

Ohio START Interim Evaluation Report February 2018

Evaluation led by:



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Questions and More Information

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EXECUTIVE SUMMARY

Ohio START (Sobriety, Treatment, and Reducing Trauma) is an intervention program that will provide specialized victim services, such as intensive trauma counseling, to children who have suffered victimization with substance abuse by a parent being the primary risk factor. The program will also assist parents of children referred to the program with their path to recovery from addiction.

The overall goals of the project are:

1. To ensure more children are able to remain safely in their home
2. Increase rates of reunification for children placed in out-of-home care
3. Reduce recurrence of child maltreatment



The Ohio State University College of Social Work and the Ohio University Voinovich School of Leadership and Public Affairs are conducting the evaluation for the Ohio START program. At the end of December 2017, each of the counties involved in Ohio START had trained their workers on the new program and were working to identify partner agencies to implement the program in early 2018. The evaluation consists of four related pieces: Outcome Evaluation, Implementation Evaluation, Process Evaluation, and Child Well-Being Evaluation. In this report, we describe in detail each of the four types of evaluations, their goals, and progress to date.

Major Findings and Successes

- Overall, caseworkers perceive a very high level of readiness for START implementation, although readiness varied across counties
- Caseworkers identified 55 behavioral health partners that deliver mental health or substance use treatment services to adults and children in the Ohio START counties
- Caseworkers tend to have the most referral partnerships with, and refer most frequently to, children's mental health organizations
- There were significant increases in test scores at post-test in three of the four trainings (i.e., Foundations I, Child Trauma, Screening and Intervention of Substance Use Disorders)—suggesting the training improved the primary knowledge related to the Ohio START program
- Modifications have been made to the Needs Portal— a hybrid web-based resource and referral system that enables individuals to receive access to social and health services more quickly—to enable better tracking of Ohio START participants and process evaluation measures

Recommendations

We identify the following next steps as possible avenues for enhancing the implementation of Ohio START.

1. Reevaluate the Family Team Meeting training
2. Add booster or refresher trainings for caseworkers
3. Provide coaching that is individualized to county needs
4. Monitor effects on changes in child welfare outcomes (e.g., reunification)

Ohio START was successful in identifying and applying strategies to increase the capacity of the intervention counties to implement the program. This is an important first step in ensuring that substance-affected families are able to reduce child maltreatment and address trauma across the life course. In order to create sustainable change, Ohio START must continue to receive support for implementation of evidence-based practices.



CONTENTS

| | |
|--|----|
| Executive Summary | 2 |
| Background | 4 |
| Goals of the Evaluation | |
| Outcome Evaluation | 5 |
| Implementation Evaluation | 5 |
| Process Evaluation | 6 |
| Child Well-Being Evaluation | 6 |
| Evaluation Assessments | |
| Outcome Evaluation | 7 |
| Implementation Evaluation | |
| Implementation Goal 1 | 7 |
| Implementation Goal 2 & 3 | 14 |
| <i>Training 1: Screening and Intervention of Substance Use Disorders</i> | 14 |
| <i>Training 2: Administration of Children's Trauma Screen</i> | 22 |
| <i>Training 3: Family Team Meetings</i> | 29 |
| <i>Training 4: Ohio START Foundations I</i> | 36 |
| Implementation Goal 5 | 43 |
| Process Evaluation | 43 |
| Child Well-Being Evaluation | 47 |
| Summary & Conclusions | 48 |
| References | 50 |
| Appendix 1: Training 1 Infographic | 51 |
| Appendix 2: Training 2 Infographic | 53 |
| Appendix 3: Training 3 Infographic | 55 |
| Appendix 4: Training 4 Infographic | 57 |
| Appendix 5: The Needs Portal Quick Start Guide for Caseworkers | 59 |



BACKGROUND

What is Ohio START?

Ohio START (Sobriety, Treatment, and Reducing Trauma) is an intervention program that will provide specialized victim services, such as intensive trauma counseling, to children who have suffered victimization with substance abuse by a parent being the primary risk factor. The program will also assist parents of children referred to the program with their path to recovery from addiction.

<http://www.pcsao.org/programs/ohio-start>

The child welfare system in Ohio has experienced increases in the cost of caring for children of parents who suffer from addiction. Currently, 1 in 4 children placed in out-of-home care (e.g., foster care, kinship care) are placed due to opiate abuse (Public Children Services Agency of Ohio [PCSAO], 2017), with these numbers generally higher in the southern and southeastern parts of the state.

Ohio START is an effort of the Ohio Attorney General, PCSAO, and Casey Family Programs designed to bring additional evidence-informed interventions to rural and Appalachian counties hardest hit by the current opioid crisis. Ohio START utilizes early screening for parental substance use (within the first 30 days), family peer mentors, and intensive case management.

Early Screening for Parental Substance Use

Child welfare caseworkers will screen for substance use in parents using the UNCOPE. The UNCOPE is a survey instrument that consists of six items designed to determine whether an individual has problems related to alcohol or drug use. By using the UNCOPE to screen for substance use early in a child welfare investigation, child welfare caseworkers can identify those families where substance use has been or may be a contributing cause to child maltreatment. Identifying a substance use problem early enables caseworkers to refer families to the services they need more quickly.

Family Peer Mentors

One of these services—family peer mentors—is designed so families involved with the child welfare system have the support and mentorship of an individual who has successfully reunified with his or her children after being removed from the home due to child abuse or neglect. Utilizing family peer mentors significantly increases reunification rates (Anthony, Berrick, Cohen, & Wilder, 2009; Berrick, Cohen, & Anthony, 2011; Enano, Freisthler, Lovato-Hermann, & Perez-Johnson, 2017).

Intensive Case Management

Finally, intensive case management ensures that early engagement continues as caseworkers, family peer mentors, and families communicate frequently to ensure the needs of the family's needs are being met.

Taken together, the use of these three intervention strategies are designed to improve safety, permanency, and well-being of children involved in the child welfare system.



GOALS OF THE EVALUATION

The Ohio State University College of Social Work (OSU) and the Ohio University Voinovich School of Leadership and Public Affairs (OU) are conducting the evaluation for the Ohio START program. The evaluation consists of four related pieces: Outcome Evaluation, Implementation Evaluation, Process Evaluation, and Child Well-Being Evaluation. Below we describe each of the four types of evaluations and their goals.

Outcome Evaluation

The outcome evaluation is designed to assess the long-term goals of the project. For this, we will utilize administrative data obtained via the Statewide Automated Child Welfare Information System (SACWIS). Caseworkers input relevant information about a case into SACWIS including date of investigation for child abuse and neglect, outcome of the investigation, demographic information about the family (e.g., date of birth, race/ethnicity, biological sex), and major case milestones (e.g., children placed in out-of-home care, date of reunification, date case is closed). Using SACWIS data, we will assess whether families receiving Ohio START (compared to those not receiving Ohio START) had:

Outcome Goals

1. More children are able to remain safely in the home of their children
2. Increase rates of reunification for children placed in out-of-home care
3. Reduced recurrence of child maltreatment

Implementation Evaluation

The implementation evaluation assesses those factors that are likely to promote the most success in achieving the long-term project outcomes. For this component of the evaluation, we (1) have conducted surveys with workers to assess implementation leadership, climate, and attitudes; (2) have assessed change in knowledge due to trainings for child welfare caseworkers and key partners; (3) are assessing changes in collaboration and contractual agreements between providers; (4) are working with the counties to better track the referral process, engagement in treatment, and coordination among the service providers; and (5) will be conducting interviews and focus groups with key stakeholders to identify key successes, barriers, and areas where the program could be improved.

Implementation Goals

1. Supportive climate for Ohio START implementation
2. Staff have received training on the assessment tools that will be used during the referral process
3. Cross-training on the START model has been provided to the teams
4. Protocols for referring, accessing treatment in a timely manner, intensive case management, team meetings, and case closures have been developed by each county team
5. Stronger collaboration established between the PCSA, behavioral health provider, and the juvenile/family court and specified in a signed MOU
6. Certified lived experience recovery coaches have been identified for the participating counties
7. Enhanced coordination of resources and support for parents and children
8. Reduced wait time for accessing treatment for referral parents
9. Increased parent engagement and retention in treatment



Process Evaluation

The Ohio START program specifies a number of timelines that must be met in order to effectively serve families. In order to track and assess the counties' effectiveness at meeting these timelines, we are continuing to develop and refine a tracking system that monitors some of these process measures. We would also conduct quality assurance to monitor implementation and provide performance feedback to clinicians and caseworkers. The specific goals of the process evaluation are to assess whether:

Process Goals

1. Substance use behaviors noted at screening
2. Universal screening tool (UNCOPE) was used at intake
3. Screener triggered referral to behavioral health or substance use disorder provider
4. Trauma screener was completed for the child and parent
5. Ohio START referral was made within 30 days of report to child protective services (CPS)
6. Substance use disorder screen completed within 30 days, if receiving a score of 3 on UNCOPE
7. First shared-decision making meeting with family occurred within 2 days of referral to Ohio START
8. Timelines for behavioral health assessment, first addiction treatment session, and minimum number of sessions were completed per the timelines outlined in the MOU
9. Initial home visit included CPS worker and family peer mentor
10. Weekly visits with family peer mentor were held for the first 60 days

Child Well-Being Evaluation

Child well-being is an important consideration in the effectiveness of whether Ohio START has achieved its stated outcomes. In order to assess the effectiveness of Ohio START to produce positive changes in child well-being, we will conduct pre-post surveys with 200 parents receiving the intervention. The survey will include information on child behaviors (e.g., how they communicate, internalizing and externalizing behaviors), parent-child attachment and bonding, and parenting sense of competence. The overarching goals of the child well-being evaluation are:

Child Well-Being Goals

1. Improve capacity of parents affected by substance abuse to care for their children
2. Maintain children safely with their parents when possible
3. Enhance child developmental and emotional well-being
4. Promote stronger, healthier attachment between children and parents



EVALUATION ASSESSMENTS

In this section, we provide information on the current state of implementation for each type of evaluation. For goals that currently have preliminary baseline or outcome data, we provide the specifics of the study design, information about who we are assessing, and our analytic methods for assessing those outcomes.

Outcome Evaluation

In support of the outcome evaluation, we have created a data use agreement with the Ohio Department of Job and Family Services (ODJFS) to obtain the SACWIS data for the evaluation. We have already received state-wide child welfare data for 2015 and 2016. We are currently in the process of analyzing these data to develop a strong sense of the baseline level of child maltreatment in the intervention and control counties.

Implementation Evaluation

Implementation Goal 1:

Supportive climate for Ohio START implementation

The purpose of this evaluation component is to assess baseline conditions for implementing Ohio START. Specifically, we examined readiness for START implementation and collaboration between behavioral health organizations and public child welfare agencies.

Data Collection Procedures

A pre-implementation survey (cross-sectional) was conducted in October 2017—toward the end of the project-planning period and before the PCSAs began to recruit families to receive START. During this time, personnel from the participating counties attended trainings and began to familiarize themselves with the knowledge, skills, and tasks needed for Ohio START.

In collaboration with the main contact in all counties, we identified the names and email addresses of all front-line child welfare workers, supervisors, and administrators who are directly involved in implementing and using the START intervention. We sent a recruitment email to all identified staff. Because surveys often suffer from poor response rates, we followed up three times (about one week in between each follow-up) with those who had not responded. Those who agreed to participate completed an online informed consent form (described the purpose of the survey, risks, benefits, voluntary nature, etc.) and then proceeded with the survey, which took about five minutes to complete. We recruited 61 participants from staff employed by 10 PCSAs.

The pre-implementation survey measured two main constructs:

1. *Readiness* – The Organizational Readiness for Change (ORIC) scale is a 10-item measure that assesses workers' perceptions about their organization's readiness to implement a program. Five



items assess perceptions of change commitment, and five items assess perceptions of change efficacy. Items are rated on a 5-point scale from 1=disagree to 5=agree (Shea, Jacobs, Esserman, Bruce, & Weiner, 2014). Scores were averaged across items to create an overall readiness score, where higher values represent greater perceived readiness to implement START.

2. **Referrals** – Workers nominated up to five referral partners in the community and the frequency with which they refer for four types of service needs (children who need mental health care, children who need substance use treatment, caregivers who need mental health care, and caregivers who need substance use treatment). Frequency was rated along a 6-point likert scale where 1=not once and 6=daily. Thus, higher scores denote more frequent referral interactions. Responses were used to create a tally of referral partners, and an average referral frequency.

Demographic Information of Training Participants. In total, 53% of all eligible staff participated (n=61); at least one participant responded from 10 of the PCSAs. Due to their greater numbers of staff involved in START, those from Fairfield, Athens, and Clinton counties account for nearly 75% of all participants (Table 1).

Table 1. *Eligible and Responding Participants by County*

| | Eligible | | Respondents | | Response Rate |
|---------------|------------|-------------|-------------|-------------|---------------|
| | # | % | # | % | |
| Athens | 23 | 20% | 12 | 19% | 52% |
| Adams* | 4 | 4% | 0 | 0% | 0% |
| Brown | NA | | 0 | 0% | NA |
| Clinton | 11 | 10% | 9 | 14% | 82% |
| Fairfield | 34 | 30% | 26 | 41% | 76% |
| Fayette | 2 | 2% | 2 | 3% | 100% |
| Gallia | 5 | 4% | 4 | 6% | 80% |
| Highland | 4 | 4% | 2 | 3% | 50% |
| Jackson | 4 | 4% | 2 | 3% | 50% |
| Lawrence | 5 | 4% | 3 | 5% | 60% |
| Meigs | 4 | 4% | 1 | 2% | 25% |
| Perry* | 8 | 7% | 0 | 0% | 0% |
| Pickaway | 3 | 3% | 0 | 0% | 0% |
| South Central | 7 | 6% | 3 | 5% | 43% |
| Total | 114 | 100% | 61 | 100% | 54% |

NA=Employee list not made available

*=PCSA deferred implementation after survey invitations sent

Participant Characteristics. Participants included front-line caseworkers (45%), supervisors (27%), and administrators (17%). Most of those who were considered “Other” included stakeholders from other community agencies (Figure 1). Participants reported working in child welfare for an average of 11.7 years (SD=8.5 years), although their tenure ranged from 1 to 29 years. For those who reported carrying a caseload (n=31), participants served an average of 14.8 families (SD=15.1 families). Participants reported a variety of disciplinary backgrounds including social work (29.7%) and general human services (12.5%) (Table 2).

Figure 1. Participants' Roles with PCSAs (n=64)

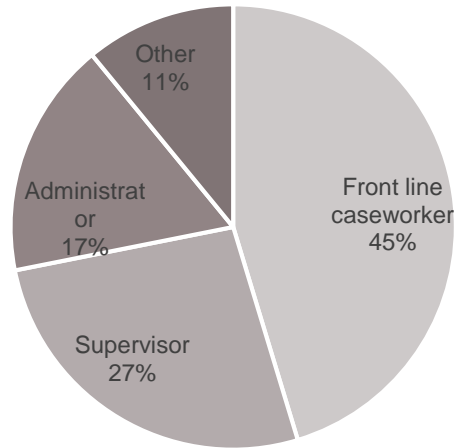


Table 2. Participant Characteristics (n=64)

| | n | % or M(SD) | Range |
|----------------------------|----|-------------|-------|
| Role | 64 | | |
| Front line caseworker | 29 | 45.3 | |
| Supervisor | 17 | 26.6 | |
| Administrator | 11 | 17.2 | |
| Other | 7 | 10.9 | |
| Years of Experience | 56 | 11.7 (8.5) | 1-29 |
| Caseload | 31 | 14.8 (15.1) | 0-60 |
| Discipline/Background | 64 | | |
| Child/Family Studies | 3 | 4.7 | |
| Counselor | 3 | 4.7 | |
| Education | 1 | 1.6 | |
| General Human Services | 8 | 12.5 | |
| Psychology | 2 | 3.1 | |
| Social Work | 19 | 29.7 | |
| Sociology/Criminal Justice | 2 | 3.1 | |
| Unknown | 26 | 40.1 | |

Findings from Caseworker Surveys

Readiness for Implementation. Overall, the 57 participants surveyed reported high levels of readiness for implementation, with a mean score of 4.57 which falls between “somewhat agree” and “agree” on the readiness rating scale (Figure 2). Although scores range from 2.5 to 5, the standard deviation (SD=.59) suggests that individuals’ scores did not vary greatly from one another.

