Interagency Partnerships and The Pathway to Prevent Child Abuse and Neglect Outcomes: A 10 year California Based Collaborative Framework for Prevention and Family Support

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Abstract

"In order to have more evidenced based practice, we need more practice based evidence", Larry W. Green, 2008, California State University Monterey Bay Matrix Conference

This paper describes the development and implementation of the Family Development Matrix Outcomes Model (FDM) in California during 2005-2015. The FDM experience provides a contribution to the discussion on how child welfare services have adapted to an outcomes-based funding model for the expansion of public/private partnerships in service delivery.

The Family Development Matrix (FDM) enhances the community's commitment to supporting at risk families while tracking family support service outcomes. The FDM is both an assessment and early intervention case management tool used to facilitate family participation to engage them to using existing strengths, to apply best practice interventions, and designing a family empowerment plan with family directed goals. This action plan and its results developed with the caseworker and the family is tracked in an internet database to measure the progress of family outcomes, the associated interventions and family engagement.

The purpose is to present the FDM as a family practice model and a public/private partnership with child welfare and community based, family support agencies. From 2005 to 2015 the FDM was implemented in 25 collaborative networks. It builds strong community networks with sustainable community programs that evaluate both the strengthening processes and the needs of at-risk families.
Outcome results are presented for 140 family resource centers throughout the state

of California. The model provides a tool for family support agencies to evaluate the effectiveness of a strength-based approach with researched interventions. Results suggest the importance of practitioners to generate a body of contextually specific evidence to support their choice of evidenced informed family interventions.

Key Words: family resource center, prevention of child abuse and neglect interventions, family assessment, family engagement, family outcomes, public/private family support partnerships, child welfare partnerships, alternative and differential response.

1. Introduction

The purpose of the article is to describe an applied family development model integrated with best practice interventions and delivered to families with child protective service referrals. It does so in the context of the movements for evidence-based practice and family empowerment suggesting the importance and providing the opportunity to generate a body of contextually specific evidence to support early intervention with at-risk families. This article describes core assessment indicators aligned with the researched Pathway to Prevent Child Abuse and Neglect interventions and outcome results for 21,000 families. Approximately 40% are child welfare differential response cases assessed to be at some level of risk for child abuse or neglect and referred by county child welfare agencies to community based family resource centers for family support and early intervention.

The Family Development Matrix (FDM) model is an agency information and support tool providing a strength-based family assessment and case management practice model. The California Department of Social Services, Office of Child Abuse Prevention supported the FDM beginning in 2005 with the goal of broadening and extending public/private partnerships with a variety of county based agencies, including county welfare representatives, in tribal communities, and a variety of family resource centers to develop the use of a prevention outcomes model.

The FDM was the designated family assessment and case management tool for these 25 community collaboratives. During the 2005-2015 period, the FDM provided each county network of agencies with a designated statewide set of family assessment indicators accompanied with a strengths-based case management practice and database capabilities allowing the documentation and analysis of their family outcome data. During the period from 2009-2015, more than 21,000 families in 140 family support agencies received child welfare referrals and provided services with families using the FDM assessment and case management tool. The funding provided an integrated family assessment tool with a standard set of 20 core assessment indicators. Agencies using the FDM had combinations of these program characteristics: they strive to be accessible, accountable for results, collaborative, community based, comprehensive, culturally sensitive, integrated, family focused, prevention focused, school linked, and tailored to individual, family and community needs, and focused on family strengths and outcomes.

During this funding period of 10 years approximately 21,000 families completed a first assessment, 10,000 (48%) a second assessment three months later, 2,800 a third and 1,200 a fourth; families with a total of 47,000 children.

2. Historical Overview

The Family Development Matrix as an assessment tool had its emergence during a period of changes in the field of child welfare and funding regulations at the federal and state levels that required a model focused on the family with an emphasis on measured outcomes and to increase capacity for public/ private partnerships providing services for families across California.

The field of child abuse prevention experienced an increased focus on the family as an integral part of the prevention and reunification efforts during the 80's and 90's. The Adoption Assistance and Child Welfare Act of 1980 was the original federal law that placed family preservation services into child welfare protective services to keep children with their families and to reduce out-of-home placement. Also, the Adoption and Safe Families Act (ASFA, PL. 105-89, 1997) to promote the adoption of children in foster care shortened the timeline child welfare workers had to work toward reunification with the families of children who have been placed in out-of-home care. These shifts in the field gave way to the development of a coalition within the family support field advocating comprehensive services in community agencies serving at-risk families. (Ahsan, N. & Cramer, L., 1989; Bruner, C., nd; Dunst, C.J., 1995; Family Support of America, 2003; Strategies, 2003 & 2008). These agencies were often organized into community-level systems of care of multiple sites that represent a partnership between public and private agencies for family support delivery. (Diehl, D., 2002; Family Support America, 2003; Olasov, L.1994; Wessels, M. 2015). A review of family support program evaluations indicates these family support programs can provide critical benefits for families (Critchfield, 2006; Dunst 1995, 2002; Endres & Simmons, 2007; Endres, 2013; Richardson, B. and Graf, N. 2004).

