Trust Fund Year 4 funding most sites receive 50%, but several sites have received enhanced funds.



Staff

All FRCs are led by a Program Coordinator who is usually supported by other full-time or part-time staff and volunteers. The number of full-time staff range from 0 to 33, with an average of three. The number of part-time staff range from 0 to 25 with an average of four and a median of two. The number of volunteers range from 0 to 204 volunteers per year with a median of five.

There are no specific State requirements regarding staff credentials and staffing levels although the Trust Fund's RFP recommends that Coordinators participate in the Cornell Family Life Development Credential Training.

Management Information System Database (2005)

This section provides an analysis of NYS Family Resource Center participants and services⁴. The data originated from the FRC Management Information System based upon data collected by FRCs funded by NYSOCFS in 2005. Among these sites, 24 were located in upstate New York, and 1 was in downstate New York.⁵

At the initial visit to an FRC, a Participant Registration Form is completed by the adult participant. The Participant Registration Form collects demographic data for both

⁴ Although the sites maintain data on community events and other group activities, these data are not analyzed for this report.

⁵ For 2 FRC sites (Calvary St. Andrews & Huntington) data were not available. The number of sites used for the analysis represents active sites in 2005, which differs from number of sites funded in 2006.

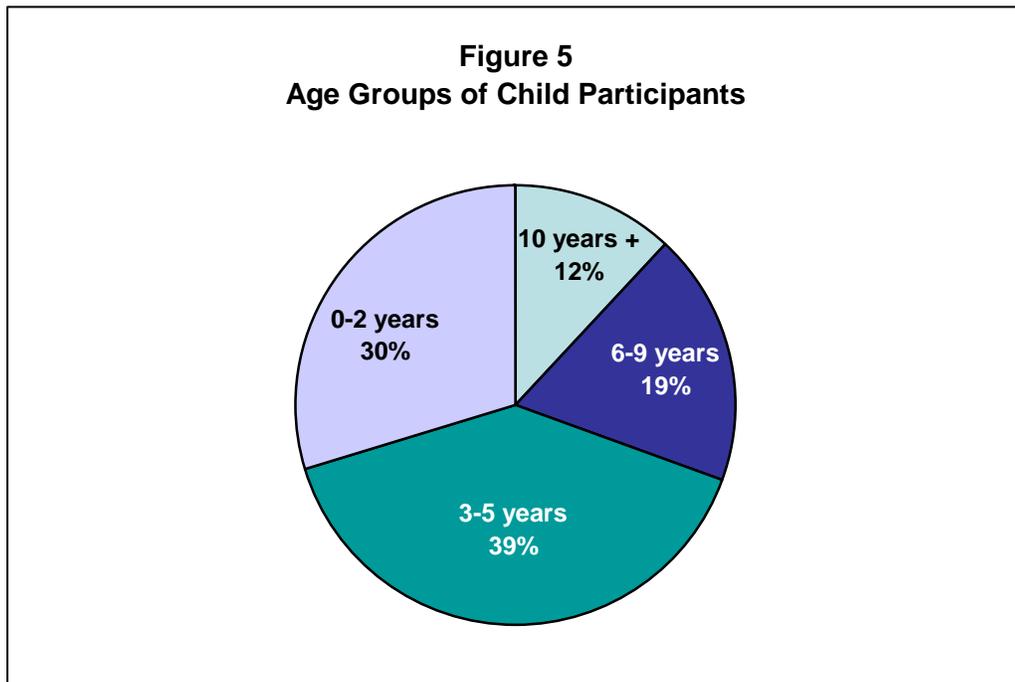
the adults and child(ren). Also a sign-in attendance sheet is completed for each visit made by the adult and/or child.

In this study, two types of datasets were used: child data sets and adult data sets. The child data set consists of two parts: background information of all registered children and the services they used. Similar to child datasets, the first portion of the adult dataset consists of the background information and the second portion contains information about services used.

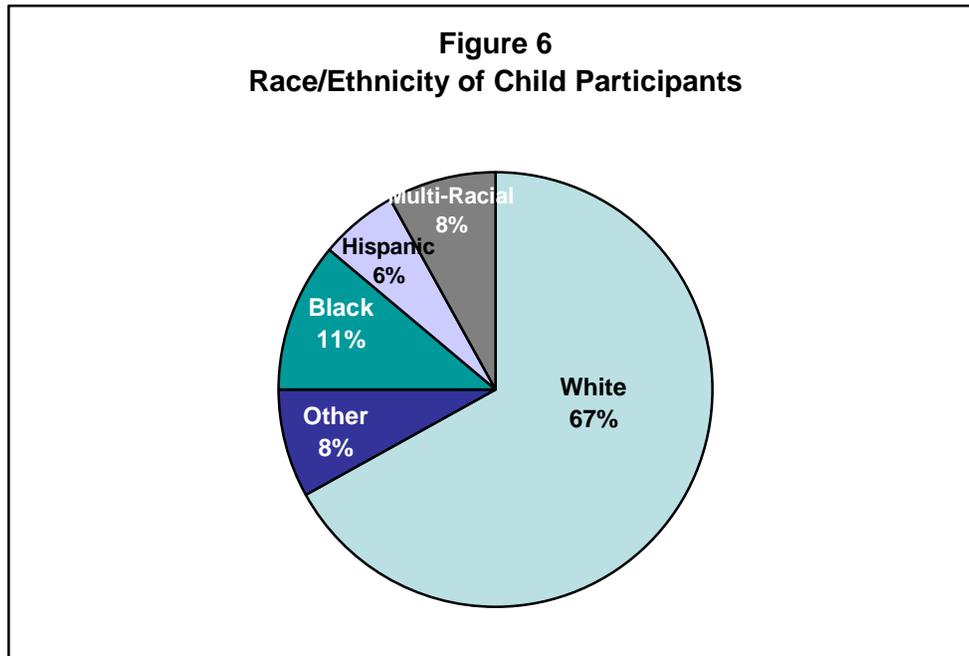
Child Participants and Service Utilization

Description of Children

FRCs offer universal access with an emphasis on target populations with children ages 0-5 years. There were 4,410 child participants who visited the 23 FRCs in 2005. Figure 5 shows that 69% of the children were 5 years or younger and 31% were older than the targeted group. All NYS FRCs serve children ages 0-5 years. However, there were several sites that had a high proportion of children over age 5 – Albany, Elizabethtown, Niagara, and Woodhull. The reasons for this disproportionate high percentage of older children relates to site-specific targeting criteria and associated program offerings. Elizabethtown FRC, for example, targets children with emotional and behavioral challenges up to 18 years and offers youth activities for children ages 6 to 12. Niagara FRC is located in a high school and targets adolescents. Woodhull FRC targets youth 2-18 years through the provision of youth programs and after-school programs for pre-K to 6th grade students.



As displayed in Figure 6, the majority of children who attended FRCs in 2005 were White (67%) reflecting the composition of communities where the sites are located. About 11% of the children who attended were Black, 6% were Hispanic, 8% multi-racial and 8% identified as Other (this includes Asian children who attended the Chinese-American Planning Council FRC in Chinatown).



FRC Services Frequently Used by Child Participants

In 2005, there were 35,373 child visits to FRCs. As displayed in Figure 7 the activity with the most visits was Preschool/Early Childhood Education (12, 928 visits). This activity was attended frequently by children in 5 sites in particular. As shown in Figure 8, preschool/early childhood education was by design the primary service provided to children in the FRCs at Family Place, Lakeside, and Peter Castle, all of which are located in the Rochester area.

There are a few possible reasons why the Preschool/Early Childhood Education service was selected most often. One reason is that these programs are offered daily, unlike other FRC child services, and therefore the total number of visits for each child results in high numbers. Additionally, after we checked with the sites, we discovered that the Preschool/Early Childhood Education category was sometimes recorded incorrectly when children accompanied their parents who attended adult programs. (The item "Child Care" should have been used).

