

# Evaluation of the Broward County Family Success Center Family Development Program

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## I. Introduction

The Family Success Centers (FSCs) were created in response to a need to serve clients more effectively and use available resources more efficiently. Families need to accumulate a critical mass of strengths in a number of areas to effectively transition to individual and family well-being. The FSCs were modeled after a collaborative service delivery system in Louisville, Kentucky. Broward County staff visited the Louisville program in the spring of 1999. The transformation of the centers began shortly thereafter, and reached a milestone with the inception of the new operational structure in the fall of 1999. Staff continued their efforts, however, to find a more effective means of assisting Broward County's low income residents to meet their basic needs, and address other functional issues. Based on exhaustive research, staff uncovered and adapted a model with proven success in achieving effective social service outcomes, which was piloted in early 2003.

The matrix model, as it is generally referred to, of family well-being was developed in response to the Government Performance and Results Act (GPRA). Sponsored by the US Department of Health and Human Services, Office of Community Services, the Monitoring and Assessment Task Force met and formed the Scales and Ladders Subcommittee to identify measures which would help providers monitor outcomes and thereby their performance, and ultimately improve service effectiveness. The model has been most extensively used by Community Action Agencies (CAAs). Others, such as Family Preservation and Support Programs, Healthy Start, Family Resource Centers and community-based agencies in several states have used the model, most notably California, Iowa, Pennsylvania, Kansas and Nebraska. Several important features that promote effective service outcomes are attributed to this model:

- a proven mechanism to assess the well-being of individuals and families;
- a strengths-based approach to addressing the needs of individuals and families;
- a focus on outcomes and accountability;
- a comprehensive, holistic assessment of clients that also encourages client involvement in the process;
- a measurement of progress over time; and
- a user-friendly case management program.

The focus of this evaluation is to document process and measure the effectiveness of the family development model as it has been implemented in Broward County Florida. The outcomes of strategies employed by staff and families, and the process by which outcomes were achieved are important for understanding how the model has worked, where it may be refined, and what lessons have been learned that can inform replication in other Centers. A second focus of the model was to improve community collaboration which is assumed to reduce fragmentation and foster a more coordinated, comprehensive service delivery system enhancing program effectiveness.

The evaluation relies in part on systematic data collected by the program during the course of case management activities using a matrix model (described further below). Utilizing these measures currently collected, and measures collected through interviews

and survey instruments, the evaluation was designed to validate measures through triangulation. The interpretation of these data is intended to provide insight into process and outcomes, and provide summative evaluation and information relevant for the purposes of program replication and improvement.

## **II. Methodology**

### **Scope and Time Frame**

The evaluation was primarily designed to assess program participant outcomes associated with the Family Success Center (FSC) implementation of a family development model. The FSC model was also intended to promote an effective and efficient service delivery system through facilitation of collaboration and the evaluation was designed to assess this important interagency element of the model. Through a series of instruments developed for the evaluation, process measures were also collected from program participants, staff, administration and community service providers. Data reflect the program implementation period beginning in early 2003. Qualitative data were collected during the summer of 2004.

### **Design**

The FSC provided data to address family outcomes. Using the Matrix model “mutually exclusive indicator approach” case managers completed the scoring tool with established consistency in scoring across case workers. The mutually exclusive indicator approach is based on the assumption that program participants either meet certain criteria or not, and therefore scoring is not the subject of interpretation on the part of the case worker but is based on reliable criteria established through knowledge of common client problems, adaptation of models work in Bucks County, Pennsylvania and others associated with the Scales and Ladders initiative of the Management and Assessment Task Force, and the matrix model approach (e.g., California Matrix Model, Endres, Richardson and Sherman, 1999; Automated Assessment of Family Progress, Richardson et al. 1998-2001a). An example of the mutually exclusive indicator approach from the program materials is: “a family is determined to either be able to afford food or not. If they are able to afford food, they can either afford a range of food options, or not. If they are not able to afford food, they are either eligible to participate in subsidized food programs, or not.”

The Family Success Centers collaborative service delivery system was also described in program materials as an essential element of the service provision model enabling access to a variety of services and facilitation of case flow through the service network. Supplemental qualitative data from direct service workers and program participants were collected to validate the quantitative data and provide context. Qualitative data were also collected from representatives of other service providers in Broward County to provide further validation and comparison with perceptions of those outside the Family Success Center. In addition, social network data were collected from representatives of provider agencies in the county.

### **Instruments and Data Collection Process**

The FSC provided data from client records with completed family development matrix measurements. During June 2004, interviews were conducted with administrative and direct service staff, program participants, and representatives of other service provider agencies in Broward County. Data were also collected through follow-up telephone interviews of clients, provider representatives, staff and administration.

The instruments developed for data collection included a Service Provider Survey which was used in face to face interviews and also guided staff interviews. A Collaboration Survey Instrument was also administered to providers which included a Social Network Survey Instrument. A Program Participant Interview was also developed to collect data from clients, who completed the program in a brief private interview about their experience with the program. The instruments are appended to this report.

### **III. Background for the Family Development Model (from Program Materials)**

Program materials state: The model selected to provide the framework for self-sufficiency assistance to clients at the Family Success Centers is based on a matrix with several functional areas of living, that facilitate intensive case management and comprehensive integrated services. This model uses a rating system with functional levels associated with specific criteria to assess, track and evaluate client progress. Clients are assessed in a number of functional areas that include **adult education, employment, housing, income, mental health, nutrition, parenting, physical health, social functioning, substance abuse and transportation**. Each area has five levels of functioning — **in crisis, at-risk, stable, safe, and thriving**. Clients are rated from 1 to 5, based on their responses to the questions in the assessment, with a score of 1 point if they are in crisis and 5 points if they are thriving.

Clients develop service goals according to the needs identified in their assessment, and are evaluated at scheduled intervals to determine progress. Based on the model, functional areas in which the client is at a growth level, that is, “in crisis” or “at risk,” must be addressed. The other three levels --- “stable,” “safe” and “thriving” --- are considered maintenance levels, whereby clients may choose whether to work on progressing to another level in the functional area or maintain that level and focus on developing in other areas. The case manager, depending on the particular case, may adopt a multidisciplinary approach by seeking the input of in-house social workers from other agencies, and/or refer clients to nonresident providers for needed services.

The model implemented in Broward County’s FSCs uses a strengths-based approach that allows case workers to conduct a thorough assessment of clients, and establish a baseline from which clients’ progress can be measured and tracked over time. (Table III-1 illustrates the difference between two employment scales; one scale exemplifies a deficit approach and the other exemplifies a strength-based model). The goal of the model is to assist eligible community residents in meeting their economic needs, and achieving their potential by strengthening the individual and the family in a number of functional areas. The process begins with determining each client’s position on the

scale in each of the functional areas. The scales feature of the model facilitates incremental progress that aids goal attainment for both clients and case workers in reaching the next level in the functional areas.

**Table III-1  
Example of Scales Showing Deficit-based versus Strengths-based Approach**

	Deficit-based language at lower thresholds	Balanced with asset-based language
<b>Thriving</b>	Full-time job in field of choice with benefits and training opportunities. Job utilizes current skills of employee, and offers opportunity for advancement. Job secure.	Current job exceeds needs for basic living expenses and values the individual's unique skill set. Employee development plans outline long-term opportunities for growth. Job is secure, and benefits include retirement plans.
<b>Safe</b>	Full-time job with benefits, paying a living wage. Job secure for up to one year, with training available for skills needed to advance.	Current job meets needs for basic living expenses, with opportunities for merit raises, transfers, and promotions to other positions. On-the-job training and in-service seminars provide chances for development of new skills.
<b>Stable</b>	Full-time employment or underemployed. Job does not utilize full range of skills of employee, does not offer job security, or opportunities for growth.	Current job meets need for basic living expenses. Raises occur as cost-of-living increases. Employee may possess skills and credentials which the current job environment does not value: degrees, trade certifications, fluency in other languages, and cross-cultural experiences.
<b>Vulnerable</b>	One or more part-time jobs. No benefits. No job security. No training opportunities.	One or more part-time jobs which may include seasonal agricultural, construction, or other outdoor employment. Employee has a range of skills and is flexible in seeking employment, although most jobs last less than six months. Employee often barter skills in exchange for rent, child care, clothing and food.
<b>In-crisis</b>	No job. No skills. No work history.	Individual has an interest and commitment to work. Most work experiences to date were unpaid, and may have included child rearing, care of family members, and illegal activity. There is a willingness to learn new skills.

Based on a community needs assessment of residents in the areas around each FSC, the following services were identified:

- Intensive Case Management
- Economic Support
- Housing Assistance
- Housing Rehabilitation
- Health Screening
- Substance Abuse
- Mental Health
- Individual/Family/Group Counseling
- Education and Vocational Training
- Elderly (community care, mental health, supportive housing, crisis intervention.)
- Veterans Support
- Basic Support (food, clothing, shelter, transportation)
- Child Care

## **Collaborative Operational Procedure**

The multipurpose nature of the FSCs facilitates the collaborative approach, and promotes an effective and efficient service delivery system. Participating providers in one location, operating as a team or independently, respond to the multifaceted needs of clients and their families, in order to improve their well-being and overall level of functioning. As the level of provider collaboration develops, (it is assumed) this will help to reduce fragmentation and foster a more coordinated, comprehensive service delivery system. The features of a provider collaborative that contribute to its effectiveness in streamlining and improving the service delivery system include:

- A single intake and screening process;
- Shared client information facilitated through the use a Consent to Release Information form;
- A multidisciplinary team approach to broaden the scope of service interventions;
- A community focus through the targeting of a specific geographic area and the needs of its residents; and
- The potential maximization of available resources accommodated through collaboration.

The model relies on interagency collaboration including case planning among direct service staff from different agencies. Access to comprehensive services in a holistic treatment philosophy is fundamental to the model. Approximately 25 providers were reported to be participants in the collaborative (according to program materials dating back to 1999) with 18 providers identified for this evaluation.

The extent of success clients achieve in meeting their needs at the FSCs is thought to be directly tied to the level of provider collaboration. Effective collaboration requires the sharing of expertise, talents and resources to achieve a common goal. Joint planning and effective communication among participants are also important, and facilitate the development of mutually agreed upon strategies designed to achieve shared goals. A major hindrance experienced by a number of provider collaborative efforts has been the development of a viable operational procedure to guide the interaction of its members.

## **Service Delivery Process**

The components of the service delivery system include community outreach; client intake, orientation and screening; comprehensive assessment; case planning; case management; case tracking and evaluation; exit assessment; and case closure. This service continuum, depicted in the Intensive Case Management Service Delivery Flow Chart provided in the program materials, is intended to ensure that clients receive an array of services, consistent with their needs that are delivered in a competent and systematic manner. The system is predicated on clients achieving sustained outcomes that will improve their well-being and, where appropriate, that of the entire family. Each component of the service delivery system is described below.

### ***Outreach***

This component is essential, in light of the recurring finding in several needs assessment of target populations regarding a lack of knowledge about the existence of

available services, the nature of and eligibility for receiving those services, and where to obtain them. Addressing residents' awareness about the availability of social services to meet various needs will better ensure that resources allocated to meet these needs are fully utilized. A broader awareness of available social service options is also likely to motivate people to seek assistance before manageable problems become chronic.

Churches, schools and civic organizations within a community play a key role in disseminating information and keeping residents informed about issues that impact them. It is also important to work cohesively with these neighborhood entities and gain their support for the efforts being made to better serve and be responsive to the needs of community residents. Community bulletins within the neighborhood announcement segment on the major networks provide another key avenue to reach residents that need to be incorporated in developing an effective outreach strategy. Another source of disseminating information, that is often underutilized, is the buses that make several trips through the targeted neighborhoods on a daily basis. The exterior surface of these buses provide an expansive canvas on which to inform residents of the services offered and where to obtain them. There is no charge to county departments for the use of this space, they only need to provide their own art work. Flyers, strategically distributed, also provide an inexpensive and effective means of broadening awareness about available social services.

### ***Orientation, Intake and Screening***

Clients presenting for services at the centers are greeted on arrival. Except for those receiving only information and referral to appropriately address their needs, clients are given forms they need to complete, necessary instructions, and are directed to sign in. They are also directed, during this initial contact, to view the continuously running video presentation, which provides a brief orientation on the Family Success Centers and the services available there. The orientation gives clients the opportunity to view their situation from a broader perspective, and consider how to take full advantage of the services offered at the center. The orientation could also be expanded to include a video presentation of former clients sharing their experience, and the impact the program has had on their life.

At the next step in the process, clients are seen on a first come, first served basis in order from the sign-in sheet, unless they have a scheduled appointment. The social worker (SW) sees the client to the office where the completed forms are reviewed. The SW ensures that the client has completely filled out the forms, seeks clarification, where necessary, and gives the client an opportunity to ask questions about the video, available services or any other matters. Arrangements are made for the client to have a comprehensive assessment after the SW has completed this initial interview.

### ***Assessment***

At this stage in the service delivery process a comprehensive assessment is made (program materials indicate the assessment includes client strengths, weaknesses and barriers). A thorough assessment is the first step in the service delivery process because it allows the development of a plan that is client-specific and focused, and

more likely to match solutions to identified needs. Clients frequently present with multiple needs in addition to their economic self-sufficiency barriers. Limitations such as education or job skills, as well as substance abuse, must be addressed to achieve sustained economic independence and well-being.

The quality of the assessment hinges on several factors, notably the interviewing skills of the case manager and the reliability of the information the client provides. It is imperative that the assessment be done in collaboration with the client, so that the process is seen as a joint problem-solving exercise and therefore, more likely that clients will participate in case planning and activities designed to promote well-being and personal growth. Consistency among case workers in comprehensively assessing clients and, where applicable, members of their household, is assured through the adoption of standard operating procedures in using the assessment tools, to which all case workers must adhere.

### **Case Planning**

The case planning process allows the case manager and the client to use the completed comprehensive assessment to determine which functional areas need improvement, and develop strategies to achieve the desired outcomes over a period of time. Based on the requirements of the Family Development Model, all functional areas where the client is at the growth level, that is, “in crisis” or “at risk” must be addressed. The other three levels — “stable,” “safe,” and “thriving” — are considered maintenance levels, whereby clients may choose whether to work on progressing to another level in the functional area or maintain that level and focus on developing in other areas. The case manager, depending on the particular case, may adopt a multidisciplinary approach by seeking the input of in-house social workers from other agencies, to incorporate different perspectives and establish the most effective strategies for meeting the client’s needs, and/or refer clients to nonresident providers for needed services.

Despite the individuality of service plans which, of necessity, are concomitant with client needs, these plans have several essential elements. These are outlined in Levine and Fleming,<sup>1</sup> and include the following:

- clearly identified priority areas for needed services;
- short and long-term measurable objectives within each of the priority areas, which can be used to evaluate client progress;
- specific actions which must be taken to reach these goals;
- agencies to which the client will be referred and, if possible, specific individuals within those agencies who will be contacted;
- realistic timeframes for completing activities; and
- identification of potential barriers to service utilization and delivery (for example, admission criteria, client attitudes or resistance, nonexistent services, inadequate resources) and proposed solutions to these problems.

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<sup>1</sup>Levine, I.S. and Fleming, M. *Human Resource Development: Issues in Case Management*. Baltimore: Center for Rehabilitation and Manpower Services, University of Maryland, 1984.

### **Case Management**

Based on standard practice, the essential elements of case management are client identification, assessment of need, service planning, service coordination and linking, and the monitoring and continuous evaluation of the client, of service delivery, and of available resources. The goal of case management “is to resolve the client’s problems in the most effective way possible within the constraints of the service program.” The case management process is most proficient when case managers are familiar with the location and availability of services. Resource inventories and other sources of information need to be consistently updated to facilitate the process of assisting clients obtain needed services. The case management process allows continuous interaction with clients in a proactive manner to ensure that the case plan is fully implemented and the objectives attained. The case manager conducts the necessary follow-up each time the client is referred for services, to ensure the service has been received and the intervention has the desired effect. The case manager plays an important role as the clients’ advocate, so clients uncertain of and unfamiliar with the process receive the support which could make the difference between success and failure in achieving desired outcomes.

### **Case Tracking and Evaluation**

Monitoring is an important aspect of the service delivery process, because it is designed to ensure that clients are receiving the services expected, and that they are appropriate and necessary to meet their needs. This is accomplished through the case managers continuous contact with the client and each service provider included in the case plan. The case manager needs to assure clients that the constant monitoring is not meant to be intrusive, but rather to ensure that clients’ needs are being addressed and that if problems arise they can be resolved. In the event of problems arising with a provider agency other than the case manager’s, the case manager should be able to intervene to keep the case plan on track. The ability of the case manager to successfully engage in interagency collaboration makes it easier to get the interprofessional cooperation necessary to negotiate on behalf of clients. The FSC operation, with a resident provider network, is conducive to provider interaction and should prove beneficial to clients.

The continuous monitoring of clients, as they implement their case plans, is a natural progression to evaluation, because it provides the information required to determine if a redefinition of needs and goals are required, and the development of a revised case plan. It also serves to confirm, in some instances, where appropriate, that the service plan is working well and no modification is required. *It is not uncommon, also, for a client to have lower scores in follow-up assessments, as they become more comfortable and more forthcoming with the case manager than they were in the initial assessment. When this occurs, the new lower score becomes the baseline against which to measure future progress.*

### **Exit Assessment and Case Closure**

Clients remain in the program until they have successfully completed their case plan or decide to discontinue receiving assistance. Those who complete the program will receive an exit assessment to ensure they have attained the necessary levels of

functioning in pertinent life areas to assure their and, where appropriate, their family's well-being after graduation. Typically, a case is closed when the risk factors and barriers identified in initial and subsequent assessments have been eliminated or reduced to a level where it does not impede the client's ability to function at a "stable" level.

### **Staff Training**

The matrix model represents a new way of serving clients for staff at the FSCs, and although it is user-friendly and should not be difficult for staff to assimilate, training was necessary. Thus, in order to facilitate the change, a consultant, with considerable experience and familiarity with the model, was retained to orient and train staff to enable them to function effectively in this new service delivery environment, and make the adjustment as seamless as possible. Staff participated in a two week family development specialist certification program that included the completion of a practicum and a minimum passing score on their final examination.

### **Review of Strengths-Based Family Centered Practice**

The paradigm shift undertaken at the FSC requires ongoing attention to the details of the intervention; it is not an easy model to fully implement. Before launching into the analysis of the data available for the program evaluation, it is important to review some of the major tenets of the model practice being implemented. This review also helps to set the stage for the use of the evaluation results. To be consistent with the model, the results should be used to acknowledge the successes measured and identify areas on which to build those successes in the future.

Fundamentally, we want to answer the two primary questions for this evaluation:

- 1) Are we achieving the desired outcomes measured by the family domain scores?
- 2) Is collaboration measurably improving among the network of service providers for families?

However, we also want to build on evaluation information for future understanding of:

- the ability to tailor services
- the effect on access
- the inclusion of extended family and other supports
- the extent of enhanced ability to build on family and community strengths and resources, and
- whether the achievement of goals is sustained

The present evaluation provides historical and baseline documentation and a report that can be referenced in the future for quality assurance purposes. There are other models such as Systems of Care, Wraparound, and Restorative Justice that contain similar practice elements and from which the program may draw. Training and technical assistance is another source of practice improvement information that can be obtained through National Resource Centers or other funding streams. The practice information, evaluation data and analysis provide a guide to ensuring, inevitable local adaptations of the family development case management model currently being implemented.

The implementation of the case management practice referred to as family development or the matrix model is essentially a systems change model. The same practice innovations targeted in direct practice apply throughout the system (c.f., Kohombian, 2002; Weisberg, 2002). It is a process and a values base which requires a support focus designed to enhance strengths at every level. Direct service workers are asked to maximize customer voice, choice and preference. Administration must also enhance effectiveness by maximizing worker voice, choice and preference. The model is intended to promote independence and stability at all levels and to challenge the difference between boundaries and barriers.

Family development models work because services are individualized, strengths-based, and family-focused, and they promote competency and build social support. Implications from previous research (Nelson, Landsman, Tyler and Richardson, 1996) are that, once stabilized in short term intervention, families become much more resilient and less likely to return for services when providers engage in a follow-on period of building an effective informal social support system (safety net).

The model seeks to improve functioning at all system levels, and the values promoted by the program philosophy help to define best care. Access to best care is thus promoted for all families in all systems, and requires simultaneous management and practice change in support of the program philosophy and the improved practices. Effective practice is inextricable with overall system improvement because these systems are inter-connected. Values and vision are correlated with direct service activities, and system flexibility and innovation must be celebrated. System functions are analyzed against the needs of each family, and the family focus is maintained throughout. The result is that constant reshaping is necessary, based on the needs of families, and staff must be encouraged to forge new and effective partnerships.

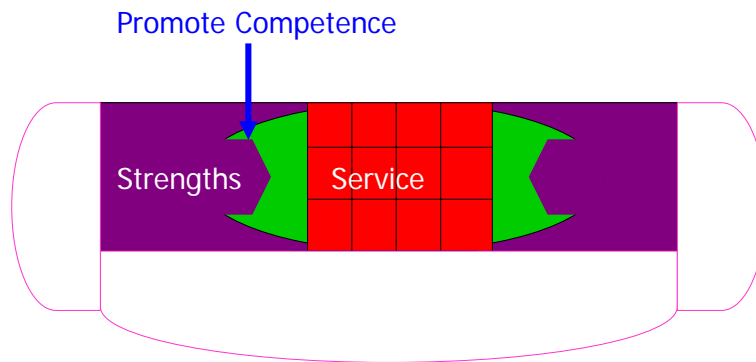
Thus, the model represents a movement from expert determined need to facilitation of the family and their strategy. This means fundamentally changing the traditional perspective from problem focus to need focus, from deficits to strengths, from service to supports, from fitting the family to available services to tailoring services to address uniqueness, and from client focus to partnership focus. The strengths base is the foundation of the model because it is based upon the family strengths that we promote hope, build competence upon competence and achieve outcomes sooner. Outcomes achieved in this way sustain longer and are more cost-effective (c.f. Nelson et al., 1996; Richardson, et al. 1995). We must assume that all families have strengths and that each individual's strengths are unique and also unique within a family system. Change is supported by identifying and building on those unique strengths. People know their strengths and needs and the identification process help to explore not only the inventory of strengths but also the recognition of commonalities. Like individuals and families, all environments have strengths upon which to build (c.f. Wollesen, 2002; Endres, 2000).

Briefly, the model tells us that we must first understand the family's perspective. We may then utilize a corrected history of events and grasp common bonds, which provide

us with opportunities for building alliances. Understanding what is believed to have been helpful in the past is a key to planning for the future (this may involve elements of solution focused therapy). This can be accomplished through listing all possible social supports and family assets in ways similar to strategic planning for organizations in which we identify strengths, weaknesses, opportunities and threats (SWOT). Figure III-1 illustrates the initial stages of solving the puzzle-like process of identifying strengths, promoting competence and identifying service needs.