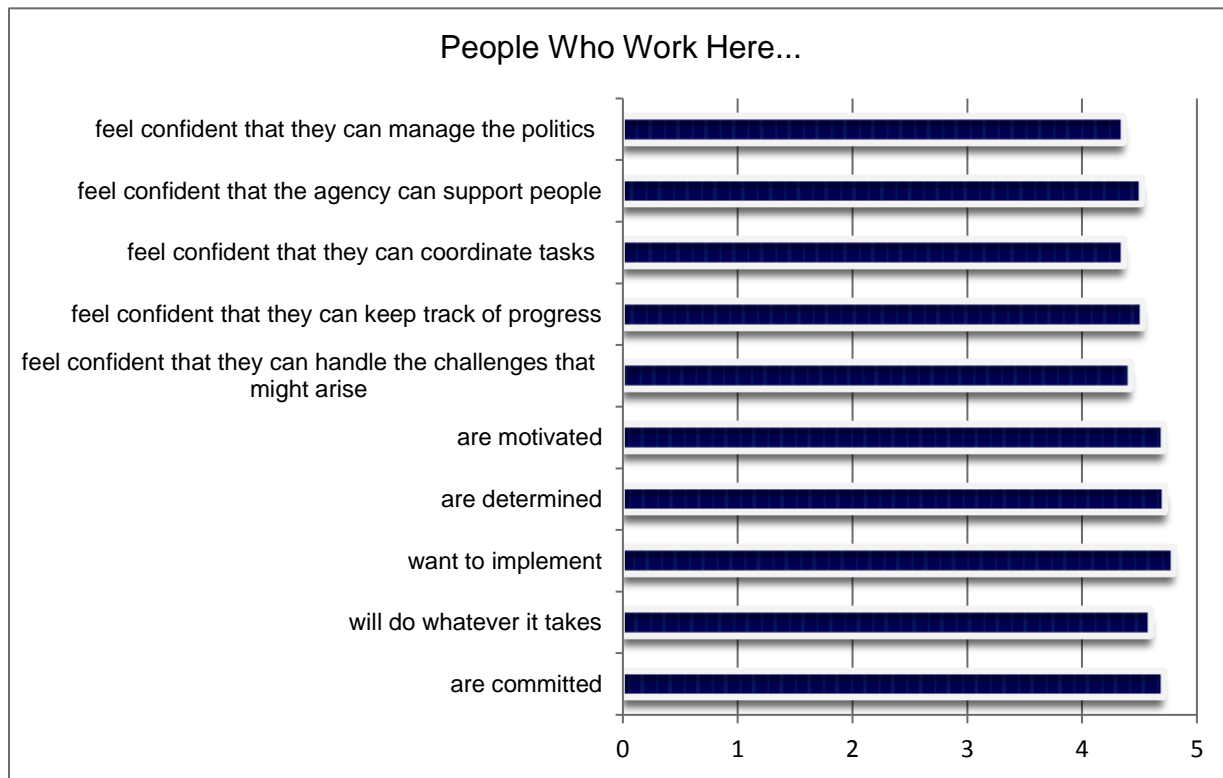


Figure 2. Average Agreement with Each Item

Note: Items are measured using an ordinal scale which should be analyzed using frequency analysis. However, means are presented for ease of interpretation.

In addition to examining overall readiness, we also examined average scores for each of the 10 readiness scale items. Average scores for each of the 10 items were high, consistently suggesting strong levels of commitment and efficacy around START implementation. Workers rated their perceptions of change efficacy (items #6-10) slightly higher than their perceptions of change commitment (items #1-5). Workers rated their confidence lowest around managing politics and coordinating tasks ($m=4.3$). These results suggest workers may be less sure of either their internal or external resources for implementation. The highest scoring item rated workers' desire to implement START ($m=4.79$) which indicates strong initial support for this initiative.

Readiness for START implementation was also examined across county PCSAs (Figure 3). Of the nine counties with at least two respondents, seven (78%) reported overall readiness scores over 4.0 (which falls at or above "somewhat agree" on the readiness scale). Six PCSAs (67%) reported very similar levels of readiness where average scores ranged between 4.9 and 4.7. One PCSA scored below 4 (3.6), and one scored below 3 (2.8); this may indicate that the workers within these two counties may need further support, education, or external resources to build skills for integrating the START model into their practice.

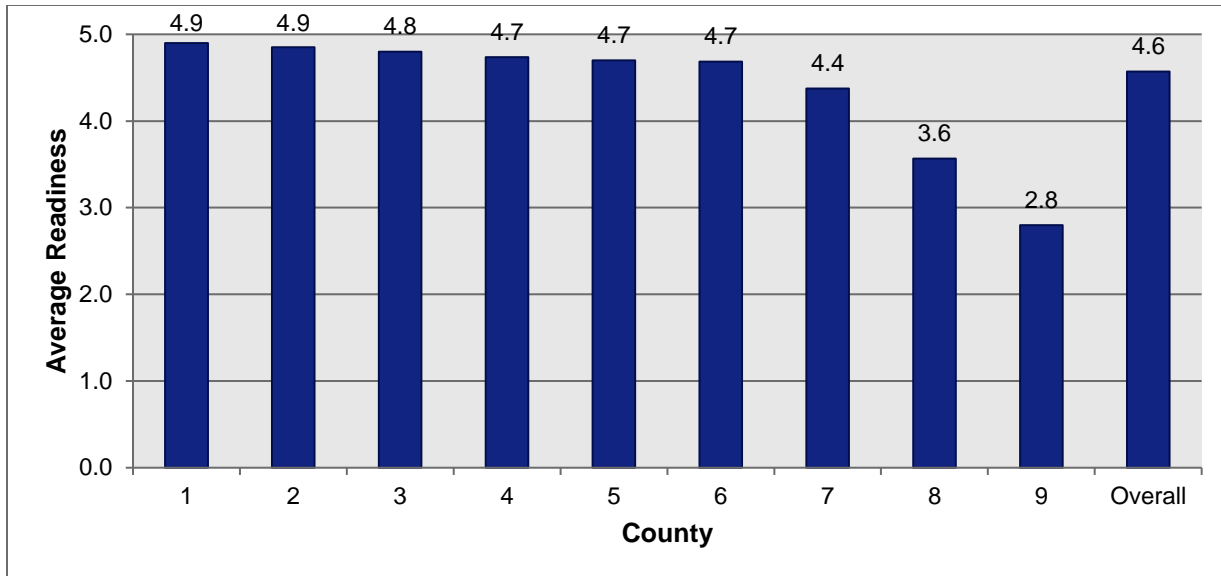


Figure 3. Variation in Readiness by County

Note: Because some of the responding counties had fewer than five participants rate their readiness, county PCSA names are not included in this figure.

Of the workers surveyed, 12 provided open text comments with additional information. Most of the comments conveyed excitement about the START program and its anticipated benefits, and details about progress toward hiring new staff. Two participants noted that their agency had utilized similar programming before, which increased their confidence to implement this program. Three participants expressed frustration regarding delays in implementation, due to confusion about funding and other aspects of the program as provided by the state.

Collaboration. Workers identified 55 behavioral health provider partners to whom they refer children or adults for mental health or substance use treatment services. Nearly all of the identified partners (81.8%) deliver mental health treatment to children and youth, while fewer partners deliver substance use treatment to children/adolescents (58.2%), adults (56.4%), or mental health treatment to adults (54.5%). As shown in Table 3, OhioGuidestone and Integrated Services for Behavioral Health were in the top five for all four kinds of services, indicating a wide range of effective services and high levels of collaboration with child welfare workers. New Horizons, Hopewell, and Mid-Ohio Psychological Services were in the top five for both child and adult mental health services, indicating an ability to collaborate and serve a wide range of ages. Health Recovery Services, Recovery Center, and TASC were in the top five for substance use treatment, also indicating the capacity to serve a wide range of ages. It should be noted that Hopewell, Integrated Services, Mid-Ohio, OhioGuidestone, Health Recovery Services, and TASC all have multiple locations across several counties in southern Ohio. Therefore, while workers may be referring to the same overall agency, the collaboration within specific counties may vary.

Table 3. Behavioral Health Partners

| Type | Total identified | Top 5 Most Commonly Nominated |
|--------------------------|------------------|---|
| Children's Mental Health | 45 (81.8%) | <ol style="list-style-type: none"> 1. Integrated Services for Behavioral Health 2. OhioGuidestone 3. New Horizons 4. Hopewell 5. Mid-Ohio Psychological Services |
| Children's Substance Use | 32 (58.2%) | <ol style="list-style-type: none"> 1. OhioGuidestone 2. Health Recovery Services 3. Recovery Center 4. Integrated Services for Behavioral Health 5. TASC |

| | | |
|---------------------|------------|---|
| Adult Mental Health | 30 (54.5%) | 1. Integrated Services for Behavioral Health 2. OhioGuidestone 3. New Horizons 4. Hopewell Health Center 5. Mid-Ohio Psychological Services |
| Adult Substance Use | 31 (56.4%) | 1. Recovery Center 2. OhioGuidestone 3. Health Recovery Service 4. Integrated Services for Behavioral Health 5. TASC |

We also examined worker's individual referral partners and patterns (Table 4). Workers report relying on between two and three organizations for delivering children ($m=2.58$) and adult ($m=2.38$) mental health care. The average number of substance abuse partners was lower for both children ($m=1.67$) and adults ($m=1.84$) suggesting that workers have fewer substance use treatment referral partners. Overall, workers refer to children's mental health, adult mental health, and adult substance use treatment providers at approximately the same average frequency—average frequency scores range from 3.24–3.41 (which corresponds to monthly referrals). Workers refer children to substance use services less frequently ($m=2.36$) perhaps due to a lower level of need for that particular group.

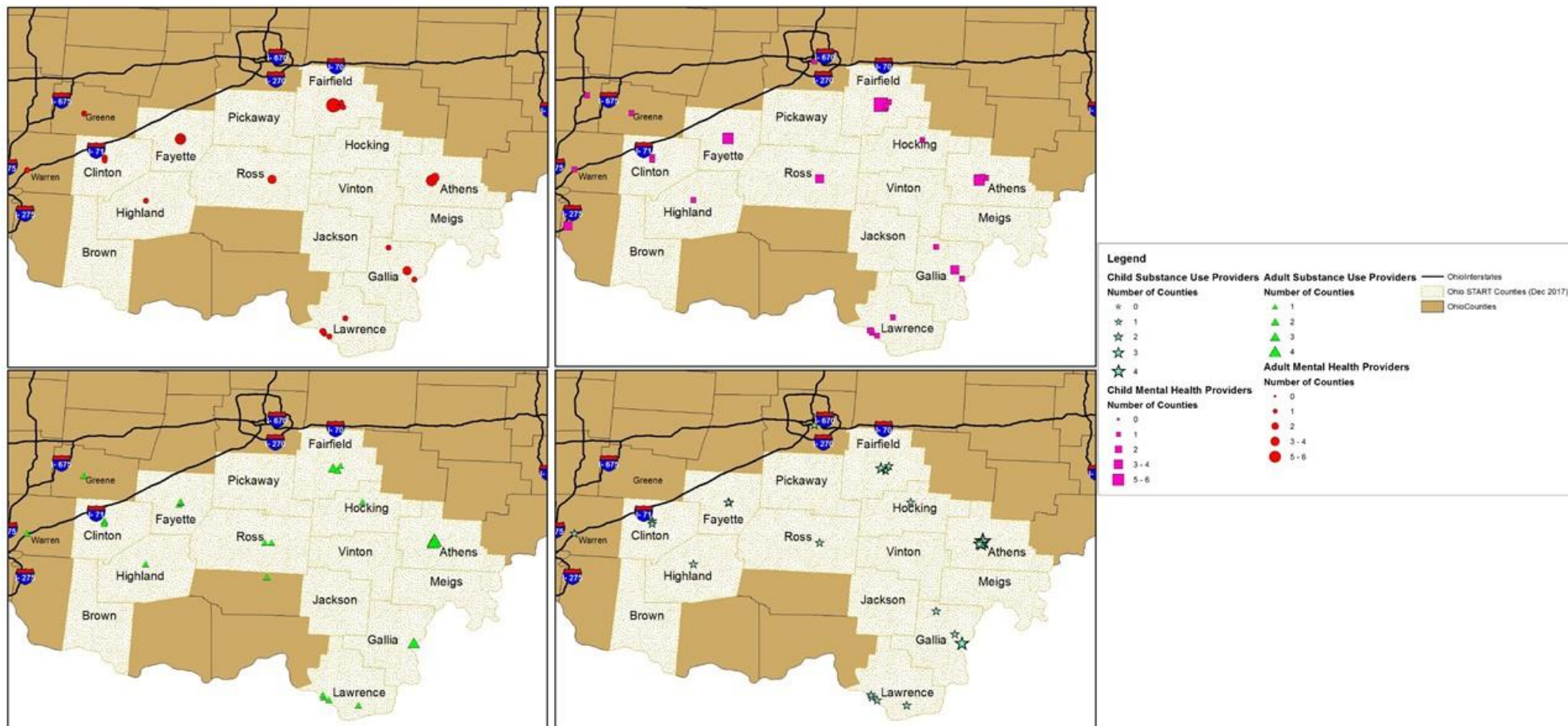
Table 4. *Workers' Referral Partners*

| | n | Mean | SD | Range |
|---------------------------------|----|------|------|--------|
| <i>Children's Mental Health</i> | | | | |
| Number of Partners | 64 | 2.58 | 1.73 | 0-5 |
| Referral Frequency | 50 | 3.33 | 1.24 | 1-5.33 |
| <i>Children's Substance Use</i> | | | | |
| Number of Partners | 64 | 1.67 | 1.72 | 0-5 |
| Referral Frequency | 40 | 2.36 | 1.22 | 1-6 |
| <i>Adult Mental Health</i> | | | | |
| Number of Partners | 64 | 2.38 | 1.64 | 0-5 |
| Referral Frequency | 49 | 3.41 | 1.24 | 1-5.75 |
| <i>Adult Substance Use</i> | | | | |
| Number of Partners | 64 | 1.84 | 1.84 | 0-5 |
| Referral Frequency | 37 | 3.24 | 1.30 | 1-6 |

Below we show the maps of the START interventions counties (as of December 2017) and locations of the service providers they were using at the time of the implementation survey. The dots on each map refer to the location of a service agency with the size denoting the number of different counties who report using that agency to provide behavioral health or substance use services to children or adults involved with the child welfare system.

Adult Mental Health Providers

Child Mental Health Providers



Adult Substance Use Providers

Child Substance Use Providers

Figure 4. *START Intervention Counties and Locations of Service Providers*

Implementation Goal 2:

Staff have received training on the assessment tools that will be used during the referral process

Implementation Goal 3:

Cross-training on the START model has been provided to the teams

The purpose of these evaluation activities were to assess who has been trained on the specific topic areas needed to implement Ohio START and to develop the skills necessary to implement the intervention activities.

Training Activities and Data Collection

Four types of training programs have been held through the end of December 2017. These include training on: (1) the substance use screening tool (UNCOPE) and the tool assessing trauma experience by parents (Adverse Childhood Experiences); (2) training on how to administer the child's trauma screening tool; (3) family team meetings; and (4) the foundations of the Ohio START program (Foundations I). Training sessions took place in September–December 2017 at multiple locations (e.g., Fairfield, Clinton, Scioto, Jackson, South Central Ohio Job and Family Services). We conducted pre- and post-tests that were tailored to the specific objectives of each training. These pre- and post-tests were then evaluated to assess changes in participants' knowledge in topic areas before and after training.

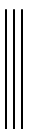
All training participants were given the same questionnaires, once before the training and again right after the training. Participants completed the pencil and paper questionnaires (the number of questions ranging from 15 to 19 depending on the topic of the training). The survey took approximately 5-10 minutes to complete and was completed in the training room. A six month post-test training questionnaire will be administered six months after the date of each training to assess continued change in knowledge due to the trainings. The first set of post-post surveys will be conducted online at the end of March. Training participants will receive an email inviting them to complete the post-post survey using a unique link to the web survey. Eight days later they will receive their first reminder to complete the evaluation and a second reminder eight days after that.