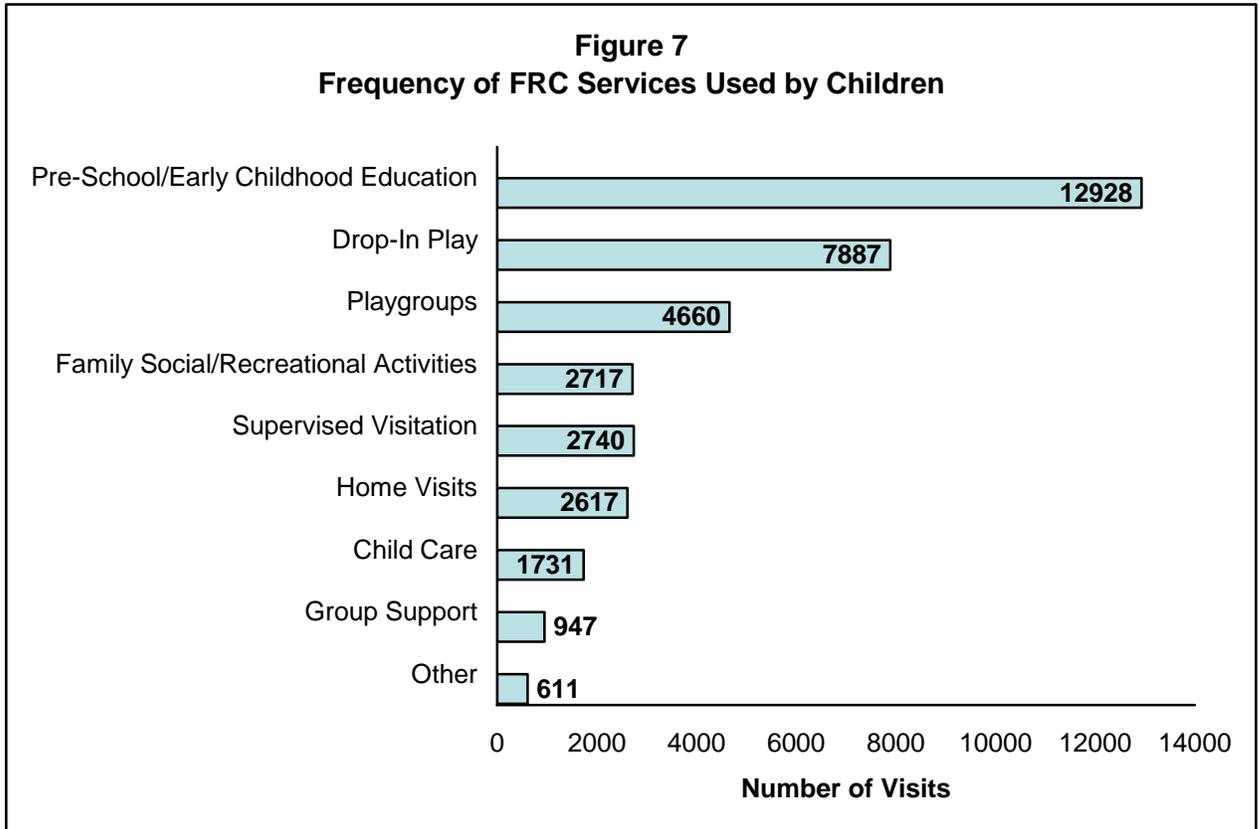


Figure 8

Sites with Preschool / Early Childhood Education

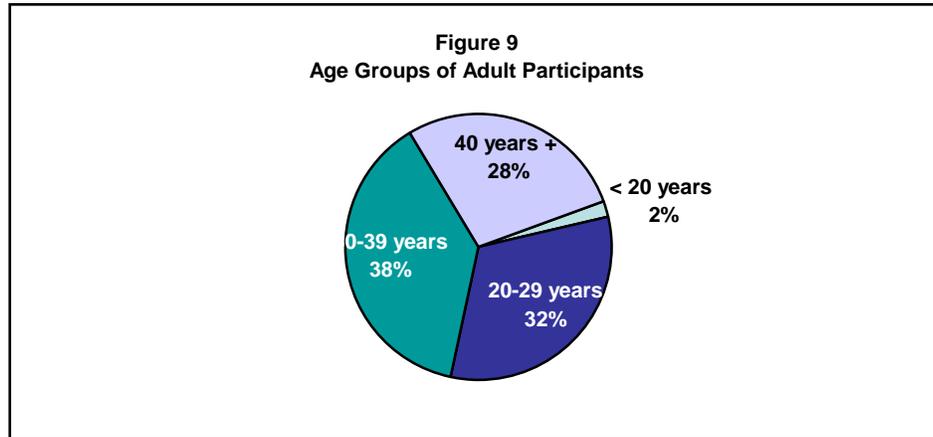
Site	% of All Services
Lakeside	99
FamilyPlace	95
PeterCastle	94
Southwest	74
Geneva	51

After Preschool/Early Childhood Education, the most widely used services by child participants included: drop-in play, playgroups, family/social recreational activities, supervised visitation, home visits, child care and group support. These activities are discussed in more depth in the next section on Adult Participants.

Adult Participants and Service Utilization

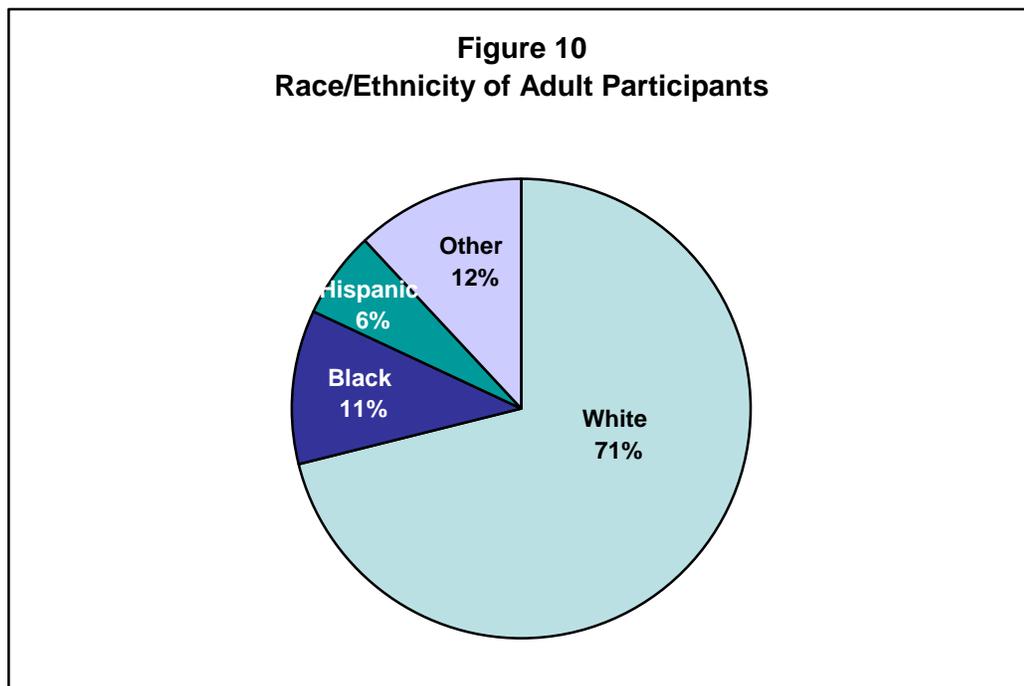
Gender and Age

A total of 3,578 adults participated in FRC services in 2005. Among these participants, 80% were females. As depicted in Figure 9, adults who were most likely to use FRC services aged from 20 to 29 (32%) and 30 to 39 (38%). About 28% were older than 40 years. Teen parents (aged 19 and below) accounted for only 2% of participants.