**Figure III-1: Service Planning Built on a Background of Family Strengths and Promoting Competencies**

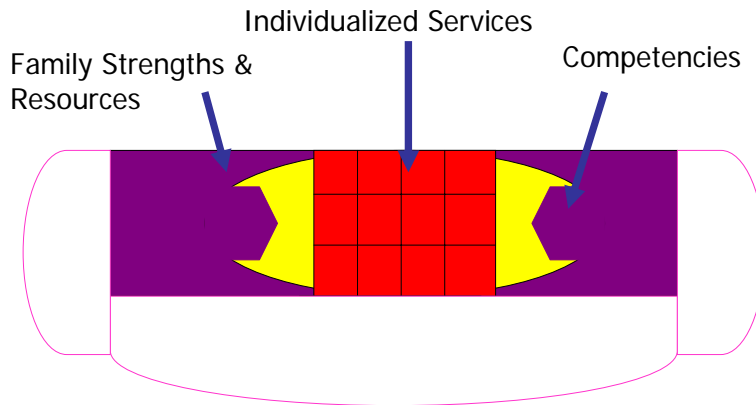
## Individualized & Strength-Based



Creating a resilient healthy family is not working toward an ideal set of strengths. What strengthens one family may not strengthen another. Strengths have to be discovered with each encounter. Similarly, the use evaluation information should mirror the model. Evaluation is a tool that should help to identify strengths and promote informed decision-making in the future (Richardson, Spears & Theisen, 2003). Figure III-2 illustrates the next stage in the process of identifying competencies and building on the base of strengths and resources, and developing individualized services that further competencies and strengths (Beyer, 1997).

**Figure III-2: Service Provision Built on a Background of Family Strengths and Promoting Competencies**

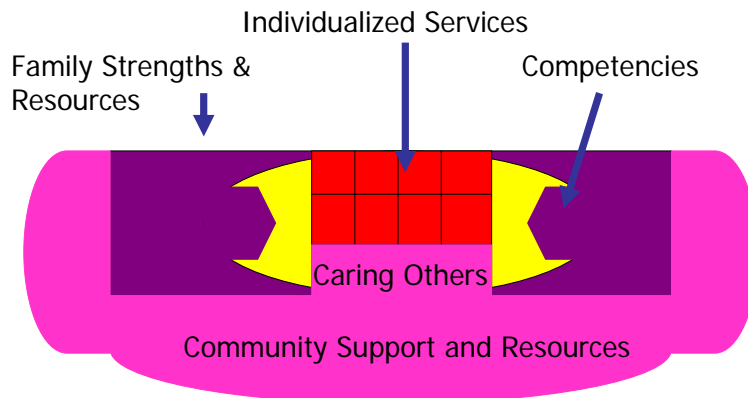
## Individualized & Strength-Based Service Delivery



In Figure III-3 we see the general model of the process described above. Family strengths and resources are the foundation and individualized services are provided in the context competencies. Individualized services are also provided in recognition that community supports and resources can provide a safety net within which informal supports can be provided by caring others who are an integral piece of family strengths and resources.

**Figure III-3: General Model of Strengths-Based Family Centered Practice**

## Individualized, Strength-Based, Family-Focused Service Delivery



#### **IV. Data Analysis and Results: Program Participant Data**

Baseline and follow-up (final assessment at program exit) data were analyzed for all (N=511) individuals with whom case managers worked during the February 2003 to June 2004 period of time. The results presented below include percentages for each category of the family development matrix domains at baseline and follow-up with paired comparisons significance tests for all family members with both initial and follow-up measures. A summary table of the data follows the discussion of the results.

Adult Education domain results indicate 96 percent entered at stable, safe or thriving (SST) and 4.0 percent were In-Crisis or At-Risk (ICAR). At follow-up 96.9 percent were SST and 3.1 percent were ICAR. The mean Adult Education domain score was 4.17 at baseline improving to 4.23 at follow-up and is statistically significant ( $p < .05$ ).

Employment domain results indicate that 37.9 percent were SST and 62.1 percent were ICAR at initial assessment. At follow-up 76.4 percent were SST and 23.6 percent were ICAR. The mean Employment domain score was 2.32 at baseline improving to 3.04 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Housing domain results indicate that 32.4 percent were SST and 67.6 percent were ICAR at initial assessment. At follow-up 91.4 percent were SST and 8.6 percent were ICAR. The mean Housing domain score was 2.06 at baseline improving to 3.26 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Income domain results indicate that 29.9 percent were SST and 70.1 percent were In ICAR at initial assessment. At follow-up 79.4 percent were SST and 20.6 percent were ICAR. The mean Income domain score was 2.05 at baseline improving to 2.83 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Mental Health domain results indicate that 84.8 percent were SST and 15.2 percent were ICAR at initial assessment. At follow-up 95.3 percent were SST and 4.7 percent were ICAR. The mean Mental Health domain score was 3.43 at baseline improving to 3.66 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Nutrition domain results indicate that 60.4 percent were SST and 39.6 percent were ICAR at initial assessment. At follow-up 98.9 percent were SST and 1.1 percent were ICAR. The mean Nutrition domain score was 2.93 at baseline improving to 3.64 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Parenting domain results indicate that 97.3 percent were SST and 2.7 percent were In ICAR at initial assessment. At follow-up 99.2 percent were SST and .8 percent were In ICAR. The mean Parenting domain score was 3.91 at baseline improving to 3.99 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Physical Health domain results indicate that 79.1 percent were SST and 20.9 percent were ICAR at initial assessment. At follow-up 90.5 percent were SST and 9.5 percent

were ICAR. The mean Physical Health domain score was 3.46 at baseline improving to 3.65 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Social Functioning domain results indicate that 71.1 percent were SST and 28.9 percent were ICAR at initial assessment. At follow-up 92.9 percent were SST and 7.1 percent were ICAR. The mean Social Functioning domain score was 3.04 at baseline improving to 3.38 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Substance Abuse domain results indicate that 99.7 percent were SST and .3 percent were ICAR at initial assessment. At follow-up 99.2 percent were SST and .8 percent were ICAR. The mean Substance Abuse domain score was 4.88 at baseline and 4.87 at follow-up. This is not statistically significant.

Transportation domain results indicate that 65.9 percent were SST and 34.1 percent were ICAR at initial assessment. At follow-up 97.2 percent were SST and 2.8 percent were ICAR. The mean Transportation domain score was 2.78 at baseline improving to 3.32 at follow-up. This is a statistically significant increase ( $p < .05$ ).

### **Summary: All Family Members in Case Management**

Analysis of the data for all family members receiving services at the Family Success Center in the Case Management Program revealed that significant improvement was obtained for all domains, with the exception of the substance abuse domain. Employment, Housing, Income, Nutrition, Social Functioning and Transportation obtained substantial gains ( $\geq 20$  percent) in the percentage of program participants assessed at stable, safe, or thriving. At program exit, follow-up assessments indicate that more than 90 percent were assessed at SST on Adult Education, Housing, Mental Health, Nutrition, Parenting, Physical Health, Social Functioning, Substance Abuse, and Transportation. While Employment and Income appear to be more intractable, more than 70 percent were SST at follow-up and gains in both areas were obtained by 40 percent of all participants.

**Table IV-1: Broward Co. Family Development Matrix Domains: All Family Members in Case Mgmt.**

<b>ADULT EDUCATION</b>								
N=375,316 n=314	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	.5%	3.5%	12.0%	45.9%	38.1%	4.17	.862	p<.05
<i>Follow-up</i>	.3%	2.8%	13.0%	41.5%	42.4%	4.23	.805	
<b>EMPLOYMENT</b>								
N=333,280 N=279	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	33.6%	28.5%	23.7%	8.7%	5.4%	2.32	1.182	p<.05
<i>Follow-up</i>	7.9%	15.7%	48.9%	19.3%	8.2%	3.04	.992	
<b>HOUSING</b>								
N=511,441 n=441	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	42.9%	24.7%	13.9%	17.4%	1.2%	2.06	1.148	p<.05
<i>Follow-up</i>	1.8%	6.8%	59.9%	27.0%	4.5%	3.26	.726	
<b>INCOME</b>								
N=467,398 n=397	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	29.6%	40.5%	27.6%	2.4%	0%	2.05	.804	p<.05
<i>Follow-up</i>	3.3%	17.3%	72.6%	6.8%	0%	2.83	.587	
<b>MENTAL HEALTH</b>								
N=434,365 n=364	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	1.8%	13.4%	28.6%	48.8%	7.4%	3.43	.908	p<.05
<i>Follow-up</i>	.3%	4.4%	35.9%	48.2%	11.2%	3.66	.746	
<b>NUTRITION</b>								
N=510,444 n=443	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	11.6%	28.0%	20.6%	31.6%	8.2%	2.93	1.189	p<.05
<i>Follow-up</i>	.2%	.9%	46.2%	39.6%	13.1%	3.64	.724	
<b>PARENTING</b>								
N=301,253 n=251	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	0%	2.7%	12.0%	73.1%	12.3%	3.91	.620	p<.05
<i>Follow-up</i>	0%	.8%	14.2%	69.6%	15.4%	3.99	.573	
<b>PHYSICAL HEALTH</b>								
N=510,442 n=441	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	8.4%	12.5%	22.9%	44.3%	11.8%	3.46	1.064	p<.05
<i>Follow-up</i>	1.6%	7.9%	27.6%	49.8%	13.1%	3.65	.862	
<b>SOCIAL FUNCTIONING</b>								
N=508,436 n=435	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	3.1%	25.8%	39.0%	29.7%	2.4%	3.04	.878	p<.05
<i>Follow-up</i>	1.6%	5.5%	48.4%	41.7%	2.8%	3.38	.707	
<b>SUBSTANCE ABUSE</b>								
N=312,259 n=259	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	.3%	0%	2.9%	8.3%	88.5%	4.88	.374	N.S.
<i>Follow-up</i>	0%	.8%	2.3%	6.2%	90.7%	4.87	.456	
<b>TRANSPORTATION</b>								
N=455,388 n=385	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	16.5%	17.6%	35.2%	26.8%	4.0%	2.78	1.091	p<.05
<i>Follow-up</i>	1.5%	1.3%	64.4%	28.9%	3.9%	3.32	.644	

N=number of initial assessments, number of follow-up assessments  
n=number of matched pairs on which significance tests are based

Baseline and follow-up (final assessment at program exit) data were also analyzed for individuals identified as the head of household (HOH) with whom the case managers worked (n=190). Table IV-2, below, presents percentages for each category of the family development matrix at baseline and follow-up along with significance tests for match pairs (i.e., those with both initial and follow-up measures).

Adult Education domain results indicate that 93 percent were SST and 7.0 percent were ICAR at initial assessment. At follow-up 94.3 percent were SST and 5.7 percent were ICAR. The mean Adult Education domain score was 4.17 at baseline improving to 4.26 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Employment domain results indicate that 32.1 percent were SST and 67.9 percent were ICAR at initial assessment. At follow-up 74.1 percent were SST and 25.9 percent were ICAR. The mean Employment domain score was 2.19 at baseline improving to 2.96 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Housing domain results indicate that 34.8 percent were SST and 65.2 percent were ICAR at initial assessment. At follow-up 92.7 percent were SST and 7.3 percent were ICAR. The mean Housing domain score was 2.12 at baseline improving to 3.28 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Income domain results indicate that 27.1 percent were SST and 72.9 percent were ICAR at initial assessment. At follow-up 80.6 percent were SST and 19.4 percent were ICAR. The mean Income domain score was 1.99 at baseline improving to 2.86 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Mental Health domain results indicate that 79.6 percent were SST and 20.4 percent were ICAR at initial assessment. At follow-up 94.7 percent were SST and 5.3 percent were ICAR. The mean Mental Health domain score was 3.31 at baseline improving to 3.63 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Nutrition domain results indicate that 64.0 percent were SST and 36.0 percent were ICAR at initial assessment. At follow-up 98.8 percent were SST and 1.2 percent were ICAR. The mean Nutrition domain score was 3.00 at baseline improving to 3.66 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Parenting domain results indicate that 97.8 percent were SST and 2.2 percent were ICAR at initial assessment. At follow-up 99.1 percent were SST and .9 percent were ICAR. The mean Parenting domain score was 3.91 at baseline improving to 3.99 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Physical Health domain results indicate that 69.8 percent were SST and 30.2 percent were ICAR at initial assessment. At follow-up 87.7 percent were SST and 12.3 percent were ICAR. The mean Physical Health domain score was 3.28 at baseline improving to 3.57 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Social Functioning domain results indicate that 74.6 percent were SST and 25.4 percent were ICAR at initial assessment. At follow-up 92.4 percent were SST and 7.6 percent were ICAR. The mean Social Functioning domain score was 3.12 at baseline improving to 3.41 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Substance Abuse domain results indicate that 99.3 percent were SST and .7 percent were ICAR at initial assessment. At follow-up 99.1 percent were SST and .9 percent were ICAR. The mean Substance Abuse domain score was 4.81 at baseline and 4.79 at follow-up. This is not statistically significant.

Transportation domain results indicate that 68.1 percent were SST and 31.9 percent were ICAR at initial assessment. At follow-up 96.8 percent were SST and 3.2 percent were ICAR. The mean Transportation domain score was 2.92 at baseline improving to 3.39 at follow-up. This is a statistically significant increase ( $p < .05$ ).

### **Summary: Head of Household in Case Management**

Results of the data analysis, restricted to the Head of Household (HOH) of families seen at the Family Success Center in the Case Management Program, indicate that all domains showed significant improvement on the final assessments administered at program exit with the exception of Substance Abuse and Parenting/Caregiving. Consistent with the results from the analysis of all family members, Employment, Housing, Income, Nutrition, and Transportation obtained substantial gains ( $\geq 20$  percent) in the percentage of program participants assessed at or above the stable threshold (i.e., stable, safe, or thriving). At follow-up assessment more than 90 percent were stable, safe or thriving on Adult Education, Housing, Mental Health, Nutrition, Parenting, Social Functioning, Substance Abuse, and Transportation. Assessment of stable, safe or thriving for Physical Health was reported for 87.7 percent of HOH. Also consistent with the results for the analysis of all family members, Employment and Income showed substantial gains with more than 70 percent stable, safe or thriving at follow-up on Employment, and more than 80 percent stable, safe or thriving on Income.

**Table IV-2: Broward Co. Family Development Matrix Domains: Head of Households in Case Mgmt.**

<b>ADULT EDUCATION</b>								
N=187,157 n=156	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	1.1%	5.9%	8.0%	42.8%	42.2%	4.17	.945	p<.05
<i>Follow-up</i>	.6%	5.1%	7.0%	41.4%	45.9%	4.26	.851	
<b>EMPLOYMENT</b>								
N=162,139 n=138	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	33.3%	34.6%	18.5%	9.3%	4.3%	2.19	1.118	p<.05
<i>Follow-up</i>	8.6%	17.3%	50.4%	15.1%	8.6%	2.96	.999	
<b>HOUSING</b>								
N=190,163 n=163	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	36.8%	28.4%	12.6%	20.0%	2.1%	2.12	1.162	p<.05
<i>Follow-up</i>	1.8%	5.5%	60.7%	26.4%	5.5%	3.28	.733	
<b>INCOME</b>								
N=188,160 n=159	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	30.9%	42.0%	24.5%	2.7%	0.0%	1.99	.800	p<.05
<i>Follow-up</i>	3.8%	15.6%	71.3%	9.4%	0.0%	2.86	.621	
<b>MENTAL HEALTH</b>								
N=181,153 n=152	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	3.3%	17.1%	29.3%	42.0%	8.3%	3.31	.998	p<.05
<i>Follow-up</i>	.7%	4.6%	37.3%	46.4%	11.1%	3.63	.770	
<b>NUTRITION</b>								
N=189,164 n=163	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	11.1%	24.9%	20.1%	36.5%	7.4%	3.00	1.165	p<.05
<i>Follow-up</i>	0.0%	1.2%	42.1%	46.3%	10.4%	3.66	.679	
<b>PARENTING/CAREGIVING</b>								
N=135,115 n=113	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	0.0%	2.2%	11.1%	70.4%	16.3%	3.97	.633	N.S.
<i>Follow-up</i>	0.0%	.9%	12.2%	68.7%	18.3%	4.04	.581	
<b>PHYSICAL HEALTH</b>								
N=189,163 n=162	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	13.8%	16.4%	20.1%	37.6%	12.2%	3.28	1.218	p<.05
<i>Follow-up</i>	2.5%	9.8%	30.1%	42.9%	14.7%	3.57	.938	
<b>SOCIAL FUNCTIONING</b>								
N=189,159 n=158	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	5.3%	20.1%	37.6%	34.9%	2.1%	3.12	.884	p<.05
<i>Follow-up</i>	1.9%	5.7%	44.7%	45.3%	2.5%	3.41	.723	
<b>SUBSTANCE USE</b>								
N=135,113 113	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	.7%	0.0%	3.0%	13.3%	83.0%	4.81	.460	N.S.
<i>Follow-up</i>	0.0%	.9%	4.4%	9.7%	85.0%	4.79	.558	
<b>TRANSPORTATION</b>								
N=185,159 n=156	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	13.5%	18.4%	34.1%	29.2%	4.9%	2.92	1.101	p<.05
<i>Follow-up</i>	1.3%	1.9%	57.2%	34.6%	5.0%	3.39	.678	

N=number of initial assessments, number of follow-up assessments.

n=number of matched pairs on which significance tests are based

Baseline and follow-up (final assessment at program exit) data were analyzed for all individuals who were not identified as participants in the Homeless Program (n=268). Table IV-3, below, presents percentages for each category of the family development matrix at baseline and follow-up along with significance tests for match pairs (i.e., those with both initial and follow-up measures).

Adult Education domain results indicate that 95.2 percent were SST and 4.8 percent were ICAR at initial assessment. At follow-up 95.7 percent were SST and 4.3 percent were ICAR. The mean Adult Education domain score was 4.13 at baseline improving to 4.19 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Employment domain results indicate that 41.3 percent were SST and 58.7 percent were ICAR at initial assessment. At follow-up 82.7 percent were SST and 17.3 percent were ICAR. The mean Employment domain score was 2.42 at baseline improving to 3.09 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Housing domain results indicate that 42.2 percent were SST and 57.8 percent were ICAR at initial assessment. At follow-up 91.1 percent were SST and 8.9 percent were ICAR. The mean Housing domain score was 2.40 at baseline improving to 3.29 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Income domain results indicate that 28.3 percent were SST and 71.7 percent were ICAR at initial assessment. At follow-up 87.0 percent were SST and 13.0 percent were ICAR. The mean Income domain score was 2.11 at baseline improving to 2.94 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Mental Health domain results indicate that 83.1 percent were SST and 16.9 percent were ICAR at initial assessment. At follow-up 97.5 percent were SST and 2.5 percent were ICAR. The mean Mental Health domain score was 3.38 at baseline improving to 3.69 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Nutrition domain results indicate that 67.9 percent were SST and 32.1 percent were ICAR at initial assessment. At follow-up 98.7 percent were SST and 1.3 percent were ICAR. The mean Nutrition domain score was 3.19 at baseline improving to 3.72 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Parenting domain results indicate that 97.1 percent were SST and 2.9 percent were ICAR at initial assessment. At follow-up 100 percent were SST. The mean Parenting domain score was 3.89 at baseline improving to 4.01 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Physical Health domain results indicate that 79.3 percent were SST and 20.7 percent were ICAR at initial assessment. At follow-up 91.4 percent were SST and 8.6 percent were ICAR. The mean Physical Health domain score was 3.51 at baseline improving to 3.68 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Social Functioning domain results indicate that 71.5 percent were SST and 28.5 percent were ICAR at initial assessment. At follow-up 95.8 percent were SST and 4.2 percent were ICAR. The mean Social Functioning domain score was 3.07 at baseline improving to 3.48 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Substance Abuse domain results indicate that 99.6 percent were SST and .4 percent were ICAR at initial assessment. At follow-up 98.9 percent were SST and 1.1 percent were ICAR. The mean Substance Abuse domain score was 4.87 at baseline and 4.83 at follow-up. This is not statistically significant.

Transportation domain results indicate that 67.0 percent were SST and 33.0 percent were ICAR at initial assessment. At follow-up 96.8 percent were SST and 3.2 percent were ICAR. The mean Transportation domain score was 2.88 at baseline improving to 3.36 at follow-up. This is a statistically significant increase ( $p < .05$ ).

**Summary: All Family Members--Not in Homeless Program**

Results of the data analysis, restricted to all family members seen at the Family Success Center in the Case Management Program, who were not in the Homeless Program, indicate that all domains showed significant improvement with the exception of Substance Abuse. The results from the analysis of all family members who were not involved in the Homeless Program indicate that Employment, Housing, Income, Nutrition, Social Functioning and Transportation obtained substantial gains ( $\geq 20$  percent) in the percentage of program participants assessed at or above the stable threshold (i.e., stable, safe, or thriving). At program exit, follow-up assessments indicate that more than 90 percent were assessed at stable, safe or thriving on Adult Education, Housing, Mental Health, Nutrition, Parenting, Physical Health, Social Functioning, Substance Abuse, and Transportation. Assessments of stable, safe or thriving for Employment and Income were obtained for 82.7 percent and 87 percent, respectively.

