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Family Services Advocate Program Evaluation, 2017-2018

Dr. Carrie L. Smith

Carrie.Smith@millersville.edu
McComsey Hall 231
717-871-7478

Center for Public Scholarship and Social Change
Huntingdon House
8 S. George Street
P.O. Box 1002
Millersville, PA 17551-0302
Millersville University
717-872-3049
http://www.millersville.edu/ccerp/research.php

INTRODUCTION

In this report, we provide a program evaluation of the effectiveness of Lancaster County's Family Services Advocate (FSA) program. Currently, the FSA program consists of one full-time paid staff member, who is housed at Compass Mark. The FSA is funded by Lancaster County's Behavioral Health and Developmental Services (BH/DS), with additional support from the Lancaster Osteopathic Health Foundation (LOHF). A key job responsibility of the FSA, among others, is to provide access to needed services for children whose parents are presently incarcerated. For this program evaluation, we examine two aspects of the program: contact with clients and ability to provide clients with access to needed services. This program evaluation covers the fiscal year 2017– 2018, which runs from July 1 through June 30.

This report consists of four main sections. First, we report on the demographics of all clients referred to the program. While the FSA program is unable to establish contact with all client referrals, it is important to keep track of referral demographics. Currently, we lack an accurate county-wide picture of children whose parents are presently incarcerated, as well as their backgrounds and needs. Collecting the demographics of all clients referred to the program helps provide some sense of the larger county-wide picture.

Second, we report on the demographics of all clients for whom intake was conducted. This is the third program evaluation we have conducted for the FSA program, but the first that we are conducting on a fiscal year basis. Our hope is that over the next few years, having several comparable years' worth of data for the clients served by this program will allow us to examine the similarities and changes in the client base over time.

Third, we focus specifically on clients for whom intake was conducted and for whom there was a 90-days follow up. Here, we track the effectiveness of the FSA program over the 90 days period to assess whether the clients' needs were met. Finally, we close this report with recommendations and suggestions for improving data collection procedures, as well as the program itself.

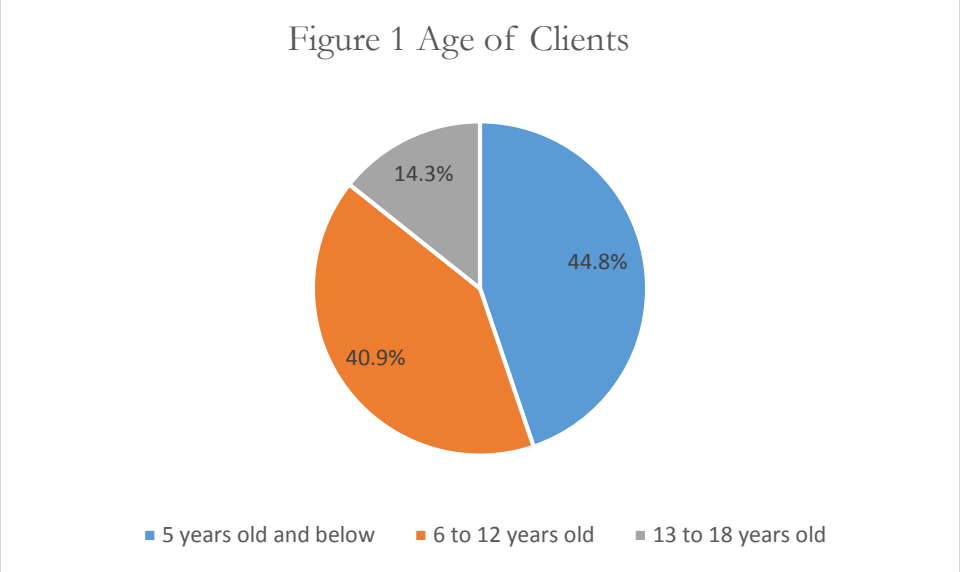
DEMOGRAPHICS OF CLIENTS REFERRED TO THE PROGRAM

In this section, we provide a detailed look at the backgrounds and demographic information for all clients referred to the program. For fiscal year 2017–2018, 217 children were referred to the program.

Clients' Age

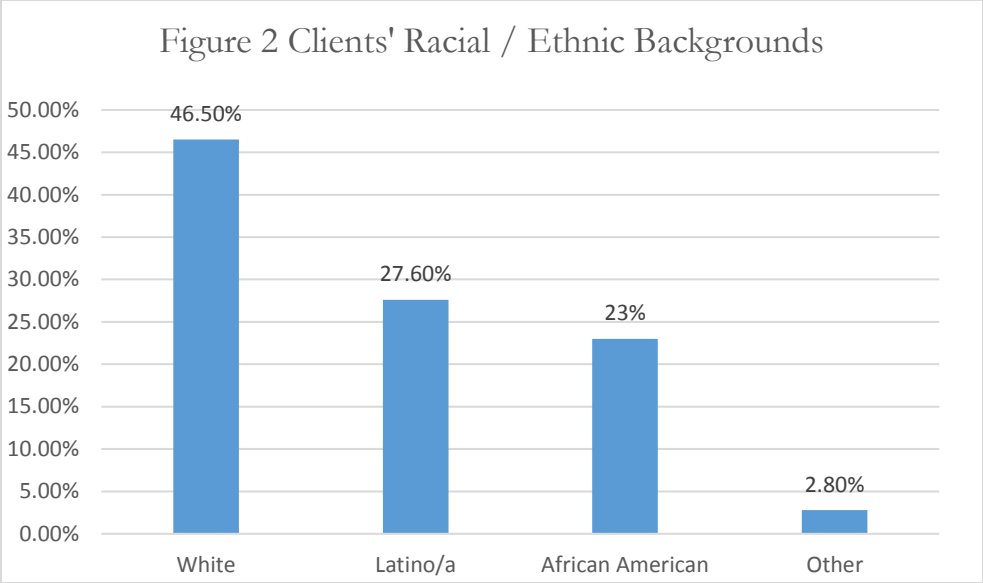
We did not have information on the child's age for seven children. Of the remaining 210 children, 94 (44.8%) were five years old and younger. Eighty-six (40.9%) were between six and 12 years old, while the remaining 30 (14.3%) were between 13 and 18 years old (see Table 1 and Figure 1 on the next page).

