CHAPTER 4:

FAMILY TEAM MEETINGS STRATEGY

Family Team Meetings (FTM) represents a paradigm shift from traditional child welfare services and has the potential to change the culture of child welfare. Specifically, FTM is a method for engaging family members and other people who can support the family for shared case planning and decision making. Different models of family team meetings such as Team Decision-Making and Family Group Decision-Making have been promoted by the Annie E. Casey Foundation and American Humane Association, respectively, as "best practice," and PCSAs throughout Ohio have experimented with various models of family team meetings. This activity potentially reduces the Waiver impact because comparison counties have been exposed to the intervention too. On the other hand, it may mean the demonstration counties experience a shorter than normal maturation time since they have already been exposed to the philosophy of FTM. One of the reasons many of the counties were interested in pursuing FTM was because they were already experimenting with various forms of family meetings and they felt it was a strategy with which their staff was familiar.

This chapter presents data about the FTM activity that occurred in the evaluation counties, describes demonstration counties' fidelity to the ProtectOhio FTM model, and explores some initial child outcomes. Most of the chapter addresses implementation of and fidelity to the ProtectOhio FTM model. Because this is an interim report, our primary purpose is to provide feedback to counties to help them reflect on their practice, not to make a conclusive judgment about their performance. For the final report, the possibility of a more structured approach to fidelity analysis, focusing on the unique practices adapted by individual counties, will be explored.

The implementation, fidelity, and outcomes analyses presented here use both child and county-level data to make comparisons between the demonstration and comparison counties. We provide details on each analysis at the beginning of the relevant report section. As their common strategy under the Waiver, all 13 demonstration counties are participating in the strategy; however, because one county provided insufficient data, this report will only present case-level data from 12 counties.

4.1 DESCRIPTION OF THE STRATEGY

The demonstration counties defined a model of FTM that targets all children who open to ongoing services with an initial case plan goal of reunification or maintain in home. The counties agreed that the model would include the following key elements, at a minimum:

- 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 completed (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 child moves to permanent custody (PC), planned permanent living arrangement (PPLA), or legal custody to kin.

4.2 EVALUATION DESIGN AND KEY QUESTIONS

4.2.1 Logic Model and Research Questions

Three research questions guide this sub-study. First, how is FTM implemented in the demonstration and comparison counties? Second, what is the demonstration counties' level of fidelity to the ProtectOhio FTM model? Third, do children receiving ProtectOhio FTM more often experience a positive outcome than children in the comparison sites?

Demonstration county staff reviewed and refined the original logic model at the January 2006 retreat and the September 2006 FTM facilitators' meeting. The logic model guiding FTM practice and evaluation is presented in Table 4.1. The revised version shown below illustrates the demonstration counties' belief that families that receive FTM, characterized by frequent meetings that include a wide range of people, will be linked to more appropriate and timely services (for which the Waiver may help to provide funding), leading to better child outcomes.

Table 4.1: FTM Logic Model

Inputs/Background Variables

- 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.

Other Considerations

- Purposes of meetings held.
- # of FTMs that result in recommendations for changes to services, placement, or custody.

Activities

For cases with case plan goal of reunification or maintain in home:

1. Families have FTMs over the entire period of ongoing services[1], including at a minimum
   - Within 30 days of case opening to ongoing services,
   - At other critical events in the case, and
   - At least quarterly.
2. 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.
3. 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.
4. FTM process includes: agenda, introduction, information sharing, planning, and decision process.

Activities 1 & 2 will be measured at the case level. Activities 3 & 4 will be measured at the county level.

Outputs

- 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

Outcomes

1. Avoiding initial placements
   - % 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
2. Shorter time in placement
   - # of days in placement
3. Of children who are placed, more children are placed with kin
   - For sampled cases with placement, the % that are placed with kin
4. Shorter time case is open (to ongoing)
   - # of days sampled cases are open to PCSA, by case plan goal
5. More reunification
   - Of children exiting out-of-home care, # who are reunified
6. Quicker reunification, quicker permanence of any kind
   - The average time between initial placement and reunification, guardianship, adoption, or legal custody to kin
7. Increase in exits to relative custody
   - Of children who are exiting out-of-home care, # who end up in legal custody of kin
8. Less re-entry to substitute care
   - # of children exiting placement who re-enter placement within a year of case closure
9. Less maltreatment subsequent to first FTM
   - % of cases with additional indicated/substantiated CAN reports any time after the sampled case is opened to within a year of case closure

[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.

4.2.2 Data Collection Methods and Process

The evaluation uses multiple data collection methods. Table 4.2 illustrates which data collection methods are used for each of the three major analyses pursued for this report.

Table 4.2: Data Collection Methods Used in Each Analysis

	Implementation analysis	Fidelity analysis	Outcomes analysis
Logs		X	X
SIS events	X	X	X
Interviews	X	X	
Facilitator's meetings		X	
FACSIS data		X	X
Family surveys			X

Logs: Demonstration counties complete running logs of families who are transferred to the ongoing services unit, tracking which families are systematically sampled (flagging every n^{th} case) for the FTM intervention, as well as any non-sampled cases which are receiving FTM (specially selected cases).[2]

SIS events: These data items are recorded by the FTM facilitator after each meeting held. Two events are entered on the child ID and one event (which provides information on who attended the FTM) is entered on the family ID.

Interviews: Annual interview protocols are used to document evaluation county policies, practices, strengths and barriers, and fidelity to the ProtectOhio model. The evaluation team collects information from key staff in each county including administrative staff, supervisors, and facilitators. For the demonstration counties, this information is used in conjunction with the case-level practice data.

Facilitators' meetings: The study team participates in the facilitators' quarterly meetings, which provide an opportunity to hear about implementation challenges and successes.

FACSIS data: ODJFS provides the study team with administrative data for each evaluation county. It includes child-level demographic information and dates of reports, case openings and closings, and placements and placement moves.

Family surveys: Family surveys gather information about families' perceptions of the services they have received in the demonstration counties. Close to the expected end of a family's course of participation in family team meetings, the facilitator gives the family a survey form with a self-addressed stamped envelope to return the completed form to HSRI.

[2] Some counties instituted a systematic sample of their cases because of concerns that their facilitator(s) could not handle the entire eligible caseload.

In addition, the study team plans to conduct focus groups of family members and caseworkers to gather their perceptions of FTM and further explore issues revealed through interim analyses. The first set of focus groups is expected to occur in Fall 2007, and a second round may occur in 2009.

Depending on the county, the first logs were submitted and the first SIS events were recorded between October 2005 and February 2006. In general, data collection commenced the day the county began the strategy, though some counties had already been doing a version of FTM with some portion of their caseload for several months to a few years. Each county's strategy start date is noted on Table 4.10.

Study team staff provided ongoing technical assistance to counties on the proper way to complete the logs and to clarify definitions of the new SIS events. We have periodically provided preliminary findings at Consortium meetings and FTM facilitator meetings. After an initial look at the SIS event data, we conducted conference calls with each county in Fall 2006, to clarify interpretations of the data and learn about barriers counties were facing or reasons for their success.

Study team staff collected additional data through phone interviews (conducted Spring 2006), quarterly facilitators' meetings (March, June, September and December 2006), and family surveys (initiated February 2006).

4.3 IMPLEMENTATION ANALYSIS: ACTIVITIES AND FINDINGS

4.3.1 Implementation Activities

Representatives from the demonstration counties met twice in Spring 2005 to work out the details of the ProtectOhio FTM strategy. Counties then began hiring independent facilitators or reassigning current staff into the facilitator role.[3] They also developed internal policies and procedures for their FTM program.

