

CHAPTER 3:

FAMILY TEAM MEETINGS

3.1 INTRODUCTION AND OVERVIEW

3.1.1 Background on Family Team Meetings

Family Team Meetings (FTM) is a method for engaging family members and other people who can support the family for shared case planning and decision making. It is characterized by regularly-scheduled meetings, facilitated by a trained professional, and brings together family, friends, service providers and advocates. The goal of FTM is to come up with creative and effective solutions to case challenges, ultimately reducing the need for foster care placement and improving permanency outcomes. The child welfare field is increasingly embracing practices like FTM with the expectation that these practices will result in more appropriate and timely services to families. Different models of family team meetings such as Team Decision-Making (TDM) and Family Group Decision-Making (FGDM) have been promoted as promising practices by the Annie E. Casey Foundation and American Humane Association, respectively. FTM, and like practices, represent a paradigm shift from traditional child welfare services and have the potential to change the culture of child welfare.

Concurrently, increasing attention is being paid in the social services field to identifying and implementing evidence-based practices (EBP), narrowly defined as using empirically supported interventions. It is within this context that the federal Children’s Bureau sought to establish better linkages between services and outcomes. Thus the second waiver authorization in 2004 mandated that the counties focus on particular service interventions, including the requirement that all counties participate in one core strategy. The ProtectOhio Waiver counties selected FTM as their common strategy because they were already experimenting with various forms of family meetings under the first waiver; therefore, staff were familiar with the philosophy and practice and believed it to be a potent strategy.

3.1.2 Description of the ProtectOhio FTM Model

In Spring 2005, the demonstration counties built on their existing practice and defined a common FTM model that targets all children in cases that open to ongoing services with an initial case plan goal of reunification or maintain in home. The counties agreed that the model would include, at a minimum, the following key elements:

- Meetings are held over the entire period of ongoing services, including at a minimum
 - (i) within 30 days of case opening to ongoing services (first FTM may be in preparation for or as part of development of the case plan),
 - (ii) at other critical events in the case, and
 - (iii) at least quarterly after the case plan is developed (if a meeting has not already occurred due to some other reason).

- Trained facilitators are staff or contractors of the PCSA and do not have direct line responsibility for the case.
- Facilitator responsibilities include: arrange the meetings, help assure that participants attend and know what to expect (provide some orientation for potential participants), and support the family in the meetings and in preparing for them.
- Participants may include the birth parents, primary caregivers and other family members, foster parents (if child goes to placement), support people, and professionals.
- FTM process includes at least these components: agenda, introduction, information sharing, planning, and decision process.

Counties would stop doing FTM with the family when the case plan goal changes from “reunification” or “maintain in home” to something else, and when the child moves to permanent custody (PC), planned permanent living arrangement (PPLA), or legal custody to kin. Demonstration counties varied in their adherence to this model when implementing FTM in their own agencies. Differences and challenges in implementation are discussed in Section 3.2.

3.1.3 Evaluation Design

While FTM is considered promising practice and is in use around the world, there remain many questions about the effectiveness of the practice. To date, only limited evaluation has been done of family team meeting models. Review of the limited research on outcomes has shown positive or neutral effects, but many of the studies suffer from small sample sizes or a lack of adequate comparison groups (Berzin, 2006; Crampton, 2007; Sundell & Vinnerljung, 2004). The evaluation of FTM practice under the ProtectOhio Waiver benefits from both a large sample size, as well as the use of comparison groups in the research design.

Three research questions guide this study:

1. How is FTM implemented? This question is addressed by comparing the demonstration counties to a subset of 13 comparison sites, including only those using some FTM-like process.
2. What is the demonstration counties’ level of fidelity to the ProtectOhio FTM model? This question looks at variations among the demonstration sites.
3. Do children receiving ProtectOhio FTM more often experience a positive outcome than children in the comparison sites? This question considers children in all demonstration sites and all comparison sites.

The logic model which guides FTM practice and evaluation is presented in Table 3.1. Created in consultation with demonstration county staff in Spring 2005, it was reviewed and refined at the January 2006 retreat and the September 2006 FTM facilitators’ meeting. The logic model illustrates the demonstration counties’ belief that families that participate in the FTM strategy, characterized by frequent meetings that include a wide range of people, will be linked to more appropriate and timely services, leading to better child outcomes in terms of reduced foster care placements and improvement in permanency.

Table 3.1: FTM Logic Model

Inputs/Background Variables	Activities	Outputs	Outcomes
<ul style="list-style-type: none"> The facilitator’s training, whether the facilitator is independent (does not have direct line responsibility for the case), and whether the facilitator facilitates full time or has other responsibilities. Demographics such as the age of children, previous history with CPS, custody and living arrangement at time of initial FTM, etc. 	<p>For cases with case plan goal of reunification or maintain in home:</p> <ol style="list-style-type: none"> Families have FTMs over the entire period of ongoing services¹, including at a minimum <ul style="list-style-type: none"> Within 30 days of case opening to ongoing services, At other critical events in the case, and At least quarterly. FTMs are attended by a variety of people: Participants may include the birth parents, primary caregiver and other family members, foster parent (if child goes to placement), support people, and professionals. Facilitator responsibilities include: arrange meetings, help assure that participants attend and know what to expect (provide some orientation for potential participants), and support the family in the meetings and in preparing for them. FTM process includes: agenda, introduction, information sharing, planning, and decision process. <p>Activities 1 & 2 will be measured at the case level. Activities 3 & 4 will be measured at the county level.</p>	<ul style="list-style-type: none"> Families are linked to more appropriate and timely services; there is more service provision More clarity in case plans Families build stronger family relationships, have more natural supports, are empowered More consistent agency practice in deciding whether to place Opportunity to educate community, improve agency operations and image 	<ol style="list-style-type: none"> Avoiding initial placements <ul style="list-style-type: none"> % of sampled cases with initial case plan goal of maintain in home that have any placement during time in FTM and within a year of case closure Shorter time in placement <ul style="list-style-type: none"> # of days in placement Of children who are placed, more children are placed with kin <ul style="list-style-type: none"> For sampled cases with placement, the % that are placed with kin Shorter time case is open (to ongoing) <ul style="list-style-type: none"> # of days sampled cases are open to PCSA, by case plan goal More reunification <ul style="list-style-type: none"> Of children exiting out-of-home care, # who are reunified Quicker reunification, quicker permanence of any kind <ul style="list-style-type: none"> The average time between initial placement and reunification, guardianship, adoption, or legal custody to kin Increase in exits to relative custody <ul style="list-style-type: none"> Of children who are exiting out-of-home care, # who end up in legal custody of kin Less re-entry to substitute care <ul style="list-style-type: none"> # of children exiting placement who re-enter placement within a year of case closure Less maltreatment subsequent to first FTM <ul style="list-style-type: none"> % of cases with additional indicated/substantiated CAN reports any time after the sampled case is opened to within a year of case closure
<p>Other Considerations</p> <ul style="list-style-type: none"> Purposes of meetings held. # of FTMs that result in recommendations for changes to services, placement, or custody. 			

¹ Counties would stop doing FTM with the family when the case plan goal changes from reunification or maintain in home to something else, and when child moves to PC, PPLA, or legal custody to kin.

Fourteen demonstration counties began implementing the ProtectOhio FTM strategy between October 2005 and February 2006. Four additional demonstration counties joined the waiver and began implementing the FTM strategy between January and April 2007. While the demonstration counties targeted ProtectOhio FTM to serve all children who have cases which open to ongoing services with a case plan goal of reunification or maintain in home, some counties decided to sample at varying rates while first implementing the strategy; as counties established staff and became more confident in their ability to meet the demand for FTM, they increased their sampling rates to 100%. Only a few counties continued to sample throughout the entire study period. Table 3.2 shows each county's strategy start date, along with their sampling rates throughout the waiver period.

Table 3.2: FTM Strategy Periods & Sampling Rates		
County	Strategy Start Date	Sampling Rate
Ashtabula	11/4/05	100%
Belmont	12/27/05	100%
Clark	10/4/05	25%
Coshocton	3/1/07	100%
Crawford	2/1/06	100%
Fairfield	1/1/06	100%
Franklin	1/1/06	25% ²
Greene	12/1/05	100%
Hamilton	10/1/05 ³	25%
Hardin	1/1/07	100%
Highland	1/1/07	100%
Lorain	10/1/05	100%
Medina	11/10/05	100%
Muskingum	10/4/05	100%
Portage	12/20/05	100%
Richland	1/1/06	50%
Stark	11/1/05	50%
Vinton	4/1/07	100%

² The sampling rate for Franklin County was 50% of all cases that transfer to ongoing services in FCCS regional offices. Because the county randomly assigns half of all cases that need ongoing services to private contractors under the county's managed care initiative, the sampling rate in effect becomes 25%.

³ From March 1, 2006 to September 30, 2007, Hamilton County temporarily ceased participation in the ProtectOhio Waiver. For those already receiving FTMs prior to March 2006, Hamilton continued to provide ProtectOhio services, but did not add any new families while out of the waiver.

In one of the four new demonstration counties, implementation was slow to get off the ground, and thus no data from this county are presented in the analysis. As a result, most of implementation analysis is based on a total of 17 demonstration counties.

3.1.4 Data Collection Methods and Analytic Approach

The study team pursued three major analyses of the ProtectOhio FTM strategy, including: (1) an implementation analysis, (2) a fidelity analysis, and (3) an outcomes analysis. These analyses mirror the three main research questions that guide the FTM study, mentioned above. The implementation analysis is presented in Sections 3.2 through 3.4. The fidelity and outcomes analyses are included in Sections 3.5 and 3.6. We first present information on data collection methods, along with the analytic approach used for the implementation analysis. Sections 3.5 and 3.6 give more detail regarding the data collection and analytic methods used in the fidelity and outcomes analyses.

3.1.4.1 Data Collection Methods

Data collection for the FTM strategy was complex and multi-dimensional. Some of the data were collected at the county level and some at the individual level; that is, the information either reflected county policy and procedures, or it was specific to a single child or family. In addition, the methods were used for different groupings of counties. Thus, Table 3.3 shows that six types of data collection methods were utilized in the demonstration sites, three to obtain information at the county level and three for data at the individual level. By contrast, three data collection methods were used to compile information on comparison counties. It is important to note that most comparison county FTM information came from a reduced set of sites: based on initial interview information that distinguished which comparison counties were utilizing some type of FTM-like practice, the set of comparison counties was limited to 13 for further FTM exploration.

Table 3.3: Data Collection Methods			
	Data Collected		Level of Data
	Demonstration	Comparison	
Telephone Interviews	18	13	County
Site Visits	17	N/A	County
Focus Groups	13	N/A	Individual
Observations and Pre-observation Interviews	17	10	Individual
Surveys	18	17	County
SIS Events/ACCESS Data	17	N/A	Individual

- *Telephone interviews*: Interview protocols were used to document demonstration and comparison county policies, practices, strengths and barriers, and county-level fidelity to the ProtectOhio model. The primarily open-ended questions focused on topics including facilitators' training and role, caseworkers' role, the meeting process, and parent and community

involvement. The study team collected information from key staff in each county including administrative staff, supervisors, and facilitators. Interviews were conducted in 2006 with all demonstration counties and seven comparison counties identified as having some sort of FTM-like activity, in 2007 with the four new demonstration counties, and in 2008 with all demonstration counties and 13 comparison counties identified as having some sort of FTM-like activity.

- *Site visits:* The 2007 site visits to each of the demonstration counties included interviews with managers, supervisors, workers, and facilitators about their perceptions of FTM and its operation; it also included focus groups of parents involved in FTM (see below) and observations of FTMs in selected counties (see below). An additional on-site visit was conducted in 2009, focusing almost entirely on observations of FTM and other practices.
- *Focus groups:* During the 2007 site visits, the study team conducted focus groups of family members to gather their perceptions of FTM. Facilitators in each of the demonstration counties invited parents to voluntarily participate in a focus group. Focus groups were conducted in 13 demonstration counties with a total of 30 parents. Focus group participants were asked open-ended questions about how FTM was different from other meetings, their contact with the facilitator, and how FTM has been helpful or difficult. The parents' perspectives are likely not representative of the experiences of all parents involved in FTM. Further, the situations of the families ranged across the spectrum: some children were living at home, some were living with kinship caregivers, and others were living in foster care; some cases in which children had been removed appeared to be heading to reunification soon while others did not.
- *Observations:* The study team observed one or more FTMs in each county. These instances of FTM enhanced the study team's understanding of actual FTM implementation and practice. County staff were asked to identify meetings that the study team could observe and to gather a signed consent form from parents prior to the meeting. Observers categorized the ways in which facilitators, parents, and caseworkers were involved in the meeting; recorded the number and types of people who attended; and noted the meeting outcomes, decisions made, and issues left unresolved (see Appendix B.2 for Observation Protocol). Demonstration county observations were conducted in 2007 and 2009; comparison county observations were done only in 2009. The observation protocol used in 2009 included a few additional items that were not on the 2007 protocol; thus, most of the analysis presented in this chapter focuses on the 2009 observations.

Prior to each 2009 observation, the study team interviewed the facilitator to learn about the family's situation, the preparation that had gone into the meeting, and the facilitator's perception of how FTM has helped this particular family (see Appendix B.3 for Pre-Observation Interview Guide).

Table 3.4 notes the number of FTMs observed in each year in demonstration and comparison counties. These meetings were not necessarily representative of all FTMs, although a range of situations was observed. Children being discussed in the FTMs were living in a number of arrangements (home, kinship care, foster care, residential care) under a variety of custody situations. Cases also varied in the

length of time they had been involved with the PCSA: 16 of the 52 demonstration county observations and four of the 11 comparison county evaluations were the parents' first FTM.

Table 3.4: Number of FTMs Observed by the Study Team by Year and by Group		
Year Observed	Demonstration Counties (n=17)	Comparison Counties (n=13)
2007	16 meetings in 10 counties	N/A
2009	36 meetings in 17 counties	11 meetings in 10 counties

- *Surveys:* Information was gathered through two separate web-based surveys that included questions regarding FTM practice: (1) a survey of PCSA managers in the 18 demonstration counties, and (2) a survey of mental health/substance abuse providers in both demonstration and comparison sites (see Appendix B.9 and B.10). The management survey explored perceptions of the overall impact of FTM in the county (see Appendix B.1). The provider survey was completed by 65 agencies in 18 demonstration counties and 59 agencies in 17 comparison counties. The survey questions examined providers' awareness of FTM, involvement in meetings and barriers to involvement, and perceptions of benefits to families.
- *SIS events/ACCESS data:* These data items are recorded by the FTM facilitator after each meeting held. Information is entered regarding each child involved with the meeting, and one data item (which provides information on who attended the FTM) is entered once for the entire family. Beginning in 2007, each demonstration county began recording its FTM data into an ACCESS database developed specifically for this purpose. See Appendix C.1 for the exact data elements collected in the ACCESS database.

Five demonstration counties opted not to serve the universe of children eligible for FTM, due to capacity issues. Each of these counties maintained running logs of cases that transferred to the ongoing services unit. Staff tracked which families were systematically sampled (flagging every nth case) for the FTM intervention, as well as any non-sampled cases which were receiving FTM (specially selected cases).

In general, data collection commenced the day the county began the strategy. Depending on the county, the first logs were submitted and the first SIS events were recorded between October 2005 and February 2006. Study team staff provided ongoing technical assistance to counties on the proper way to complete the logs, clarify definitions of the SIS events, and enter data into the ACCESS database.

In addition to the discrete data collection methods described above, the study team had ongoing opportunities to interact with demonstration county managers, supervisors and facilitators, especially through facilitators' quarterly meetings, Consortium meetings, and two retreats. These interactions provided the study team with valuable feedback and insight on implementation challenges and successes. In addition, the study team occasionally used these interactions as opportunities to share formative evaluation feedback, which could be used to inform practice improvements. One example

worthy of note: the day-long FTM Retreat held in September 2009 not only helped to clarify overall strengths and challenges in implementation, but also led to identification of the need for more comprehensive FTM Facilitator training. To meet this need, a small group of four ProtectOhio FTM facilitators met several times via teleconference in November and December of 2009. The meetings focused on producing a set of recommendations that would drive development of a comprehensive training for both new and ongoing FTM facilitators, with the goal of sustaining FTM as a practice beyond the second waiver period. The group compiled a set of recommendations and presented it to the Consortium members in January 2010. In February 2010, the Ohio Child Welfare Training Program (OCWTP) began working with a small group of FTM facilitators and ODJFS staff to develop a statewide training on FTM facilitation.

3.1.4.2 Analytic Approach

The implementation analysis presented here describes similarities and differences between county-level practice in the demonstration and comparison sites, plus provides some basic data on the volume and nature of FTM activity that occurred in the demonstration counties.⁴

An analysis of the policies, perceptions, and observations of FTM, both in demonstration and comparison counties, brings together qualitative data collected between 2006 and 2009. Nudist 6 and NVivo were used to code interview data for themes and assign categories within themes. Coding was done primarily by one evaluator but was systematically and thoroughly discussed with the study team. The study team used an Excel worksheet to consolidate all interview data at the county-level by listing categorical codes for all inputs, processes, activities and outputs that were examined. The study team searched for correlations among the different variables and for differences between demonstration and comparison sites, indicating practice differences resulting from adoption of the ProtectOhio FTM model. As mentioned previously, the study team consistently uses a qualitative rubric for expressing differences between small groups of cases, where statistical testing is inappropriate or unfeasible: “substantial” for differences in percentages exceeding 50 points, “moderate” for differences in percentages of between 35-50 points, and “slight” or “somewhat” for percentage differences of between 20-34 points. Data from the observations, pre-observation interviews, management surveys and provider surveys were entered into Excel and analyzed using a combination of Excel and SPSS to run frequencies and cross-tabulations. Notes from the focus groups were coded for themes by hand and representative quotes were selected.

The analysis of the volume and nature of FTMs that occurred in practice in the demonstration counties uses all data gathered in the ACCESS database, plus the previous SIS Event data (hereafter referred to collectively as “Strategy Data”). This includes information on all FTMs held between October 2005 and June 2009. This analysis provides an overview of FTM activity across all 17 demonstration counties, and thus includes all meetings and children for which strategy data were provided. A variety of descriptive statistics, frequencies, and cross-tabulations were then run on the available data to highlight what was accomplished across all demonstration counties and the important variations in practice across the sites.

⁴ Section 2.2.2.2 provides an overview of the analytic approach used for the entire ProtectOhio evaluation.

In order to complete the analysis of the strategy data, family-level data were added to each child in the record, the data were thoroughly cleaned in order to minimize data entry errors, and various files were created dependent on the unit of analysis desired. For example, when we explore the range of attendees at FTMs, we look at the attendees at a specific FTM, which is an element common to all the children involved in the meeting -- the unit of analysis is the *family-meeting*. In this case, the family-meeting information represents one unit in the analysis, regardless of how many children were in the specific meeting. In contrast, when we explore the purpose of FTMs, we look at the specific reason the meeting was held; because this reason may be different for each of the children involved, we differentiate among the children -- the unit of analysis is the *child-meeting*. In this case, each child is a separate unit in the analysis. The *child-meeting level* is also used for child living arrangements, child custody status, and recommendations resulting from the FTM. This means that there are multiple entries for the same physical meeting because the information may differ for each child that is involved. Consequently, tables that represent data at the *child-meeting* level are counting a meeting for each child that was involved or discussed, and therefore the total number of units differs from the total number of meetings presented in Table 3.12. While this approach would give greater weight to meetings held for larger families, the study team determined that risk of bias to be minor -- 78% of Franklin families and 69% of the families in the other demonstration counties have 2 children or less, illustrating that larger families do not dominate the data set. Also of note is that the total number of meetings may vary across tables that use the same unit of analysis due to missing data for certain data questions.

A few challenges arose when analyzing the strategy data:

- *Missing data/data entry errors*: Most counties assigned a data entry person to enter information about each FTM into the ACCESS database (in larger counties, multiple staff entered the data). As is expected with different people entering data and turnover in staff over time, there were various data entry errors and/or missing data. The study team took the time to clean the data wherever possible, often directing questions about particular cases to the county staff.
- *Inconsistent use of categories*: With turnover in facilitators and data entry staff, the study team discovered that various people were recording data differently. For example, some staff were only recording a recommended change in service when there was an actual case plan amendment, while others were recording any recommendation that came out of the meeting, regardless of actual services provided or case plan amendments. The study team corrected for inconsistencies between and within counties wherever possible, incorporating the maximum amount of information on recommended service changes.
- *SACWIS conversion*: As was previously mentioned, the conversion to SACWIS in the middle of the waiver period had multiple effects on the evaluation; one of these effects was in regards to the FTM data. Although the study team tried to anticipate the challenges that this conversion would cause by adding space to record the old FACSIS Child ID and Family ID, not all counties used this feature. While the study team worked to address this concern through data cleaning and assignment of SACWIS IDs obtained from ODJFS, there likely remains some duplication in children and families.

3.1.5 Organization of Chapter 3: Family Team Meetings

As stated, the FTM study is guided by the three overarching research questions related to implementation, fidelity, and outcomes; this chapter mirrors those areas and is designed to answer the following key questions concerning FTM:

- *Section 3.2: FTM Strategy in Demonstration Counties: Policies, Perceptions and Observations*
What does FTM look like in demonstration counties?
- *Section 3.3: FTM in Comparison Counties*
How is the demonstration county's practice different from comparison counties?
- *Section 3.4: Volume and Nature of FTM Activity that Occurred in Practice*
What was accomplished across all demonstration counties at the case level in regards to the volume and nature of FTM activity?
- *Section 3.5: FTM Model Fidelity*
How well did the demonstration counties adhere to the ProtectOhio FTM model?
- *Section 3.6: Child-Level Outcomes: Demonstration versus Comparison Counties*
Are children in the demonstration counties experiencing a more positive outcome than children in the comparison counties?
- *Section 3.7: Summary and Conclusions*

3.2 FTM STRATEGY IN DEMONSTRATION COUNTIES: POLICIES, PERCEPTIONS AND OBSERVATIONS

This section presents qualitative data about the FTM activity that occurred in the 17 demonstration counties, describing FTM policies and procedures as well as observed practice, and highlighting variations among the counties in the demonstration group.

3.2.1 Building the Infrastructure to Support FTM

This section describes the demonstration counties' approach to implementing the ProtectOhio FTM initiative and the effort put into hiring and training facilitators, training caseworkers, and informing community agencies of the initiative. It includes a measure of the "overall capacity" or investment demonstration counties made in encouraging all professionals to support the FTM process.

3.2.1.1 Implementation Process

As stated above, the ProtectOhio waiver county managers selected FTM as their common strategy because they were already experimenting with various forms of family meetings under the first waiver. Therefore, staff were familiar with the philosophy and practice and believed it to be a potent strategy. While this approach represents a common way in which interventions are chosen, it does not reflect a consideration of research evidence. Gambrill (2006) points out that, according to its originators, evidence-based practice (EBP) is more than simply using empirically supported interventions, but "the integration of best research evidence with clinical expertise and [client] values" (Sackett, Straus,

Richardson, Rosenberg & Haynes, 2000, as cited by Gambrill, 2006). As explained by Gibbs and Gambrill (2002), the EBP approach involves line workers and clients in formulating research questions regarding decisions in their practice, searching electronically for the answer, critically appraising what they find, carefully considering whether the findings apply to a particular client, and then, taking into account the client's values and expectations, selecting an option to try, and evaluating the results.

Research has shown that not only is it important that EBP be used in selecting an intervention, but also that the intervention is put into practice using a specified set of planned activities. A recent review of the research on implementation concluded, "implementation appears most successful when:

- Carefully selected practitioners receive coordinated training, coaching and frequent performance assessments;
- Organizations provide the infrastructure necessary for timely training, skillful supervision and coaching, and regular process and outcome evaluations;
- Communities and consumers are fully involved in the selection and evaluation of programs and practices; and
- State and federal funding avenues, policies, and regulations create a hospitable environment for implementation and program operations." (Fixsen, Naoom, Blase, Friedman & Wallace, 2005, p. vi).