Table 1	Age of Children (N=210; information not available for 7 children)	
Age Range	Number of Children (percentage in parentheses)	
5 years old and below	94	(44.8%)
6 to 12 years old	86	(40.9%)
13 to 18 years old	30	(14.3%)
	210	(100%)



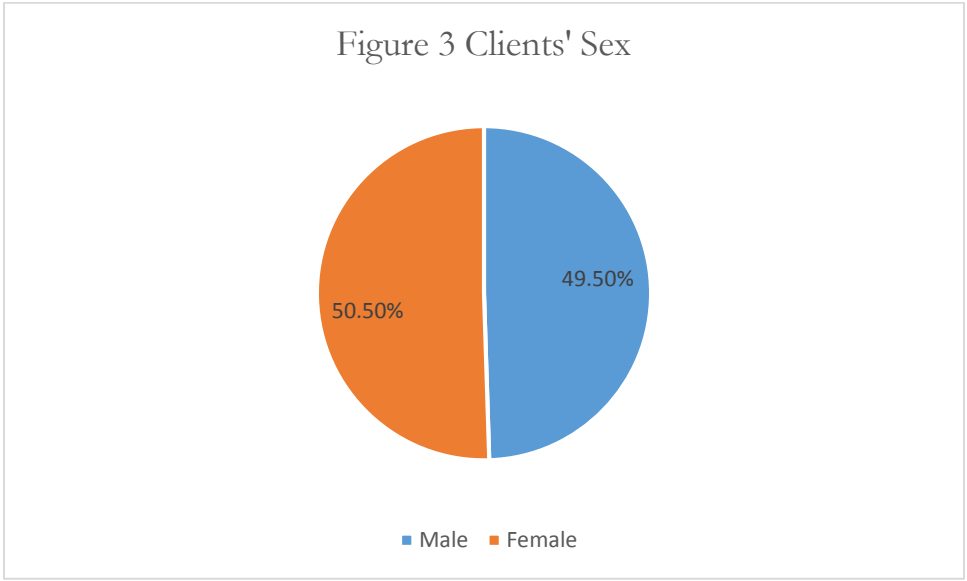
Clients' Racial and Ethnic Backgrounds

Out of the 217 children referred to the program, 101 (46.5%) were white, 60 (27.6%) were Latino/a, and 50 (23.0%) were African American. The remaining six (2.8%) children were of "other" racial and ethnic background (see Figure 2 on the next page).



Clients' Sex

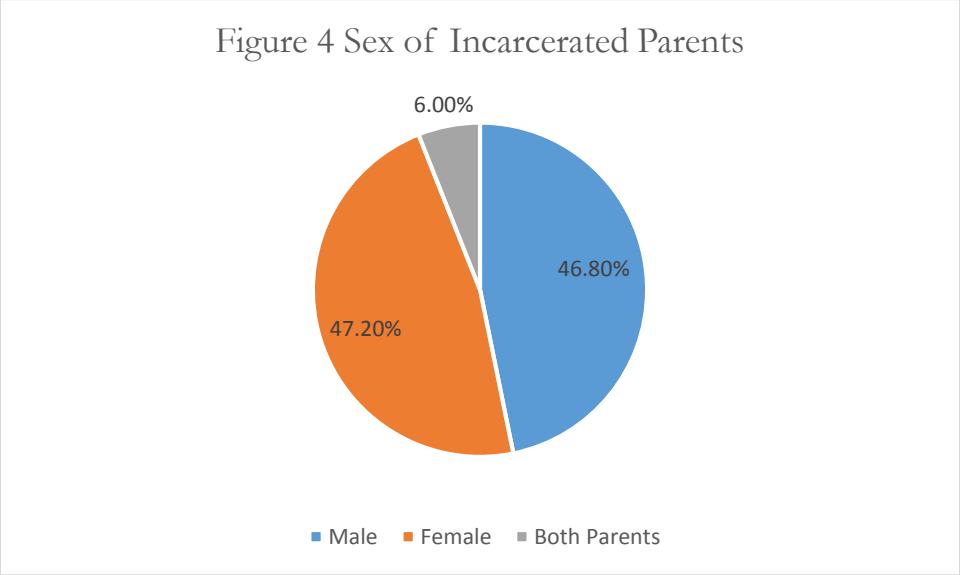
For 2017–2018, we did not have gender information for one child. Of the remaining 209 children, 107 (49.5%) of the children were male and 109 (50.5%) were female (see Figure 3).