Counties 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 more targeted than the ProtectOhio model. Eight counties sent facilitators to the training, and at least two more counties held their own training sessions.[4] No formal training was provided in mediation: Many facilitators had mediation training prior to becoming a facilitator, and some obtained it later on their own. As part of their ongoing development, facilitators have been meeting quarterly since March 2006 to discuss implementation challenges, clarify aspects of the practice model, and review evaluation data.

[3] Lorain County decided not to use independent facilitators and instead allows the case-carrying caseworker to facilitate the meeting.

[4] Since November 2005 at least four counties have hired new facilitators who have not received this formal training.

4.3.2 Implementation Analysis Methods

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 amount of FTM activity that occurred in the demonstration counties.

The analysis of the total FTM activity in the demonstration counties uses the child SIS events, adding the family-level data to each child record.[5] The analysis includes all meetings for which SIS data was provided, regardless of whether the child's family was sampled and regardless of the dates of the meetings.

4.3.3 FTM Practice in the Comparison Counties

During the time period covered in this interim report, seven of the 14 comparison counties provided services for families that were similar to the ProtectOhio FTM model in at least some respects (Table 4.3). In particular:

Table 4.3: FTM in the Comparison Counties

ProtectOhio FTM Component	Number of comparison counties following the practice
Consistent agenda that includes introduction, information sharing, planning, and decision process	5
Facilitator assists in preparing for meetings	5
Trained facilitator	5
Independent facilitator	4
First meeting within 30 days of case opening	3
Meetings are held over the course of the case	2
Target population is all cases that open to ongoing services	2
Doing none of the above	7

- Where there were FTM-like services in the comparison counties, the county practice was most often defined by use of a consistent FTM agenda, facilitator involvement in preparing for meetings, and trained facilitators. Each of these elements was used by five comparison counties.
- Only three of the comparison counties with FTM services consistently held the first meeting within 30 days of case opening, and four made sure that their facilitators had no line responsibilities for the cases.

[5] This means that data tables that count "meetings" are counting a meeting for each child that was involved or discussed. We recognize that using the child as the unit of analysis gives greater weight to meetings held for larger families. In the coming months, we will examine the magnitude of the variation in family size as part of an exploration of alternative methods for capturing family-level fidelity (see Section 4.4.1).

- Only two of the comparison counties held the minimum number of meetings (at all critical events or at least quarterly) specified in the ProtectOhio model: The other five counties with some FTM services held only one meeting over the course of the case.
- Only two comparison counties held meetings with all cases that opened to ongoing services. Other counties targeted children at-risk of removal or coming into foster care, families in crisis, or families in need of outside services.

Thus, there appears to be a considerable difference between the comparison counties' practice and the ideal ProtectOhio model.

4.3.4 Description of All FTM Activity Recorded in the Demonstration Counties

For the demonstration counties, the availability of considerable case-level data enables us to look more closely at their FTM activity than is possible in the comparison counties. For the demonstration counties, SIS data indicates that the total number of meetings exceeded 5,440. In this section of the report, we describe the nature of the meetings which were held and for which data was provided. Children and their FTMs are included in this section regardless of whether or not they were sampled and regardless of when their case opened to ongoing services.[6] Additional tables, found in Appendix C, provide individual county data and in some cases break out results by first, second, and third FTMs.

Table 4.4 provides an overview of the total number of meetings held for each child in non-metro counties and Franklin County.[7] In non-metro counties, 53% of children who had FTM had only one meeting. Thirty-seven percent of children in non-metro counties had two or three meetings, and 10% had four or more meetings. In Franklin County, 40% of children who had FTM had one meeting, 57% had two or three meetings, and three percent had four meetings.

Table 4.4: Number of Meetings Held per Child (Child's Case May Still Be Open)

County	One Meeting	Two Meetings	Three Meetings	Four Meetings	Five to Nine Meetings	Total Children
Non-metros	950 (53%)	444 (25%)	216 (12%)	112 (6%)	74 (4%)	1796 (100%)
Franklin	453 (40%)	411 (36%)	238 (21%)	35 (3%)	0 (0%)	1137 (100%)

[6] As we describe in subsequent sections of the chapter, only a subset of all the children who received FTM (presented in Tables 4.4 through 4.9) are used in the fidelity and outcomes analyses.

[7] Tables throughout this chapter present data for Franklin County, a major metro county, separately from the remaining 11 counties which range in size from rural to minor metro. We present Franklin County's data separately because their numbers are so large that their results would otherwise over-power the total results.

Subsequent tables, Table 4.5–4.9, present data at the meeting level.[8] Table 4.5 examines the number of people (not counting the independent facilitator) who attended each FTM. For all practical purposes, an FTM should include at least three people—a caseworker, a parent, and another person; otherwise, it would be hard to distinguish FTM from an ordinary worker-parent meeting. In non-metro counties, 71% of FTMs had between three and six attendees. In Franklin County, 50% of FTMs had between three and six attendees; this percentage is smaller largely because Franklin County had a substantial percentage (46%) of FTMs attended by only one or two people.

Table 4.5: Number of Attendees at FTMs (Excluding Facilitators)

County	One	Two	Three	Four	Five	Six	Seven or More	Total Meetings
Non-Metros	42 (1%)	236 (7%)	512 (16%)	679 (21%)	601 (18%)	512 (16%)	675 (8%)	3257 (100%)
Franklin	333 (16%)	635 (30%)	436 (21%)	329 (16%)	221 (11%)	73 (3%)	74 (2%)	2101 (100%)

Adding more detail to the numbers above, Table 4.6 shows who attended FTMs. Non-metro counties had at least one parent at 83% of FTMs, at least one staff at 97% of FTMs, and at least one relative at 29% of FTMs. In Franklin County, by contrast, many fewer FTMs included a parent (44%), and 11% had a relative in attendance.

Table 4.6: Who Attended FTMs

County	Total # of Meetings	FTM Included Parent(s)	FTM Included Staff	FTM Included Relative(s)
Non-Metros	3257 (100%)	2690 (83%)	3163 (97%)	949 (29%)
Franklin	2101 (100%)	934 (44%)	2098 (>99%)	229 (11%)

The custody and living arrangements of children at the time of their FTM are displayed in Table 4.7. At the time of their FTM, most children were living with their parents. The second most common arrangement was substitute care: Children were in PCSA custody and living in substitute care for 15% of the FTMs in non-metro counties and 22% of the FTMs in Franklin County.

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

[8] This means that if a child had more than one meeting, they are represented more than once in the data. The total number of meetings presented in the tables in this section is really the total number of meetings for which data were provided. Due to missing data for certain data questions, the total number of meetings may vary across tables.

Table 4.7: Custody and Living Arrangements of Children at Time of FTM							
County	**Custody of Parents, Live w/ Parents**	**Custody of Kin, Live w/ Kin**	**Custody of Parents, Live w/Kin**	**PCSA Custody, Live w/Kin**	**PCSA Custody, in Foster Care**	**All other***	**Total # FTMs**
Non-metros	1674 (51%)	319 (10%)	377 (12%)	246 (8%)	489 (15%)	161 (5%)	3266 (100%)
Franklin	1253 (59%)	141 (7%)	26 (1%)	173 (8%)	463 (22%)	65 (3%)	2121 (100%)

Table 4.8 displays the purpose of FTMs, revealing considerable variation across the meetings. The majority of Franklin County FTMs are held for the purpose of an initial planning meeting (42%) or a quarterly review (58%). Initial planning meeting (31%) was the most common purpose of non-metro county FTMs, followed by quarterly review (28%). Nearly a quarter of non-metro county meetings were held at the request of an agency (21%), but this situation did not occur in Franklin County. Meetings held due to a "critical event"—defined here as having a purpose of crisis–possible placement, placement change, or reunification—make up 15% of FTMs in the non-metro counties and 1% of FTMs in Franklin County.