The increased interest in the family as the focus of prevention efforts was accompanied by changes in funding regulations at the federal and state levels. Most notably the creation of the FDM was influenced by the implementation of Results Oriented Management and Accountability (ROMA, NASCSP) formulas using what has become known as a "scales and ladders" model; and the Government Performance and Results Modernization Act (Office of Management and Budget, 2010) that updated aspects of the Government Performance and Results Act (GPRA, 1993; Brizius, J.A. 1991) requiring state agencies receiving federal funds to utilize outcomes for performance reports.

At the state level, the California Legislature passed the Child Welfare System Improvement and Accountability Act (AB 636, California Department of Social Services, 2005 & 2007). This groundbreaking legislation was designed to improve outcomes for children in the child welfare system while holding county and state agencies accountable for the outcomes achieved. It provided through a Differential Response referral process a role for family resource centers, as a community partner, to help keep children safe, improve their family's situation across a holistic set of conditions and prevent their entering or re-entering the child welfare system (Oppenheim, 2005). Systems of public/private partnerships with child welfare

expanded as tax supported children and family intervention resources began to shrink and as effective family resource center practices are evidenced (California Department of Social Services, 2012; Endres & Simmons, 2007, Endres, J. & Navarro, I. A. (2013). Public funding invested into resource centers increased the need to document their service outcomes and evaluate their programs to comply with funding requirements (Friedman, M., 1995; Gardner, S.; Kellogg, W.K., 1998). 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" (program intervention)? Recognizing the need to build evaluation capacity across family resource centers prompted the California Department of Social Services, Office of Child Abuse Prevention (OCAP) to support the development of assessment tools (California Department of Social Services, 2005). The FDM was chosen by OCAP in 2005 as the preferred tool.

3. The FDM model

The FDM model rests on 5 pillars: the collaborative design teams, the shared assessment indicators, the case management protocol, the empowerment plan, and program support services. Each of them is described in detail below.

3.1. Building a Family Development Matrix Design Team

We use our design teams as the collaborative group. Collaboration can be thought as a process of dealing with problems, issues or opportunities common to two or more individuals, groups or organizations that involves cooperation, coordination, mutually supportive behavior, the development and maintenance of trust and, ultimately, the integration of activity and effort toward mutually agreed upon goals. The collaboration process is characterized by participants jointly developing and agreeing to a common set of goals, sharing responsibility for achieving those goals and utilizing the expertise of each participant in the collaborative. Collaboration is a means to an end. It occurs among people, not institutions, and it is time and process intensive. True collaboration has an "inside", a deeper meaning and is essential for sharing decisions and resources. (Stuart Foundation, 2001; Wessells, 2015) Melaville, A., 1994; Linden, R., 2002; Poulin, J., 2000; Brier-Lawson, 2001; Pickel, 1994; Rosenthal, B., 1994; Kahwaja, M.S., 2014).

Collaborative design teams in each of 25 county locations agreed to core measurement indicators for a shared set of outcomes to deliver program support services with families in their community. An initial step developed a "collaborative prevention philosophy" with their vision, shared values and agency leadership roles for preventing child abuse and neglect. The collaborative prevention plan includes team objectives to address cross-agency collaboration challenges and an action plan

to implement the shared outcome measures (Matrix Outcomes Model).
The public/private community partnership with child welfare is organized around a "collaborative coordinator" who maintains communication and liaison with FDM staff. Each participating agency has an "agency coordinator". These coordinators responsibility are to maintain staff participation through all elements of a shared outcomes design, FDM implementation and evaluation processes. These include: a) selection of family outcome indicators specific to their agencies and agreeing to a core set shared across agencies, b) alignment of Pathway and unique interventions to each of the indicators as a program and resource application, c) maintain a practice protocol and use a shared client coding for data tracking, d) maintain staff training, e) monitor data entry integrity and f) use data reports for program improvement and informing their community. A design process can last from 6 weeks to 3 months and includes staff training for each person who plans to use the FDM for assessment and case management.