Sex of Incarcerated Parent

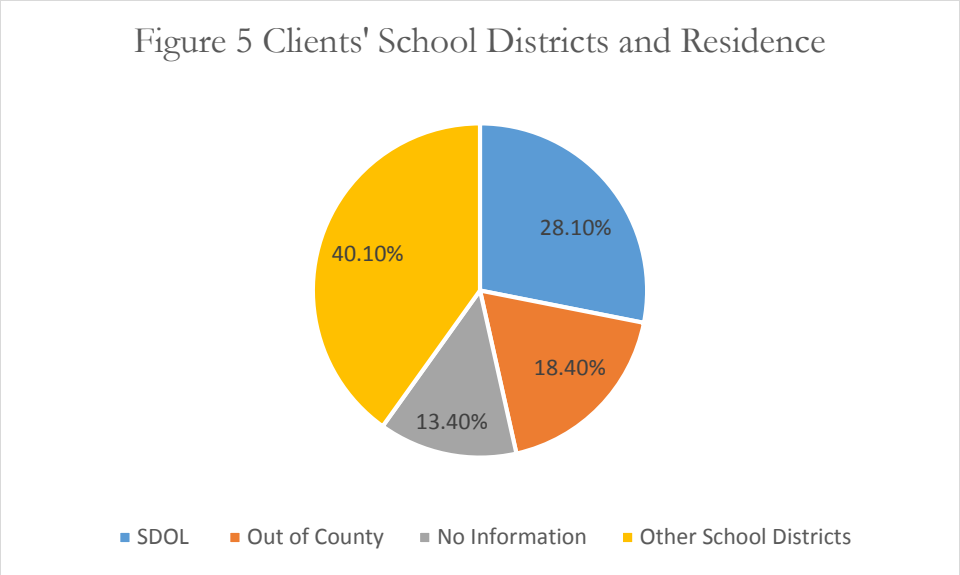
For the sex of the incarcerated parent, we did not have information for one client. Out of the remaining 216 clients, 101 (46.8%) of the children's fathers were incarcerated, 102 (47.2%) of the

children's mothers were incarcerated, and 13 (6.0%) children had both parents incarcerated (see Figure 4 below).



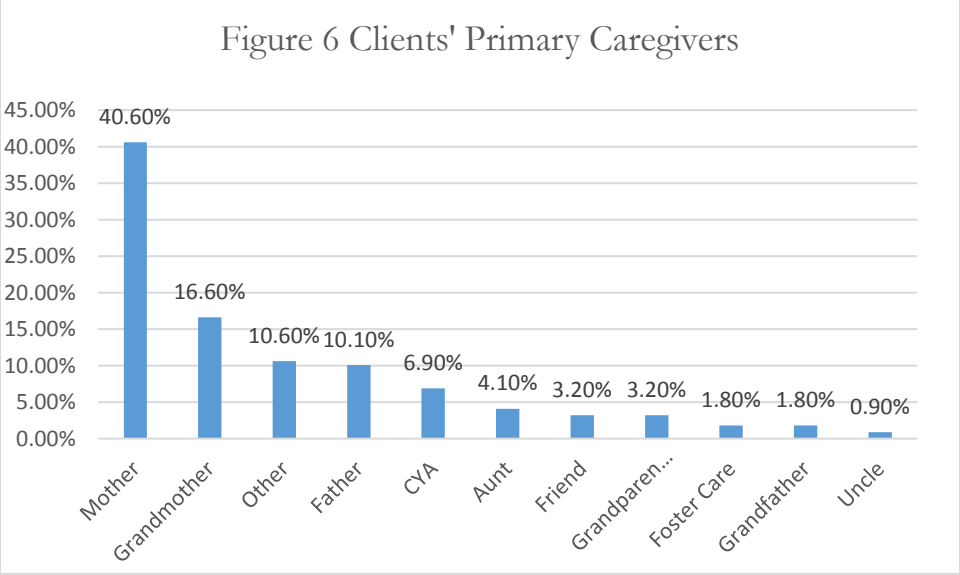
Clients' Residence and Location

Of the 217 children referred to the program, 61 (28.1%) were from the School District of Lancaster. Children also attended the following school districts: Cocalico, Columbia Borough, Conestoga Valley, Donegal, Eastern Lancaster County, Elizabethtown Area, Ephrata, Hempfield, Lampeter-Strasburg, Manheim Central, Manheim Township, Penn Manor, Pequea Valley, Solanco, Warwick, and Twin Valley School District. We did not have school district information for 29 (13.4%) children. Of note, 40 (18.4%) children were attending school outside of the county, but their parent(s) were incarcerated in Lancaster County. As with the previous program evaluation, while a large percentage of the children were from the School District of Lancaster, the phenomenon of children with an incarcerated parent is by no means a "Lancaster City problem." Children with an incarcerated parent lived and attended schools across the county (see Figure 5 on the next page).