**Table IV-3: Broward Co. Family Development Matrix Domains:  
All Family Members/Not in Homeless Program**

<b>ADULT EDUCATION</b>								
N=268,211 n=211	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	.7%	4.1%	10.8%	48.9%	35.4%	4.13	.893	p<.05
<i>Follow-up</i>	.5%	3.8%	12.8%	42.2%	40.8%	4.19	.835	
<b>EMPLOYMENT</b>								
N=247,197 n=197	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	30.8%	27.9%	27.5%	9.3%	4.5%	2.42	1.138	p<.05
<i>Follow-up</i>	6.1%	11.2%	57.9%	17.8%	7.1%	3.09	.902	
<b>HOUSING</b>								
N=353,291 n=291	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	26.6%	31.2%	19.0%	21.5%	1.7%	2.40	1.117	p<.05
<i>Follow-up</i>	1.7%	7.2%	54.0%	35.1%	2.1%	3.29	.703	
<b>INCOME</b>								
N=329,268 n=268	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	25.2%	46.5%	26.1%	2.1%	0.0%	2.11	.744	p<.05
<i>Follow-up</i>	1.1%	11.9%	79.1%	7.8%	0.0%	2.94	.489	
<b>MENTAL HEALTH</b>								
N= 302,240 n=240	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	2.0%	14.9%	26.2%	49.3%	7.6%	3.38	.943	p<.05
<i>Follow-up</i>	0.0%	2.5%	39.6%	44.6%	13.3%	3.69	.731	
<b>NUTRITION</b>								
N=353,294 n=294	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	7.9%	24.1%	18.4%	39.1%	10.5%	3.19	1.157	p<.05
<i>Follow-up</i>	.3%	1.0%	40.5%	42.9%	15.3%	3.72	.743	
<b>PARENTING/CAREGIVING</b>								
N=209,163 n=162	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	0.0%	2.9%	10.0%	76.6%	10.5%	3.89	.600	p<.05
<i>Follow-up</i>	0.0%	0.0%	12.9%	73.0%	14.1%	4.01	.523	
<b>PHYSICAL HEALTH</b>								
N= 353,292 n=292	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	10.8%	9.9%	21.5%	45.9%	11.9%	3.51	1.079	p<.05
<i>Follow-up</i>	2.1%	6.5%	27.1%	50.0%	14.4%	3.68	.872	
<b>SOCIAL FUNCTIONING</b>								
N=351,287 n=287	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	3.7%	24.8%	35.9%	33.3%	2.3%	3.07	.907	p<.05
<i>Follow-up</i>	2.1%	2.1%	44.6%	48.4%	2.8%	3.48	.689	
<b>SUBSTANCE USE</b>								
N=232,180 n=180	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	.4%	0.0%	3.9%	7.8%	87.9%	4.87	.401	N.S.
<i>Follow-up</i>	0.0%	1.1%	3.3%	6.7%	88.9%	4.83	.523	
<b>TRANSPORTATION</b>								
N=318,257 n=255	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	13.2%	19.8%	33.3%	29.6%	4.1%	2.88	1.052	p<.05
<i>Follow-up</i>	1.6%	1.6%	59.1%	33.9%	3.9%	3.36	.661	

N=number of initial assessments, number of follow-up assessments.  
n=number of matched pairs on which significance tests are based

Baseline and follow-up (final assessment at program exit) data were analyzed for family members who participated in the Homeless Program (n=107). The table below presents percentages for each category of the family development matrix at baseline and follow-up along with significance tests for match pairs (i.e., those with both initial and follow-up measures).

Adult Education domain results indicate that 98.1 percent were SST and 1.9 percent were ICAR at initial assessment. At follow-up 99.0 percent were SST and 1.0 percent were ICAR. The mean Adult Education domain score was 4.26 at baseline improving to 4.30 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Employment domain results indicate that 27.9 percent were SST and 72.1 percent were ICAR at initial assessment. At follow-up 61.5 percent were SST and 38.5 percent were ICAR. The mean Employment domain score was 2.09 at baseline improving to 2.91 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Housing domain results indicate that 10.8 percent were SST and 89.2 percent were ICAR at initial assessment. At follow-up 92.0 percent were SST and 8.0 percent were ICAR. The mean Housing domain score was 1.41 at baseline improving to 3.20 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Income domain results indicate that 44.0 percent were SST and 56.0 percent were ICAR at initial assessment. At follow-up 63.8 percent were SST and 36.2 percent were ICAR. The mean Income domain score was 1.92 at baseline improving to 2.60 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Mental Health domain results indicate that 88.7 percent were SST and 11.3 percent were ICAR at initial assessment. At follow-up 91.2 percent were SST and 8.8 percent were ICAR. The mean Mental Health domain score was 3.52 at baseline improving to 3.60 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Nutrition domain results indicate that 43.4 percent were SST and 56.6 percent were ICAR at initial assessment. At follow-up 99.3 percent were SST and .7 percent were ICAR. The mean Nutrition domain score was 2.42 at baseline improving to 3.50 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Parenting domain results indicate that 97.8 percent were SST and 2.2 percent were ICAR at initial assessment. At follow-up 97.8 percent were SST and 2.2 percent were ICAR. The mean Parenting domain score was 3.96 at baseline and 3.96 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Physical Health domain results indicate that 78.3 percent were SST and 21.7 percent were ICAR at initial assessment. At follow-up 87.6 percent were SST and 11.4 percent were ICAR. The mean Physical Health domain score was 3.37 at baseline improving to 3.58 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Social Functioning domain results indicate that 70.1 percent were SST and 29.9 percent were ICAR at initial assessment. At follow-up 87.2 percent were SST and 12.8 percent were ICAR. The mean Social Functioning domain score was 2.97 at baseline improving to 3.20 at follow-up. This is a statistically significant increase ( $p < .05$ ).

Substance Abuse domain results indicate that 100 percent were SST and none were ICAR at initial assessment. At follow-up 100 percent were SST and none were ICAR. The mean Substance Abuse domain score was 4.90 at baseline and 4.95 at follow-up. This is not statistically significant.

Transportation domain results indicate that 63.5 percent were SST and 36.5 percent were ICAR at initial assessment. At follow-up 97.7 percent were SST and 2.3 percent were ICAR. The mean Transportation domain score was 2.60 at baseline improving to 3.22 at follow-up. This is a statistically significant increase ( $p < .05$ ).

### **Summary: All Family Members/ in Homeless Program**

Results of the data analysis, restricted to all family members seen at the Family Success Center in the Case Management Program who participated in the Homeless Program indicate that all domains showed significant improvement with the exception of Parenting/Caregiving. The results from the analysis of all family members who participated in the Homeless Program indicate that Employment, Housing, Income, Nutrition and Transportation obtained substantial gains ( $\geq 20$  percent) in the percentage of program participants assessed at or above the stable threshold (i.e., stable, safe, or thriving). At follow-up, assessments indicate that more than 90 percent were assessed at SST on Adult Education, Housing, Mental Health, Nutrition, Parenting, Social Functioning, Substance Abuse, and Transportation. Assessments of SST for Employment and Income were obtained for 82.7 percent and 87 percent, respectively.

**Table IV-4: Broward County Family Development Matrix Domains:  
All Family Members/ in Homeless Program**

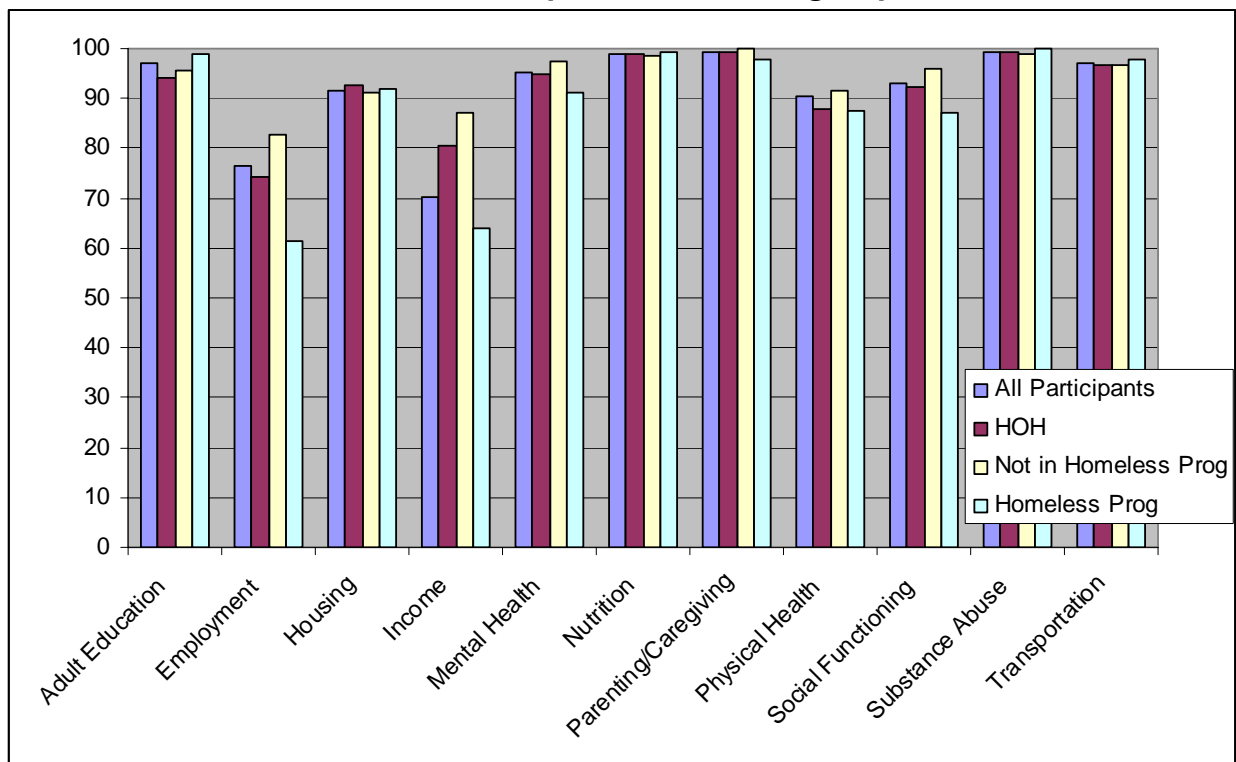
<b>ADULT EDUCATION</b>								
N=107,105 n=103	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	0.0%	1.9%	15.0%	38.3%	44.9%	4.26	.792	p<.05
<i>Follow-up</i>	0.0%	1.0%	13.3%	40.0%	45.7%	4.30	.739	
<b>EMPLOYMENT</b>								
N=86,83 n=82	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	41.9%	30.2%	12.8%	7.0%	8.1%	2.09	1.259	p<.05
<i>Follow-up</i>	12.0%	26.5%	27.7%	22.9%	10.8%	2.91	1.178	
<b>HOUSING</b>								
N=158,150 n=150	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	79.1%	10.1%	2.5%	8.2%	0.0%	1.41	.906	p<.05
<i>Follow-up</i>	2.0%	6.0%	71.3%	11.3%	9.3%	3.20	.769	
<b>INCOME</b>								
N=138,130 n=129	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	39.9%	26.1%	31.2%	2.9%	0.0%	1.92	.907	p<.05
<i>Follow-up</i>	7.7%	28.5%	59.2%	4.6%	0.0%	2.60	.701	
<b>MENTAL HEALTH</b>								
N=132,125 n=124	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	1.5%	9.8%	34.1%	47.7%	6.8%	3.52	.831	p<.05
<i>Follow-up</i>	.8%	8.0%	28.8%	55.2%	7.2%	3.60	.775	
<b>NUTRITION</b>								
N=157,150 n=149	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	19.7%	36.9%	25.5%	14.6%	3.2%	2.42	1.085	p<.05
<i>Follow-up</i>	0.0%	.7%	57.3%	33.3%	8.7%	3.50	.664	
<b>PARENTING/CAREGIVING</b>								
N=92,90 n=89	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	0.0%	2.2%	16.3%	65.2%	16.3%	3.96	.656	N.S.
<i>Follow-up</i>	0.0%	2.2%	16.7%	63.3%	17.8%	3.96	.656	
<b>PHYSICAL HEALTH</b>								
N=157,150 n=149	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	3.2%	18.5%	26.1%	40.8%	11.5%	3.37	1.029	p<.05
<i>Follow-up</i>	.7%	10.7%	28.7%	49.3%	10.7%	3.58	.840	
<b>SOCIAL FUNCTIONING</b>								
N=157,149 n=148	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	1.9%	28.0%	45.9%	21.7%	2.5%	2.97	.816	p<.05
<i>Follow-up</i>	.7%	12.1%	55.7%	28.9%	2.7%	3.20	.709	
<b>SUBSTANCE USE</b>								
N=80,79 n=79	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	0.0%	0.0%	0.0%	10.0%	90.0%	4.90	.304	p<.05
<i>Follow-up</i>	0.0%	0.0%	0.0%	5.1%	94.9%	4.95	.221	
<b>TRANSPORTATION</b>								
N=137,131 n=130	<i>In Crisis</i>	<i>At Risk</i>	<i>Stable</i>	<i>Safe</i>	<i>Thriving</i>	<i>Mean Response</i>	<i>Standard Deviation</i>	<i>Significance</i>
<i>Baseline</i>	24.1%	12.4%	39.4%	20.4%	3.6%	2.60	1.145	p<.05
<i>Follow-up</i>	1.5%	.8%	74.8%	19.1%	3.8%	3.22	.601	

N=number of initial assessments, number of follow-up assessments  
n=number of matched pairs on which significance tests are based

### Client Assessment Data: Summary and Findings

The results obtained indicate achievement of the goal of assessment at SST for all participants. More than 90 percent of all participant were assessed at SST on 9 of the 11 domains measured, and more than 70 percent were assessed at SST on the remaining domains of Employment and Income on the follow-up assessment. Figure IV-1 presents the percentage assessed at SST for the entire service population (All Participants) and for three subsets of participants on which analyses were performed (i.e., heads of households, those not participating in homeless programming, and those participating in homeless programming).

**Figure IV-1: Percent Safe, Stable or Thriving by Domain for Service Population and Subgroups**



Significant differences were obtained on nearly all measures between initial assessment and follow-up. Figures IV-2 through IV-4 illustrate the magnitude of change calculated as the difference between the percent assessed at SST at follow-up and the percent assessed at SST at initial assessment. Figure IV-2 illustrates change scores for the Adult Education, Employment, Housing and Income domains. Adult Education obtained relatively small change scores (1 percent). The magnitude of change for Employment was near 40 percent with a lower percent change for those in the homeless program. The Housing domain obtained change scores near 50 percent with 81 percent of those in the Homeless Program moving from In-Crisis or At-Risk to SST. For the Income domain 59 percent moved from ICAR to SST although lower Income gains were obtained for the Homeless Program participants (19.8 percent).

**Figure IV-2: Percent Change by Domain (Adult Education, Employment, Housing, Income) for Service Population and Subgroups**

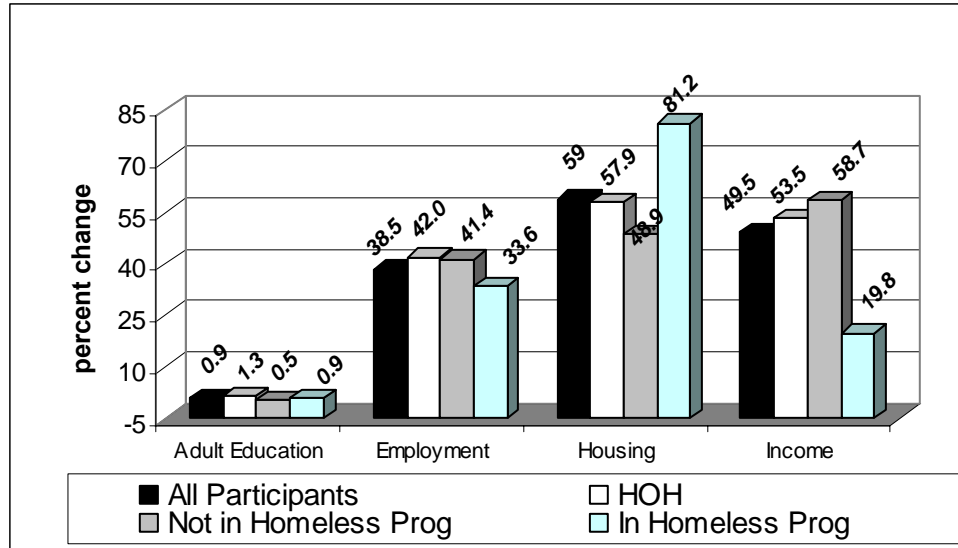


Figure IV-3 illustrates change scores for the Mental Health, Nutrition and Parenting domains. For the Mental Health domain relatively small change scores obtain (10 - 15 percent) with assessment of those in the Homeless Program exhibiting lower change scores (2.5 percent). The magnitude of change for the Nutrition domain was in the 30 percent range with a higher percent change for those in the homeless program (55.9 percent). The Parenting domain obtained relatively small change scores.

**Figure IV-3: Percent Change by Domain (Mental Health, Nutrition, Parenting) for Service Population and Subgroups**

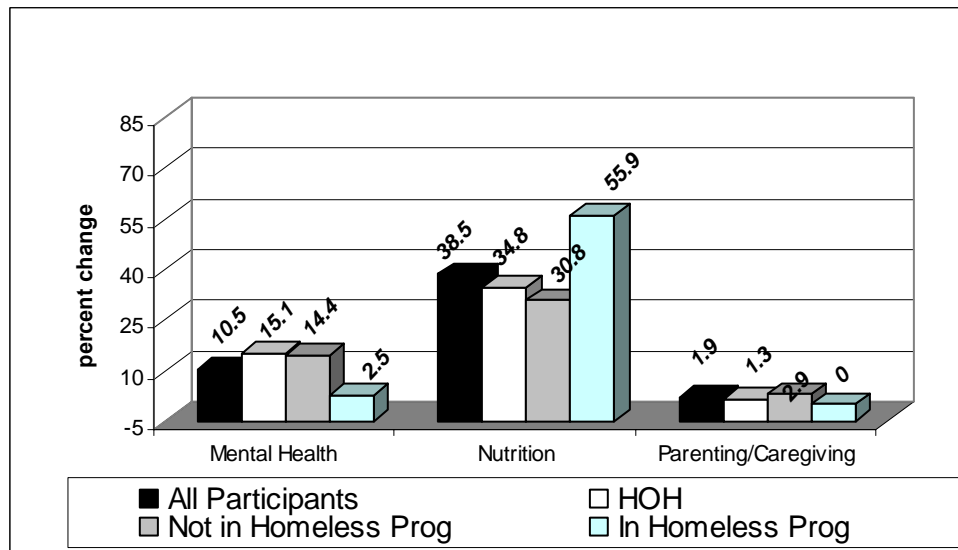
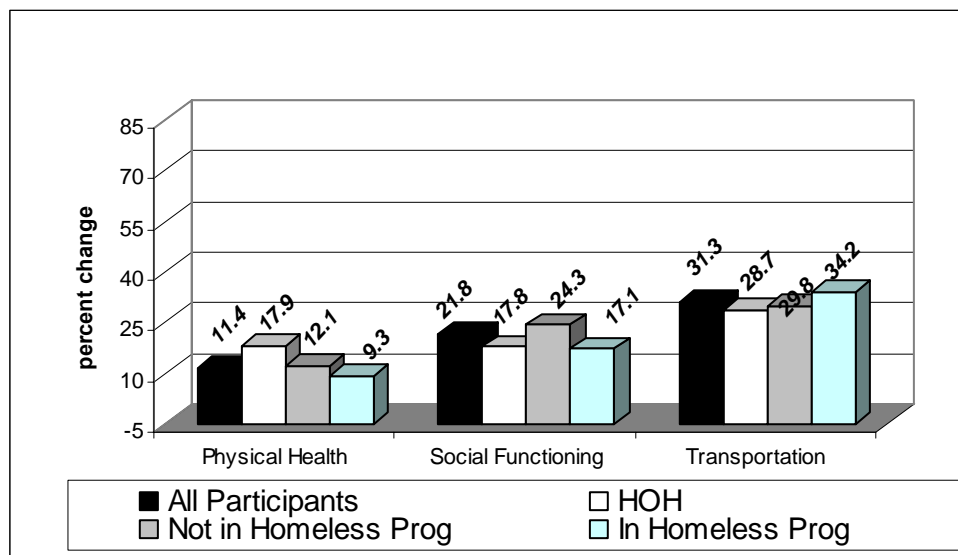


Figure IV-4 illustrates change scores for the Physical Health, Social Functioning and Transportation domains. For the Physical Health domain small change scores were obtained for Homeless Program participants (9.3 percent) and higher change scores were obtained for participants not in the Homeless Program (12.1 percent) and those who are HOH (17.9 percent). The magnitude of change for the Social Functioning domain was near 20% across all subgroups and 21.8 percent for all participants. The Transportation domain was in the 30 percent range with a higher percent change for those in the homeless program (34.2 percent).

**Figure IV-4: Percent Change by Domain (Physical Health, Social Functioning, Transportation) for Service Population and Subgroups**



## V. Data Analysis and Results: Community Collaboration

Table V-1, below, presents the results from the community collaboration survey responses at baseline and follow-up (i.e., beginning of 2003 prior to the implementation of the family development case management model and after the first year of implementation during the summer 2004). Data were collected from representatives of 18 agencies reported to be key in providing service to the target population. Mean scores and standard deviations were calculated using response codes from 1 (strongly disagree) to 5 (strongly agree). Table V-1 also presents the percentage assessment by each category of the response continuum. Further analyses are described below.

**Table V-1: Assessment of Community Collaboration (2003 to 2004)**

<b>1. Staff of providers in this community demonstrate trust for one another.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	11.1%	38.9%	33.3%	16.7%		3.44	.922
<i>Follow-up</i>	22.2%	72.2%		5.6%		4.11	.676
<b>2. There is a clear, shared vision for what the community is trying to do to serve families in need</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	11.1%	22.2%	38.9%	27.8%		3.17	.985
<i>Follow-up</i>	33.3%	50.0%	5.6%	11.1%		4.06	.938
<b>3. We do a good job at documenting our progress (outcomes).</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	17.6%	17.6%	47.1%	17.6%		3.35	.996
<i>Follow-up</i>	41.2%	35.3%	23.5%			4.18	.809
<b>4. We have identified specific, measurable results that we want to achieve.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	17.6%	29.4%	23.5%	29.4%		3.35	1.115
<i>Follow-up</i>	35.3%	52.9%	5.9%	5.9%		4.18	.809
<b>5. Tasks are appropriately distributed among providers in the community with respect to serving families in need.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>		33.3%	38.9%	22.2%	5.6%	3.00	.907
<i>Follow-up</i>	5.6%	61.1%	22.2%	5.6%	5.6%	3.56	.922
<b>6. Agency members are representative of the populations they work with.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	5.6%	44.4%	27.8%	16.7%	5.6%	3.28	1.018
<i>Follow-up</i>	11.1%	55.6%	22.2%	11.1%		3.67	.840
<b>7. We have effective rules for handling conflict among providers.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	5.6%	16.7%	50.0%	27.8%		3.00	.840
<i>Follow-up</i>		52.9%	35.3%	11.8%		3.41	.712
<b>8. Providers have an effective process for making decisions.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>		33.3%	50.0%	16.7%		3.17	.707
<i>Follow-up</i>	11.1%	50.0%	27.8%	11.1%		3.61	.850
<b>9. The provider community has a clear action plan.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	16.7%	16.7%	38.9%	22.2%	5.6%	3.17	1.150
<i>Follow-up</i>	22.2%	44.4%	22.2%	11.1%		3.78	.943

<b>10. Some provider agencies seem to have more power in making decisions than others.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	16.7%	33.3%	44.4%	5.6%		3.61	.850
<i>Follow-up</i>	16.7%	33.3%	38.9%	11.1%		3.56	.922
<b>11. Our service provider community adequately meets the cultural and language needs of minority groups.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	17.6%	17.6%	29.4%	29.4%	5.9%	3.12	1.219
<i>Follow-up</i>	16.7%	61.1%	5.6%	16.7%		3.78	.943
<b>12. Our provider network seeks to bring in new members to participate in planning on an on-going basis</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	5.6%	33.3%	50.0%	11.1%		3.33	.767
<i>Follow-up</i>	22.2%	38.9%	33.3%	5.6%		3.78	.878
<b>13. The amount of time spent in meetings is appropriate.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	5.6%	16.7%	50.0%	27.8%		3.00	.840
<i>Follow-up</i>	11.1%	50.0%	27.8%	11.1%		3.61	.850
<b>14. The service community keeps the larger community well-informed about our work.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	5.6%	5.6%	55.6%	33.3%		2.83	.786
<i>Follow-up</i>	22.2%	38.9%	11.1%	27.8%		3.56	1.149
<b>15. Our community has a plan for evaluating results and using results to improve services</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>		44.4%	27.8%	27.8%		3.17	.857
<i>Follow-up</i>	11.1%	50.0%	16.7%	22.2%		3.50	.985
<b>16. I feel that the community is making progress toward improving social services.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	16.7%	55.6%	22.2%	5.6%		3.83	.786
<i>Follow-up</i>	33.3%	61.1%		5.6%		4.22	.732
<b>17. Consumers are involved in planning and decision-making.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>		27.8%	55.6%	16.7%		3.11	.676
<i>Follow-up</i>	16.7%	27.8%	38.9%	16.7%		3.44	.984
<b>18. The provider network plans for sustaining initiatives after initial grant funds run out.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	5.6%	33.3%	38.9%	22.2%		3.22	.878
<i>Follow-up</i>	16.7%	38.9%	27.8%	16.7%		3.56	.984
<b>19. I have an equal voice within this provider community.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	11.1%	55.6%	27.8%	5.6%		3.72	.752
<i>Follow-up</i>	22.2%	66.7%	5.6%	5.6%		4.06	.725
<b>20. Members of the provider community openly discuss self-interests.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>		27.8%	50.0%	22.2%		3.06	.725
<i>Follow-up</i>	11.1%	50.0%	33.3%	5.6%		3.67	.767
<b>21. Service providers effectively communicate with each other.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>		38.9%	44.4%	16.7%		3.22	.732
<i>Follow-up</i>	27.8%	44.4%	16.7%	11.1%		3.89	.963

<b>22. People in our community of providers agree on issues of importance for our community.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	5.6%	38.9%	38.9%	16.7%		3.33	.840
<i>Follow-up</i>	27.8%	50.0%	11.1%	11.1%		3.94	.938
<b>23. Service providers in this community commonly share information and resources to assist difficult-to-reach populations.</b>							
	<i>Strongly Agree</i>	<i>Agree</i>	<i>Neither Agree/Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>	<i>Mean Response</i>	<i>Standard Deviation</i>
<i>Baseline</i>	11.1%	50.0%	27.8%	11.1%		3.61	.850
<i>Follow-up</i>	38.9%	38.9%	11.1%	11.1%		4.06	.998

Table V-2 presents the mean scores and mean score differences by item of the collaboration survey. The mean score for each item was greater at follow-up than baseline with one exception: some agencies have more power. Table V-3, below, reproduces the results sorted by the magnitude of the difference score.