The Ohio demonstration counties conducted a set of implementation activities which resemble the list above. Representatives from the demonstration counties met twice in Spring 2005 to define the ProtectOhio FTM strategy and logic model. Counties then independently began their implementation processes: they hired facilitators, developed internal policies and procedures for their FTM programs, and provided training or orientation for caseworkers. Several counties offered an orientation to FTM practice for community partners. Because all these counties operated under the ProtectOhio Waiver, all had the same degree of flexibility in using Title IV-E funds.

The initial implementation period lasted for several months as staff struggled with the definition of the model and the collection of new data. Recognizing these issues helped the facilitators work as a group to improve the consistency of their practice. To assist them in their implementation, the facilitators began meeting together on a quarterly basis. These meetings provided an opportunity for the facilitators to clarify aspects of the practice model, review evaluation issues and data, and discuss other implementation challenges. Melde, Esbensen, and Tusinski (2006) note the importance of continued communication among program stakeholders as an important element in maintaining some level of cross-site consistency.

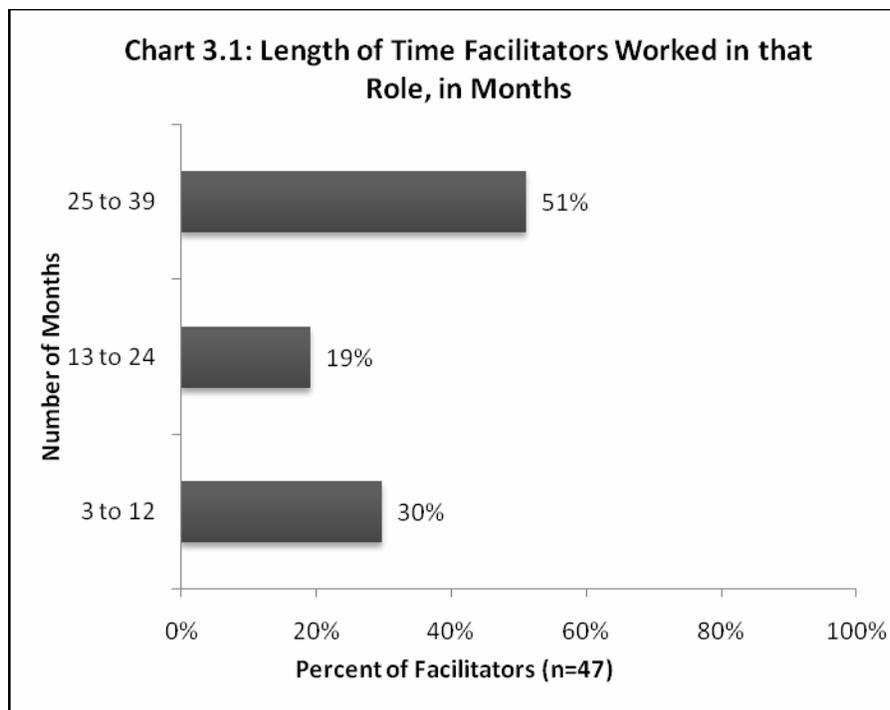
3.2.1.2 Facilitators' Work Experience

One of the first implementation steps was to designate someone to be the independent meeting facilitator (that is, someone who does not have line responsibility for the cases she is facilitating). In Spring 2005, counties began hiring facilitators or reassigning current staff into the facilitator role. The study team collected data regarding training and experience on 47 facilitators from 16 counties who

worked between the county’s implementation start date (as early as October 1, 2005) and December 31, 2008 (for a maximum of 39 months).⁵

Ten counties designated a single person to be the facilitator for the agency. Four counties, those in urban areas, hired a team of facilitators, ranging from three to eight staff (the remaining two counties switched between having one or two facilitators at a time). Appendix C.2 provides details on the number of facilitators and their longevity in each county.

Overall, the facilitators’ tenure over the course of the study appeared to be quite stable. Fifty-one percent of the facilitators had been working in their role for at least 25 months (Chart 3.1), and an additional 19% had been in the role for more than one year. Thirty percent of the facilitators had been working in their role for 12 months or less.



Eight counties had the same facilitator(s) for the entire study period. Four counties experienced some turnover, and four additional counties experienced moderate turnover (that is, averaging about one facilitator replaced per year). Thus, the counties varied in the amount of opportunity their facilitators had to garner experience on the job.

Based on the open-ended questions that the study team asked about facilitators’ previous work experience, we were able to determine that at least two-thirds of the facilitators had previously worked

⁵ As stated earlier, one of the new counties is not included in the analysis due to their slow implementation. An additional county did not use independent facilitators until Spring 2009, instead relying on the caseworker to facilitate her own meetings; thus no data are presented for this county on facilitator training, facilitator experience or communication between the facilitator and caseworker.

as a caseworker or supervisor (Table 3.5). A small minority had previous experience as a facilitator of FTM or similar process (e.g. domestic court mediation). Overall, the facilitators appeared to have substantial prior work experience in the social services field: at least one-third of facilitators had more than 15 years experience, and at least one-half had more than five years experience.

	Yes	No	Unclear
Previous work as caseworker or supervisor	64%	9%	28%
Previous facilitation experience	9%	51%	40%
More than 15 years experience in social services	34%	23%	43%
More than 5 years experience in social services	53%	4%	43%

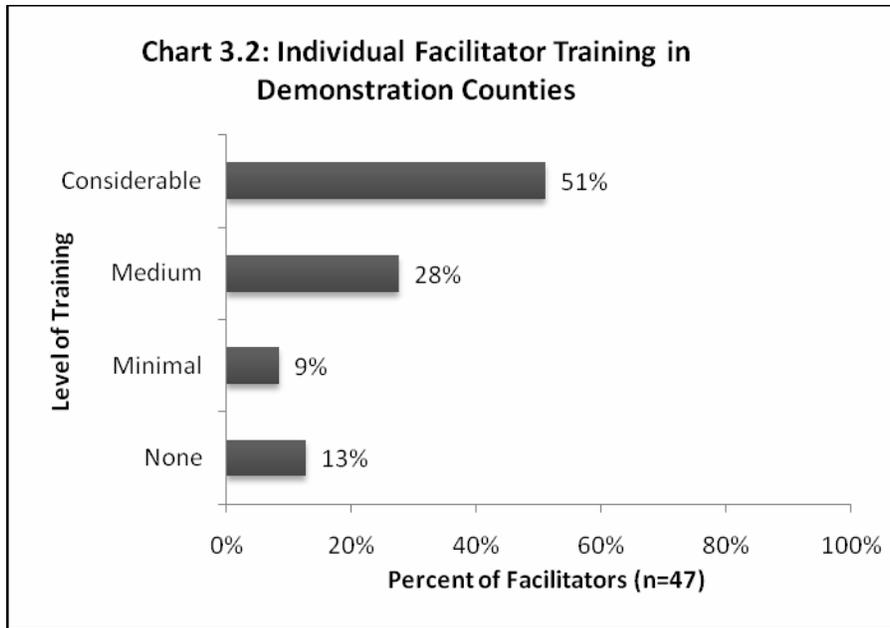
3.2.1.3 Facilitator Training

As part of defining the FTM model, the PCSAs agreed that facilitators would be trained in FTM and mediation. In November 2005 the counties sponsored a four-day training in Team Decision Making, a model which is similar to the ProtectOhio model. Eight counties sent facilitators to the training, and at least two more counties held their own training sessions. A second two-day training on FTM facilitation was sponsored in March 2008 and attended by facilitators from six counties. No formal training was provided in mediation, which facilitators have said is a key skill: many facilitators had mediation training prior to becoming a facilitator, and some obtained it later on their own.

The study team gathered detailed information on the types and amount of training that the facilitators had received, which can be categorized into three levels:

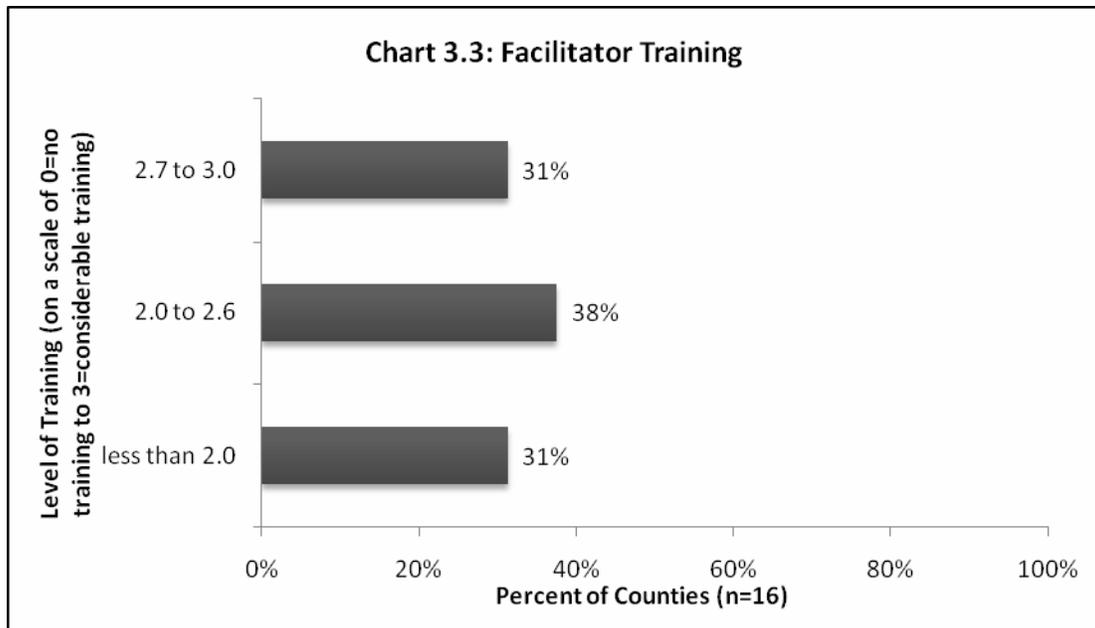
- **Considerable training:** The facilitator had participated in at least two training “events,” one of which consisted of some sort of formal training in facilitating an FTM model. The other “event” could include shadowing, additional FTM training, mediation training, Families and Children First (FCF) training, or similar training.
- **Medium training:** The facilitator had participated in one training event in an FTM model. The training could be shadowing or training by another facilitator.
- **Minimal training:** The facilitator had received an orientation in FTM (e.g. by another ProtectOhio facilitator), and/or mediation training, FCF training, or some other non-FTM type of training.

Applying these categories, the majority of facilitators received considerable training, but one in five (21%) received minimal or no training (Chart 3.2). Overall, the facilitators did not receive a large amount or high intensity of training. No coaching or performance assessments were built into the training. The training was also not highly uniform, but pieced together differently for each facilitator.



In order to examine the amount of training at the county level, the study team calculated a summative score for each county, taking into consideration the level of training and the longevity of each facilitator in the county.⁶ The results (Chart 3.3) fell into three natural groupings. About one-third of the counties (five of 16) had county scores between 2.7 and 3.0. This means that in these five counties, nearly all or all of the designated facilitators over the entire course of the study had considerable training. Another third of the counties (six of 16) had county scores between 2.0 and 2.6. This means that in these particular counties, the facilitators during the study period had medium or considerable training (or perhaps a brief period with a facilitator with minimal training). In the remaining third of counties (five of 16), some facilitators in the county may have had medium or considerable training but this was offset by other facilitators in the county who had minimal or no training. Appendix C.3 shows each county’s level of facilitator training.

⁶ To calculate the summative score for each county, each individual facilitator was given a numeric score based on the amount of training they had received: 3 equaled considerable training, 2 equaled medium training, 1 equaled minimal training, and 0 equaled no training. Each facilitator score was then weighted proportionally according to how many months the facilitator worked and how many facilitators were in the county, to arrive at a final county score based on a scale of 0 (no training) to 3 (considerable training).

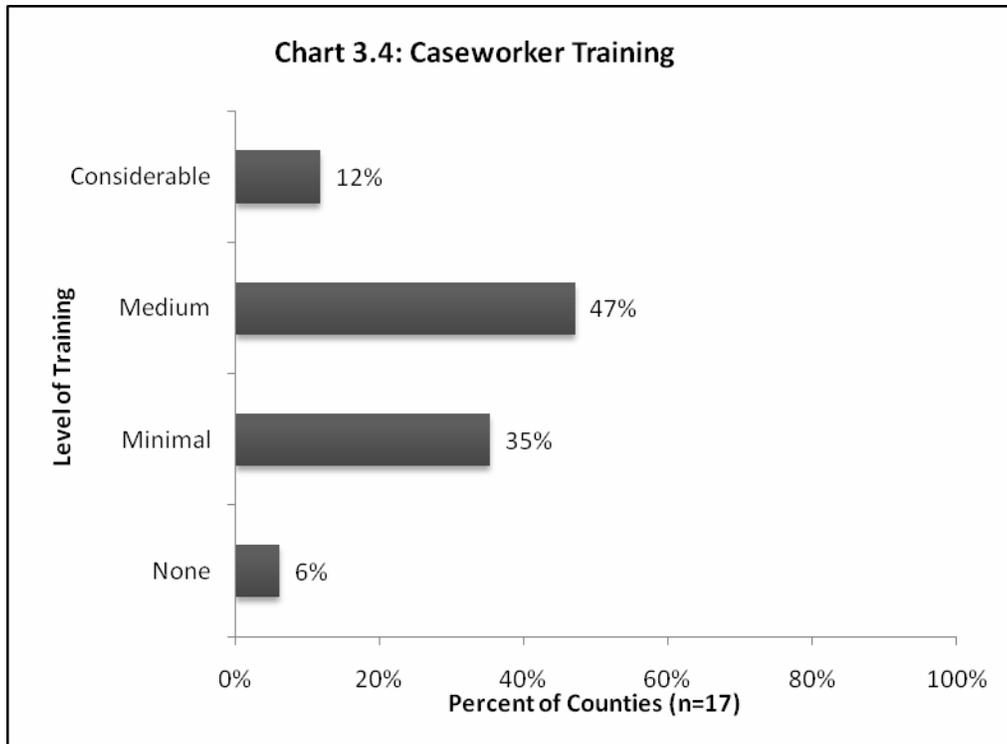


3.2.1.4 Caseworker Training

While the Consortium made some joint decisions about facilitator training, training for caseworkers was left for the counties to independently arrange. At the September 2009 retreat, participants suggested that caseworker training was one way to improve communication and collaboration between the facilitator and caseworker, and to assure that caseworkers take an active role in FTM so that the process is successful. The study team used a three-point scale, similar to that used to rate facilitator training, to rate the amount of training that each county provided to caseworkers.

- Considerable training: The caseworkers had participated in at least two training “events”, one of which consisted of some sort of formal training in an FTM model. The other “event” could include additional in-house FTM training and substantive discussion at staff meetings.
- Medium training: The caseworkers had participated in one training event in an FTM model. The training could be in-house training by the facilitator or repeated discussion at staff meetings.
- Minimal training: The caseworkers had observed meetings, received an orientation in FTM at staff meetings or at new hire training, or received some other type of general family meeting training.

Based on these categories, caseworkers in only two of 17 counties received considerable training, while seven counties received minimal or no training (Chart 3.4). While there is much that we do not know about the quality, content or duration of the training, overall, caseworkers did not receive very much training. While 10 counties received at least medium training, it appears that the caseworkers’ training had less intensity and duration than the facilitators’ training. Appendix C.4 lists each county’s level of caseworker training.



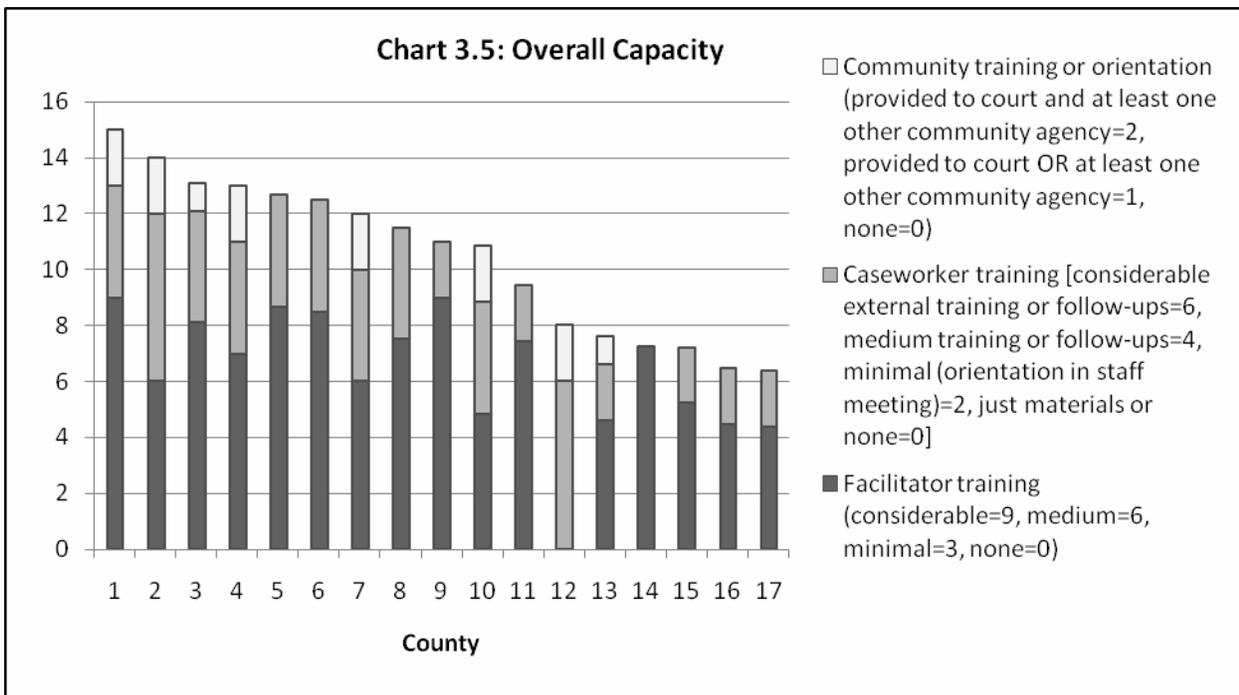
3.2.1.5 Orientation for Community Agencies and Court

The logic model suggests that FTM leads to more appropriate and timely services to families, presumably due in part to the involvement of community service providers in case decision-making. Many PCSAs decided to provide some sort of orientation or training in FTM to the court and other community agencies whose professionals they wanted involved in FTM. The PCSA involvement ranged from discussion with judges or agency managers, to mini-trainings provided by PCSA staff. Six counties provided some sort of orientation or training to both the court and at least one community agency, one additional county provided orientation to the court only, and one additional county provided orientation to community agencies only. But in more than half of the counties (nine), no formal effort was made to prepare community partners for participation in FTM. Appendix C.5 lists the sectors to which each county provided training. In Section 3.4.4, the study team explores whether providing some sort of orientation to both the court and at least one community agency has an effect on the number of providers attending FTMs.

For court-involved child welfare cases, the court has the power to either reinforce or reject decisions that come out of FTMs, thus enhancing or diminishing the credibility of FTM. Six of the seven PCSAs that provided orientation or training to their court felt that their court was supportive of FTM. Overall, 13 PCSAs stated in interviews that they thought their court was supportive of or “bought into” FTM, with three counties mentioning that the court will go so far as to order FTM or postpone court dates to allow an FTM to be held.

3.2.1.6 Overall Capacity

Bringing together all the training information discussed above, the study team developed a sense of the overall capacity of each county’s professional participants in FTM and a measure of the investment each county has made in encouraging professionals to support this family involvement process. Scores for facilitator, caseworker and community training were weighted and combined to yield an overall capacity score.⁷ The results appear in Chart 3.5. On a 17-point scale, county scores ranged from 6.38 to 15. Looking at the component parts of each bar, we see that eight of the 17 counties had at least a “medium” level of training for both facilitators and caseworkers, and five of these also provided some sort of community orientation or training.



3.2.2 Important Components of the FTM Process

From practice, the importance of three components of the FTM process has emerged. In this section the study team examines these three components: (1) family engagement, (2) facilitator-caseworker preparation and ongoing communication, and (3) performance in the meeting that fosters parent involvement. We address the basic question, “to what degree are demonstration sites meeting their

⁷ To compute the overall capacity measure, scores were assigned to each county based on the amounts of facilitator, caseworker and community agency/court training that was provided. The county-level facilitator scores (Chart 3.3) were multiplied by 3 to give the facilitator training the most weight in the overall capacity score. Facilitator training ranged from none (0 points) to considerable (9 points). Each county was scored on the amount of caseworker training provided based on a scale of none (0 points), minimal (2 points), medium (4 points), and considerable (6 points). Counties then received one additional point if they provided some orientation or training to the court, and one additional point if they provided some orientation or training to a community agency.

own expectations for FTM practice?” Where relevant we also look at how these practices have evolved from the model definition set out at the beginning of the initiative.

3.2.2.1 Family Engagement

At the September 2009 retreat, PCSA managers, supervisors and FTM facilitators suggested that family engagement in FTM is promoted by three main factors:

- Preparing the family prior to the meeting;
- Encouraging the family to bring support people, and then involving them in the meeting; and
- Holding the meeting in a comfortable, family-friendly environment.

Preparing Family Prior to the Meeting: Using data from interviews and observations, workers appear to be in charge of inviting and preparing family members in nine counties, facilitators are responsible in five counties, and the remaining counties appear to share responsibility between caseworkers and facilitators. This shows a slight departure from the original definition of the ProtectOhio model, which suggested that facilitators would “arrange the meetings, help assure that participants attend and know what to expect (provide some orientation for potential participants), and support the family in the meetings and in preparing for them.” This raises the question of whether the counties still believe that trained FTM facilitators might do a better or more consistent job of arranging and preparing participants for meetings. Based on our interviews and observations, it appears that caseworkers tended to take on these responsibilities due to three main reasons: (1) The facilitator’s workload is often too large for them to take on these tasks; (2) the caseworker has already established a relationship with the family so, at least for the first FTM, the familiarity is an asset; and (3) in striving to maintain an independent perspective in the meeting, facilitators prefer not having any extended contact with the family or caseworker prior to the first meeting. Often, subsequent FTMs are scheduled at the prior FTM, making the arrangements much simpler to do.

Seven counties appear to rely on personal or phone contacts to invite and prepare families, nine counties make personal or phone contacts occasionally, and one county appears to rely on letters. In the pre-observation interviews, facilitators reported that they or the caseworker had talked to the family in person or by phone in order to prepare for the meeting in 19 of 36 observations.

It is unclear how important it is to the family whether the facilitator or caseworker prepares them for FTM and the impact this has on attendance and their likelihood of bringing support people. Here are some quotes or paraphrases from parents who participated in focus groups who said that they had some preparation or contact before the meeting:

- “In advance of the meeting, the facilitator asks who I want at the meeting and where I want to have it held; I always get to say what I think, she respects me.”
- “At the FTM I got to invite my supports.”
- “The facilitator is neither for or against you; this is not something I get from everyone! She talked to me in advance of FTM, to get to know me. Her approach is not blaming, but ‘this is what’s happening, so let’s make a plan to make things better.’”

- “Caseworker (who served as meeting facilitator) stopped by to let me know what’s to be discussed, who would be there and time and place. There was lots of contact before the meeting and I felt well-prepared by the caseworker.”

Here are some additional quotes or paraphrases from parents who said that they had not been prepared prior to the meeting:

- “I didn’t know what to expect. I didn’t really have much preparation, just found that the caseworker did a lot of talking, but it wasn’t really helpful for me.”
- “Not told much; they told me we were going to talk about the case plan.”
- “Didn’t know I could bring someone.”

Given the variations among and within the counties, this may be an important topic for further discussion or study by the facilitators and Consortium. While we could expect that the preparation of the family might make a difference in participation, our data are not detailed enough to draw conclusions.