Pre- and post-test questionnaires for each training were developed by the Ohio START evaluation team at OSU and OU. Demographic information of training participants was collected at pre-test. Once collected, data were entered into Qualtrics (an online survey software program) by the research teams at OSU and OU. All data were entered twice. The data were then de-duplicated to ensure all data were entered correctly. This procedure minimizes the number of errors that might occur during data entry (e.g., a person answered "C" but the data point was entered as "B"). This process also maximizes the accuracy of the information collected.

Below we present the results for each type of training.

1. Training 1: Screening and Intervention of Substance Use Disorders (UNCOPE and ACE)

The Screening and Intervention of Substance Use Disorders training was designed to assist workers with how to use the evidence-based screening tools UNCOPE and ACE, interpret the results, provide feedback to the parent, and offer recommendations to seek further assessment for treatment services.



Demographic Information of Training Participants. As of the December 2017, 91 people participated in the Screening and Intervention of Substance Use Disorders training. 91 received trainings where the pre and posttest materials were available for use. Of those, 75 (82.4%) completed both the pre- and post-test information available for inclusion in analysis. 9 completed the pre-test only and 7 completed the post-test only. Almost 75% (n=56) of those with pre- and post-test data had complete data and comprise the final analytic sample.¹

For the training on 9/22, 15 surveys were completed by 9 people. Of the 9 people, 1 completed a pre-test only, 2 completed a post-test only, and 6 completed both. Of the 6 people with both, 4 had complete data. For the training on 10/6, 29 surveys were completed, by 15 people. Of the 15 people, 1 had a pre-rest only and 14 had both. Of the 14 people with both, 10 had complete data. For the training on 10/17, 33 surveys were completed by 17 people. Of the 17 people, 1 completed the post-test only and 16 completed both. Of 16 people with both, 11 had complete data. For the training on 12/5, 53 surveys were completed by 29 people. Of the 29 people, 2 had a pre-test only, 3 had a post-test only, and 24 had both. Of the 24 people with both, 19 had complete data. For the training on 12/12, 36 surveys were completed by 21 people. Of the 21 people, 5 had a pre-test only, 1 had a post-test only, and 15 had both. Of the 15 people with both, 12 had complete data.

Table 5 presents the demographic information of the Screening and Intervention of Substance Use Disorders training.

The average age of those being trained was about 39 years old. The majority of participants were female (89%) and white (94%). Most participants had a Bachelor's degree (75%), while 19% had a Master's degree. The majority of participants were newer (0-4 years) to the agency (63.1%) and the current position (70.2%). The most common job title was social worker (53.6%).

Table 5: *Screening and Intervention of Substance Use Disorders Training Participant Demographics (n = 84)*

| | Mean (SD)/ % |
|--|---------------------|
| Age (in years) | 38.72(10.87) [n=82] |
| Sex | |
| Female | 89% |
| Male | 11% |
| Race | |
| Caucasian/White | 94% |
| Black/African American | 2% |
| American Indian or Alaskan Native | 1% |
| Decline to state | 1% |
| Other | 1% |
| Education | |
| High school graduate, diploma or the equivalent (e.g. GED) | 2.4% |
| Associate's Degree | 3.6% |
| Bachelor's Degree (BA, BS, BSW) | 75% |
| Master's Degree (MA, MS, MSW) | 19% |
| Doctor of Philosophy (PhD) | - |
| Others | - |
| Length of employment at the current organization/agency | |
| 0 to 4 years | 63.1% |
| 5 to 9 years | 7.1% |
| 10 to 14 years | 15.5% |
| 15 to 20 years | 3.6% |
| 20 years or longer | 10.7% |
| Length of employment at the current position | |

¹ All who completed the pre-test are included in the demographics though not all respondents answered every demographic question.

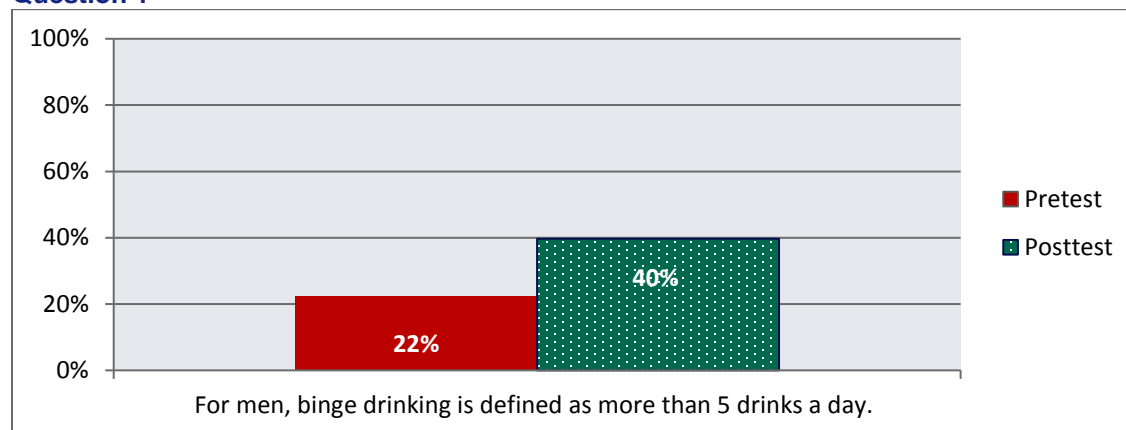
Table 5: Screening and Intervention of Substance Use Disorders Training Participant Demographics (n = 84)

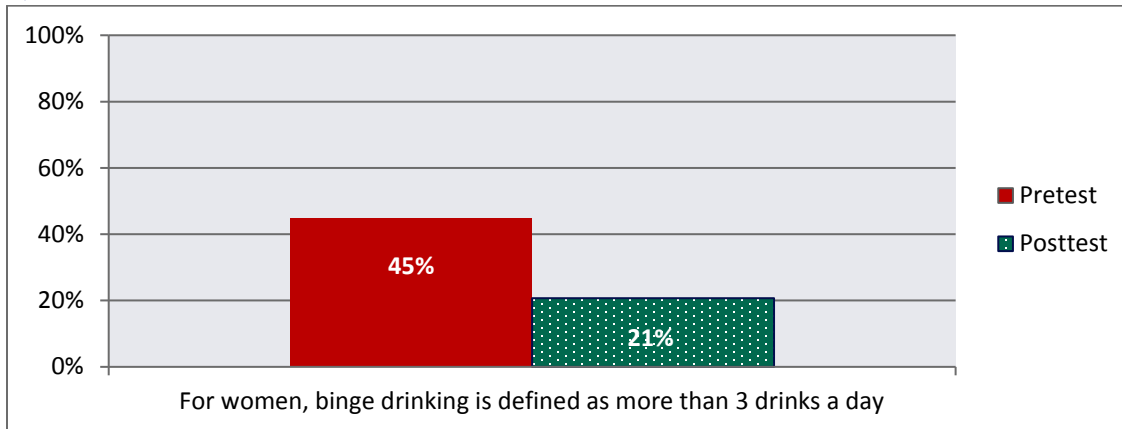
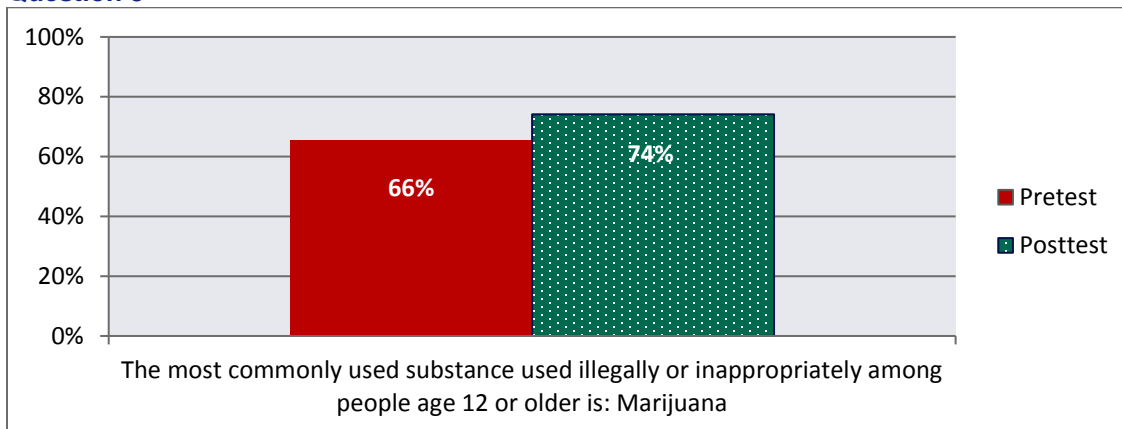
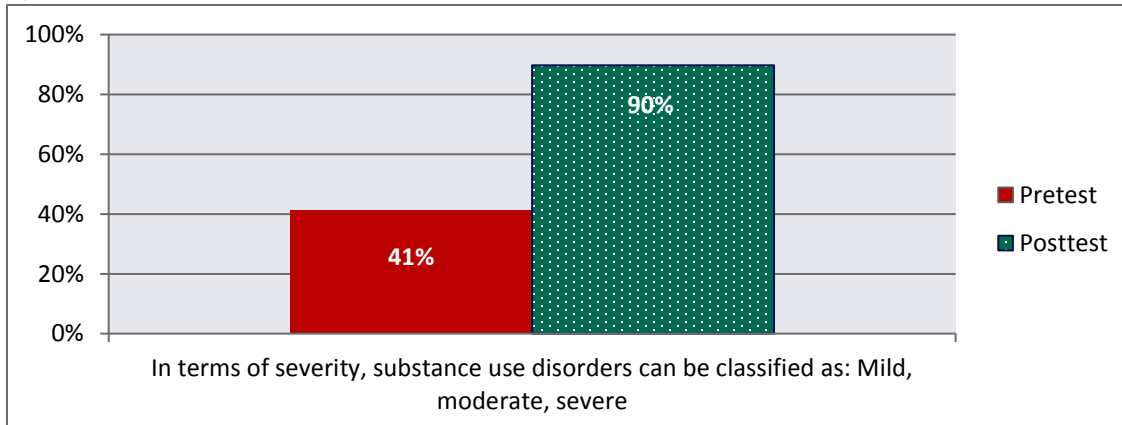
| | |
|---|-------|
| 0 to 4 years | 70.2% |
| 5 to 9 years | 15.5% |
| 10 to 14 years | 10.7% |
| 15 to 20 years | 1.2% |
| 20 years or longer | 2.4% |
| Job title | |
| Social worker | 53.6% |
| Therapist/Counselor | 1.2% |
| Program coordinator | 1.2% |
| Mental health counselor/Specialist/Consultant | 1.2% |
| Case manager/Case management aide | 16.7% |
| Behavioral specialist | 1.2% |
| Physician's Assistant | - |
| Administrative staff | 4.8% |
| Medical doctor | - |
| Other* | 20.2% |

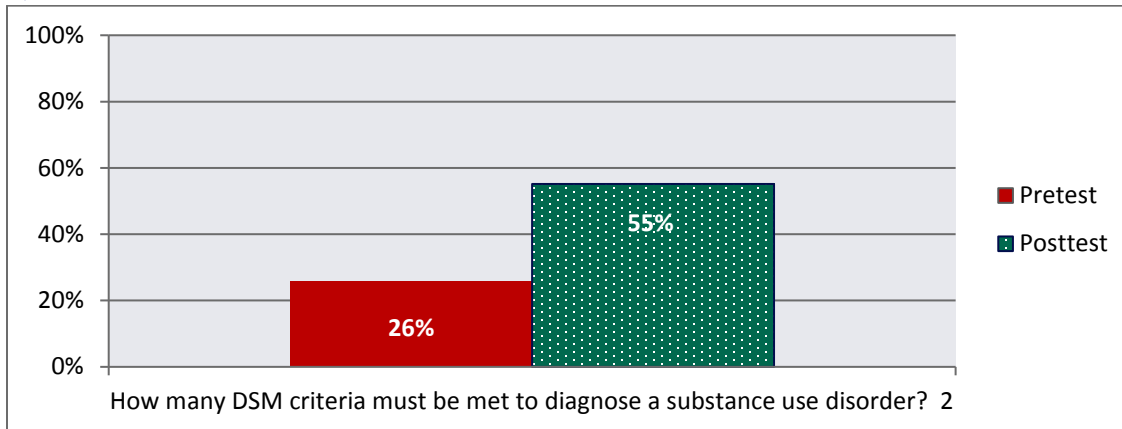
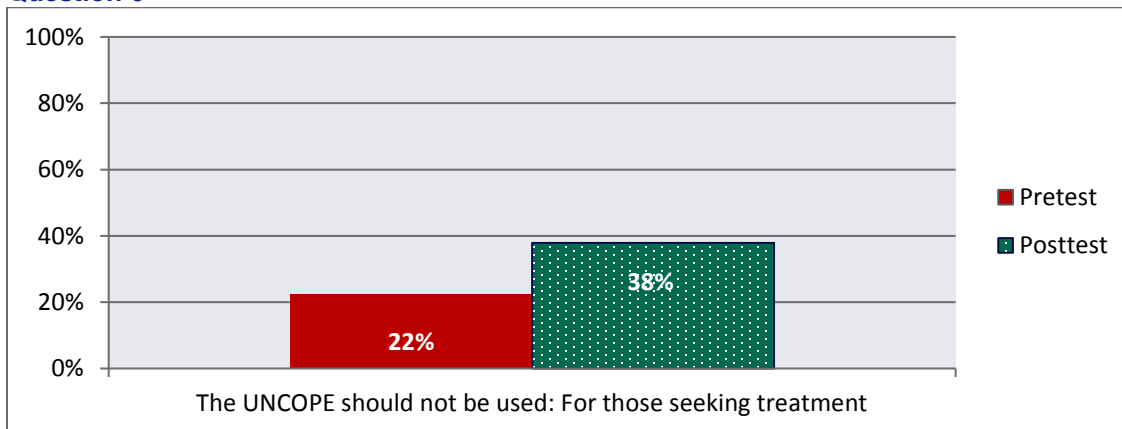
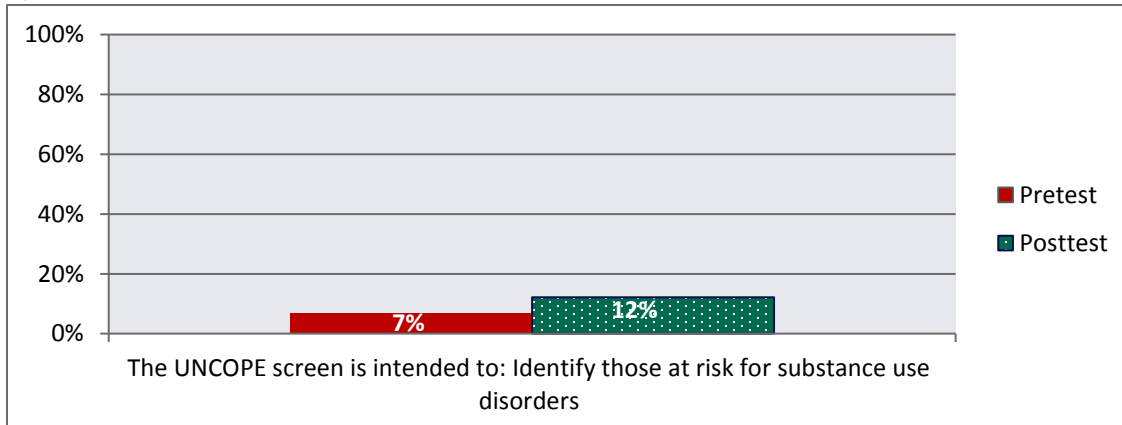
*Responses in this category included BH agency county manager, consultant, deputy director, intake screener, PCSA supervisor, social service caseworker, supervisor, clinical coordinator, clinical director, family peer mentor, AREA manager, business administrator, community behavioral health worker, trainer, fiscal specialist, and assistant director