Table 4.8: Purpose of FTMs Held								
County	**Crisis-Possible Placement**	**Initial Planning Meeting**	**Agency Requests Meeting**	**Quarterly Review**	**Placement Change**	**Family Requests Meeting**	**Other**	**Total Meetings**
Non-Metros	363 (11%)	1034 (31%)	700 (21%)	917 (28%)	103 (3%)	56 (2%)	145 (4%)	3318 (100%)
Franklin	13 (1%)	878 (41%)	0 (0%)	1232 (58%)	0 (0%)	0 (0%)	0 (0%)	2123 (100%)

* Reunification, PPLA/TPR, Guardianship/ Legal Custody, or Other

One might expect that FTMs would frequently result in recommendations for changes in services or placement. As illustrated in Table 4.9, the majority of meetings in both non-metro (62%) and Franklin Counties (94%) resulted in no recommendation for a change in services, custody, or placement. For those meetings that did result in a change, we hope to further examine whether the recommended change occurred. For meetings that did not result in a recommendation for a change, some questions worthy of further exploration are raised: Are other things being accomplished in FTMs that are not being documented by this question? Does the high number of FTMs that result in no change contribute to or reflect the low levels of staff buy-in to the FTM model experienced in some counties?

Table 4.9: Service and Custody/Placement Recommendations[9]				
County	**Recommendation for no change**	**Recommendation for change in service**	**Recommendation for change in custody/placement**	**Total # of meetings**
Non-Metros	2007	854	686	3241
Franklin	1999	41	93	2122

4.4 FIDELITY ASSESSMENT

The preceding tables and discussion paint a fairly detailed portrait of FTM activity in the demonstration sites. Within that larger context, this section examines how well the demonstration counties adhered to the ProtectOhio FTM model. This fidelity analysis uses only a subset of the cases described above which received FTM.

4.4.1 Analysis Methods and Challenges

FTM is a family intervention and clients are selected to participate in FTM at the family level. However, at this time, we have chosen to analyze fidelity and outcomes at the child level rather than the family level. SIS information comes to us at both the child and the family level. Critical FACSIS information, such as date of opening to ongoing services and case closure, is recorded as child-level data. Converting data elements for multiple children into a single family measure is complex. Doing any analysis at the family level raises many questions, such as how to characterize a "family change" if it occurs for only one of several children, or how much effect to expect from a meeting that is focused on a single child compared to one that addresses the needs of several children. At this time, the study will focus on child-level process and outcome measures.

To determine which children would be included in the fidelity and outcome analyses, the study team took the child SIS events that were completed after each FTM and matched each child record to the FACSIS file which provided a date of opening to ongoing services and other administrative data. Children who were in both files are counted as receiving FTM and included in the fidelity and outcomes analysis; these children constitute a subset of those used in the implementation discussion above.[10] For counties that used a sampling ratio at any point during the study period, we added an additional restriction, only including children who were associated with a family that was sampled according to the log.[11]

[9] A meeting could have resulted in a recommendation for a change in service(s) and a change in placement or custody: If so, it is counted twice in this table.

[10] Some children were in the FTM data file but not in the FACSIS file. This likely occurred because the case opening date was outside of our study period, an issue that will largely work itself out as more time passes. The study team will continue to monitor the magnitude and causes of this data loss.

[11] We understand that this results in counties that sampled a portion of their caseload being treated differently than counties that served the whole population. In counties that served the whole population, we use the broader criteria in order to include as many children as possible in the study; even if these children do not appear on the log, we know they would have been eligible for FTM. In counties that sampled a portion, children may receive an FTM but

4.4.2 Sampled Population

Table 4.10 presents the number of children associated with sampled families who received FTM, as a proportion of the entire caseload that was newly transferred to ongoing services.[12] That is, for each county it shows the number of children that received FTM as a proportion of all children that opened to ongoing services between the county's start date and September 18, 2006, adjusted according to the county's sampling rate. For counties that changed their sampling rate since implementation, we have separately computed an "expected" number of cases for each period covered by a different sampling ratio. The second column from the right shows the group of children used for the fidelity analysis; the right-hand column indicates how close the county came to providing FTM to the number of cases it should have served.

In choosing to use the group of children who received FTM as the population for the fidelity analysis, the study team recognizes that we may be introducing a bias into this aspect of the evaluation. Theoretically, the entire target population should be examined – including those who were supposed to receive FTM but did not. For this interim report, we have deliberately chosen *not* to use this larger, intent-to-treat population. Two factors strongly influenced this decision. First, the mismatch between the cases expected to receive FTM and those which actually received it appears to be larger than it really is. Among other things, data lags in the FACSIS file mean cases with recent SIS data are excluded inappropriately. Until we can be more certain that both files have complete information, it is premature to use the intent-to-treat population as the base for the analysis. Second, it can be argued that the FTM process in the demonstration counties has only fairly recently matured to the point where practice has settled into a routine. PCSAs are now able to focus on their overall use of the model and on outcomes, and can begin to address internal variations in implementation and, perhaps, commitment to the intervention. By using this report to highlight for each county its own performance vis a vis the model, the PCSA can choose to take steps to improve its "hit" rate in terms of serving the entire intended population. Thus, studying the "intent-to-treat" population later on in the evaluation period will yield much more valid and complete findings.

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that family may not have been put on the log and subjected to the sampling assignment, so their data is excluded from the fidelity and outcomes analysis.

[12] Our child-level approach means that we do not present any measure of how well the family sampling worked. We know there are cases that the FACSIS file suggests should have been on the log but weren't. We know there are a variety of reasons for the mismatch but we cannot yet say how many families were "missed" by the counties' logging process. The evaluation team has no evidence of widespread bias in the logging and sampling process, but it is an issue we hope to explore in the coming months.

Table 4.10: Number of Sampled Children who Received FTM						
County	**Start Date/ Strategy Period**	**# children transferred to ongoing during period**	**Sampling Rate[13]**	**# of cases expected to receive FTM[14]**	**Actual # of cases receiving FTM[15]**	**Cases receiving FTM as % of Expected**
Ashtabula	11/4/05-2/20/06	58	50%	29	11	
	2/21/06-9/18/06	127	100%	127	55	
	Total	185		156	66	42%
Belmont	12/27/05-9/18/06	95	100%	95	80	84%
Clark	10/4/05-9/18/06	339	25%	85	62	73%
Crawford	2/1/06-9/18/06	100	100%	100	61	61%
Fairfield	1/1/20-5/31/06	59	25%	15	9	
	6/1/06-9/18/06	87	100%	87	60	
	Total	146		102	69	68%
Franklin	1/1/06-9/18/06	4104	25%[16]	1026	1018	99%
Greene	12/1/05-5/31/06	108	50%	54	39	
	6/1/06-9/18/06	95	100%	95	58	
	Total	203		149	97	65%
Medina	11/10/05-2/28/06	26	33%	9	3	
	3/1/06-5/11/06	21	50%	11	7	
	5/12/06-9/18/06	23	100%	23	10	
	Total	70		43	20	47%
Muskingum	10/4/05-9/18/06	288	100%	288	237	82%
Portage	12/20/05-9/18/06	116	100%	116	96	83%
Richland	1/1/06-9/3/06	466	25%	117	107	
	9/4/06-9/18/06	55	50%	28	16	85%
	Total	521		145	123	
Stark	11/1/05-9/18/06	636	50%	318	236	74%
Total		6803		2621	2165	83%

[13] Sampling rates changed over time. As counties began to feel more confident in their ability to meet the demand for FTM, they increased their sampling rates.