Encouraging Family to Bring Support People: In county interviews and pre-observation interviews, 11 of 17 counties reported that they talk to the family to determine who to invite to the FTM, tell parents that they can bring support people, and/or help parents to invite the support people. Two of these counties went on to state that they generally call extended family to invite them. In six counties, it appears that nothing is done; some of these counties stated that this task is left to the family. Some counties rely on a form the caseworkers have completed to determine who to invite to the FTM, but it is unclear how involved the family is in completing this form. Overall, the amount of effort that caseworkers and facilitators put into encouraging family to bring support people appears to be low to mixed.

Holding the Meeting in a Comfortable, Family-Friendly Environment: In order to promote family attendance, participants at the September 2009 retreat further suggested that PCSAs provide help with transportation, choose a convenient and neutral location; make the room more family-friendly with decorations, an area for children, etc.; use a round table to encourage a feeling of equality; offer snacks/drinks; select a time convenient to parents’ work and school schedules; and schedule the next meeting at the end of the prior one. Table 3.6 shows that nearly all counties help families with transportation to meetings, but far fewer numbers hold meetings at flexible times and in flexible locations. While many counties try to take the family’s schedule into account when scheduling meetings, the definition of “flexible times” used in Table 3.6 specifically looks at the ability to schedule meetings in evenings or on weekends. Refer to Section 3.4.4 for further discussion on the impact that these accommodations have on actual parent attendance.

Table 3.6: Ways Counties Support Family-Friendly Environments	
Types of accommodations for families	Percentage of Counties (n=17)
County assists with transportation to meetings	88% (15)
County holds meetings at flexible times (especially evenings, weekends)	35% (6)
County holds meetings in flexible locations	29% (5)
County only offers transportation	47% (8)
County offers all three	25% (4)

Another point related to the timing of meetings is the county’s policy if the family does not show up at the last minute. In this scenario, all demonstration counties except for one proceed with the meeting. However, if parents call ahead to cancel, all demonstration counties except for one will reschedule the meeting.

Nearly all of the observed meetings occurred in a conference room or office at the agency, though two counties made use of former group home facilities (one has been transitioned into a Family Advocacy Center), and one meeting took place in the conference room of the MRDD school. Among meetings that occurred in conference rooms or offices at the agency, some took measures to make the room more comfortable by having toys available for children, comfortable office chairs, children’s drawings on the wall, and/or providing water or snacks. The meetings that took place in former group home facilities convened around large dining room tables; in one of the meetings the children were able to play and watch TV in an adjacent room. A few counties mentioned that they will do meetings at the family’s home and that the family often appreciates this. Other community settings are reportedly used occasionally. Several counties mentioned that they will provide child care if needed.

3.2.2.2 Facilitator-Caseworker Preparation for Doing FTM Together and Ongoing Communication

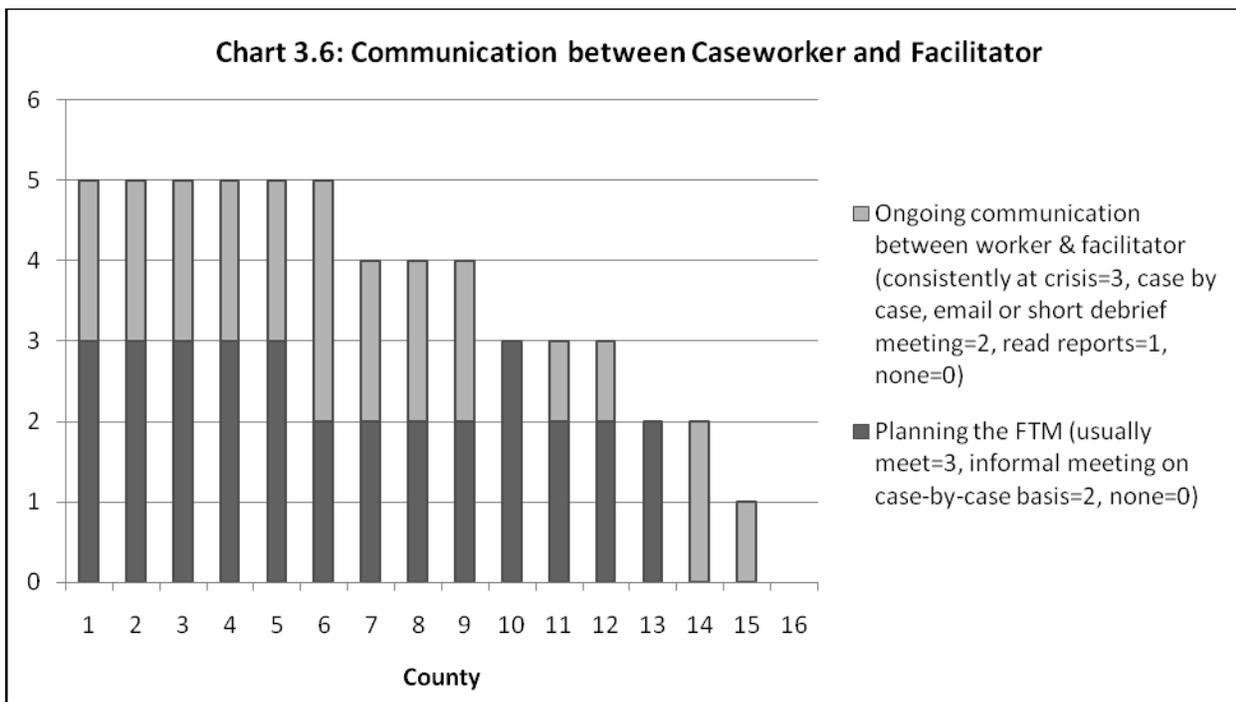
At the September 2009 retreat, participants suggested that it is valuable for the caseworker and facilitator to prepare together for the meeting, by sharing the referral form, reviewing the basic family situation and potential sources of conflict in the meeting, and discussing roles in the meeting. There appeared to be agreement that it is valuable for the facilitator to know basic information and potential sources of conflict; however, there was debate around whether knowing too much family history and details can make it difficult for the facilitator to have a neutral or fresh view. Participants suggested that communication between facilitators and caseworkers can be improved through four types of interactions: training; regularly scheduled time to talk, especially face-to-face; learning each other’s style and strengths; and putting concerns about FTM on the table for discussion.

In county interviews, six counties stated that the caseworker and facilitator tend to talk in advance of the FTM to prepare, review the case history and discuss who should be invited. An additional seven

counties stated that the caseworker and facilitator meet on an informal basis, particularly if a case appears to be challenging. Many counties characterized these discussions as either “hallway chats” or updates right before the FTM begins. It is worth noting that, while these types of discussions may be typical in these counties, they may not happen in every case. For example, in the pre-observation interviews, several facilitators mentioned that they had not talked specifically with the caseworker but that they reviewed a referral sheet or case notes prior to the observed meeting.

On an ongoing basis, only one county noted that caseworkers regularly communicate with the facilitator when crises arise that would indicate that another FTM is warranted (e.g. removal or placement disruption). Eight counties suggested that this type of communication is more discretionary and on a case-by-case basis. Three counties stated that facilitators rely on reading reports or previous meeting minutes to update themselves on a case. These data underscore a discussion later in this chapter (Section 3.4.3) regarding the most common reasons that an FTM was held in the demonstration counties: only six percent of the meetings across the demonstration sites were characterized as critical event meetings.

These differing degrees of communication are illustrated in Chart 3.6. While no county was rated at the highest level on both planning and ongoing communication (i.e., a total score of six), six counties were rated high on one aspect (usually planning the FTM) and medium on the other.⁸ While we might expect a relationship between the degree of communication and staff training, there appears to be no



correlation.

⁸ Each county separately earned a score of 1 through 3 for each aspect of communication between caseworker and facilitator: ongoing communication (consistently at crisis=3; case by case, email or short debrief meeting=2; read reports=1; and none=0) and planning the FTM (usually meet=3; informal meeting on case-by-case basis=2; none=1).

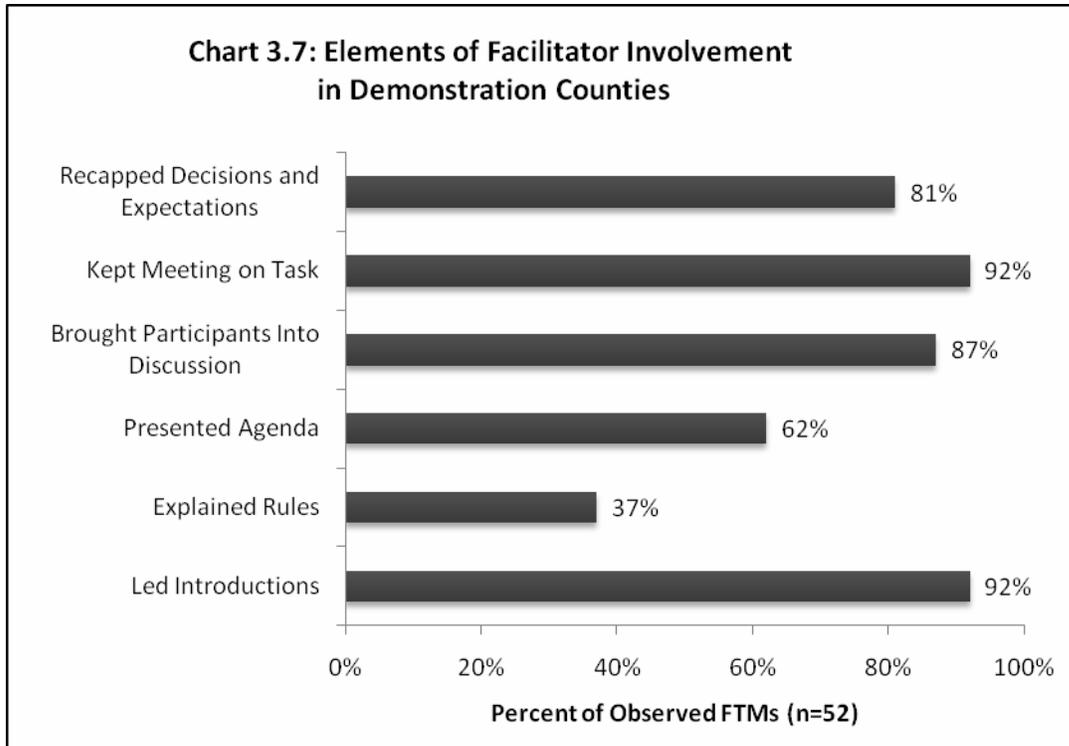
3.2.2.3 Performance in the Meeting that Fosters Parent Involvement

This section examines the involvement of facilitators, parents and caseworkers in the meetings we observed.

Facilitator Role: The study team systematically observed six aspects of the facilitator’s role in the meetings. These six types of involvement were based on the model definition (i.e., that the meeting will include introductions, agenda, information sharing, planning and decision-making, and that the facilitator will support the family in meetings). The importance of these items was later affirmed in discussions at the September 2009 retreat of how parent involvement is fostered (Table 3.7).

Table 3.7: Types of Facilitator Involvement Observed and How They Might Foster Parent Involvement	
Types of Involvement Observed	What PCSA Staff Believe Fosters Parent Involvement
Led Introductions	Helping the family feel comfortable by greeting them and doing things to break the ice
Explained Rules	Having well-defined rules
Presented Agenda	Explaining the process and goals at the outset
Brought Participants Into Discussion	Helping the parents to be clear and honest and helping assure that the parents are heard by all participants, assuring that PCSA staff are supportive, involving family support people in the meeting
Kept Meeting on Task	Conducting the meeting at a reasonable pace (not rushing)
Recapped Decisions and Expectations	Assuring that the outcome arises from the meeting (not pre-determined), assuring that PCSA staff are accountable

Chart 3.7 shows the degree to which these types of facilitator involvement were witnessed in the 52 FTMs observed by the study team between 2007 and 2009. Four of the six types were observed in at least 80% of the meetings. The other two types—explaining rules and presenting agenda—were observed less overall. However, these two types were observed more often in the 16 observations which were the family’s first FTM: rules were explained in 56% of the “first meetings” and the agenda was presented in 81% of the “first meetings.”



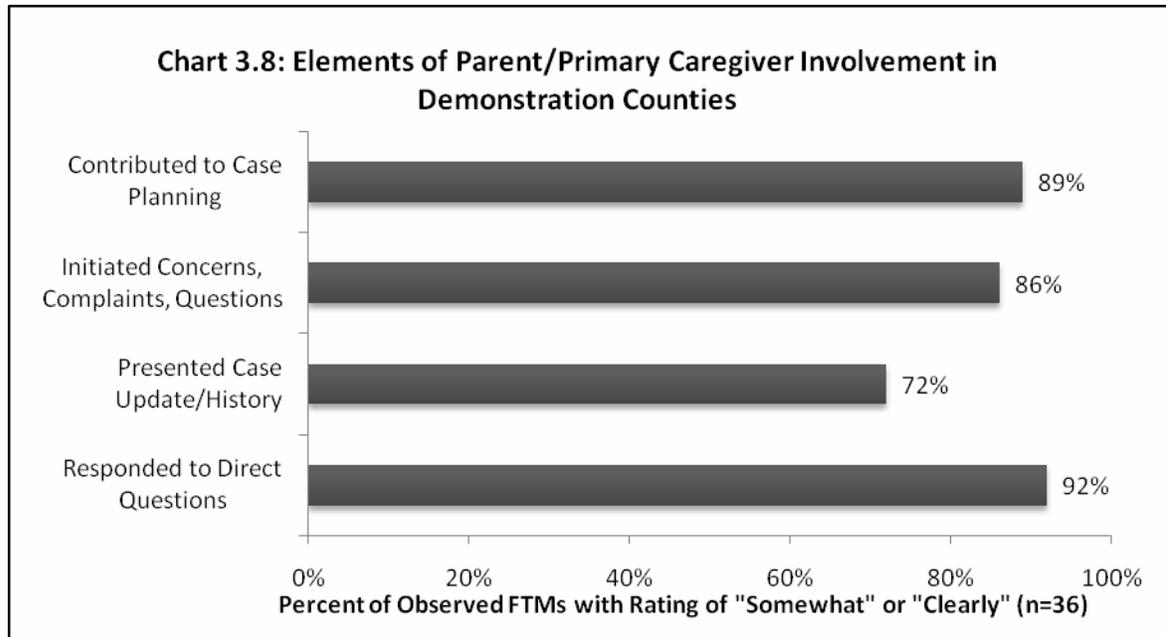
Parents made many positive comments about the role of the facilitator in their FTMs:

- “When things got tense, the facilitator helped everyone calm down. There were lots of confrontations, but she tries to stay neutral.”
- “They are always very friendly and they give me plenty of chances to say something and to voice myself.”
- “Felt my voice was heard, which I think would have been difficult without this meeting.”

One interesting change that occurred in many counties had a direct effect on whether facilitators performed some of the tasks described above. Before the ProtectOhio FTM initiative began, many counties already had a system of case planning meetings, staffings and reviews in place. During the study period, the state began mandating a system of quarterly (CAPMIS) and semi-annual reviews (SARs). Thus counties had to determine how FTM would fit into this existing or mandated structure. Fifteen demonstration counties decided to “merge” the FTM with meetings for CAPMIS, SAR, or initial case planning, and had to grapple with how to keep the FTM focus on the family while fulfilling the CAPMIS or SAR mandates. In these merged meetings, facilitators were slightly less likely to explain rules (one of eight did so, compared to 10 of 28 in non-merged meetings), but they were slightly more likely to bring participants into the discussion (all of the merged meetings, but 22 of the 28 non-merged ones). While the primary purpose of the meetings may have differed from FTMs, there were no other systematically observed differences between the two types of meetings. Further, it is unclear whether the new mandates on regularly scheduled reviews had an impact on the need or likelihood that FTMs would occur at critical events in the case.

Parent/Primary Caregiver Role in FTM: Perhaps the most important data the study team collected in the observed meetings pertained to the degree to which parents and primary caregivers were involved in the meeting. The study team monitored four aspects of parent or primary caregiver involvement. Chart 3.8 shows the percent of meetings where the parent/primary caregiver was found to at least somewhat engage in each type of involvement.

In each of the four areas the vast majority of parents/primary caregivers had at least some involvement. Furthermore, in 80% of the observed meetings, parents/primary caregivers were highly involved across the four areas.⁹



Caseworker Role in FTM: Participants at the September 2009 retreat suggested that it is important for the facilitator and worker to develop a relationship and establish a balance or dynamic for the meetings, which can be adjusted as needed to keep parents engaged and progressing. They argued that the nature of the caseworker role depends on the experience of the worker, the experience of the facilitator, and how challenging the case is.

The study team monitored four aspects of caseworker involvement in the observed meetings. Chart 3.9 shows the percent of meetings where the caseworker engaged at least somewhat in each type of involvement. Overall, there was a high level of involvement from caseworkers. Furthermore, workers were rated as “clearly” demonstrating all four of these types of involvement in 50% of the observed meetings.

⁹ Parents/primary caregivers were described as highly involved across the four areas if they were rated as “clearly” involved in at least three areas or rated as “clearly” involved in two areas and “somewhat” involved in the other two areas.

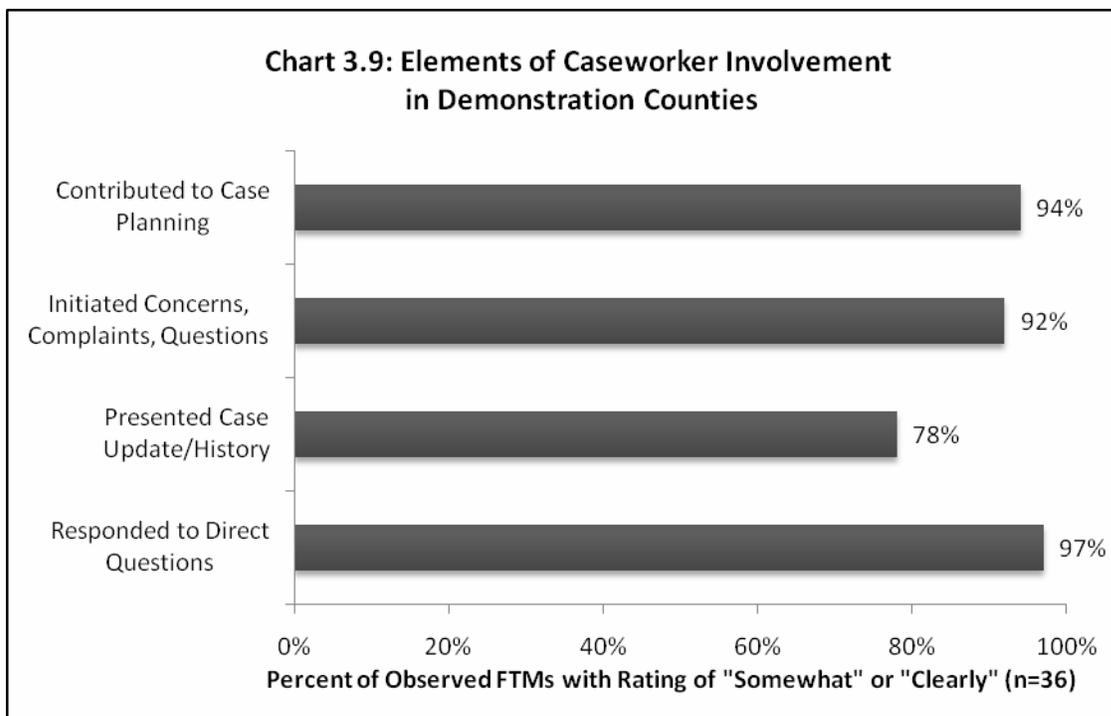
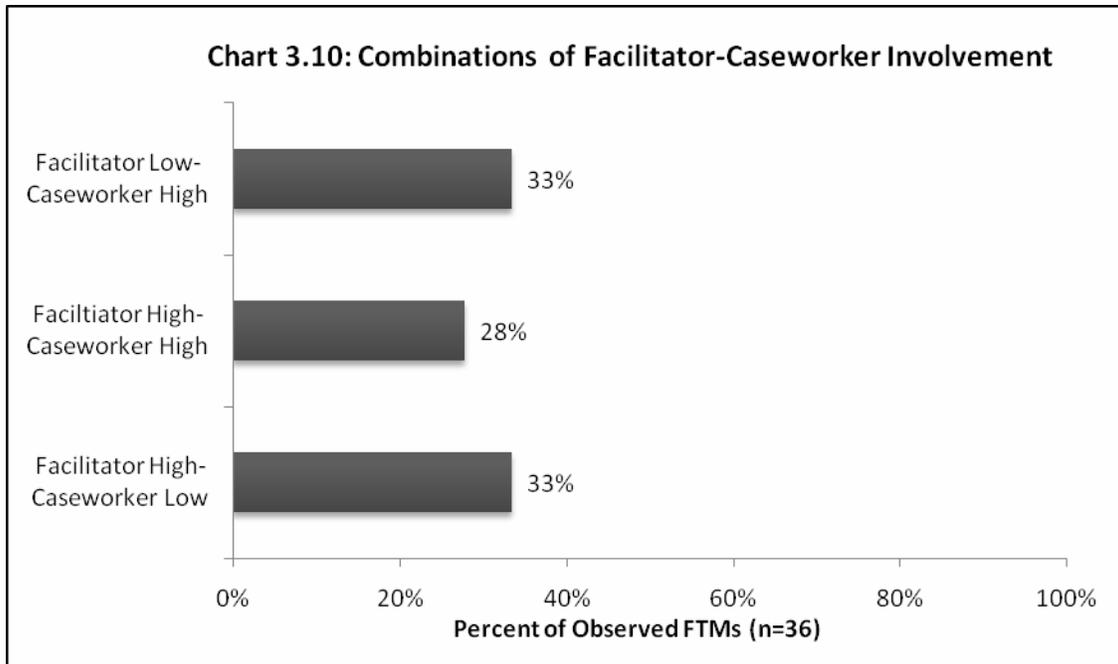


Chart 3.10 compares the level of facilitator and caseworker involvement in each of the observed meetings. Participants at the September 2009 retreat suggested that the best scenario is to have both caseworker and facilitator take an active role in the meeting. They felt that if neither one dominates the meeting, it gives parents options for connecting to one or the other, and likely increases the amount of information that comes out of the meeting. As the chart shows, in about a third of the meetings, both facilitator and caseworker were rated as highly involved. In another third, the facilitator was not highly involved, but the caseworker was, and in the remaining third, the facilitator was highly involved but the caseworker was less involved.¹⁰ Best practice is ambiguous at this point; further discussion among facilitators may be helpful in understanding the benefits of each pairing of roles.

¹⁰ A facilitator was rated as highly involved if she demonstrated five of the six types of involvement; a caseworker was rated as highly involved if she demonstrated “clear” involvement on three types of involvement and “somewhat” involvement on the fourth type.



3.2.3 Perceived Strengths, Challenges, and Barriers of the ProtectOhio FTM Model

Overall, demonstration county PCSAs were highly positive about FTM. In a survey of managers conducted in Fall 2009, all 17 counties felt that FTM had had an impact on their agency’s overall practice, and 11 counties felt that it had had a significant impact. Specifically, managers felt that families were more engaged, that the development of case plans had improved, that there was improved accountability, and that more kin had been located. If the waiver were to end, eliminating the flexible funding believed to enable the strategy as well as the requirement to participate in a common strategy, managers in 12 counties stated that they would continue FTM with no changes, and the remaining five counties said that they would continue FTM but with modifications such as reducing the number of meetings or the number of staff dedicated to FTM.

Reviewing the outputs expected from ProtectOhio FTM and identified in the logic model (Table 3.1), we find the same set of themes reflected in interviews with agency staff and providers. Table 3.8 summarizes the benefits of FTM identified by staff, facilitators and providers. We discuss these data in the sections below.