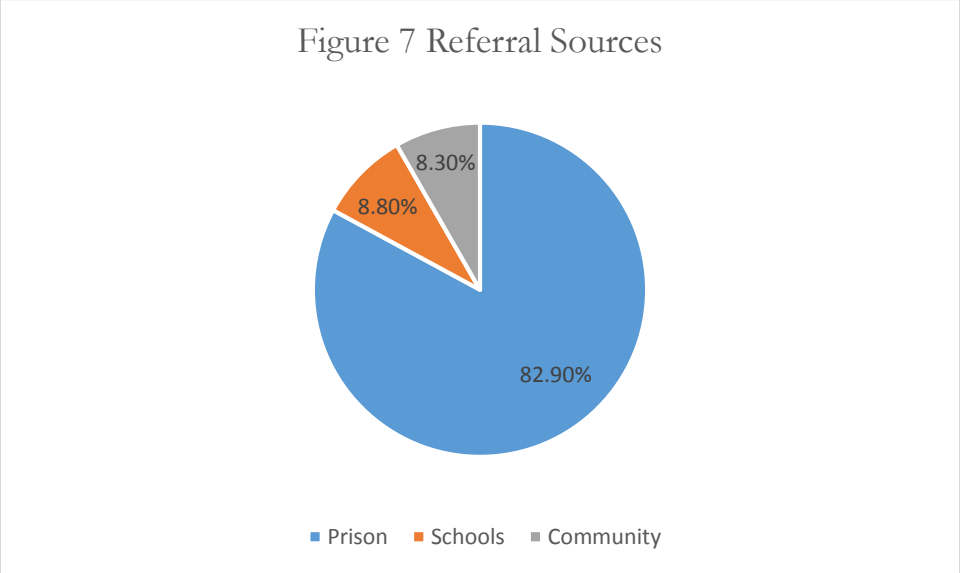
Primary Caretakers

Mothers were the largest category of primary caregivers for the children referred to this program (88; 40.6%), while grandmothers were the second largest category (36; 16.6%). 22 (10.1%) of the children had their father as their primary caregiver. Other primary caregivers also included aunts, uncles, and friends (see Figure 6 below). It should be noted that the majority of primary caregivers are women – mothers and grandmothers make up 57.2% of the primary caregivers for this group of children. While fathers and grandfathers are serving as primary caregivers, the impact of incarceration remains gendered as women are more likely to shoulder the primary responsibility of child rearing.



Program's Referral Sources

For 2017–2018, most of the referrals were made through the FSA's visits to the county prison (180; 82.9%). Nineteen (8.8%) referrals were made through the schools, while 18 (8.3%) referrals were made through the community and community organizations (see Figure 7 below).



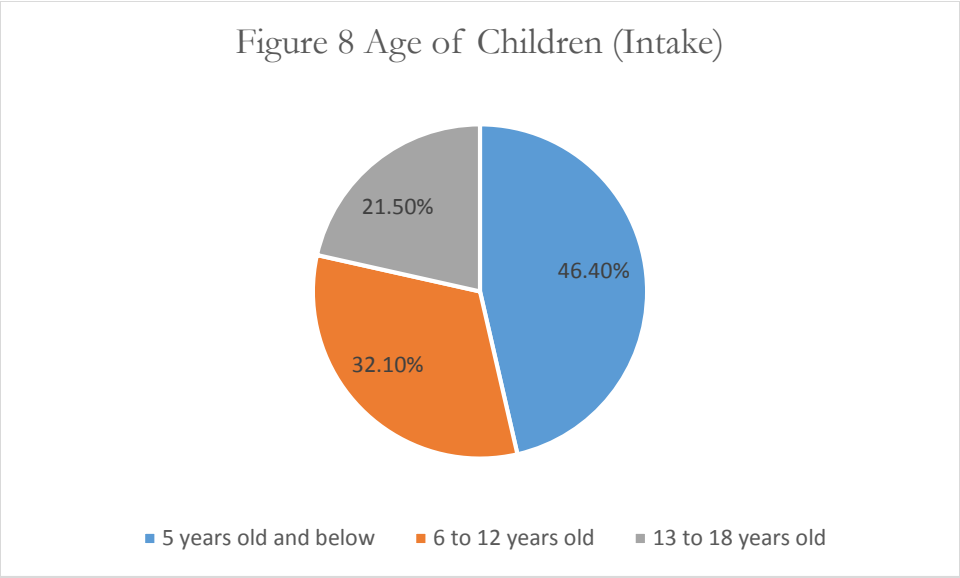
DEMOGRAPHICS OF CLIENTS FOR WHOM INTAKE WAS CONDUCTED

In this section, we provide a detailed look at the backgrounds and demographic information for the clients for whom intake and case management was conducted. It can be difficult to reach clients, and the FSA works diligently to do so. For each referral, the FSA makes three attempts to establish contact. For fiscal year 2017-2018, contact was established, and intake and case management conducted, for 56 (25.8%) of the original 217 clients referred to the program.

Clients' Age

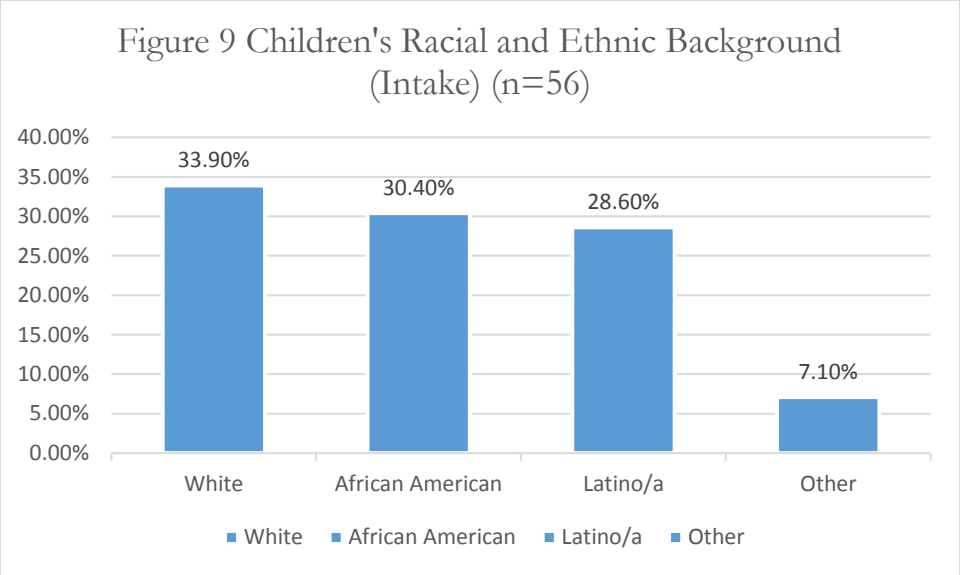
Of these 56 children, 26 (46.4%) were five years old and younger. Eighteen (32.1%) were between six and 12 years old, while the remaining 12 (21.5%) were between 13 and 18 years old (see Table 2 and Figure 8 on the next page).

