Family Assessment Effectiveness of California Family Resource Centers Using Family Development Matrix Outcomes

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Abstract

The Family Development Matrix (FDM) is a comprehensive and strengths-based assessment and practice tool that enhances the community's commitment to supporting at risk families while tracking family and service outcomes. The FDM is a prevention and early intervention assessment and case management tool used in partnership with referral agencies to engage families to achieve change. The FDM facilitates family participation in case management providing reliable information from which to plan family goals using existing their strengths, application of best practice interventions and a family empowerment plan. Results track change through family engagement to measure the progress of family outcomes and the effectiveness of interventions.

The purpose of the article is to present the FDM as a family practice model with community based, family support agencies. From 2009 to 2015 the FDM was implemented in 25 collaborative networks across the state of California. Outcome results are presented for 140 family resource centers. The model provides a means 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, case management.

Introduction

The Government Performance and Results Modernization Act of 2010 updated aspects of the Government Performance and Results Act (GPRA) of 1993 requiring states and [1]counties to utilize outcomes for agency performance reports (Friedman, M.,1995; Office

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of Management and Budget, 2010). Private and government funders today 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)?

Through the 1980's into the 90's, Family Support America, formerly Family Resource Coalition of America , helped move forward a coalition of the family support field by advocating comprehensive services in community agencies serving at-risk families. (Ahsan, N. & Cramer, L., 1989; Bruner, C., 2004; Dunst, C.J., 1995; Family Support of America, 2003; Strategies, 2003 & 2008). The evolution of family support is with community-based agencies, typically known as family support or family resource centers. These agencies are 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).

With a direct influence on the development of the FDM a review of family development outcome measures was conducted for the U.S. Department of Health and Human Services, Office of Community Services (ROMA, NASCSP; Brizius, J. A., 1991, Richardson, et.al. 2004). Of the five family development outcomes models reviewed (ROMA, NASCSP), only the California Family Development Matrix has been subjected to scientific scrutiny though reliability testing which has been documented (Endres, J., Richardson, B. & Sherman, J. 1999; Richardson, B. et.al. Matrix Outcomes Model.com/publications 2015).

Study Setting

From 2009 through 2015, the Family Development Matrix was funded by the California Department of Social Services, Office of Child Abuse Prevention (California Department of Social Services, 2012). The funding provided an integrated family assessment tool with a standard set of 20 core assessment indicators. With a baseline and subsequent assessments the outcome data provides family resource centers their ability to share results across sector programs often with local child welfare agencies. Agencies using the FDM have 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, focused on family strengths and outcomes.

During this funding period 25 California county collaboratives were organized to use the FDM assessment and case management practice model. With 144 family resource center agencies participating: Approximately 21,000 families completed a first assessment,

10,000 (48%) a second three months later, 2,800 a third and 1,200 a fourth; with altogether a total of 47,000 children served.

The Practice Protocol

With a 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) and in the context of the family situation: a) identify the status level within each indicator that best represents their immediate situation, b) identify family strengths and issues of concern using both the assessment in a dialogue and the computer programmed "visit summary", c) make choices for interventions and agency support services, d) create a family-directed empowerment plan, e) track family and worker activity for case management, and, f) evaluate family engagement prior to the next assessment. The protocol identifies the agency approach for assessment and case management, including which agency clients, when to conduct an assessment, how it is completed with the family and when the information is entered into the database.

Model Structure and Measures

Outcome indicators are used to measure the current conditions of a population. A FDM outcome assessment is a determination of the extent a stated condition that describes the family situation or goal is achieved or changed. FDM outcomes are measured in terms of "this moment in time" for an assessment of the family's actual situation. Subsequent assessment meetings take place quarterly or based on an agency timetable depending upon the duration of services and the program's service goals. In the subsequent assessments the FDM "scores" established at the previous meeting are re-scored together in a dialogue with the family (member).

Status levels within each indicator measure the family behaviors, conditions and circumstances. The status levels are the measures of the family's circumstances at the time of the assessment. While some status levels may signal a need for immediate assistance, other ones find the family to be stable or self-sufficient without need for support or intervention. Rather, these status level measures are considered family strengths. Each set of (four) status levels contains statements of a behavior or a condition that are specific descriptors of an in-crisis, at-risk, stable or safe & self-sufficient situation.

