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“Evaluation data from 12,000 family cases in California and prevention policy recommendations for family resource agencies and child welfare partners”

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ABSTRACT

The California Child Welfare system is confronting massive change in the way it does business. Child Welfare agencies and their non-profit partners, community-based Family Resource Agencies, have formed public/private partnerships to expand services to families considered at-risk for child abuse and neglect. A statewide assessment study using the Family Development Matrix (FDM) funded by the California Department Social Services, Office of Child Abuse Prevention (OCAP) is built on a family assessment process with 140 Family Resource Centers (FRCs) in 23 county-based collaboratives and tribal communities. The purpose of the policy paper is to describe the early lessons learned from this standardized evaluation model described in the context of California public/private partnerships, with shared family outcomes designed with the foundational principles of strengths-based case management practice. Described is the FRC utilization of shared outcome measures, their protocol for conducting client assessments for early intervention, family directed empowerment planning and the subsequent measurement of family functioning. Evaluated results from 12,000 families demonstrate the impact of community

based, collaborative public/private partnerships and the data suggests policy recommendations for the field of practice.

Key Words: Prevention of child abuse and neglect, family assessment, family engagement, public/private partnerships, outcomes measurement, case management, prevention policy

1.1 Introduction

In the late nineties, the California Department of Social Services invested in building a system of Family Resource Centers (FRC) and in the past ten years they have increasingly emerged throughout the state. The community based FRC serves families in historically under-served, ethnically and culturally diverse communities. Located in urban and rural communities, FRC programs provide an array of interconnected services and interventions with families whose diverse issues require an inter-professional or multidisciplinary set of practices (Stuart Foundation). Based on family strengthening and protective factor goals (Schorr and Marchand, Center for the Study of Social Policy, Strategies), Many of the FRCs in our assessment study are also in public/private partnerships with county child welfare departments to use the Family Development Matrix (FDM), a strength-based model for family assessment, case planning and client outcomes management (Endres, 1999, 2007, 2013).

1.2 Child Welfare Legislation

Recent developments in the field of child welfare in the United States have identified the need to better understand both the processes and outcomes of family engagement in child welfare services. The Adoption and Safe Families Act (ASFA, PL. 105-89) has shortened the timeline child welfare workers have to work toward reunification with the families of children who have been placed in out-of-home care. The Child Welfare Systems Improvement and Accountability Act (California AB636) created a mandate for partnerships between county child welfare systems and local community-based organizations, “This legislation reflects an understanding that public agencies have the mandate and expertise…to address the most vulnerable

populations, with many non-profits having strong community links and the flexibility to try innovative approaches and respond creatively to emerging needs" (Watson). Through a Differential Response referral process FRC resources are employed to assist to keep children safe, improve their family's situation across a holistic set of conditions and prevent their entering the child welfare system (Oppenheim). These partnerships with Child Welfare are expanding as tax supported children and family intervention resources shrink and as effective FRC practices are evidenced. In California,

1.3 Principles of Family Support

The Principles of Family Support, developed by the Family Resource Coalition of America (2003), are widely accepted as foundational for quality services. FRCs community-based nonprofits play two critical roles in their communities: 1) to provide direct services to individuals and families, and 2) to partner with residents and other organizations to build strong communities both through resource development and improved access to healthy living. Family Resource Centers are the most commonly known, though many other types of organizations including child care centers, parent-led organizations, domestic violence response agencies and after-school programs are among others. FRCs provide services across a broad spectrum including prevention efforts to build strong families, early and intermediate intervention to help families overcome existing challenges and enrichment activities to sustain and further improve family well-being. Most serve as a hub of activities designed to improve the lives of the residents of that community. According to the S. H. Cowell Foundation, "FRCs play a unique and pivotal role in bringing together services, resources and opportunities that improve the well-being of low-income children, their families and communities". Centrally located in their communities and meant to be easily accessible to families most in need of support, they are often a place where families come to reduce social isolation and develop supportive relationships both with the family worker and others within the community. A review of family support program evaluations indicates these family support programs can provide critical benefits for families (Dunst, Groark et al., Huebner et al.). Participating in family support programs often brings clear improvements in general family functioning and their support networks (Comer & Fraser; Dagenais, Begin, Bouchard, & Fortin).

1.4 Family Outcomes Evidence

The measurement and reporting of outcomes is required by the Federal Government Performance

and Reporting Act, 1993 (GPRA). Both private and government funders are looking toward outcomes to answer the question: *"What difference did the services delivered to the family make?"* This focus on outcome change represents a shift in thinking from "what we are doing" (process) to "what happened when we provided services" (impact) to "what changes took place with the family while engaged in our program" (outcome), and "how did the program overall and family worker specifically help produce results in the life situation of the family" (Gardner, nd). Most recently, Lisbeth Schorr (2007) from Harvard University warns us to utilize "practice-based evidence" similar to this FDM assessment study, "If government agencies and private grant makers, afraid of being considered not rigorous, unscientific, or wasteful, choose to support only those efforts that meet the randomized-trial test, we will be robbed of good programs that do not lend themselves to random-assignment evaluations, reforms that are deeper and wider than individual programs and innovations of all kinds" (Chorpita, Issacs et.al.).