3.2 The FDM's Practice Protocol

During the first 30 days of engagement with the agency the family caseworker conducts an assessment of family conditions across the core set of 20 indicators. Assessment forms are utilized in English, Chinese, Spanish, Vietnamese and Hmong languages. With the standard protocol practice the FDM is used by paraprofessionals as well as licensed professionals. They are trained to conduct an assessment with the family member(s). The FDM practice protocol specifically defines the building of a family/worker relationship to conduct assessments using probing questions to stimulate a dialogue across the core set of indicators. Each assessment process includes a conversation with the family; a) to identify the status level within each indicator that best represents their current situation, b) identify family strengths and issues of concern using the computer programmed "visit summary", c) together make decisions for interventions and agency support services, d) create a family–directed empowerment plan that describes both family and worker roles for the next steps moving toward specific goals, e) use the Matrix database to track family and worker activity for case management, and, f) subsequently evaluate family progress for reporting. Second and subsequent assessments are conducted every 3 months for as long as the family is engaged with the agency.

Collaboratives share a written protocol and data entry client codes protecting confidentiality. When this data is entered in the database a "visit summary" of their assessment scores displays in two parts – areas of strengths and the issues for concern based on the scoring differences between in-crisis and at-risk compared to stable and safe/self sufficient scores. Following this strength-based assessment, the agency program services like nurturing parenting, father involvement, trauma therapy, healthy families, and others depending on the family assessment, are selected in consultation with the family's willingness to be engaged. The practice is to discuss what is working well and what may not be working for the family and

where immediate goals are able to use the family's knowledge, skills, and abilities as support in the context of improvement and overcoming challenges. This information is integrated into the family empowerment plan.

3.3 The Family Empowerment Plan

Developed from over 35 years of scientific research on intervention development and empirical studies on empowerment and engagement models the Transtheoretical Model for Change (Prochaska JO, Norcross JC, Di Clemente CC, 1994) forms a basis for principles of the FDM empowerment approach.

It is not easy for a family that is in-crisis or at-risk in their current situation to identify strengths where they have been successful or have coped earlier with difficult situations. The FDM is meant to uncover strengths, issues or challenges and to assist family goal setting and action planning. The following principles are designed to characterize strength-based interview questioning:

- All people possess strengths that can be used as a foundation to improve the quality of their lives.
- Motivation to change is fostered by a consistent emphasis on strengths as best defined by the family.
- Discovering strengths requires a process of cooperative exploration between the family and the worker.
- Focusing on strengths turns attention toward discovering how families have managed to survive even in the most inhospitable environments.

Using a strengths perspective does not negate the very real problems facing a family. When the family sees their situation from a strength-based perspective, they begin to recognize areas in their lives where they have solved problems, made good choices and survived difficult situations. The current "problem" is a part of their life, but not all their life. On an on-going basis, the FDM tool can be used to empower clients by demonstrating the link to concrete goals and outcomes. The "Family Empowerment Plan" outlines family goals for improvement and describes situation awareness, application of strengths including a family's prior experience, knowledge and skills, challenges in their environment requiring problem solving, and the maintenance of achievements. Together in consultation, the caseworker and family identify indicators where improvement is needed. Using the indicators to guide the focus of future goals, the integration of interventions, and local programs and services form the basis for assistance in achieving family-directed goals with mutually agreed upon roles and activities for both family members and the caseworker. This approach is thoroughly described in the protocol and further supported in a report showing "family engagement". In this manner, the caseworker and family determine how well and in what way progress is being made from baseline assessment through each quarterly assessment. Case management processes

were drawn from the evidence base of case management and home visitation (e.g., Hawaii Healthy Start; Healthy Families America; FRIENDS; Fuller, T., 2000; Dunst, C.J., 2002).

3.4 The Core Indicators

At the heart of the FDM are the critical life domains measured as indicators. In 1997 the Institute for Community Collaborative Studies at California State University, Monterey Bay convened a Matrix Design Team (MDT) to address the demands emerging at the time for training and technical assistance, reliability and validity testing and incorporating best practices for family support evaluation. The work of the MDT resulted in the identification of important family functioning domains and within those domains forming scales to comprehensively assess family strengths and needs. From 2005 to 2008 collaboratives piloted the indicators they determined to be best for their practice. Beginning in 2009, all agencies contracted to serve families under the state child welfare agency (OCAP) were required to adopt a set of common indicators (i.e., core indicators). At the time there were more than 100 indicators (many addressing domains beyond child welfare). Through an online survey child welfare agencies and family resource centers using the FDM selected the 20 core indicators to be used as common measures essential for the child welfare service population.