[14] Calculated by applying sampling ratio to the number of FACSIS cases which transferred to ongoing services by 9/18/2006.

[15] The counts for Portage and Clark counties may be somewhat lower because the SIS event data provided by those counties only ran through September 2006, whereas other counties provided data into October 2006.

[16] 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%.

If counties were doing well in providing FTM to all the children it was intended for, we would expect the percent of children who had an FTM to be close to the sampling percentage. This expectation appears to be met in only a few of the counties. Clearly, in certain circumstances it is understandable that an FTM was not held. Counties reported the following reasons why a family may not get FTM:

- The case may close before FTM can be held.
- A different organization or purchased services provider (residential center, Family and Children First Council) may be holding family meetings with a similar purpose.
- The court may order the agency to pursue permanent custody.
- There may be a criminal investigation in a case which makes any open discussion problematic for the investigation. In these cases, the child's case plan goal may have initially been reunification or maintain in home but likely quickly changed to something else.
- The family may refuse or not show up. In general, most counties will continue to pursue a family to encourage them to participate in FTM, but, in Stark County, the agency stops holding FTMs if the parent fails to show up at the first two attempts to hold a meeting.

These reasons may not completely explain why so many fewer children are receiving FTM than the sampling ratio would lead us to expect. This issue is further explored below in Section 4.4.3, and will be a subject of ongoing study for the evaluation team.

4.4.3 Fidelity Assessment Findings

This section of the report explores how well implementation in the demonstration counties follows the ProtectOhio model and the factors that appear to facilitate or hinder implementing ProtectOhio FTM. To what extent is the ProtectOhio FTM model feasible to implement across the full population of cases transferring to ongoing services? We first present data on selected model components, then describe the overall fidelity in each county.

4.4.3.1 Initial FTM Within 30 Days of Opening to Ongoing Services

Component 1: *Initial FTM within 30 days of opening*

As shown in Table 4.11, of children associated with sampled families who had FTM, 80% of children in non-metro counties and 71% of children in Franklin County had their first meeting within 35 days[17] of the case opening to ongoing services. Among the counties, the rate varies from 20% to 100%.

[17] We use 35 days rather than 30 to accommodate differing understandings of calendar days versus working days; this adjustment makes the counties look marginally more in compliance with the measure.

Table 4.11: Children That Have Their Initial FTM Within 35 Days of Opening to Ongoing Services, by County		
County	**# children who had an FTM[18]**	**# children who had an FTM within 35 days of case opening[19]**
Ashtabula	66	56 (85%)
Belmont	80	73 (91%)
Clark	62	44 (71%)
Crawford	61	12 (20%)
Fairfield	69	69 (100%)
Greene	97	69 (71%)
Medina	20	14 (70%)
Muskingum	237	207 (87%)
Portage	96	79 (82%)
Richland	123	107 (87%)
Stark	236	184 (78%)
Total non-metro	1147	914 (80%)
Franklin	1018	722 (71%)

Given the variation in Table 4.11, it is important to examine the factors that appear to promote the timeliness of initial meetings:

- While the ProtectOhio model calls for the initial FTM to be held within 30 days of opening to ongoing, several counties have policies or practices assuring the initial FTM is held earlier. In Greene County, the initial FTM may be held while the case is still in the assessment unit if the worker sees it as appropriate in order to resolve issues quickly. Other counties, such as Portage and Fairfield, have policies or practices by which they hold the initial FTM within one week or two weeks, respectively. If there is an emergency removal, Ashtabula and Richland counties try to have the FTM immediately before or after the court hearing.
- Agencies have processes for immediately notifying the facilitator when a case is about to open to ongoing services. In Portage County, the supervisor does a write-up of the case and sends it to the facilitator and ongoing supervisor. Similarly in Stark County, the supervisor contacts a designated person in the facilitators' unit to find out which facilitator is assigned to the case and their schedule. In Richland County, the facilitator attempts to attend all transfer meetings so that she hears the intake worker's perspective on the case and knows which ongoing worker has been assigned. In

[18] That is, children who are associated with sampled families. The child had to have a case opening on or before 9/18/06. County start dates varied.
[19] A meeting could have occurred 35 days before or after the case opening.

Belmont County, the facilitator makes an effort to informally meet with workers and supervisors to keep abreast of case events.

- Agencies have procedures for quickly scheduling the meetings. In Belmont, Fairfield, and Medina counties, facilitators meet with intake and ongoing workers, and possibly other staff, to schedule the meeting and plan who the agency will invite to attend. In Portage County, the facilitator has privileges to view staff's online calendars so she can automatically schedule a meeting without trying to contact workers and find out their availability. A similar process is used in Franklin County, where the unit supervisor uses a central scheduling book to assign a meeting slot to a family.
- Agencies have found it important to develop methods for streamlining the workload for caseworkers and supervisors. Fairfield County uses FTM to expedite the transfer and case plan development process, which makes caseworkers more supportive of FTM. In Portage County, the staffing meeting is taken care of at the FTM rather than held separately, meeting the assessment supervisors' needs for a timely staffing and garnering their support. Portage County also allows workers to complete risk assessments in the FTM.

Despite following such practices outlined above, many counties still struggle to hold meetings within the first month. Among the problems that arise:

- The facilitator is not notified immediately of the transfer. Sometimes cases "slip though the cracks." In other selected instances staff may deliberately fail to notify the facilitator that a case needs FTM: Two counties reported incidents where selected workers went so far as to keep a case in the intake unit in order to prevent it from being sampled for FTM. At this stage, there is no way to judge the magnitude of this practice; the study team may be able to explore it in the future.
- Staff have already written the case plan, a task usually completed at the first FTM. Although the "30 day" model component was designed to fit within case planning timelines, in some cases a court date or other circumstances will compel staff to write the case plan before FTM. After the case plan has been written, staff may resist holding a meeting so soon and families may feel there is no purpose in meeting.
- Family members do not show up to the meeting. In some counties, the meeting is cancelled and rescheduled if the family does not attend, and it may not be rescheduled right away.

4.4.3.2 Subsequent Meetings at Critical Events in the Case

Holding FTMs when critical events are about to occur provides another opportunity to engage the family at a crucial point in the case. The demonstration counties defined critical events as including:

- Placement
- Removal

Component 2: *FTMs held at critical events*

- Disruption in placement
- Placement move
- Reunification
- Status changes in the family such as a death
- Difficult cases or cases where the agency is having trouble communicating
- Anything from the caseworker's perspective that would be considered critical, crisis, or emergent

The study team has explored several methods for determining, at a child-level, whether FTMs are being held at critical events. However, we do not feel we currently have a satisfactory way to make judgments about fidelity for this interim report. Critical events that occur are recorded in FACSIS, but it is difficult to interpret whether an FTM was held due to a critical event, or whether the critical event (e.g. a placement move, perhaps a step-down in care) occurred because of planning that occurred at the FTM. In addition, if a critical event was avoided because a "critical-event FTM" occurred, we would see no evidence of the avoided event. We plan to work with the demonstration counties to further explore possible analyses of the critical event data.

One possible source of information about meetings related to critical events is the SIS element "purpose of FTM." However, to date, most meetings are recorded as having a purpose of "initial planning meeting" or "quarterly meeting." 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 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.
- Scheduling meetings and pulling people together for them is challenging, according to at least a few counties. Trying to schedule meetings while something urgent is going on in a case is even more difficult.
- In Franklin County, a separate department facilitates meetings when a child goes to placement or disrupts from placement, but no FTM data is recorded from those meetings.