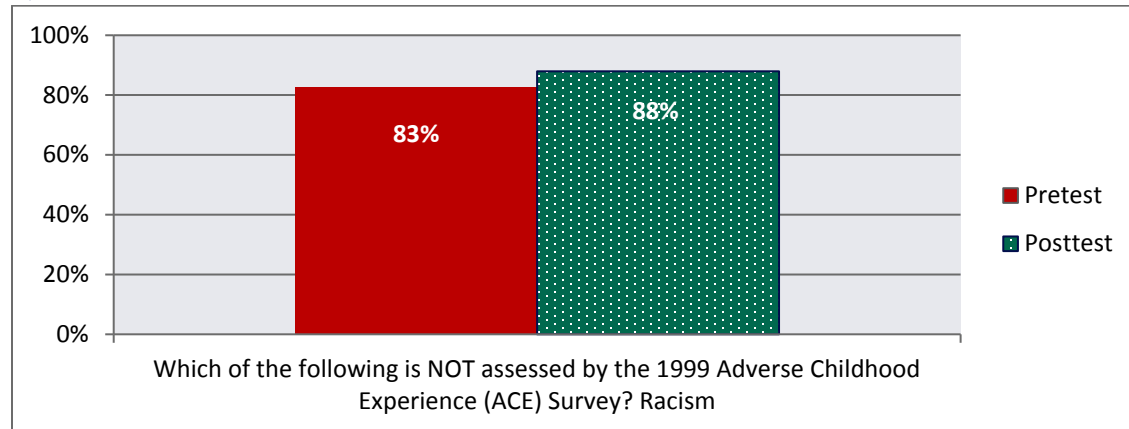
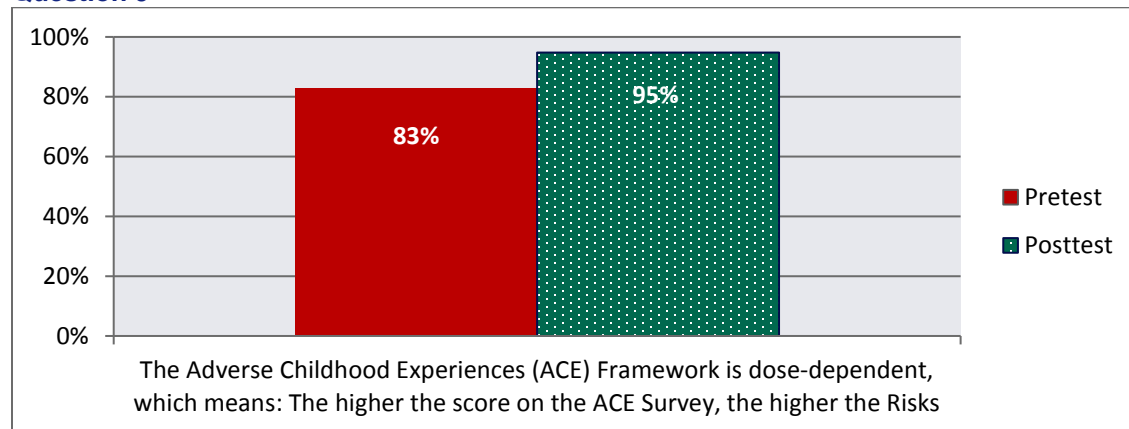
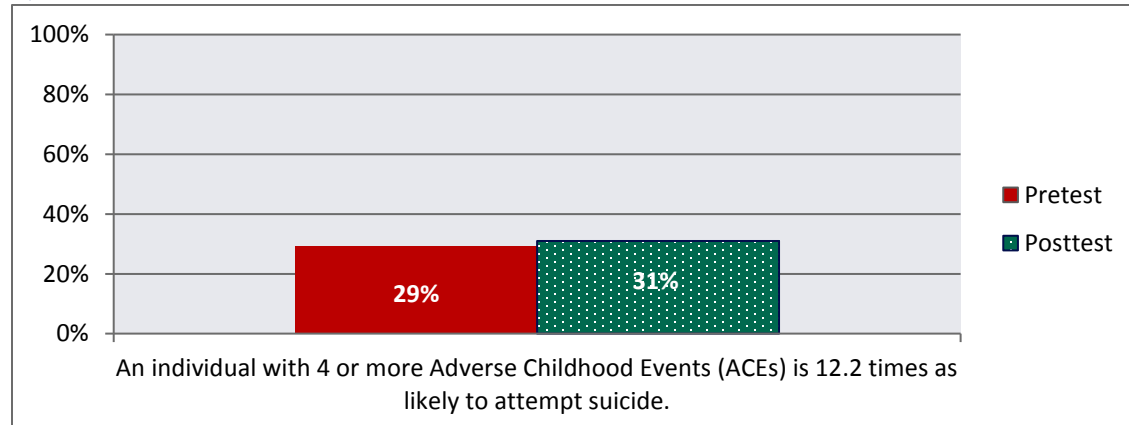
Findings from Pre- and Post- Training Assessments. The average score of the pre-test for the Screening and Intervention of Substance Use Disorders training was 8.45 (out of a possible 18). At the completion of training (post-test), participants scored an average of 9.71 (out of a possible 18), indicating a 14.91% increase in knowledge about UNCOPE and ACE. The difference between scores at the pre-test ($M = 8.45$, $SD = 2.04$) and post-test ($M = 9.71$, $SD = 2.06$); $t(4.18) = 1.27$, $p < .001$ [were] statistically significant using a paired-sample t-test. The individual question results (and correct answers) used in creating the pre- and post-test scores can be found below. As with comparing averages, we only use the analytic sample ($N=56$) as it contains those people who answered all items at both time points.

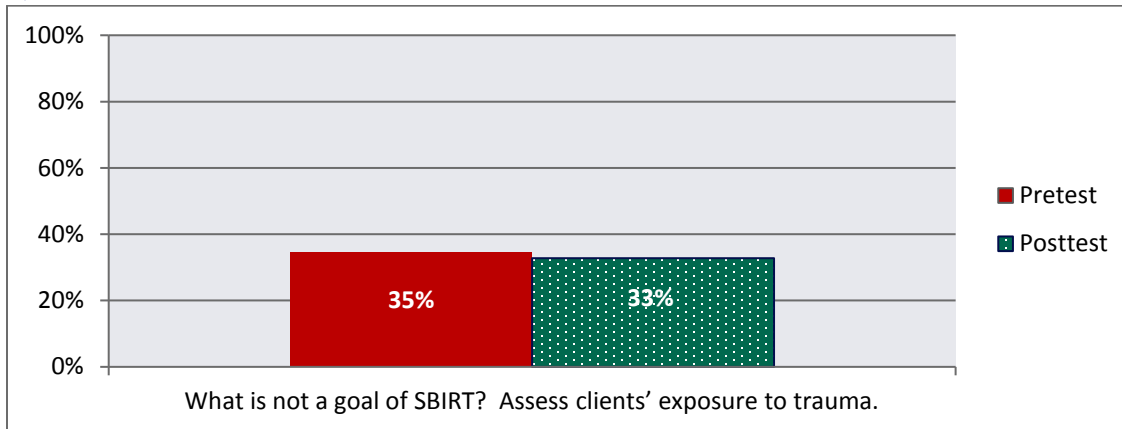
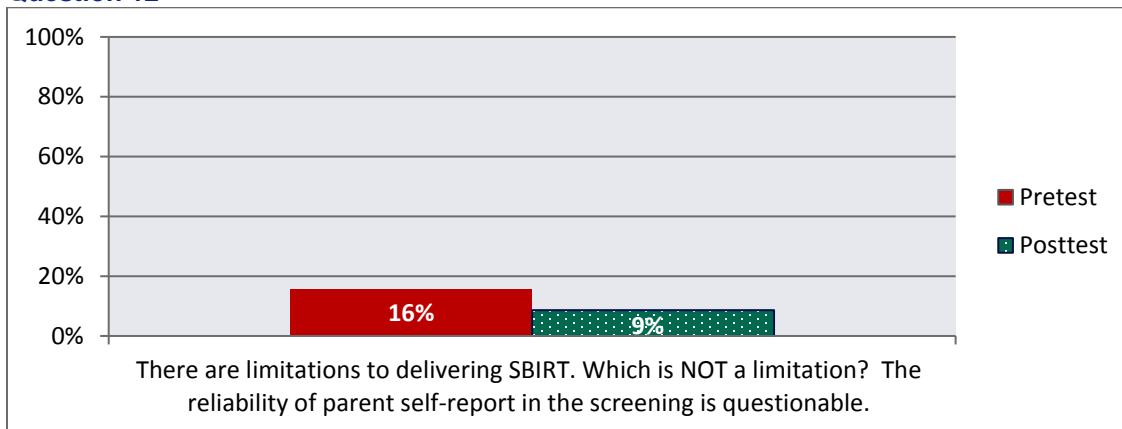
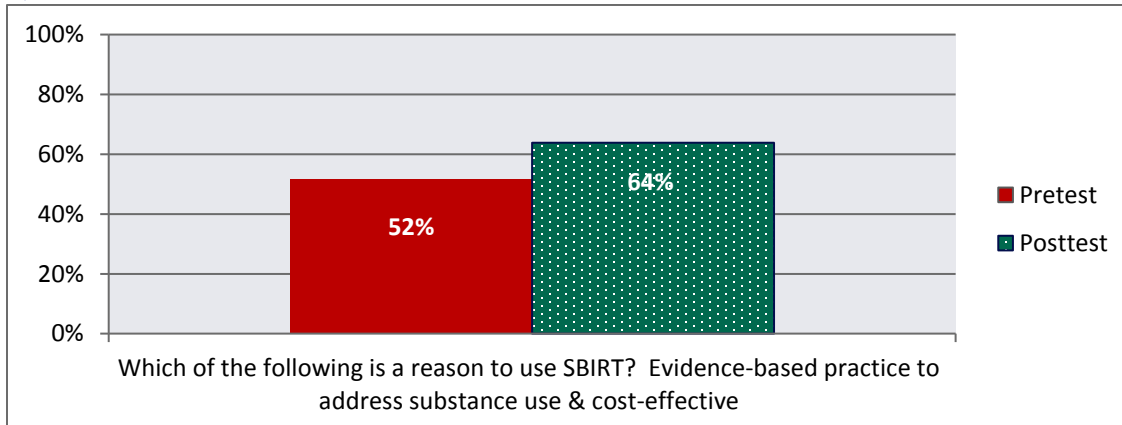
Question 1



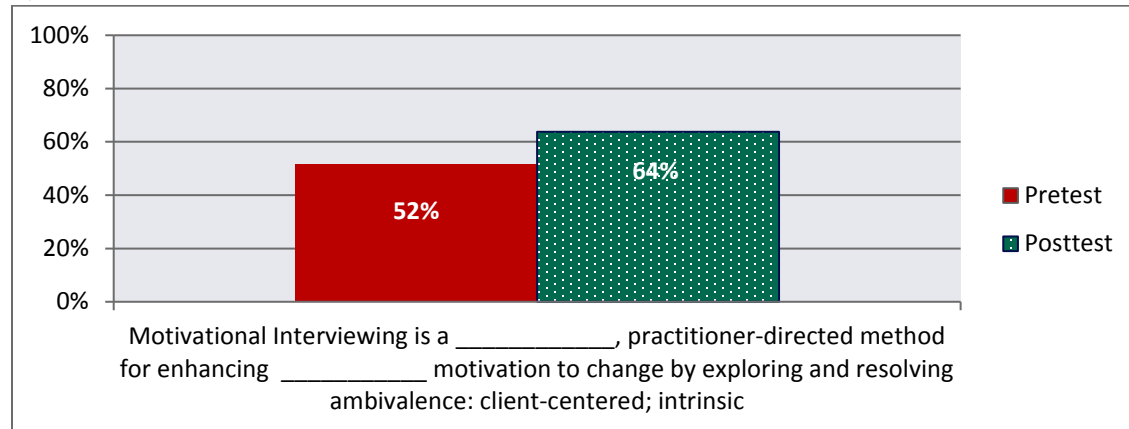
Question 2**Question 3****Question 4**

Question 5**Question 6****Question 7**

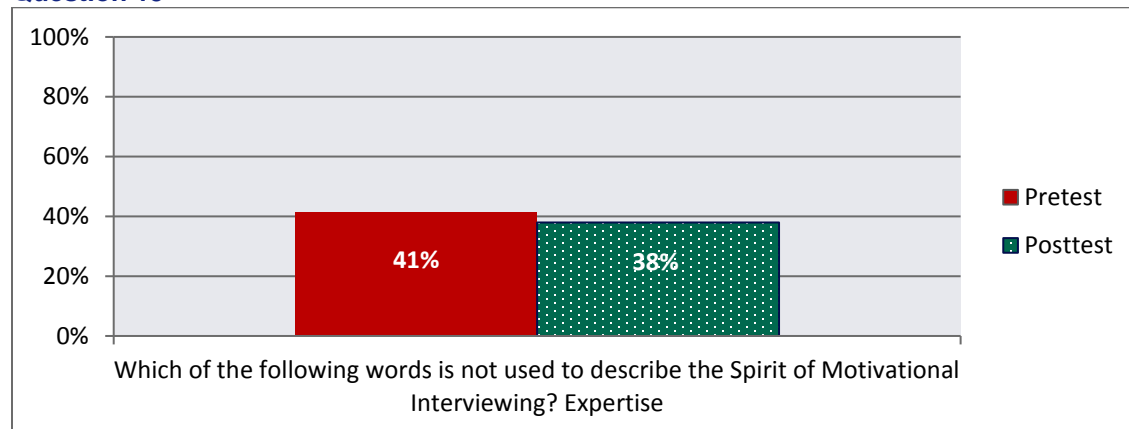
Question 8**Question 9****Question 10**

Question 11**Question 12****Question 13**

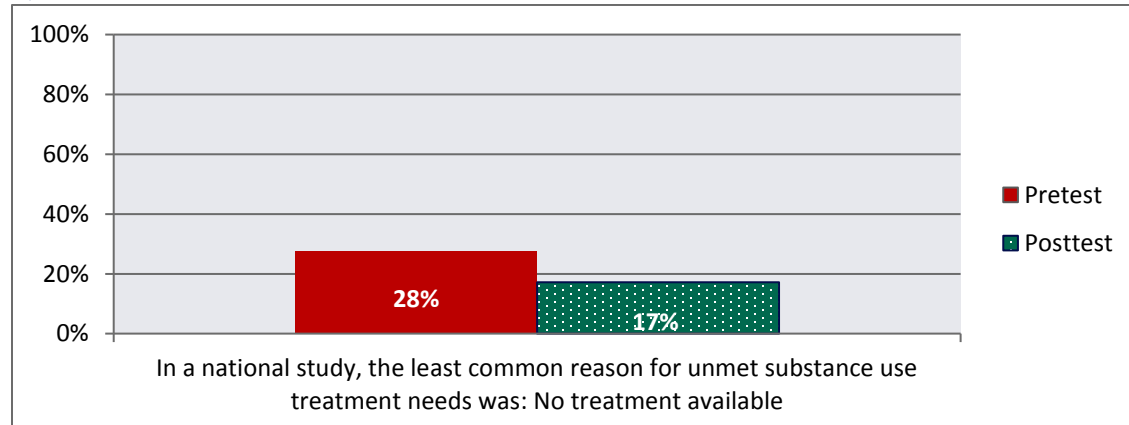
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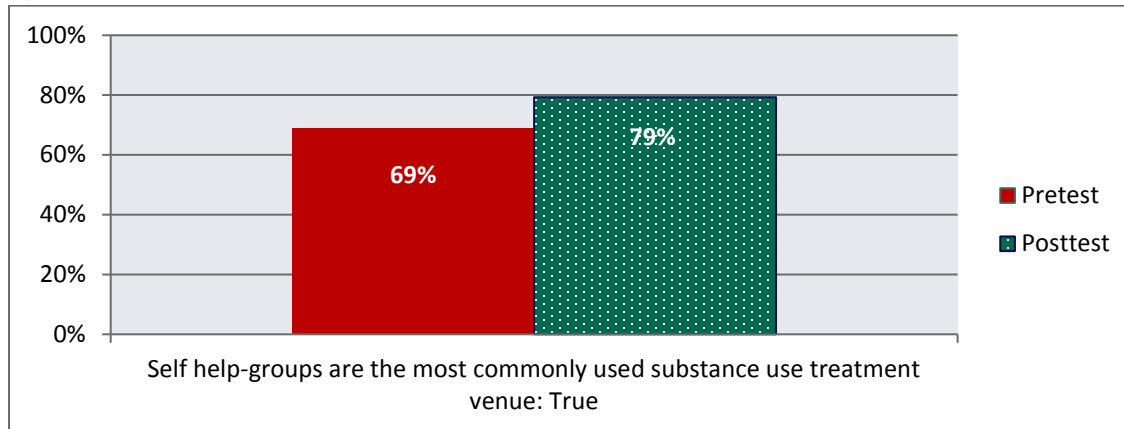
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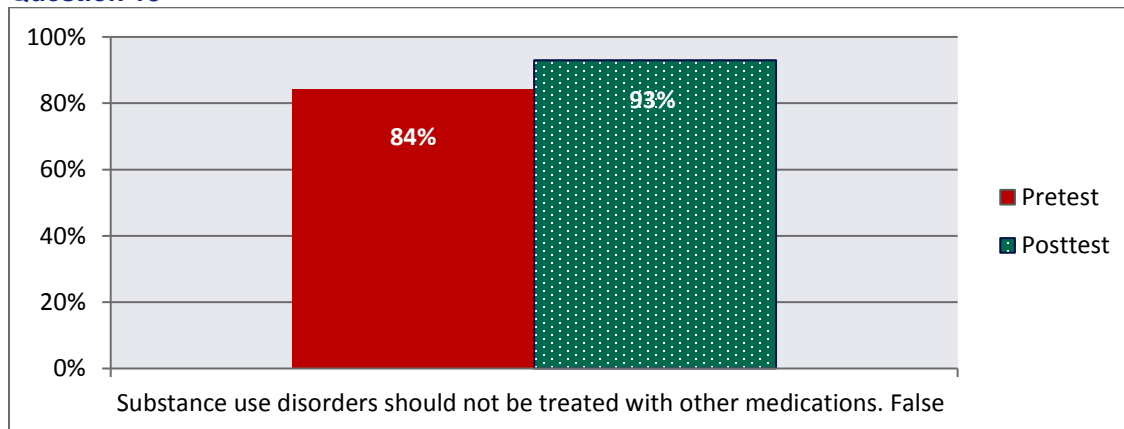
Question 16



Question 17



Question 18



In Appendix 1, we provide this training-specific data in a one-page infographic that provides the information in a visual format.