During a family assessment a family's score in each of the indicators responds to a negotiated agreement through discussion between the caseworker and the family. Each indicator has four status levels with definitional statements that describe conditions or behaviors. Through discussion the score that best describes the current family situation of the four status levels is chosen. The four status levels used to facilitate the scoring discussion are provided below. Indicator measurement aligns with a continuum of in-crisis, at-risk, stable and safe/self-sufficient.

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. 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 changing as needed to become 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 and take action 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 is often required to move the family to at least the "At-risk" level and higher.

Examples of core indicators:
BASIC EXPENSES
I need immediate financial help to meet the basic needs of my family.
I do not have enough income or financial assistance to cover expenses.
I know where to receive assistance to help cover expenses.
My income is sufficient to cover my expenses.

COMMUNITY RESOURCES
I have no knowledge or access to community resources that might help my family
I have limited knowledge of community programs I think could be of help to me
I am receiving some community services and would like information about other services.
I have knowledge and access to community resources if needed.

EMPLOYMENT
I do not have any work history or job skills
I have little work experience and few job skills
I have some job skills and work experience
I have a solid work history with strong work skills that I can rely on when searching for employment

Indicator Reliability

Since the creation of the original set of core indicators, intra-rater and inter-rater reliability studies were undertaken using case scenarios with participation of member agencies. The original reliability study conducted in 1999 established a set of highly reliable indicators FDM networks could choose from (1999, Endres, Richardson and Sherman). A second reliability study was conducted in 2014 to assess the reliability of the core set of 20 indicators (Gardner, H.J. 2007; Haynes, 1995; KOKSAL, M.b., 2014; Symeonaki, M., 2015). Inter-rater reliability was performed based on comparison of ratings on indicators scored at the same time across raters (Richardson, 2015). The reliability study used case descriptions that included information on each of the 20 core indicator areas. The descriptions were presented as case scenarios with questions being asked by a worker and family responses. Based on the information available, status levels were chosen by study participants for each indicator. In 2014, a total of 189 caseworkers completed assessments at two times. Participants in the study came from family resource

agencies participating in the FDM project. Agencies arranged for all paid staff (those who use the FDM as well as those that have not) to participate in the study.

Results obtained from the inter-rater reliability study indicated that 19 of 20 indicators achieved high consistency levels of 80% percent or above; 14 indicators obtained agreement at greater than 90%. The *support system* indicator obtained a consistency score of 58% suggesting refinement of the definitions of the categories may be necessary. Rater agreement obtained in the study is presented in table 1.

Table 1: Proportion of raters that agreed on the core indicator's family's status level (inter-rater reliability)

Core Indicator	Proportion of raters agreeing on a status level
1. Access To Transportation	0.87
2. Child Health Insurance	0.88
3. Community Resources Knowledge	0.83
4. Health Services	0.89
5. Budgeting	0.98
6. Clothing	0.90
7. Employment	0.97
8. Child Care	0.99
9. Risk of Emotional or Sexual Abuse	0.94
10. Supervision	0.87
11. Appropriate Development	0.95
12. Nutrition	0.99
13. Family Communication Skills	0.90
14. Emotional Well-being/ Sense of Life Value	0.96
15. Nurturing	0.86
16. Parenting Skills	0.95
17. Home Environment	0.99
18. Stability of Home or Shelter	0.94
19. Support System	0.58
20. Presence of Abuse	0.97
Number of participants	189

By administering the test a second time, intra-rater reliability was assessed. When results from those who took both the initial and the second wave were compared to the overall sample, the findings were consistent (i.e., parallel) to analysis of all the respondents regardless of whether they participated in only (first assessment) or both assessments. After thorough examination of the data, Richardson (2015) concluded that the FDM indicators have a high degree of reliability.

3.5. Researched Interventions

The goal for this feature in the FDM is to assist agencies in linking the assessment and empowerment plan with a specific intervention plan in a systematic way that allows the worker to assess the family's level of engagement and outcome change. Following the strength-based assessment, both researched interventions and localized services are identified for improving parenting, father involvement, trauma therapy, healthy families, and other issues depending on agency programs and family decisions. The FDM researched interventions are based on *The Pathway to the Prevention of Child Abuse and Neglect* (Schorr and Marchand, 2007). The Pathway assembled findings from research, practice, theory and policy about what it takes to improve the lives of children and families. The Pathway goals and interventions are aligned with the Family Strengthening Protective Factors (Center for the Study of Social Policy, 2007; Counts, J. M., 2010). Both the Pathway interventions and Protective Factors are aligned with the FDM indicators and selected online to provide best practice and evidenced based program and support to the Family Empowerment Plan (FRIENDS, nd; Fuller, T. & Wells, S. J., 2000; Gambrill, E., 1999, 2001, 2006). The program support services were grouped into 6 goal areas and linked to specific indicators in the database. Table 2 presents the alignment of goals indicators and Pathway program services. As the table describes, the FDM provides 17 service categories that are aligned to specific indicators and Pathway goals. Individual agencies further aligned their specific programs and local interventions directly to indicators to additionally serve their service and evaluation needs.