**Table V-2: Collaboration Item Mean Scores (Baseline and Follow-up) and Mean Score Difference**

Item #	ITEMS	Mean Score at Baseline	Mean Score at Follow up	Mean Score Difference
1	Demonstrate trust for one another.	3.44	4.11	0.67
2	Clear, shared vision	3.17	4.06	0.89
3	Progress well documented	3.35	4.18	0.82
4	Specific, measurable results	3.35	4.18	0.82
5	Tasks appropriately distributed	3.00	3.56	0.56
6	Providers representative of people they serve	3.28	3.67	0.39
7	Effective rules for handling conflict	3.00	3.41	0.41
8	Effective process for making decisions	3.17	3.61	0.44
9	Clear action plan	3.17	3.78	0.61
10	Some agencies have more power	3.61	3.56	-0.06
11	Meet the cultural/language needs of minorities	3.12	3.78	0.66
12	Regularly bring in new members to help plan	3.33	3.78	0.44
13	Time spent in meetings is appropriate	3.00	3.61	0.61
14	Keep the larger community well-informed about our work	2.83	3.56	0.72
15	Plan for evaluating results & using them to improve services	3.17	3.50	0.33
16	Making progress toward improving social services	3.83	4.22	0.39
17	Consumers are involved in planning and decision-making	3.11	3.44	0.33
18	Plan for sustaining initiatives	3.22	3.56	0.33
19	I have an equal voice	3.72	4.06	0.33
20	Providers openly discuss self-interests	3.06	3.67	0.61
21	Providers effectively communicate with each other	3.22	3.89	0.67
22	People agree on issues of importance	3.33	3.94	0.61
23	Share info & resources to assist difficult-to-reach populations	3.61	4.06	0.44

Table V-3 shows that 12 items obtained difference scores of more than .5 indicating substantial increase in agreement with statements describing positive community collaboration. Of the 11 items with mean difference scores less than .5, three items had follow-up scores exceeding 4.0 which indicates very strong agreement with the statements describing community collaboration. The average mean score was 3.27 at baseline and 3.79 at follow-up which is an increase overall of .52; this is another indicator of the magnitude of positive assessment of change in community collaboration since implementation.

**Table V-3: Collaboration Item Mean Scores (Baseline and Follow-up)  
Sorted by Mean Score Difference**

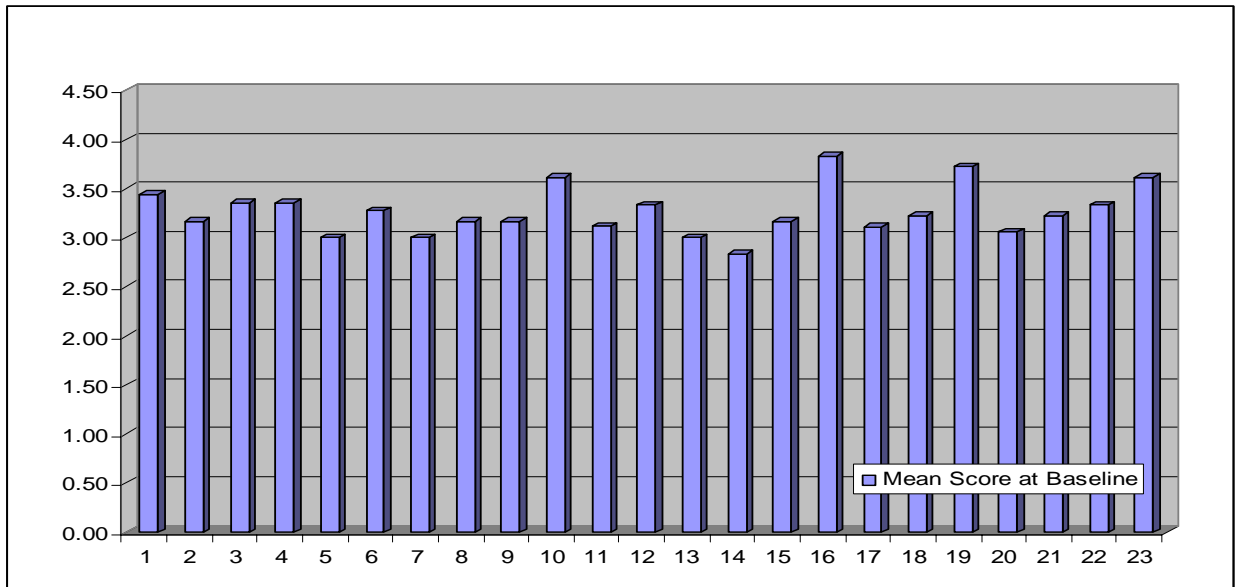
Item #	SURVEY ITEMS	Mean Score at Baseline	Mean Score at Follow up	Mean Score Difference
2	Clear, shared vision	3.17	4.06	0.89
3	Progress well documented	3.35	4.18	0.82
4	Specific, measurable results	3.35	4.18	0.82
14	Keep the larger community well-informed about our work	2.83	3.56	0.72
1	Demonstrate trust for one another	3.44	4.11	0.67
21	Providers effectively communicate with each other	3.22	3.89	0.67
11	Meet the cultural/language needs of minorities	3.12	3.78	0.66
13	Time spent in meetings is appropriate	3.00	3.61	0.61
20	Providers openly discuss self-interests	3.06	3.67	0.61
9	Clear action plan	3.17	3.78	0.61
22	People agree on issues of importance	3.33	3.94	0.61
5	Tasks appropriately distributed	3.00	3.56	0.56
8	Effective process for making decisions	3.17	3.61	0.44
12	Regularly bring in new members to help plan	3.33	3.78	0.44
23	Share info & resources to assist difficult-to-reach populations	3.61	4.06	0.44
7	Effective rules for handling conflict	3.00	3.41	0.41
6	Providers representative of people they serve	3.28	3.67	0.39
16	Making progress toward improving social services	3.83	4.22	0.39
15	Plan for evaluating results & using them to improve services	3.17	3.50	0.33
17	Consumers are involved in planning and decision-making	3.11	3.44	0.33
18	Plan for sustaining initiatives	3.22	3.56	0.33
19	I have an equal voice	3.72	4.06	0.33
10	Some agencies have more power	3.61	3.56	-0.06

The figures below illustrate the collaboration survey results described above. Figure V-1 and V-2, below, illustrate the data from Table V-1. Figure V-1 illustrates the magnitude of the mean collaboration item assessment scores at baseline (i.e., the beginning of 2003 prior to the implementation of the family development case management model). Figure V-2 illustrates the magnitude of the mean item assessment score after the first year of implementation (summer 2004). Figure V-3 illustrates the magnitude of the difference in the mean item assessments after the first year of implementation (2004 assessment mean score minus 2003 assessment mean score). Figure V-4 illustrates the difference in the mean assessments sorted from greatest magnitude of positive difference. (An Item reference key is provided below to aid the reader in identifying the content of the item number of the survey in the figures).

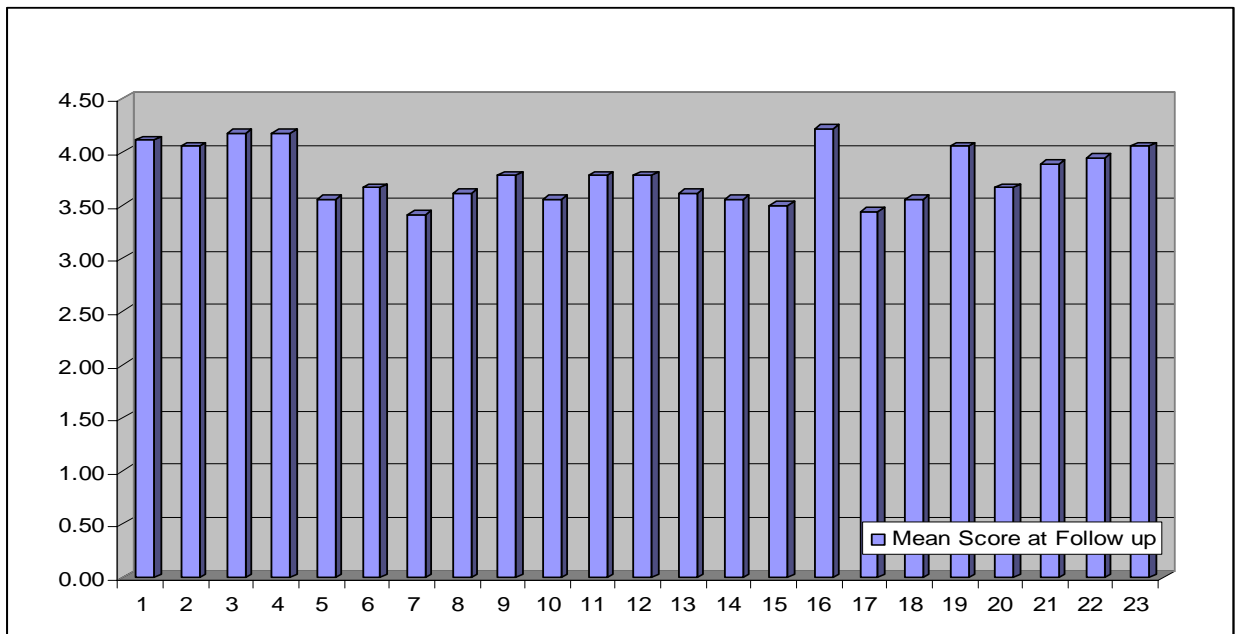
**Item Reference Key:**

Key: 1. Demonstrate trust for one another 2. Clear shared vision 3. Progress documented 4. Measure results 5. Tasks evenly distr. 6. Representative of target pop 7. Rules for handling conflict 8. Decision-making proc. 9. Clear action plan 10. Some agencies have more power 11. Meet cultural/language needs 12. New members included to help plan 13. Time spent in meetings appropriate 14. Larger community informed about work 15. Plan for evaluating results and using them to improve services 16. Making progress toward improving services 17. Communities involved in planning/decision-making 18. Plan for sustaining initiatives 19. I have an equal voice 20. Providers discuss self-interest 21. Providers effectively communicate with each other 22. People agree on issues of importance 23. Share information on difficult to reach population

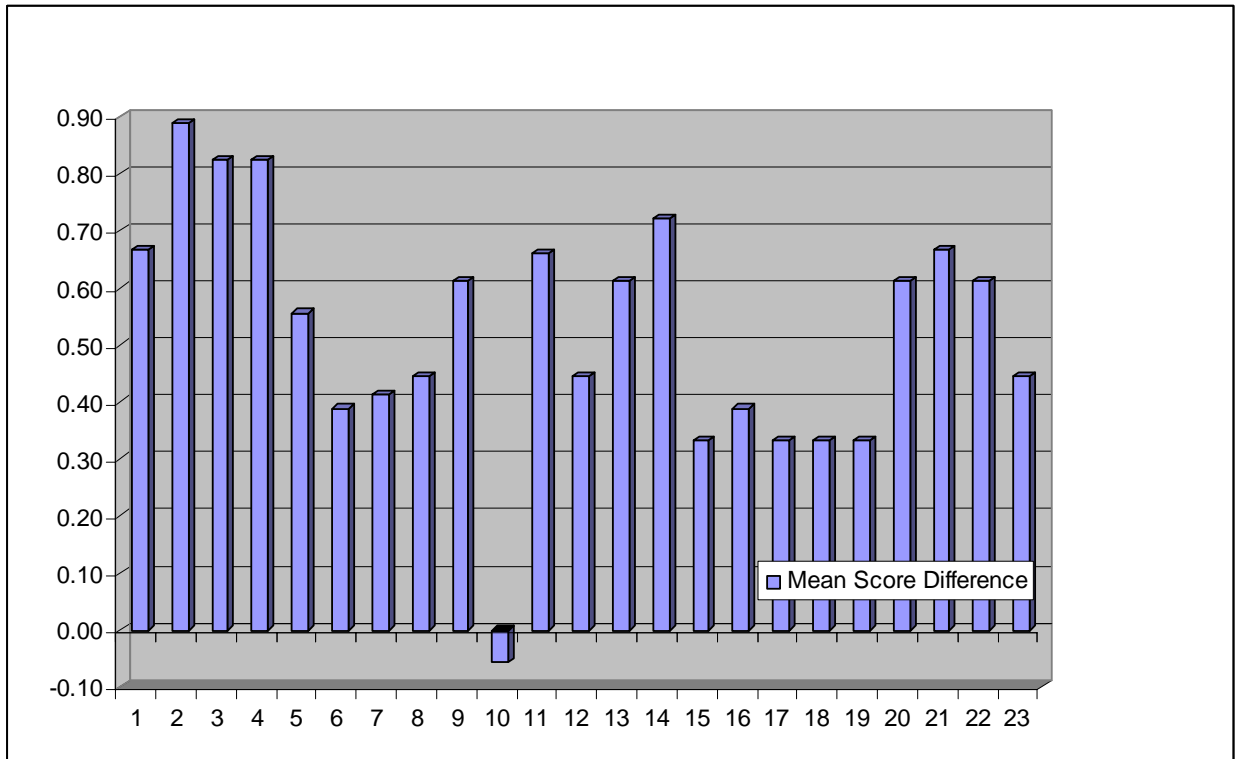
**Figure V-1: Assessment of Community Collaboration (Beginning of 2003)**



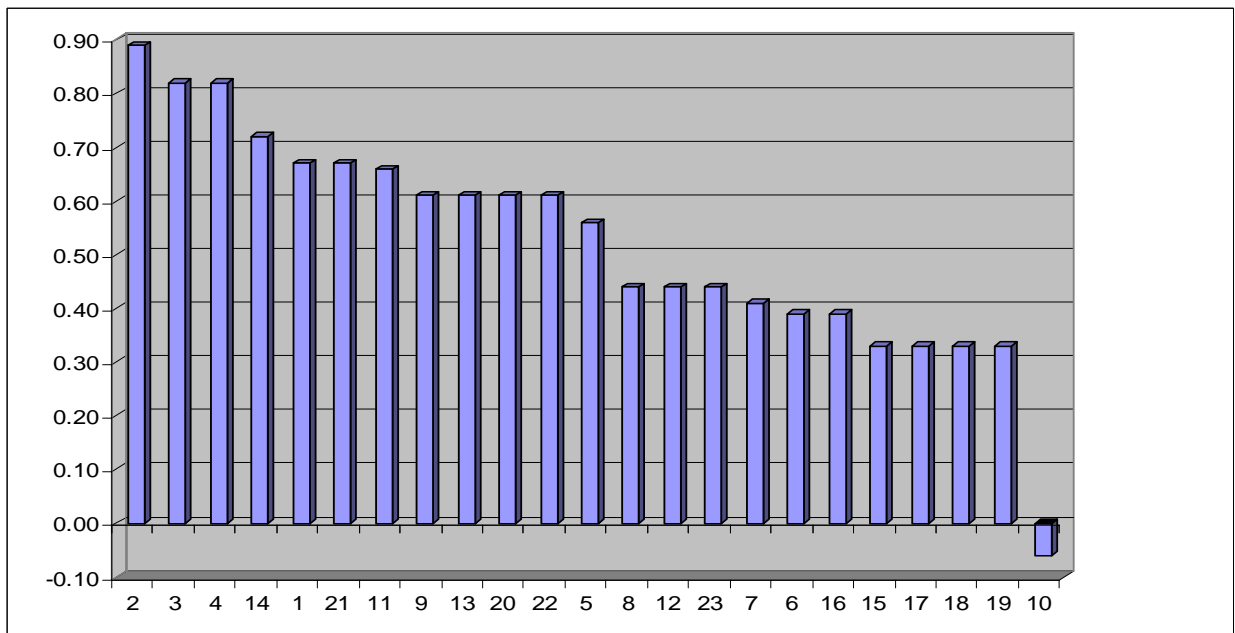
**Figure V-2: Assessment of Community Collaboration (Summer 2004)**



**Figure V-3: Change in Assessment of Community Collaboration  
(Difference Score)**



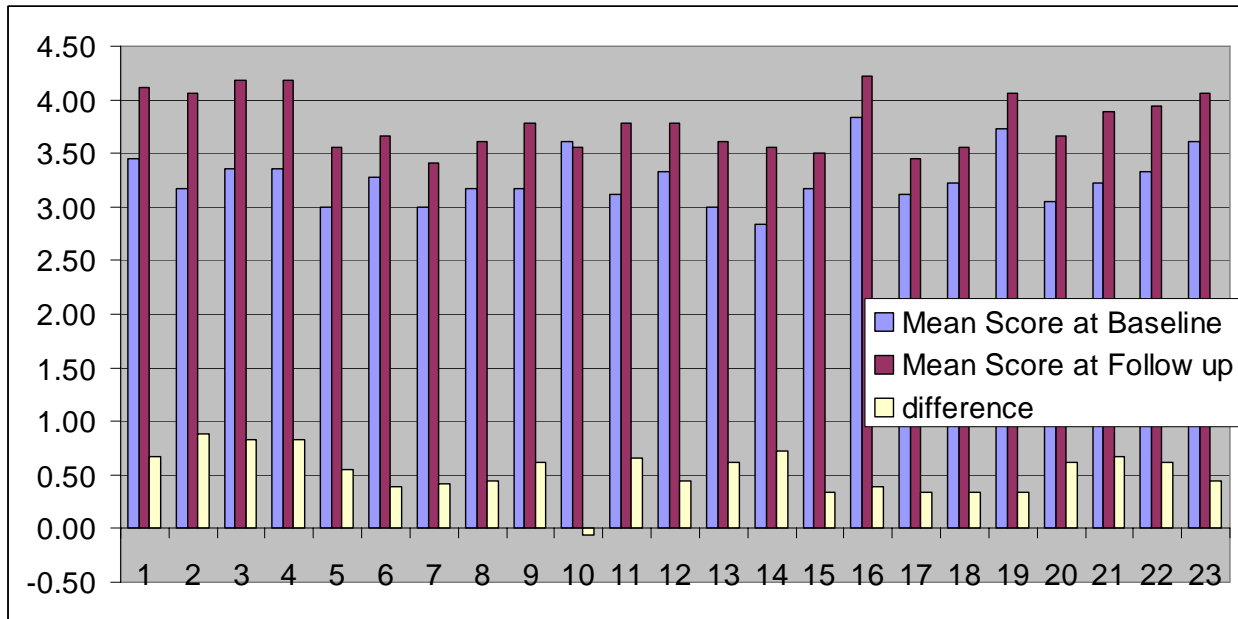
**Figure V-4: Change in Assessment of Community Collaboration  
(Sorted by Magnitude of Difference)**



### Collaboration Survey Data: Summary and Findings

Figure V-5 illustrates improvement in the assessment of community collaboration among the service providers in Broward County since the implementation of the family development model. While the results indicate good collaboration in the past, they indicate substantial improvement since implementation.

**Figure V-5: Change in Assessment of Community Collaboration and Mean Score Difference (by Item)**



Key: 1. Demonstrate trust for one another 2. Clear shared vision 3. Progress documented 4. Measure results  
 5. Tasks evenly distr. 6. Representative of target pop 7. Rules for handling conflict 8. Decision-making proc.  
 9. Clear action plan 10. Some agencies have more power 11. Meet cultural/language needs 12. New members  
 included to help plan 13. Time spent in meetings appropriate 14. Larger community informed about work 15. Plan for  
 evaluating results and using them to improve services 16. Making progress toward improving services 17.  
 Communities involved in planning/decision-making 18. Plan for sustaining initiatives 19. I have an equal voice 20.  
 Providers discuss self-interest 21. Providers effectively communicate with each other 22. People agree on issues of  
 importance 23. Share information on difficult to reach population

## **VI. Data Analysis and Results: Provider Network Analysis**

### **Introduction to Network Measures**

Network measures include: 1) walks and reachability; 2) geodesics and distance; 3) nodal degrees; and 4) network density. Network analysis nearly always includes some basic network properties. Nodes are the actors in a network and paths are the connections among those actors. A walk is a sequence of nodes (agencies) and paths (lines indicating a tie or connection between two agencies). The walk begins and ends with a node and each node in the path is connected by the lines following and preceding it in the sequence. For example, Agency A collaborates with Agency B would be represented by a line between these two nodal points. Assume also that Agency B collaborates with Agency C and that Agency A and Agency C do not collaborate. The span between Agency A and Agency C would be considered a walk. The length of a walk is the number of lines (in our example, two). Reachability is the measure of how many paths there are leading to a particular node. For example, since Agency A collaborates with Agency B, then both agencies are said to be reachable. Since Agency B also collaborates with Agency C and Agency A does not, Agency B is said to be more reachable than Agency A or Agency C. A geodesic (distance) is the shortest path between a given pair of nodes (the geodesic for Agency A and Agency C is two). A nodal degree is the number of lines connected with the node in a graph. Using the example above, it is the number of agencies indicating they work with a particular agency (for Agency B the nodal degree would be 2, and for Agency A and Agency C the nodal degree would be 1). Density is a measure of connectedness of the agencies in the network (percentage of all possible nodal degrees that the network exhibits).