Table 2	Age of Children (n=56)	
Age Range	Number of Children (percentage in parentheses)	
5 years old and below	26	(46.4%)
6 to 12 years old	18	(32.1%)
13 to 18 years old	12	(21.5%)
	56	(100%)



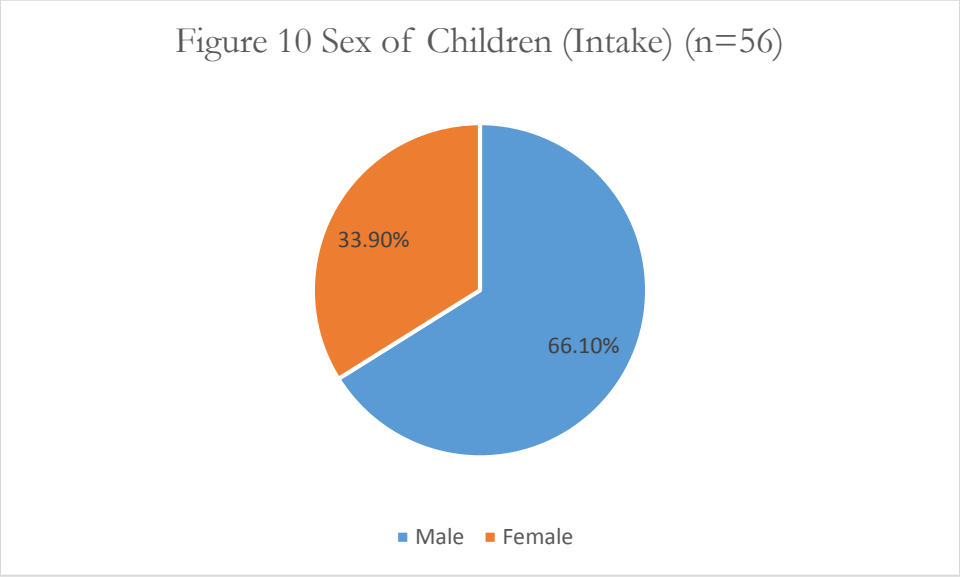
Clients' Racial and Ethnic Backgrounds

Out of the 56 children for whom intake and case management were conducted, 19 (33.9%) were white, 17 (30.4%) were African American, and 16 (28.6%) were Latino/a. The remaining four (7.1%) children were of "other" racial and ethnic background (see Figure 9 on the next page).



Clients' Sex

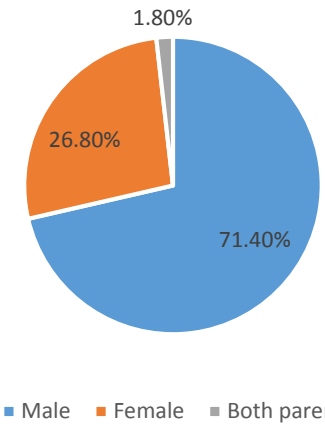
Of the "intake group," 37 (66.1%) of the children were male and 19 (33.9%) were female (see Figure 10 below).



Sex of Incarcerated Parent

For the sex of the incarcerated parent, 40 (71.4%) of the children's fathers were incarcerated, 15 (26.8%) of the children's mothers were incarcerated, and one (1.8%) child had both parents incarcerated (see Figure 11 on the next page).

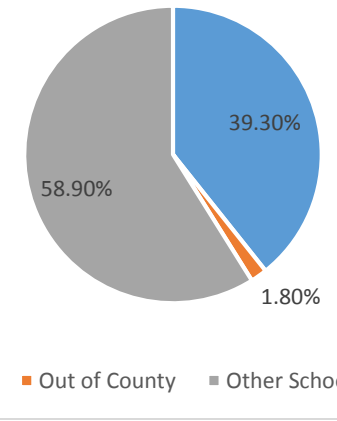
Figure 11 Sex of Incarcerated Parent(s) (Intake) (n=56)



Clients' Residence and Location

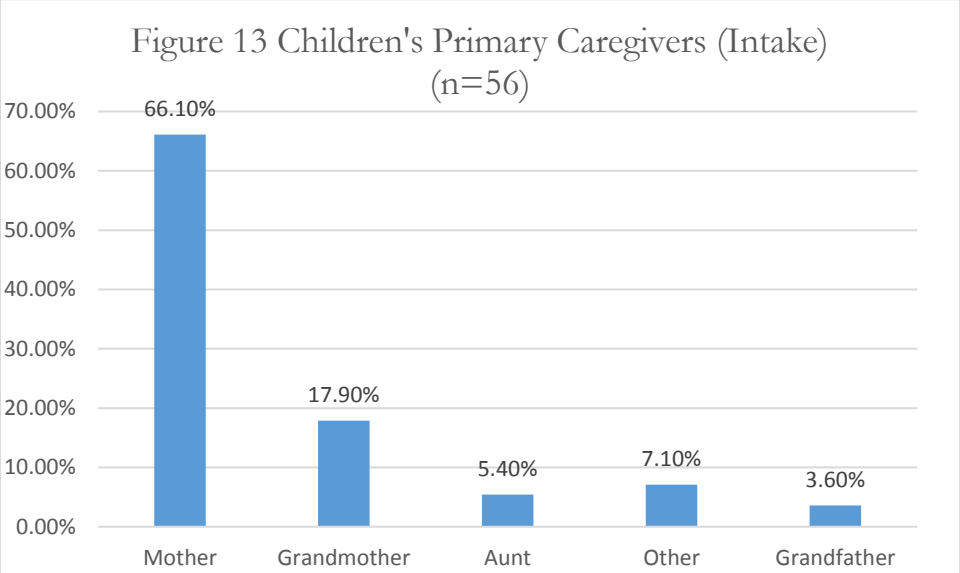
Of the 56 children in the "intake group," 22 (39.3%) were from the School District of Lancaster. Children also attended the following school districts: Columbia Borough, Conestoga Valley, Donegal, Eastern Lancaster County, Ephrata, Hempfield, Manheim Central, Manheim Township, Penn Manor, Pequea Valley, Solanco, and Warwick. As with the referral group, while a large percentage of the children were from the School District of Lancaster, the phenomenon of children with an incarcerated parent is by no means a "Lancaster City problem." Children with an incarcerated parent lived and attended schools across the county (see Figure 12 below).