While a number of definitions of evidence-based practice in the field of social work have been offered, O'Hare's is as straightforward as any. He says that EBP is "the planned use of empirically supported assessment and intervention methods combined with the judicious use of monitory and evaluation strategies for the purposes of improving the psychosocial well being of families." There are, then, three critical components to EBP as practiced by FRCs in the FDM project:

I. *Conducting qualitative assessments accompanied by the use of reliable and valid quantitative assessment instruments that are used for monitoring family progress.* Beginning in 1999 (Endres, Richardson and Sherman), the FDM has undergone reliability and localized validity processes to establish and maintain assessment scoring and data consistency. The current FDM Theory of Change (TOC) defines the building blocks required to reach the long-term outcomes to prevent child abuse and neglect and increase child, family and community wellbeing. The TOC is based on the assumption posited in this paper that families achieve positive outcomes while engaged with FRCs. The TOC is an evaluation descriptor for testing the effectiveness of a case management practice including both family and worker activities, and the relevance of interventions in the pursuit of positive outcome change. The TOC illustrates the systematic approach on how to reach those outcomes. It represents the relationship between the worker and family activities and the interventions with goal motivation that enables movement towards the

outcomes (see appendix). In order to determine the worker activities for case management practice, the project interviewed FDM agency coordinators from the 2006-2008 project. A review of case management/home visiting models (Hawaii Healthy Start, Healthy Families America, FRIENDS) further assisted a validation effort to list worker activity variables. Additionally, family workers were asked to describe what they expected families to contribute to the case management relationship. Many described wanting families to be on time and follow up on referrals. Few had broader expectations for families. Again, the above models were used as a source to expand the list, though at this point in time, the literature is less explicit on the expectations for family behavior than for worker behavior. Thus, our choice is to use the Transtheoretical Model for Change (Prochaska, et. al) as evaluation criteria for family involvement and participation in a change process.

II. *The interventions are specifically tied to the goals from The Pathway to the Prevention of Child Abuse and Neglect (Schorr and Marchand).* Schorr helps to articulate the TOC's long-term outcomes and "makes explicit the links among actions, the context within which actions occur and intended outcomes". While the Pathway interventions are agency focused, in the TOC they are stated to be child, family and community focused. In this way, they are more in line with the referrals and interventions typically used by family support workers and more likely operational in working with families and when reporting on their activities.

The six goal areas are:

1. Children and youth are nurtured, safe and engaged
2. Families are strong and connected
3. Identified families access services and supports
4. Families are free from substance abuse and mental illness
5. Communities are caring and responsive
6. Vulnerable communities have the capacity to respond

III. *Implementing evaluation methods through data collection as part of practice at the individual client and program level.* The FDM project created an extensive database positioning

in sequence an assessment scoring for 20 core indicators, a summary of family strengths and issues of concern to assist the worker and family to make decisions for targeting Pathway or localized interventions and services, creating an empowerment plan, tracking intake and worker activity for case management and the evaluation of interventions and family engagement. Agencies are trained with a standard protocol for assessments, and the local coordinators role is to maintain the quality of data entry.

The assessment model described below meets all three components for the evaluation of family outcomes evidence.

Methods and Objectives

The Family Development Matrix Pathway to Prevent Child Abuse and Neglect project is guided by the principles of family support and specifically designed for family directed assessment and empowerment planning, a measurement of worker activities, family participation and reports for change as measured from a baseline assessment. Another objective is building the capacity of collaborative partnerships to utilize shared outcome measurement indicators. The FDM/Pathway project since 2009 has developed partnerships in 24 counties in California (map located at www.matrixoutcomesmodel.com).

2.1 Partnership with Child Welfare.

The public/private, county-based partnerships support a key Child Welfare Redesign element: shared responsibility across the broader community for the protection and wellbeing of children (California Department of Social Services 2005). Referrals from the county Child Welfare agency along from other community institutions and/or self-referrals enables FRC case managers to implement early interventions as part of the differential response strategy for at-risk families. In our experience these collaborative networks with an active presence by Child Welfare representatives results in more sustainable partnerships.

2.3 Building a Collaborative FDM Team.

The FDM design process with each collaborative is a teambuilding process in itself (Linden). Collaborative partners range from two to fourteen agencies. We engage partners in a "design

team" which has an FDM coordinator for each member agency, and includes a collaborative coordinator who coordinates the work of the design team (Brier-Lawson, K.Lawson, Petersen, Meleville, Pickel). The collaborative is provided with onsite training to develop a child abuse prevention plan that outlines their philosophy and goals, their approach to collaboration, team objectives that address challenges and an action plan to jointly implement the FDM. Each agency showcases their programs and the collaborative prevention plan is posted on the website (www.matrixoutcomesmodel.com). Following is a staff training session for all users of the database. Topics include FDM structure, outcomes, theory of change, working with family strengths, identifying interventions, family directed empowerment planning, tracking case management activities, assessing family participation, protocol for ongoing assessments, and entry into the internet database. Ongoing training and technical assistance is continuously provided.