2. Training 2: Administration of Children's Trauma Screen

The Children's Trauma Screen training was designed to train workers on how to use the Southwest Michigan Children's Trauma Assessment Center (CTAC) screening tool, interpret the results, provide feedback to the family and offer recommendations for further assessment for treatment services. This tool will help caseworkers better identify trauma exposure in the children they serve. With proper training, this tool supports appropriate triaging of services and/or referrals in child welfare agencies.

Demographic Information of Training Participants. As of the December 2017, 103 people participated in the Children's Trauma Screen training. Of those, 96 (93.2%) completed both the pre- and post-test information available for inclusion in the analysis. 2 had a pre-test only and 4 had a post-test only. Approximately 86% (n=83) of those with pre- and post-test data had complete data and comprise the final analytic sample.²

For the training on 10/26, there were 52 surveys completed by 28 people. Of the 28 people, 1 had a pre-test only, 3 had a post-test only, and 24 had both. (1 person with pre-only, 3 people with post-only, 24

² All who completed the pre-test are included in the demographics though not all respondents answered every demographic question.

people with both). Of the 24 people with both, 21 had complete data. For the training on 10/30, 39 surveys were completed by 20 people. Of the 20 people, 1 had post-test data only, and 19 had both. Of the 19 people with both, 13 had complete data. For the training on 11/7, 50 surveys were completed by 25 people, all of whom had both a pre- and a post-test. Of the 25 with both, 23 had complete data. For the training on 11/28, 30 surveys were completed by 16 people. Of the 16 people, 1 had a pre-test only, 1 had a post-test only, and 14 have both a pre- and a post-test. Of the 14 people with both, 12 had complete data. For the training on 11/30, 28 surveys were completed by 14 people, all of whom had a pre- and post-test. All 14 had complete data.

Table 6 presents the demographic information of the Children's Trauma Screen training.

The average age of the training participant was about 41 years of age. The sample was largely female (86%) and white (89%). The majority of the participants had a Bachelor's Degree (70.4%) followed by a Master's Degree (20.4%). Most participants (54.1%) had been at the agency 0-4 years and had been in their current position 0-4 years (63.3%). Social worker was the most common title held by participants (56.1%).

Table 6: *Child Trauma Training Participants Demographics (n = 98)*

| | Mean (SD)/ % |
|--|---------------------|
| Age (in years) | 40.59(11.35) [n=94] |
| Sex | |
| Female | 86% |
| Male | 14% |
| Race | |
| Caucasian/White | 89% |
| Black/African American | 3% |
| American Indian or Alaskan Native | 1% |
| Hispanic/Latino | 1% |
| Decline to state | 5% |
| Other | 1% |
| Education | |
| High school graduate, diploma or the equivalent (e.g. GED) | 1% |
| Associate's Degree | 5.1% |
| Bachelor's Degree (BA, BS, BSW) | 70.4% |
| Master's Degree (MA, MS, MSW) | 20.4% |
| Doctor of Philosophy (PhD) | 1% |
| Others | 1% |
| Decline to state | 1% |
| Length of employment at the current organization/agency | |
| 0 to 4 years | 54.1% |
| 5 to 9 years | 8.2% |
| 10 to 14 years | 14.3% |
| 15 to 20 years | 7.1% |
| 20 years or longer | 15.3% |
| Length of employment at the current position | |
| 0 to 4 years | 63.3% |
| 5 to 9 years | 16.3% |
| 10 to 14 years | 11.2% |
| 15 to 20 years | 5.1% |
| 20 years or longer | 3.1% |
| Job title | |
| Social worker | 56.1% |
| Therapist/Counselor | 2% |
| Program coordinator | - |
| Mental health counselor/Specialist/Consultant | - |
| Case manager/Case management aide | 15.3% |

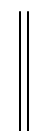


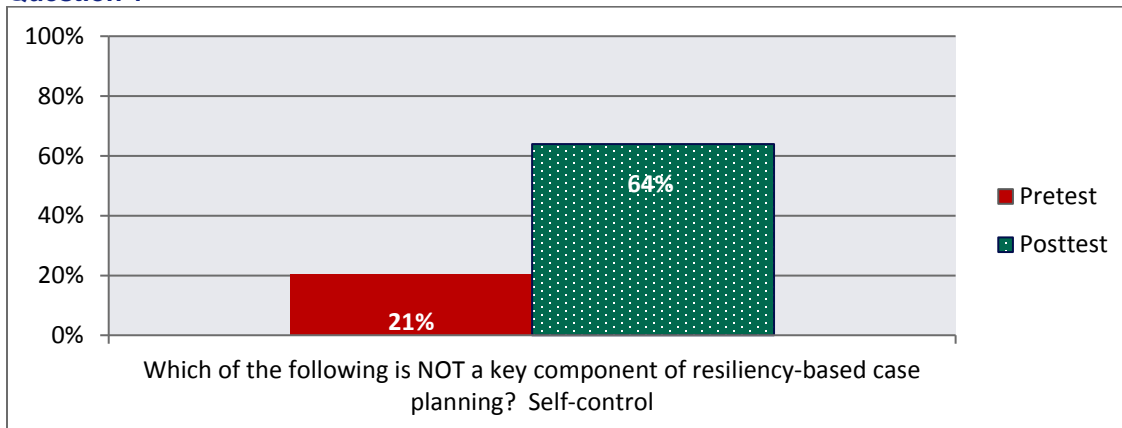
Table 6: *Child Trauma Training Participants Demographics (n = 98)*

| | |
|-----------------------|-------|
| Behavioral specialist | - |
| Physician's Assistant | - |
| Administrative staff | 4.1% |
| Medical doctor | - |
| Other* | 21.4% |
| Decline to state | 1.1% |

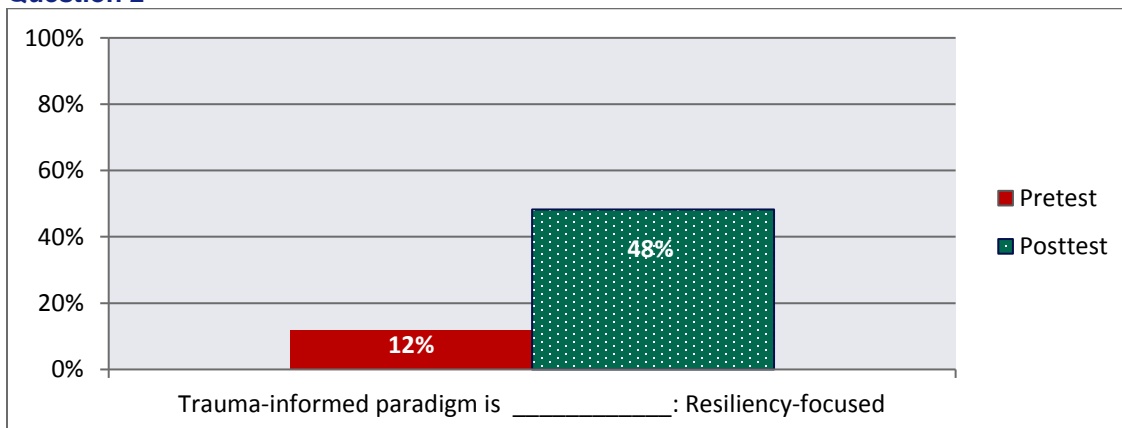
*Responses in this category included BH agency county manager, consultant, deputy director, intake screener, PCSA supervisor, social service caseworker, supervisor, clinical coordinator, clinical director, family peer mentor, AREA manager, business administrator, community behavioral health worker, trainer, fiscal specialist, and assistant director

Findings from Pre- and Post- Training Assessments. The average score of the pre-test for the Children's Trauma Screen training was 7.22 (out of a possible 15). At the completion of training, participants scored an average of 9.10 (out of a possible 15), indicating a 26.04% increase in knowledge about child trauma. The difference between scores at the pre-test ($M = 7.22$, $SD = 1.70$) and those scores at post-test ($M = 9.10$, $SD = 1.97$); $t(7.84) = 1.88$, $p < .001$ were statistically significant using a paired-sample t-test. The individual question results (and correct answers) used in creating the pre- and post-test scores can be found below. As with comparing averages, we only use the analytic sample ($n=83$) as it contains those people who answered all items at both time points.