The data for program categories presented in table 2, show wide variation on the type of programs used and indicators that are addressed (Chorpita, B.F., 2010; Issacs, M.R., 2005; Kline,M. 2007; Wollesen, L. 2005). The overall data, however, show during the 2009-2014 period the indicators the program support services most frequently used were: connecting families to financial supports for self-sufficiency (28%); providing health information (10%), and providing positive parenting education (10%). These correlate with the indicators frequently tagged in the FDM as receiving a support service: Employment (12%), knowledge of community resources (11%), and family communication skills (7%).

Table 2: Pathway for the Prevention of Child Abuse and Neglect program services alignment to indicators and goals, 2009-2015

Pathway Goal	Indicators *	Pathway Support Programs**
Children and youth are nurtured, safe and engaged	• Child Care (4.69) • Supervision (0.71) • Risk of Emotional & Sexual Abuse (5.16) • Nutrition (2.74) • Appropriate	• Confirm safety of child (3.33) • Work in partnership with Child Welfare (2.76) • Connect to childcare opportunities (4.26) • Identify developmental concerns (3.89)

	Development (4.94)	• Support children's social and emotional competence (1.71) • Support family to advocate for child in school (2.4)
Families are strong and connected	• Nurturing (1.7) • Parenting Skills (7.68) • Family Communication Skills (7.01)	• Positive parenting education (10.04) • Effectively involve fathers and other relatives in parenting (1.85) • Connect to parent support groups and education (5.72)
Identified families access services and supports	• Budgeting (5.51) • Clothing (4.64) • Employment (11.87) • Stability of Home or Shelter (5.35) • Home Environment (1.67) • Health Services (3.22) • Community Resources Knowledge (11.49) • Child Health Insurance (3.56) • Transportation (3.21)	• Connect to financial supports for self-sufficiency (27.81) • Provide health information (10.34) • Provide transportation to access medical/counseling appointments as needed (4.16) • Participate in multi-disciplinary teams to coordinate services (6.32)
Families are free from substance abuse and mental illness	• Presence of substance abuse (3.59) • Emotional Wellbeing/Sense of Life Value (6.94)	• Connect to weekly group meetings for parents and children (4.57) • Provide linkages to remove barriers to mental health and substance abuse services (3.99)
Communities are caring and responsive	• Support Systems (5.32)	• Connect to informal community supports (4.18) • Work with families to identify system gaps (2.93)

* Number in parenthesis represents the percentage of cases that received a support service associated with the indicator.

** Number in parenthesis represents the program support service's relative frequency of use.

3.6 Examples of Family Resource Center Family Strengthening Practices

A) Children's Social and Emotional Development. Complete age-appropriate ASQ-ASQ'SE screenings on all children under the age of 5. Refer families to community based early mental health, dental and health care services. Complete Home Visits that address barriers to the use of medical services, transportation. Provide parenting classes to assist families with tools in developing communication skills and in early childhood development and best practices in child rearing. Assist families to access early childhood programs that support cultural & linguistic needs of family's work-related needs and/or child's need for social and emotional development.

B) Knowledge of Parenting and Child Development. Parent Educator provides clients with 8-10 parenting sessions. Together, the family and the Parent Educator identify parenting goals utilizing the Family Development Matrix and Parent Practice Survey to develop the "Empowerment Plan" which includes positive discipline techniques and other goals agreed upon by the parent. Evidenced based Parenting classes like Nurturing Parenting; Triple P; 1,2,3 Magic; Effective Black Parenting; PIPE; Incredible Years - Enhanced Visitation that incorporates coaching and role modeling.

C) Concrete Support in Times of Need. State and county child welfare agencies implement "differential response" protocols to connect families to community resources. Referrals made daily for basic needs, housing, employment, food and clothing. Family support workers collaborate through joint training and team consultation with participants from governmental, academic, and community-based settings. Establish strength-based, individualized, family-oriented solutions based on an understanding of family strengths, needs and circumstances. Action plans clearly delineate roles and responsibilities and establish mechanisms for on-going communication and coordination.