Table 3.8: Benefits of FTM			
Benefit \ Source	County interview of managers, caseworkers, and facilitators (n=17)	Pre-observation interview asking facilitator about family being observed (n=25)	Mental health provider survey (n=56)
1. Families have more natural supports	59% (10)	56% (14)	75% (42)
2. Families more willing to participate; bought-in more quickly	53% (9)	68% (17)	62% (35)
3. Cases moving faster and decisions about permanency made more quickly	41% (7)	N/A	N/A
4. Increased family involvement in case planning	88% (15)	N/A	N/A
5. Families have quicker access to services	53% (9)	52% (13)	61% (34)
6. More partners at the table	59% (10)	60% (15)	N/A
7. Improved agency image	53% (9)	N/A	N/A
8. Holds everyone more accountable	59% (10)	92% (23)	N/A

3.2.3.1 Families build stronger family relationships, have more natural supports, and feel empowered

Staff from 10 of 17 counties (59%) reported that FTM enhanced natural supports for families by getting kin more involved (Benefit 1 in Table 3.8). Similarly, in the 25 meetings observed by the study team which were not first FTMs, 56% of facilitators stated that they felt FTM had enhanced the natural supports for this specific family. Respondents to the provider survey seemed to especially feel that FTM increased informal services for families, with 75% of 56 providers agreeing.

Nine of 17 counties reported in county interviews that they felt families were more willing to participate and bought-in more quickly as a result of FTM (Benefit 2 in Table 3.8). In the 25 observed meetings, 68% of facilitators reported that they believed the family being observed bought into the case plan more quickly due to FTM. Respondents to the provider survey also agreed that clients were more committed to the service plan (62% of 56 providers). Similarly, seven counties thought that cases were

moving along faster and decisions about permanency were able to be made much more quickly as a result of the family being more engaged (Benefit 3 in Table 3.8); this number seems low relative to the other benefits in the table, but it is unique in being the only benefit of a longer-term nature – the other items in the table are more immediately evident to staff and thus would be expected to be noted more often.

While their views were not universally held, parents who participated in focus groups often had positive things to say regarding the degree to which they felt listened to or empowered in the FTM:

- “I felt we were listened to. The meeting helped keep responsibilities/accountability straight and keep everyone on the same page.”
- “Felt like the facilitator was trying to help me.”
- “They asked me if I had any questions, treated me like a person.”
- “It’s nice to be face-to-face with people. Lots of times it is just you and the caseworker, but this brings us in front of people who are making the decisions. We were well listened to when we had things to say.”
- “In the FTM my opinions were heard and everyone involved was asked if my goals sounded good. In the FTM everyone can bring up a connection on how to accomplish certain goals...I really felt like I had the support to get the job done; I enjoyed it!”
- “I can say whatever I want, they’ll listen; and I will listen to them.”
- “Ideas came up at the FTM that otherwise wouldn’t have happened without the meeting.”
- “It’s good that they don’t just criticize, they also tell you your strengths.”

3.2.3.2 Families are linked to more appropriate and timely services; there is more service provision

Staff in 15 of 17 counties reported that with FTM there was increased family involvement in case planning, which was thought to not only increase buy-in, but increase the likelihood the family will be linked to more appropriate and timely services (Benefit 4 in Table 3.8). Staff in 9 of 17 counties stated that due to FTM families had quicker access to services. Some suggested that due to FTM, families are more quickly linked to the “right” services (Benefit 5 in Table 3.8). In the observed meetings, facilitators reported in 52% of cases that this had been one benefit of FTM for the family being observed. Sixty-one percent of the mental health providers responding to our survey felt that this was a benefit of FTM. Eighty-four percent of the mental health providers also thought that FTM increased the formal services provided to families.

Staff in 10 of 17 counties stated that due to FTM there were more partners at the table (Benefit 6 in Table 3.8). In the observed meetings, facilitators felt that this was the case for 60% of the meetings.

3.2.3.3 Opportunity to educate community, improve agency operations and image

Staff in more than half of the counties reported in interviews that they felt FTM had improved or changed the agency’s image (Benefit 7 in Table 3.8). In the 2009 survey of managers, six stated that FTM had significantly impacted the agency’s image, and nine felt it had somewhat impacted their image.

In interviews, staff also reported various ways in which they felt FTM had helped them to improve agency operations, by increasing communication among team members, forcing them to look at their data, focusing workers on goals, helping workers to know their cases better, being more direct with families about issues, dealing with progress or lack thereof more quickly and efficiently, and focusing on the client.

Staff in 10 counties believed that FTM holds everyone more accountable (Benefit 8 in Table 3.8). In the meetings observed by the study team, facilitators reported in 92% of cases that this had been a benefit of FTM for the family being observed. On a related note, 61% of the mental health providers surveyed felt that parents were more likely to complete services due to FTM.

3.2.3.4 Challenges in Implementing FTM

Despite all the strengths and benefits noted by participants, the demonstration counties faced a number of challenges to getting FTM up and running. These challenges reveal both weaknesses in their implementation processes and weaknesses in the model definition. These implementation challenges have substantial impact on the sites' ability to adhere to the defined FTM model, i.e. to have high model fidelity.¹¹ These findings about the implementation process strongly underscore the central role of local contextual factors in fostering or impeding program fidelity.

The implementation challenges included:

- *Working together to implement common service interventions:* PCSAs in Ohio are county-administered and thus practice normally varies somewhat among any particular group of counties, as they are accustomed to operating independently. Related to this independence, there was no single state-level leader or strategic champion for the FTM initiative.
- *Gaining worker, line supervisor, and sometimes management commitment to the ProtectOhio FTM model:* Six of the 17 counties specifically noted in interviews that caseworkers who are used to working alone may perceive that they have reduced control and authority over the case, and not be interested in coordinating with other partners. An additional four counties reported that caseworkers viewed FTM as a burden or were not properly prepared for meetings, perhaps related to their levels of buy-in. Even when staff were supportive, the agency sometimes lacked leadership commitment to a philosophy change and needed technical assistance and training for the new service intervention.
- *Recruiting, training, and retaining qualified and effective FTM facilitators:* Turnover among facilitators, arising from reassignment within the agency or resignations, made recruitment and training a necessity throughout the waiver period for one-quarter of the demonstration counties, and was experienced to some degree by half of the counties. While staff in most counties highly valued the role of the independent facilitator, caseworkers and managers in eight counties mentioned in interviews that they had concerns about the skills or style of a particular facilitator.
- *Meeting the evaluation mandate to serve all cases transferring from intake to ongoing services:* Despite agencies' general desire to learn what works for whom, the requirement to serve all

¹¹ A full fidelity assessment is presented in Section 3.5 of this chapter.

cases transferring to ongoing services did not reflect what the agencies would have chosen to do, absent the evaluation. Even with the evaluation, five counties struggled to have enough facilitator capacity to serve all cases, and provided ProtectOhio FTM to only a subset of cases.

- *Adapting to new data collection demands:* Workers and facilitators often struggled to incorporate new data collection processes into existing systems and to build shared understanding of the correct usage of the data elements.
- *Integrating the new practice into larger patterns of agency practice:* This required clarifying staff roles, incorporating legal requirements for case plan development and review, and maintaining confidentiality. Insofar as PCSAs routinely hold many case planning and review meetings, sometimes it was unclear how FTMs differed from other meetings held. Managers or staff in nine counties expressed that they felt there were too many meetings, even though eight of these counties had integrated FTMs with their transfer meetings, CAPMIS or SARs. In five counties managers or staff stated that they were unsure of the purpose of FTMs, at least in some cases, yet in most of these counties FTMs and SARs were conducted simultaneously and managers felt that FTM fit well with the agency's philosophy.
- *Managing limited resources:* Families requiring FTM services accumulate over time; unless the agency is immediately successful at shortening the time cases are open or otherwise streamlining the workload, they need to develop more and more FTM capacity.
- *Assuring the attendance of all relevant people at the meeting:* If the primary concern in a case is parental drug abuse, it would be important to have the parent's drug treatment counselor attend. However, mental health and substance abuse providers responding to our survey said that they often found it difficult to attend meetings because they were not informed of scheduled meetings in a timely manner, or because of their own workloads or defined boundaries (e.g., they may not be able to bill time they spend in an FTM). For parents, challenges to attending included their own physical or mental health, nervousness about attending the meeting, and work or other constraints on their time. Conversely, six counties stated that one of their issues was that there were too many people at FTMs, underscoring the challenge of getting the right balance of people to attend.
- *Gaining the cooperation of other parties:* When the agencies were already holding so many meetings, it was difficult to maintain a schedule of quarterly FTMs unless they could merge or integrate some of the existing meetings, which might have somewhat distinct stakeholders and agendas. In addition, the juvenile court's receptivity to FTM impacted whether the decisions made in the meetings were supported and able to be implemented, or were overridden by the judge. (See Section 2.5 for further discussion.)
- *Keeping focused on the intervention:* Other major initiatives, such as the federally-mandated transition to SACWIS, have demanded time and effort from PCSA staff.

3.2.4 Summary of FTM Practice in Demonstration Counties

Overall, demonstration counties were positive in their views about FTM and its benefits. However, the process for implementing the FTM initiative was loosely structured and largely left to individual counties to determine. The ProtectOhio FTM strategy lacked strong training, supervision, and

monitoring components, which hindered the counties' ability to fully and widely implement the program.

The county programs varied in numerous aspects including: amount of facilitator turnover, facilitator training, orientation of community agencies, who prepares the family for FTM and how frequently the agency personally prepares families, the degree to which agencies talk to the family about inviting supports and assist them with doing so, holding meetings at flexible times and in flexible locations, and facilitator-caseworker participation for meetings and ongoing communication. These variations will make it difficult to draw conclusions about which elements are necessary and important for successful child outcomes. The FTM model the counties agreed to adopt lacked specificity in many areas, which helped to cement the agreement of all of the demonstration counties, but also left the model open to variation. With such difference among counties in implementing FTM, it will be difficult to understand the effects that the FTM intervention has on child outcomes.¹² This is addressed further in the fidelity and outcomes analyses later in this chapter.

3.3 FTM IN COMPARISON COUNTIES

The analysis presented here describes the similarities and differences between the demonstration and comparison sites, both at the policy level and among the sample of meetings observed by the study team. We examine the extent to which FTM practice in the demonstration counties differed from normal child welfare practice as evidenced in the comparison sites.

3.3.1 Differences on the Core Elements of the Model

Based on interviews with agency managers, the study team identified 13 of the 17 comparison counties as having some sort of practice similar to FTM—that is, a formal planning and decision-making meeting that includes the family, involved professionals, and informal support and friends. While this report compares similarities and differences between the 17 demonstration and 13 comparison sites, it is worth remembering that there are four additional comparison counties—representing nearly a third of the comparison sites—which reported no FTM-related practice. Table 3.9 presents a detailed look at how the comparison counties' FTM programs compare to demonstration county FTM programs, on five key model that define the ProtectOhio model.

¹² For further discussion of the implementation and evaluation challenges, see Stuczynski, A. & Kimmich, M. (Forthcoming).

Table 3.9: ProtectOhio FTM Components in the Demonstration and Comparison Counties		
Model Component	Percentage of Demonstration Counties With the Policy (n=17)	Percentage of Comparison Counties With the Policy (n=13)
Independent facilitator	94% (16)	38% (5)
Target population is all cases that open to ongoing services	100% (17)	54% (7)
Meetings are held over the course of the case	100% (17)	38% (5)
Doing all of the above	94% (16)	8% (1)
Doing none of the above	0	8% (1)

In general, the comparison counties are far less likely to use an independent facilitator, to target all cases that open to ongoing services, or to hold meetings over the course of the case:

- In counties that do not use an independent facilitator, the case-carrying caseworker or his or her supervisor commonly serves as the meeting facilitator. In a few instances, the facilitator is a worker or therapist from another agency working with the case.
- Counties that do not target all cases tend to target cases at risk of removal or where there has been a removal. Some counties also target cases where multiple service providers are involved.
- Counties that do not hold meetings over the full course of the case tend to limit when meetings are held so that they have only one case planning meeting, or only hold meetings at specific events like a removal or placement change.

3.3.2 Differences in FTM Structure and Practice

This section runs parallel to Sections 3.2.1 and 3.2.2, revisiting the areas discussed in the description of the demonstration counties’ FTM practice, but now focusing on some of the key differences found between demonstration and comparison counties. In a few instances aspects discussed in the section on the demonstration counties’ practices are not mentioned here because we did not gather sufficiently detailed data from the comparison sites on those subjects. In addition, items related to facilitator-caseworker communication and collaboration were difficult to draw conclusions from because in many of the comparison counties caseworkers served as facilitators.

3.3.2.1 Elements of the Infrastructure to Support FTM

This section describes similarities and differences in the training and orientation provided to facilitators, caseworkers, and community agencies in demonstration and comparison counties.

Facilitator and Caseworker Training: Given the policy-level differences between demonstration and comparison counties, it is difficult to compare the level and amount of training provided to facilitators and staff in the two county groups. In interviews, it appeared that demonstration counties were more likely to think about FTM as a “special initiative” and thus describe specific trainings and meetings that

occurred, whereas comparison counties were more likely to explain that caseworkers were trained in FTM via the standard new-hire orientation and shadowing.

Orientation for Community Agencies and Court: Between demonstration and comparison sites, there was no meaningful difference in the number of counties that stated that they provide some sort of orientation or training to community agencies who may participate in FTMs. When considering PCSAs' reports of providing orientation or training to their court, again no meaningful difference emerged between the two county groups. However, among the PCSAs that provided orientation or training to their court, six of the seven demonstration sites felt that their court was supportive of FTM, compared to only two of the four comparison sites, signifying a slight difference between the county groups. A small number of counties in both groups state that the court will order FTM or will move court dates to allow time for an FTM.

3.3.2.2 Components of FTM Process

This section examines similarities and differences between demonstration and comparison sites regarding two aspects: preparation for family engagement and performance in the meeting that fosters parent involvement. We also describe who we observed attending meetings in comparison counties. Since we do not have meeting-level administrative data from the comparison counties, the small number of meetings observed by the study team is our only source of this information.

Preparation for Family Engagement: This section examines similarities and differences between the demonstration and comparison counties in encouraging the family to bring support people and in holding meetings in comfortable, family-friendly environments.

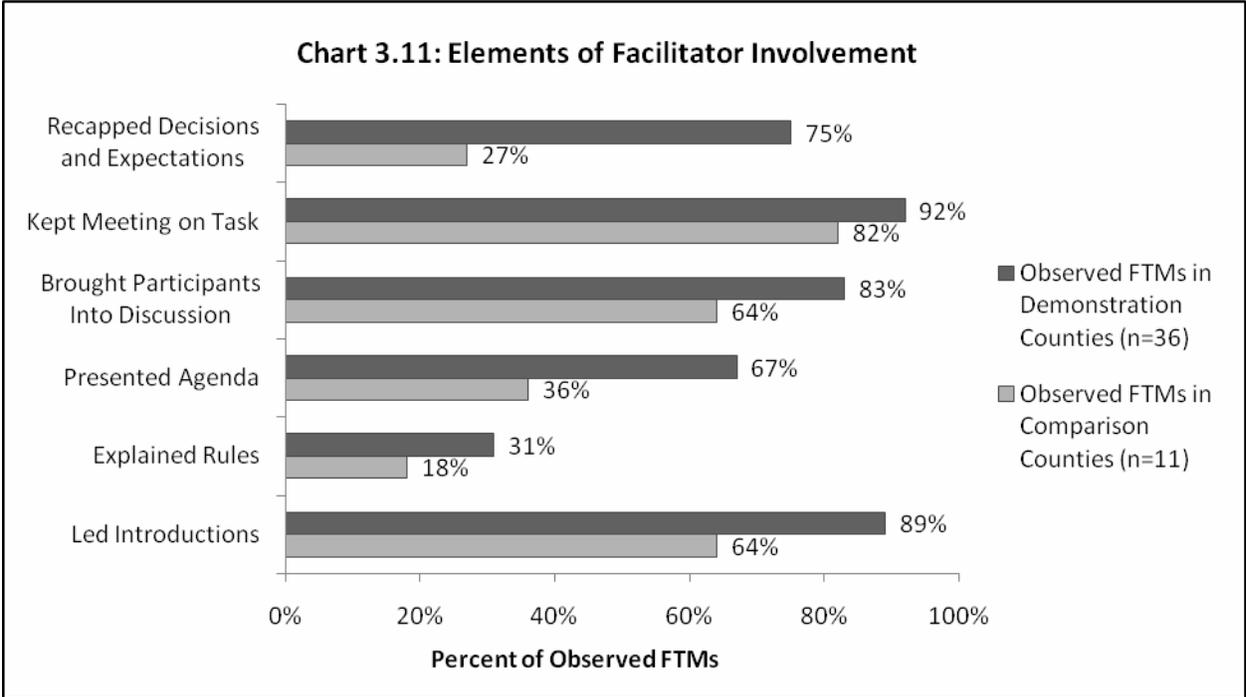
- *Encouraging Family to Bring Support People:* Little difference appears between the demonstration sites and the comparison sites in terms of involving support people in the FTM. Seven of the 13 comparison counties, or 54%, reported that they encourage parents to bring support people such as kin, clergy, attorneys, GALs or CASAs, similar to the proportion doing so in demonstration counties (65%). Similarly, observations of FTMs in the two groups of counties revealed comparable involvement by advocates or other kin: 47% of demonstration county meetings and 36% in comparison county meetings.
- *Holding the Meeting in a Comfortable, Family-Friendly Environment:* Three aspects of a family-friendly environment are location, timing, and access to transportation. Comparison counties are slightly more likely than demonstration counties to hold meetings in flexible locations, meaning outside of the agency, perhaps reflecting the fact that comparison counties hold many fewer FTMs per family and thus it may be easier to accommodate family preferences. On the other measures of family-friendly environments, no differences appear between the two county groups (Table 3.10). Both groups are very likely to assist with transportation (88% and 92%); they are similarly less likely to offer flexible meeting times. The difference between groups in holding meetings in flexible locations also means that comparison counties are slightly more likely than demonstration counties to offer all three of these aspects of family-friendly environments.

Table 3.10: Ways Counties Support Family-Friendly Environments		
Type of Support	Percentage of Demonstration Counties (n=17)	Percentage of Comparison Counties (n=13)
County holds meetings at flexible times (esp. evenings, weekends).	35% (6)	54% (7)
County holds meetings in flexible locations.	29% (5)	62% (8)
County assists with transportation to meetings.	88% (15)	92% (12)
County offers all three.	24% (4)	46% (6)

It is also interesting to note that if parents do not show up to the FTM, only seven of 13 comparison counties proceed with the meeting, compared to 16 of 17 demonstration sites, a moderate difference.

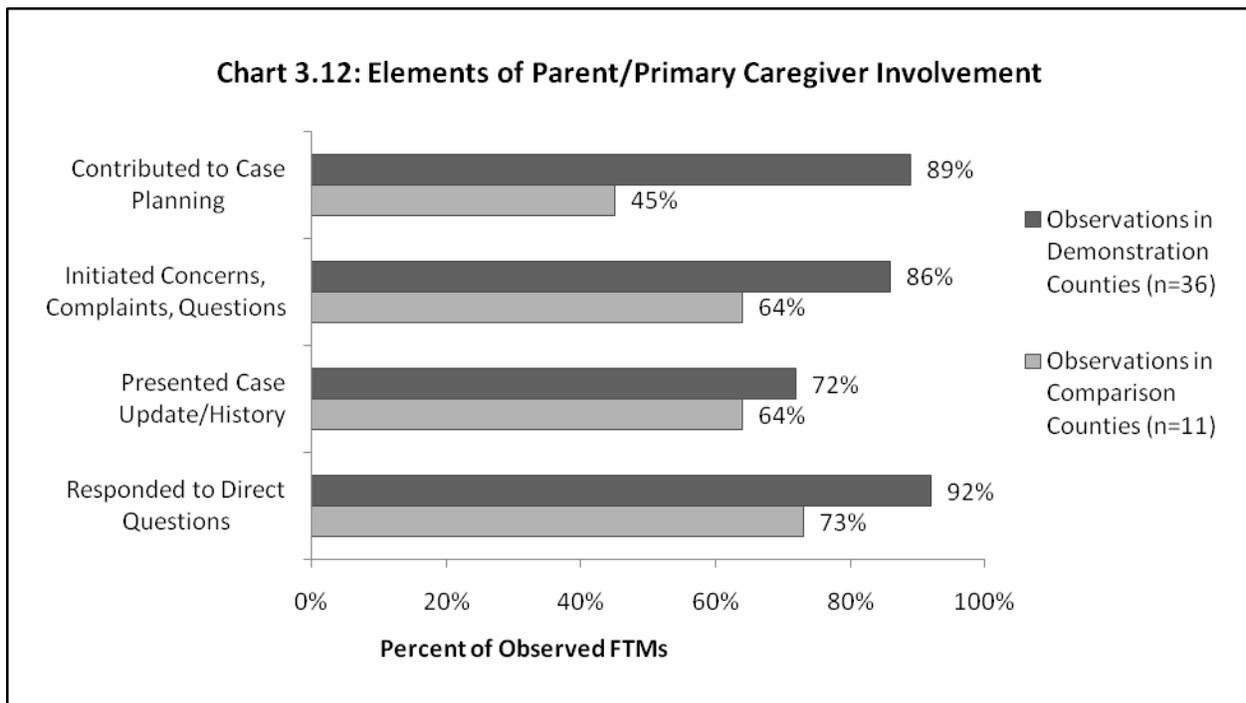
Performance in the Meeting that Fosters Parent Involvement: This section examines differences between demonstration and comparison sites in the involvement of facilitators, parents and caseworkers in the meetings we observed.

- Facilitator Role in FTM:** In FTMs that were observed by the study team, facilitators in demonstration counties were more involved than facilitators in comparison counties (Chart 3.11). Facilitators in demonstration counties were moderately more likely to recap decisions and expectations, and slightly more likely to present the agenda and lead introductions. This may be partly explained by the fact that in five of the observed comparison site meetings, it was the caseworker who was serving as facilitator, perhaps focusing her involvement elsewhere.



Overall, facilitators were involved in at least five of the six areas in 58% of demonstration county observations, compared to 36% of comparison county observations, a slight difference. Comparison county FTMs were moderately more likely to have the facilitator doing two or fewer of these tasks, 46% compared to 11% in demonstration sites.

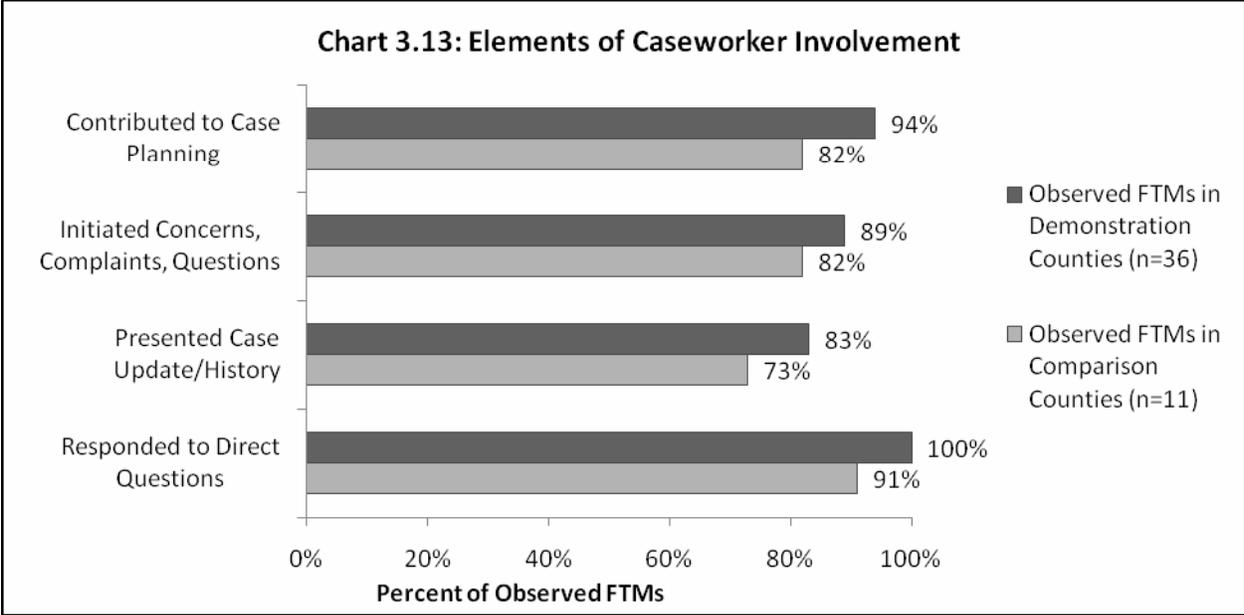
- Parent or Primary Caregiver Role:** The study team observed parents and primary caregivers as more involved in the demonstration county meetings than in the comparison county meetings (Chart 3.12). In particular, parents in 89% of the demonstration county FTMs were observed to contribute to case planning, whereas parents in only 45% of the comparison county FTMs were observed doing so, a moderate difference. The degree to which parents initiated concerns, complaints and questions was slightly higher in the demonstration group.