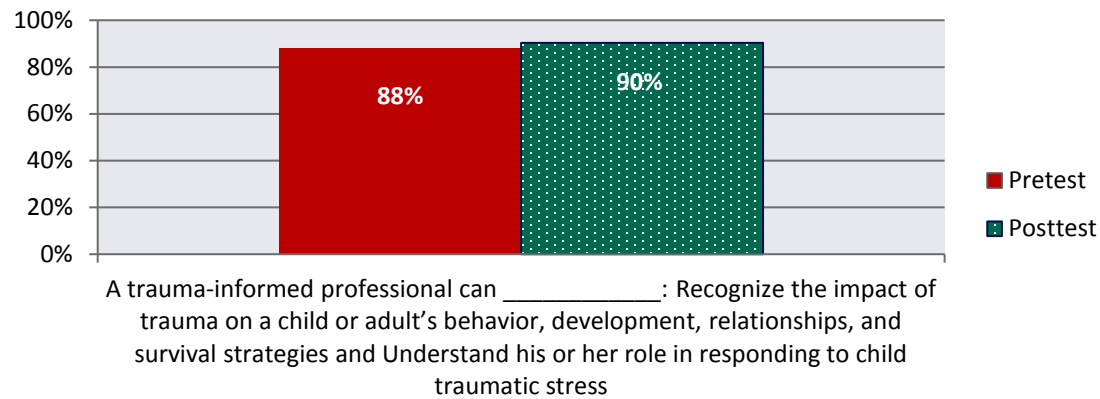
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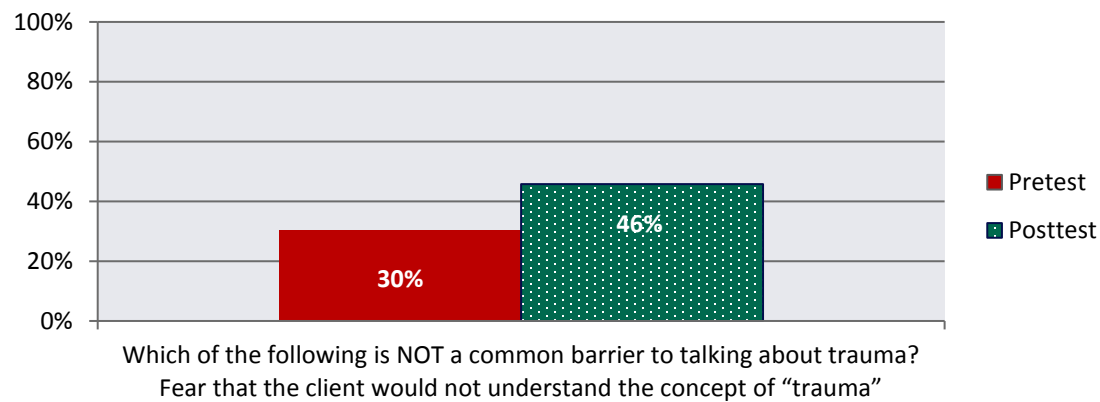
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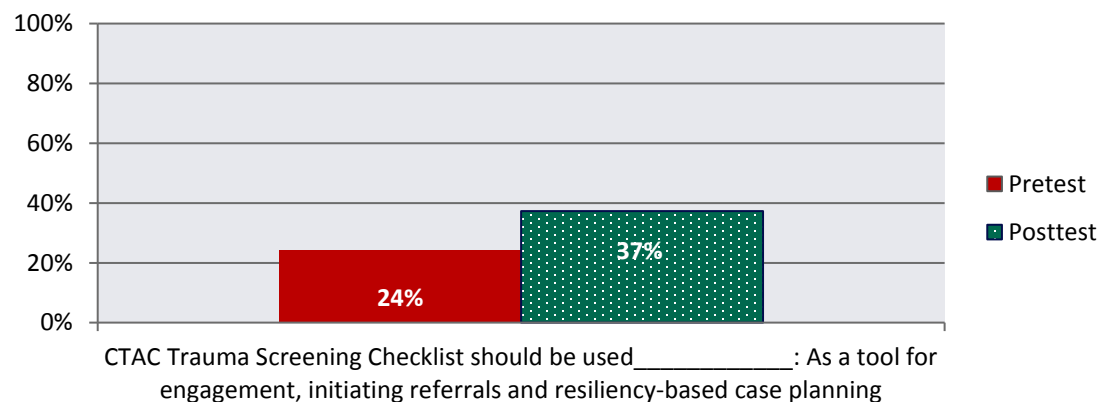
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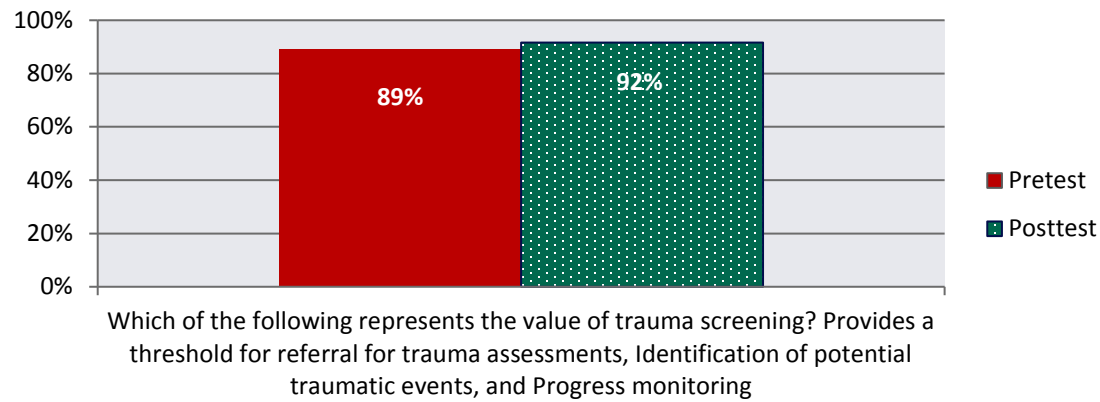
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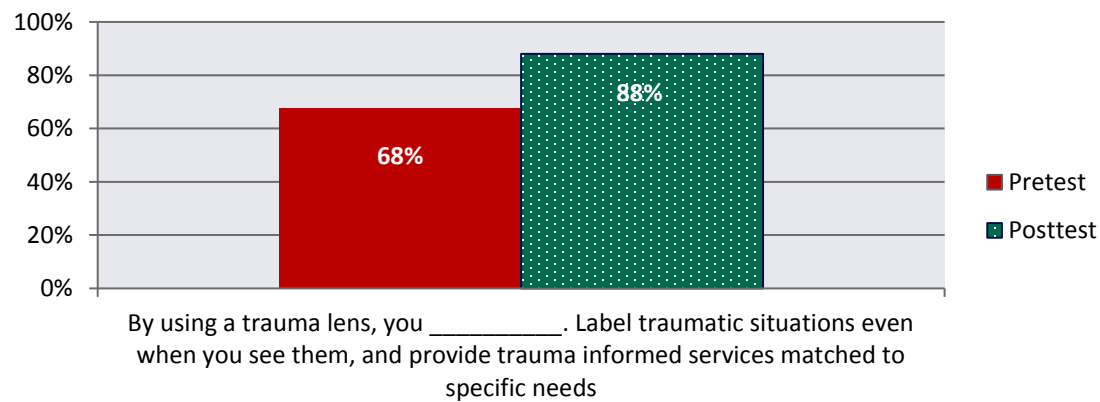
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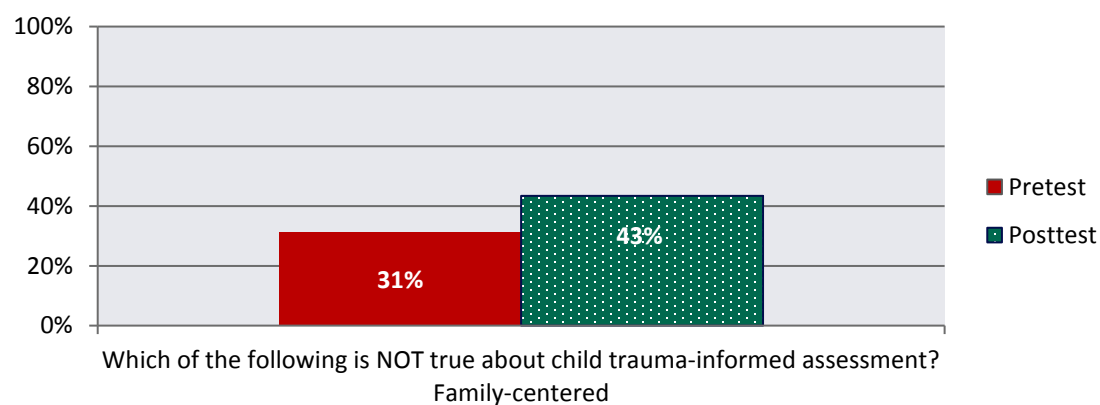
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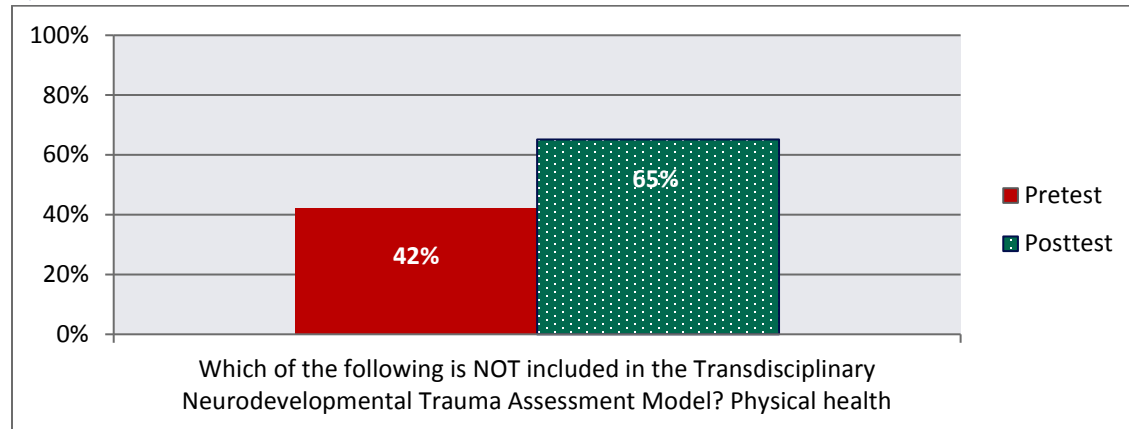
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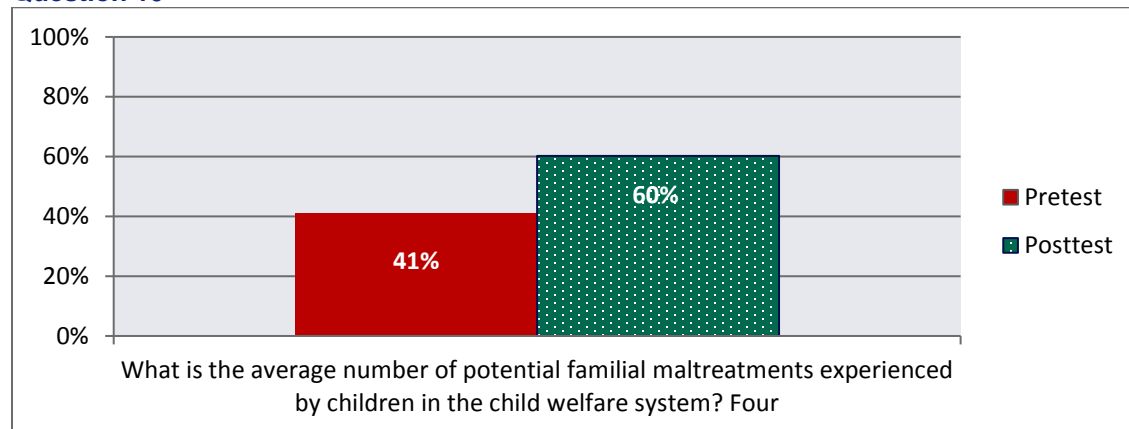
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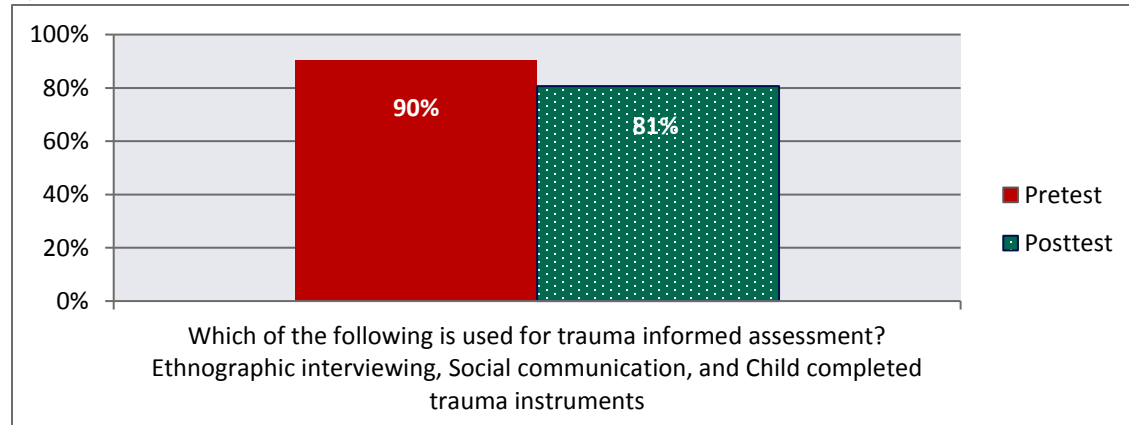
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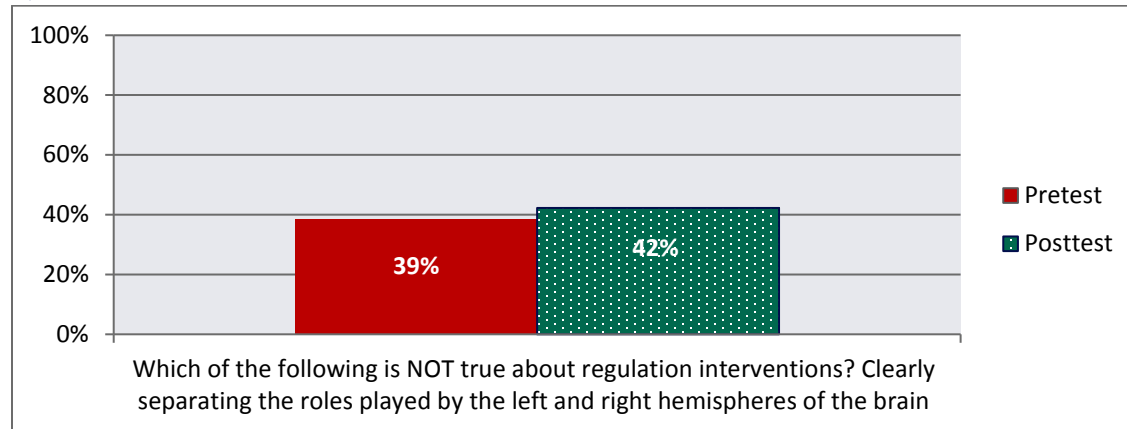
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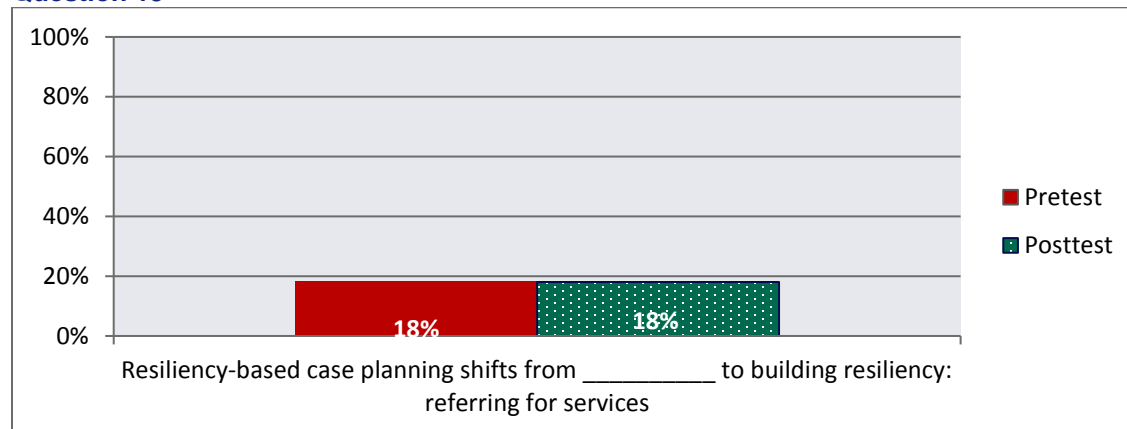
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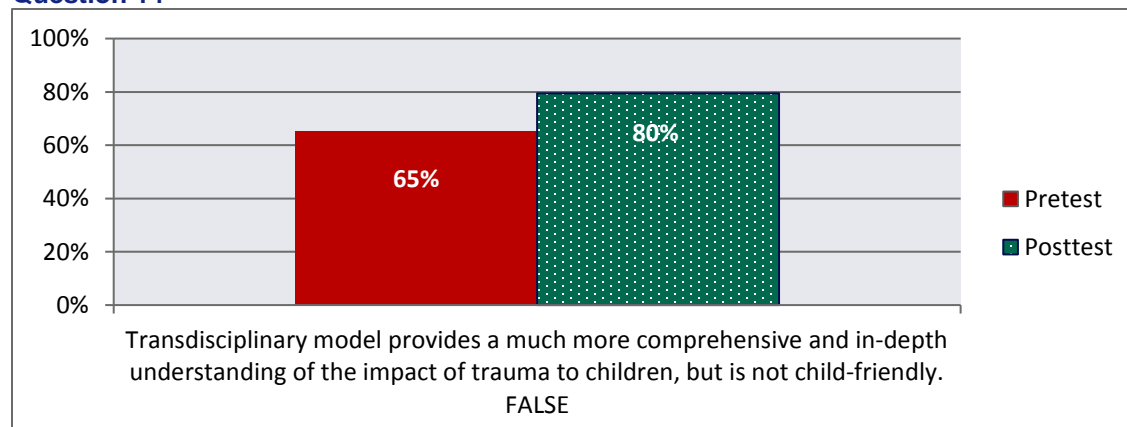
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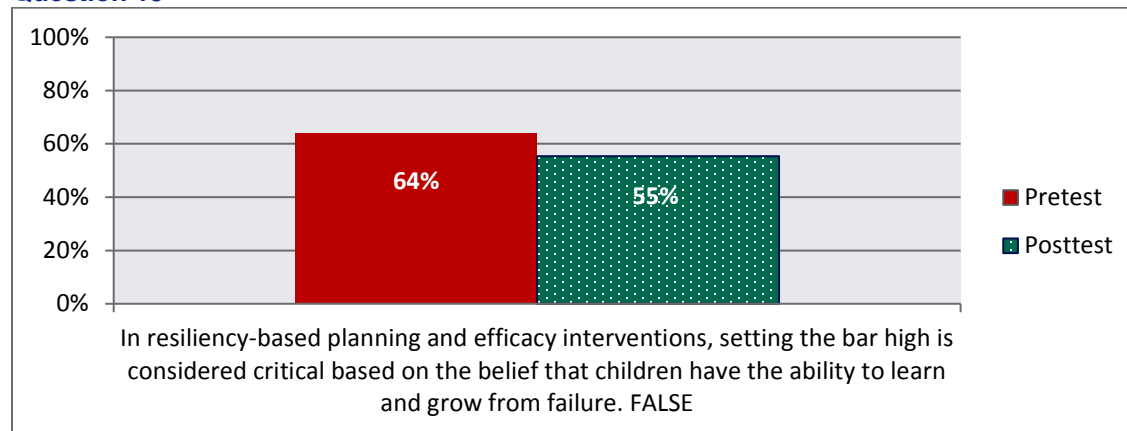
Question 13



Question 14



Question 15



In Appendix 2, we provide this training-specific data in a one-page infographic that provides the information in a visual format.

3. Training 3: Family Team Meetings

The Family Team Meeting training is designed as a joint training for child welfare, behavioral health practitioners, and community partners. These partners participate in a teaming process with families to serve the behavioral health needs of those in the Ohio START program. This training provided an overview of the teaming process in order to meet the needs of the family, including: preparing families and providers for participating in Family Team meetings; basic structure and guidance for facilitating Family Team Meetings; and guidance for handling challenges that may arise in the teaming process.

Demographic Information of Training Participants. As of the December 2017, 26 people participated in the Family Team Meetings training. Of those, 23 (88.5%) completed both the pre- and post-test information available for inclusion in the analysis. In all, 82.6% (n=19) of those with pre- and post-test data had complete data and comprise the final analytic sample.³

Table 7 presents the demographic information of participants in the Family Team Meeting trainings.

Table 7: *Family Team Meeting Participants Demographics (n=19)*

| | Mean (SD)/ % |
|--|--------------|
| Age (in years) | 37 (SD=10.5) |
| Sex | |
| Female | 87.5% |
| Male | 12.5% |
| Race | |
| Caucasian/White | 93.8% |
| Black/African American | 6.3% |
| American Indian or Alaskan Native | 0 |
| Decline to state | 0 |
| Other | 0 |
| Education | |
| High school graduate, diploma or the equivalent (e.g. GED) | 6.3 |
| Associate's Degree | 0 |
| Bachelor's Degree (BA, BS, BSW) | 68.8% |
| Master's Degree (MA, MS, MSW) | 25.0% |
| Doctor of Philosophy (PhD) | 0 |

³ All who completed the pre-test are included in the demographics though not all respondents answered every demographic question.