Figure 12 Clients' School Districts and Residence (Intake) (n=56)



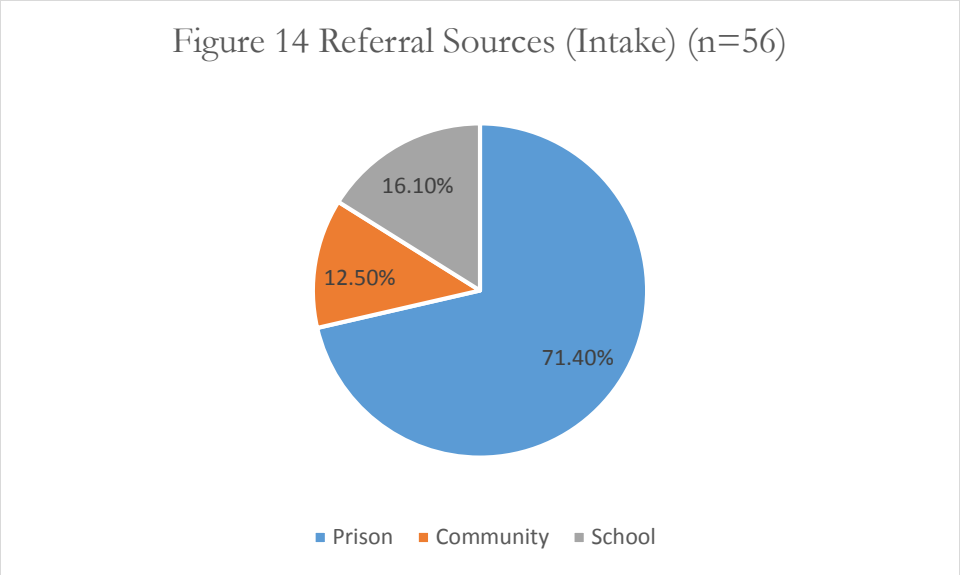
Primary Caretakers

Mothers were the largest category of primary caregivers for the children in the intake group (27; 66.1%), while grandmothers were the second largest category (10; 17.9%). Other primary caregivers included aunts, grandfathers, and others (see Figure 13 below).



Program's Referral Sources

Finally, in terms of referral sources, the majority of the children in the intake group were referred through the FSA's visits to the prison (40; 71.4%). Nine (16.1%) of the children were referred through the schools, while seven (12.5%) were referred through the community and community organizations (see Figure 14 on the next page).



Comparisons Between All Referrals and Clients for Whom Intake Was Conducted

We see some interesting differences in age between the overall referral group and clients for whom intake was conducted. There was a similar percentage of children ages five years old and below in both groups – 44.8% (referral) compared to 46.4% (intake). However, the percentage of children aged six to 12 years old differed much more – 40.9% (referral) to 32.1% (intake). Interestingly, the percentage of children aged 13 to 18 years old for whom intake was conducted is higher, compared to the referral group – 21.5% (intake) to 14.3% (referral). Primary caregivers are most likely to begin the intake and case management process for the youngest age group – children who are five years old and younger. This would be an interesting pattern to explore more in-depth. Are there more programs focusing on this age group (e.g., WIC), or are programs better advertised? It also raises the question of whether there might be better ways to initiate intake and case management for children aged six to 12 years old. Perhaps, establishing connections and collaborations with the schools might prove to be an effective way of reaching out to these children and their caregivers.

Compared to the referral group, children who are white were less likely to follow through with the intake and case management process – 46.5% (referral) to 33.9% (intake). In contrast, African Americans were more like to follow through with this process – 23% (referral) to 30.4% (intake), while there was not much difference in the percentages of Latino/as. The major data point here is that the impact of incarceration is clearly shared by all major racial and ethnic groups in Lancaster County. It is also more likely that male children would proceed with the intake and case management process – 49.3% (referral) to 66.10% (intake). Conversely, female children were less likely to proceed with the intake and case management process.

Of note, comparing the referral and intake groups, children whose fathers were incarcerated were far more likely to initiate the intake and case management process – 46.8% (referral) to 71.4% (intake). Children whose mothers were incarcerated were much less likely to do so – 47% (referral)

to 26.8% (intake). Even more than the referral group, overwhelmingly, women serve as the primary caregivers for these children. It is perhaps not surprising that primary caregivers with a familial relationship are more likely to initiate intake and case management for the children in their charge.