Figure 1: Indicator Status Levels Descriptions

In Crisis Family cannot meet its needs. They are unwilling or unable to work toward positive change. Family systems have collapsed or are in immediate danger of collapse. Strong outside intervention is required to move the family to at least an "at-risk" level.

At-Risk Family is secure from immediate threats to health and safety, but has not yet developed or committed to strategies/plans for growth and change. Continuing safety-net intervention provides a platform on which the family can build its plans for improving circumstances.

Stable Family no longer is in danger, and is ready and willing to make needed changes. Planning occurs for its future goals. Supportive services are provided to assist the family in implementing their plans. Family is using its resources to move forward.

Safe/Self-Sufficient Family is strong and has made significant progress in improving its circumstances. Family is generally secure as a result of their efforts. The family has a clear vision of its ultimate goals. Intervention is to maintain this status level. Motivation is from within the family.

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

<u>The Assessment Dialogue</u>

The initial purpose of the FDM assessment is to document the current status of a family and track change/progress during participation in the agency's programs and services. Families begin their involvement with the agency through their own initiative and/or through referral. Initially, a level of trust must be established and maintained.
The family worker builds this relationship by :

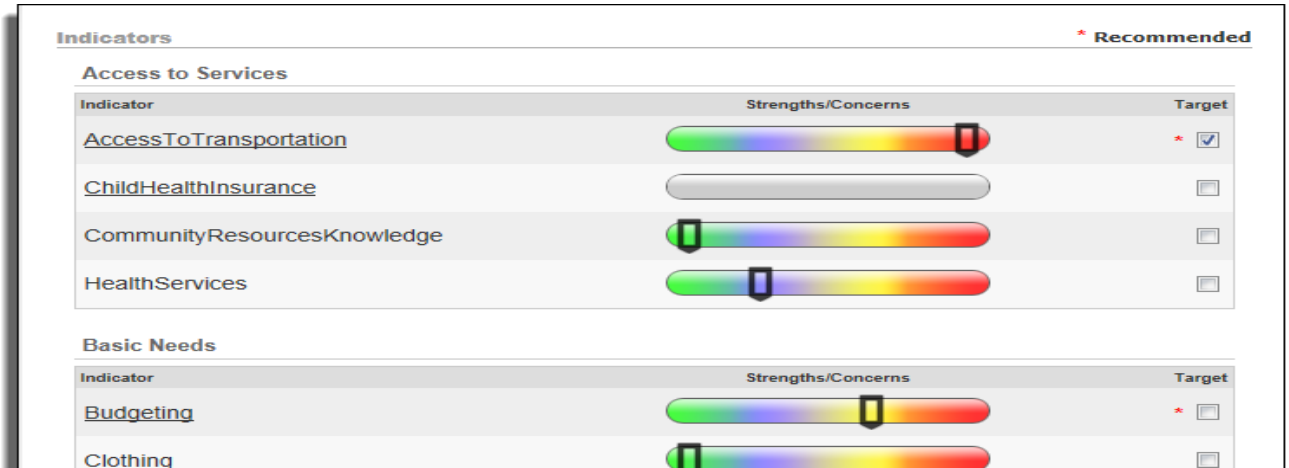
- Listening to the family situation asking about issues or concerns and learning about the family's makeup and history;
- Explain the family worker's role to assist the family by exploring their current situation, helping to identify strengths, and developing a plan to provide support in a plan to achieve family goals.
- They let the family member know there are a series of questions *(probing)* in a number of different areas *(indicator descriptions)* such as with children, parenting, housing, etc. Together with the family to select the answer *(status level)* that most reflects their situation "right now" *(at this point in time)*
- With the family member conduct an initial (baseline) assessment. What is going on in the family *(their story)* and where they would like support.
- Using all of the core indicators and any optional indicators, the assessment facilitates a conversation where the family member tells their story.
- The assessment is a guideline for a conversation; however, it doesn't exactly flow like a natural conversation and it sometimes helps the family to move the order of questions to flow more naturally.
- Culture and language is taken into account as each question is fully explained to their understanding. The assessment is translated in five languages.
- The family member and the agency case manager together score each indicator's status level to fit the family's current situation.