D) Parental Resilience. Support Groups particularly those that bring parents together around common issues and experience (maternal depression, domestic violence, anger management, substance abuse) NA/AA/Al-anon/Alateen support groups - Maternal depression group – Domestic violence groups; Referral to inpatient and outpatient treatments; - Therapist on site - Services and supports by Early Childhood Mental Health consultants (supervision, co-facilitation, staff coaching, case consultation) - Case Management - CTRP referral (Center for Trauma Response, Recovery and Preparedness).

E) Social Connections. Connect a family with another family involved in the system that have received their children back from CPS removal, or connect two folks who've been to jail and have them mentor and support each other. As a collaborative identify gaps in services such as substance abuse prevention and

treatment programs and address this need by working in collaboration with the California Family Resource Association to bring attention to this area on a policy level related to the Mental Health Services Act.

4. FDM Implementation and Results

The FDM was implemented in county-based collaboratives across the state of California. As table 3 presents, by 2013 there were 25 collaboratives with an average of about 6 agencies with each organized from combinations of child welfare departments, First5 children commissions, programs for home visiting, domestic violence, Head Start, tribal social services, education, community action, cultural broker/advocates, clinic health systems, teen pregnancy and a variety of urban or rural family resource agencies. Since 2009, 21,212 families received a baseline assessment. About 59% of these families identified themselves as Hispanic (of any race); 17% as white; 14% as African American; 4% as Asian/Pacific Islander; 2% as Native American; and 4% as mixed or other race. As table 3 details, these families represented a total of 47,312 children. Further, out of the total number of families assessed, 41-50% received services under child welfare differential response referrals, while 59% received services from participating family resource centers through other types of community based program referrals (e.g. schools, churches, substance abuse, food and clothing) or in a walk-in basis.

Table 3: Number of families in the FDM database 2009-2014

	Year						
	2009	2010	2011	2012	2013	2014	
Number of collaboratives	5	6	18	22	25	22	
Number of agencies	35	40	100	120	150	140	Total
Number of families with first assessment	437	4,200	2,747	4,235	5,139	4,454	21,212
% of families with a second assessment	59.2	71.0	67.3	50.1	45.2	40.8	53.5
% of families classified as Differential Response referrals	49.4	28.9	40.4	41.3	41.4	50.3	40.8
Number of children served	991	9,228	5,802	9,502	11,786	10,003	47,312

Table 4 presents a summary of baseline scores under each indicator for all families that underwent an assessment with the FDM during 2009-2014. The indicators with at least 1 in 4 families scored at “in crisis” or “at risk” levels were in the areas of employment (48%), community resource knowledge (39%), budgeting (26%), and support system (25%). Other areas such as family communication skills (21%), clothing (22%), and emotional wellbeing (19%) were also areas where 1 in 5 families scored at the “at risk” or “in crisis” levels.

Table 4: Distribution of status levels by indicator (All families with a 1st assessment 2009-2014)

Indicator	In Crisis %	At Risk %	Stable %	Self Sufficient %	n
Childcare	11.9	8.4	31.4	48.4	14,910
Supervision	0.8	2.2	13.5	83.6	19,349
Risk of emotional or sex abuse	2.8	12.9	10.9	73.4	19,080
Nutrition	1.4	4.4	20.3	73.9	19,858
Appropriate development	1.5	11.2	25.6	61.7	19,333
Nurturing	0.7	8.4	23.7	67.2	19,884
Parenting skills	1.6	13.3	39.2	45.9	20,003
Family communication skills	3.2	17.5	34.0	45.3	21,052
Budgeting	6.5	19.6	43.6	30.3	21,045
Clothing	4.2	17.8	33.5	44.5	21,045
Employment	40.6	7.6	38.5	13.4	16,239
Stability of home shelter	6.2	9.6	20.5	63.8	21,028
Home environment	1.5	5.9	30.4	62.3	21,037
Health services	2.4	9.0	54.3	34.3	21,052
Comm. resources knowledge	11.3	28.1	34.4	26.1	21,059
Child health insurance	6.8	4.7	11.2	77.4	19,666
Access to transportation	4.1	6.6	29.0	60.4	21,063
Presence of (substance) abuse	3.6	6.0	19.6	70.9	21,037
Emotional wellbeing/ life value	3.0	15.9	52.3	28.9	21,056
Support system	4.4	20.7	39.1	35.8	21,041

It is important to note that most families in the FDM tend to arrive to the family resource agencies with specific needs, few areas of additional concern, and many areas of strength. Our data shows that 70% of families have 2 or less indicators at the “at risk” or “in crisis” level at the first assessment. Indicators where families tend to be “stable” or “self-sufficient” were child supervision, nutrition, and home environment, with more than 90% of families at safe or self-sufficient levels.