EFFECTIVESS OF FSA PROGRAM IN MEETING CLIENTS' NEEDS

Clients' Needs at Intake

One of the main responsibilities of the FSA program is to help children and their primary caregivers access the services they need. To that end, we measure several services that children with incarcerated parents might require. Table 3 (next page) focuses on the intake group of 56 clients and the identified services that they reported needing help accessing. We should note that in the prior two program evaluations, we had measured whether a child needed access to a school advocate. In this program evaluation, we did not measure that need. However, for 2017–2018, we measured whether a child and their primary caregiver needed access to domestic violence services and to parenting classes.

Not surprisingly, a large percentage of children in the intake group requested access to their incarcerated parent (41; 73.2%). Of note, the other service requested by a majority of the children is that of access to food stamps (29; 51.8%). About a third of the children in the intake group requested access to clothing (21; 37.5%) and to food (18; 32.1%), and about a quarter requested access to health insurance, cash assistance, stable housing, and WIC (each at 15; 26.8%).

Interestingly, there did not seem to be as much as a request for access to therapy (11; 19.6%). This is a stark contrast to the previous program evaluation for 2015 and 2016, where 91 out of 176 children (51.7%) requested access to therapy. There also did not appear to be much request for access to domestic violence services (2; 3.6%) and to parenting classes (4; 7.1%). Finally, we should note the extremely high percentage of children in the intake group who have requested access to multiple services (45; 81.8%).

There is a high level of need for basic subsistence needs among this group of children. In particular, there is high demand for food security – as indicated by the percentages of children needing access to food stamps, food, and WIC. The impact of incarceration is widespread and creates immense instability in a child's life. That 81.8% of the children's caregivers in the intake group requests access to multiple services serves as a reminder that our approach to working with children with incarcerated parents must be holistic and take into account all aspects of a child's life.

Table 3 Children's Needs Assessments at Intake (2017–2018) (n=56)

Need	Number of Children Whose Caregivers Requested Access to Service (percentage in parentheses)	
Access to incarcerated parent	41	(73.2%)
Access to food stamps	29	(51.8%)
Access to clothing	21	(37.5%)
Access to food	18	(32.1%)
Access to health insurance	15	(26.8%)
Access to cash assistance	15	(26.8%)
Access to stable housing	15	(26.8%)
Access to WIC	15	(26.8%)
Establishment of legal guardianship	13	(23.1%)
Access to therapy	11	(19.6%)
Access to primary care physician	5	(8.9%)
Access to support through CYA	3	(5.4%)
Access to parenting classes	4	(7.1%)
Access to domestic violence services	2	(3.6%)
More than one service requested	45	(81.8%)

Clients' Needs at 90 Days Follow Up

In assessing the program's effectiveness, we focus on the 24 children for whom an intake was conducted, as well as a 90-day follow-up. Our evaluation of the program's effectiveness focuses on the percentage of children whose need for assistance declined at 90 days' assessment. **If the program is effective, the percentage of children who need assistance will be lower at 90 days.** By this indicator, the program has been **highly effective in meeting the needs of the children, as the percentage of children needing assistance in every area decreased at 90 days (see Table 4 on the next page)**.

Table 4 Children's Needs Assessments at Intake and at 90 Days for 2017–2018 (n=24)

(Number of Children Whose Caregivers Requested Access to Service; Percentages in parentheses)

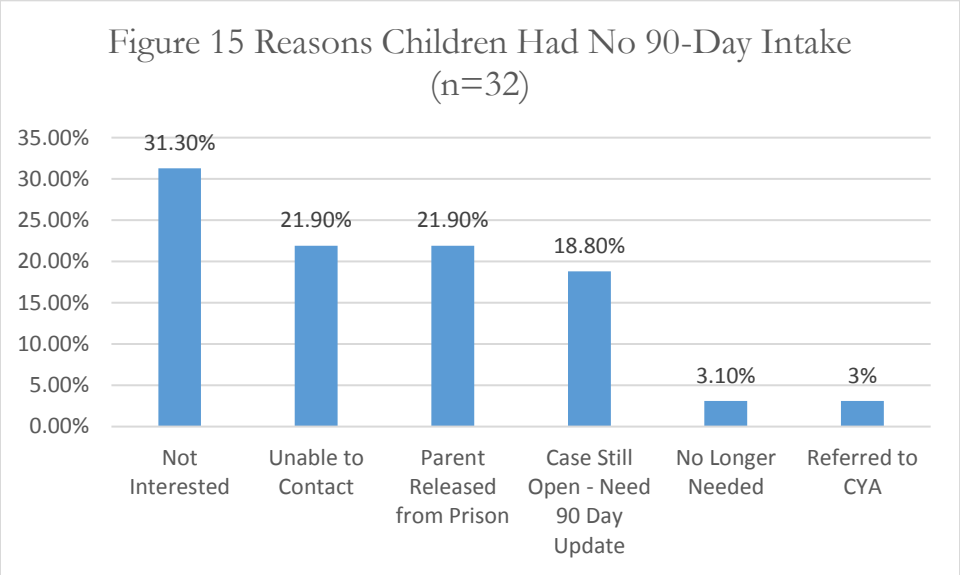
Need	Intake	90 Days	Outcome
Access to incarcerated parent	20 (83.3%)	6 (25.0%)	**IMPROVED**
Access to food stamps	17 (70.8%)	7 (29.2%)	**IMPROVED**
Access to clothing	9 (37.5%)	7 (29.2%)	**IMPROVED**
Access to food	8 (33.3%)	4 (16.7%)	**IMPROVED**
Access to health insurance	9 (37.5%)	5 (20.8%)	**IMPROVED**
Access to cash assistance	9 (37.5%)	7 (29.2%)	**IMPROVED**
Access to stable housing	6 (25.0%)	3 (12.5%)	**IMPROVED**
Access to WIC	9 (37.5%)	3 (12.5%)	**IMPROVED**
Establishment of legal guardianship	9 (37.5%)	8 (33.3%)	**IMPROVED**
Access to therapy	5 (20.8%)	1 (4.2%)	**IMPROVED**
Access to primary care physician	3 (12.5%)	1 (4.2%)	**IMPROVED**
Access to support through CYA	3 (12.5%)	2 (8.3%)	**IMPROVED**
Access to parenting classes	2 (8.3%)	1 (4.2%)	**IMPROVED**
Access to domestic violence services	0 (0%)	0 (0%)	**IMPROVED**
More than one service requested	23 (95.7%)	9 (39.1%)	**IMPROVED**