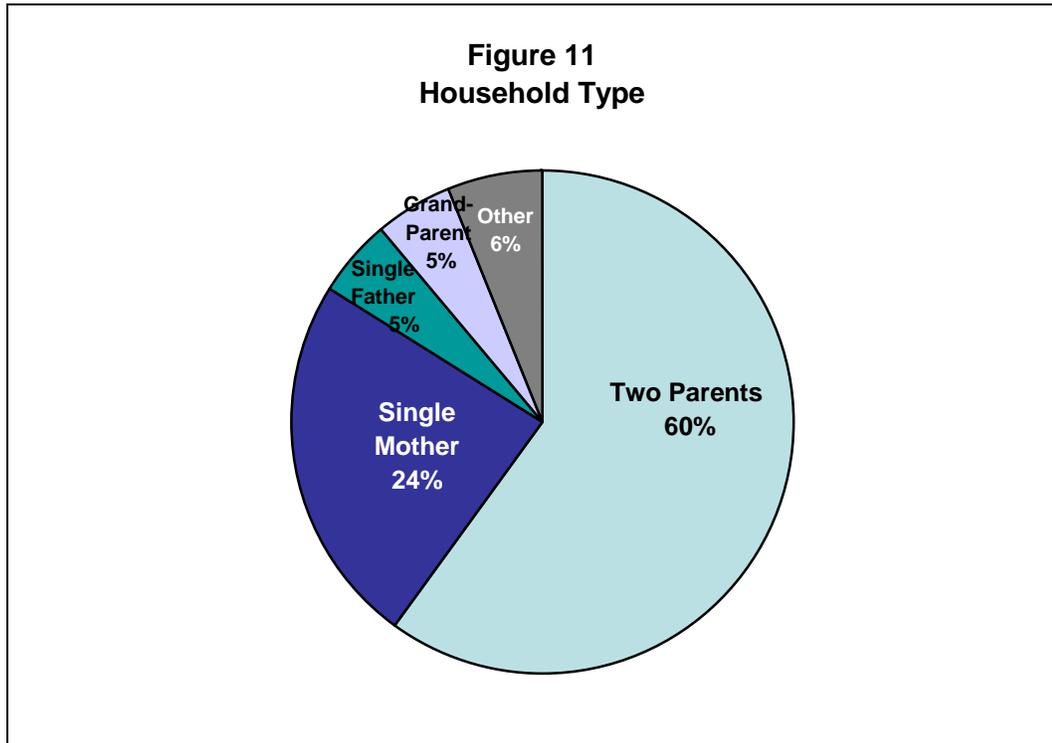
Race/Ethnicity

Among all the adult participants, the majority of participants were White (71%), reflecting the composition of communities where sites are located. 11% were Black, 6% were Hispanic and 12% were in the Other category. (See Figure 10).



Household Type

As shown in Figure 11, most participants identified as two-parent families, which accounted for 60% of all participants. About 29% were single parents (including single mothers and single fathers), 5% were grandparents, and another 5% consisted of other household types.



Education

Within the 3,474 valid cases, 20% of the adults did not finish high school, 30% had a high school degree or GED and 50% had some postsecondary education (30% had some college education and 20% had a Bachelor's Degree or some graduate education). Five sites had a high percentage of adult participants with postsecondary education: Hillcrest (84%), Tupper Lake (78%), Owego (68%), Waverly (67%), and Malone (62%). Three sites had high proportions of adults without a high school degree or GED: Amsterdam (42%), Chinatown (41%), and Albany (40%).

Annual Family Income

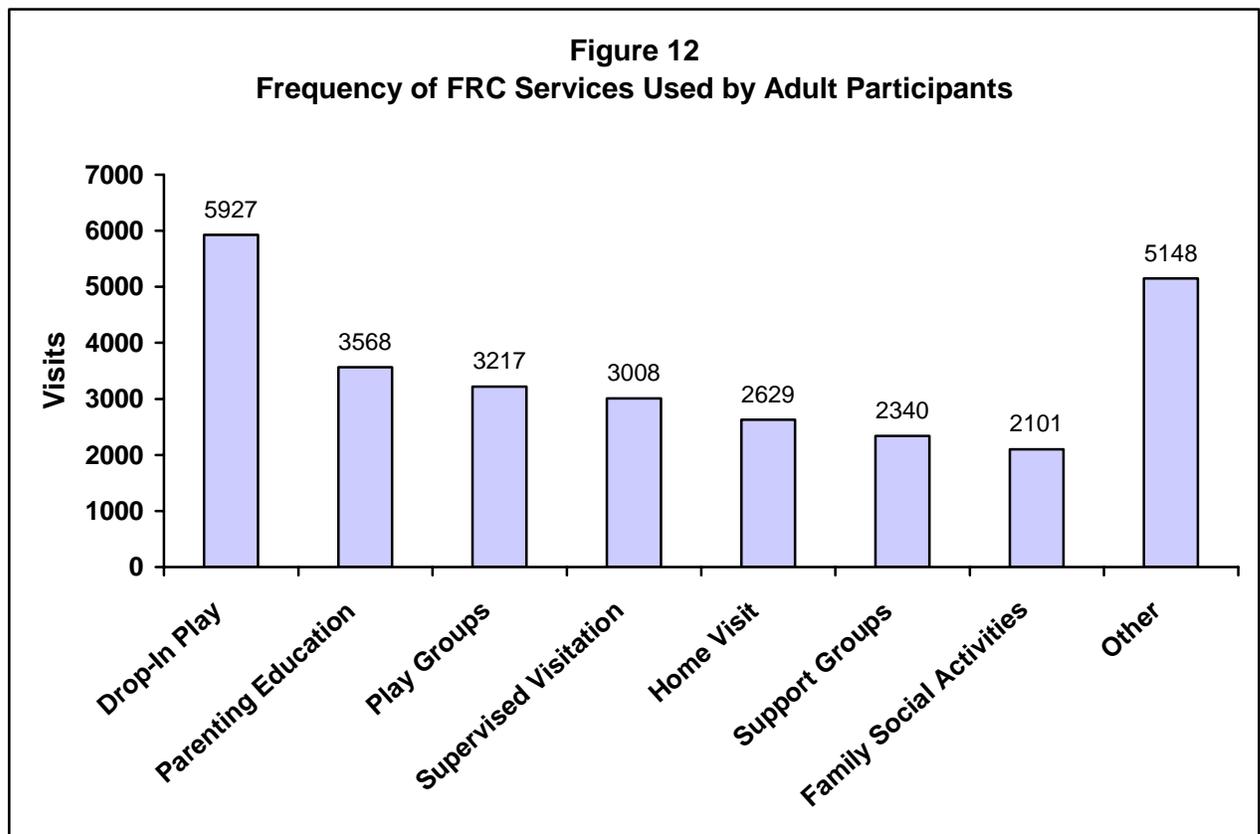
On the Participant Registration Form income was divided among five categories: less than \$10,000, \$10,000-14,999, \$15,000-24,999, \$25,000-34,999, and \$35,000 and above. The lowest income participants and the highest income participants were more likely to register for FRC services than other income groups.

About 30% of the adults belonged to the lowest income group and 26% to the highest income group. More than half the participants at three sites were in the highest

income category: Hillcrest (66%), Waverly (55%), and Owego (54%). These three sites had a disproportionate number of adult participants with postsecondary education as well. Sites that had a majority of participants with family incomes below \$10,000 were Family Place (63%), Niagara (61%), and Peter Castle (58%).

FRC Services Used by Adult Participants

There were 23,458 adult visits to FRCs in 2005. The service utilization pattern by adults closely corresponds to the service utilization patterns of children (see Figure 12). Drop-in play, parenting education, playgroups, supervised visitation, support groups, and family social activities were frequently used among the choice of 20 activities and programs. There were a few activities that had low rates of participation: respite care, job readiness programs, and health programs (see Figure 13 for Program Service Definitions).



⁶See footnote below for description of other

⁶ Other includes: adult education, information and referral, family support counseling, transportation, life skills, ESL, advocacy, basic needs, library, health programs, job readiness, counseling, and respite care.