When examining interagency collaboration, one use of social network analysis is to identify the “most important” members in the network because those members have relatively more influence. Measures of importance in a network include: 1) centralization; 2) closeness; 3) betweenness; and 4) prestige. The degree of centralization quantifies the range or variability of the individual member indices. The index or measure ranges from 0 (no variability) to 1 (extreme variability for one member). For example, if each agency in a network is connected with the others equally then there are no variability for members because they are equally and exhaustively connected, then the degree of network centrality is 0. If one agency works with all other agencies and all other agencies work only with this agency, then the degree of network centrality is 1 (also known as a star network). Closeness measures how closely a member of the network is to all the other members of the network. This concept addresses the extent to which a member can directly access other members of the network. The closeness index also ranges from 0 to 1, where 0 represents the lengths of geodesics as equal among network members, and 1 represents extreme variability with respect to one member. Betweenness is a measure of interactions between nonadjacent members of a network where one must access another member in the network in order to reach another. The betweenness index ranges from 0 (all members are equal in betweenness) to 1 (extreme variability with respect to one member). Prestige is similar to what is commonly referred to as popularity, or how many members choose a particular other node or member. The members of the

network who are most prestigious are those most frequently chosen by others. The index for prestige reaches its maximum value of 1 when a member is chosen by all other members of the network. (For further description and interpretation of network measures see Richardson and Graf, 2004, *Measuring the Strengths of Community Collaboration*; Wasserman and Faust, 1994; Wasserman and Galaskiewicz, 1994; Scott, 2000; and Knoke & Kuklinski, 1982).

The provider network analysis is an assessment of the level of provider collaboration that has developed since the implementation of the model. Using data from representatives of 18 agencies identified as key service providers to the target population we analyzed five dimensions of collaboration:

- 1) Working with other agencies;
- 2) Joint case planning among these agencies;
- 3) Shared programs among these agencies;
- 4) Sharing information related to families with the other agencies;
- 5) Collaborating with other agencies to provide services to clients/families.

The analysis of these relations is important to assess change in the working relationships between FSC and service providers, and among service providers during implementation. Not only do these data provide measures of change in the network, they may also be used for further development of collaboration identifying strong relations among providers as well as areas where relations can be strengthened.

### **Relation 1. Community Collaboration: Working Together**

Table VI-1, below, presents the baseline and follow-up results from the question: do you work with other agencies? Figure VI-1 illustrates these results. The measures presented include: outdegree (ties “sent”), prominent actors are most extensively involved in relationships with other actors; indegree (ties “received”), a measure of prestige where network members receiving more nominations or choices are considered more prestigious; average number of degrees or ties to other agencies; maximum number of nodal degrees or ties possible; average geodesic distance (based on shortest path between each pair of nodes); average density of the network (a measure of group cohesion); and network centralization, an index of the variability of connectedness of the members of the network where a lower index indicates more agencies are equal and central to network activities. (For further description and interpretation of network measures see Richardson and Graf, 2004, *Measuring the Strengths of Community Collaboration*).

### ***Reachability and Average Geodesic Distance***

Each agency had an established connection to the other agencies by at least one path; all 18 agencies were reachable at baseline (prior to implementation) and follow-up (summer 2004). The average geodesic distance among agencies was 1.363 at baseline and 1.248 at follow-up. This is a decrease of nine percent indicating a reduction in the average of the shortest paths between pairs. These measures also indicate reduced distance and greater connectedness of the Broward County agencies.

### ***Outdegree***

Outdegree percentages increased for 11 agencies from baseline to follow-up and remained the same for seven agencies. The greatest change was for Agency 15 with an increase of 35%.

### ***Indegree***

Indegree percentages increased from baseline to follow-up for 17 agencies and remained constant for one agency. The greatest change in indegree percentage was experienced by Agency 8 and 18 with increases of 24% at follow-up.

### ***Average Nodal Degree and Density***

From baseline to follow-up, the average nodal degree (number of ties between nodes) increased from 10.9 to 12.8. The average degree increased and variability, based on the standard deviations, decreased indicating more agencies working together at follow-up. At baseline, 64% of the total possible connections were present; 75.2% were present at follow-up. There was a net increase of 33 collaborative connections.

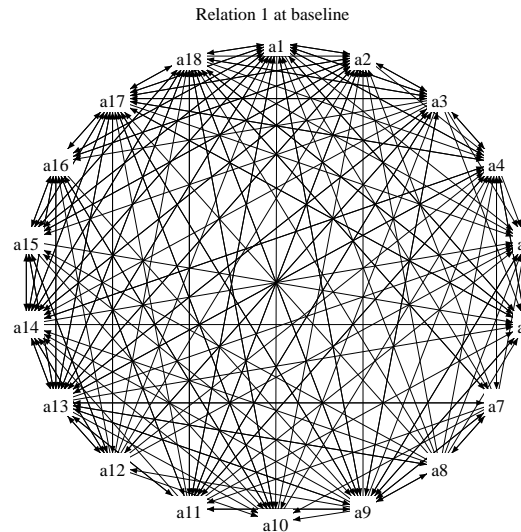
### ***Summary of Relation 1, Illustrations and Network Centralization***

These data show that there are strong working relationships among providers in Broward County. When compared to the level of “working together” prior to implementation of the family development model, the network measures indicate that providers are working together more now than they were at the beginning of calendar year 2003. Of 18 provider agencies included in the analysis, two-thirds of the agencies indicate especially strong and active network relations. The following figures illustrate the relations in the data described in the corresponding table. Figure VI-1a and Figure VI-1b are circle illustrations of the connections in the data among agencies at baseline and follow-up, respectively. Figure VI-1c and Figure VI-1d use multi-dimensional scaling (MDS), a statistical procedure, to locate and illustrate the relative position of the nodes. (The MDS algorithm locates nodes based on their geodesic distances or shortest path between each pair of nodes.) Agencies with more connections have more lines and the arrowheads indicate direction matching the indegrees (lines with arrowheads coming in) and outdegrees (lines with arrows extending out) of the tabular results.

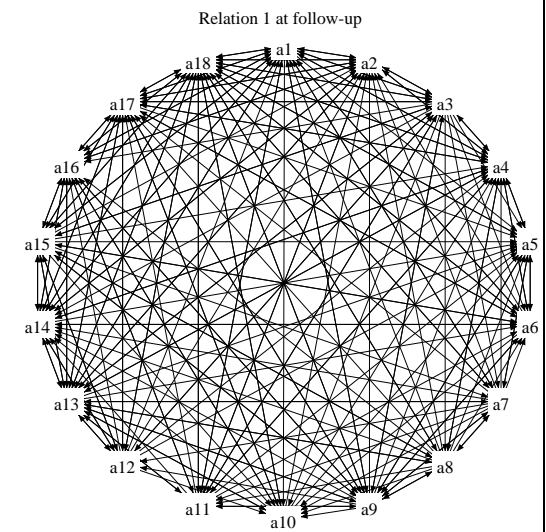
Comparing Figure VI-1d to Figure VI-1c, one observes that several agencies (e.g., a15, a10, a4) appear peripheral to the network in Figure VI-1c (baseline), but in Figure VI-1d, they are closer to the center. This movement illustrates decrease in network centralization, from 19.1% at baseline to 7.4% at follow-up indicating that nearly all ties are present at follow-up and most agencies are working together (see Appendix for agency code key).

**Table VI-1. Community Collaboration: Working Together**

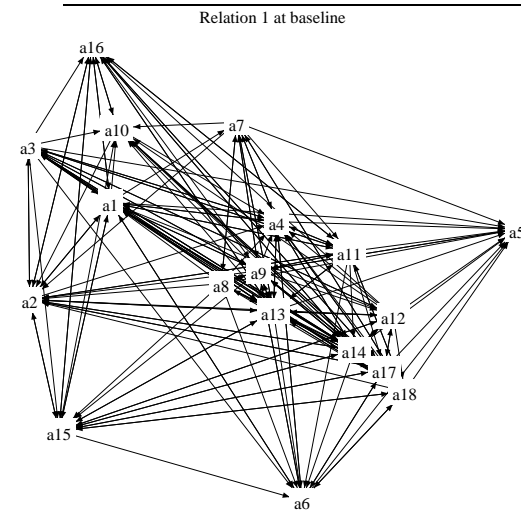
Agency #	At Baseline				At Follow-Up			
	Outdegree		Indegree		Outdegree		Indegree	
	#	%	#	%	#	%	#	%
1	15	88.2	14	82.4	15	88.2	15	88.2
2	9	52.9	14	82.4	9	52.9	16	94.1
3	15	88.2	9	52.9	17	100.0	10	58.8
4	9	52.9	14	82.4	11	64.7	16	94.1
5	1	5.9	13	76.5	5	29.4	15	88.2
6	6	35.3	11	64.7	10	58.8	13	76.5
7	9	52.9	6	35.3	14	82.4	8	47.1
8	12	70.6	3	17.7	15	88.2	7	41.2
9	16	94.1	11	64.7	17	100.0	12	70.6
10	6	35.3	10	58.8	8	47.1	12	70.6
11	12	70.6	9	52.9	12	70.6	10	58.8
12	12	70.6	6	35.3	12	70.6	8	47.1
13	17	100.0	14	82.4	17	100.0	15	88.2
14	11	64.7	14	82.4	11	64.7	16	94.1
15	10	58.8	11	64.7	16	94.1	11	64.7
16	9	52.9	10	58.8	10	58.8	13	76.5
17	14	82.4	15	88.2	14	82.4	16	94.1
18	14	82.4	13	76.5	17	100.0	17	100.0
Average Degree (std dev)	10.9 (3.95)		10.9 (3.27)		12.8 (3.46)		12.8 (3.10)	
Max Nodal Degrees	17		17		17		17	
Avg Geodesic Distance	1.363				1.248			
Average Density (std dev)	64.4% (0.4789)				75.2% (0.4321)			
Network Centralization	19.1%				7.4%			



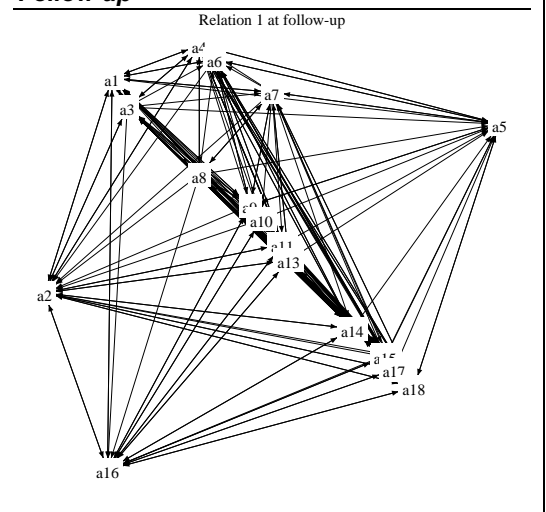
**Fig VI-1a: Circle Drawing of Collaboration at Baseline**



**Fig VI-1b: Circle Drawing of Collaboration at Follow-up**



**Fig 1c: Multidimensional Scaling Drawing of Distances and Similarities at Baseline**



**Fig 1d: Multidimensional Scaling Drawing of Distances and Similarities at Follow-up**

### ***Relation 2. Community Collaboration: Participation in Joint Trainings***

Table VI-2, below, presents the baseline and follow-up results from the question: do you participate in joint trainings with other agencies? The figures illustrate the results. The measures presented include: outdegree (ties “sent,” a measure that demonstrates levels of influence in the network); indegree (ties “received,” network members who receive more choices are regarded as more prestigious); average number of degrees or ties to other agencies; maximum number of nodal degrees or ties; average geodesic distance (average of the shortest paths between agency pairs); average density of the network (a measure of group cohesion); and network centralization, an index of the variability of connectedness of the members of the network where a lower index indicates more agencies are equal and central to network activities.

#### ***Reachability and Average Geodesic Distance***

Not all agencies were reachable at baseline (Agency 12 showed no outdegrees or indegrees at baseline), while all agencies were reachable at follow-up. The average geodesic distance among pairs was 2.015 at baseline and 1.706 at follow-up, a decrease of 15%. These measures indicate that agencies in this network were able to work more directly and share training experiences with each other at follow-up.

#### ***Outdegree***

Outdegree percentages increased for 11 agencies from baseline to follow-up, decreased for one, and remained the same over time for six agencies. The largest change in outdegree was shown by Agency 18 with an increase of 65% at follow-up.

#### ***Indegree***

The percentage of indegree activity increased for participation in joint trainings: 13 agencies showed an increase, 2 showed a decrease, and three remained the same. Agency 18 demonstrated the largest change in indegree percentage with an increase of 30% at follow-up.

#### ***Average Nodal Degree and Density***

From baseline to follow-up, the average nodal degree for participation in joint trainings increased from 4.4 to 6.0. Average density increased from 26.1% at baseline to 35.3% of the maximum connections at follow-up; this is an increase of 28 connections in the collaborative network.

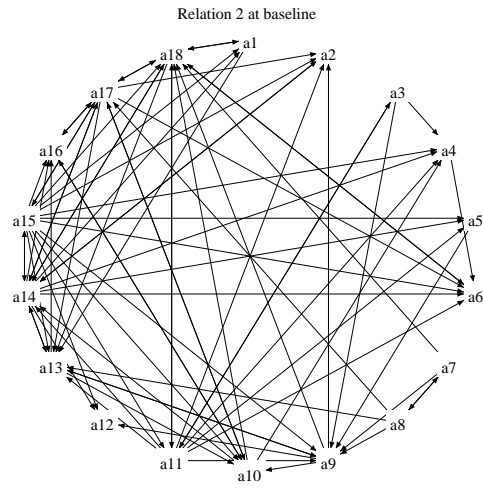
#### ***Summary Relation 2, Illustrations and Network Centralization***

Figure VI-2a and Figure VI-2b, below, are circle illustrations of the connections in the data among agencies at baseline and follow-up. Figure VI-2c and Figure VI-2d were constructed using multi-dimensional scaling (MDS) to locate the relative position of the nodes in the illustration. MDS produces sociograms by mapping geodesic distances and similarities among nodes or agencies. The increase in network centralization (from 45.6% at baseline to 56.6% at follow-up) is demonstrated in the difference of the illustrations where agencies are more clustered in the center of the network in Figure VI-2d than in Figure VI-2c. Some nodes or agencies appear closer to the center at follow-up (e.g., a7 and a10) and others are more peripheral (e.g., a6, a15, and a4).

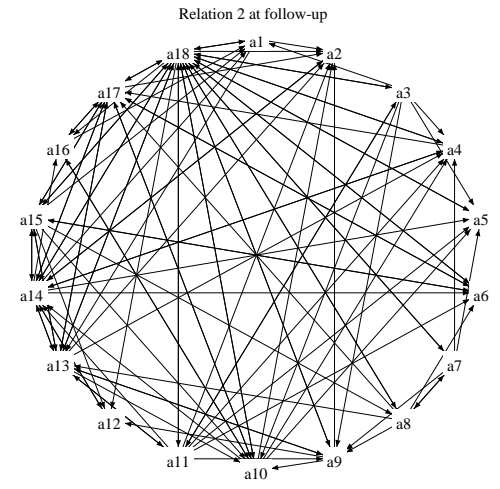
Agencies a1, a2, a12, and a5 were on the periphery both at baseline and follow-up. These results suggest that collaboration in joint trainings has increased overall; however, some agencies are more connected at follow-up at the expense of others.

**Table VI-2. Community Collaboration: Participation in joint trainings**

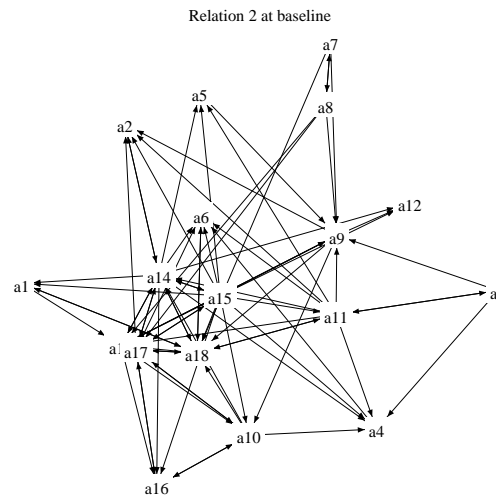
Agency #	At Baseline				At Follow-Up			
	Outdegree		Indegree		Outdegree		Indegree	
	#	%	#	%	#	%	#	%
1	2	11.8	3	17.7	3	17.7	5	29.4
2	1	5.9	5	29.4	1	5.9	8	47.1
3	3	17.7	1	5.9	7	41.2	2	11.8
4	1	5.9	5	29.4	3	17.7	7	41.2
5	1	5.9	3	17.7	1	5.9	6	35.3
6	1	5.9	6	35.3	3	17.7	6	35.3
7	3	17.7	1	5.9	5	29.4	2	11.8
8	4	23.5	1	5.9	6	35.3	3	17.7
9	5	29.4	7	41.2	5	29.4	6	35.3
10	5	29.4	5	29.4	7	41.2	7	41.2
11	9	52.9	3	17.7	9	52.9	3	17.7
12	0	3	0	17.7	1	5.9	4	23.5
13	4	23.5	8	47.1	9	52.9	8	47.1
14	11	64.7	7	41.2	11	64.7	9	52.9
15	14	82.4	2	11.8	9	52.9	5	29.4
16	2	11.8	5	29.4	3	17.7	4	23.5
17	8	47.1	6	35.3	8	47.1	9	52.9
18	6	35.3	9	52.9	17	100.0	14	82.4
Average Degree (std dev)	4.4 (3.76)		4.4 (2.39)		6.0 (4.03)		6.0 (2.91)	
Max Nodal Degrees	17		17		17		17	
Avg Geodesic Distance	2.015				1.706			
Average Density (std dev)	26.1% (0.4394)				35.3% (0.4779)			
Network Centralization	45.6%				56.6%			



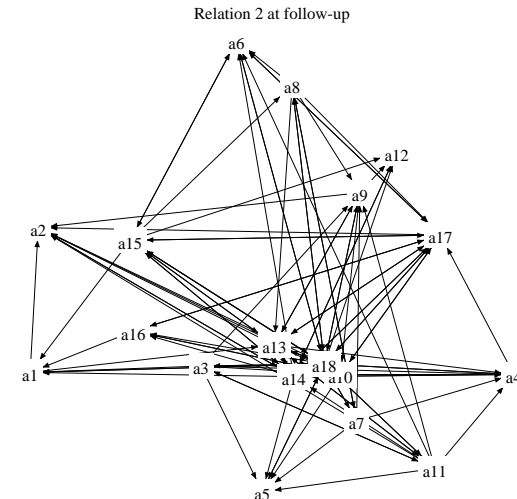
**Fig. VI-2a: Circle Drawing of Collaboration at Baseline**



**Fig VI-2b: Circle Drawing of Collaboration at Follow-up**



**FigVI- 2c: Multidimensional Scaling Drawing of Distances & Similarities at Baseline**



**Fig VI-2d: Multidimensional Scaling Drawing of Distances & Similarities at Follow-up**

### ***Relation 3. Community Collaboration: Participation in Shared Programs***

Table VI-3, below, presents the baseline and follow-up results from the question do you share programs with other agencies? The figures illustrate the results. The measures presented include: outdegree, indegree, average number of degrees, maximum number of nodal degrees, average geodesic distance, average density of the network and network centralization.

#### ***Reachability and Average Geodesic Distance***

All agencies were reachable by all other agencies at baseline, however, Agency 2 and Agency 5 indicated that they were not active in shared programs with any other agency. At follow-up, only Agency 2 reported no active involvement in a shared program. The average geodesic distance was 1.640 at baseline and 1.564 at follow-up, a 5% reduction in the average shortest distance.

#### ***Outdegree***

Outdegree percentages increased for nine agencies from baseline to follow-up, decreased for five, and remained the same over time for four agencies. The largest changes in outdegree were shown by Agency 18 with an increase of 29% at follow-up and by Agency 12 with a decrease of 41%.

#### ***Indegree***

The percentage of indegree activity showed little change for participation in shared programs: seven agencies showed an increase, seven decreased, while four remained at the same level. Agency 18 demonstrated the largest change in indegree percentage with a decrease of 24% at follow-up.

#### ***Average Nodal Degree and Density***

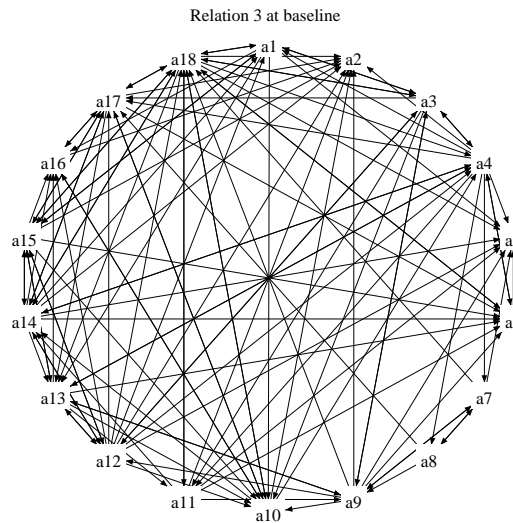
The average nodal degree increased from 6.7 at baseline to 7.1 at follow-up. Average density increased from 39.5% at baseline to 41.8% at follow-up; this is an increase of seven connections in the network.

#### ***Summary Relation 3, Illustrations and Network Centralization***

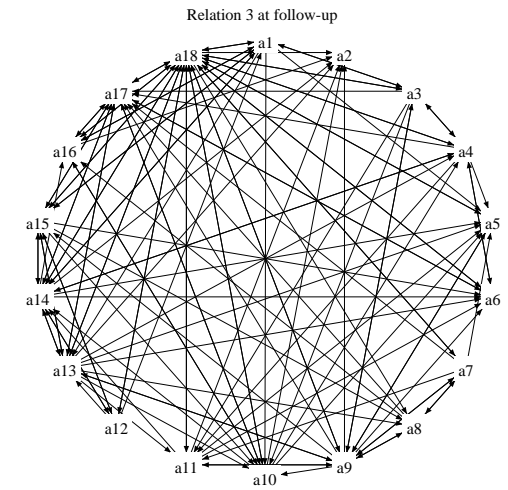
Figure VI-3a through VI-3d illustrate the results in Table VI-3. Network centralization increased from 31.6% at baseline to 48.5% at follow-up. This increase is illustrated by Figure VI-3c and Figure VI-3d. Several agencies are closer together and nearer the center at follow-up compared to the baseline illustration (a14, a18), and one agency appears to have moved from periphery to the center (a16). Many of the agencies on the periphery at baseline remain so at follow-up (a3, a11, and a17), and nodes/agencies a2 and a12 are now farther from the center at follow-up compared to baseline. While more connections are present, some agencies are more central at follow-up at the expense of others.