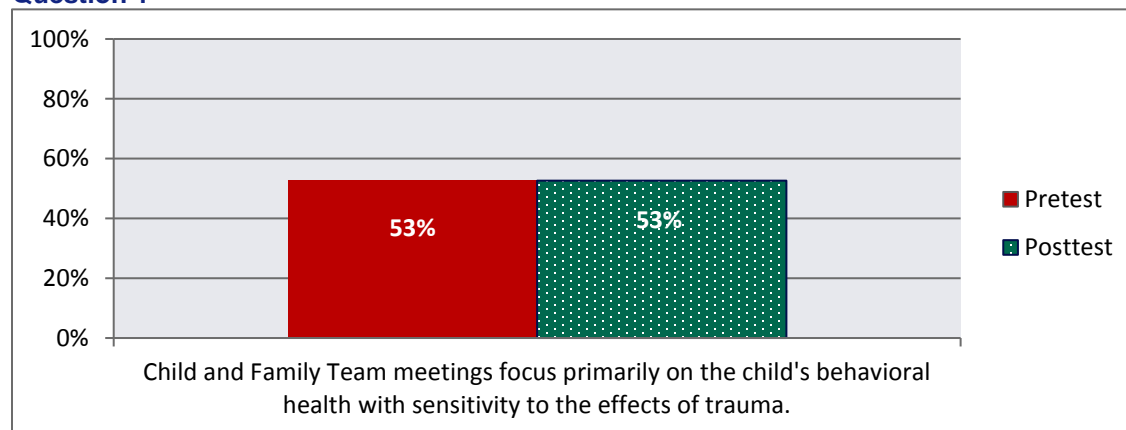
Table 7: Family Team Meeting Participants Demographics (n=19)

| | |
|---|-------|
| Others | 0 |
| Length of employment at the current organization/agency | |
| 0 to 4 years | 68.8% |
| 5 to 9 years | 18.8% |
| 10 to 14 years | 0 |
| 15 to 20 years | 0 |
| 20 years or longer | 12.5% |
| Length of employment at the current position | |
| 0 to 4 years | 87.5% |
| 5 to 9 years | 12.5% |
| 10 to 14 years | 0 |
| 15 to 20 years | 0 |
| 20 years or longer | 0 |
| Job title | |
| Social worker | 37.5% |
| Therapist/Counselor | 0 |
| Program coordinator | 0 |
| Mental health counselor/Specialist/Consultant | 0 |
| Case manager/Case management aide | 0 |
| Behavioral specialist | 6.3% |
| Physician's Assistant | 0 |
| Administrative staff | 6.3% |
| Medical doctor | 0 |
| Other* | 50.2% |

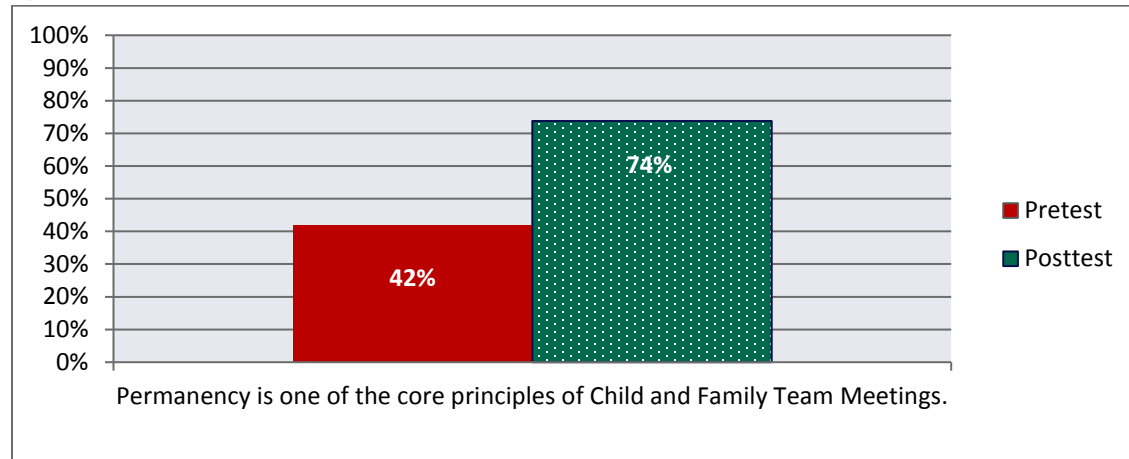
*Responses in this category included: Assistant Director, Caseworker, Certified Peer Specialist, Social Service Worker, Intake Supervisor PCSN

Findings from Pre- and Post- Training Assessments. The average score of the pre-test for the Family Team Meeting training was 11.84 (out of a possible 16). At the completion of training, participants scored an average of 12.16 (out of a possible 16), indicating a 6.41% increase in knowledge about Family Team Meetings. The differences between scores at the pre-test ($M = 11.84$, $SD = 2.04$) and those scores at post-test ($M = 12.16$, $SD = 1.64$) was not statistically significant using a paired-sample t-test. The individual question results (and correct answers) used in creating the pre- and post-test scores can be found below. As with comparing averages, we only use the analytic sample as it contains those people who answered all items at both time points.

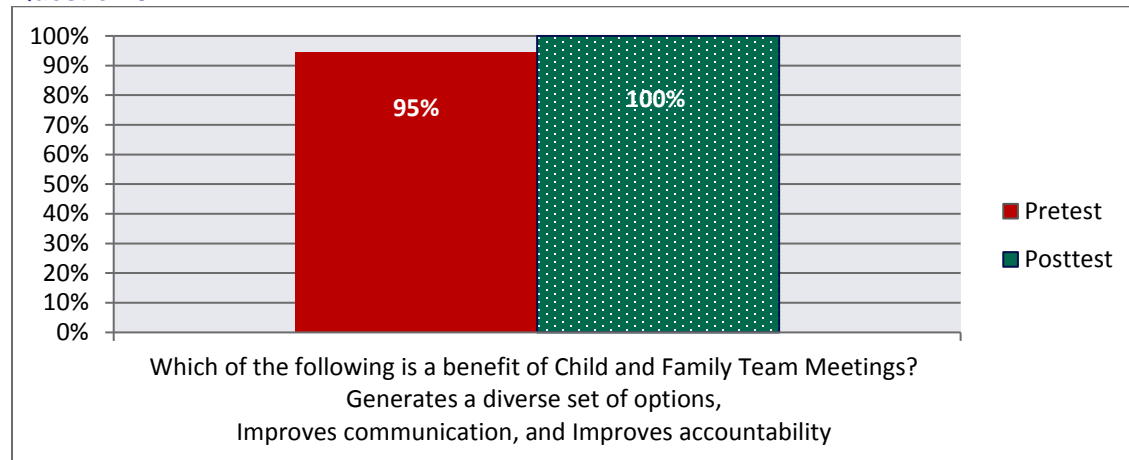
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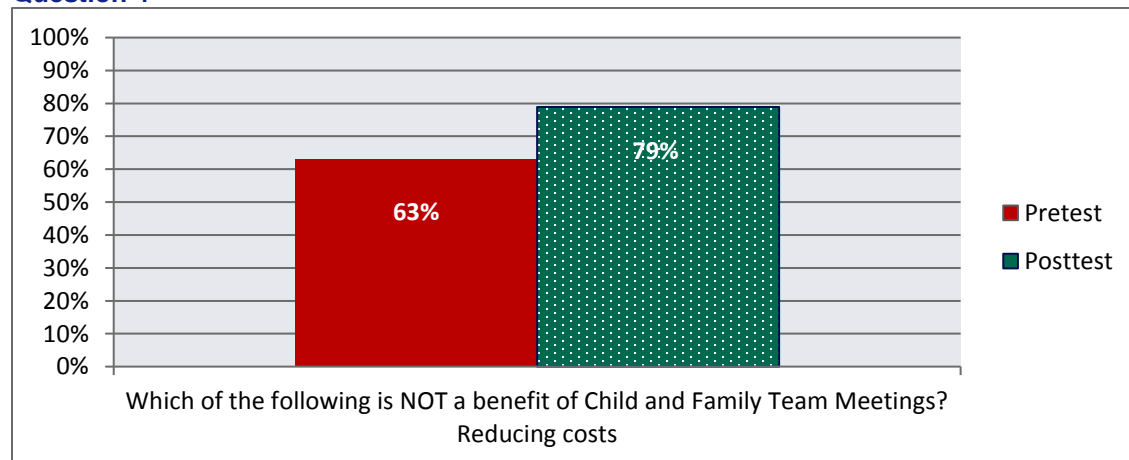
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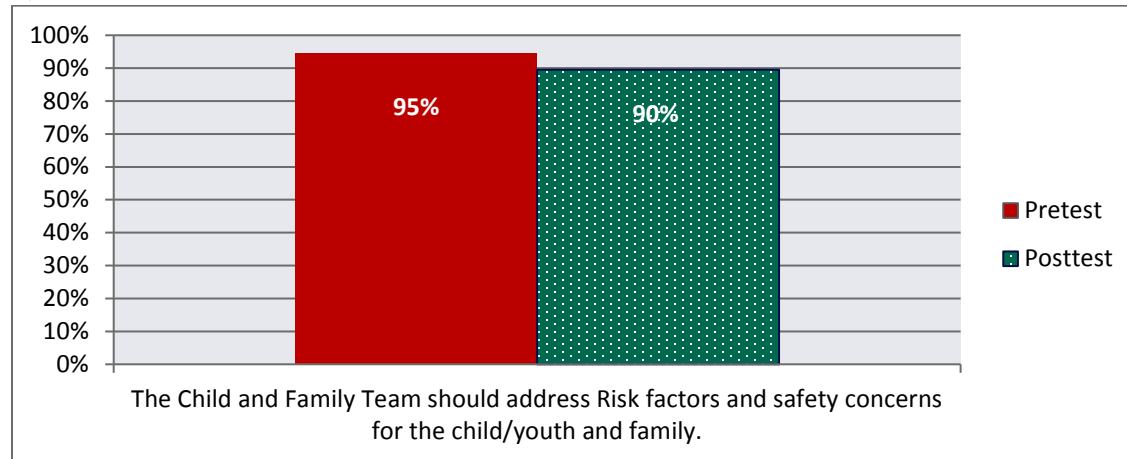
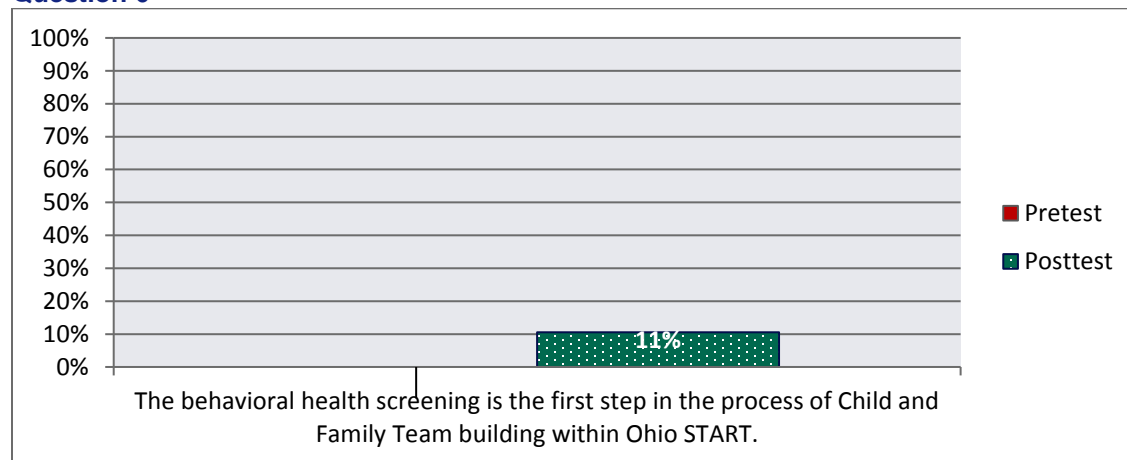
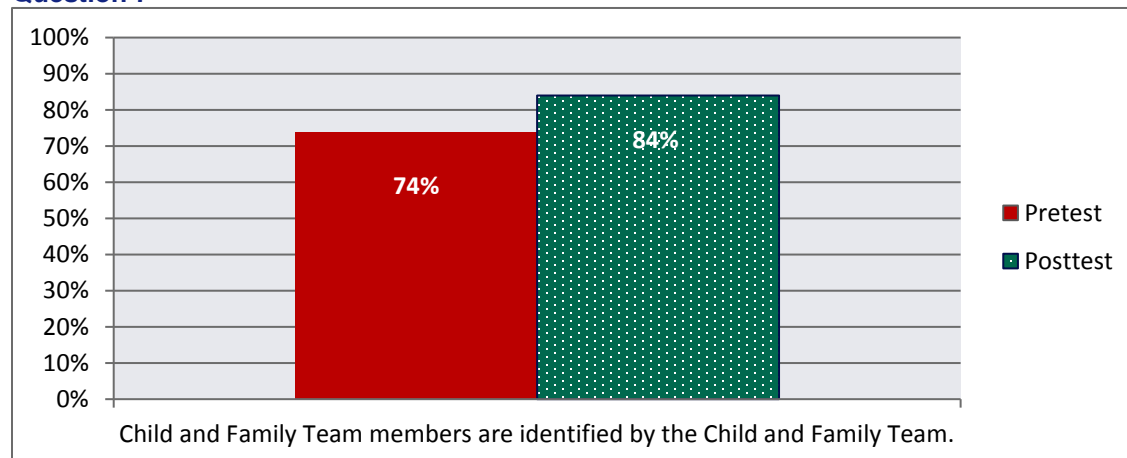


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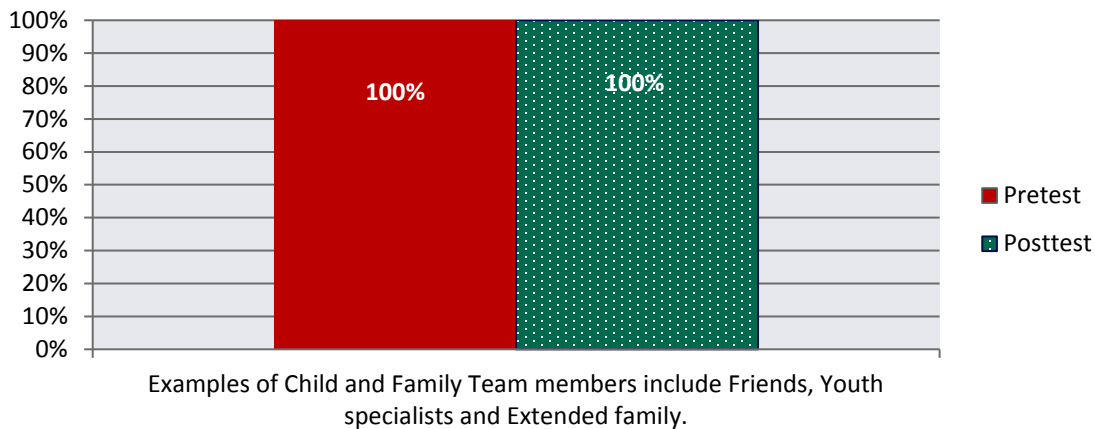


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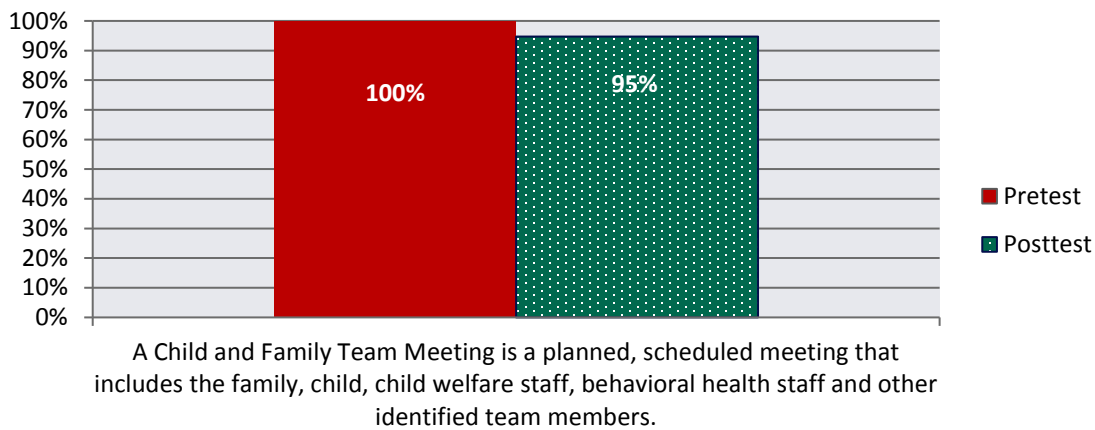