Figure 13

New York State Children and Family Trust Fund Program Service Definitions	
<p>Information/Referral ... Offer information to families to assist them with accessing other resources and services that are not provided directly by the program.</p> <p>Adult Education ... Conduct classes to teach participants the necessary knowledge and/or skills to participate in higher education or gain employment. Examples include basic literacy, GED, college prep and computer literacy.</p> <p>Job Readiness ... Conduct activities to help participants find employment such as resume writing, interview techniques, job searches, and job coaching.</p> <p>Life Skills Training ... Offer generally structured activities to enhance daily living. Includes coping skills, balancing roles, budgeting, driver's education and nutrition. <i>Instruction is in areas that do not necessitate a parenting role.</i></p> <p>ESL/Citizenship ... Conduct classes to learn English or gain citizenship</p> <hr/> <p>Basic Needs ... Provide food pantries or access to used clothes, household goods, toys, etc., generally on-site.</p> <p>Lending Library ... Loaning books, toys, videos or other educational materials for children and adults.</p> <p>Transportation ... Provide participants transportation to the program and/or transport families/individuals to other needed services or off-site program activities.</p> <hr/> <p>Child Care ... Supervising children while a) caregivers are attending program activities or b) parent requests crisis respite or short-term relief (timeout) from parenting responsibilities.</p> <p>Respite Child Care Services ... Provide caregivers with the opportunity for time away from their children at the caregiver's request (either planned or emergency).</p> <p>Supervised Visitation ... Provide non-custodial parents with opportunities to build relationships with their children in a nurturing and supportive environment.</p> <hr/> <p>Health Programs ... Provide on-site health education programs or services such as vision and hearing screenings, car seat safety, fire safety, dental health, Child Health Plus enrollment, and immunization information.</p> <p>Developmental Screening/Early Intervention ... Provide developmental screening services and/or Early Intervention (DOH) services for young children on-site.</p>	<p>Drop-In Play Time ... Provide access to unstructured free playtime with open hours for caregivers and children together.</p> <p>Playgroups ... Provide generally structured, scheduled, time limited (e.g., 10-11:30) activities for children and their caregivers. Includes arts and crafts, toddler playgroups, "bubbles for baby", etc.</p> <p>Preschool/Early Childhood Education ... Programs that operate preschool programs as part of funded services.</p> <p>Family Social/Recreational Programs ... Facilitate organized family activities that may be focused around holidays (e.g., Mother's Day, Halloween) or sponsoring special events to promote healthy family relationships, opportunities for peer support and community involvement (e.g., picnics, field trips).</p> <p>Parent Education ... Provide instruction relating to the participant's role as a parent and/or caregiver. This is typically curriculum-based; while the program may include providing peer support, the main purpose is to impart information about parenting. Includes breastfeeding class, grandparents group, raising healthy children, father's groups, etc.</p> <hr/> <p>Advocacy ... Provide active intervention or liaison services on behalf of an adult or child to assist them in obtaining a right, benefit or service to address a family related issue such as housing advocacy, legal assistance, social services etc.</p> <p>Family Support Counseling (Not Clinical) ... Offer extended support and resources to individual family or family member to respond to a particular issue, need or concern.</p> <p>Counseling (therapeutic) ... <i>(Subcategories [group or individual] for family, adult and children)</i> Provide intensive scheduled counseling to assist family and/or individual family members (adults or children) with resolving personal or family related issues.</p> <p>Group Support ... Offer groups for adults that are facilitated by staff or participants and are primarily designed to provide social and emotional support rather than information dissemination. Groups can be time-limited, one time only, and/or weekly.</p> <p>Group Support ... Offer groups that are primarily designed to provide social and emotional support for children (e.g., children's group for Parent's Anonymous). Groups can be time-limited, one time only or weekly.</p> <hr/> <p style="text-align: center;">Key: Adults Only Children Only Adults & Children</p>

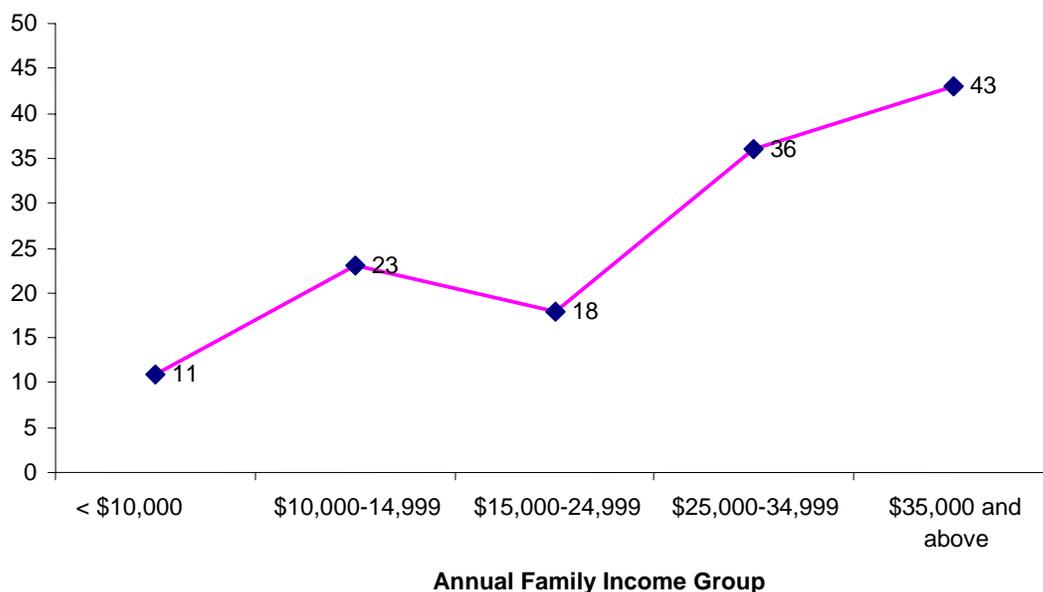
Patterns of Service Use Among Adult Participants

The majority of adults (53%) visited FRCs 1 to 2 times during 2005. About 18% used the services 3 to 5 times, 14% had 6 to 10 visits, and the remaining 16% made more than 10 visits.⁷ The number of visits varied by site. Sites that had high proportions of adults visiting only 1 to 2 times were Elizabethtown (83%), Corning (72%), Binghamton (71%), Chinatown (69%), Geneva (69%) and Malone (68%). On the other hand, there were a few sites that had high proportions of adults participating 6 or more times: Southwest (63%), Lakeside (51%), Tupper Lake (45%), and Gouverneur (45%).

Drop-In Play

Drop-in play provides access to unstructured free playtime with open hours for caregivers and children together. Drop-in play accounted for 26% of all the services provided by FRCs, and it was the most frequently used service by adults. This program was offered by 16 sites. It amounted for more than half of all the services utilized in these sites: Hillcrest (91%), Binghamton (85%), Waverly (71%), Owego (66%), Corning (59%), and Cortland (52%). In terms of family income, Figure 14 suggests that drop-in play was more likely to be used as participants annual family income increased. Regarding household type, drop-in play accounted for about one third of all the services used by two-parent families (31%) and grandparents (37%). It accounted for only 12% of all the services used by single parent families, and 24% of the services used by other household type. Therefore, it can be concluded that drop-in play was more likely to be used by higher income participants and non-single parent household participants.

Figure 14
Utilization of Drop-in Play by Family Income



⁷ The total amount of the percent is more than 100 due to rounding.

Parenting Education Classes

While parenting education occurs both formally (such as through organized classes) and informally (such as through advising a parent who raises a concern), the information system collects data on formal parenting education only. Parenting Education classes provide instruction relating to the participant's role as a parent and/or caregiver and is typically curriculum-based. Parenting Education classes serve both mandated and voluntary participants. Mandated parenting education classes are for parents and/or caregivers who are required to attend by either the Department of Social Services or the Judicial System. Parenting Education class offerings varied across sites. Only two sites did not provide any Parenting Education. However, Parenting Education accounted for more than half of all the services used by three sites: Family Place (95%), Peter Castle (74%), and Niagara (58%). These three sites offered mandated Parenting Education, which might have contributed to the high percentage in this category.

A variety of parenting education curricula are used at the sites offering formal parenting classes (see Figure 15). Some are evidence-based that have demonstrated effectiveness through rigorous research studies, others have been studied less rigorously and have demonstrated promising results, and others have not been tested.

Parenting Education classes were much more likely to be attended by the lowest income families: it contributed to 25% of the services used by participants with an annual family income below \$10,000 and no more than 13% for any of the other income groups. As to household type, Parenting Education classes were more likely to be attended by single parent families: it contributed to 24% of all the services used by single parent families, 12% by two-parent families, 7% by grandparents, and 15% by other household types.

Playgroups

Playgroups provide generally structured, scheduled, time-limited activities for children and their caregivers. Among the 23 FRCs, 16 offered playgroups. As a whole, this activity contributed to 14% of the services provided by FRCs. One site (Malone) had a high percentage of playgroups: it accounted for 57% of all the services provided in this site. Like drop-in play, playgroups were more likely to be used by high income and two-parent families. It contributed to 22% of the services used by the highest income group. However, for any of the other income groups, playgroups accounted for no more than 14% of the services. In relation to household type, playgroups accounted for 18% of all services used by two-parent families, 10% of services used by single parent families, and 5% for both grandparent families and other household types.