2.4 Assessment of Shared Outcomes and FDM Data Criterion

The counties assess their families to determine how well they are progressing from a baseline assessment within the first 30 days of agency engagement and continue in quarterly assessments throughout the family's engagement period. The data represents the family situation in each assessment across four status level descriptions. Each indicator status level describes a condition or behavior of family functioning. The family and worker together determine the best fit within the choice of four status levels. The four status levels are:

Safe/Self-Sufficient status level

Indicates that a family is largely able to address its own immediate needs and to plan and act on its future. Long-term maintenance at this level is a goal. In this example, the family is generally secure as a result of its own efforts and has a clear vision of its goals. Motivation comes from within the family and any interventions are to maintain their level of achievement.

Stable status level

The family has begun to plan and use internal resources. This status level is selected when the family is no longer is in danger, and is ready to change as needed to be more secure and safe in the specific indicator area. Planning occurs for the family's future. Supportive services are provided as needed to assist the family in implementing their plans.

At-Risk

The family is secure from immediate disaster and with planning and use of external resources and with initial action the family can continue an upward trend. Continuing intervention and program support provides a platform on which the family can build its plans for improving circumstances.

In-Crisis

Reflects a family in survival mode. Resources are dangerously inadequate and the family does not have the will or the breathing room to plan for the future. Family systems may have collapsed or are in immediate danger of collapse. Strong outside intervention and program resources are often required to move the family to at least the “At-risk” level and higher.

Subsequent assessments are conducted every 3 months providing a snapshot of current family status and progress over time as change from the baseline measures.

2.5 Family Involvement.

Family involvement is essential to determine the relevance of indicators and to insure the measurement language for each indicator is culturally and family relevant. For example, San Francisco along with other regions in California have diverse neighborhood and ethnic cultures and they translated the English language FDM into Chinese, Vietnamese, Spanish and Hmong versions.

Families have a major role during each FDM assessment. Families identify their family situation in a discussion guided by the family worker. The worker leads the family member(s) through an assessment and identification of the family strengths and concerns. The database provides a strength and concerns summary. Together they identify the steps they each will take to move toward family goals using the identified strengths and concerns to target interventions and identify services. Next the Family Empowerment Plan helps to plan activities the worker and the family both follow to meet their individual activities and mutual objectives. The worker’s role is to help to identify interventions (services and resources) supporting the family activities and monitor the empowerment plan. Family engagement is essential to the process of change and a dynamic variable to the FDM evaluation.

2.6 FDM Database.

Each agency is provided with a web connection to the FDM database. While there was initial concern FRC staff might resist computerized data entry, the database receives high marks in evaluations because it went beyond simple assessment to a computer generated family strengths summary and empowerment planning and evaluation. An informed consent and client coding system protects family privacy and assists with retrieving data for reports. The database also facilitates the staff training and provides outcome data reports for the family, agency and collaborative partners. Training and technical assistance is provided for both collaborative and agencies that includes webinars and data downloads.

Results

Policy question 1: What is the role of FDM participating FRCs working with Child Welfare for addressing issues related to the prevention of child abuse and neglect?

This report presents an analysis of cases that were identified as Differential Response (DR) referrals in the FDM database in the August 2008 – February 2013 period. The report gives special emphasis on a comparison of outcomes between clients classified as DR referrals and clients not classified as DR referrals by the family resource centers.

The report is organized as follows. The first section presents an overview of the total number of cases and their demographic characteristics. The second section presents a comparison and overview of outcomes for DR and non-DR cases on the 20 core FDM indicators; the third section presents an analysis of family engagement for DR cases, while the fourth section concludes.

I. DR referrals in the FDM

Between August 2008 and February 2013, 12,050 first assessments were entered in the FDM database. Out of this total number of cases, 4,302 (36%) were classified as DR referrals in all DR paths. (See table 1)

Out of the 4,302 DR cases in the FDM the majority were path 2 (67%) followed by path 1 (20%) and path 3 (13%). (See table 2). Differential Response (DR) is a strategic, three-path approach that provides counties with flexibility in how to respond to reports of abuse and neglect. In DR, a Child Welfare Emergency Response/Hotline social worker (CWS) assesses risk to the child and

then directs the child and family to one of three paths, with higher numbered paths providing services for progressively higher levels of risk to the child.

Path #1: Community Response

- No CWS assessment (assessed out)
- Partner agency engages the family in an assessment of family needs and provides feedback to CWS concerning family participation, per county agreements.