Overall, parents in 80% of the demonstration county FTMs were observed as being highly involved across the four areas.¹³ By contrast, parents performed similarly in only 45% of the observed meetings in comparison counties, a moderate difference.

- Caseworker Role:** Caseworkers appeared to be highly involved in both demonstration and comparison counties, and no meaningful differences appeared across the four types of involvement observed (Chart 3.13).

¹³ To be described as being highly involved across the four areas, parents had to be rated as “clearly” involved in at least three areas, or rated as “clearly” involved in two areas and “somewhat” involved in the other two areas.



This similarity in the involvement of caseworkers in the two county groups seems to further emphasize the importance of the facilitator role, suggesting that it may be the influence of the facilitator that leads to an increased role by the parent. In some meetings it was clear that simply having a neutral third party present gave parents confidence to be more open and involved; it was also observed that, by having a facilitator in the meeting, the worker can be straightforward, blunt, and even negative, because this can be mediated by the facilitator who can assure that all sides have an opportunity to be heard. Indeed, when we look at the observed levels of involvement across facilitator, caseworker, and parents, slightly more demonstration county meetings had all three participants highly involved (25%) compared to none of the comparison county meetings.

Attendance of Kin, Advocates and Service Providers in FTM: The study team noted the attendance of kin, family advocates, and service providers at the observed meetings (Table 3.11). Somewhat more demonstration county meetings had kin in attendance.

The types of advocates observed were attorneys, GALs, and CASAs. The types of service providers observed included foster parents, parole/probation officers, therapists, early intervention or youth intervention, and residential care providers. Although the two county groups did not differ in how often these types of attendees were present at the observed FTMs according to our qualitative rubric for expressing differences between small groups of cases, explained above, the demonstration counties seemed to be more likely to have kin and advocates in attendance, while the comparisons were more likely to have service providers participating in the meetings.

Table 3.11: Number of Observed Meetings with Attendance by Certain Roles		
	Demonstration Counties (n=36)	Comparison Counties (n=11)
Kin	47% (17)	27% (3)
Advocates	31% (11)	18% (2)
Service Providers	36% (13)	54% (6)

3.3.3 Outcomes of Observed Meetings

When observing meetings, the study team noted the meetings’ end results or major outcomes. The outcomes fell into two categories:

- 1) “Operative” outcomes related to living arrangement, placement, custody, or visitation decisions. Some specific examples include: generation of a list of possible placements; decisions made about possible permanency options (i.e. to file for a change in custody, to step down placement, or to close a case); or a parent’s decision to terminate her rights. Meetings observed in comparison counties were slightly more likely than demonstration county meetings to have operative outcomes, 45% of comparison site meetings compared to 25% of meetings observed in demonstration counties.
- 2) “Process” outcomes related to the establishment of the case plan, general updates on progress, or decisions about services. Meetings observed in demonstration counties were slightly more likely to have this type of outcome, 75% of demonstration site meetings compared to 55% of meetings observed in the comparison counties.

Meetings observed in the demonstration counties were substantially more likely to have “process” outcomes (75%) than “operative” outcomes (25%). Meetings observed in the comparison counties were about equally likely to fall into either category (55% with “process” outcomes and 45% with “operative” outcomes). This may be the result of the demonstration counties’ emphasis on holding regularly scheduled meetings. It may also be a reason why some counties feel that they are holding too many meetings or are unsure of the purpose of FTMs. For further discussion on the outcomes of meetings, specifically around recommendations for a change in services or custody and placement, see Section 3.4.5.

Topics were discussed but left unresolved in half of the meetings in both groups (50% of demonstration county meetings and 55% of comparison county meetings). The types of subjects left unresolved included parent substance abuse treatment issues, child contact with parents and visitation schedules, and defining the situation that causes the case to be open. In some cases those present were not the ones who could make a decision or more information was needed before action could be taken. In some ways this points to the often difficult challenges that are discussed in the meetings. However, a few staff and parents remarked that on a regular basis difficult issues that needed to be addressed were not.

On the other hand, parents in the demonstration counties had some of the following positive things to say about the outcomes of FTM:

- “FTM always ends up with a written plan so everyone knows what happened and is supposed to happen next. Expectations are clear.”
- “It helps to have [a copy of the action plan] because it provides a recap, which is what is needed because I’m so stressed in the meeting, I can’t always remember.”
- “Because FTM was held before the court hearing, everyone was in agreement and could present a single recommendation to the court; court then gave more visitation and sooner reunification. [The] judge was influenced by all the people involved in recommending it. And FTM enabled me to express what I wanted from the hearing—I asked them to push for more visits.”
- “Made it possible to work together with my family to get my kids back. This would have happened without the meeting, but it would have taken longer.”
- “I had an issue with the GAL concerning visits. The GAL had asked for no visit rights for me; after bringing this up with the FTM facilitator, it was discussed at the FTM. The visitation status did not change as a result but I felt supported by the facilitator who brought up the issue at the FTM. It made me feel good that she at least tried to help me.”
- “They explain things for you so you understand what they are talking about. They don’t rush you through. For example, the caseworker always makes sure that the facilitator knows all the positive things that my son has been doing. They are very respectful. The atmosphere at the meetings is very positive. They go over everything twice so everyone understands and will read the paper back to make sure that they understand and agree. They take their time and don’t worry if it is half hour or one hour or whatever. I have always felt very positive after leaving a meeting.”

3.3.4 Summary of Qualitative Differences between Demonstration and Comparison Sites

While there was variation among the demonstration counties surrounding aspects of their implementation, there were also notable differences overall between demonstration and comparison sites. In terms of their overall program structure and policies, the demonstration counties were:

- Substantially more likely to use independent facilitators and to provide regular meetings over the entire case episode.
- Moderately more likely to target the entire population of cases that transfers to ongoing services.

Comparison counties, on the other hand, were:

- Moderately more likely to reschedule the FTM if the family does not show up at the last minute.
- Slightly more likely to hold meetings in locations other than the agency.
- Slightly more likely to offer all three aspects of family-friendly environments that were measured.

Overall, demonstration counties appear to have a broader initiative aimed at a larger population, while comparison counties' practice appears to be more targeted to specific types of cases (for example, only those children who are at risk of removal). It is possible that this targeting by the comparison counties makes it easier for them to postpone meetings until the family can be involved and to take steps to hold meetings outside of the agency.

In the meetings observed by the study team, many differences were noted between the demonstration and comparison counties, including:

- Demonstration counties were moderately more likely than those in comparison counties to have a facilitator (or caseworker, in the absence of a facilitator) recap decisions and expectations that came out of the meeting.
- Facilitators in demonstration counties presented the agenda and led introductions slightly more often than those in comparison counties.
- Facilitators in demonstration counties were slightly more likely than comparison counties to be involved in the meeting in five of the six areas we monitored; in contrast, facilitators in comparison counties were moderately more likely to perform only two or fewer of the six types of involvement.
- Parents in demonstration county meetings were moderately more likely than parents in comparison county meetings to contribute to case planning and to be highly involved across the four areas of involvement that were monitored. Parents in demonstration county meetings were slightly more likely to initiate concerns, complaints and questions.
- The number of meetings where facilitators, caseworkers and parents were all highly involved was slightly higher in the demonstration counties than in comparison counties.
- Kin attended the meetings we observed in demonstration counties slightly more often than the comparison county meetings.

Overall, the role of the independent facilitator appears to be larger and more common among the demonstration counties. Parents and kin in demonstration counties also appear to be more highly involved than in the comparison counties (despite the program policy differences in postponing meetings until the family can be involved and in holding meetings outside of the agency). Further study is needed to determine whether this higher parent involvement is due to the ProtectOhio FTM model in general and the role of the independent facilitator in particular. The outcomes analysis attempts to determine whether the ProtectOhio FTM model is associated with better child outcomes.

3.4 VOLUME AND NATURE OF FTM ACTIVITY THAT OCCURRED IN PRACTICE

The following section of the implementation analysis provides an overview of FTM activity during the second waiver period in order to highlight the characteristics of FTM across the demonstration sites. Using primarily quantitative data that the counties collected about each meeting, the study team explored both the volume and nature of FTM activity among the 17 demonstration counties.¹⁴

¹⁴ As referred to earlier in Chapter 3, this includes all FTM strategy data collected in the ACCESS database.

Equivalent data from the comparison counties were not available for this analysis. Topics include: the total amount of FTMs and families served; the common situations of children experiencing FTMs; the most frequent reasons for meetings; the number and types of attendees at the meetings; and recommendations that result from the FTMs. From this information, one begins to develop a sense of what was accomplished across the demonstration counties, and the array of FTM activity that families and children experienced. Tables and charts throughout this section present data for Franklin County separately from the remaining 16 demonstration counties. The study team chose to keep Franklin separate because it contributes over a third of the FTM data, and, if presented with the other 16 demonstration sites, Franklin County findings would dominate the total results. While we present the two groups side by side in the tables, it is not appropriate to make a direct comparison between the two; the underlying dynamics of Franklin County may be different from other counties in many unmeasured ways.

3.4.1 Volume of Activity

The amount of FTM activity in the demonstration counties throughout the second waiver has been substantial; the total number of meetings exceeds 21,000. In these meetings, over 13,800 children were served in a little over 6,800 families. Table 3.12 provides information about the volume of activity among Franklin County and the remaining 16 demonstration counties.

Table 3.12: Volume of Activity			
	Franklin	16 Demos	All 17 Demos
Total FTMs	7,720	13,776	21,496
Total Children	3,609	10,209	13,818
Total Families	2,058	4,790	6,848

Although the information in this section presents the aggregate of demonstration county activity, it is interesting to note the contribution that each county made to the whole. While population size may contribute to the proportion, time in the waiver and capacity in terms of the number of facilitators doing ProtectOhio FTMs have the greatest impact on the number of meetings held and children and families served in each county. Charts 3.14 – 3.16 illustrate the relative contribution of each of the 16 counties to the total figures in column two of Table 3.12. As the table shows, Franklin County contributed 36% of the total number of meetings, 35% of children, and 43% of families engaged in FTM. Greene, Hamilton, Portage and Richland also each contribute considerably to the total volume of FTM activity.

Chart 3.14: Total Number of FTMs (n= 3,776 meetings)

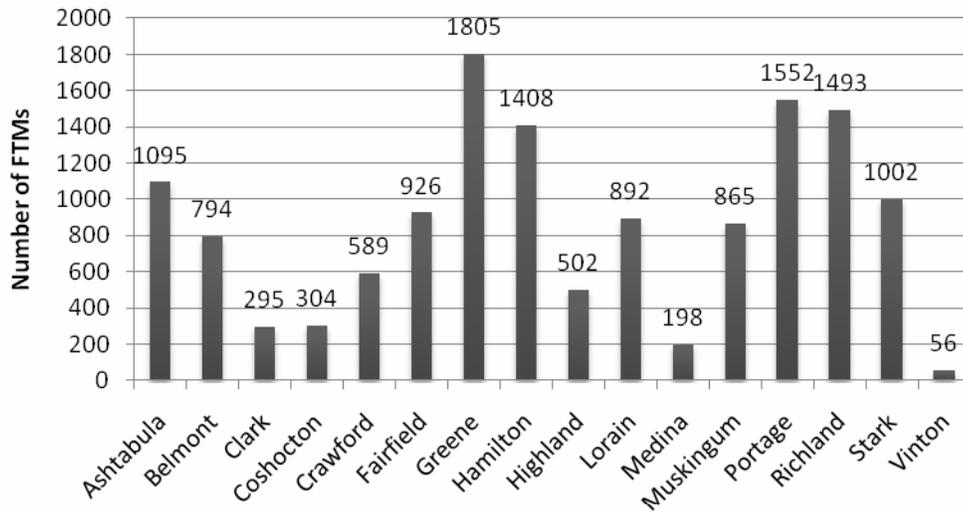
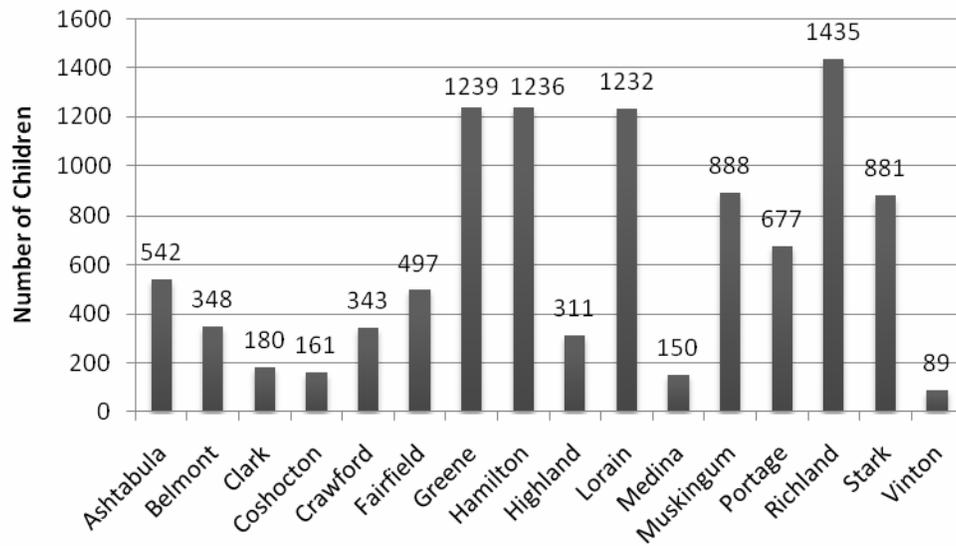
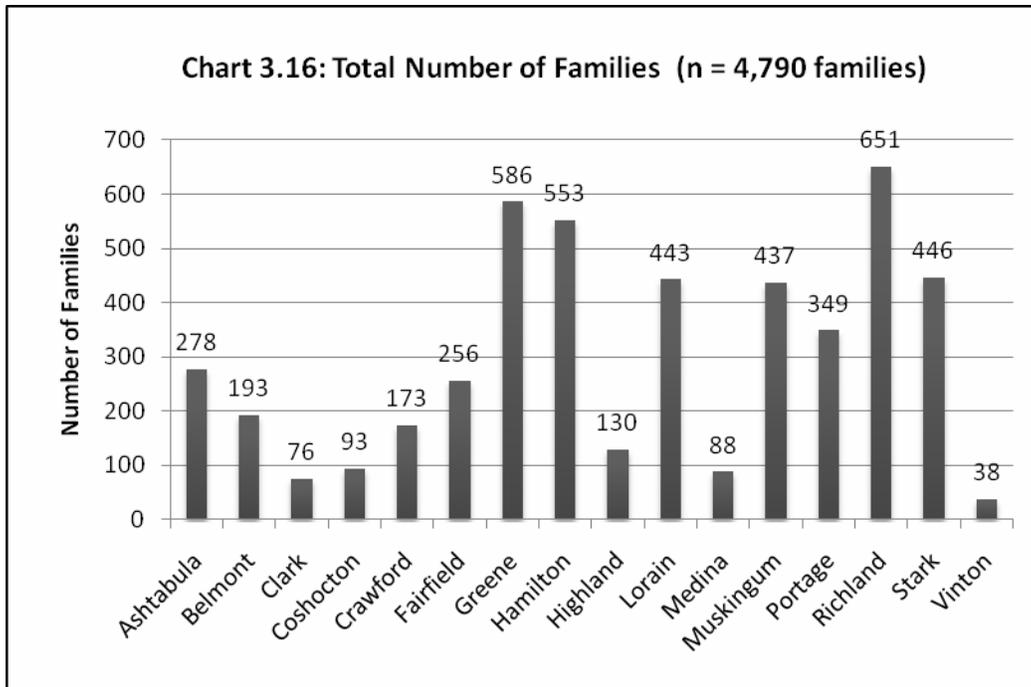


Chart 3.15: Total Number of Children (n =10,209 children)





3.4.2 Common Situations of Children Experiencing FTMs

The following information regarding the frequency of the number of meetings held per child (Table 3.13) and the living arrangement and custody status of children at the time of the FTM (Table 3.14) is explored in this section. This information illustrates the extent to which the FTM process could influence a child’s case history, as well as children’s particular situations at the time of the meeting. It is important to note that the data shown in Table 3.13 represent all meetings held. These may span multiple case episodes (meaning the case closed and re-opened). Also, meetings may still be ongoing for a child’s case, because the case had not closed by the end of the data period. Overall, the average number of FTMs per child is three; Franklin County’s average is slightly higher at four FTMs per child. Most counties had some children with up to nine FTMs. If a county is having meetings every 90 days, as specified in the model, the number of FTMs per child may just be a function of the length of time that a case is open. Further analysis is needed to explore whether the number of meetings that a child experiences has an impact on child outcomes.

Table 3.13: Distribution of Number of FTMs Held per Child		
	Franklin (n = 3,609 children)	16 Demos (n = 10,209 children)
One Meeting	24%	39%
Two Meetings	22%	22%
Three Meetings	14%	14%
Four Meetings	11%	9%
Five Meetings	8%	5%
Six Meetings	5%	4%
Seven Meetings	5%	2%
Eight Meetings	3%	2%
Nine or More Meetings	7%	3%

Child's living arrangement and custody status: In order to better describe who these meetings are serving, the common types of living arrangements and custody status of children at the time of the FTM are examined in Table 3.14. About half of the children were living with their parents and in the custody of their parents at the time of their FTM: 49% in Franklin County and 52% in the other demonstration counties.¹⁵ The second most common arrangement was children in PCSA custody and living in substitute care: 29% in Franklin County and 20% in the other demonstration counties. However, another 24% of children in the 15 demonstration counties are living with kin, although they may be in the custody of kin, their parents, or PCSA. Given that two main goals of FTM are to decrease the number of children in foster care and increase permanency, it is interesting to note that the majority of children are living with parents or kin and in the custody of parents or kin (57% in Franklin County and 69% in the other demonstration counties). Further analysis is needed to examine whether these living arrangements and custody patterns lead to increased permanency.

¹⁵ Due to insufficient data for certain data questions, one county is not included in the child-meeting level unit of analysis. Therefore, only 15 demonstration counties, in addition to Franklin, are included in information related to the living arrangements and custody of children at the time of the FTM, the purpose of meetings, and recommendations resulting from the FTM (Tables 3.14, 3.15, and 3.20).

Table 3.14: Living Arrangements and Custody of Children at Time of FTM¹⁶			
		Franklin (n=13,147 meetings)	15 Demos (n=25,081 meetings)
Live w/ Parents, Custody of Parents		49%	52%
Live in Substitute Care, PCSA Custody		29%	20%
Live with Kin	Custody of Kin	7%	9%
	Custody of Parents	1%	8%
	Custody of PCSA	8%	7%
All Other*		5%	4%

**Includes living in hospital, juvenile facility, unapproved setting, or AWOL with various custody arrangements.*

3.4.3 Most Frequent Reasons for FTMs

As mentioned earlier, workers, line supervisors, and managers sometimes questioned how FTM differed from other case planning and review meetings. This could indicate low levels of buy-in from staff and an overall feeling of FTM as a burden rather than a benefit. Therefore, the study team explored the variety of reasons that were recorded for why the FTM was held. Table 3.15 displays the percentages of each type of FTM purpose. Most FTMs are held as either initial planning meetings or quarterly reviews (more than 99% in Franklin County, and 83% in the other demonstration sites). This is not surprising given that these are the two types of meetings that are part of the ProtectOhio model, and underscores the challenges mentioned above. Another consideration however, is that meetings might fall in two categories. For example, an FTM may serve two purposes: a placement change and a quarterly review. In this case, the meeting may have been recorded in the overarching category of “quarterly review.” Therefore, the secondary reason for a meeting is not represented in the distribution in Table 3.15. These data appear to offer an incomplete picture of the impetus for holding FTMs.

¹⁶ This data table uses information at the child-meeting level, meaning that a meeting is counted for each child involved.

Table 3.15: Purpose of FTMs Held¹⁷		
	Franklin (n = 13,159 meetings)	15 Demos (n = 25,102 meetings)
Initial Planning Meeting	22%	28%
Quarterly Review	78%	55%
Critical Event Meeting	<1%	6%
Agency Requests Meeting	<1%	9%
Other*	<1%	3%

**Includes PPLA/TPR, Guardianship/Legal Custody, Family Request Meeting, and Other.*

Meetings held due to a “critical event” – defined here as having a purpose of crisis-possible placement, placement change, or reunification – are also prescribed as part of the ProtectOhio model, but make up less than one percent in Franklin County and six percent of FTMs in the other demonstration counties. While critical event meetings may have been avoided due to the more frequent quarterly FTMs, the study team cannot distinguish when this might have occurred. In interviews, only five counties specifically mentioned that they hold meetings at critical events. Facilitators noted several barriers to consistently holding FTMs at critical events:

- Workers may not notify the facilitator that a critical event has occurred. One facilitator stated that she thought some workers viewed FTM as a hurdle to be avoided. Another county noted that some workers feel a meeting once per quarter is frequent enough to go over anything that occurred.
- Workers may be unclear about when an FTM is warranted. One county explained that, in their county, intake workers are responsible for getting the initial meeting scheduled but ongoing workers are responsible for getting subsequent meetings scheduled, a task which may be less straight-forward than scheduling the initial meeting.
- In general, scheduling meetings and pulling people together for them is challenging. Trying to schedule meetings while something urgent is going on in a case is even more difficult.

So that FTMs are scheduled when critical events occur, a few counties have developed the following processes:

- In one county, the facilitator makes time to informally talk to workers on a weekly basis so that she hears of any critical events that occur.
- In another county, facilitators have started emphasizing at meetings that, if a critical event occurs, the worker is to notify the facilitator and a meeting should be held.

¹⁷ This data table uses information at the child-meeting level, meaning that a meeting is counted for each child involved.

- With an eye toward preventing critical events from occurring, five counties choose to schedule meetings more regularly than quarterly, generally every one to two months, based on caseworker recommendation.
- Two counties deliberately schedule subsequent meetings immediately before or after court hearings and believe that this arrangement ensures everyone is on the same page.

3.4.4 Attendees at FTMs

An integral piece of FTMs is its attendees. FTMs are a promising practice primarily because they embrace the idea of engaging the family, natural family supports, and community providers in case planning and group decision making. Therefore, it becomes important to the value of the FTM to have a good mix of attendees, and enough people gathered around the table to support and work with the family in accomplishing their goals. The following section provides detail on the types and number of attendees at the FTMs in the demonstration counties.¹⁸

The study team first explored the parent and/or primary caregiver's (PCG) attendance rates, as they are one of the most critical attendees at the meetings. In the 16 demonstration counties, 72% of meetings had at least one parent and/or PCG in attendance; for Franklin County, the proportion was 41%.