Of note, the percentage of children whose caregivers requested access to multiple services has improved significantly – declining from 23 (95.7%) to 9 (39.1%). We also see high levels of improvement in helping children gain access to their incarcerated parent (a decline from 20 (83.3%) to 6 (25%)) and to food stamps (a decline from 17 (70.8%) to 7 (29.2%)). While less mathematically impressive, the improvements in providing children with access to food (a decline from 8 (33.3%) to 4 (16.7%)), health insurance (a decline from 9 (37.5%) to 5 (20.8%)), stable housing (a decline from 6 (25%) to 3 (12.5%)), WIC (a decline from 9 (37.5%) to 3 (12.5%)), and therapy (a decline from 5 (20.8%) to 1 (4.2%)) should not be noted as well.

We note two areas where there could be higher levels of improvement: access to clothing and establishment of legal guardianship. While there were improvements for both needs, the improvement is slight – a decline from 9 (37.5%) to 7 (29.2%) for access to clothing, and a decline from nine (37.5%) to eight (33.3%) for establishment of legal guardianship.

Retention in the FSA Program

At 90 days, 24 (42.9%) of the 56 children served at intake maintained contact with the FSA. What happened to the 32 (57.1%) children who had lost contact (see Figure 15 below)?



Of these 32 children, 10 (31.3%) indicated that they were no longer interested in working with the FSA program. The FSA was unable to contact seven (21.9%) of the children (the FSA makes three attempts to contact the client), and seven (21.9%) additional children no longer qualified for the program as their parent had been released from prison. Six (18.8%) children's cases continue to maintain an "open" status, and follow-up is needed. In effect, 13 out of 32 children (40.6%) in the original intake pool did not have a 90-day intake conducted because of a lack of contact. We mentioned in the last program evaluation that there were extraordinary demands placed on the county's sole Family Services Advocate. The data for 2017–2018 once again support our assertion – it is simply not feasible, for one staff member, to have the time to continually attempt to contact the children and their primary caregiver. In addition to the caseload for the current fiscal year, it is important to remember that the FSA also continues to work with clients from previous fiscal years. We continue to recommend that additional resources be provided for the program to assist with contacting referrals, as well as to assist with follow up post-intake.

RECOMMENDATIONS AND FUTURE DIRECTIONS

In addition to more staffing, we offer recommendations that could help fine-tune the program evaluation and provide us with a more detailed look on the needs of children with incarcerated parents in this county. First, a few of the needs assessment measurements should be refined and more clearly defined. We recommend that "access to incarcerated parent" be more refined. There are different ways that a child can continue to maintain contact with their parent, and we should indicate how they are doing so – through visits, letters, and/or phone calls. This would help provide us with a clearer understanding of the efficacy of various ways of maintaining contact with the incarcerated parent. In addition, we recommend that additional information – when possible – should be collected on the specific issues and concerns that the child needs help with in therapy. It has become axiomatic to state that children with incarcerated parents experience severe mental health challenges. However, we know also that these challenges run the gamut, and children could be better served if we could more clearly identify their mental health needs and challenges. A child who has a warm and positive relationship with their incarcerated parent probably has very different mental health challenges than a child who has an estranged relationship with their incarcerated parent.

Second, we would recommend that the FSA once again collect data on whether a child's caregiver has requested access to an advocate in school. School age children spend a large amount of their waking hours in schools, and we need to be cognizant of the additional support and advocacy they can, and should, receive there. Specifically, we need to collect information on the type(s) of advocacy and support that children need in schools. Not only might this help us provide improved services for the children, these are data that we could share with county school faculty and staff. These data could help school faculty and staff to tailor programs and services to better serve the unique needs of children with an incarcerated parent. In addition, we recommend that the FSA make note of the individual schools and community organizations from which she is receiving referrals. This will provide the program with data that will assist in future outreach efforts.

Finally, we are aware that we continue to measure one specific measure of program effectiveness – that of whether children's access to services have been met. While this is an important measure of program effectiveness, it is important to hear from the clients themselves. Ideally, we should collect data from the children themselves – the clients in this program. Several established scales and measurements already exist which aim at assessing children's mental and emotional wellness. We could adopt and/or modify one of these scales and conduct assessments of our clients' mental and emotional well-being. Conducting assessments of children's mental and emotional well-being can be quite problematic – since the children are minors and constitute a "protected population" in terms of research ethics, not to mention that we would be collecting sensitive data. A compromise might be to survey their primary caregiver. We should survey primary caregivers about their experiences in working with the FSA, and their perceptions of the assistance they have received. We should also survey primary caregivers on their perceptions of how the program could better work with them. If possible, we should also investigate the possibility of asking primary caregivers to provide their assessments of their charges' mental and emotional well-being.