Path #2: Child Welfare Services and Agency Partners Response

- Teamwork approach between CWS and interagency and community partners
- Involves an initial face-to-face assessment by CWS, either alone or with one or more interagency and/or community partner who are enlisted based on the information gathered at screening.

Path #3: Child Welfare Services Response

- Most similar to the child welfare system‘s traditional response
- CWS is responsible for the first face-to-face visit
- CWS initiates a comprehensive family assessment and arranges for any immediate support services needed

The distribution of DR referrals varies by ethnicity. Hispanic families represent 52% of DR cases, and 63% of non-DR cases. On the other hand, White families represented 14% of non-DR cases, and 23 % of DR cases. (See table 4)

II. Family Outcomes: DR vs. non-DR

Table 5 shows a comparison of families rated as “safe” or “self-sufficient” in each of the 20 core indicators for Non-DR and DR families. As the table shows, DR families tend to be (slightly) more likely to be “safe” or “self-sufficient” in the indicators of Child health insurance, Budgeting and Nutrition; but they are less likely to be rated as “safe” or “self-sufficient” in 14 of the other 20 indicators. The largest differences are in the indicators of Risk of emotional or sexual abuse, Family communication skills, Parenting skills, and Presence of (substance) abuse.

Table 6 shows differences in the percentage of families rated as "safe" or "self-sufficient" in each of the 20 core indicators between Non-DR and DR cases for families that have at least 3 assessments in the FDM. DR families tend to have lower percentages of cases starting at "safe" or "self-sufficient" levels, in the majority of the 20 core indicators than non-DR families. However, by the third assessment these differences are reduced in all indicators (with the exception of employment) and become non-statistically significant in all but 8 indicators. For the indicators that showed the biggest difference at the first assessment, (Risk of sexual or emotional abuse) the difference remains in the third assessment, but is greatly reduced (from about 13 percentage points to 5). (See table 6)

With the exception of employment, all the differences in scores between DR and non-DR cases are reduced from 1st to 3rd assessment, suggesting that DR cases improve at a higher rate than non-DR cases. (See table 6)

III. The regression hypothesis

The potential for clients to experience a regression in their scores is possible as they disclosed additional information to their case managers as a result of a more trustful relationship developed over time between client and case manager. With 3 assessments and large number of cases we explored this hypothesis by looking at the percentage of clients that experience a regression in scores going from a "stable" or "self-sufficient" status to an "in crisis" or "at risk" level between assessments. Table 7 presents these distributions by indicator and assessment.

About 4.9% of clients experienced a drop in status (going from a "stable" or "self-sufficient" status to an "in crisis" or "at risk" level) from first to second assessment. This was the largest drop across indicators and assessments. For the rest of the indicators the drops in status are smaller with between 1 and 4 % of clients changing their status downwards. Sensible indicators where families would tend to withhold information such as risk of abuse or substance abuse, the drops in status are pretty consistent across assessments and fairly low (around 2% of cases). Interestingly, this data show that regression in scores is not that common. Further, it does not offer evidence that the regression hypothesis is true at least for the vast majority of cases.

Tables

Table 1: Distribution of First assessment by DR referrals and collaborative (2009-March 2013)

Collaborative *	Non DR (%)	DR (%)	Total Number of First Assessments
Alpine	85.71	14.29	7
Butte	23.3	76.7	176
Del Norte	91.89	8.11	37
Fresno	19.01	80.99	584
Humboldt	64.1	35.9	39
Lake	31.25	68.75	256
Los Angeles	98.57	1.43	906
Madera	11.36	88.64	44
Mendocino	13.04	86.96	23
Orange	58.48	41.52	1,698
Sacramento	83.07	16.93	1,618
San Joaquin	93.71	6.29	1,002
Santa Barbara	77.29	22.71	1,889
Santa Clara	0	100	13
San Francisco	58.56	41.44	1,163
San Luis Obispo	93.33	6.67	165
Smith River	85.71	14.29	14
Stanislaus	41.11	58.89	1,102
Siskiyou	12.7	87.3	126
Tehama	95.51	4.49	245
Tulare	64.43	35.57	149
Ventura	9.72	90.28	648
Yolo	68.52	31.48	108
Yurok	81.58	18.42	38
Total	64.29	35.71	12,050

Table 2: Differential Response clients by path

DR path	Families	%
Path 1	862	20.04
Path 2	2,877	66.88

Path 3	563	13.09
Total	4,302	100

Table 3: Number of children by DR referral

Number of Children	**Non DR (%)**	**DR (%)**	**ALL (%)**
No children	8.21	1.51	5.82
1	28.3	27.75	28.11
2	29.4	30.17	29.68
3	20.16	21.04	20.47
4	8.66	11.13	9.54
5 or more	5.27	8.39	6.38
Total First Assessments	7,748	4,302	12,050