Figure 15
Parenting Education Curricula Used by FRCs

FRC Site	Parenting Education Curricula⁸
Addison	Peaceful Parents, Peaceful Children & 5 Essentials of Successful Parenting
Amsterdam	Active Parenting & 1,2,3,4 Magic
Binghamton (Hillcrest)	Discipline Not a Dirty Word
Binghamton (PAL)	S.T.E.P./Discipline Not a Dirty Word
Corning	Active Parenting
Cortland	Parenting Skills (Cornell)
Elizabethtown	Love & Logic
Geneva	Parents As Teachers/Steps into Parenting
Gouverneur	Creating Lasting Family Connections
Malone	Parents Anonymous®
Niagara Falls	Parents As Teachers/S.T.E.P.
Owego	Parenting Skills (Cornell)
Plattsburgh	Parenting with Dignity/Parents Anonymous®
Rochester (Peter Castle)	Incredible Years/Family Talk
Rochester (Southwest)	Parents as Teachers/Family Talk
Tupper Lake	Parents Anonymous®
Woodhull	Active Parenting

Supervised Visitation

Supervised visitation provides non-custodial parents with opportunities to build relationships with their children in a nurturing and supportive environment. Supervised visitation arrangements are made between the FRC site and its local Department of Social Services agency in order for the FRC site to provide supervised visits between non-custodial parents and their children who are involved in the child welfare system. Fourteen of the 23 FRCs provided this service in 2005. As a whole, it contributed to 13%

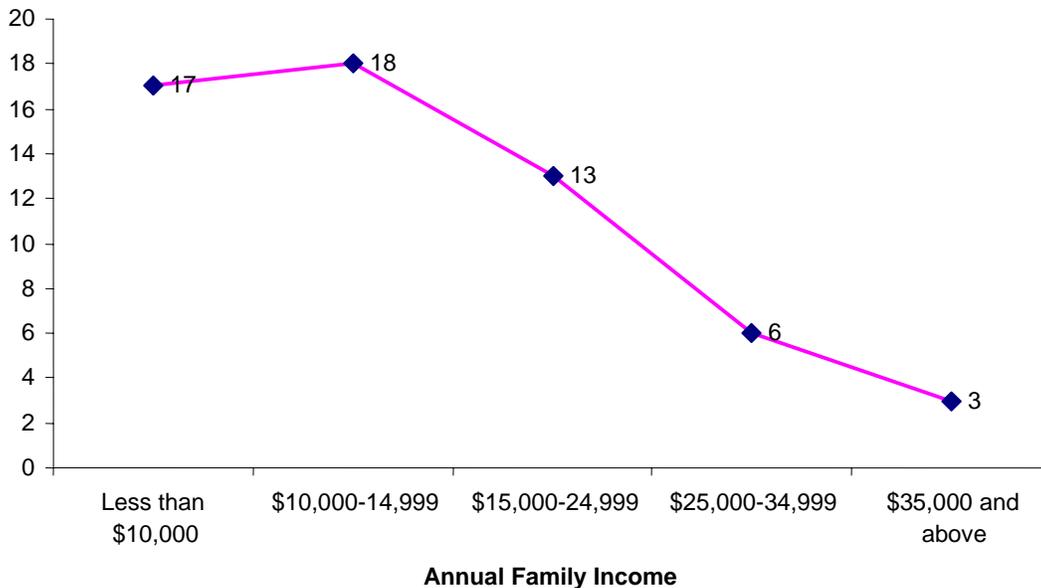
⁸ Sites may use other curricula in combination with these listed

of the services in all FRCs. It was concentrated in a few sites: Geneva (37%), Plattsburg (36%), and Corning (27%). The other sites had a very small proportion utilizing this service or did not offer it. The lowest income group was more likely to use this service: it contributed to 18% of all services used by this income group, and accounted for no more than 14% of services among any of the other income groups. Considering the fact that it is usually the mother who receives custodial rights of the children, it is not surprising that supervised visitation was most often used by single parent fathers: it accounted for 52% of all the services used by single parent fathers. For any of the other household types, supervised visitation contributed to no more than 20% of the total services people used during the year.

Home Visits

In some cases FRCs provide services in the participant's home, particularly as a supplement to parenting education classes. A total of 11 of the 23 FRCs offered this service. As a whole, it contributed to 11% of all services in FRCs. It accounted for 90% and 50% of all services in Bath (Steuben family enrichment collaborative home visiting program) and Southwest, respectively. Home visits were more likely to be used by lower income families, as shown in Figure 16. This service was far more likely to be used by single parent mothers than any other household type: it accounted for 21% of all the services used by single parent mothers, and accounted for no more than 9% of services used by any of the other household type groups.

Figure 16
Utilization of Home Visit Program Services by Family Income



Summary and Conclusions

As a whole, FRCs offered many services that would be expected to influence the intermediate outcome areas identified in the logic model – increasing knowledge of child development and positive parenting, fostering positive parent child interaction, reducing social isolation, and developing parents’ sense of confidence and empowerment in their parenting role. There were a few complimentary services that had lower participation rates: respite care, job readiness programs, and health programs, possibly hindering the achievement of some goals, especially in the area of health where FRCs identified several specific outcomes.

There was an enormous variation among the sites regarding the populations served, the intensity of services, and the program offerings. Not one structured program or activity for the adults or children was consistently noted in the database of all 23 sites. For example, one of the most popular programs for both adults and children, drop-in play, was provided in 16 sites. Some programs like preschool/early childhood education were concentrated in a few sites, although it had a high frequency use.

In regards to the FRC participants, there were differences in both the child participants and adult participants. For example, as a whole, 70% of the children who participated in FRC activities and programs were 5 years old or younger. However, in a few sites, a very high proportion of child participants older than 5 years participated in activities and programs. Further more, more site variation existed in relation to the household type, education, and income of the adult participants and the types of services used. Drop-in play and playgroups were more likely to be used by higher income participants, while home visits and supervised visitation were more likely to be used by lower income participants.

III

Future Direction and Recommendations

Evaluation of Family Resource/Support Centers

Program evaluation remains a major challenge for Family Resource Centers. Increasingly, there is a call for FRCs nationally, as well as within New York State, to provide evidence of program effectiveness. Indeed, FRCs funded under Community-Based Child Abuse Prevention (CBCAP) are being held accountable for two long-term child abuse outcomes: to decrease the rate of first-time victims and to decrease the rate of first-time perpetrators. In addition, CBCAP and NYSOCFS are increasingly promoting the adoption of evidence-based strategies to maximize the use of existing resources in the most effective way. There is widespread acceptance among many social science fields that the use of evidence-based or evidence-informed practices promotes the efficiency and effectiveness of funding as there is an increased chance that the program will produce its desired effect.

A new efficiency measure is being proposed by CBCAP to ascertain progress toward adapting evidence-based practices. Evidence-based and evidence-informed programs are defined along a 5-level continuum ranging from programs and practices lacking support or positive evidence to programs and practices which are well supported. A description of each level's programmatic characteristics and research and evaluation characteristics is included in Appendix A (DHHS, 2006).

While there is increased emphasis on measuring outcomes, there are few studies measuring the effectiveness of FRC programs. Much of the research consists of implementation studies that report on the types and amounts of services provided. Commonly, FRCs measure participant satisfaction with services. Others assess the extent to which the Centers adhere to the guiding principles of family support. The few outcome studies that are conducted have been criticized for lacking group comparisons (either experimental or quasi-experimental), adequate sample size, or measuring "bottom line" outcomes like future abuse or neglect (Chaffin, et al 2001).

Under the work for the federally-funded FRIENDS National Resource Center for the Community- Based Child Abuse Prevention (CBCAP) programs, staff from Chapel Hill Outreach-Training Project (CHTOP) developed *the FRIENDS Guide to Outcome Accountability for Family Support Programs* in April 2001 to help family support programs begin identifying, measuring, and reporting the outcomes of their services (FSA, 2002)

Peer-to-peer efforts to facilitate program evaluation, self-assessment, and program improvement are evident in many states, including California and New York, and virtually every other state has been working to develop peer review processes for their CBCAP networks. Programs are also engaging in participatory evaluations in which program participants play a stronger role in shaping and conducting the evaluation process. In addition, many programs utilize participant satisfaction measures to evaluate program quality. These efforts reflect an increased attention to participant input into program planning and evaluation efforts (FSA, 2002).