**Table VI-3. Community Collaboration: Participation in shared programs**

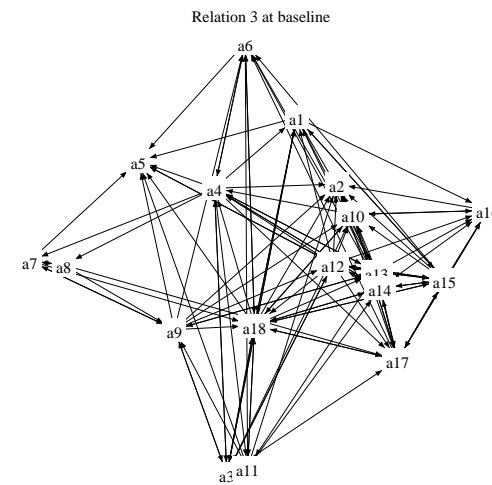
Agency #	At Baseline				At Follow-Up			
	Outdegree		Indegree		Outdegree		Indegree	
	#	%	#	%	#	%	#	%
1	7	41.2	6	35.3	8	47.1	6	35.3
2	0	0	10	58.8	0	0	7	41.2
3	8	47.1	5	29.4	7	41.2	4	23.5
4	11	64.7	7	41.2	7	41.2	6	35.3
5	0	0	9	52.9	2	11.8	9	52.9
6	3	17.7	8	47.1	3	17.7	8	47.1
7	4	23.5	3	17.7	6	35.3	3	17.7
8	3	17.7	2	11.8	4	23.5	5	29.4
9	9	52.9	5	29.4	12	70.6	7	41.2
10	6	35.3	9	52.9	7	41.2	8	47.1
11	6	35.3	4	23.5	6	35.3	6	35.3
12	12	70.6	5	29.4	5	29.4	3	17.7
13	8	47.1	8	47.1	12	70.6	7	41.2
14	11	64.7	7	41.2	11	64.7	9	52.9
15	10	58.8	6	35.3	9	52.9	7	41.2
16	3	17.7	7	41.2	5	29.4	6	35.3
17	8	47.1	9	52.9	7	41.2	12	70.6
18	12	70.6	11	64.7	17	100.0	15	88.2
Average Degree (std dev)	6.7 (3.75)		6.7 (2.38)		7.1 (3.94)		7.1 (2.87)	
Max Nodal Degrees	17		17		17		17	
Avg Geodesic Distance	1.640				1.564			
Average Density (std dev)	39.5% (0.4889)				41.8% (0.4933)			
Network Centralization	31.6%				48.5%			



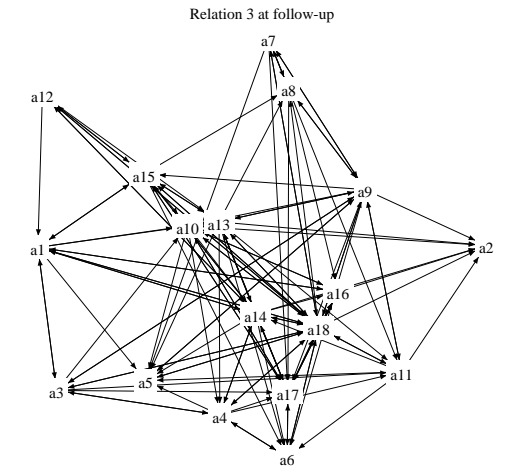
**Fig VI-3a. Circle Drawing of Collaboration at Baseline**



**Fig. VI-3b: Circle Drawing of Collaboration at Follow-up**



**Fig VI-3c: Multidimensional Scaling Drawing of Distances & Similarities at Baseline**



**Fig. VI-3d: Multidimensional Scaling Drawing of Distances & Similarities at Follow-up**

#### ***Relation 4. Community Collaboration on Sharing Information Related to Families***

Table VI-4, below, presents the baseline and follow-up results from the question do you share information related to families with other agencies? The figures illustrate the results in the table. The measures presented include: outdegree, indegree, average number of degrees, maximum number of nodal degrees, average geodesic distance, average density of the network and network centralization.

#### ***Reachability and Average Geodesic Distance***

All agencies were reachable; the average shortest distance at baseline was 1.388 and this distance decreased by 7.5% to 1.291 at follow-up.

#### ***Outdegree***

Outdegree percentages increased for 11 agencies from baseline to follow-up, decreased for five, and remained the same for two agencies. The greatest change in outdegree occurred for Agencies 7 and 8 with both exhibiting increases of 52.9% at follow-up.

#### ***Indegree***

The indegree percentage increased for sharing information related to families: 14 agencies exhibited an increase, one showed a decrease, and three remained constant. Four agencies (Agency 4, 6, 7, and 14) exhibited a 24% increase in indegree at follow-up.

#### ***Average Nodal Degree and Density***

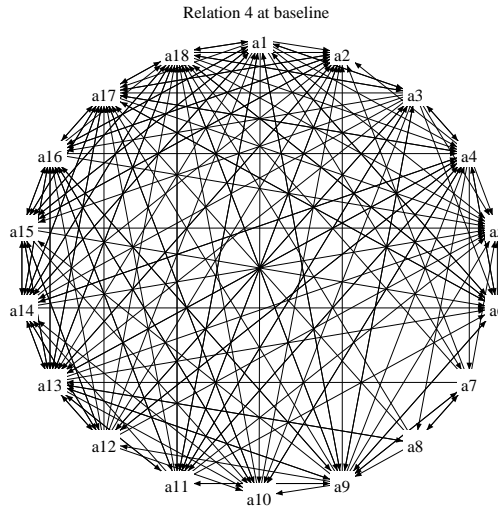
The average nodal degree increased from 9.9 at baseline to 12.1 at follow-up. Average density increased from 58.2% of all possible connections at baseline to 70.9% at follow-up, an increase of 39 collaborative connections in the provider network.

#### ***Summary Relation 4, Illustrations and Network Centralization***

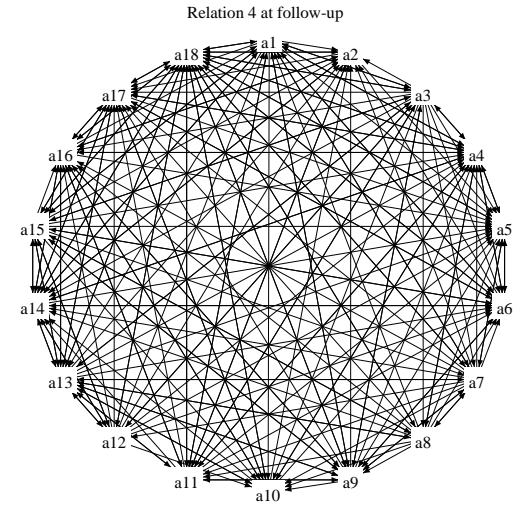
The figures in Table VI-4 illustrate the tabular results. Figures VI-4a and VI-4b are circle illustrations of the connections among agencies at baseline and follow-up, respectively. Figures VI-4c and VI-4d were constructed using multi-dimensional scaling (MDS) to locate the relative position of the nodes mapping geodesic distances and similarities among nodes or agencies. Figures VI-4d and VI-4c illustrates that some agencies (e.g., a11 and a15) are peripheral to the network at baseline (VI-4c) and appear more central at follow-up (VI-4d). This is consistent with the decrease in network centralization from 23.5% at baseline to 7.4% at follow-up. Increased collaboration is evident based on responses from agencies about sharing information related to serving families. Network density, the total number of ties or connections has increased substantially and centralization has decreased substantially indicating more and more open sharing among agencies.

**Table VI-4. Community Collaboration: Sharing Information Related to Families**

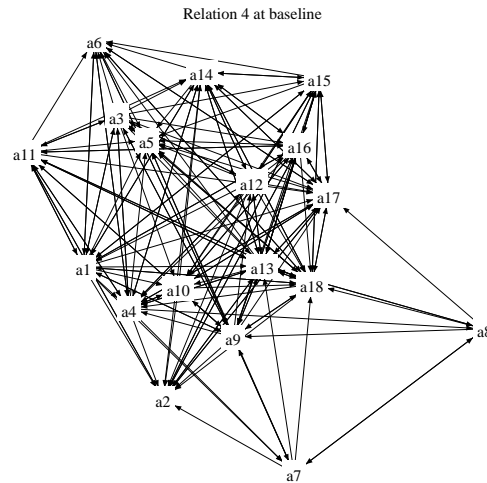
Agency #	At Baseline				At Follow-Up			
	Outdegree		Indegree		Outdegree		Indegree	
	#	%	#	%	#	%	#	%
1	15	88.2	9	52.9	14	82.4	12	70.6
2	5	29.4	13	76.5	6	35.3	13	76.5
3	14	82.4	6	36.3	17	100.0	8	47.1
4	12	70.6	12	70.6	11	64.7	16	94.1
5	0	0	14	82.4	5	29.4	16	94.1
6	6	35.3	10	58.8	9	52.9	14	82.4
7	6	35.3	4	23.5	15	88.2	8	47.1
8	5	29.4	3	17.7	14	82.4	6	35.3
9	15	88.2	9	52.9	13	76.5	11	64.7
10	6	35.3	9	52.9	8	47.1	12	70.6
11	12	70.6	8	47.1	12	70.6	10	58.8
12	12	70.6	6	35.3	13	76.5	6	35.3
13	14	82.4	14	82.4	16	94.1	13	76.5
14	11	64.7	11	64.7	11	64.7	15	88.2
15	11	64.7	10	58.8	16	94.1	10	58.8
16	12	70.6	11	64.7	11	64.7	14	82.4
17	10	58.8	15	88.2	9	52.9	16	94.1
18	12	70.6	14	82.4	17	100.0	17	100.0
Average Degree (std dev)	9.9 (4.10)		9.9 (3.43)		12.1 (3.52)		12.1 (3.37)	
Max Nodal Degrees	17		17		17		17	
Avg Geodesic Distance	1.388				1.291			
Average Density (std dev)	58.2% (0.4933)				70.9% (0.4542)			
Network Centralization	23.5%				7.4%			



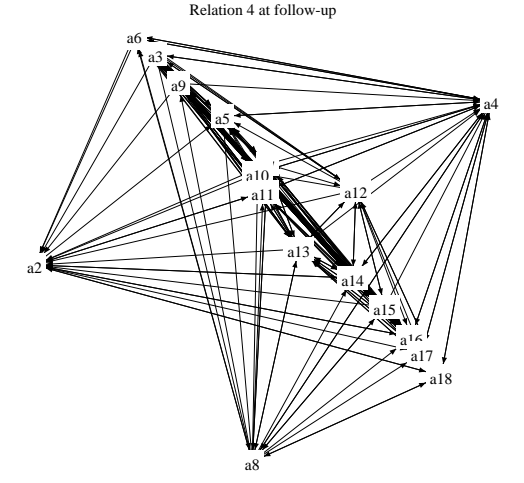
**Fig. VI-4a: Circle Drawing of Collaboration at Baseline**



**Fig. VI-4b: Circle Drawing of Collaboration at Follow-up**



**Fig. VI-4c: Multidimensional Scaling Drawing of Distances & Similarities at Baseline**



**Fig. VI-4d: Multidimensional Scaling Drawing of Distances & Similarities at Follow-up**

### ***Relation 5. Community Collaboration for Better Service to Families***

Table VI-5, below, presents the baseline and follow-up results from the question: are agencies serving families better through collaborative efforts? The figures in Table VI-5 illustrate the tabular results. The measures presented include: outdegree, indegree, average number of degrees, maximum number of nodal degrees, average geodesic distance, average density of the network and network centralization.

#### ***Reachability and Average Geodesic Distance***

All agencies were reachable; the average geodesic distance was 1.405 at baseline and 1.284 at follow-up. The 9 percent decrease indicates shorter average distances among agencies at follow-up.

#### ***Outdegree***

Outdegree percentages increased for 12 agencies, decreased for three agencies, and were constant for three agencies. Agency 7 and Agency 8 showed the greatest change in outdegree (working with others) from baseline to follow-up with increases 47.0 percent and 41.1 percent, respectively.

#### ***Indegree***

Indegree percentages increased for 16 agencies and were constant for two agencies. Three agencies (Agency 4, 8, and 18) showed the largest change in indegree activity from baseline to follow-up, each with an increase of 29%.

#### ***Average Nodal Degree and Density***

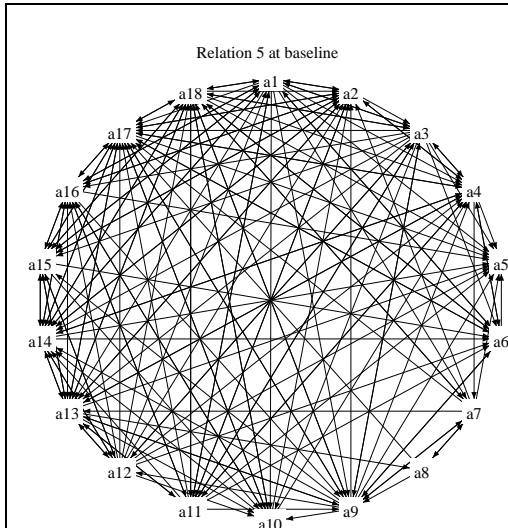
The average nodal degree increased from 9.8 at baseline to 12.2 at follow-up, an increase of 25%. Average density increased from 57.5% of all possible connections at baseline to 71.6% at follow-up; this is a gain of 43 collaborative connections from baseline to follow-up.

#### ***Summary Relation 5, Illustrations and Network Centralization***

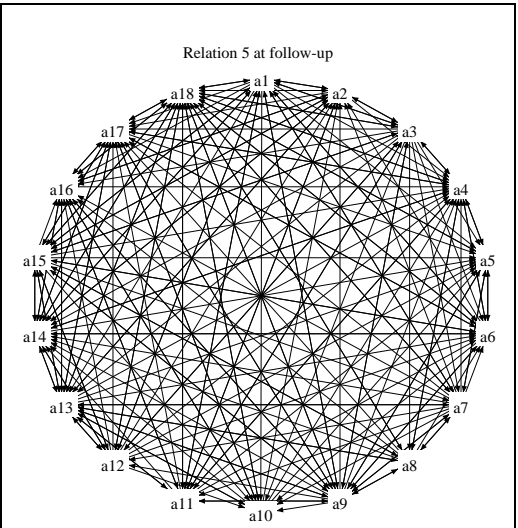
The figures below illustrate the tabular results. Figures VI-5a and VI-5b are circle illustrations of the connections in the data among agencies at baseline and follow-up, respectively. Figures VI-5c and VI-5d were constructed using multi-dimensional scaling (MDS) to locate the relative position of the nodes, mapping geodesic distances and similarities among nodes or agencies. Network centralization decreased from 25.0% at baseline to 8.8% at follow-up. This reduction in centralization is illustrated by comparing Figures VI-5c and VI-5d. In VI-5d more agencies (e.g., a7, a6, and a4) are in the center of activity and their distances are more equal compared to VI-5c. Some agencies (e.g., a2 and a8) remain peripheral at follow-up, however, there is a larger core group sharing influence and prestige for the dimension of collaborating to better serve clients and families. Overall, there are substantially more connections and centralization has decreased indicating improved collaboration in work to serve families better.

**Table VI-5. Community Collaboration: Collaborating to Serve Client/Family**

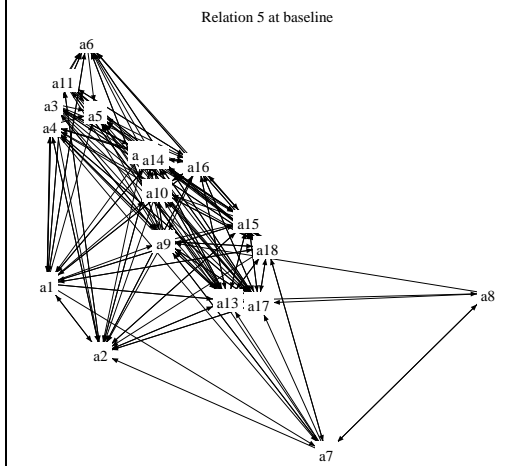
Agency #	At Baseline				At Follow-Up			
	Outdegree		Indegree		Outdegree		Indegree	
	#	%	#	%	#	%	#	%
1	15	88.2	9	52.9	16	94.1	10	58.8
2	9	52.9	13	76.5	10	58.8	13	76.5
3	14	82.4	7	41.2	17	100.0	8	47.1
4	9	52.9	12	70.6	8	47.1	17	100.0
5	0	0	13	76.5	5	29.4	14	82.4
6	6	35.3	10	58.8	10	58.8	14	82.4
7	7	41.2	5	29.4	15	88.2	8	47.1
8	3	17.7	2	11.8	10	58.8	7	41.2
9	13	76.5	10	58.8	17	100.0	12	70.6
10	6	35.3	9	52.9	8	47.1	11	64.7
11	12	70.6	7	41.2	12	70.6	9	52.9
12	13	76.5	5	29.4	13	76.5	8	47.1
13	13	76.5	13	76.5	15	88.2	14	82.4
14	11	64.7	13	76.5	11	64.7	16	94.1
15	10	58.8	10	58.8	16	94.1	11	64.7
16	10	58.8	10	58.8	9	52.9	14	82.4
17	11	64.7	16	94.1	10	58.8	16	94.1
18	14	82.4	12	70.6	17	100.0	17	100.0
Average Degree (std dev)	9.8 (3.95)		9.8 (3.44)		12.2 (3.59)		12.2 (3.22)	
Max Nodal Degrees	17		17		17		17	
Avg Geodesic Distance	1.405				1.284			
Average Density (std dev)	57.5% (0.4943)				71.6% (0.4511)			
Network Centralization	25.0%				8.82%			



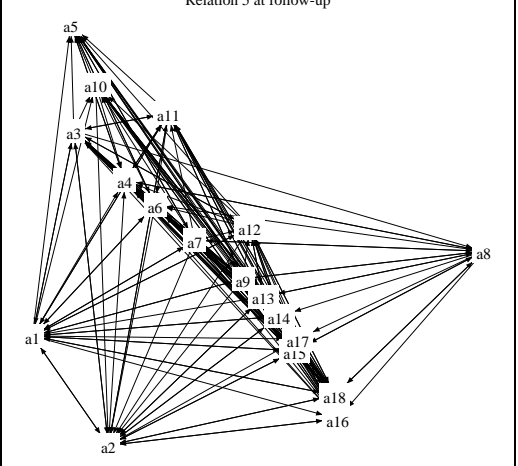
**Fig. VI-5a: Circle Drawing of Collaboration at Baseline**



**Fig. VI-5b: Circle Drawing of Collaboration at Follow-up**



**Fig. VI-5c: Multidimensional Scaling Drawing of Distances and Similarities at Baseline**



**Fig. VI-5d: Multidimensional Scaling Drawing of Distances and Similarities at Follow-up**

## **VII. Provider Collaboration Survey and Network Analysis: Summary of Findings**

An important element of the model is collaboration among the service providers. Results showed Broward County providers were collaborating prior to implementation of the model. However, since implementation substantial improvement in collaboration is evident. This spirit of collaboration facilitates access to resources by those working in the community, more importantly it provides easier access to resources by families who need them and communication among providers to serve those families.

Areas in which collaboration was rated especially high at baseline ( $\mu > 3.5$ ) included making progress toward improving services, having an equal voice and sharing information on the difficult to reach population. At follow-up, with one exception (i.e., we do not have effective rules for handling conflict) all items obtained an average score greater than 3.5.

Areas in which change was greatest included: having a clear shared vision, documenting progress, having specific measurable results to achieve, keeping the larger community well-informed about our work, demonstrating trust for one another and effectively communicating with each other.

Network data collected from agency directors illustrated strong working relationships among providers in Broward County. When compared to the level of “working together” prior to implementation of the family development model, the network measures indicated that providers are working together even more now than they were before implementation. Of 18 provider agencies included in the analysis, two-thirds of the agencies indicate especially strong and active network relations. Nearly all agencies attend trainings together, share some programs and have increased information sharing related to service to families and collaboration to serve families better.

## VIII. Findings from Qualitative Data: Service Providers

### Findings from Survey of Providers: Interviews

#### ***Over the past year-and-a-half, what do you think has changed about the way Broward County works with families?***

Providers perceived a change in the way families were treated and in how providers were able to collaborate with Family Success. The previous model was described as able to do “band aid” approaches (e.g., the power is going off today, being evicted today, etc.) while the Family Success Center is now perceived as a more long-term approach to family capacity building.

#### ***Has your agency’s relationship with Broward County changed?***

Some providers indicated that in order to obtain services, families were told that they “must go to case management as a condition.” One consequence of this orientation is that more referrals are being made. More referrals are also being made for a variety of other reasons (e.g., more knowledge of the services of the Family Success Center, widespread perception that the services available are high quality.

#### ***How do you feel about the changes over the past year at the FSC?***

The case management function is available to community agencies and this helps coordinate services in a more effective way. As a result, some agencies make referral to FSC to “get things started.” FSC has access to many immediate services and also provides case management so it is a good place to begin.

The community of providers nearly universally indicated that many positive changes had occurred in the process of adopting the family development model. Services and supports were perceived to be more effective in the short term and in the long term. It is unclear whether greater need has been identified through better service to the community or if the community is seeking out services because of better service. Regardless, increased need is evident from the number of families being seen at FSC and at other collaborating provider agencies.

#### ***What are the current strengths in the service delivery system?***

The Coordinating Council, First Call and connections to the Faith-based/Community Based Organizations were all mentioned. Another strength mentioned was the workers.

#### ***What would you like to see changed to improve services?***

Early contact with clients needs to be increased and diminishing over time as they become self-sufficient. We must ask who is already working on the case. Many times families will go from one provider to another and the providers will be unaware that services are also being provided elsewhere. This may ultimately overwhelm clients and it is important that this not happen, and that effort be maintained in achieving desired outcomes and not in “processing the process”(sic) the means not become the end.

## **Overall**

The program is perceived to represent more than a change from emergency services to case management. Duplication, turf wars, gaps in services, and shopping for services have all improved since the move to the new model. Service providers in the community know to whom they can refer clients, and there is a better sense of the community of providers working together. The one stop shop reduces the travel burden and cost too. Many more people in the community are aware of the services offered through the FSC.