Table 4: Ethnicity by DR referral

Race/Ethnicity	Non DR (%)	DR (%)	ALL (%)
African American	12.67	16.66	14.09
Latino/Hispanic	62.97	51.74	58.96
Asian/Pacific Islander	4.82	3.68	4.42
White	14.26	23.46	17.54
Native American	1.47	1.56	1.5
Mixed/Other	3.8	2.91	3.48
Total First Assessments	7,734	4,293	12,027

Table 5: Percentage of clients that score at “safe” or “self-sufficient” level in the first assessment by indicator and DR referral (all first assessments)

Indicator	Non DR (%)	DR (%)	Difference (DR-Non DR)	
Child health insurance	85.94	89.53	3.59	*
Budgeting	71.24	73.32	2.08	*
Nutrition	94.17	96.24	2.07	*
Employment	48.74	50.57	1.83	
Health services	87.33	87.67	0.34	
Childcare	79.33	78.97	-0.36	
Supervision	97.29	96.28	-1.01	*
Access to transportation	89.66	88.33	-1.33	*
Clothing	78.35	75.31	-3.04	*
Home environment	93.37	90.17	-3.20	*
Stability of home shelter	85.86	82.53	-3.33	*
Support system	76.43	73.06	-3.37	*
Community resources knowledge	64.71	60.52	-4.19	*
Appropriate development	89.63	84.67	-4.96	*
Nurturing	92.9	87.37	-5.53	*
Emotional wellbeing/sense life value	82.39	76.38	-6.01	*
Presence of (substance) abuse	93.26	86.78	-6.48	*
Parenting skills	88.76	80.41	-8.35	*
Family communication skills	83.35	74.09	-9.26	*
Risk of emotional or sexual abuse	89.64	77	-12.64	*

* Difference is statistically significant at the .05 level

Table 6: Percentage of clients that score at "safe" or "self-sufficient" level in first and third assessment by indicator and DR referral (clients with at least 3 assessments)

	1st Assessment			3rd Assessment		
	NON DR	DR	Difference	NON DR	DR	Difference
Risk emotional or sexual abuse	87.65	74.46	-13.20*	96.26	91.38	-4.88*
Family communication skills	81.37	68.61	-12.76*	91.1	84.79	-6.31*
Support system	75.19	65.39	-9.79*	90.52	84.75	-5.77*
Comm. resources knowledge	63.03	54.04	-8.99*	94.63	94.41	-0.23
Nurturing	92.06	83.33	-8.72*	96.77	94.56	-2.21
Emotional wellbeing/life value	80.4	71.69	-8.71*	91.43	87.67	-3.76*
Appropriate development	87.68	79.05	-8.63*	94.29	88.45	-5.84*
Presence of (substance) abuse	94.04	86.07	-7.98*	95.96	92.15	-3.80*
Childcare	80.55	73.48	-7.06*	91.31	90.31	-1
Clothing	76.34	69.28	-7.06*	90.43	89.04	-1.39
Parenting skills	86.29	79.45	-6.84*	93.47	90.45	-3.02
Stability of home shelter	85.1	78.43	-6.67	92.33	86.55	-5.78*
Home environment	93.05	87.16	-5.89*	96.37	95.28	-1.09
Health services	89.25	84.08	-5.17*	94.8	94.85	0.06
Employment	57.88	53.61	-4.27	70.7	61.16	-9.54*
Supervision	97.18	94.48	-2.69*	99.04	97.68	-1.36
Budgeting	70.74	68.09	-2.65	88.05	87.02	-1.02
Access to transportation	90.32	89.44	-0.88	96.45	95.07	-1.38
Nutrition	95.55	95.86	0.31	98.45	98.41	-0.05
Child health insurance	83.61	88.61	5	94.22	96.15	1.92

- Difference is statistically significant at the .05 level

Table 7: Percent of clients going from a "stable" or "self-sufficient" to an "in crisis" or "at risk" status

Indicator	**1st to 2nd (%)**	**2nd to 3rd (%)**	**1st to 3rd (%)**	**N**
Clothing	4.86	2.82	2.82	1028
Family Communication	4.57	3.99	4.09	1028
Budgeting	4.47	3.79	3.50	1028
Employment	3.60	4.69	4.38	639
Emotional WB	3.60	3.70	4.47	1028
Development	3.28	2.65	2.43	945
Support System	3.21	4.18	3.99	1028

Parenting	3.06	1.33	2.45	981
Health	2.63	1.36	1.95	1028
Child Insurance	2.58	1.86	2.27	970
Transportation	2.43	2.04	2.14	1028
Home Environment	2.33	0.97	1.65	1028
Shelter	2.24	3.89	3.79	1028
Abuse	2.14	2.14	2.43	1028
Resource Knowledge	2.04	2.24	1.65	1028
Abuse risk	2.00	2.56	2.45	899
Childcare	2.00	2.66	2.83	601
Nurturing	1.84	1.74	1.74	978
Supervision	0.96	0.43	0.64	936
Nutrition	0.93	0.21	0.52	965

Families come to family resource center agencies looking for specific forms of assistance. Utilizing 20 FDM indicators in assessments, the measures– employment, community resource knowledge, emotional wellbeing and health issues - are most often rated as in-crisis or at-risk, meaning the family situation as represented by this indicator is disintegrating or under continuing threat. Within 6 months, 60% of the families were able to move out of a crisis situation in all of 19 indicators except for employment. The far majority (60-80%) moved to stable and self-sufficient status levels. Family communication, child health insurance, child supervision, and parent emotional wellbeing had the greatest up movement in an economic environment where employment opportunities were in short supply. As an example, 25% of employment scores became worse over time.