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

- In Belmont 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 Stark 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.

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. Belmont and Richland deliberately schedule subsequent meetings immediately before or after court hearings and believe that this arrangement ensures everyone is on the same page.

4.4.3.3 Subsequent Meetings At Least Quarterly

Component 3: *FTMs held at least quarterly*

If a meeting is not held for some other reason (i.e. a critical event), the ProtectOhio model calls for meetings to be held at least quarterly. Table 4.12 shows the number of children who had their second meeting within a quarter (100 days).[20] Of children who were eligible for a second FTM (i.e., their case was open long enough that we would expect to see another FTM in the data), 69% of children in non-metro counties and 94% of children in Franklin County had their second FTM within 100 days of the previous FTM. Among counties, the rate ranged from 12% to 98%.

Table 4.12: Children Whose Second FTM Was Within 100 Days of the First FTM, by County

County	Start Date	# children who should have had a second FTM	# children who had a second FTM within 100 days of the first FTM
Ashtabula	11/4/05	34	4 (12%)
Belmont	12/27/05	64	61 (95%)
Clark	10/4/05	40	39 (98%)
Crawford	2/1/06	14	2 (14%)
Fairfield	1/1/06	46	45 (98%)
Greene	12/1/05	64	45 (70%)
Medina	11/10/05	8	2 (25%)
Muskingum	10/4/05	169	97 (57%)
Portage	12/20/05	80	51 (64%)
Richland	1/1/06	54	37 (69%)
Stark	11/1/05	173	133 (77%)
Total non-metro		746	516 (69%)
Franklin	1/1/06	683	642 (94%)

Table 4.13 shows the much smaller number of children who were eligible for a third FTM, and the number who received one within 100 days.[21] Of children who were eligible for a third FTM, 76% of children in non-metro counties and 82% of children in Franklin County had their third FTM within 100 days of the previous FTM. Individual county calculations can be found in Appendix C.

[20] 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, we chose to use 100 days as the measure.

[21] Second and third meetings account for 88% of subsequent FTMs.

Table 4.13: Children Whose Third FTM Was Within 100 days of the Second FTM		
County	**# children who should have had a third FTM**	**# children who had a third FTM within 100 days of the second FTM**
Non-Metros	336	256 (76%)
Franklin	270	222 (82%)

County interviews indicated that policies and procedures for scheduling subsequent meetings appear to be less formalized than those for scheduling initial meetings. In several counties, supervisors are involved in scheduling initial meetings, but scheduling subsequent meetings appears to be largely left to the ongoing worker. In an effort to ensure that meetings are held quarterly, at least three counties have started scheduling the next quarterly meeting 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. Franklin County has set up an automated spreadsheet that tracks when each case becomes due for a quarterly meeting.

Demonstration counties report that they have struggled with the purpose for subsequent FTMs. To give these meetings purpose and reduce duplication, at least seven counties report that they combine the FTM with the Semi-Annual Review in at least some cases. Counties have frequently discussed among themselves at Consortium meetings and facilitator's meetings possible methods for combining these two meetings while retaining a family-friendly focus. Additionally, the facilitator at Fairfield County helps meeting participants set goals for what to talk about at the next FTM.

4.4.3.4 Meeting Participants

Component 4: *Range of FTM participants*

In reviewing the logic model, agency staff emphasized the importance of having the right mix of people attending an FTM. Table 4.14 shows the number of meetings that included different types of people. PCSA staff (caseworkers, supervisors and non case-related employees) were the most common participants, attending approximately 99% of all meetings. Parents were also commonly present, although there was quite a range by county (see Appendix C). A mother or father attended 83% of the non-metro counties' meetings and 44% of Franklin County's meetings. Among counties, the rate ranged from 44% to 90%. The noticeably lower rate of parent attendance in certain counties is a subject the evaluation team hopes to examine further: How do the counties vary in their philosophies of who needs to attend an FTM? What underlies the apparent higher level of tolerance in some counties for proceeding with FTMs when the only attendees are one or two staff?

Table 4.14: Who Attended Meetings

# of Meetings that Included:	Total non-metro	Franklin
Parents	1843 (83%)	849 (44%)
Staff	2190 (99%)	1949 (>99%)
Child Voice	659 (30%)	362 (19%)
Relatives	588 (27%)	205 (11%)
Providers	518 (23%)	228 (12%)
Parent Supports	259 (12%)	10 (1%)
Primary Caregivers	406 (18%)	144 (7%)
Total Number of FTMs	**2221**	**1952**

Smaller but notable proportions of the meetings included other key people. Having a child voice at the meeting (defined to include the children being reviewed, siblings, GAL/CASAs, or child attorneys) occurred in 30% of the non-metro counties' meetings and 19% of Franklin County's meetings. Slightly less often, a relative attended 27% of the non-metro counties' meetings and 11% of Franklin County's meetings. A provider (mental health, alcohol and drug, or intellectual and developmental disability providers; probation officers; health providers;

TANF or child support workers; sports coaches, school counselors, or education providers; or other purchased services providers) was present at 23% of non-metro counties' meetings and 12% of Franklin County's meetings. Overall, parent supports (parent attorneys or legal representatives, parent advocates or mentors, or clergy) and non-parent primary caregivers were the groups least likely to be present at FTMs.

The ProtectOhio model does not specify what participant grouping is the minimum standard for a meeting, merely stating that meeting participants may include the birth parents, primary caregivers and other family members, foster parents (if applicable), support people, and professionals. Table 4.15 shows the number of meetings that were attended by what might be considered an absolute minimum number of people: at least one parent or primary caregiver, at least one caseworker or other agency staff, and at least one other type of person, not including the facilitator. Of the meetings held, 69% of meetings in the non-metro counties included this minimum participant grouping, and 28% of meetings in Franklin County did so. Among counties the rate varied from 19% to 91%. It could be argued that meetings falling short of this minimum combination of attendees should not be counted as legitimate FTMs. If this argument is followed, the total number of meetings would be reduced to the figures presented in the final column of the table: 1,536 meetings in non-metro counties and 553 meetings in Franklin County. The evaluation team will explore this issue for the final report.

Table 4.15: Meetings That Included At Least One Parent or Primary Caregiver, One PCSA Staff, and One Other Type of Person

County	# meetings	# meetings that included at least one parent or primary caregiver, one staff, and one other type of person
Ashtabula	73	35 (48%)
Belmont	218	171 (78%)
Clark	139	77 (55%)
Crawford	70	13 (19%)
Fairfield	165	110 (67%)
Greene	217	112 (52%)
Medina	22	20 (91%)
Muskingum	409	334 (82%)
Portage	213	141 (66%)
Richland	197	168 (85%)
Stark	498	355 (71%)
Total non-metro	2221	1536 (69%)
Franklin	1952	553 (28%)

Counties have hypothesized that meeting attendance may vary as time progresses within a case. In Appendix C, the study team has taken an early look at this issue as part of the implementation analysis, using data for all children for which we have received data. Staff attendance at meetings stayed fairly constant across first, second, and third meetings. However, parent and relative attendance rates for second and third meetings fell short of attendance rates at initial meetings in both non-metro counties and Franklin County.