## **Verbatim Responses**

### ***What do you think is needed most in Broward County to help decrease the percentage of families needing services?***

- More extensive case management, more and cheaper child care, more funds.
- Families are in need of services more at this time because of increasing rents, increasing population and services that have not increased at a rapidly enough rate.
- Collaboration between existing agencies and an infusion of new money in the county would increase services. Politics hinders this.
- More Jobs, childcare
- Subsidized childcare, services to homeless clients, transitional emergency assistance.
- More employment resources for individuals seeking employment. More willingness of employers to consider qualified persons with disabilities. More physical and mental health community based treatment for persons without insurance coverage.
- Case management, housing, childcare.
- Early access to intervention services related to assessment, assistance, and direct stabilization activities such as emergency, financial assistance to prevent homelessness.
- Homelessness programs, homeless shelters, better paying jobs, drug abuse programs.
- Employment, housing, transportation, medication –low cost.
- There is a need of more information related to services provided within the community and also a need for more education/skills.
- I believe employment assistance programs are most needed in Broward County. I believe that many clients lack skills/education they need to obtain gainful employment.
- I think that there are not enough resources. For example: Financial resources.
- Education, Employment, outreach program and awareness.
- Increase & better coordinated services to avoid duplication and extend limited resources. Improved outreach to those with greatest need.
- Affordable housing and affordable/subsidized child care is essential! Working to streamline services, avoid duplication of efforts; and overcoming turf wars!
- Easy access to services. User friendly for clients – less bureaucracy. Better jobs & more affordable housing – affordable daycare near where people live.

- Support to improve their situation, rather than services without responsibility which tend to enable the status quo.
- Affordable housing, living wage, case management services (intensive), emergency assistance services.
- Case Management, Diverse Employment Opportunities, Affordable Housing, Homeless & Prevention Services, Integrated Service Delivery System.

***Please list individuals, community groups, government agencies or service organizations that should be included in efforts to help families in need in Broward County.***

- All groups should coordinate and work together.
- The County Commission, United Way, Faith-Based Groups, the Federal Government, the State Government, Local Advocacy Groups, Philanthropic Groups, Civic Groups, Private Corporations, the School Board, the Families themselves.
- All social service providers, Child Care providers, Providers (Family Central) (everybody), Workforce One, TANF.
- Child Net, Department of Children & Families, Kids in Distress & Camelot Community Care.
- Too numerous to list! VR, Workforce One, Memorial Healthcare, Henderson, voc. schools, BCC, physicians, psychiatrists, psychologists, hospitals, med. equip. providers, transportation, housing, child care providers, drug and alcohol treatment, churches, food banks, Centers for Ind. living, job coaching.
- Family Success Centers, Family Central, Broward Coalition for Homeless, Children Services Council, Broward schools, Kiwanis, Rotary, Broward Coordinating Council, Broward Human Services.
- Broward County residents need help including direct care and concrete services from churches with women and men's community action groups. Due to this critical shortage of low-income and subsidized housing; county, state and federal funds are needed.
- Department of Juvenile Justice – counseling services for at risk youth.
- Unemployment Agencies, children & families/ different cities where each city can share information and help.
- I believe the County should work together with each city in Broward – especially those with a Human Services Department, Dept of Children & Families, Legal Aide, local hospitals should all work together to ensure communities are able to maintain self sufficiency. All groups should be included.
- DCF, CAA, Family Central, Legal Aid, Churches, FSC, Hispanic Unity, CSC, Henderson.
- Private forms. City council and agencies.
- Comprehensive case management with assessment, measured outcomes, multiple dimensions, input from partner agencies, consistent client access.
- Each local “high risk” neighborhood has its own inventory of local agencies, churches, etc. Dept of Juvenile Justice, Broward County Human Services, Hospital..., law enforcement, schools, universities, children services, ...Workforce One...

- I think the public/private partnerships and coordination of efforts from all cities, the county and not-for-profit in Broward Co. Need to define role of United Way.
- Public human service agencies – Private Human Service Agencies – Federal (DCF) & state & county agencies. School system – children services – elderly services
- Churches, youth groups – YMCA, Boys & Girls Clubs, service organizations which could encourage mentoring
- B.C. Elderly and Veteran’s Services, B.C. Homeless Services, B.C. Housing Finances and Community Services, B.C. Family Success, Workforce One, DCF, Henderson Mental Health, Substance Abuse & H.C., B.C. Housing Authority, Memorial Health Care Systems
- Broward County Family Success Administration, Housing Authority, Churches & Faith Based Organizations

***What are the goals of the Family Success Center and the Broward County Family Development program?***

- To stabilize clients.
- Increase self sufficiency in families, decrease dependence in government assistance, provide emergency assistance and case management to facilitate the above
- I do not know
- To provide emergency services for families in need, to provide case management for families in need
- Holistic assessment and services to assist individuals to be self sufficient
- Prevent families from loss of housing or certainly of life due to personal loss or illness.
- To “stabilize” and “strengthen” the family unit by assisting the parent/head of household to identify goals and activities and tasks which will “begin” to help him (or her) become a more independent, productive adult with the ultimate goal of “enhancing” their ability to care for him/her and children or dependents. To prevent family crisis or reduce the causes and reasons/factors and stressors which cause or contribute to the problems in the family.
- Goals are to help with housing, employment, rent assistance, parenting, counseling, transportation issues.
- To provide services to families in need. To help families stay together and for individuals with mental health issues get counseling and the appropriate help they need.
- The goals of the Family Success Center are to provide a thorough assessment of the client, identifying various needs, then provide multiple services such as case management and/or emergency assistance to ensure that client and/or family can remain self-sufficient ...
- To assist the community to achieve its economic needs and achieve it’s potential by strengthening the individual and the family in different functional areas. During the last year our relationship with FSC and other agencies has improved significantly. I think that now we work together on the same objective and vision. The communication has improved (between the agencies). The only problem now is that there are not enough resources to help the people.

- To bring people in and around the community together in one place, services and resources.
- Comprehensive case management with assessment, measured outcomes, multiple dimensions, input from partner agencies, convenient client access.
- To holistically assess and address the needs of families and individuals, to put them on the path to economic self-sufficiency & stability, and proactively work towards productive, successful families with an improved quality of life. Gainfully employed, education etc. When I first came to work in Broward Co. I was frustrated by the lack of centralized information & list of resources. Turf-wars among agencies were apparent; and, I believe there was significant duplication of services in some areas – and a complete lack in other needed areas. The FSC’s “Holistic Model” of addressing the total needs within a family, cuts down on “band-aid” measures & “emergency assistance” & focuses on the underlying causes & circumstances which placed a client in jeopardy. This is more cost effective, economical; and, provides a much greater base for success within the family (Richardson, Landsman & Tyler, 1995).
- To provide a Holistic approach to case management to help families in crisis or at risk, toward the goal of self sufficiency & change the conditions that got them in crisis.
- From my standpoint, the goal would be to have open communication which would encourage positive outcomes for families
- The goals of the FSC & Family Development are to increase the well being of the low income families in Broward County.
- To increase the Self-Sufficiency of families in Broward County

## **IX. Findings from Qualitative Data: Staff and Administration**

### **Introduction**

Of course the central provider in this evaluation is the FSC. Interviews were conducted with staff in a group and with four staff and three program administrators in individual sessions. Interview questions addressed the current philosophy, how that has changed compared to the previous model, how the new philosophy has influenced interactions with program participants, how the new practice was learned, what is valued the most and what should be changed about the FSC.

### **Program Philosophy**

The program philosophy staff described is consistent with the documentation of the model, and provides some evidence of fidelity to the model selected. Staff reported that the matrix model provided a useful mechanism for assessment and tracking the progress of individuals and families throughout the intervention period. While the focus is on outcomes, the relationship to people presenting at the FSC for services is reported to be much more holistic and encouraging. Staff report being more invested in clients and better able to provide needed services.

### **Change in Philosophy Compared to Previous Model**

The new approach was frequently described as “a more holistic approach to addressing family needs.” The assessment questions from the matrix, asked as part of the case management approach, are reported to be more helpful in identifying what the family needs and what services are needed immediately, such as rent, electricity, water, or food. The initial assessment helps identify multiple needs such as homelessness and mental illness, which may need to be addressed in parallel process. It is described as an assessment that allows the FSC to “get the whole story.”

There is a change in the relationship to people at FSC. “It’s not just a building,” rather it is described more as a caring community, where participants can receive needed support toward stability and a focus on their strengths rather than on crises or deficits.

### **How does the new philosophy influence your interaction with families?**

Integrating case plans among providers is occurring now in a way that has not happened in the past. The case management function is available to community agencies and this helps coordinate services in a more effective way. This is consistent with information from providers that some agencies are making referrals to FSC to “get things started.” FSC has access to many immediate services and also provides case management, so it is a good place to begin, especially for families where emergency child care is needed (FSC appears to be the only local agency with access to child care outside the child care waiting list which is reported to be about 3,000 long).

Movement is a focus now, not simply taking care of an emergency and getting on to the next emergency. The philosophy is much better because there is more flexibility in what can be done. Rarely do case managers have to say “no, can’t help.”

There are better community connections which also result in more clients. “The City has learned that we’re there and they’re sending clients too.” Other agencies are sending clients to begin the case management process.

“People I work with are helpful every step” (staff member). The FSC has progressed from “a building” serving emergency needs to embracing a philosophy of preventing the re-appearance of families in need. The intensive case management function is a very important element. Advocacy for the client is central to the approach. Measures are for case tracking purposes and are relevant, not just reporting.

The overall philosophy results in an orientation to families that make people’s lives better. “When I do follow-up with families, most of the time I find that they are still working after six months and remain stable or better.”

### **How did you learn the practice elements?**

Training was important, however, there is a synergy that has developed that has enhanced the skills of workers at FSC. They report being able to grow professionally because of the use of the matrix model, and the different orientation of the program to the delivery of social services is better. Where there were always roadblocks to service, those roadblocks are “not here.” Learning practice elements is an ongoing process. Many things contribute to ongoing practice improvement: an improved facility, meetings with intake workers

### **What do you value about working at FSC?**

The FSC has progressed from “a building” serving emergency needs, to a program to make people’s lives better. Staff report feeling “more professional” than under the old system. Significant professional growth is attributed to work using the matrix model. With increased professional growth, staff report that more community resources have become available, and this too has contributed to the development of increased professional skills.

The designing of the new system in the computer is an exciting and important step because it holds the promise of reducing some paperwork. Working at FSC is more flexible than what many have experienced in other programs encouraging finding solutions which contributes to staff satisfaction. As one staff member stated, you rarely have to say, “no, I can’t help.”

Better community connections have resulted although that has also produced more clients. Referrals come from other agencies sending people too. The community and the city seem to be more aware that the program exists and this is important to staff.

Ultimately, as in most organizations, the people with whom one works are perhaps the most important. Employees at FSC are reported to be “helpful at every step.”

**What would you like to change about the program?**

The first change that has become nearly a cultural universal is that there is too much paperwork.

A second major improvement suggested is a better facility.

Within the Center, having meetings among intake and case management workers that deal specifically with cases was desirable to some; there are general meetings but not specific to cases.

## **X. Findings from Qualitative Data: Follow-up with Program Participants**

Interviews were conducted with a sample of clients who were contacted by FSC and said they were willing to meet with the evaluator and provide a narrative description of their experience with the FSC. For comparative purposes, at the request of Broward County following the site visit, an additional data collection effort was undertaken. This effort sought to determine similarities and dissimilarities between families who did not participate in case management and families who participated in case management (e.g., had more or fewer ICAR domains, appeared more or less difficult to serve, were better or worse off at subsequent follow-up, etc.). This additional follow-up involved fifty randomly selected program participants who either received case management services in the past, or did not participate in case management services. The telephone follow-up was conducted in late August and early September, 2004.

From the descriptions provided by those participating in case management, it was reported that, for most, functional levels on the scales in the matrix were maintained. Some indicated that they had improved since leaving the program (e.g., several former case management participants indicated obtaining better housing since they were last contacted by FSC). Comparison of the presenting needs of those participating in case management and those not participating in case management indicates that those in the case management condition had more domain areas in which they were in crisis or at-risk than those who did not participate in case management. This finding suggests that those in case management were more likely to present with “multi-problem” needs compared to those who did not participate in case management.

Whether families were better off with case management or not participating in case management was not the focus of the evaluation and is a complicated question that deserves further investigation. However, those in case management appeared to have more presenting issues and received more intervention services. Those not in case management had seemingly isolated needs and did not receive the intensity or duration of intervention. The impressionistic data provide some evidence that those in case management on the whole were “worse off” to begin with. However, on follow-up, these families are sustaining their level of outcomes at similar levels as those not in case management. So while families are comparable at follow-up, the gains achieved for those in case management appear to be greater.

Throughout the follow-up interviews, the evaluation attempted to collect data that would provide insight into several substantive areas. These areas of inquiry included the following questions about client experiences with the FSC:

- What were you looking for, and what was the identified need when you first appeared at the Family Success Center?
- Which services were recommended?
- Which services did you participate in?
- How much time did it take to receive services?
- What changed as a result of your involvement with the FSC?

### **What were clients looking for and what did they say was needed on initial appearance at FSC?**

The first appearance by the vast majority of clients was precipitated by a crisis. The loss of a job and income, eviction, or a medical emergency resulting in financial crisis were most frequently referenced reasons for seeking assistance. Other reasons included the need for short term rent assistance, or assistance with child care, food, water, or electricity. Most of those with whom I spoke did not indicate that they came to the FSC seeking case management. While there is some recognition of a specific individual with whom those not participating in case management had contact, nearly all of those not in the case management condition referred to case managers or intake workers as “the person I talked to.” In contrast, those in case management identified the case manager by name and it was clear that there was a developed personal relationship.

Face-to-face and telephone follow-up with randomly selected individuals who had participated in case management, and follow-up with randomly selected individuals among those who did not participate in case management were conducted. These interviews suggested that there was little difference in the *perceived* magnitude of the presenting needs. However, those in the case management condition indicated that there were perhaps *more* issues of an in-crisis or at-risk nature than those who did not participate in case management services. These data provide indications that those in case management were more likely to have multiple needs at the ICAR level while those who did not enter into case management were more likely to have identified specific singular issues.

### **What services were recommended, and which services did you participate in?**

A range of services are available at the FSC (e.g., mental health, refugee services, life skill classes, counseling, and a community action program with services such as low income energy assistance is co-located at the FSC). Among those with whom I spoke were participants in case management and those who did not participate in case management services. Services that were recommended were reported to be appropriate by participants with whom I spoke. Overwhelming clients in crisis with services is an oft repeated scenario that was not evidenced in interviews with clients at follow-up. The family development model is designed to identify no more than three areas for intensive intervention, and it appears that fidelity to that aspect of the model has been highly maintained.

In comparing the experience of those participating in case management with the experience of those who did not participate in case management services, it is clear that those participating in case management received services for a longer period of time, and received a wider range of services focusing on multiple needs. Those who did not participate in case management appeared content to focus on a single need and that need was either met or not met. The experience with FSC began and ended with the identified need for those service recipients. Case management service recipients reported a developed relationship with their case manager and many volunteered that what they did for them, and what they do for others, is very good.

**How much time from initial appearance to service receipt?**

The amount of time it takes from initial appearance until services are received varies according to the level of need. An informal system of triage appears to be in operation at the FSC. Those identified as needing immediate services receive service sooner than others. There is an overall impression that response time is relatively slow due to high caseloads and not enough staff for peak times. Some also indicated that those with whom initial contact is made are not as quick to respond and are more likely to say “no” than case managers and intake workers. FSC case managers and intake workers have developed a “can do” reputation and clients indicated great respect and appreciation for their abilities to find ways to access needed resources for families.

**What changed in your family as a result of your involvement with family development services?**

Families reported that they were more stable following involvement with the FSC. Improvements in the areas targeted by case management were realized and among those with whom I spoke appear to be sustaining. As with the client level outcomes analysis above, both the functional level and the extent of change are important to examine. For domains which are measured at ICAR at intake, there is greater possible change; however, it is also important to examine the extent to which domain scores are SST and the number of SST scores which yield critical family resiliency. While it may be attributable to the goal and practice that families be at SST on all domains prior to case closure that the percentage of scores at SST is so high, follow-up interviews support the contention that scores at case closure sustain.

Clients report that the FSC provides “very good service.” If the focus on strengths is not explicit in intervention, it is not lost on clients. In no interview were there any negative comments about the overall services provided by the FSC, and the few negatives were phrased in the form of what could be done to improve services at the FSC.

**Were there any things you would have liked better, or things you would have liked to be different?**

The abundance of forms and paperwork was mentioned as an area that could use improvement. Some said that some forms seemed to be of little use. A few clients indicated that services could be more proactive in the sense that planning could target somewhat longer term outcomes for some clients. For those not in case management, there was mention of the limited amount of assistance available and this was not echoed by those in the case management condition. All clients indicated that staff showed an interest in them and a desire to resolve issues in the most effective and efficient manner they could.

Following are some case summaries as told by program participants exemplifying how services are received and perceptions of benefits received for those who received case management services:

Mary was living with her Grandfather, and they were splitting expenses. She said that her grandfather died, and she could no longer pay the rent. Day care had to be obtained because the children could not stay at home while she worked. The FSC located her brother and sister for her, and they agreed to help out. The FSC also arranged for their family to receive help that was needed (“coaching”) on how to use other community resources

Jane was very nervous telling her story. She was referred to the South FSC by another Center because she resided closer to the South FSC. She reported that her lights had been shut off several months earlier because Child Support Recovery had information that the father was not identified. The father was in fact unknown. The FSC arranged an appointment for her with Legal Aid. Legal Aid took the case, and Jane’s food stamps were restored.

Jan lived in the neighborhood, and had a car accident which resulted in her not being able to go to work for nearly two months. The FSC was able to help locate resources that paid her rent until she was able to return to work. Jane reported that without the FSC she would have been homeless.

John, through a series of events he described, had “come into some money.” Thinking he “had it made,” he was devastated when his wife left him and “took all the money.” He described his state as suicidal when he came to the FSC. Though “one month of rent does not help enough,” John said, the help he received was enough to keep him housed.

Tom was having difficulty seeing and could not work. He had spent 11 years in the military and came to FSC seeking medical and financial assistance. In addition to Tom’s medical needs, he needed housing. He was staying at the shelter and was also frustrated that the shelter “is set up for those with substance abuse problems.” Although Tom expressed dissatisfaction with services in the community and believes that services need to be more individualized and that “people often get the runaround,” he went on to say that “because of his case worker and the FSC [he] was able to get his cataracts removed and I can see again. [Case Manager Name] helped me through the system; without her, I don’t know where I’d be.”

Jack stated that he could not hold a job because of multiple mental illnesses. He is not able to maintain a job and has not been able to afford rent. He expressed frustration with trying to get help and stated that “ [Case Manager Name] was extremely helpful. The only help I have been able to get has been here at the Family Success Center.”

Dave has a long history of mental illness and points out that there are no substance abuse issues. He indicates that he has not worked steadily for more than a year and still finds shelter at a local storage facility. “I did a work up at VR, but didn’t find anything out until years later. I was having dental problems and I’m diabetic. [Case Manager Name] has done her best to get what I need.” Dave said that he originally came for case

management and does not qualify for many services. He reported that he received more than he expected through FSC.

Jim was an older gentleman who dressed up for the meeting (white shirt and tie) and brought flowers. He originally appeared at the FSC seeking legal services. After working with the case management program, he now reports that he has a job. He has sent letters more than once thanking FSC for the help he has received.

Anna immigrated from another country and reported that she was educated in her country and had a difficult time in this country. Anna reported that she lost her job, and her husband left her with 2 children. She had been on unemployment and then it "ran out." She received many services at FSC, and [Case Manager Name] helped her to obtain money so that she could obtain a license to work as a nurse. She repeatedly expressed thanks to her case manager.

Jeanne worked for a temporary agency, and her work visa had expired. In order to remain in the country, she took classes for which the FSC located funding. She said that her need for assistance was limited although, for others, services could be more proactive, positive and long-term.

## **XI. Findings from Qualitative Data: Follow-up Summaries of Interviews with Participants and Non-Participants in Case Management**

The follow-up data above speak to the similarity of experience in the quality of services received and the impressionistic difference in the quantity of services received between those participating in case management and those not participating in case management at the FSC. Examples of some of the personal accounts from telephone follow-up interviews are provided below illustrating some of the differences in the experience of those who participated in case management **(CM)** and those who did not participate in case management **(-CM)**.

Carol sought legal aid, but wasn't able to get help there. She has not received a disability check for 3 months. As a homeowner, she does not qualify for some services. Although she was not able to receive assistance, she reported that she knew that many people do receive services and are helped by "what they do there." **(-CM)**

[Case Manager Name] was very helpful but "I fell back into some of my old ways, back into the same old trap. They're very good at working with you... you have to fill out a lot of paperwork, but you have to give something to get something." It wasn't their fault. **(CM)**

Marie came to FSC seeking assistance with housing (Scored 1 on entry, 3 at follow-up). "Very helpful....The people at the front desk are not so helpful, they will tell you 'no, we can't help' sometimes." But once you get past the front desk the workers there are very helpful. You just don't have enough staff. There are more people coming through there than you can handle." She went on to say: "I tell you one thing, if you're ever in need of someone to work, you can call me back (indicating she would like to work on a project similar to "what you're doing"). Marie continues to work with FSC and is looking for "575 housing but I will be going to 524-beds." (524 beds is a shelter.) Currently Marie is temporarily residing at her sister's house while her sister is gone. Marie has a job and maintains her job but can't afford housing. **(CM)**

"[Case Manager Name]...helped me when I had no hope. She helped me and my mother find a place. Since then I've moved to a better place. She helped me with getting assistance for the lights. She helped me look for jobs on the computer, and she had me go out to [location] every day until I got a job there. ....she gave me hope when I had no hope. They are very helpful. She worked with me to fill out the forms [matrix], and I could see where I was and how I was doing in all these areas. That woman, I just can't say enough about her. "**(CM)**

"Me? Oh, I live in Hollywood Housing since 1991. I only needed help with my light bill. I talked to them over the phone and they said you had to be in your job for at least 30 days to get assistance with electricity." [This respondent then asked for the telephone number because she had some needs for assistance now, even though she has been in her job for 6 months.] **(-CM)**

## **XII. Summary and Conclusion**

The evaluation was primarily designed to assess program participant outcomes associated with the Family Success Administration Division, Family Success Center (FSC) implementation of a pilot family development case management model. Because an essential element of the FSC model was to promote an effective and efficient service delivery system through facilitation of collaboration, the evaluation was also designed to assess change in interagency relationships. The data were collected during the summer of 2004 and reflect the pilot program implementation period beginning in early 2003.

Client level outcomes were evaluated using the scores from initial assessment and final assessment data collected by the program on the matrix domains and through interviews conducted with program participants. The matrix data were also analyzed to compare subgroups including only those listed as head of household, those who were not in the homeless program, and those who were in the homeless program and received case management services. For comparative purposes, telephone interviews were also conducted with a sample of clients who received services at FSC and did not participate in case management.