Policy question 2: What is the role of FDM family strengthening organizations and increased family engagement?

Families have strengths as well as some issues for concern as measured by the FDM assessment. The family worker discusses the family's positive scores across all indicators (together they average 3.3 in a 4 point scale) and balances these family strengths into an empowerment plan to address issues of concern. The dialogue emphasizes that past success in other indicator(s) areas which represent family based knowledge, skills and abilities useful for addressing current issues of concern. These strengths are imbedded into family-directed goal setting, and an empowerment plan with role clarity and action steps.

IV. Family engagement: DR vs. non-DR

The FDM collects data on family engagement as perceived by the case manager in the FRC using an ordinal measure of how much the family followed the steps it agreed to in the first assessment.

DR Families were less likely to be perceived as "participating fully" (non-DR=66%; DR=54%) and more likely to be perceived as having an "uneven follow through" or "not participating" in the process than non-DR families. This difference remained unaltered regardless of family scores in the 20 core indicators[1]. (See table 8)

DR families were (slightly) less likely to return to a second assessment than non-DR families (non-DR=68%; DR=62%). However, when comparing non-DR families to DR families with similar scores in the 20 indicators, this difference was not statistically significant[1]. This suggests that the difference between the probabilities of having a second assessment between DR and non-DR cases is explained by family baseline scores in the 20 indicators. (See table 9)

Table 8: Worker assessment on family engagement (follow-through with empowerment plan) by DR referral

Level of Follow Through	Non DR (%)	DR (%)	ALL (%)
No action taken by family	6.73	11.9	8.61
Uneven follow through	27.18	34.01	29.67
Full participation by family	66.09	54.09	61.71
First assessments with engagement evaluation	4,727	2,714	7,441

[1] This result was assessed using a propensity score matching algorithm.

Table 9: Percentage of clients receiving a second assessment by DR referral*

Family has a second assessment	Non DR (%)	DR (%)	ALL (%)
No	32.33	37.96	34.42
Yes	67.67	62.04	65.58
Clients with a first assessment more than six months ago	5,876	3,454	9,330

*When controlling for initial scores (using propensity score matching) the difference disappears

Families that initially scored in-crisis or at-risk and were committed to the empowerment plan were more likely to move upward than families that were not as engaged. This finding was statistically significant across 16 indicators leading to the proposition the FDM is a reliable tool for measuring family engagement.

Policy Question 3: What do we know about the capability of family resource centers for evaluating family progress?

The majority of family resource centers using the FDM system have a 501©3 status, are 11 years old or younger, with less than 6 FTE. The FDM assessment component was assessed in terms of its initial goal: to serve as a multi-level (county and agency) information system tool for evaluative and planning purposes as well as increased agency efficiency. For this purpose, the FDM project used a survey questionnaire designed to capture how agency FDM coordinators assessed their own agencies' information systems in three areas:
(1) Their system capabilities for collecting and sharing information within the agency
(2) Their system capabilities to input and retrieve valuable information about families' and workers' activities
(3) Their system capabilities to serve as an information system that allows them to evaluate their work
In summary, the results of our quasi-experimental study show that FDM users increased their scores much higher than comparable agencies in the control group of 12 agencies in each of the three evaluation measures. The greatest positive gains were experienced by agencies that implemented the FDM for the first time and had an entire year to use it. In conclusion, our results show that FDM system increases the perceptions of agency managers in regards to their own information and evaluation systems. Our results also show that time plays a significant role in the

way the FDM increases agency perceptions of effectiveness of their information and evaluation systems. As agencies input data in their systems and are able to track client outcomes, they seem to have increased their positive perceptions of their information systems significantly.

Conclusion

Using a primary and secondary prevention strategy (Kline) a primary goal of the FDM project is to provide family strengthening interventions prior to, and in some cases after, families and children enter the child welfare system. The public/private, county-based partnerships support a key Child Welfare Redesign element: shared responsibility across the broader community for the protection and wellbeing of children (CDSS). Referrals from the county Child Welfare agency along with other community institutions and families own self-referrals, enables FRC case managers to implement early interventions as part of the differential response strategy for at-risk families. In our experience these collaborative networks with an active presence by Child Welfare representatives results in more sustainable partnerships.