The family worker acknowledges the family is the expert of their own situation. They use the assessment to seek the highest value of the family's understanding of their situation. The assessment covering the 20 core indicators are discussed in a dialogue and checked for information with the family member to best understand the current family situation.

Identification of Family Strengths

An assessment summary *(Visit Summary) is* generated by the database and the assessment information is organized in three parts; *areas of strengths*, *concerns* and *targets for interventions.* The visit summary is used to discuss strengths and concerns exploring how the family has achieved stability and self-sufficiency in certain indicator areas and how they can apply their experience, knowledge, and skills to problem solving for identified issues for concern.

Figure 2: Visit Summary Following this strength-based discussion and targeting one or two areas to plan activities, the family receives a copy of the visit summary and they move to selecting an intervention.



Following the strength-based assessment, a selection of evidence based interventions, best practices and/or localized services are identified for improving parenting, father involvement, trauma therapy, healthy families, and other goals depending on agency programs and family decisions to accept services. In a pilot study there were expressed concerns that an emphasis on "programs" would take importance from other "interventions" they routinely use with their clients. There was a consensus on the point that while all programs are interventions, "*not all interventions can be considered programs.*" Additionally FDM coordinators felt very strongly about conveying the idea that family resource centers do "*a lot more than run or connect clients to programs.*"(Navarro, I. 2015 (2).

The FDM best practice interventions were researched and 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). All interventions 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).

Figure 3: Alignment Of FDM Indicators With Researched Interventions

Family Development Matrix Pathway Project

Family Strengthening, Protective Factors and Pathway to Prevent Child Abuse and Neglect Alignment Table, Matrix Outcomes Model

Protective Factors	*Pathway Goals*	*FDM Categories*	*Family Development Matrix Indicators*	*Pathway Interventions*
Children's Social and Emotional Development	Children and Youth are Nurtured, Safe and Engaged	*Child Safety*	Child Care Supervision Risk of Emotional & Sexual Abuse	Confirm safety of child, Work in partnership with Child Welfare, Connect to childcare opportunities
		Children's Physical and Mental Health	Nutrition Appropriate Development	Identify developmental concerns, Support children's social and emotional competence, Support family to advocate for child in school
Parental Resilience & Knowledge of Parenting and Child Development	Families are Strong and Connected	*Parent/Child Relationships*	Nurturing Parenting Skills	Positive parenting education, Effectively involve fathers and other relatives in parenting, Connect to parent support groups and education
		Family Communication	Family Communication Skills	
Concrete Support in Times of Need	Identified Families Access Services and Supports	*Basic Needs*	Budgeting Clothing Employment	Connect to financial supports for self-sufficiency
		Shelter	Stability of Home or Shelter Home Environment	
		Access to Services	Health Services Community Resources Knowledge Child Health Insurance Transportation	Provide health information, Provide transportation to access medical/counseling appointments as needed, Participate in multi-disciplinary teams to coordinate services
Parental Resilience	Families are Free from Substance Abuse and Mental Illness	*Substance Abuse*	Presence of Abuse	Connect to weekly group meetings for parents and children, Provide linkages to remove barriers to mental health and substance abuse services
		Life Value	Emotional Wellbeing/Sense of Life Value	
Social Connections	Communities are Caring and Responsible	*Social Emotional Health*	Support Systems	Connect to informal community supports, Work with families to identify system gaps

Examples of Family Resource Center Practices

A) Children's Social and Emotional Development. We 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 "Service and Empowerment Plan" which includes positive discipline techniques and other goals agreed upon by the parent. Evidenced based Parenting classes like 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 that do not meet abuse or neglect criteria. 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, we 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.

The Family Empowerment Plan

The FDM empowerment plan organizes the family situation into achievable goals, interventions and actions to move forward toward desired family outcomes. Goals are easier to understand when the family states them in their language. The worker encourages the family to develop steps to achieve these goals, help develop realistic time frames, resources and an action plan. The family and worker also redesign the plan and celebrate successful outcomes all the while the family is engaged with the family resource center.