All family members participating in case management showed significant improvement on each domain with the exception of substance abuse. Large gains were found for Employment, Housing, Income, Nutrition, Social Functioning and Transportation in the percentage of program participants assessed at stable, safe, or thriving on final assessment. Final assessments in the program indicate that more than 90 percent were assessed at SST on Adult Education, Housing, Mental Health, Nutrition, Parenting, Physical Health, Social Functioning, Substance Abuse, and Transportation. For Employment and Income more than 70 percent were SST at follow-up and gains in both areas were obtained by 40 percent of all participants.

A separate analysis of subgroups revealed that for those listed as head of household (HOH), significant improvement on the final assessment for all domains was obtained with the exception of Substance Abuse and Parenting/Caregiving. For those who were not in the homeless program, significant improvement was obtained on all domains with the exception of Substance Abuse. Those in the homeless program showed significant improvement on all domains with the exception of Parenting/Caregiving. Follow-up with those in case management and those who did not participate in case management suggested that those who participated in case management may have appeared at FSC with more in-crisis or at-risk domains, and functioning consistent with the final assessment, while those who did not participate in case management may have appeared with more resiliency and isolated (single domain) in-crisis or at risk status. Taken together, these are remarkable results when one considers that at final assessment each domain showed more than 90 percent for all individuals at stable, safe or thriving with the exception of employment and income which were at 70 percent or greater, and these results include the data from those in the homeless program.

Data collected from agencies on the survey indicate perceptions of substantially improved community collaboration. While collaboration was good at baseline, areas showing the most change included perceptions of improved: clear shared vision, progress well documented, specific measurable results, informing the larger community about their work, demonstration of trust for one another, effective communication with one another, meeting cultural and language needs, appropriate time spent in meetings, open discussion of self-interests by providers, and a clear action plan. The network analysis showed improved collaboration on participation in joint trainings and in shared programs with substantial gains in working more closely together, sharing information related to families, and collaborating to better serve those families. Data that addressed reasons for changes in the collaborative network were not collected though such data would be extremely useful for planning efforts to improve the working relationships among agencies and for more effective and efficient service to families.

Staff and providers said that the current philosophy is a meaningful change in how services are delivered and contributes to more effective service to families. The use of the matrix for assessment was mentioned as an example of how the philosophy is more holistic and family-centered, and how the model facilitates working together with clients toward self-sufficiency rather than short-term crisis intervention where workers see clients repeatedly appear for services without seeing improvement in their lives. This approach is valued as more effective, and the “right way” to treat clients. Caseload size is a concern, as is the amount of paperwork, reporting and the availability of resources. Client referral sources, especially referrals from County Commissioners, and seasonal patterns including fiscal year factors were also cited as affecting case loads as well as case weights (the level of intensity required for cases).

### **XIII. Recommendations**

#### **1. Measure treatment fidelity along with matrix outcomes.**

An important element of implementation is fidelity to the model being implemented. From a practice perspective, it is important to follow procedures of an evidence-based model to expect results consistent with those promised by the practice. For quality assurance, practice improvement, and documentation of local adaptation, it is important to assess fidelity to the model being implemented by systematically collecting measures of the intervention. Frequency, intensity and duration of contact with families are important for “dosage” measurement. For the family development model implemented in Broward County, it may also be important to collect data on the proportion of time spent focusing on strengths (rather than problems), and the degree that interaction is client driven, which may also be an indication (proxy) for the level of cultural competence employed, and should be measured to track this important service component. Forms currently in use should also be reviewed and changed to better reflect the current philosophy of practice at the FSC.

## **2. Use results to guide decisions about practice.**

In previous work, important aspects of “Using Outcomes in Decision-Making” have been identified: Involvement of stakeholders, appropriateness of **M**easurements, **C**omplexity of the system, **L**inkages between outcomes and services, and **U**nderstanding and responding to the needs for outcomes (IMCLU). Lessons learned have also included:

1) use technical assistance for initial consultation, 2) start small, 3) expedite feedback of results, 4) use project outcomes with other data, 5) develop a local strategy for using outcomes (see Richardson and Huff, 2001).

A routine mechanism for incorporating results into practice is the most effective way to use data for program improvement. Routine review of results by administration and practitioners provides a fact base for making decisions that also have legitimacy in the family centeredness of the decisions. It is clear that efforts are underway to facilitate incorporating results into management through the creation of the CSMS and this should be supported and use of the data should also be encouraged.

Data are not currently organized in a way that make them easy to use. Reporting (“paperwork”) should also contribute to the work or one would like to think it should be eliminated. Establishment of direct connections between information recorded and information needs should be established in order to reduce unnecessary recording and paperwork. A case flow processing analysis could be undertaken to identify critical decision points and information needs. Input from consumers on effectiveness of strategies and important decision points could also be included.

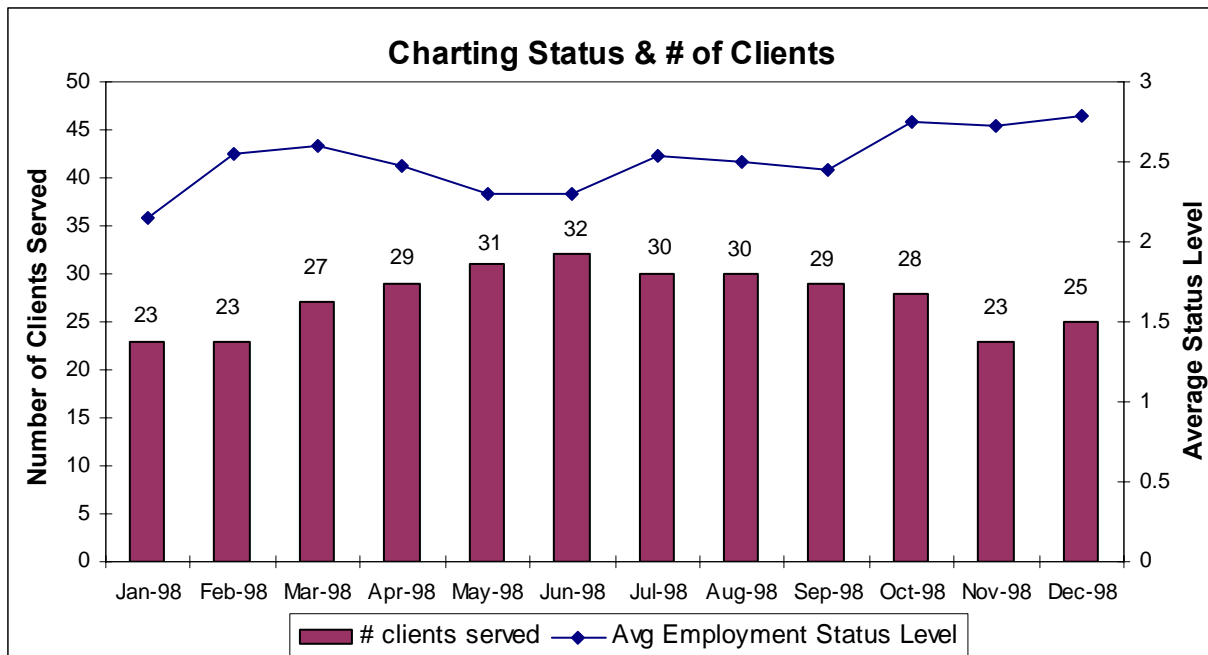
**3. Predictive validity of outcome measures should be established.** Some attempts were made through this evaluation to follow-up with clients to determine if program termination levels on the various domains corresponded to subsequent levels. Establishing predictive validity of the outcomes is necessary to support the use of the matrix approach. Though the program conducts follow-up with clients who can be reached by phone, current records only indicate whether clients at follow-up are stable or in-crisis. The matrix model is not used for follow-up, so follow-up measures collected are not on the same metric. For predictive validity, it would be preferable if the same measures were used at follow-up as during involvement in the program. Though the model addresses reliability through the adoption of standard operating procedures in using the assessment tools and requires all case workers to follow those procedures, this evaluation did not find evidence that reliability has been measured to ensure consistency throughout the program on completion of the matrix.

## **4. High follow-up and retention rates will require improved locator information.**

Federally funded projects are now routinely requiring 80 percent retention and follow-up. Attempts to establish measurement validity require similarly high rates. Working with youth in a substance abuse assessment and treatment program has taught us that what clients provide as contact information may not be reliable, and what is reliable today may not necessarily be reliable tomorrow. We have produced a protocol for recruitment and retention of clients, and a large portion of that document addresses locator and

contact information. For example, one strategy is to ask for phone numbers of three contacts and then, with the client, verify those contacts through a phone call. This procedure also legitimizes subsequent contact, if needed. The client can make the call, tell the contact what they are calling about and why (we have scripts that can be used), and then allow us to talk with the contact to complete the verification process. Through our procedures, we currently retain more than 96%.

**5. Exceeding capacity of the program may compromise the achievement of results.** Capacity of the program was designed for approximately 300 families per year and approximately 370 were reportedly served. (The data set provided for the evaluation contained data from 511 cases for the period from February 2003 through June of 2004, 17 months, which is consistent with the reported number of referrals and caseload). According to all sources, referrals are continuing to increase. Previous work has demonstrated that exceeding capacity is correlated with diminution of results. The figure below is excerpted from an evaluation conducted of a program where family development workers were expected to serve 20-25 clients. We see from the illustration that during the program startup phase beginning in late 1997, employment outcomes were measured at relatively low levels (i.e., 35% in January of 1998). Outcomes then increased; however, once caseloads exceeded capacity (around 29 cases in April) outcomes began to decrease. As caseloads declined, outcomes returned to their higher levels. It will continue to be important to monitor outcomes, interventions (process or “dosage”) and caseload capacity.



**6. Further analysis of existing data could provide answers to some questions raised in this evaluation and added measures of treatment activity provide information for quality assurance, and continuous quality program and practice improvement.**

Follow-up is conducted with a convenience sample of clients, and the results suggest sustained family functioning at SST. Several improvements in this system are suggested by this evaluation. Changes in the follow-up scales so that they are on the same metric as the matrix domains (i.e., 1 to 5), and improved locator information for follow-up would provide better evidence of the predictive validity of the measures (do scores at one point in time predict future points in time), and, at the same time, would provide measures of the extent to which matrix domain states are sustainable. Additional subsequent follow-up would also be useful in terms of measuring durability of sustainability (length of time) and furthering predictive validity of the measures. Using the same metric at follow-up, as is used during participation in the program, will allow comparison of the measures to determine if families realize sustainable outcomes. This process simultaneously provides a measure of how predictive a score at case closure is of a follow-up score at, for example six months and one year post-program intervention.

Additional analysis is also recommended to explore critical bundling of outcomes or configurations that are correlated with long-term family self-sufficiency and resiliency. In conjunction with the analysis of outcomes, it is important to measure and analyze family centeredness and strengths-based practice (two measures of fidelity), and combine those with the measure of length of service and durability of the outcomes. Data are available for the analysis of length of service and outcomes achieved, given configurations of domains identified as treatment goals. The addition of measures of family centeredness and strengths-based practice could yield useful information for program improvement as well as practice improvement if used in an ongoing “continuous quality improvement” approach. Feedback from such a process would provide valuable information for documenting outcomes and more evidence-based adaptation of the model for local needs.

**7. Network data are most effectively used when integrated with efforts to improve community collaboration.**

The network data and collaboration survey data were collected to measure change in relationships among community agencies that ostensibly resulted from changes at the FSC. When we surveyed representatives of community agencies, relational measures were collected about how agencies worked together before the new program was implemented, and how agencies were currently working together. During presentation of results to the Core Management Team it was pointed out that the survey did not seek responses providing an account for why respondents thought changes occurred. Were changes due to changes at the FSC?

To enhance reliability and validity of our measures, we typically collect network data “at the time” (i.e., baseline data are ideally collected before implementation of a program,

followed by collection of network data at critical points in time such as six months later, one year later and so on). Due to the nature of the current evaluation, in which an overall evaluation was conducted approximately 1 ½ years post-implementation, we asked respondents to provide data on network measures “as if it were prior to implementation,” and we compared those data to the current measures we asked the respondents to provide.

It would have been interesting to examine respondent accounts for changes when and where those changes occurred. However, to most effectively use the network data at this time, it is suggested that the results now be presented to those in the community participating in collaborative work. The nature of the presentation of the results would be to describe the results, seeking feedback from those in the collaborative to account for areas which appeared to improve, remain the same or require action for improvement. With proper facilitation, this approach would provide valuable information for the evaluation, potentially improve collaboration through the further understanding of the information, and serve as a model and mechanism to infuse evidence-based practice into the process for the local community. In addition, any agency seeking to improve collaboration from their perspective could use the data in practice. The approach would thus serve to model effective use of evidence-based practice and generate additional information which could be used to improve community collaboration. Subsequent follow-up would further reinforce the importance for using data and for community collaboration providing up-to-date measures of the current state of the relationships among agencies on relational content determined to be important as local conditions change.

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## **Appendix**

Provider Survey and Network Analysis Instrument  
Service Provider Survey Guide  
Program Participant Interview Guide  
Agency Code Key

Broward County is evaluating services provided by the Family Success Centers with the assistance of the University of Iowa School of Social Work, National Resource Center for Family Centered Practice. The purpose of this survey is to gain information from provider organizations and agencies that may work with families in Broward County.

Please complete the questionnaire and return it via fax to 319.335.4964. Your responses will be kept confidential. Only the researcher will have access to your questionnaire. If you have any question, please contact Brad Richardson, Ph.D. at 319-335-4924 or (cell) 319-431-3922.

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**Please answer the following questions that tell us a little about you:**

Name of Agency you represent: \_\_\_\_\_ Number of years at this agency: \_\_\_\_\_

**Please check a response in each box.**

GENDER:  Male  Female

ETHNICITY:  Hispanic or Latino  Not Hispanic or Latino

RACE:  White  Black  Asian  Native American  Multiracial  Other/please specify: \_\_\_\_\_

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**Please answer the following questions. You may use the other side of this sheet if there is not enough space for your responses.**

1. What do you think is needed most in Broward County to help decrease the percentage of families needing services?
  
  
  
  
  
  
  
  
  
  
2. Please list individuals, community groups, government agencies or service organizations that should be included in efforts to help families in need in Broward County.
  
  
  
  
  
  
  
  
  
  
3. What are the goals of the Family Success Center and the Broward County Family Development program?

**Thinking back to the beginning of 2003, for your agency or organization, please indicate your response (1=yes, 0=no) to the questions in the columns about the relationship between your agency and the other agencies listed.**

<b>For your organization→</b> <i>With these agencies: ↓</i>		Did you work with this agency? 1 = yes 0 = no	Did you participate in joint trainings with this agency? 1 = yes 0 = no	Did you share programs with this agency? 1 = yes 0 = no	Did you share information related to families with this agency? 1 = yes 0 = no	Did you collaborate with this agency to better serve clients/families? 1=yes 0=no
1	BC Community Action Agency					
2	Henderson Mental Health					
3	Hepburn Center					
4	Legal Aid of BC					
5	BC Housing Authority					
6	Hispanic Unity of Florida					
7	Davie Housing & Commun. Develop.					
8	Hope Outreach					
9	Memorial Health Care System					
10	BC School Board					
11	BC Elderly & Veteran's Services					
12	Children's Home Society					
13	Broward Outreach					
14	Women in Distress					
15	Family Central					
16	Vocational Rehabilitation					
17	Work Force One					
18	Family Success Center					

**Please indicate the extent to which you would have agreed or disagreed with the following statements on March 1, 2003.**

[SA = strongly agree, A = agree, N =neither agree nor disagree, D = disagree, SD = strongly disagree]

1. Staff of providers in this community demonstrated trust for one another. SA    A    N    D    SD	13. The amount of time spent in meetings was appropriate. SA    A    N    D    SD
2. There was a clear, shared vision for what the community was trying to do to serve families in need. SA    A    N    D    SD	14. The service community kept the larger community well-informed about our work. SA    A    N    D    SD
3. We did a good job at documenting our progress (outcomes). SA    A    N    D    SD	15. Our community planned for evaluating results and using results to improve services. SA    A    N    D    SD
4. We identified specific, measurable results that we wanted to achieve. SA    A    N    D    SD	16. I felt that the community was making progress toward improving social services. SA    A    N    D    SD
5. Tasks were appropriately distributed among providers in the community with respect to serving families in need. SA    A    N    D    SD	17. Consumers were involved in planning and decision-making. SA    A    N    D    SD
6. Agency members are representative of the populations they worked with. SA    A    N    D    SD	18. We planned for sustaining initiatives after initial grant funds ran out. SA    A    N    D    SD
7. We did not have effective rules for handling conflict among providers. SA    A    N    D    SD	19. I had an equal voice within this provider community. SA    A    N    D    SD
8. Providers had an effective process for making decisions. SA    A    N    D    SD	20. Members of the provider community openly discussed self-interests. SA    A    N    D    SD
9. The provider community did not have a clear action plan. SA    A    N    D    SD	21. Service providers effectively communicated with each other. SA    A    N    D    SD
10. Some provider agencies seem to have much more power in making decisions than others. SA    A    N    D    SD	22. People in our community agreed on issues of importance for our community. SA    A    N    D    SD
11. Our service provider community adequately met the cultural and language needs of minority groups. SA    A    N    D    SD	23. Service providers in this community commonly shared information and resources to assist the difficult-to-reach populations. SA    A    N    D    SD
12. Our provider network sought to bring in new members to participate in planning on an ongoing basis. SA    A    N    D    SD	

Survey adapted from: Landsman, M.J., Barber, G., Thompson, K. (2002). Expediting permanency through community decision-making. *Juvenile and Family Court Journal*, 53 (4), 79-90. Winer, M. (n.d.). How's it going? Auditing your collaborative effort. Boise, ID: 4Results Together.

**Please indicate your response (1=yes, 0=no) to the questions in the columns about the current relationship between your agency and the other agencies listed.**

<b>For your organization→</b> <i>With these agencies: ↓</i>		Did you work with this agency? <b>1 = yes 0 = no</b>	Did you participate in joint trainings with this agency? <b>1 = yes 0 = no</b>	Did you share programs with this agency? <b>1 = yes 0 = no</b>	Did you share information related to families with this agency? <b>1 = yes 0 = no</b>	Did you collaborate with this agency to better serve clients/families? <b>1=yes 0=no</b>
1	BC Community Action Agency					
2	Henderson Mental Health					
3	Hepburn Center					
4	Legal Aid of BC					
5	BC Housing Authority					
6	Hispanic Unity of Florida					
7	Davie Housing & Commun. Develop.					
8	Hope Outreach					
9	Memorial Health Care System					
10	BC School Board					
11	BC Elderly & Veteran's Services					
12	Children's Home Society					
13	Broward Outreach					
14	Women in Distress					
15	Family Central					
16	Vocational Rehabilitation					
17	Work Force One					
18	Family Success Center					

**Please indicate the extent to which you currently agree or disagree with the following statements.**

[SA = strongly agree, A = agree, N =neither agree nor disagree, D = disagree, SD = strongly disagree]

1. Staff of providers in this community demonstrated trust for one another. SA    A    N    D    SD	13. The amount of time spent in meetings was appropriate. SA    A    N    D    SD
2. There was a clear, shared vision for what the community was trying to do to serve families in need. SA    A    N    D    SD	14. The service community kept the larger community well-informed about our work. SA    A    N    D    SD
3. We did a good job at documenting our progress (outcomes). SA    A    N    D    SD	15. Our community planned for evaluating results and using results to improve services. SA    A    N    D    SD
4. We identified specific, measurable results that we wanted to achieve. SA    A    N    D    SD	16. I felt that the community was making progress toward improving social services. SA    A    N    D    SD
5. Tasks were appropriately distributed among providers in the community with respect to serving families in need. SA    A    N    D    SD	17. Consumers were involved in planning and decision-making. SA    A    N    D    SD
6. Agency members are representative of the populations they worked with. SA    A    N    D    SD	18. We planned for sustaining initiatives after initial grant funds ran out. SA    A    N    D    SD
7. We did not have effective rules for handling conflict among providers. SA    A    N    D    SD	19. I had an equal voice within this provider community. SA    A    N    D    SD
8. Providers had an effective process for making decisions. SA    A    N    D    SD	20. Members of the provider community openly discussed self-interests. SA    A    N    D    SD
9. The provider community did not have a clear action plan. SA    A    N    D    SD	21. Service providers effectively communicated with each other. SA    A    N    D    SD
10. Some provider agencies seem to have much more power in making decisions than others. SA    A    N    D    SD	22. People in our community agreed on issues of importance for our community. SA    A    N    D    SD
11. Our service provider community adequately met the cultural and language needs of minority groups. SA    A    N    D    SD	23. Service providers in this community commonly shared information and resources to assist the difficult-to-reach populations. SA    A    N    D    SD
12. Our provider network sought to bring in new members to participate in planning on an ongoing basis. SA    A    N    D    SD	

Survey adapted from: Landsman, M.J., Barber, G., Thompson, K. (2002). Expediting permanency through community decision-making. *Juvenile and Family Court Journal*, 53 (4), 79-90. Winer, M. (n.d.). How's it going? Auditing your collaborative effort. Boise, ID: 4Results Together.

**SERVICE PROVIDER SURVEY GUIDE**

Over the past year-and-a-half, what do you think has changed about the way Family Success Center works with families?

How has your agency's relationship with the Family Success Center changed?

How do you feel about the changes over the past year at the Family Success Center?

What would you like to see done differently

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Administer Provider Network Survey

**PROGRAM PARTICIPANT INTERVIEW GUIDE**

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Q1. When you first came to the Family Success Center, what were you looking for/what did you need?

Pr. What services did you think you needed?

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Q2. What services were recommended?

Pr. How much time from initial appearance to service receipt

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Q3. Which services did you participate in?

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Q4. What changed in your family as a result of your involvement with family development services?

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Q5. How did these changes come about?

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Q6. Were there any things you would have liked better, or things you would have liked to be different?

Pr. about the way services were identified or chosen?

Pr. about what you were able to do?

Pr. The level of interest the case worker showed toward you and circumstances/toward helping you resolve issues

Pr. about what was provided?

Pr. about results/outcomes of your participation?

<b>AGENCY CODE KEY</b>	
<b>BROWARD COUNTY AGENCIES</b>	
<b>included in collaboration survey and network analysis</b>	
<b>Agency #</b>	<b>Agency Name</b>
1	BC Community Action Agency
2	Henderson Mental Health
3	Hepburn Center
4	Legal Aid of BC
5	BC Housing Authority
6	Hispanic Unity of Florida
7	Davie Housing & Community Development
8	Hope Outreach
9	Memorial Health Care Systems
10	BC School Board
11	BC Elderly & Veteran's Services
12	Children's Home Society
13	Broward Outreach
14	Women in Distress
15	Family Central
16	Vocational Rehabilitation
17	Work Force One
18	Family Success Center