As explained in the previous section a second appointment is established typically 90 days after the first baseline assessment to evaluate client progress. Table 5 presents family outcomes on the 20 core indicators for the first and second assessments. As the table describes, the percentage of families at the “stable” or self-sufficient” level tend to increase substantially between the first and second assessment in every indicator for both Differential Response referrals and walk-in

families. All of the changes in table 2 are statistically significant at the .05 level. As the table shows, overall, the greatest gains tend to be in the areas of community resource knowledge, budgeting, and support system with 33, 13, and 12.5 percentage point increases respectively. Other areas that exhibit at least 10 point increases in the percentages of families at the stable or self-sufficient levels were clothing (10.6), risk of emotional or sexual abuse (10.6), emotional wellbeing (10.4). Table 5 also highlights the differences between Differential Response and non-Differential Response families in the FDM, with the former group presenting lower percentages of families at the stable or self-sufficient levels in the first assessment across all indicators. These differences, however, tend to diminish or disappear by the second assessment.

Table 5: Percent of families at the "stable" or "self-sufficient" level in first and second assessment (families with at least 2 assessments 2010-2014)

Indicator	Non DR		DR		ALL	
	1st A	2nd A	1st A	2nd A	1st A	2nd A
Childcare	80.0	89.1	79.6	90.8	79.9	89.7
Supervision	97.7	98.3	96.8	98.1	97.3	98.2
Risk of emotional or sex abuse	88.7	95.4	75.4	92.1	83.5	94.1
Nutrition	90.6	97.9	96.6	98.3	92.9	98.1
Appropriate development	90.0	94.3	84.4	91.3	87.8	93.1
Nurturing	93.8	96.8	86.0	94.4	90.8	95.9
Parenting skills	88.4	94.2	78.7	91.0	84.7	93.0
Family communication skills	82.8	89.8	72.1	83.8	78.9	87.6
Budgeting	72.7	86.6	74.4	86.6	73.3	86.6
Clothing	79.3	89.1	75.7	87.5	77.9	88.5
Employment	51.2	62.3	54.8	63.5	52.5	62.7
Stability of home shelter	86.4	90.0	83.8	88.2	85.4	89.3
Home environment	94.1	96.5	91.1	94.7	93.0	95.8
Health services	87.0	94.6	88.5	94.3	87.6	94.5
Comm. resources knowledge	59.4	91.0	55.9	90.6	58.1	90.9
Child health insurance	84.8	93.3	90.9	95.7	87.2	94.2
Access to transportation	90.7	95.0	89.1	93.6	90.1	94.5
Presence of (substance) abuse	93.4	95.5	87.4	91.8	91.2	94.2
Emotional wellbeing/ life value	82.3	91.7	77.8	90.0	80.7	91.0
Support system	77.0	88.8	72.0	85.8	75.2	87.7

Family outcomes as measured by the FDM show significant improvement over a period of 90 days. Richardson also finds that families under Differential Response

with higher scores on a second assessment were less likely to have a case opened in Child Welfare after receiving services. Positive changes in FDM scores for the indicators of community resource knowledge, risk of emotional or sexual abuse, and support system were also associated with lower numbers of subsequent referrals (Richardson, 2015).

5. Family Engagement

Family engagement is crucial for the success of interventions in child welfare (Littell & Tajima, 2000; Altman, J.C., 2008, Gockel, A., 2008). The FDM includes a 3-point scale that caseworkers use to rate the level of follow-through with the empowerment plan demonstrated by the family between the first and second assessments When a family comes back to the agency for a second assessment, the caseworker records in the database whether the family exhibited "full participation," an "uneven follow through," or if there was "no action taken by the family." Overall, workers perceived 66% of all families with at least 2 assessments as exhibiting "full participation" and 29% and 5% as exhibiting an uneven follow through and no action respectively. Consistent with previous findings on the effect of family engagement on outcomes, FDM data shows a strong correlation between the two. As table 6 presents, the percentages of clients that moved from a level of "in crisis" or "at risk" in the first assessment to a "stable" or "self-sufficient" level by the second assessment is related to worker's perceived level of engagement. Families that exhibited full participation were more likely to move to a stable or self-sufficient level in each and all of the indicators with the highest differences in the indicators of parenting skills and nurturing (34 and 29 percentage point difference respectively)

Table 6: Percent of families that moved from a level of "in crisis" or "at risk" in the first assessment to a "stable" or "self-sufficient" level by the second assessment by indicator and workers' perceived level of engagement