The process begins when the worker and family member(s) discuss what they hope to accomplish and after sharing the visit summary with the family where they examined strengths the family already has to help them reach the desired outcome. With an empowerment process it is imperative the family be involved to select indicators, interventions and actions for a family-directed action plan. A written plan is entered in

the database establishing the goals to achieve, use of family strengths, the agency applied resources, and a clear plan for family and worker roles and responsibilities to carry out a plan. True empowerment is allowing the family to make these determinations with the support and facilitation of the family worker. The empowerment plan represents a "structured social contract" which families report is a strong incentive for their participation and engagement.

The change model (Figure 4) portrays the progression a family may go through to implement an empowerment plan. These stages represent growth and shifts of knowledge and behaviors and are related to cognitive and skills development, empowerment decisions, and reinforcement of desired change (Transtheoretical Model: Prochaska, DiClemente, and Norcross, 1992).

Figure 4: Strength Based Change Model

AWARENESS	Family sees their situation from a strength-based perspective
SKILLS	Family has the knowledge, skills and ability to move toward self-selected goals
MOTIVATION	Rewards and benefits for change outweigh attitudes or obstacles that may prevent family from achieving goals
MAINTENANCE	Family is using tools for self-reliance and maintaining that status level

Family Engagement

Family engagement is crucial for the success of interventions in family support programs including child welfare referrals to family resource centers (Altman, J.C., 2008; Littell & Tajima, 2000). The FDM includes a 3-point scale where the family worker rates the level of empowerment plan follow-through demonstrated between the first and subsequent assessments. When a family comes participates in a subsequent assessment, the family worker records whether the family exhibited "full participation," an "uneven follow through," or if there was "no action taken by the family." Also tracked in the database are encountered barriers and meetings as well as levels of family support.

Results

Beginning in 2009 through 2015, 25 collaboratives with a total of 140 agencies had been organized from combinations of county based child welfare departments, First5 children and family commissions, programs for home visiting, domestic violence, Head Start, tribal services, cultural broker/advocates, clinic health systems, teen pregnancy and a

variety of urban or rural family resource agencies. From 2009-2015, using the FDM assessment with 20 core indicators, 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 1 details, these families represented a total of 47,312 children. Further, out of the total number of families assessed, 41% attended 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, etc) or in a walk-in basis.

Table 1: Number of families in the FDM database 2009-2015

	Year						
	2009	2010	2011	2012	2013	2014	
Number of collaboratives	5	6	18	22	25	22	
Number of agencies	35	40	100	120	150	144	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 2 presents a summary of baseline scores under each indicator for all families that underwent an assessment with the FDM during 2009-2015. The indicators with at least one of four families scored at “in crisis” or “at risk” levels were in employment (48%), community resource knowledge (39%), budgeting (26%), and support system (25%). Other areas such as family communication skills (21%), clothing (22%), and emotional well-being (19%) were also areas where around one in five families scored at the “at risk” or “in crisis” levels.

Table 2: Distribution of status levels by indicator (All families with a 1st assessment 2009-2015)

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 a previous section, after the analysis of strengths and challenges is completed by the worker and the family, an empowerment plan that identifies goals and make appropriate referrals to family support services, a second assessment is established typically 90 days after the first baseline assessment to evaluate family progress or change. Table 3 presents family data on the 20 core indicators in both 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. All of the changes are statistically significant at the .05 level. 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 3: Change in scores for core FDM indicators (organized in Protective Factor goal areas):
Number of observations with at least 2 assessments= 8,206

Indicator	1st Assessment	2nd Assessment	Difference	P< .05
Childcare	54.7	62.1	7.43	*
Supervision	89.2	90.2	1.00	*
Risk of emotional or sex abuse	75.1	85.5	10.38	*
Nutrition	88.6	92.8	4.24	*
Appropriate development	79.4	85.3	5.92	*
Nurturing	85.7	90.7	4.93	*
Parenting skills	81.0	88.5	7.50	*
Family communication skills	79.3	87.9	8.65	*
Budgeting	72.2	85.5	13.35	*
Clothing	76.8	87.5	10.74	*
Employment	39.5	46.4	6.86	*
Stability of home shelter	85.2	89.3	4.04	*
Home environment	92.5	95.7	3.16	*
Health services	87.4	94.2	6.79	*
Comm. resources knowledge	60.0	90.5	30.43	*
Child health insurance	80.4	87.6	7.20	*
Access to transportation	89.8	94.1	4.34	*
Presence of (substance) abuse	91.5	94.2	2.68	*
Emotional wellbeing/ life value	80.7	90.7	9.97	*
Support system	74.6	87.4	12.79	*