Some of the research on FRCs and family support programs has found disappointing results. "Overall, evaluation of parenting education and family support programs have shown modest impacts, at best" (Brunner, 2004). A meta-analysis of evaluation of family support programs commissioned by the federal government indicated very modest program results (Layzer, Goodson, Bernstein, and Price, 2001). In addition to producing inconclusive results, evaluations of family strengthening programs often fail to help programs improve themselves or understand where they are having impacts, and where they are not.

Evaluating New York State Family Resource Centers

Presently, NYSOCFS Family Resource Centers utilize *the FRIENDS Guide to Outcome Accountability for Family Support Programs* (FSA, 2002) to supplement its work to develop measurable targets and milestones for project contracts. NYS uses both a peer review process and participant satisfaction measures to increase participant input into each center's program planning and evaluation.

Beginning in 2000, the NYS Children and Family Trust Fund in partnership with the Family Resource Center Network implemented the program self assessment and peer review process. The goal was to establish best practice and identify lessons learned, in addition to increasing recognition and validation for each Center. The process was developed using both the family support principles, as well as Family Support America's "How Are We Doing?" self-assessment toolkit (NYS, 2005).

The Center for Human Services Research and NYSOCFS has also conducted annual telephone survey interviews with participants from various family resource center sites across New York State. In 2002, Cortland and Geneva FRCs were selected to participate; in 2003, Binghamton, Malone, and Niagara FRCs were selected to participate; in 2004, Amsterdam and Plattsburgh FRCs were selected to participate; and in 2005, Addison and Rochester (Rochester's 2 sites) FRCs were selected. In general, respondents were satisfied with their FRC experience, felt that the FRC had changed their lives in positive ways, and would recommend the FRC to other families. Respondents found that FRCs offered positive socialization opportunities for their children and gave them the opportunity to interact with other parents. The most common reason for respondents not attending the Centers on a more regular basis was due the location of the

FRC and/or the hours of operation which did not coincide with their required weekday work schedule.

A total of seventeen peer reviews have been conducted by review teams across NYS Family Resource Centers. Teams were comprised of FRC Program Coordinators, NYSOCFS staff, other state agency staff, parents, and other members of the community. Following the completion of all peer reviews, recommendations were made for promoting best practice for the NYS Family Resource Centers. Several recommendations from the peer reviews are summarized in Figure 17.

It has been suggested by some researchers that in order to conduct a meaningful outcome evaluation it is necessary to break down FRC programs into its component services (Manalo, et al. 2000). This would allow for the development of clearly articulated long range and short term outcomes linked specifically with program processes. In 2006-2007 CHSR will evaluate one of the FRC component services – formal parenting education for several reasons. The parenting education programs have a formalized structure and occur over a number of sessions, allowing for enough exposure to elicit change. Parenting education programs are designed to prevent child maltreatment or family violence, or to improve family functioning in a more general fashion (Britner & Reppucci, 1997), the major outcome areas identified by NYSOCFS and CBCAP. Parenting education is a core service component and offered by the majority of FRCs (17 NYS FRCs offer parenting education programs). The programs enroll large numbers of participants annually. Because the programs often serve mandated clients from DSS, the study can have broader implications beyond FRCs by gaining an understanding of what are the most effective practices for high-risk clients. Little is known in the field of the effectiveness of parent education programs for high-risk or abusive parents who are court-mandated (DHHS, 2005)

Figure 17
Summary of Several Recommendations from Peer Reviews

- **Exterior Sign/Door:** Use colorful signs to define and identify the Center. Paint the exterior doors of the Center in bright child-friendly colors.
- **Space:** The indoor space should be comfortable for both children and parents and conducive to open group conversation. A private area for more confidential discussions should be available. Each Center should have wheelchair accessibility. The outdoor space should reflect the same welcoming atmosphere as indoors. Picnic tables and park benches are inviting to both parents and children.
- **Outreach:** Promote the unique aspects of the Center which make it stand apart from other services. Locate partners in the community that are interested in collaborating with the Center and make an agreement to share space in the Center for their programs. Create a logo that reflects what the Center does. Dedicate staff time for continued outreach.
- **Marketing Strategies:** Seek parents at locations where they congregate in the community, such as community fairs, schools, churches and other events. Recruit colleges and universities to develop brochures for the Center. Distribute brochures in pediatricians' offices and other community health centers. To promote credibility of the Center, it is important to tell parents and other local agency professionals about the experience and credentials of the staff. Use the internet to create a website with help from local college students. Use community bulletin boards through local cable access television. Host an annual open house as well as contact the local ad council for free advertising.
- **Parent and Volunteer Engagement:** Welcome parents and volunteers with an information packet telling them about the center. Follow-up families' initial participation with the center by follow-up phone calls. Conduct needs assessment with new families. Supply parent information in multi-languages for parents who do not speak English. Extended center hours are very important. By collaborating with other agencies, it makes it possible to stay open in the evenings or weekends without creating the need for additional staff.
- **Childcare:** Playgroups have been very successful at many centers because they incorporate learning for parents and children. Respite care can be exchanged for participation in education workshops and parent group activities.
- **Parent Leadership:** Let parents implement and organize activities and trips. Through skills assessment parents can identify other parents who can take on responsibilities.
- **Diversity:** Invite parents and staff to teach about their culture and customs incorporating learning in support groups, workshops, and classroom activities. Celebrate diversity through posters, bulletin boards, etc.
- **After School Activities:** Create events for the entire family whereby older children are included and encouraged to return. YMCA's and local schools are family oriented places for after school activities.
- **Transportation:** Recruit volunteer drivers from local community service groups. Provide bus passes and tokens (if they are available) and utilize funds from civic groups for taxi service. Learn about opportunities within a walking distance of the center.
- **Documentation:** Create a portfolio of each family's activities in the Center. Maintain comments from parents on each attended activity and keep a record in their portfolio.

Model Programs of National Family Resource/Support Centers

This section discusses some of the model FRC programs from around the country. Some programs were identified in the publication *Emerging Practices in the Prevention of Child Abuse and Neglect*, produced by the US Department of Health and Human Services (DHHS, 2005). There were two categories of programs we chose from this publication that had some relevance to FRCs: “Reported Effective Programs” and “Programs with Noteworthy Aspects.” We also describe a few other innovative programs found in our searches that have program components that could be incorporated by FRCs.

Reported Effective Program

The Families and Centers Empowered Together (FACET), based in Wilmington Delaware, was chosen as a “reported effective” program because it uses quasi-experimental methodologies that have demonstrated credible positive outcomes in the prevention of child abuse and neglect (DHHS, 2005).

FACET is a family support program which seeks to develop and sustain an environment of family support and empowerment within child care centers in high-risk neighborhoods by providing a range of services on site for families whose children are enrolled (DHHS, 2005). The program is based upon the National Parent Services Project (www.parentservices.org) and offers the following components: parent council, family support and family-building activities, parent decision making fund, family lending library, family support services, joint meetings of program sites, training, and consultation.

The FACET program is designed to increase social support and reduce isolation among parents with children, empower parents to become equal partners in the education and care of their children, and to build strength and resiliency of families.

Two preliminary evaluations of FACET have been conducted. The first evaluation used a quasi-experimental pre-and post-design with a comparison group of families from non-FACET child care centers. The other evaluation was a post-only, follow-up study that also included a comparison group of families from non-FACET child care centers (DHHS, 2005).

Although further evaluation studies using more rigorous research are needed to determine the impact of the FACET program, the preliminary findings have been positive. FACET may have increased parenting efficiency and effective decision-making skills. Among families who participated frequently, the intervention increased family cohesion, communication, and coping. (DHHS, 2005). Additional information is being gathered on FACET to inform program development in NYS.

Programs with Noteworthy Aspects

There are several other family support programs in the United States that did not meet the criteria as “effective” due to their methodological design issues, but were recognized by the *Emerging Practices in the Prevention of Child Abuse and Neglect Project* because of interesting and unique program characteristics which may be informative to professionals in the field. Listed below are several programs with noteworthy aspects as well as other programs that have innovative approaches.