Indicator	Uneven or no follow through %	Full participation %	ALL %
Childcare	52.6	64.7	65.6
Supervision	61.5	80.0	71.2
Risk of emotional or sex abuse	61.9	78.8	71.9
Nutrition	70.9	78.4	75.3
Appropriate development	53.7	66.8	62.0
Nurturing	52.3	81.3	68.8
Parenting skills	42.3	76.8	65.2
Family communication skills	43.2	61.3	53.5
Budgeting	47.2	66.7	58.8
Clothing	55.8	66.3	62.2
Employment	21.6	29.5	26.5

Stability of home shelter	43.4	51.8	48.5
Home environment	55.0	68.5	61.7
Health services	56.8	77.3	68.1
Comm. resources knowledge	75.7	84.5	81.1
Child health insurance	58.6	69.0	59.7
Access to transportation	49.0	71.0	62.4
Presence of (substance) abuse	42.3	60.5	52.6
Emotional wellbeing/ life value	53.0	76.5	67.1
Support system	49.6	69.7	61.6

Interestingly, perceived engagement levels for Differential Response referrals tend to be significantly different than those for walk–in clients. Using FDM data Navarro (2015), finds family engagement to be correlated to Differential Response path even after controlling for demographic characteristics, and scores on the 20 indicators. His analysis argues that part of this relationship may be explained by families' perception of how voluntary the referral was and the self-selection of families arriving into family resource agencies determined by their readiness to change, and levels of buy-in and trust.

5. Conclusion

This paper describes the development and implementation of the Family Development Matrix (FDM), an assessment tool that informs case management and tracks outcomes. The California Department of Social Services, Office of Child Abuse Prevention supported broadened public/private partnerships to use the FDM to measure outcomes and extend the prevention of child abuse and neglect. The main goal for this initiative was to build capacity across family resource centers in the state by providing a common protocol to conduct strengths-based case management and family support services. The outcomes data argues for a family strengths assessment and individual empowerment planning responding to unique needs. A focus on strengths during these prevention interventions develops skills for motivating the particular family across life domains and supports sustainability of participation. Children in stable families are less likely to be victims of child abuse, neglect and trauma. Families needing support in particular life domains may not have the same needs as other families and do not start at the same baseline. Measuring important life domains and building on strengths allows a case management model to recognize the distinctiveness of each family and gives solid benchmarks measuring improvement and self-suffiency. Measuring important life domains and building on strengths allows any model to recognize the distinctiveness of each family and gives solid benchmarks measuring improvement.

The California experience shows much promise for assessment tools like the FDM building community collaborative capacity in a multiple array of agency types.

Using a collaborative design process with an emphasis for a prevention plan, shared outcome measures, common protocol and a step-by-step, case managed, strength based empowerment plan during the 2009-2014 period more than 21,000 families received services using the FDM model as described in this paper. The data from this period shows that FRCs used the FDM to provide evidenced and local resources for clients referred by child welfare and walk-in cases alike (especially those exhibiting higher levels of engagement). Furthermore, the data on outcomes achieved by families as measured by the FDM indicators reveal a remarkable pattern of positive change across all types of clients, with the wide array of support services. The rapid growth in the number of California counties and agencies using the FDM in the 2009-14 period may serve as evidence of its perceived value across different agency types.

The Family Development Matrix is a strengths-based assessment for family goal setting and outcomes measurement. It assists by tracking family outcomes over time in relation to prevention and/or intervention activities. Its data increases agency program assessment, program planning and outcomes measurement. This practice model assists staff in the following ways:

- Family workers are more effective in assessing family strengths and areas for improvement;
- The assessment empowers family decisions and action plans;
- Improves program services with better data to analyze practices;
- Enhances accountability and reporting methods based on family outcomes; and,
- In a collaboration of programs or agencies it provides shared language to communicate with partners and funders about client outcomes.

There are several areas of future research to further explore the FDM's potential as an assessment tool. First, while the results on the indicator reliability are strong and the correlation with subsequent allegations of child abuse and neglect are promising, more studies on the indicator's predictive validity of the number and severity of clients subsequent allegations of abuse and neglect would enhance the FDM's full potential as a prevention assessment tool. A second important area of further study involves the extent to which agencies use their data to perform evaluations and pursue funding. While there is ample evidence that agencies use their data (as evidenced by the number of downloads or reports and raw data) the specifics on how they use their data could further inform assessment tools as the FDM on enhancing agency capacity and strengthening public private partnerships in child welfare. As the field of prevention of child abuse and neglect increases its focus on outcomes and its reliance on interagency partnerships and the need for assessment tools that can provide shared outcomes will only become greater. The paper presents the California's FDM model as promising alternative to build upon.

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