Table 4: Change by protective factor (all clients with at least 2 assessments): Percentage of families at the "safe" or "self-sufficient" level in all indicators considered for the protective factor

Protective Factor	1st Assessment	2nd Assessment	Difference	p<.05
Children's social and emotional development	38.5	53.3	14.8	*
Parental resilience & knowledge of parenting and child development	66.2	79.0	12.8	*
Concrete support in times of need	13.6	29.5	15.9	*
Parental Resilience	75.9	86.7	10.8	*
Social connections	74.6	87.4	12.8	*

Table 5: An Alignment Order Of Indicator Selections With Associated Pathway interventions Selected By Family And Worker

Most Selected Core Indicators and Interventions

Indicator	Pct Targeted	Intervention	Pct Selected
Employment	11.79	Connect to financial supports for self sufficiency	91%
		Participate in Multi-disciplinary teams to coordinate services	5%
		Work in partnership with Child Welfare	4%
		Support children's social and emotional competence	0%
		Connect to parent support groups and education	0%
		Connect to child care opportunities	0%
CommunityResourcesKnowledge	11.56	Provide health information	40%
		Participate in Multi-disciplinary teams to coordinate services	33%
		Provide transportation to access medical, counseling appointments as needed	13%
		Work with families to identify system gaps	12%
		Connect to financial supports for self sufficiency	1%
		Confirm Safety of Child	0%
		Support children's social and emotional competence	0%
DevelopingParentingSkills	7.59	Positive parenting education	60%
		Connect to parent support groups and education	29%
		Effectively involve fathers and other relatives in parenting	8%
		Identify developmental concerns	2%
		Support family to advocate for child in school	0%
FamilyCommunicationSkills	6.9	Positive parenting education	53%
		Connect to parent support groups and education	34%
		Effectively involve fathers and other relatives in parenting	13%
		Provide transportation to access medical, counseling appointments as needed	0%
EmotionalWellbeing	6.88	Connect to weekly group meetings for parents and children	49%
		Provide linkages to remove barriers to mental health and substance abuse services	38%
		Connect family to informal community supports	10%
		Provide transportation to access medical, counseling appointments as needed	3%
StabilityHomeShelter	5.63	Connect to financial supports for self sufficiency	100%
		Work with families to identify system gaps	0%
		Work in partnership with Child Welfare	0%
SupportSystem	5.45	Connect family to informal community supports	59%
		Work with families to identify system gaps	27%
		Connect to parent support groups and education	9%
		Support family to advocate for child in school	4%
Budgeting	5.35	Connect to financial supports for self sufficiency	100%
		Participate in Multi-disciplinary teams to coordinate services	0%
RiskOfEmotionalOrSexualAbuse	5.12	Confirm Safety of Child	44%
		Work in partnership with Child Welfare	26%
		Connect to child care opportunities	17%
		Positive parenting education	14%
AppropriateDevelopment	4.88	Identify developmental concerns	46%
		Support family to advocate for child in school	26%
		Support children's social and emotional competence	24%
		Provide health information	4%