As was discussed previously in Section 3.2.2.1, staff at the September 2009 retreat mentioned many key factors to increasing parent attendance at FTMs, including holding meetings at flexible times and locations, and offering transportation assistance if needed. Four counties were identified as providing all three of these supports to families (see Table 3.6). When we used this information on county supports to explore attendance patterns (using a chi-square statistical test), we found a statistically significant difference in parent attendance rates between those counties that offer all accommodations, and those that do not offer the supports to families. However, this statistical test is sensitive to sample sizes. Therefore, the study team investigated the effect size, which determines the degree to which the relationship is a result of identification with a certain group. Here, we found a small association between counties providing all three of these types of accommodations and parent attendance at FTMs.¹⁹ Nonetheless, it is interesting to note that of the meetings in those counties that provide a comfortable and family-friendly environment (providing the three types of accommodations), 93% had at least one parent or primary caregiver in attendance (Table 3.16). In contrast, counties that do not provide all of the above supports to families have substantially lower parent attendance: only 41% of meetings in Franklin and 65% of meetings in the other counties had a parent in attendance. This finding suggests that offering meetings at flexible times and locations, combined with assisting with transportation, may increase parent attendance rates at FTMs. Then again, both findings may be due to a more family-friendly approach at some PCSA's overall. Further research is needed to better understand the effect of providing these supports on parent attendance at FTMs.

¹⁸ All information presented in section 3.4.4 uses data at the family-meeting level, meaning that one meeting includes all siblings involved.

¹⁹ $\chi^2_{(df=1)}=1065.29; p<.05$. Cramer's V = .280.

Table 3.16: Parent/PCG Attendance & Accommodations to Families			
	County Offering Accommodations to Families		
	Yes	No	
	4 Demos	12 Demos	Franklin
Total Number of Meetings	3,600	9,973	7,505
Number of Meetings with at least one Parent or PCG in Attendance	93% (3,356)	65% (6,467)	41% (3,087)

In addition to parents and primary caregivers, many other types of attendees can enhance the FTM process. Table 3.17 shows the percent of FTMs that included at least one attendee from each of following eight categories: parent, primary caregiver, relative, parent supports, child voice, provider, and PCSA staff. Parents and primary caregivers are separated in this table, offering added insight into the prevalence of each at the meetings.

Several categories need further explanation: (a) parent supports include parent attorneys, parent advocates, and clergy; and (b) child voice includes the child, sibling, child attorneys, and GAL/CASAs. Child voice showed fairly high representation at FTMs, at nearly 30% of the meetings. The percentage of parent supports in attendance is lower (eight percent in the 16 demonstration counties). However, it is worth noting that parents may also receive support in the meeting from other participants, notably relatives, who are present at another 21% of meetings in the 16 demonstration counties.

Table 3.17: Types of Attendees at FTMs		
	Franklin (n = 7,505 meetings)	16 Demos (n = 13,573 meetings)
Parent	39%	67%
Primary Caregiver	7%	15%
Relative	10%	21%
Parent Supports	1%	8%
Child Voice	23%	32%
Provider	26%	28%
PCSA Staff	97%	94%
Other ²⁰	51%	22%

²⁰ There were many attendees marked in 'other' that would better fit in a more specific category, particularly the supervisor. However, the study team was able to account for a large number of these discrepancies by moving supervisor to PCSA Staff.

PCSA staff were the most common participants, attending over 90% of the meetings.²¹ Providers attended less often (26%-28% in the demonstration counties), which includes staff from mental health, alcohol and drug, developmental disability, health, TANF, child support, foster care, probation, court, sports coaches, school counselors, education, or other purchased service providers.

Although providers are in attendance less often than some other types of attendees, their involvement in FTMs is no less important; by participating in FTMs, providers are able to offer additional support to the family, as well as create linkages and increase access to community services. In addition, court representatives, included here as community providers, are key participants in the FTMs. As mentioned previously, the court’s support of FTM, and the decisions that result from the meeting, can have a considerable affect on the integrity of FTM. Therefore, the study team looked for a relationship between a county’s efforts in orienting their community partners to the practice of FTM, and subsequent rates of provider attendance at meetings. The study team used a chi-square statistical test, determining that while there is a statistically significant difference between groups, there is no practical relationship between a county providing FTM orientation to the community and provider attendance (the effect size was weak).²² Six counties provided FTM orientation to both their court and community agencies; 33% of the meetings in these counties had at least one provider in attendance. In the 10 counties that did not provide FTM orientation to community partners, 26% of the meetings included a provider (Franklin County, which is separated from the other 10 counties not providing orientation to community partners, also had 26% of its meetings with a provider in attendance). Table 3.18 provides further detail on the relationship between community orientation and provider attendance at FTMs.

Table 3.18: Community Orientation & Provider Attendance at FTMs			
	County Offered FTM Orientation to Community Providers		
	Yes	No	
	6 Demos	10 Demos	Franklin
Total Number of Meetings	3,812	9,761	7,505
Number with at least one Provider in Attendance	33% (1,252)	26% (2,533)	26% (1,964)

While attendance by the parent or primary caregiver is essential to a meaningful FTM, it is also important to recognize that parents can be supported by others’ voices at the meeting – even if the parents themselves are not present. Indeed, if a meeting includes only PCSA staff and providers some might argue that these meetings do not qualify as FTMs; with no one to give voice to the family’s concerns, does the FTM lose its unique value? Table 3.19 shows the percent of meetings that included at least one parent and/or primary caregiver. This table also reveals the percent of meetings that included a “family voice.” These meetings involved at least one person who could give voice to the family’s concerns; this voice may include parents or primary caregivers, as well as relatives, child voice representatives, or general parent supports. Over three quarters of the FTMs in the 16 demonstration

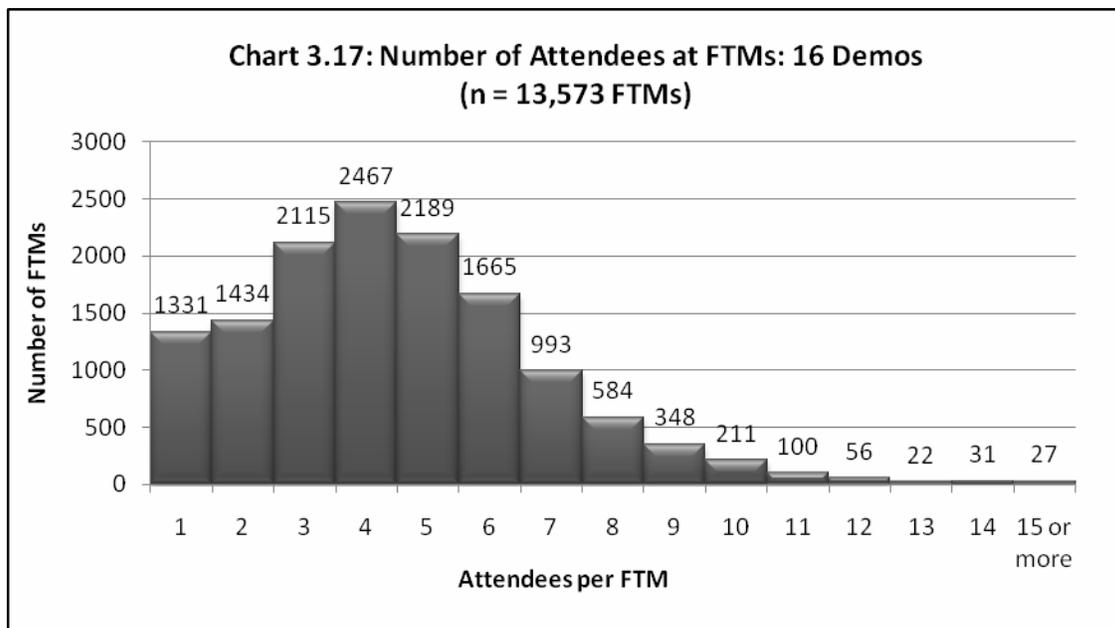
²¹ The FTM facilitator is not included as an attendee at the meetings.

²² $\chi^2_{(df=1)}=64.78; p<.05$. Cramer’s V = .069.

counties included at least one person, outside of providers and agency staff, to give a voice to the family’s concerns (79%). In Franklin County half of the meetings included a representative of family voice. It is important to keep in mind that the proportion of meetings that included a family voice varied considerably among counties (from 42% to 98%). Further analysis is needed to explore whether child outcomes are correlated to parent and/or primary caregiver attendance, as well as the significance of having family voice at the meeting.

Table 3.19: Parent/Primary Caregiver and Family Voice at FTMs		
	Franklin (n = 7,505 meetings)	16 Demos (n = 13,573 meetings)
Parent/PCG	41%	72%
Family Voice	51%	79%

As mentioned previously, as important as it is to have a good mix of people around the table, it is also critical to have enough people in the room to engage in a meaningful discussion. Chart 3.17 illustrates the number of attendees at each meeting. The chart explores how common it is for an FTM to have one person in attendance, as opposed to 10 attendees (for example, 1,331 meetings had one person in attendance, as opposed to 211 meetings with 10 people in attendance).²³ Five attendees was the average size of an FTM across all 16 demonstration counties, with a maximum of 21 attendees; in Franklin County, the average was three attendees and a maximum of 14 participants. Further analyses are needed to reveal whether the overall number of attendees at FTMs has an impact on child outcomes.



²³ The FTM facilitator is not included in the total number of attendees.

Parents in the demonstration counties had some of the following things to say about who attends the FTM, frequently citing concerns:

- “It’s scary, lots of people in a room. Some try to understand, but mostly it’s intimidating.”
- “I have never had anyone else come to the meetings because I didn’t think it would matter. However, I would like to have the counselor come in sometimes.”
- “There are some people at the meetings who don’t have much information, and probably shouldn’t be there.”
- “The meetings can be boring; usually it’s just me and the caseworker, maybe her supervisor.”
- “It’s confusing, all the different people involved.”
- “They never forced me to talk about anything I didn’t want to talk about. I haven’t wanted anyone else to attend.”
- “More people in the room helps with brainstorming and identifying new resources that might be available.”
- “... [It is] easier for me to deal with all the different providers at once, rather than having to make separate phone calls and appointments.”

Some of these statements reiterate that it is essential to find the right mix of people, and also to have a good balance in terms of the amount of people at the FTM. In addition, in order to ease the parents’ concerns and increase their comfort in the meeting, it seems to be equally important to fully prepare the family in what to expect from the meeting and who they can bring for support.

3.4.5 Decisions/Recommendations Arising from FTMs

Many of the FTMs that the study team observed in the demonstration counties had either “operative” (related to living arrangement, placement, custody, or visitation decisions) or “process” outcomes (related to the establishment of the case plan, general updates on progress, or decisions about services), even though topics were sometimes left unresolved (refer to Section 3.3.3 for a discussion of outcomes of observed meetings). In addition, as mentioned earlier, workers, line supervisors, and managers sometimes stated service accessibility as one of the major benefits of FTM. Given this, one would expect that a large percentage of FTMs would result in recommendations for change in services. However, many FTMs (84% in Franklin and 71% in the remaining demonstration counties) did not result in a recommendation for change in services.²⁴ On the other hand, the large percentage of those that did not have a recommendation for change in services may be a positive sign. This could be attributed to other benefits of FTM previously mentioned: families are more willing to participate, increased family involvement in case planning, and the meetings hold everyone more accountable. Possibly, the child’s case plan included the most beneficial and appropriate services from the beginning, and the family was more willing to follow-through with participation in those services; therefore, no change in services was needed at later meetings.

²⁴ As mentioned previously, due to insufficient data for certain data questions, one county is not included in the child-meeting level unit of analysis. Therefore, only 15 counties, in addition to Franklin, are represented in this information.

Furthermore, as Table 3.20 illustrates, a high percentage of meetings do not result in a recommendation for change in placement and/or custody: 88% in Franklin County and 86% in the other demonstration counties. However, it is important to note that many counties were incorrectly recording data in both of these categories (recommendations in service and custody/placement), resulting in under-representing the actual percentage of time that a recommendation was made at an FTM. Unfortunately, the study team does not know the extent to which this issue has affected the data.

Table 3.20: Recommended Changes in Placement and/or Custody at FTM²⁵		
	Franklin (n = 13,183 meetings)	15 Demos (n = 25,072 meetings)
Change in Placement & Custody	4%	4%
Change in Custody	5%	5%
Change in Placement	2%	4%
No Change	88%	86%

3.4.6 Summary

Thus far, the study team explored the FTM strategy in 17 demonstration counties and 13 comparison counties identified as having some FTM-related activity, meant to answer one main research question: how is FTM implemented in the demonstration and comparison counties? This section provided an overview of case-level FTM activity in the demonstration counties during the second waiver period in order to highlight the characteristics of FTM across the sites.

In order to increase family involvement in child welfare cases and ultimately improve child outcomes, the 17 demonstration counties have implemented the ProtectOhio FTM strategy. Together, the counties provided over 21,000 FTMs to about 13,800 children in 6,850 families. Further information about these meetings provides an overview of actual FTM activity, and the children that were served, during the second waiver period. Most children have an average of three FTMs throughout the history of their involvement with the child welfare system. Over half of these children are in the custody of and living with their parents at the time of the FTM. Most meetings are held as either initial planning meetings or quarterly reviews. While this is not surprising given that these are two types of meetings in the ProtectOhio model, there are very few meetings held for the purpose of responding to critical events, also a component of the model definition. Critical to FTMs is the participation of a good mix of people around the table, and enough people in the room in order to engage in a meaningful discussion. An FTM of five attendees is the average size in the demonstration counties. Parents and primary caregivers, considered the most important participants in the meeting, are in attendance at almost three-quarters of the meetings in the demonstration counties. In addition, findings suggest that offering meetings at flexible times and locations, combined with assisting with transportation, may increase parent attendance rates at FTMs.

²⁵ This data table uses information at the child-meeting level, meaning that a meeting is counted for each child involved.

Next, the study team turns to an analysis of each demonstration county’s adherence to the ProtectOhio FTM model using case-level quantitative data, along with an analysis of the association between outcomes for children in the demonstration counties versus children in the comparison sites.

3.5 FTM MODEL FIDELITY

As mentioned in the introduction to this chapter, the evaluation of FTM under the ProtectOhio Waiver is guided by three overarching research questions related to implementation, fidelity, and outcomes. Thus far in this chapter, the study team thoroughly explored FTM implementation. In this section, the study team addresses the second research question -- what is the demonstration counties’ level of fidelity to the ProtectOhio FTM model? -- looking at variations among the demonstration sites.

Implementation fidelity refers to how well the demonstration counties adhered to the activities of the ProtectOhio FTM model. Before evaluating the impact of a specific service intervention on outcomes, it is critical to measure fidelity to the defined practice model. Only by understanding fidelity can one reliably attribute outcomes to the intervention. In addition, understanding the degree of adherence to model fidelity provides a context for interpreting the outcome findings, and identifies some of the caveats to those findings. While exploring FTM implementation, the study team discovered variation among the demonstration counties, but also found notable differences overall between demonstration and comparison sites. In the remainder of the chapter, the study team first explores FTM model fidelity using case-level quantitative data, and then turns to child outcomes by means of an intent-to-treat analysis.

3.5.1 Data Collection and Analytic Methods

The following section provides detail on the data elements and populations utilized in the fidelity analysis, as well as analytic methods. The study team collected data at the case level in the FTM ACCESS database described previously in this chapter as the “strategy data” (Sections 3.1.4.1 and 3.1.4.2). We used the child as the unit of analysis to explore variations among demonstration sites.²⁶ We included fifteen of the 18 demonstration counties in the fidelity analysis; implementation in one county was slow to get off the ground, and two other counties provided insufficient data for this analysis. In order to obtain key information that was not available in our primary data set, we matched the county strategy data with administrative SACWIS data provided by ODJFS. This secondary data set provided a variety of critical measures, including case opening and closing dates, placement information, removal termination reasons, subsequent case openings, and demographics such as age and race.

The study team used those children who were in both the strategy file and SACWIS file for the fidelity analysis. One would expect all children served with FTM to be included in the state administrative data. However, some children who were in the FTM strategy data were not in the SACWIS data. This may have occurred for a variety of reasons, including the following:

²⁶ The study team recognizes that FTM is a family intervention and clients participate at the family level. However, critical SACWIS data are provided at the child level. Converting data elements for multiple children into a single family measure is complex. The study team found the effect of large families on using this data at the child level to be minimal.

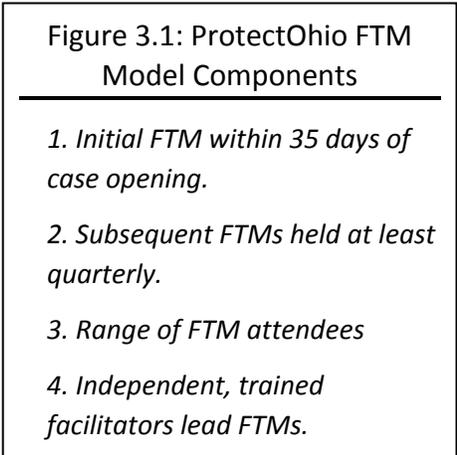
- The study team created the merged file by matching the first FTM for each child within a SACWIS-provided case episode. This means that where SACWIS data failed to give us a chronologically appropriate case episode, the strategy case was eliminated.
- In fact, initially establishing a case episode in the SACWIS file was complex. A case episode begins when a child’s case opens to ‘ongoing services.’ Due to the complications in the changeover from FACSIS to SACWIS, and the disparity in available information between the two systems, we determined that the most reliable proxy for an official ‘case open’ date would be the date when the investigation of maltreatment was completed and an allegation disposition determined; it is generally at that point that a PCSA decides whether or not to transfer the case to ongoing services or to close it. In some cases, multiple allegation disposition dates were associated with one case stop date. In these cases, we chose the disposition date closest to the case stop. Given these limitations, some children were removed whose first FTM otherwise would have matched within a case episode.
- For unknown reasons, not all eligible children served by the PCSA appeared in the SACWIS files.

At this point, in order to conduct a more meaningful analysis, the study team made some strategic decisions regarding the cases to include in the fidelity analysis. First, the study team used only cases with a full span of FTM exposure. This means that we included only those children with case closures; therefore, we eliminated those still open to the PCSA with ongoing cases. Second, we only analyzed their first case episode. Therefore, this group is a subset of those used in the implementation analysis presented thus far in this chapter.

We present the four major fidelity components below. The study team explored these elements by looking at frequency distributions, measures of central tendency, and cross-tabulations among the 15 demonstration counties. In order to conduct more rigorous statistical tests, the study team used the mean within groups to examine differences and associations; however, because the mean is sensitive to outliers, we are also reporting the median where appropriate to provide an alternate view of the distribution.²⁷

3.5.2 Measures of ProtectOhio FTM Fidelity

This section of the report explores how well the demonstration counties have adhered to the ProtectOhio FTM intervention model. In the prior sections, we spoke to this broadly at the county level, describing differences in implementation activity. Here, we are bringing this to the case level in order to provide a more in depth look at adherence to the model. Figure 3.1 outlines the four specific components of the ProtectOhio FTM model that the study team explored. We first present data on each of the individual model components, and then discuss overall fidelity across the 15 demonstration counties.



²⁷ The median is a measure of central tendency representing the middle value for an ordered set of values.

Table 3.21 shows the total number of children in the fidelity analysis, along with the number and percentage from each county.

Table 3.21: Number & Percent of Cases in Fidelity Analysis		
County	Number of Children	Percent of All Cases in Fidelity Analysis
Ashtabula	396	6%
Belmont	226	3%
Clark	134	2%
Coshocton	80	1%
Crawford	256	4%
Fairfield	193	3%
Franklin	1357	20%
Greene	673	10%
Hamilton	790	12%
Highland	225	3%
Medina	115	2%
Muskingum	643	9%
Portage	354	5%
Richland	768	11%
Stark	568	8%
TOTAL	6778	100%

For the children presented in Table 3.21, the average length of a case episode was 420 days and the median length was 343 days, with a range between 1 day and 1596 days (more than four years). This suggests that, even though the study team made a series of strategic decisions that created a subset of those that were served with FTM, we still have a large sample size with a wide range of time and exposure to FTM on which to conduct our fidelity analysis.

3.5.2.1 Initial FTM within 35 Days of Case Opening

Engaging family and supports soon after a case opens assists in retaining their engagement and buy-in to the child welfare process. In addition, best practices indicate that the sooner the family is engaged in the process, the faster case plans can be developed and goals defined for the family and agency to begin working towards; the ideal is that early family engagement leads to shorter case episodes. Given the limitations of the data around case openings, the study team was unable to establish a specific date in order to calculate this measure. Further data collection and analysis is needed to fully understand and

measure each county’s ability to hold their initial FTMs within 35 days of a case opening to ongoing. This component remains a critical aspect of FTM fidelity.

3.5.2.2 Subsequent FTMs Held at Least Quarterly

If a meeting is not held for some other reason, the ProtectOhio model calls for meetings to be held at least quarterly. Having meetings regularly throughout the life of the case has a variety of benefits, such as increasing accountability and expectations, ensuring that all parties remain involved and knowledgeable about the case and case plan goals, and supporting the case in continually moving forward, ultimately decreasing the time that a case stays open. Table 3.22 shows the number of children who were eligible for and had a second FTM, as well as further detail regarding the timing of their second FTM. Overall, 61% of the children had their second FTM within 100 days of the first FTM, with a median of 83 days.²⁸

Table 3.22: Timing of Second FTM						
COUNTY	Target: Second FTM within 100 days of First FTM					
	Total Children Eligible for a 2nd FTM [†]	Total Children who had a 2nd FTM	# & % of eligible children who met Target		Average Days to 2 nd FTM	Median Days to 2 nd FTM
Ashtabula	355	300	265	75%	91	79
Belmont	203	182	168	83%	73	80
Clark	124	110	90	73%	97	90
Coshocton	61	58	40	66%	93	85
Crawford	221	193	134	61%	94	85
Fairfield	185	142	115	62%	85	75
Franklin	1149	1006	910	79%	74	63
Greene	585	475	372	64%	74	63
Hamilton	660	520	462	70%	87	84
Highland	186	169	141	76%	86	90
Medina	100	63	39	39%	120	96
Muskingum	520	279	192	37%	91	85
Portage	346	310	265	77%	83	85
Richland	702	417	210	30%	136	100
Stark	540	327	251	46%	94	90
ALL COUNTIES	5937	4551	3654	62%	89	83

[†] This includes children who had an FTM earlier than required.

²⁸ Strictly speaking, quarterly would be 91 days; if translated into months, three months could be 90 days or as much as 93 days. For simplicity, and to allow for differing understandings of working days versus calendar days, the study team chose to use 100 days as the measure.

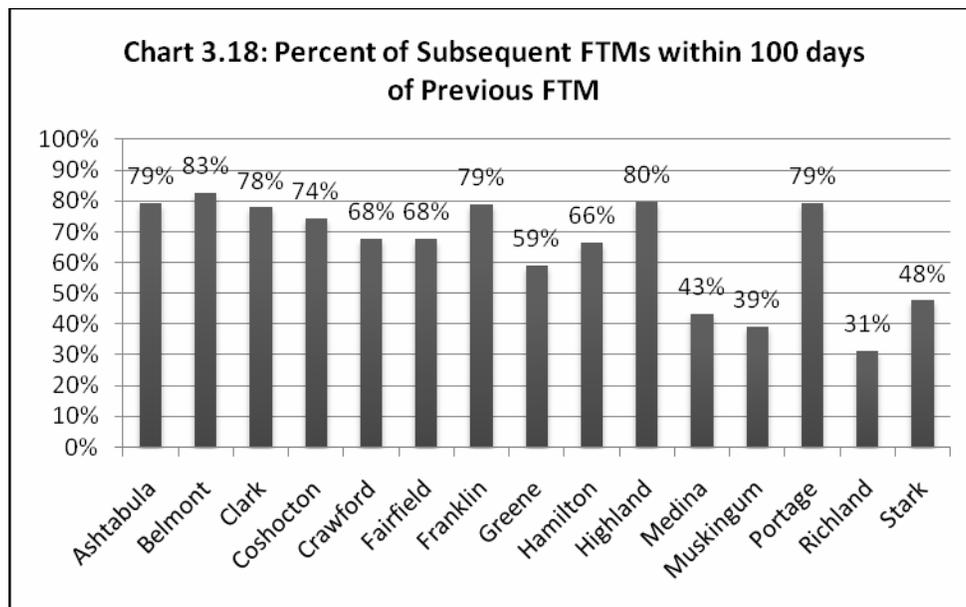
County interviews indicated that policies and procedures for scheduling subsequent meetings appear to be less formalized than those for scheduling initial meetings. Scheduling initial meetings usually involves supervisors and is often done with phone calls or letters to family members and supports, while scheduling subsequent FTMs is much less structured. In an effort to ensure that meetings are held quarterly, several counties have started scheduling the next quarterly meetings at the end of an FTM. Some facilitators have started keeping lists of cases so that they can contact the ongoing worker when it looks like a case is due for an FTM. At least one county has set up an automated spreadsheet that tracks when each case becomes due for a quarterly meeting.