Family support programs need to establish collaborative relationships to develop outcome measures that monitor and support their work to ensure potential partners such as funders, evaluators, and assist professional networks to move forward a collaborative vision to measure family functioning. We define collaboration as the ability to work in teams in inter-professional settings across traditional lines of programs, agencies, disciplines and diverse communities to establish common missions and purposes (Stuart Foundation). A primary purpose is to integrate effective client services. Other objectives include increasing limited resources for tracking client outcomes. Organizational support is essential to the design and delivery of integrated services because of the complexity of family and community conditions. (Bruner; Endres; Gardner; Linde; Rosenthal)

The FDM/Pathway theory of change defines the building blocks required to reach the long-term outcomes to prevent child abuse and neglect and increase child, family and community wellbeing. The FDM data from this report demonstrates that families engaged with family resource centers achieve positive outcomes in these variables. The Matrix Outcomes Model provides an empirical tool to evaluate practice in the specific context of the identified unique

needs of the individual client. While interest in the topic of family engagement in child welfare services overall is growing few empirically based FRC practices are designed to evaluate engagement, “Increasingly needed is work that moves beyond seeing engagement as a measurable outcome or factor, and to embrace the underlying complexity of the processes of this important stage of helping” (Altman).

We suggest the FDM has the following strengths:

● Communications among partners has been upgraded into a working partnership building capacity for future collaborations. The Matrix Model is easy to use with shared outcomes across agencies in the same community, agencies in the same community working with the same families agreeing on the common definitions of outcome variables.

● The Matrix provides a great degree of flexibility. Given that the agencies collaborating on the community’s families are the ones who decide what additional variables such as additional indicators (to the core set), and customized interventions fit their geographical and cultural populations.

● The process for standardizing the outcome indicators across participating agencies provides for a quasi-reliability and validity and thus allows cross-agency comparison and analysis of outcome data. The FDM provides FRCs a “practice-base evidence model”.

● The project has increased and strengthened family support agencies’ capacity to assess outcomes and build empowerment relationships based on the strengths of families. Agency staff are trained to assess the current family condition using a consistent protocol and utilization of family based data to discuss the current strengths and areas of concern and develop an empowering case (intervention) plan. This plan is designed to use the stable and self-sufficient indicator knowledge and competencies of the family to improve in-crisis and at-risk level indicators. Improvement in outcomes may well be positively related to this relationship building and the use of this family data communicated by the family worker is then essential.

● Increased accountability and data analysis capability through the use of statewide protocols and the web based data system. The FDM database enables the charting of findings for the family, the aggregate data of worker cases, agency program outcomes and is used to improve program practices and ultimately to report to funders, boards and the community.

We are also mindful of the following limitation of the Matrix Outcomes Model:

● While the orientation to the Matrix Outcomes Model specifically contains a training to maximize consistency in the application of the indicators by multiple users, indicators lack multiple validation and reliability checks and therefore lack generalizablity beyond their respective jurisdictions. Thus, while we support agencies' adopting the mindset of generating their own evidence in support of their practice theories and interventions, no claim is made to achieving the kind of statistically confirmed inter-rater reliability and valid measures typically associated with rigorous research studies. The Matrix Outcomes Model specifically sacrifices that level of rigor for the ease of use that is its hallmark. In keeping with the original EBP philosophy, however, it also provides local practitioners with an additional base of evidence with which to modify their practice choices with the specific population with which they are working.

Bibliography

Altman, J.C. (May 2008). *Engaging families in child welfare services: worker versus client perspectives*. (Report), Child Welfare 87.3, p 41(21)

Brier-Lawson, K., Lawson, H., & Petersen, N. (2001). *From conventional training to empowering design teams for collaboration and systems change.* Working Paper.

Bruner, C. (n.d.) . *A Matter of commitment: From agreed-upon outcomes to results-based accountability.* NCSI Clearinghouse, Des Moines. Iowa.

California Department of Social Services. (2005) *Child welfare system improvements in California: Early implementation of key reforms.*

Center for the Study of Social Policy (2007). *Five Protective Factors*, Strengthening Families.

Chorpita, B. F. (2010, July). *Understanding and implementing effective practices: There must be a better way.* Plenary presentation at Georgetown Training Institutes: New Horizons for Systems of Care: Effective Practice and Performance for Children and Youth with Mental Health Challenges and Their Families, Washington, DC.

Critchfield, B., Custer, M., Huebner, R.A., Jones, B.L., et al. (July 2006). *Comprehensive family services and customer satisfaction outcomes.* Child Welfare Journal.

Dunst, C.J. (Fall 2002). *Mapping the adoption, application, and adherence to family support principles*. Working Strategies. Retrieved from www.familyresourcecenters.net

Dunst, C.J. (1995). *Key characteristics and features of community-based family support programs*. Chicago: Family Resource Coalition.