		Work in partnershp with Child Welfare	0%
ChildCare	4.77	Connect to child care opportunities	67%
		Confirm Safety of Child	15%
		Work in partnership with Child Welfare	13%
		Connect family to informal community supports	5%
Clothing	4.63	Connect to financial supports for self sufficiency	86%
		Support family to advocate for child in school	5%
		Participate in Multi-disciplinary teams to coordinate services	5%
		Work in partnership with Child Welfare	3%
ChildHealthInsurance	3.43	Provide health information	70%
		Participate in Multi-disciplinary teams to coordinate services	13%
		Provide transportation to access medical, couseling appointments as needed	10%
		Identify developmental concerns	5%
		Work in partnership with Child Welfare	3%
AccessToTransportation	3.23	Provide transportation to access medical, counseling appointments as needed	48%
		Provide health information	29%
		Participate in Multi-disciplinary teams to coordinate services	15%
		Connect to financial supports for self sufficiency	7%
		Work in partnership with Child Welfare	0%
		Work with families to identify system gaps	0%
HealthServices	3.22	Provide health information	66%
		Provide transportation to access medical, counseling appointments as needed	15%
		Participate in Multi-disciplinary teams to coordinate services	15%
		Provide linkages to remove barriers to mental health and substance abuse services	5%
Nutrition	2.7	Identify developmental concerns	43%
		Support children's social and emotional competence	22%
		Support family to advocate for child in school	22%
		Connect to financial supports for self sufficiency	13%
PresenceAbuse	2.56	Provide linkages to remove barriers to mental health and substance abuse services	50%
		Connect to weekly group meetings for parents and children	47%
		Provide transportation to access medical, counseling appointments as needed	3%
HomeEnvironment	1.83	Connect to financial supports for self sufficiency	94%
		Confirm Safety of Child	6%
		Effectively involve fathers and other relatives in parenting	0%
		Connect to child care opportunities	0%
Nurturing	1.69	Positive parenting education	53%
		Connect to parent support groups and education	34%
		Effectively involve fathers and other relatives in parenting	13%
Supervision	0.79	Confirm Safety of Child	39%
		Connect to child care opportunities	35%
		Work in partnership with Child Welfare	18%
		Positive parenting education	6%
		Effectively involve fathers and other relatives in parenting	2%

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

Family Engagement

As explained in a previous section 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 subsequent assessments. 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 family 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)

Discussion

This article describes the development and implementation of the Family Development Matrix (FDM), an assessment tool that informs case management and tracks outcomes with family resource center. The California Department of Social Services, Office of Child Abuse Prevention supported 25 county-based, collaboratives with 140 community based family support agencies. The main goal for this study was to build capacity across family resource centers in the state by providing a common protocol and family strengthening measures for their clients and to equip them with an assessment tool with database capabilities that allowed them to document and analyze client outcomes measured by a common set of indicators. The data from this period (2009-2015) reveals a consistent pattern of positive change across all types of clients, with the use of a wide array of support services. The rapid growth in the number of California counties and agencies using the FDM in the period may serve as evidence of its perceived value across different agency types.

Richardson & Verploegh, M. (2015) finds that families under DR with higher scores on a second FDM assessment were less likely to have a case opened in Child Welfare after receiving services. Positive changes in 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. 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.

This article's analysis indicates the FDM model can effect and measure changes in indicators of family functioning. These indicators are measures of Family Strengthening Protective Factors using interventions from the Pathway to Prevent Child Abuse and Neglect. This finding is important because the results show significant effects and the results are encouraging given the substantial body of work. Reliability studies for the FDM indicators strengthen the case for it as an evidence based screening and assessment tool (Richardson, B., Endres J. and Rayman, N. (2015).

The Principles of Family Support, developed by the Family Resource Coalition of America (2003), are widely accepted as foundational for quality services. The family resource centers as 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. According to the S. H. Cowell Foundation, "FRCs play a unique and pivotal role in bringing together services, resources and opportunities that improve the

wellbeing 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 (Strategies 2008). High risk and hard to reach families generally do not participate in standing alone prevention programs. Positive prevention outcomes are more likely to coincide with basic needs being addressed. Therefore, co-located prevention programs with FDM agencies that are meeting primary needs and provide service access for families with high risk factors, i.e. ACES, poverty, child welfare referrals (Office of Child Abuse Prevention, 2000).

Conclusion

Lisbeth Schorr in an article on evidence informed practice states "To get better results in this complex world, we must be willing to shake the intuition that certainty should be our highest priority. We must draw on, generate, and apply a broader range of evidence including the practice-based evidence that spotlights the realities and subtleties of implementation that account for success and the importance of fitting interventions and strategies to the strengths, needs, resources and values of particular populations and localities" (Schorr, L. B. 2016).

The FDM assessment and case management model facilitates improvement from an in-crisis/at-risk status to a stable/safe and self-sufficient status for in a relatively brief period of client engagement. Evidence based and evidence informed practices are delivered within the structure of a case management model (O'Hare, T., 2005). Increased family engagement evaluation comprised with the utilization of strengths analysis, family-directed empowerment planning and supportive case management leads to empirically consistent positive outcomes. Improvement in outcomes may well be positively related to family/worker relationship building, thus, adequately trained staff in the use of family data is essential to the FDM theory of change effectiveness.

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