Table 3.23 shows similar information to Table 3.22, but for the third FTM. In the fidelity population, only 27% of the children had a fourth FTM, and 17% had a fifth FTM. This percentage continues to decrease for each additional FTM per child. Therefore, the study team concentrated on the first three FTMs for the fidelity analysis. Timing of the third FTM seems to conform slightly more to the model than the timing for the second FTM: 67% met the target for the third FTM in contrast to 62% who met the target for the second FTM.

Table 3.23: Timing of Third FTM						
COUNTY	Target: Third FTM within 100 days of Second FTM					
	Total Children Eligible for a 3rd FTM⁺	Total Children who had a 3rd FTM	# & % of children who met Target		Average Days to 3rd FTM	Median Days to 3rd FTM
Ashtabula	246	228	212	86%	84	83
Belmont	164	140	135	82%	76	82
Clark	84	79	72	86%	87	86
Coshocton	48	45	41	85%	84	84
Crawford	149	126	116	78%	83	83
Fairfield	131	109	99	76%	70	63
Franklin	741	648	580	78%	93	87
Greene	387	296	202	52%	100	89
Hamilton	419	313	255	61%	101	87
Highland	135	127	115	85%	85	88
Medina	46	37	24	52%	120	91
Muskingum	206	135	93	45%	97	91
Portage	282	251	233	83%	81	84
Richland	327	195	111	34%	120	92
Stark	292	186	145	50%	85	84
ALL COUNTIES	3657	2915	2433	67%	92	86

⁺ This includes children who had an FTM earlier than required.

It is unclear whether differences in timing of the second and third FTMs are meaningful. We present below a chart (Chart 3.18) that illustrates the variability across the counties. Here, the study team combined second and third FTMs for each county, analyzing the percent of each county’s FTMs that met the target of having subsequent FTMs within 100 days of the previous FTM. Most counties had more than half of their FTMs within 100 days of the previous FTM, and six counties had more than 75% of their FTMs within 100 days. While this is encouraging, it is still important to note the wide variation in meeting the target for model fidelity.



3.5.2.3 Range of Attendees at FTMs

FTMs may include a wide variety of participants; anyone the family or the worker determines would be helpful in making decisions about the child’s future. The ProtectOhio model does not specify what participant grouping is the minimum standard for a meeting; rather, it merely states that meeting participants may include the birth parents, primary caregivers and other family members, foster parents (if applicable), support people, and professionals. As previously discussed in Section 3.4.4, an integral piece of FTM is its attendees. Having a good mix of attendees makes the FTM more valuable, because the people gathered around the table can directly support and work with the family in accomplishing their goals. In Section 3.4.4, the study team presented information about a wide array of types of participants involved with FTM. Here, we define this component of fidelity by what might be considered an absolute minimum number of people: at least one parent or primary caregiver, at least one caseworker or other PCSA staff, and at least one other type of person, not including the facilitator. Overall, 49% of the meetings had this minimum number of attendees (Table 3.24).

The rate at which counties are meeting the attendee fidelity component is considerably lower than their conformance to the component regarding the timing of subsequent meetings. This raises several questions: If the counties are focused on holding meetings in a timely fashion, is this reducing their ability to accommodate the schedules of all the people who ideally would be around the table to have a meaningful FTM? Is it simply that the timing of meetings is an element of fidelity that the PCSA can more

easily control, and therefore they are able to experience more success in following this piece of the model? Several counties have commented on these questions, specifically the difficulty of getting attendees to participate in the FTMs, as well as the importance of having the FTM in a timely manner; in fact, with more counties combining their subsequent FTMs with SARs and CAPMIS reviews, the state mandates around timing almost guarantee that subsequent FTMs will occur quarterly. At this time, the study team is not able to determine the specific reasons for differences in the rate at which demonstration counties are meeting the fidelity components, nor can we systematically explore the relative importance of adhering to the timing components versus the attendee component of fidelity.

Table 3.24: FTM Attendees - ALL FTMS (1ST - 3RD)			
COUNTY	Target: At least one parent/PCG, at least one PCSA staff, and at least one other person.		
	Total # of FTMs²⁹	# and % of FTMs that met Target	
Ashtabula	924	222	24%
Belmont	548	418	76%
Clark	323	177	55%
Coshocton	183	155	85%
Crawford	575	228	40%
Fairfield	444	304	68%
Franklin	3009	1013	34%
Greene	1446	570	39%
Hamilton	1623	408	25%
Highland	521	184	35%
Medina	215	143	67%
Muskingum	1057	750	71%
Portage	915	581	63%
Richland	1380	1150	83%
Stark	1081	624	58%
ALL COUNTIES	14276	6947	49%

²⁹ For this fidelity component the child is still the unit of analysis even though the type of attendee is a meeting level variable. This means that a separate FTM is counted for each child, regardless of whether multiple children are in the same meeting. The study team is aware that this leads to some duplication in attendees but would have little effect on the findings.

Table 3.24 considers each child’s first through third FTM. However, the demonstration counties have hypothesized that meeting attendance varies as time progresses within a case. The study team briefly examined this idea: our initial look suggests that attendance rates in terms of the target grouping are slightly higher at the first FTM, but similar for the second and third FTMs (53% at the first FTM versus 44% at the second FTM, and 45% at the third FTM). A separate preliminary analysis of parent and primary caregiver attendance rates provided some evidence that parents and primary caregivers are more likely to attend subsequent meetings if they attended the previous meeting.³⁰ This argues that it is most important to engage parents and primary caregivers early in the FTM process in order to increase the likelihood of keeping them engaged throughout the case. Further exploration is needed around the variations in attendance rates over time.

3.5.2.4 Independent, Trained Facilitator Leads FTMs

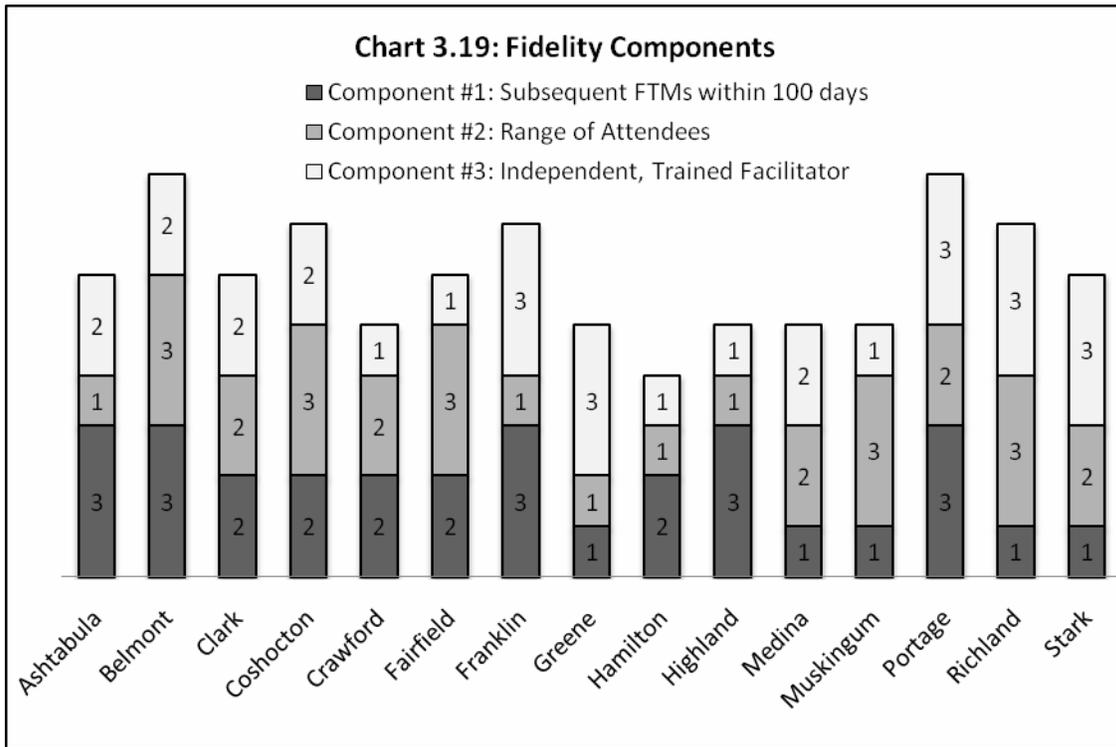
The ProtectOhio FTM model states that FTMs should be led by a facilitator who is independent of the case and trained in FTM facilitation. All demonstration counties employed an independent facilitator during the second Waiver, but there was a range of facilitator training levels among the counties. For this fidelity component, the study team used the summative scores calculated to examine the amount of training at the county level; the process that the study team used to create these scores is described further in the implementation analysis above (Section 3.2.1.3). About two-thirds of the counties had medium to considerable facilitator training. Even though the training levels and responsibilities of the facilitator in terms of arranging the meeting were found to be variable, findings from the implementation analysis seem to show that just having an independent and unbiased person facilitating the FTM is beneficial (see Sections 3.2 and 3.3).

3.5.3 Overall FTM Model Fidelity

This section synthesizes the data presented above on the four key components of the ProtectOhio FTM model. Chart 3.19 depicts the differences among the counties in their overall fidelity to the model. Each county-specific bar shows the contribution of each of the fidelity components to the composite county rank; while some counties may rank lower on one fidelity component, they most often will rank higher on another component.³¹

³⁰ *Preliminary Analysis of Attendees at Family Team Meetings* presented by HSRI on May 4, 2009 at the FTM Facilitator’s Quarterly Meeting.

³¹ Each stacked bar represents a county on the three fidelity components that the study team was able to measure. Each component was separated into levels (high, medium, and low). The counties that ranked in the top third were given 3 (high), those in the middle third were given 2 (medium), and those in the bottom third were given 1 (low).



While this illustrates where each county ranks in comparison to the other counties in terms of fidelity, it does not show an absolute level of fidelity, in terms of ideal overall adherence to the model. As discussed above, fidelity is quite variable among the demonstration counties; for example, the range in percentages of those that had their subsequent FTMs within 100 days of the case start goes from 31% in one county to 83% in another county. The study team found that at the case level this variability is even greater. Further evaluation is necessary to understand the impact of case-level fidelity on outcomes, rather than simply looking at county-level fidelity.

3.6 CHILD-LEVEL OUTCOMES: DEMONSTRATION VERSUS COMPARISON COUNTIES

The following section answers the third and final research question that guides the evaluation of FTM under the ProtectOhio Waiver: Do children receiving ProtectOhio FTM more often experience a positive outcome than children in comparison sites? This question considers children in all demonstration sites (who had the benefit of both the waiver and ProtectOhio FTM) and all comparison sites (who did not have the waiver or ProtectOhio FTM). Exploring the full set of outcomes is a core aspect of the sub-study of ProtectOhio FTM; these findings provide an enhanced understanding of the impact that the availability of flexible funding and a defined FTM model together have on children in the Ohio child welfare system.

3.6.1 Data Collection and Analytic Methods

For the outcomes analysis, the study team compared children in all 18 demonstration sites to children in all 17 comparison sites. Again, we used the child as the unit of analysis. The administrative

SACWIS data provided by ODJFS were used to create an “intent-to-treat” (ITT) population. An intent-to-treat analysis is based on the initial treatment intent, not the actual treatment administered. Rather than looking at just those who actually received FTM, this type of analysis examines a population of children that FTM was intended to treat, which includes those that were treated as well as other eligible children. By taking this approach one can potentially gain a better understanding of how a change in *policy* is likely to impact children and families across a *system* rather than the degree to which change might occur as a function of the fidelity with which the intervention has been applied to individual cases.

To create comparable populations of children in the two county groups, the study team made a series of strategic decisions. The outcomes of interest required us to have three critical types of data: a complete case episode, defined by a ‘start date’ and a ‘stop date’ designating the time the child’s case was actively being served by the PCSA; a set of placement episodes within that case episode, each defined by a placement start date and a placement discharge date, and a series of maltreatment reports, including date of initial report and date & nature of disposition, i.e. the findings of the investigation into the maltreatment report. Using SACWIS data, the *first* completed case episode was identified for all children within demonstration and comparison counties.³² For each county, the study team used cases whose case open date fell after that county’s FTM implementation date; a date of July 1, 2005 was used for the comparison counties. In addition, the study team limited the file to those cases whose disposition finding was indicated or substantiated. For those counties not serving the universe, the study team drew a random sample equal to the percentage of cases sampled in each of those counties (see Table 3.2).

While it would be ideal to use the same sampled population in both the fidelity and outcomes analysis, limitations in the data prohibited the study team from doing so; an effort has been made to ensure that the populations are as similar as possible across analyses. The main reason why all of the children who were in the fidelity analysis (i.e. received FTM) are not included in the ITT group is because the study team made the decision to use only those children whose disposition finding was indicated or substantiated; some of the children who received FTM had an unsubstantiated allegation disposition finding in the SACWIS data. It is possible for a case to open to ongoing services without an indicated or substantiated disposition finding (e.g. a voluntary case); however, had we included those with unsubstantiated allegations, we would have included a much larger group than would have been intended to receive FTM. Therefore, we erred on the safe side and by doing so, eliminated some cases which it would have been appropriate to include.

A few additional data challenges and limitations arose as the study team conducted the FTM evaluation.

- *Case Start Limitations:* A case episode begins when a child’s case opens to ‘ongoing services.’ As we stated in the fidelity analysis, due to the complications in the changeover from FACSIS to SACWIS, and the disparity in available information between the two systems, we determined that the most reliable proxy for an official ‘case open’ date would be the date when the

³² The counties have stated that a three month time period is needed to fix any data errors entered in the SACWIS data in the previous months. The study team received its latest SACWIS file February 1, 2010; therefore, we used an end date of October 31, 2009 in order to ensure that we were analyzing the most reliable and accurate SACWIS data. All cases whose case close date fell after the end data date were eliminated from the file.

investigation of maltreatment was completed and an allegation disposition determined. Where there were multiple allegation disposition dates associated with one case stop, we chose the disposition date closest to the case stop; our assumption was that a larger percentage of cases will have multiple dispositions before a case actually opens to ongoing services than dispositions after it has already opened.³³ We recognize that this may bias the data in some instances where the case may have opened earlier. Thus, our estimate of case episode length may be shorter than it truly was. Additionally, by using the final disposition date closest to the case stop, we may be losing maltreatment activity that might have occurred during the case episode. For this reason, we were only able to explore outcomes related to subsequent case openings after a case closed, rather than any maltreatment after case start.

In addition, as described previously, we limited the cases in the ITT analysis to those with a substantiated or indicated disposition; lacking any more conclusive way to determine whether a case actually transferred to ongoing services, we decided to focus on cases with confirmed reports, all the while recognizing that this definition brings into the analysis some cases that did not in fact transfer to ongoing services. It thus represents a more conservative approach to the ITT analysis, both in terms of including more cases than likely would have become eligible for FTM (those that did not actually transfer to ongoing services) and including many more cases in the demonstration group than actually received the strategy.

- *Placement Episodes:* An additional limitation of the SACWIS data was the nesting of placement episodes within the correct case episode. The study team found it necessary to reconstruct the SACWIS file in order to ensure that the placement episodes were associated with the right case episode. Through a series of data manipulation methods based on case start and stop dates, the study team was able to position each placement episode into the correct case episode in order to measure placement outcomes. The study team recognizes that some placements may in reality fall outside of the exact case start and stop dates. However, we feel that the occurrence of this situation is minimal compared to the number of placements that genuinely fall within a case episode.
- *No historical data:* Without historical data for demonstration or comparison counties prior to the implementation of the family team meeting strategy, it is not possible to control for differences among counties that were present prior to the study period.
- *Targeted Cases:* The study team expected to use information from the SACWIS file to narrow the population of children in ongoing services to those with an appropriate initial case plan goal of maintain in home or reunification, which would qualify them for FTM; however, this variable was not available in SACWIS, and unreliable in the previous FACSIS data. Therefore, the outcomes analysis focuses on all children who opened to ongoing services (given the case start limitation defined above). Although we have encountered this challenge, the demonstration counties believe that, for 99% of clients, the initial goal is maintain in home or reunification.

³³ The Trajectory Analysis from the Interim Evaluation Report (HSRI, 2007) shows that only a third of the cases that had an initial allegation disposition of substantiated were subsequently transferred to ongoing services. A much larger percentage of cases have multiple allegations before the case is opened.

However, a small number of children will appear in the study that did not have an appropriate initial case plan goal from both the comparison and demonstration county groups.

Below, we present the six major outcomes that the study team explored. Analytic methods used in the outcomes analysis include frequency distributions, cross-tabulation and chi-square statistical tests, independent t-tests, one-way ANOVAs, and factorial ANOVAs. As mentioned above, in order to conduct more rigorous statistical tests, the study team used the mean within groups to examine differences and associations; however, because the mean is sensitive to outliers, we are also reporting the median where appropriate to provide an alternate view of the distribution.³⁴ Throughout this section, an asterisk (*) within a table indicates a bivariate comparison that was statistically significant at the .05 level. In a chi-square test, the asterisk indicates where there is a significant difference between actual and expected figures (either in the positive or negative direction).

3.6.2 Child Outcome Findings

The study team explored six major outcomes included in the FTM logic model (Table 3.1):

- Shorter time the case is open (to ongoing services);
- Avoiding initial placements;
- Among children who are placed, more placement with kin;
- Shorter time in placement;
- Increased reunification and exits to kin; and
- Fewer subsequent case openings after case close.

For each outcome, the study team explored differences between the demonstration group and the comparison group. In addition, sub-group effects³⁵ by county size, race, and age were analyzed. County size is defined as metro (Franklin & Hamilton in the demonstration group, Summit & Montgomery in the comparison group of counties) versus non-metro; race includes black versus white & other; and age is categorized into three groups: infants (less than one year old at case start), children (1 through 12 years old at case start), and teenagers (13 and older at case start).

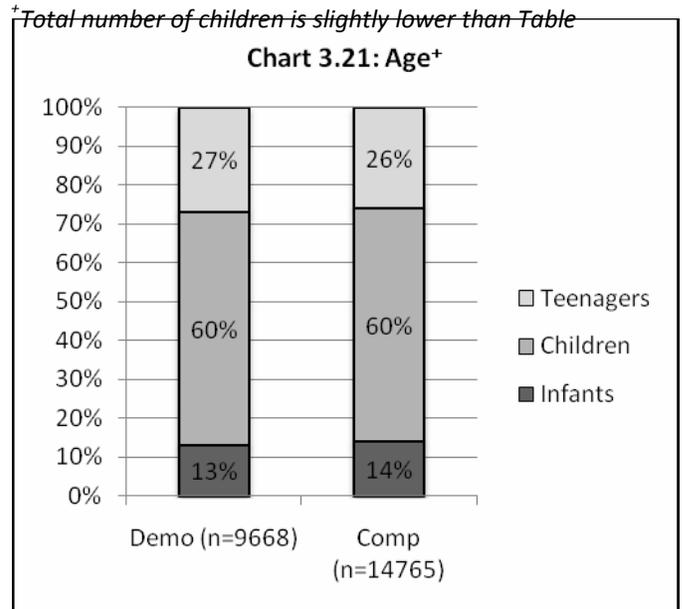
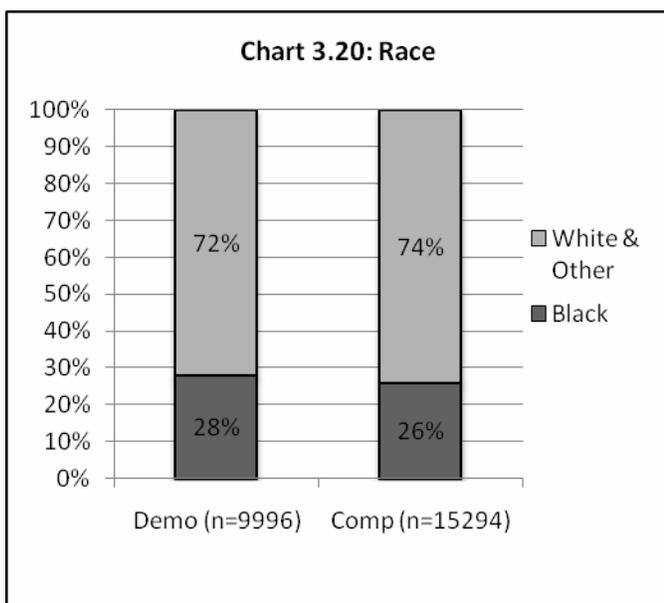
Table 3.25 gives an overview of the number and types of children that are included in the ITT analysis. The total number of children with completed, first case episodes is 25,290. Children in the demonstration counties make up 40% of the cases. Sixty-six percent of the total cases had a close date that was at least 12 months prior to the end data date, ensuring a sufficiently large sample size for our analysis of subsequent case openings. Only 16% of all the children had some type of placement during their case episode.

³⁴ The median is a measure of central tendency representing the middle value for an ordered set of values.

³⁵ These are associations and should not be interpreted as causal relationships. We have no way of knowing whether case mix differences pre-date the strategy and are influencing the apparent sub-group effect.

Table 3.25: Overview of Children Included in the ITT Analysis			
	Demos	Comps	Total
Total # Cases with Full, 1 st Case Episodes	9996	15294	25290
Percent of Cases with Placements	15% (1468)	17% (2535)	16% (4003)
Percent of Cases that Closed 12 months before End Data Date (10/31/09)	63% (6277)	69% (10498)	66% (16775)
Percent of Full Case Episodes that are Metro	30% (2949)	40% (6184)	36% (9133)
Percent of Full Case Episodes that are Non-metro	70% (7047)	60% (9110)	64% (16157)

Before proceeding with the outcomes analyses, the study team looked for any underlying disparities in demographic distributions in terms of race and age; none were discovered (Charts 3.20 – 3.21).



3.25 because of missing data.

3.6.2.1 Outcome #1: Shorter time case is open

One of the major objectives of the FTM strategy is to decrease the length of time a child’s case is open. Demonstration counties believe that FTM can help bring all parties together so that decisions and resolutions occur faster, ultimately leading to a shorter case length. Results from an independent t-test show an overall significant difference in length of case episode between the demonstration and comparison groups.³⁶ Children in demonstration counties had shorter case episodes (mean = 329 days; median = 266 days) than those in the comparison counties (mean = 366 days; median = 287 days). The mean difference was 37 days between the demonstration and comparison sites. It seems that the availability of flexible funding combined with FTMs could assist in shortening the case by an average of a

³⁶ $t_{(df=23723)}=-10.48; p<.05$

month. The study team is not able to distinguish, however, which dynamics of the strategy and/or waiver had the most influence in creating the observed difference. Regardless, a shortened length of case episode is an advantageous and valuable outcome for children, and also results in considerable county financial savings.