Endres, J., Richardson, B. & Sherman, J. (1999). *Testing the reliability and validity of the California Matrix*. Publication retrieved from http://hhspp.csumb.edu/community/

Endres, J. & Simmons, B. (2007). *Generating local evidence for practice:* Retrieved from www.matrixoutcomesmodel.com

Endres, J. (2013). *The Family Development Matrix Outcomes Model*, Retrieved from www.matrixoutcomesmodel.com

Family Support of America. (2003). *Standards for prevention programs: Building success through family support.* New Jersey Task Force on Child Abuse and Neglect, New Jersey, Department of Human Services.

Fischer, J. (1973). *Is casework effective?: A review*. Social Work, 18, 5-20.

FRIENDS, (n.d.) *Evidence based and evidence informed programs.* National Resource for Community-based Child Abuse Prevention. Retrieved from http://www.friendsnrc.org/download/eb_prog_direct.pdf

Fuller, T. & Wells, S. J. (2000). *Elements of best practices in family centered services.* School of Social Work, University of Illinois.

Gambrill, E. (1999). *Evidence-based practice: An alternative to authority-based practice.* Families in Society: The Journal of Contemporary Human Services, 80, p. 341-350.

Gambrill, E. (2006.). *Evidence-based practice and policy: Choices ahead.* Research on Social Work Practice, 16, 338-357.

Gambrill, E. (2001). *Social work: An authority-based profession.* Research on Social Work Practice, 11, 166-175.

Gardner, S. (n.d.). *Beyond collaboration to results*, Arizona Prevention Center, ND.

Glasziou, P., Haynes, R.B., Richardson, W.S., & Straus, S.E. (2005). *Evidence-based medicine: How to practice and teach EBM*, *3rd ed.* New York: Churchill Livingstone.

Gockel, A., Harris, B., and Russell, M. (2008). *Recreating family: Parents identify worker-client relationships as paramount in family preservation programs.* Child Welfare Journal, Issue 6.

Haynes, R.B., Richardson, W.S., & Sackett, D.L. (1997). *Evidence-based medicine: How to practice and teach EBM*. New York: Churchill Livingstone.

Isaacs, M. R., Huang, L. N., Hernandez, M., & Echo-Hawk, H. (2005). *The road to evidence: The intersection of evidence-based practices and cultural competence in children's mental health.* Washington D.C.: National Alliance of Multi-Ethnic Behavioral Health Associations

Kellogg, W.K. (1998). *Foundation evaluation handbook.* Retrieved from http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf

Kline, M. & Huff, R. (2007). *Health Promotion in Multicultural Populations, 2nd Ed.* Sage Publishing.

Linden, R. M. (2002). *Working across boundaries.* Jossey-Bass.

Melaville, A. & Blank, M. (1994). *What it takes: Structuring interagency partnerships to connect children and families with comprehensive services,* Education and Human Services Consortium, Washington, D.C.

No author (2007). *Recommendations on preventing entrance into foster care*. California Working Families Policy Summit. Retrieved from www.familyresourcecenters.net

No author (Spring-Summer 1999). *The future of children*. David and Lucile Packard Foundation, 9(1).

Office of Child Abuse Prevention (2000). *Family resource centers: Vehicles for change*. The California Family Resource Center Learning Circle, California Department of Social Services.

O'Hare, T. (2005). *Evidence-based practices for social workers: An interdisciplinary approach*. Chicago: Lyceum.

Oppenheim, S. & Schene, P. (2005). *Choosing the path less traveled: Strengthening California families through differential response.* Policy Brief, Foundation Consortium for California's Children and Youth.

Pickel, B., et. al. (1994). *The collaboration framework,* National Network for Collaboration.

Poulin, J. et al. (2000) *Collaborative social work; Strengths-based generalist practice*: F.E. Peacock Publishers, Inc. Itasca, Illinois. p. 7-9.

Prochaska JO, Norcross JC, DiClemente CC. (1994). Changing for good: the revolutionary

program that explains the six stages of change and teaches you how to free yourself from bad habits. New York: W. Morrow.

Rosenthal, B. & Mizrahi. (1994). *Strategic partnerships: How to create and maintain inter-organizational collaborations and coalitions*, Education Center for Community Organizing at Hunter College School of Social Work.

Schorr, L. B. (2009). *To judge what will best help society's neediest, let's use a broad array of evaluation techniques*. The Chronicle of Philanthropy.

Schorr, L.B. and Marchand, V. (2007) *Pathway to the Prevention of Child Abuse and Neglect*, Harvard University Press.

Strategies (2008). An appreciative inquiry: Reflections from family resource centers in California.

Strategies (Winter 2003). *FRCs/FSPs and the CWS redesign.* Working Strategies, 7(2).

Stuart Foundation, The (2001-03). *Defining the knowledge base for interprofessional education*. Vols. 1-3, San Francisco.

Watson, C. (2000). *Beyond the rhetoric*, Interface Children Family Services. Strategies Region 2.

Wood, K. (1978). *Casework effectiveness: A new look at the research evidence.* Social Work, 23, 437-457.