Further exploring the variance in parent attendance, Table 4.16 shows the different policies counties follow on whether to hold a meeting if the family is not present or does not show up at the last minute.[22] Managers from counties that proceed with the meeting maintain that, even if the parent does not come, there is value in bringing together everyone else involved in the case. However, caseworkers and supervisors seem to struggle with this idea. The county interviews revealed that eight counties feel that one of the barriers to implementing FTM is the lack of staff support. When this finding was shared at a facilitators' meeting, facilitators expressed the opinion that staff's lack of buy-in was largely due to not understanding the purpose of holding an FTM without the family.[23]

Table 4.16: County Policies on Whether to Hold a FTM if the Family Is Not Present or Does Not Show Up

Policy	Number of counties (n=13)
Do not hold the meeting	4
Usually proceed but cancel the meeting under certain circumstances	3
Proceed with the meeting	6

Counties described the particular measures they take to include parents in FTM. Some of their practices include:

- Holding meetings in homes or other agencies that are more convenient or comfortable for the family. (All counties state a willingness to do this, but it occurs to different degrees.)
- Providing child care (7 counties) and transportation (9 counties).
- Holding meetings before or after the scheduled parent-child visitation.
- If they are having trouble locating the parent, contacting family members and asking them to invite the parent.

[22] This results in different standards for recording meetings, that is, whether a meeting is "counted."

[23] This issue will be explored further in future interviews and focus groups.

- Postponing a meeting while a relative goes to get the parent, in cases where the parent is nearby.
- If the parent is out of the city or otherwise cannot attend, including them via conference call.
- If the parent is in jail, asking jail to bring the parent to the meeting.

Counties have also described the steps taken to bring in participants other than parents or staff. Facilitators have pointed to the necessity of informing parents that they can bring support people. They have found it important to spend time on the phone with professionals explaining that the agency wants their input. Fairfield County has gone so far as to provide training to stakeholder groups including mental health providers, education providers, and defense attorneys.

4.4.3.5 Facilitators Are Independent, Trained, and Assist in Preparing for the Meeting

Component 5: *Independent, trained facilitators assist with FTM preparation*

The level of participant attendance raises the question of what child welfare agencies can do to persuade and support parents and others to participate in FTM. In addition to the other barriers they may face, families may find the prospect of attending an FTM intimidating. Providers or other professionals may not understand the purpose of FTM and their role. How meetings are arranged and how well participants are prepared for FTM may make a difference in their eagerness and ability to attend. The ProtectOhio model states that the facilitator responsibilities will 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. In fact, caseworkers play a large part in arranging the meetings and inviting participants in most counties, as Table 4.17 shows. It seems natural that caseworkers would play a large part in preparing for FTMs. However, it is of concern that only a few counties have mentioned that they have provided training to their workers on the FTM process. Without an opportunity to figure out how to incorporate this new model into their practice, caseworkers may find it difficult to give the right messages to participants about FTM and to use FTMs to their full potential.

Table 4.17: Staff Roles in Arranging FTMs and Inviting Participants	
Role[24]	**Number and names of counties (n=13)**
Caseworkers lead meeting planning and participant recruitment	5 (Ashtabula, Clark, Greene, Lorain, Stark)
Caseworker and facilitator share responsibility, but caseworker does more	4 (Belmont, Franklin, Muskingum, Richland)
Caseworker and facilitator share responsibility, but facilitator does more	2 (Crawford, Portage)
Facilitators lead meeting planning and participant recruitment	2 (Fairfield, Medina)

4.4.3.6 County Level Fidelity

The above discussion presented data on the five key components of fidelity. We here synthesize those data at a county level, making a rough judgment about the degree to which individual counties are following the ProtectOhio FTM model. Table 4.18 shows the "thresholds" that were established for each component part, based on current practice and reasonable expectations of what "best" practice would look like. The thresholds set a high standard that will be used throughout the evaluation to assess change over time for each demonstration county.

[24] Clerical staff provide additional support in arranging FTMs and inviting families in Clark and Franklin counties.

Table 4.18: Fidelity Assessment Measures	
Component	**Threshold**
Initial FTM within 35 days	At least 90% of children who had FTM had their initial FTM within 35 days of transfer to ongoing services. Refer to Table 4.11 for individual county performance.[25]
Second FTM within 100 days	At least 90% of children who had FTM had their second FTM within 100 days of the previous FTM. In the final evaluation report, this component will include additional subsequent meetings beyond the second FTM. Refer to Table 4.12 for individual county performance.
Range of attendees at meetings	At least 75% of meetings included the minimum participant grouping: at least one parent or primary caregiver, at least one staff person, and at least one other type of person. Refer to Table 4.15 for individual county performance.
Meetings at critical events	This component will be included in the fidelity assessment in the final evaluation report; we are unable to make a determination at this time.
Facilitators are trained, independent, and help organize meetings	Based on interviews and discussions with the counties, the county must have used a facilitator who has received external training for the entire period from the county's implementation start date through April 2007 (new facilitators must have been trained before facilitating meetings), and that facilitator must play at least some role in helping to organize meetings. Refer to Table 4.17 for information on counties where the facilitator helps organize meetings.

Table 4.19 profiles each county's performance against the component thresholds, for the snapshot in time under study. All of the demonstration counties have implemented FTM, but their level of fidelity to the ProtectOhio model has been fairly weak. One county met the threshold for all four components, one county met three of the four components, and six counties met one or two of the four components. Over the coming months, the study team will focus on identifying specific causes of the overall poor level of fidelity. Does the model not fit the counties' needs? Is it unrealistic to serve the entire population of cases transferring to ongoing services? Or is it a useful model, but being poorly implemented, perhaps because staff lack education in the model, are not convinced of the model's efficacy, or other system barriers exist?

It is interesting to note that counties that met the timing components of holding the initial meeting within 35 days and the second meeting within another 100 days tended to not do very well on the range of attendees component; counties that met the range of attendees component tended to score lower on the meeting timing components. This raises some questions: Does the effort involved in convening the right people for the meeting make it more difficult to hold meetings within the specified time frames? Which components are more important for children's outcomes?

[25] The date of Event 172, Initial Case Type Assignment, was used to calculate Initial FTM within 35 days, rather than Event 040, Client Worker Assignment, which may occur as much as 30 days later. This may have adversely impacted the county fidelity scores on this measure.

Table 4.19: Fidelity to the ProtectOhio Model—Selected Components				
County	**Initial meetings within 35 days**	**Second meetings within 100 days**	**Range of attendees at meetings**	**Facilitators are independent, trained, and help organize the meetings**
Ashtabula	Not met	Not met	Not met	Not met
Belmont	Met	Met	Met	Met
Clark	Not met	Met	Not met	Not met
Crawford	Not met	Not met	Not met	Not met
Fairfield	Met	Met	Not met	Met
Franklin	Not met	Met	Not met	Met
Greene	Not met	Not met	Not met	Not met
Medina	Not met	Not met	Met	Met
Muskingum	Not met	Not met	Met	Not met
Portage	Not met	Not met	Not met	Met
Richland	Not met	Not met	Met	Met
Stark	Not met	Not met	Not met	Not met

In the coming months, the study team will explore methods creating a single county fidelity score and/or for assigning fidelity scores to individual children. We then hope to compare outcomes based on these fidelity scores.

4.5 OUTCOME EVALUATION: ACTIVITIES AND FINDINGS

4.5.1 Parent Perceptions: Family Survey

4.5.1.1 Analysis Methods and Challenges

Survey forms with self-addressed stamped envelopes were distributed to families at the expected end of the course of their participation in family team meetings. After several months with a small return rate, facilitators reported that it was difficult to know whether or not a family's meeting would be its last one. Facilitators also reported that family members were less inclined to complete a survey after their last meeting. In December 2006, demonstration counties decided to distribute the family survey at each quarterly meeting in an effort to improve the return rate. However, as of March 2007, the response rate is not significant enough to justify any analysis beyond what is provided here and so the evaluation team recommends discontinuing the family survey. This analysis includes survey responses through March 22, 2007.