Parent's Anonymous® Children's Program

The Parents Anonymous® Children's Program in Claremont, California is a family education and support program which provides a supportive, safe environment for children where they gain positive social skills, improve their problem-solving abilities, and increase their self esteem through activities, while their parents attend the Parents Anonymous Groups. Staff are trained on the nationally standardized Parents Anonymous model. The Parents Anonymous® group model is based on the belief that parents are the most effective agents of their own change. Parents Anonymous principles of shared leadership, mutual support and personal responsibility have contributed to the success of the program (www.strengtheningfamilies.org). Presently, NYS FRCs in Malone, Plattsburgh, and Tupper Lake use the Parents Anonymous® model through the provision of their parenting education programs.

Parent Leadership Program

The Parent Leadership Program in Claremont, California is notable for making parent leadership a priority and building a system for promoting leadership among parents and service providers through innovative training and technical assistance strategies. Parents Anonymous®, Inc. has developed and disseminated best practices for creating and supporting meaningful leadership roles for parents.

Community Based Family Support Collaborative

The Parenting Life Skills Center in Springfield, Missouri established a community-based support program to assist at-risk families referred to the family resource center, called Community-Based Family Support Collaborative: Development, Sustainability, and Family Outcomes. Due to a fragmented patchwork of specialized services, community collaboration and leadership were needed to promote and facilitate service coordination to better serve families.

The University of Missouri-Columbia was contracted by the Children's Trust Fund of Missouri to evaluate this program. An experimental design was used, randomly selecting participants for treatment and control groups. Families who were referred were all voluntary families who had children in their care. No families involved in the program were court mandated or had children placed in care. Families for both groups were

assessed using standardized assessment tools. Treatment families' needs were discussed at large collaborative agency meetings to decide which agency would be the "lead agency" to coordinate an interdisciplinary team of professionals from multiple agencies to render services to the family, as well as provide direct service delivery in its areas of specialty (i.e. mental health agency). In addition to the treatment family's lead agency, a personalized family support team was developed among other agencies who would provide wrap-around services to assist the family to build on their strengths and overcome their challenges.

The control group received resource information and referrals to agencies for further assistance in areas such as housing, education, counseling, medical care, utilities, transportation, parenting skills and support, stress and anger management, or health and nutrition. The control group did not receive the Community-Collaborative lead agency model approach. Both treatment and control groups were followed at 6 month and 12 month intervals.

At the 6 month follow-up, treatment families had significant gains when tested by the measurement tools; however, at the 12 month follow-up, no significant gains were seen. Presently, 6 more agencies are implementing the model and these programs will be evaluated in the future (Missouri, 2005).

Family Development Matrix

The Family Development Matrix Pilot Project is a 36-month family outcomes project funded by the California Department of Social Services, Office of Child Abuse Prevention specifically designed to assist with the partnership implementation of differential response activities between local child welfare and family support agencies. The project goals are to build capacity of FRCs to use an integrated family outcomes tool, the Family Development Matrix (FDM), for client assessment, program and strategic planning for quality improvement and sustainability. The Family Development Matrix is a strengths-based tool designed to measure family progress by tracking outcomes over time (California State University Monterey Bay, 2005).

Wisconsin Retrospective Study

In 2005, Wisconsin adopted the FRIENDS Evaluation Model and expanded the survey instrument to measure protective factors. The Wisconsin Family Resource Centers use an on-line data reporting system allowing each Center to compare Center results to statewide results. A Program Feedback Survey is completed by FRC participants following a six or eight week program (e.g. parenting education or long-term home visiting). Participants complete the survey by answering questions about how they felt prior to the program and how they felt following the program. (www.wctf.state.wi.us)

Recommendations

As stated in *From Neurons to Neighborhoods* (National Research Council, 2000) two profound changes have occurred over the past several decades that have considerable implications for early childhood policy and service delivery. First, scientific gains have resulted in a much deeper appreciation of the importance of early life experiences on the development of the brain and the unfolding of human behavior. Related to this has been evidence of the capacity to influence development outcomes through planned interventions.

Second, there have been a number of dramatic transformations in the social and economic circumstances under which families with young children are living. For instance, (1) there have been marked changes in the nature, schedule, and amount of work engaged in by parents of young children; (2) there have been continuing high levels of economic hardship among families; (3) there have been increases in cultural diversity and the persistence of significant racial and ethnic disparities in health and developmental outcomes; (4) there have been growing numbers of young children spending considerable time in child care settings of highly variable quality, starting in infancy; and (5) there is a greater awareness of negative effects of stress on young children, particularly as a result of serious family problems and adverse community conditions that are detrimental to child well being.

The gains in scientific knowledge coupled with changes in social conditions have occurred since the family support movement was initiated. Family support programs and family resource centers in particular, are operating in a different world and have to continually adapt to meet new challenges and circumstances. These factors form the basis of our recommendations.

1. Target Vulnerable Families

According to the most recent statistics in the *2006 Kids Count Data Book* (www.aecf.org/kidscount/sld/db_press.jsp), national trends in child well-being are no longer improving in the steady way they did in the late 1990s. While there have been some improvements in trends for older children such as decreased teen death rates, birth rates, and high school dropout rates, well being indicators for younger children have worsened since 2000. There were more than 13 million children living in poverty in 2004 – an increase of 1 million over four years. There was an increase in the percentage of low birth weight babies between 2000 and 2003 and increases in the number of children living in families where no parent has full-time, year round employment. Early childhood programs can play an important role in supporting these vulnerable families.

Since FRCs are established to prevent child abuse and neglect and promote healthy child development, it is important to target families who are in greater need for services and are at the highest risk for poorer child outcomes. FRCs may expend effort

inefficiently by targeting far too many parents who will never maltreat their children while failing to provide sufficient focus and intensity for those who are truly at risk.

At a minimum, FRCs should target low income families. Children living in families with less than \$15,000 in annual income are 22 times more likely to be abused or neglected than families with incomes of \$30,000 (Clasp Center for Law and Social Policy, 2003). Approximately 70% to 90% of children who receive child welfare services belong to families receiving cash assistance (Clasp Center for Law and Social Policy, 2003). In addition to living in poverty, there are three risk factors in early childhood that are associated with poor developmental outcomes: residing in a single parent households, residing with a mother who has less than a high school education, and having parents who do not speak English at home (Rand Corporation, 2006).

The economic benefits of early childhood interventions are likely to be greatest for programs that effectively serve targeted, disadvantaged children compared with universal programs or programs that serve more advantaged children. Clearly, there are many FRCs that target very vulnerable families. We recommend that priority be given to recruiting these families and centers located in neighborhoods where the most vulnerable families reside. NYSOCFS Family Resource Center staff can work more intensively with sites that have a high proportion of higher income and better educated families, to implement participant recruitment strategies that target more vulnerable families. More attention should be devoted to recruiting teen parents, a particularly vulnerable group that has been shown to benefit from parenting education efforts. Additionally efforts should be directed toward recruiting families with children 0 to 5 years.

Finally, NYSOCFS may want to direct resources to communities where there are higher numbers of minority families. Presently, about 71% of the participants enrolling in FRCs are White. It is well documented that African American and Hispanic children are disproportionately represented in the child welfare system. For example, 59% of the children living in foster care are children of color, although they represent only 41% of the child population in the United States. (DHHS, 2005). Child maltreatment is more likely to be indicated when families are African American or Hispanic than they are Caucasian and the children of color have slower rates of exit from care. While there are varying explanations about what causes disproportionate representation of children of color in the child welfare system, there is some agreement that families of color have higher social and economic needs and would benefit from family support programs such as Family Resource Centers. Family support programs have an opportunity to provide preventive services to these families to preserve well being and safety and help children remain with their families and in their communities.

2. Reexamine Hours of Operation

In the Peer Review Report and yearly participant telephone survey reports, it has been recommended that Family Resource Centers set their hours of operation in order to better accommodate families' work schedules. It has been suggested Centers collaborate with other community agencies to share available staff for additional hours in the

evenings and weekends. Currently, most children in low income families have parents who are employed full-time and year round. (Koball & Douglas-Hall, 2006). Variable day time hours are not feasible for these families. To reach the families that may need services the most, FRCs should continue to offer and expand their hours to better accommodate family work schedules. (required to be open at least 20 hours a week)

3. Extend Outreach to Subsidized Legally-Exempt Child Care Providers and Child Care Centers

Family, friend, and neighbor care is an increasing form of child care, especially for welfare-to-work families. This is a form of child care offered in a home-based or family-based setting often by unregulated providers who are not formally trained in child care. Approximately 6.5 million kids under the age of 6 spend all or part of their time in a home based or family based setting (www.aecf.org/kidscount/sld/db_press.jsp). Studies have shown that informal care is less stable than licensed care based in centers, and its safety and educational value are largely unknown (Kaufman, 2004).