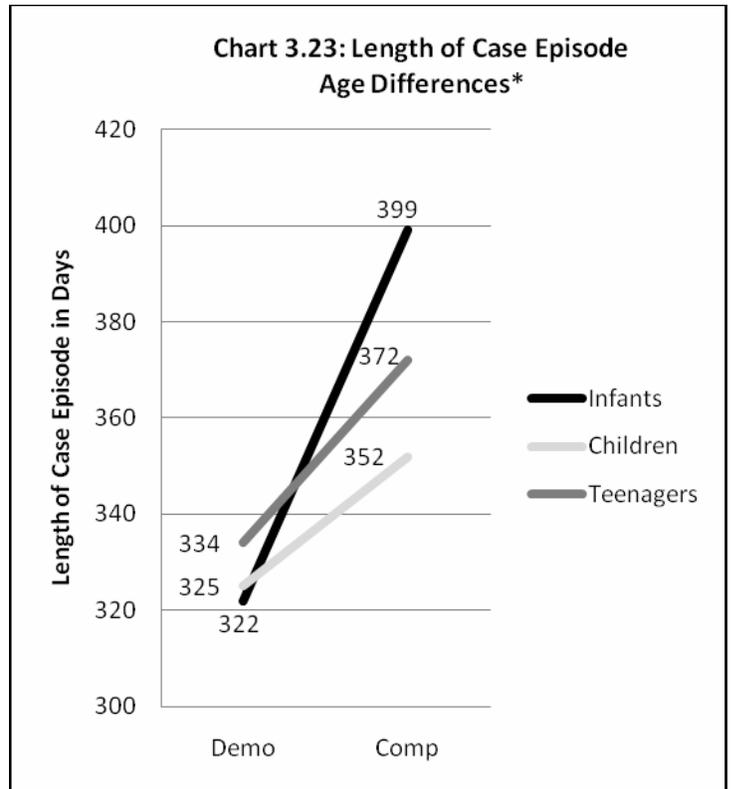
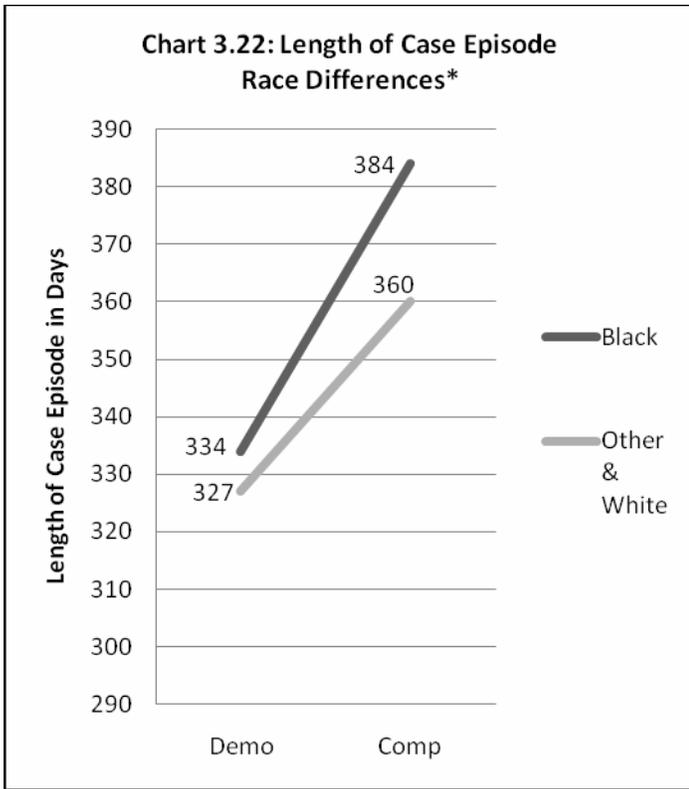
When looking at the moderation of county size on the overall association in length of case episode between demonstration and comparison groups, the study team found that the metro counties seem to be having a stronger effect than the non-metro counties. A significant difference in length of case episode was found between both demonstration and comparison non-metro counties, and demonstration and comparison metro counties; the overall effect of difference carries through to both size groups. ³⁷ Interestingly, a much larger differential was found between metro county groups: a mean difference of 59 days between demonstration and comparison counties (Table 3.26).

Table 3.26: Length of Case Episode Metro vs. Non-Metro						
	Metro			Non-Metro		
	Demonstration	Comparison	Mean Difference	Demonstration	Comparison	Mean Difference
Average Length of Case Episode*	323 days	382 days	59 days	331 days	354 days	23 days

Similarly, the study team found a significant difference among both the race and age sub-groups.³⁸ The two following charts (Chart 3.22 – 3.23) show that the difference in length of case episode seems to be accentuated for black children, with a demonstration/comparison difference of 50 days, and for infants, with a demonstration/comparison difference of 77 days. The finding regarding infants is elaborated below.

³⁷ $F_{(df=3)}=46.45; p<.05$

³⁸ Race: $F_{(df=1)} = 4.78; p<.05$; Age: $F_{(df=2)} = 10.13; p<.05$



3.6.2.2 Outcome #2: Avoiding Initial Placement

A primary goal of the Waiver is to reduce the number of children entering out-of-home care; the FTM strategy is seen as an important means to that end. Eighty-four percent of the children in the ITT population, regardless of county group membership, had no placement within their first full case episode. A chi-square test revealed a small but significant association between placement and county group membership.³⁹ As Table 3.27 shows, children in demonstration counties are less likely to have an initial placement (15%).

Table 3.27: Avoiding Initial Placement		
	Demonstration	Comparison
Placement*	15% (1468)	17% (2535)
No Placement*	85% (8528)	83% (12759)
TOTAL	100% (9996)	100% (15294)

³⁹ $\chi^2_{(df=1)}=16.20; p<.05$. Cramer's V = .025.

When looking at the sub-group effects on avoiding initial placement, the study team consistently found significant associations in placement between each of the size, race, and age sub-groupings. Both metro and non-metro groupings followed similar patterns as the overall association in avoiding initial placement between demonstration and comparison sites; the effect was stronger in the metros than in the non-metros.⁴⁰ Analysis of racial sub-groups showed that black children were less likely to be placed in demonstration counties than comparison counties (14% versus 19%).⁴¹ In addition, a significant association was found when looking at age as a sub-group effect. Interestingly, the strongest effect appeared among infants: infants were less likely to be placed in demos (21%) and more likely to be placed in comps (27%).⁴²

Much like the previous outcome regarding length of case episode, these findings offer support for the hypotheses of FTM impact on children. Many PCSA staff believe that removing a child from the home can have a far reaching impact on everyone involved, and it is preferable to maintain the child in the home as long as it is safe and appropriate to do so. FTM assists in decreasing the need for out of home placements, as is evidenced by several of the benefits mentioned previously (Section 3.2.3), including: families have more natural supports; families have quicker access to services; and there is increased family involvement in the case. The demonstration counties seem to be successful in working towards their goal of avoiding initial placement, especially with black children and infants.

3.6.2.3 Outcome #3: Among Children who are Placed, More Placements with Kin

Demonstration counties believe that the FTM process assists in revealing information about the family's support network, so that, if children need to be placed out-of-home, it will be more likely that relatives or friends would already be involved in the case process and thus children would be more likely to be placed with kin.⁴³ As Table 3.28 shows, half of the children who went to placement were placed in foster care, regardless of county group membership. The second most common placement type was with kin (42%). The results of a chi-square test show a significant association in placement type between the demonstration and comparison groups.⁴⁴ Compared to the comparison group, children in placement in demonstration counties were more likely to be placed with kin (47% versus 40%), and less likely to be placed in foster homes (46% versus 53%).

⁴⁰ $\chi^2_{(df=3)}=28.66; p<.05$. Cramer's V = .034.

⁴¹ $\chi^2_{(df=1)}=22.83; p<.05$. Cramer's V = .058.

⁴² $\chi^2_{(df=1)}=13.14; p<.05$. Cramer's V = .063.

⁴³ Only 7% of the children in all counties had a second placement within their case episode, and <1% had a third placement. Therefore, the study team only looked at initial placements within a case episode.

⁴⁴ $\chi^2_{(df=5)}=21.68; p<.05$. Cramer's V = .074).

Table 3.28: Placement Type			
	Demonstration	Comparison	TOTAL
Residential	4% (51)	3% (82)	3% (133)
Group Home	2% (33)	2% (60)	2% (93)
Kin ⁺	47% (682)*	40% (1002)*	42% (1684)
Foster Home	46% (668)*	53% (1341)*	50% (2009)
Adoptive Placement	<1% (12)	1% (20)	1% (32)
Other ⁺⁺	1% (22)	1% (30)	2% (52)
TOTAL	100% (1468)	100% (2535)	100% (4003)

⁺Kin includes both licensed and non-licensed relatives.

⁺⁺Other includes independent living; own home; detention center; or other type of placement not previously mentioned.

When examining sub-group effects on placement type, the study team found a significant association with county size groups.⁴⁵ While the overall effect of difference carries through to non-metro counties, in metro counties the association is contradictory to the overall relationship found in placement type between demonstration and comparison counties. Table 3.29 shows that children are more likely to be placed with kin in the metro comparison counties, and less likely in the metro demonstration counties: 50% of the children are placed with kin in the comparison metro counties as opposed to 45% in the demonstration metro counties. However, the strongest effect is seen in the non-metro counties, likely mediating the overall association in placement type between demonstration and comparison sites.

Table 3.29: Placement Type Metro vs. Non-Metro				
	Metro		Non-Metro	
	Demonstration	Comparison	Demonstration	Comparison
Kin	45% (172)	50% (530)*	47% (510)*	32% (472)*
Foster Home	45% (173)	43% (458)*	46% (495)*	60% (883)*
Other ⁴⁶	10% (39)	7% (80)	7% (79)	8% (112)
Total	100% (384)	100% (1068)	100% (1084)	100% (1467)

⁴⁵ $\chi^2_{(df=15)}=129.35; p<.05$. Cramer's V = .104.

⁴⁶ The 'other' category includes all other placement types highlighted in Table 1.9; these were run separately in the analysis, but grouped together here as no single variable had an effect on the significance.

No significant association was found when looking at race as a sub-group. Age, on the other hand, does moderate the association.⁴⁷ Again, the overall association is strongest with infants. In the demonstration counties, infants are more likely to be placed with kin (56%). In the comparison sites, 43% of infants are placed with kin. The demonstration counties seem to be working hardest with infants, as they are having the strongest sub-group effect; infants are less likely to be placed, and when they are placed, they are the most likely to be placed with kin. In addition, infants have shorter case episodes overall.

3.6.2.4 Outcome #4: Shorter Time in Placement

Another crucial aspect of child placement is how long a child is out of the home. One hypothesis of the FTM strategy is that, if a child must be placed out of the home, the length of stay will be shorter than would have been the case without FTM. An independent t-test showed no significant difference between length of stay in placement and county group membership. The average length of stay for children in the demonstration counties was 226 days; in the comparison counties the average time was 219 days.

3.6.2.5 Outcome #5: Increased Reunification and Exits to Kin

A primary goal of FTM is to increase permanency for children involved with the PCSA, either by maintaining children in their birth home, reunification, or exiting to relative custody when reunification is not possible. Ninety-three percent of the children in the demonstration counties closed their case in the custody of parents or primary caregivers.⁴⁸ This percentage was the same for those in comparison counties. Delving a bit deeper, the study team looked at only those children who were in placement during their first case episode. Results of a chi square test show a significant association in permanency (defined here as reunification or exit to relative custody) between demonstration and comparison counties.⁴⁹ Those in placement in the demonstration counties were less likely to reunify than children in placement in the comparison sites: 51% of the children reunified in demonstration sites versus 60% in comparison counties (Table 3.30).

Although this finding contradicts the anticipated outcome, it is still important to note that half of the children who were in placement in the demonstration counties did reunify. In addition, more children exited placement into relative custody in the demonstration counties (37%), then in the comparison counties (33%).⁵⁰

⁴⁷ $\chi^2_{(df=4)}=12.81; p<.05$; Cramer's V = .126).

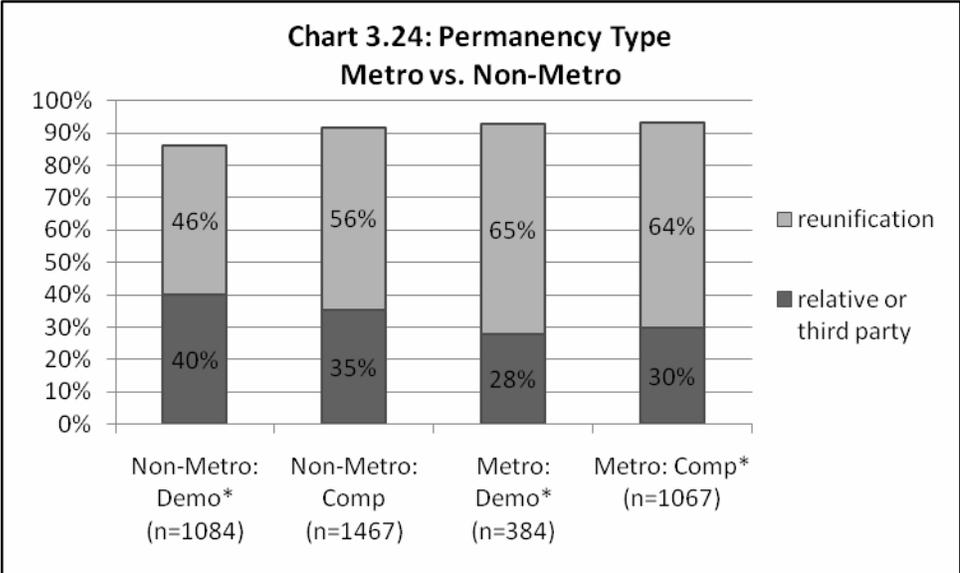
⁴⁸ This was calculated by looking at the number of children who were either reunified or were maintained in their homes, as a percent of all children in the county group.

⁴⁹ $\chi^2_{(df=5)}=45.34; p<.05$. Cramer's V = .106.

⁵⁰ This finding was not statistically significant. In addition, guardianship and relative were combined to form a 'relative and third party' category.

Table 3.30: Permanency Type (only Children in Placement: n=4003)		
	Demonstration	Comparison
Reunification	51% (750)*	60% (1508)*
Relative or third party	37% (547)	33% (838)
Adoption	2% (23)	1% (32)
Emancipation	3% (46)	3% (74)
Runaway	1% (11)	<1% (11)
Other	6% (91)	3% (71)
Total	100% (1468)	100% (2534)

When examining sub-group effects, the study team found a significant association between metros and non-metros in regards to permanency type.⁵¹ Chart 3.24 highlights this difference. Similar to the sub-group effects of county size in regards to placement with kin, the non-metro county sub-group comparison follows a similar pattern to the overall association in permanency type between demonstration and comparison sites, while the other sub-group (metros) is inconsistent with the overall relationship. The demonstration metro counties have slightly more reunifications than the comparison metro counties.



⁵¹ $\chi^2_{(df=15)}=102.86; p<.05$. Cramer's V = .093.

Also significant is the moderating effect of race on FTM outcomes, particularly in regards to black children.⁵² Black children are much more likely to be placed with relatives in the demonstration counties (35%) versus the comparison counties (26%). There was no significant effect when looking at age sub-groups.

3.6.2.6 Outcome #6: Fewer Subsequent Case Openings after Case Close

The final desired outcome of FTM is that children who receive FTM will have fewer subsequent case openings once their case is closed. It is hypothesized that a child who receives FTM will have their needs identified and more completely met so that when the case is closed, it is fully resolved and thus less likely to need to return to PCSA services. Re-opening to the PCSA suggests a new or continuing risk to the safety of the child. Using a chi square test, the study team found a small, although significant, relationship between subsequent case openings and county group.⁵³ Among those cases that closed at least a year before the end data date, hence only looking at those which would even have had the chance to have a subsequent case opening, children in demonstration counties have slightly less subsequent case openings within a year of case closure (11%) than children in comparison counties (12%). These children could have returned to care for a variety of reasons, including as a voluntary case or from an unrelated incident. Further study is needed to understand the type of maltreatment report that initiated the second case opening, as well as whether the subsequent case opening placed the child in a less restrictive setting than they were placed in the first case episode (if a placement occurred). Overall, children in demonstration counties seem to be just as safe as those in comparison counties.

When exploring sub-group effects, the study team found a significant association in subsequent case openings among the metro and the non-metro sub-groups.⁵⁴ As Table 3.31 shows, the metro counties are having a much stronger effect: a large differential is evident between metro demonstration (seven percent) and comparison sites (12%).

Table 3.31: Subsequent Case Opening Metro vs. Non-Metro				
	Metro		Non-Metro	
Subsequent Case Opening within a Year	Demonstration	Comparison	Demonstration	Comparison
YES	7% (132)*	12% (538)	13% (564)*	12% (745)
NO	93% (1784)*	88% (3822)	87% (3797)	88% (5393)
Total	100% (1916)	100% (4360)	100% (4361)	100% (6138)

⁵² $\chi^2_{(df=5)}=12.55; p<.05$. Cramer's V = .105.

⁵³ $\chi^2_{(df=1)}=4.85; p<.05$. Cramer's V = .017.

⁵⁴ $\chi^2_{(df=3)}=51.67; p<.05$. Cramer's V = .056.

No significant association was found in regards to race. A significant association was found when looking at the effect of age; however, it followed a similar pattern as the overall association in subsequent case openings between demonstration and comparison counties.⁵⁵ The largest effect fell with children ages 1 to 12 years old in demonstration counties: they were significantly less likely to have subsequent case openings within a year of case closure (10.5%).

3.7 SUMMARY AND CONCLUSIONS

The study team explored the ProtectOhio Family Team Meeting strategy in 18 demonstration counties and 17 comparison counties. Three major analyses were conducted in order to answer the three guiding research questions:

1. How is FTM implemented? This question was addressed in the implementation analysis by comparing 17 demonstration counties to a subset of 13 comparison sites, including only those using some FTM-like process (Sections 3.2 through 3.4)
2. What is the demonstration counties' level of fidelity to the ProtectOhio FTM model? This question was addressed in the fidelity analysis by looking at variations among 15 demonstration sites (Section 3.5).
3. Do children receiving ProtectOhio FTM more often experience a positive outcome than children in the comparison sites? This question considers children in all 18 demonstration sites and all 17 comparison sites using an intent-to-treat outcomes analysis (Section 3.6).

In the implementation analysis, the study team thoroughly explored three areas: (1) policies, perceptions and observations in the demonstration counties; (2) the extent to which FTM practice in the demonstration counties differed from normal child welfare practice as evidenced in the comparison sites; and (3) the nature and volume of FTM activity that actually occurred in the demonstration counties. Through this analysis, a sense of how FTM was implemented and what was accomplished in the demonstration counties emerged.

In order to increase family involvement in child welfare cases and ultimately improve child outcomes, the 18 demonstration counties have implemented the ProtectOhio FTM strategy.⁵⁶ Specifically, these counties have hired and trained independent FTM facilitators, provided regular FTMs over the course of each case, and served all ongoing cases with a case plan goal of reunification or maintain in home. Together, the counties have provided over 21,000 FTMs to about 13,800 children in 6,850 families. Through interviews, site visits, focus groups, and surveys, the counties have identified the following as key components of the FTM strategy:

- Capacity building in terms of FTM training and orientation for facilitators, caseworkers, and community partners,
- Family engagement in the FTM process,

⁵⁵ $\chi^2_{(df=1)}=7.14; p<.05$. Cramer's V = .027.

⁵⁶ In one of the four new demonstration counties, implementation was slow to get off the ground; therefore, this study primarily uses data from 17 demonstration counties in the analyses.

- Facilitator-caseworker preparation and ongoing communication, and
- Facilitator and caseworker performance in the meeting that fosters family involvement.

Overall, demonstration counties were positive in their views about FTM and its benefits, including: families build stronger family relationships, natural supports, and feel empowered; families are linked to more appropriate and timely services; and there is an opportunity to educate the community and improve agency operations and image. However, the process for implementing the FTM initiative was loosely structured and largely left to individual counties to determine. It lacked strong training, supervision and monitoring components, which hindered the counties' ability to fully and widely implement the program. This led to wide variation in practice among the demonstration counties. While there was variation among the demonstration counties surrounding aspects of their implementation, there were also notable differences overall between demonstration and comparison sites, such as:

- In program policy, the demonstration counties appear to have a broader initiative aimed at a larger population, while comparison counties' practice appears to be more targeted (for example, only offering FTM to children at risk of removal).
- In the meetings observed by the study team, facilitators, parents, and kin appear to be more highly involved in the demonstration counties than in comparison sites. It is interesting to note that, although the comparison counties are slightly more likely than demonstration sites to offer the three accommodations that lead to a more family-friendly environment (which may increase parent attendance rates), they appear to have lower parent engagement in the meeting.

Another primary difference is the use of independent facilitators in the demonstration counties; 16 of the 17 demonstration counties, and only five of the 13 comparison counties, have an independent FTM facilitator. The similarity of the involvement of the caseworkers in the two county groups seems to further emphasize the importance of the facilitator role in increasing parent involvement in the meeting. This suggests that although getting the parent to the meeting may be related to county accommodations that lead to a more family-friendly environment, having them engaged once at the meeting could be related to having an independent facilitator. Further study is needed to determine if this higher parent involvement is due to the ProtectOhio model in general and the role of the independent facilitator in particular.

In the fidelity analysis, the study team used quantitative data to take a closer look at the demonstration county's fidelity to the ProtectOhio FTM model. The study team highlighted four main components of the model: 1) Initial FTM within 35 days of case opening, 2) subsequent FTMs held at least quarterly, 3) having a range of attendees, and 4) using independent, trained facilitators to lead FTMs. Although data limitations prohibited the study team from exploring the first component, the remaining three fidelity elements were examined. On average, 63% of the children had their subsequent FTM within 100 days of their previous FTM. Forty-nine percent of the FTMs had a minimum grouping of attendees (at least one parent or primary caregiver, at least one PCSA staff, and at least one other person). All counties had an independent facilitator leading FTMs, and a little over half of them had a medium-level amount of training. Overall, the demonstration counties showed wide variability in meeting the targets for each component; however, it seemed that if a county ranked lower in one area, it more than likely ranked higher in another aspect of the FTM model.

In the outcomes analysis, the study team created an evaluation population of all eligible children within the demonstration counties compared to those in comparison counties, regardless of whether they were formally identified as having been served through the FTM strategy, and regardless of the fidelity with which individual demonstration counties may have implemented the strategy. The intent-to-treat (ITT) approach gives greater insight into how a change in *policy* is likely to impact children and families across a *system* rather than the degree to which change might occur as a function of model fidelity. Analysis focused on differences and similarities among the two groups of counties, with some additional attention to how these differences varied across demographic sub-groups and corresponding strategy and/or waiver effects. Primary outcomes findings included:

- Children in demonstration counties had statistically significantly shorter case episodes than did comparison county children (an average of 329 days versus 366 days);
- Children in demonstration counties were significantly less likely to go to placement than were comparison county children (15% versus 17%);
- Compared to the comparison group, children in placement in demonstration counties were more likely to be placed with kin in the demonstration counties (47% versus 40%), and less likely to be placed in foster homes (46% versus 53%);
- No statistically significant difference was found in the length of stay in placement between demonstration and comparison counties;
- Children in placement were significantly less likely to reunify in demonstration counties than in comparison sites (51% versus 60%); and
- Children in demonstration counties were less likely to have subsequent case openings within a year of case closure than children in comparison counties, but the effect was slight (11% versus 12%).

When examining the sub-group effects of county size, race, and age in regards to each outcome, the following effects emerged:

- When looking at the effect of county size, a statistically significant association was found with each outcome. Most of the associations followed similar patterns as the overall relationship; in these cases the effect of metro counties seemed to be stronger. In a couple of instances, the association between metro demonstration and metro comparison counties was contradictory to the overall association. This could be lessening the strength of association that we observed between county groups.
- The effect of race was only statistically significant in half of the outcomes. In each of these outcomes the effect reinforced the overall association found between county groups; however, the effect was stronger for Black children.
- In four of the six outcomes, age had a statistically significant effect. Interestingly, in three of these instances infants were the group with the strongest effect: infants are less likely to be placed, and when they are placed, they are the most likely to be placed with kin. In addition, infants have shorter case episodes overall.

Although fidelity was variable, several positive outcomes emerged for children in the demonstration counties, relative to the comparison group. This suggests a definitive impact of the ProtectOhio Waiver and the FTM strategy. Given that all counties implemented FTM, the study team believes that further study is merited to examine the full impact of this intervention, specifically by looking at individual child-level fidelity and how it may enhance the outcome effects. Further research could address whether child outcomes are related to key components of the FTM model, such as parent and/or primary caregiver attendance at FTMs, having a family voice at the FTMs, the number and mix of attendees at FTMs, and FTM dosage per child.