Table 4.20 shows that 425 surveys were received. Nearly two-thirds of the surveys came from Portage, Belmont, and Stark counties. Birth mothers comprised 49% of survey respondents, 20% of respondents were birth fathers, 10% were non-parent primary caregivers, and 17% identified themselves as other.

Table 4.20: Number of Surveys Received, by County (as of March 22, 2007)	
County	**Number of surveys received**
Ashtabula	19
Belmont	88
Clark	12
Crawford	6
Fairfield	35
Franklin	20
Greene	23
Lorain	9
Medina	6
Muskingum	0
Portage	117
Richland	15
Stark	67
Unknown	8
Total	425

Tables 4.21, 4.22, and 4.23 show the responses to the survey questions. The responses were very positive. For all of the questions in Table 4.21, at least 88% of respondents said "always" or "usually." Participants responded most favorably to the question, "Were you able to talk and were you able to ask questions at the Family Team Meetings?", with 95% saying this was always or usually the case. While still very positive, respondents were somewhat less enthusiastic when asked, "After attending Family Team Meetings, do you feel more prepared to keep your children and family safe and stable in the future?"—81% reported being more or much more prepared.

Table 4.21: Family Survey Responses (n=425)[26]					
Survey Question	**Always**	**Usually**	**Sometimes**	**Seldom**	**Never**
Did the Family Team Meetings occur at convenient times?	57%	34%	8%	1%	1%
Did the Family Team Meetings occur in convenient places?	74%	20%	4%	1%	1%
Did the meetings include the people that you wanted or needed to have there?	65%	23%	8%	2%	1%
Were you asked to talk and were you able to ask questions at the Family Team Meetings?	83%	12%	4%	1%	1%
Did the meetings help to address the safety concerns for the children?	77%	17%	4%	1%	1%
Did the meetings help you to better understand your family's strengths and challenges?	64%	24%	9%	2%	1%

Table 4.22: Family Survey Responses--Keeping Children Safe in the Future (n=425)					
Survey Question	**Much more prepared**	**More prepared**	**About the same**	**Less prepared**	**Much less prepared**
After attending Family Team Meetings, do you feel more prepared to keep your children and family safe and stable in the future?	49%	32%	13%	1%	1%

Table 4.23: Family Survey Responses--Overall Rating (n=425)					
Survey Question	**Very positive**	**Positive**	**Neutral**	**Negative**	**Very negative**
Overall, how would you describe your experience with Family Team Meetings?	51%	34%	11%	1%	2%

[26] Totals for Tables 4.21, 4.22, and 4.23 may not equal 100% due to rounding or missing responses.

In examining respondents' views on what is "best" about FTM, several themes emerge:

- Helpful and supportive environment
- Open discussion of strengths and concerns
- Interaction with everyone at once
- Feeling heard; being able to provide input
- Issues are addressed

Some typical responses were:

- "Addressed many areas of need. Respected my choices."
- "Open forum; team effort to come up with a solution to current concerns…"
- "Being able to express my concerns and actually being listened to."
- "The relaxed environment; it was easy to talk and get answers."
- "How they helped me."

Positive responses far outnumbered negative responses, but when asked what they liked *least* about FTM, respondents generally noted:

- Intense emotions
- Inconvenience
- Certain people attended/not everyone attended
- Issues not addressed

Some typical responses were:

- "Feeling so helpless when it comes to my family."
- "I missed a lot of work to attend."
- "Being cut off when trying to talk."
- "We go over the same stuff and really never hear anything new."

4.5.2 Child-level FACSIS Outcomes

4.5.2.1 Analysis Methods and Challenges

The primary outcome evaluation compares FTM children (who had the benefit of the Waiver and ProtectOhio FTM) to all children in ongoing services in the comparison counties (which did not have the Waiver and would be eligible for FTM but in general did not receive it).[27] Children in demonstration non-metro counties who received FTM are compared to children in comparison

[27] The goal is to examine the outcomes of children who actually receive ProtectOhio FTM, as we do not anticipate there to be much benefit to merely having a case open in a county where FTM is available.

non-metro counties; children in Franklin County (the only demonstration metro county) who received FTM are compared to children in the comparison metro counties. A secondary evaluative piece involves comparisons focused on outcomes for cases that have closed.

The population analyzed is the same as that used in the fidelity analysis, described in Section 4.4.1. At this point, the study considers a demonstration child to have received FTM if any meeting occurred, regardless of its fidelity to the ProtectOhio model. While the overall level of fidelity to ProtectOhio FTM among the demonstration counties leaves much room for improvement, the demonstration counties as a group are likely more uniform in their practice and more consistent in providing FTM than the comparison counties (whose practices were described in Section 4.3.3).

Challenges of the data collection and outcomes analysis include:

- *Targeting:* The study team expected to use goal data in the FACSIS files to narrow the population of children in ongoing services to those with an appropriate initial case plan goal (maintain in home or reunification) that would qualify them for FTM. After examining the FACSIS files we observed that one-third of all children did not have any goal recorded; in addition, we learned that even when a goal was recorded, it was not necessarily the initial case plan goal. Therefore, analysis will focus on all children who opened to ongoing services. Even if it is not recorded, the demonstration counties believe that, for 99% of clients, the initial goal is maintain in home or reunification. However, a small number of children will appear in the study who did not have an appropriate initial case plan goal from both the comparison counties and those demonstration counties which are serving the entire ongoing caseload.
- *Sampling*[28]*:* In order to track and monitor the sampling process, the study team requested that counties submit monthly logs of newly opening cases. After matching the log data with FACSIS data, we recognized some slippage in the sampling: approximately 10–20% of newly transferred cases were not on the logs, with the amount varying by county. This slippage may have introduced bias into the population that received FTM—the cases that were not recorded on the log may have been easier or harder. In the coming months, we hope to explore the extent of the slippage and various reasons why it may have occurred. The extent of cases missing from the log led us to recommend dropping the log except in counties that sample; in those four counties, it is very important to improve use of the log to include all cases.

To judge whether a desired outcome occurred, we first look at a four-month period beginning with the date of opening to ongoing services.[29] This is a modification of the outcome measures,

[28] Out of concern that they would not have enough staff capacity to do FTMs with all cases, some counties chose to systematically select families at the point when they transfer to ongoing services, according to a pre-determined sampling ratio. Families that were not sampled received services as usual, which may have included FTM. As the sampling counties became more comfortable with the intervention, and out of a desire to have a greater impact on their caseload, four of the eight sampling counties switched to a 100% sampling rate. After seven months of implementation, all but 4 counties were sampling 100% of their caseload newly opening to ongoing services.
[29] In a 4-month period, a family could be expected to have at least two FTMs.

necessary because our data is only reliable through September 18, 2006, less than a year after the first demonstration counties began implementation. By examining the outcomes in this abbreviated way, we offer an initial view of the flow of FTM cases and maintain a focus on child outcomes.

Our second perspective on outcomes is also very preliminary. We examine only that small group of cases which experienced the complete FTM process, that is, the case closed by 9/18/06.

By its very nature, an "interim" report like this one presents incomplete results, but nonetheless it focuses attention on the essential question of child-level impact. The inquiry into three outcomes presents tentative, illustrative findings, all of which will be explored further in the final report.