FRCs can play an important role to support early childhood development by reaching out to home-based child care providers. Indeed, many FRCs already reach out to this community. About 13% of the adult participants indicated that they are child care providers. Children spend many hours with these providers who can benefit from family support programs. Innovative approaches are being developed around the country to strengthen connections between early childhood programs, including legally-exempt care, with parent education programs such as FRCs to reduce the incidence of child maltreatment among vulnerable families (www.cssp.org/uploadFiles/KaganExecSummary.pdf).

The NYSOCFS Bureau of Program Development and the Bureau of Early Childhood Services might consider ways to collaborate to support local cooperative efforts. The local FRCs can partner with local districts to advertise services among the subsidized legally exempt providers.

One of the national models that has been reported as effective is the FACET program in Wilmington Delaware. This program delivers its services in child care centers. This might be a strategy to reach working parents and more vulnerable families if the services are delivered to child care centers located in high risk neighborhoods.

4. Reexamine Program Offerings

It may be time for FRCs to reexamine the variety of service offerings and turn more to evidence-based practice. Knitzer (2006) suggests that family support programs adapt research-informed intensive interventions to help families at higher risk for poor outcomes. While playgroups and drop-in play may be helpful in supporting parents, FRCs may consider adopting other strategies among its core services. Playgroups and drop-in play are also services utilized less frequently by low income families, the most at-risk population.

Furthermore, research suggests that the issue of “dosage,” or the intensity and duration of involvement with families, is crucial for driving the potential for change and improvements in functioning (DHHS, 2004). Particularly for vulnerable populations, there may need to be significant involvement (relatively high dosages) to produce sufficiently meaningful and durable changes. Perhaps more sustained involvement in fewer programs should be considered.

FRCs might consider adapting comprehensive assessments of family needs, such as the Family Development Matrix that was developed by the Institute for Community Collaborative Studies in California.

Finally, NYSOCFS may invest in a few evidence based programs and offer centralized training to offset costs to the Centers

5. Increase Collaboration and Coordination of Services

As stated in the Peer Review Report, it is important to increase collaboration among agencies within the community. There is an increasing movement for agencies to come together recognizing that individuals are dealing with issues that are multidimensional. Many Family Resource Center participants are involved with multiple agencies in the community. It is important to build partnerships among child welfare agencies, early intervention, mental health, substance abuse treatment, and domestic violence services in order provide more efficient services to improve the well-being of families (Knitzer et al., 2006).

6. Develop Staffing Guidelines

NYSOCFS might consider developing staff guidelines which may include standards such as full-time program coordinators for each site, staff with early childhood educational backgrounds, and screenings and background checks on all staff, including volunteers.

Future Steps

There is a wealth of data on participants and services in the FRC database. This report is the first attempt at conducting an analysis. Further analyses by CHSR will provide deeper insight into FRC services. CHSR is in the process of upgrading the FRC Management Information System which will provide better reporting to local sites and NYSOCFS Contract Managers. A more systematic procedure should be developed by CHSR and FRC staff to review site-specific data with NYSOCFS to support program managers’ efforts to provide technical assistance to local programs as needed. This would include examining the characteristics of participants and the range of service offerings. In addition, the analysis of model programs is incomplete. Additional work on model practices should be continued.

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APPENDIX A

Level I – Programs and Practices Lacking Support or Positive Evidence

PROGRAMMATIC CHARACTERISTICS

- The program is not able to articulate a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes.
- The program does not have a book, manual, other available writings, training materials that describe the components of the program.

RESEARCH & EVALUATION CHARACTERISTICS

- Two or more randomized, controlled trials (Rats) have found the practice has not resulted in improved outcomes, when compared to usual care.
- If multiple outcome studies have been conducted, the overall weight of evidence does NOT support the efficacy of the practice.

Level II - Emerging Programs and Practices

PROGRAMMATIC CHARACTERISTICS

- The program can articulate a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes. This may be represented through a program logic model or conceptual framework that depicts the assumptions for the activities that will lead to the desired outcomes.
- The program may have a book, manual, other available writings, training materials, OR may be working on documents that specifies the components of the practice protocol and describes how to administer it.

The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving child abuse prevention or family support services.

RESEARCH & EVALUATION CHARACTERISTICS

- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- Programs and practices may have been evaluated using less rigorous evaluation designs that have with no comparison group, including “pre-post” designs that examine change in individuals from before the program or practice was implemented to afterward, without comparing to an “untreated” group – or an evaluation may be in process with the results not yet available.
- The program is committed to and is actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities.

Level III - Promising Programs and Practices

PROGRAMMATIC CHARACTERISTICS

- The program can articulate a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes. This is represented through presence of a program logic model or conceptual framework that depicts the assumptions for the activities that will lead to the desired outcomes.
- The program may have a book, manual, other available writings, and training materials that specifies the components of the practice protocol and describes how to administer it. The program is able to provide formal or informal support and guidance regarding program model.
- The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving services child abuse prevention or family support services.

RESEARCH & EVALUATION CHARACTERISTICS

- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- At least one study utilizing some form of control or comparison group (e.g., untreated group, placebo group, matched wait list) has established the practice's efficacy over the placebo, or found it to be comparable to or better than an appropriate comparison practice, in reducing risk and increasing protective factors associated with the prevention of abuse or neglect. The evaluation utilized a quasi-experimental study design, involving the comparison of two or more groups that differ based on their receipt of the program or practice. A formal, independent report has been produced which documents the program's positive outcomes.
- The local program is committed to and is actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities. Programs continually examine long-term outcomes and participate in research that would help solidify the outcome findings.
- The local program can demonstrate adherence to model fidelity in program or practice implementation.

Level IV - Supported Programs and Practices*

PROGRAMMATIC CHARACTERISTICS

- The program articulates a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes. This is represented through the presence of a detailed logic model or conceptual framework that depicts the assumptions for the inputs and outputs that lead to the short, intermediate and long-term outcomes.

- The practice has a book, manual, training, or other available writings that specifies the components of the practice protocol and describes how to administer it.
- The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving services child abuse prevention or family support services.

RESEARCH & EVALUATION CHARACTERISTICS

- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The research supporting the efficacy of the program or practice in producing positive outcomes associated with reducing risk and increasing protective factors associated with the prevention of abuse or neglect meets at least one or more of the following criterion:
 - At least two rigorous randomized controlled trials (Rats) in highly controlled settings (e.g., university laboratory) have found the practice to be superior to an appropriate comparison practice. The Rats have been reported in published, peer-reviewed literature.

OR

- At least two between-group design studies using either a matched comparison or regression discontinuity have found the practice to be equivalent to another practice that would qualify as supported or well-supported; or superior to an appropriate comparison practice.
- The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.
- Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.
- If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.
- The program is committed and is actively working on building stronger evidence through ongoing evaluation and continuous quality improvement activities.
- The local program can demonstrate adherence to model fidelity in program implementation.

Level V - Well Supported Programs and Practices*

PROGRAMMATIC CHARACTERISTICS

- The program articulates a theory of change which specifies clearly identified outcomes and describes the activities that are related to those outcomes. This is represented through the presence of a detailed logic model or conceptual framework that depicts the assumptions for the inputs and outputs that lead to the short, intermediate and long-term outcomes.

- The practice has a book, manual, training or other available writings that specify components of the service and describes how to administer it.
- The practice is generally accepted in clinical practice as appropriate for use with children and their parents/caregivers receiving services child abuse prevention or family support services.

RESEARCH & EVALUATION CHARACTERISTICS

- Multiple Site Replication in Usual Practice Settings: At least two rigorous randomized controlled trials (Rat's) or comparable methodology in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. The Rats have been reported in published, peer-reviewed literature.
- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has been shown to have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.
- Outcome measures must be reliable and valid, and administered consistently and accurately across all subjects.
- If multiple outcome studies have been conducted, the overall weight of the evidence supports the effectiveness of the practice.