4.5.2.2 Placement Outcomes

A primary goal of the Waiver is to reduce the number of children entering out-of-home care. The study team performed a chi-square test to test the null hypothesis of no association between placement and group membership (demonstration non-metro counties vs. comparison non-metro counties, and Franklin County vs. comparison non-metro counties). As Table 4.24 shows, for children who have been open four months or more, 34% of children in demonstration non-metro counties and 30% of children in comparison non-metro counties entered placement within four months of case opening, a difference that is not statistically significant. In looking at children served in metro counties, we find a statistically significant difference – a higher proportion of the children in Franklin County entered placement than did children in the comparison metro counties (44% versus 20%).[30] At this point, it is difficult to know the possible reasons for this difference. It may be that the populations of the two groups vary by key characteristics such as risk-level. Note also that this analysis was not able to take into account whether an FTM was held before the placement occurred.

Table 4.24: Children That Were Placed Within 120 Days of Case Opening

Demonstration/ Comparison	Non-metro/Metro	# children in sampled families who received FTM and had a case open 120 days or more	# children that were placed within 120 days of case opening
Demonstration	Non-metro	594	202 (34%)
Comparison	Non-metro	1132	344 (30%)
Demonstration	Metro	537	234 (44%)*
Comparison	Metro	1005	199 (20%)*

Conducting this analysis with closed cases yields somewhat similar results. Among the 198 children in non-metro demonstration counties with closed cases, 21% experienced a placement at some time during their case episode, compared to 13% of children in non-metro comparison

[30] $\chi 2$ (1, N = 1542) = 97.955, p = 0.000

counties, a statistically significant difference.[31] In metro counties, 24% of the 199 children from demonstration counties with closed cases were placed, versus 17% of children from comparison counties, a difference that is not statistically significant.

If children need to be placed out of home, the demonstration counties believe that, through FTM, they would be better informed about the family's support network and thus children would be more likely to be placed with kin. The evaluation team performed a chi-square test to test the null hypothesis of no association between group membership and placement setting. Of children who were placed within 120 days of case opening, a significantly higher proportion of children in demonstration counties were initially placed with kin than were children in comparison counties (Table 4.25). To restate: A significantly higher proportion of placed children in the demonstration non-metro counties (29%) were initially placed with kin than were children in the comparison non-metro counties (17%).[32] Similarly, a significantly higher proportion of placed children in Franklin County (36%) were initially placed with kin than were placed children in the comparison metro counties (23%).[33] This shows that, in the metro counties, even though a higher proportion of children are placed, they are more likely to be placed with kin, a less disruptive and traumatic removal option than paid foster care. This difference could be due to conditions that existed before the implementation of FTM. We hope to explore in the coming months whether this is due to children in the demonstration counties being placed as a necessary transition point before the kinship caregiver takes custody.

Table 4.25: Children That Were Initially Placed With Kin

Demonstration/ Comparison	Non-metro/Metro	# children who had placement	# children that were initially placed with kin
Demonstration	Non-metro	202	58 (29%)*
Comparison	Non-metro	344	58 (17%)*
Demonstration	Metro	234	84 (36%)*
Comparison	Metro	199	45 (23%)*

Examination of closed cases yields very similar results. In both metro and non-metro counties, children in demonstration counties are more likely to be placed initially with kin than their comparison county counterparts (34% vs. 15% in non-metros[34] and 29% vs. 4% in metros[35]).

4.5.2.3 Incidence of Maltreatment Subsequent to First FTM

A third desired outcome of FTM is that children who receive FTM will have fewer indicated or substantiated child abuse or neglect (CAN) reports after the case opens to ongoing services.

[31] $\chi 2$ (1, N = 572) =6.590, p = 0.010
[32] $\chi 2$ (1, N = 546) =10.685, p = 0.001
[33] $\chi 2$ (1, N = 433) = 9.074, p = 0.003
[34] $\chi 2$ (1, N = 88) =4.467, p = 0.035
[35] $\chi 2$ (1, N = 72) =6.063, p = 0.014

Of the children who had a case open for 120 days or more, Table 4.26 shows the number of children that had an indicated or substantiated report any time in the 120 days after case opening. The study team performed a chi-square test to test the null hypothesis of no association between group membership and subsequent maltreatment. While children in the demonstration counties appeared to have fewer reports after case opening than children in the comparison counties, the difference is not significant.

Table 4.26: Children With an Indicated or Substantiated Report After Case Opening

Demonstration/ Comparison	Non-metro/Metro	# children in sampled families who received FTM and had a case open 120 days or more	# children that had an indicated or substantiated report after case opening
Demonstration	Non-metro	594	15 (2.5%)
Comparison	Non-metro	1132	48 (4.2%)
Demonstration	Metro	537	23 (4.3%)
Comparison	Metro	1005	62 (6.2%)

In analyzing the closed cases, the total number of subsequent reports for closed cases is not large enough to make any meaningful comparisons between closed cases in demonstration and comparison counties.

4.5.2.4 Other Outcomes

Other outcomes shown on the logic model (Table 4.1) cannot be meaningfully computed at this time, due to the short time span of data that is available. In the final report, the evaluation team will address the full set of outcomes, examining whether outcomes vary based on the amount of FTM received or the level of fidelity to the ProtectOhio model. If possible, we will also explore case mix differences between children in demonstration and comparison counties.

4.6 SUMMARY

In order to increase family involvement in child welfare cases and ultimately improve child outcomes, all demonstration counties have implemented the ProtectOhio FTM strategy. Specifically, these counties have:

- Hired or appointed facilitators for FTMs who also participate in quarterly facilitator's meetings;
- Collected and submitted data to the evaluation team for over 5800 meetings;
- Responded to qualitative interviews related to implementation and practice of the strategy;
- Maintained communication with the evaluation to team to problem-solve county-specific obstacles.

While the overall level of fidelity to ProtectOhio FTM among the demonstration counties leaves much room for improvement, the demonstration counties as a group appear to be more uniform in their practice and more consistent in providing FTM than the comparison counties. Among the 14 comparison counties, only seven do any sort of family team meetings, and their programs were more likely to serve a selected part of the ongoing services caseload or consist of only one meeting. Demonstration counties continue to work to improve parent attendance at meetings and staff buy-in to the FTM process.

With a limited time span of data available, only initial outcomes can be reported. It appears that, among metro counties, children in the demonstration group are more likely to be placed, and that placement is more likely to be with kin, compared to children in the comparison counties. The latter finding, that kinship placements are more common in the demonstration sites, also applies to non-metro counties. Brief examination of the smaller group of closed cases reveals similar patterns.

In the final report, the study team will address a full set of outcomes, examining whether outcomes vary based on the amount of FTM received or the level of fidelity to the ProtectOhio model. If possible, we will also explore case mix differences between children in demonstration and comparison counties.

Results so far indicate that the following lines of inquiry may be worth future exploration by the study team:

- Monitoring differences in characteristics of children who receive FTM and children who are sampled but do not receive FTM.
- Measuring the magnitude of failure to notify facilitators that a case needs FTM, and exploring possible reasons for this practice, including lack of change arising from meetings and family attendance problems.
- Gaining insight into staff and parent perceptions of FTM and reasons parents do or do not attend meetings.
- Collaborating with demonstration counties to clarify interpretations of FTMs held at critical events and learn more about the recommendations for change that come out of FTMs and how those recommendations are acted upon.

Additionally, the following data issues will be investigated, to the extent possible:

- Examining the mismatch in child data between the FTM SIS data and the administrative FACSIS data, as well as the mismatch with the counties' logging processes.
- Creating a single measure to track county fidelity scores and/or assigning fidelity scores to individual children.
- Investigating case mix differences between demonstration and comparison counties.