Question 5**Question 6****Question 7**

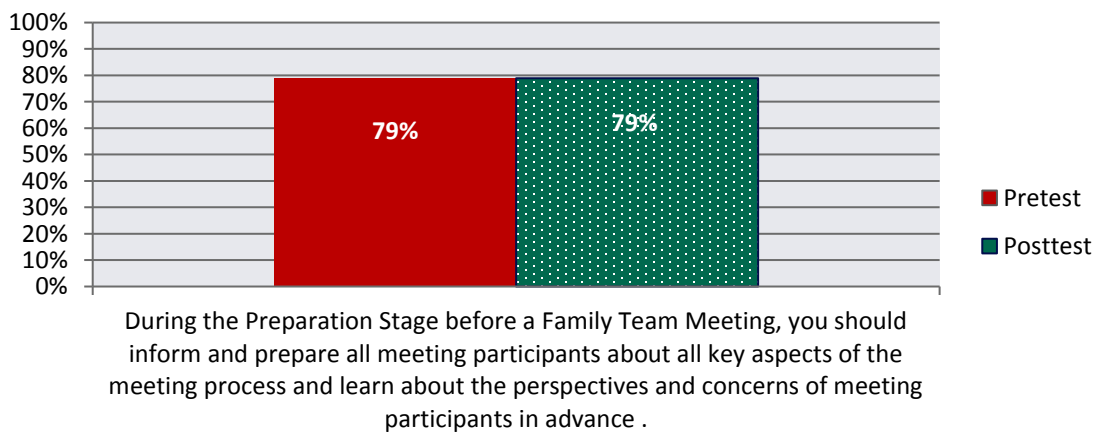
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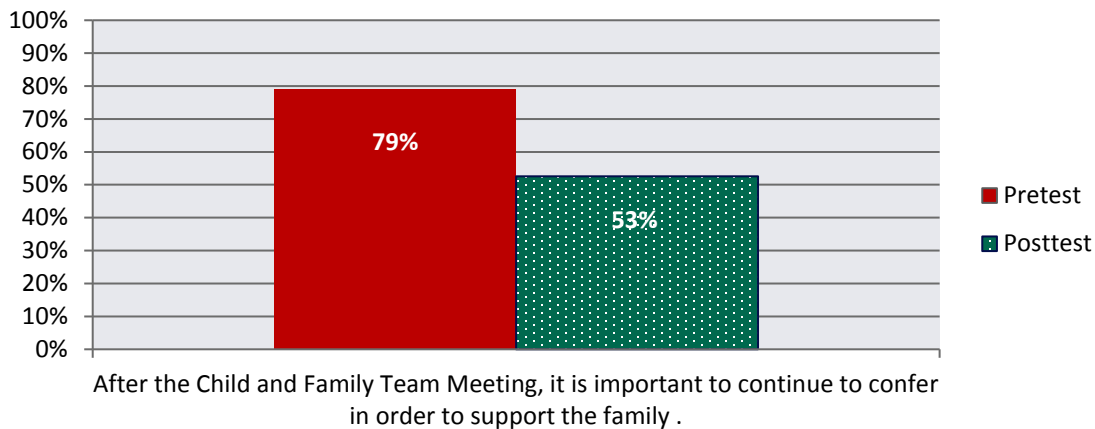
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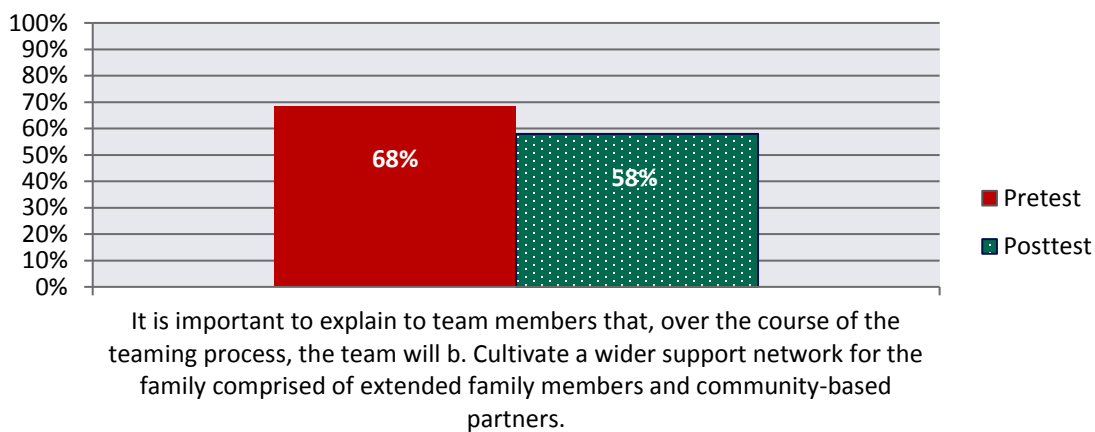
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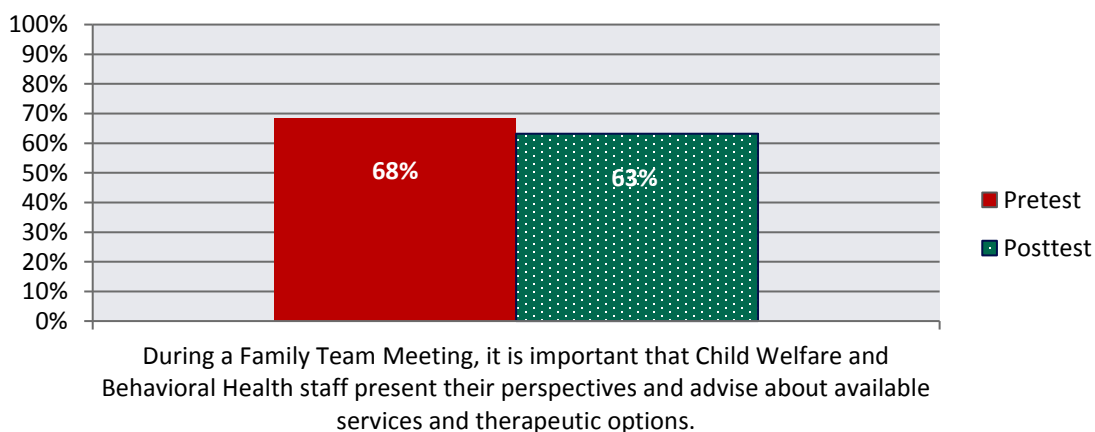
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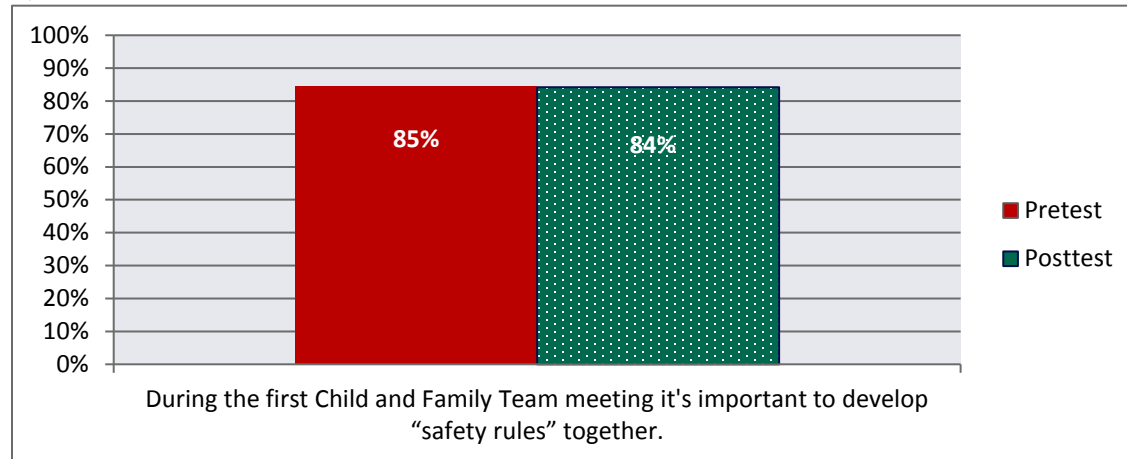
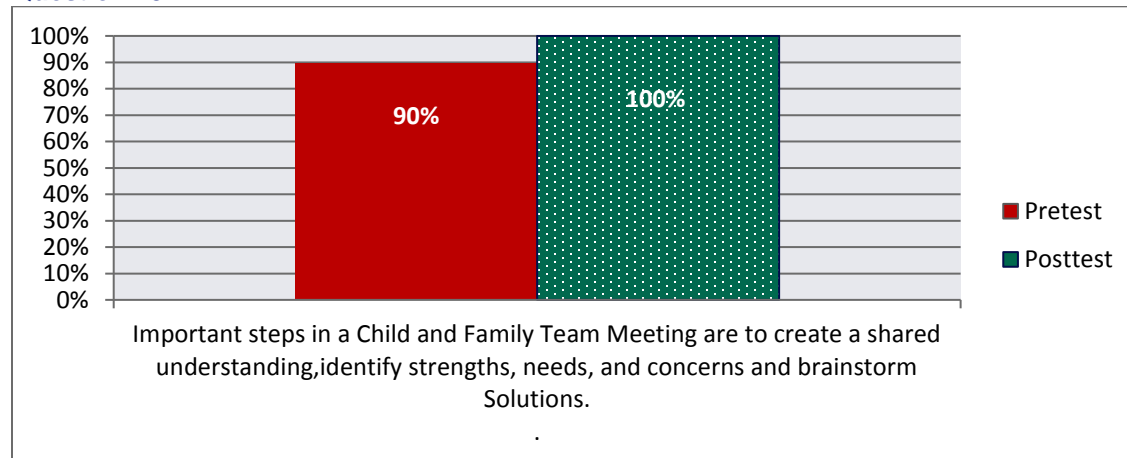
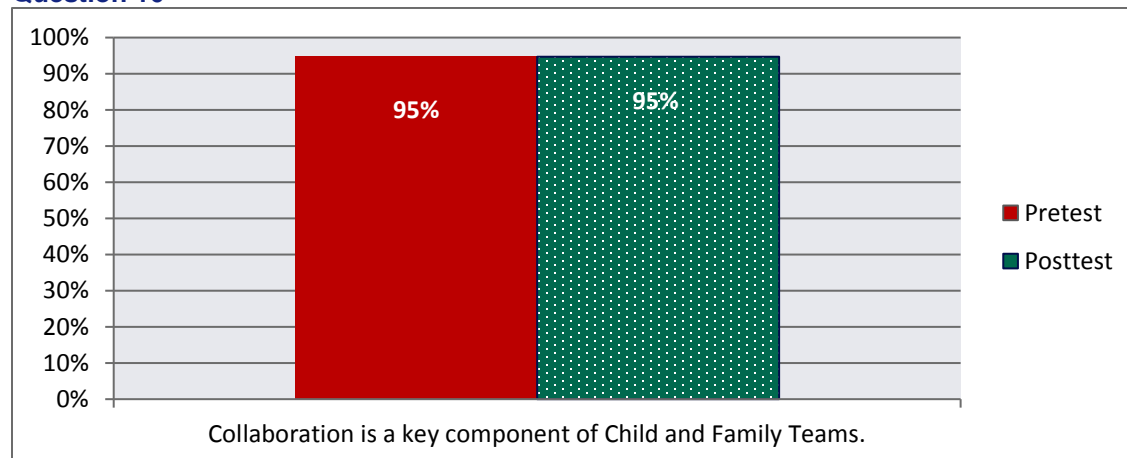


Question 12



Question 13



Question 14**Question 15****Question 16**

In Appendix 3, we provide this training-specific data in a one-page infographic that provides the information in a visual format.

4. Training 4: Ohio START Foundations I

Content for the Ohio START Foundations I training included an overview of the critical elements of collaborative practice that are necessary for the successful implementation of OhioSTART. Components of the OhioSTART model include: using universal screening tools for substance use and trauma screening, developing protocols for quick access to treatment, information sharing with treatment partners and courts, focus on family centered services, implementing family team meetings and decision-making, and integrating recovery support into the entire process. Ohio START Teams assessed their implementation progress, received technical support and worked together on an action plan for moving their program forward.

Demographic Information of Training Participants. As of December 2017, 63 people participated in the Foundations I training. 63 received trainings where the pre- and post-test materials were available for use. Of those, 53 (84.1%) completed both the pre- and post-test information available for inclusion in the analysis. 9 had pre-test only, 1 had a post-test only, and 53 had both. Almost 36% (n=19) of those with pre- and post-test data had complete data and comprise the final analytic sample.⁴

For the training on 10/31, 35 surveys were completed, from 20 individuals. Of these 20 people, 5 completed a pre-test only, and 15 had both a pre- and post-test. Of the 15 with both tests, only 4 answered every question. For the training on 11/1, 41 surveys were completed by 21 individuals. Of those 21 people, 1 person completed a pre-test only and 20 had both a pre-and post-test. Of the 20 with both surveys, only 9 had complete data. For the training on 11/2, there were 40 surveys completed by 22 people. Of those 22 people, 3 completed the pre-test only, 1 completed the post-test only, and 18 completed both. Of the 18 people who completed both surveys, only 6 had complete data.

Table 8 presents the demographic information of the Ohio START Foundations I training.

The average age of training participant was about 45 years old. Most participants were female (80%) and white (96.6%). Many participants had a Bachelor's degree (45.8%) or Master's degree (47.5%). 40.7% of the participants were at the agency for 0-4 years, while 59.3% of participants were in their current position 0-4 years. The most common job held by participants was social worker (44.1%).

Table 8: *Foundations I Participants Demographics (n=59)*

| | Mean (SD)/ % |
|--|--------------------|
| Age (in years) | 44.70(9.83) [n=57] |
| Sex | |
| Female | 80% |
| Male | 20% |
| Race | |
| Caucasian/White | 96.6% |
| Black/African American | 1.7% |
| American Indian or Alaskan Native | -- |
| Latino/Hispanic | 1.7% |
| Decline to state | -- |
| Other | -- |
| Education | |
| High school graduate, diploma or the equivalent (e.g. GED) | 3.4% |
| Associate's Degree | 3.4% |
| Bachelor's Degree (BA, BS, BSW) | 45.8% |
| Master's Degree (MA, MS, MSW) | 47.5% |

⁴ All who completed the pre-test are included in the demographics though not all respondents answered every demographic question.

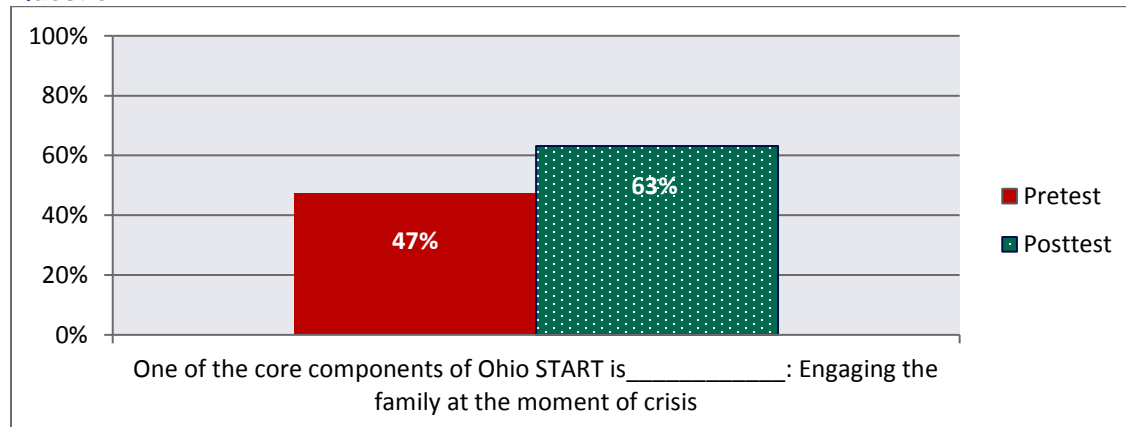
Table 8: Foundations I Participants Demographics (n=59)

| | |
|---|-------|
| Doctor of Philosophy (PhD) | -- |
| Others | -- |
| Length of employment at the current organization/agency | |
| 0 to 4 years | 40.7% |
| 5 to 9 years | 8.5% |
| 10 to 14 years | 11.9% |
| 15 to 20 years | 18.6% |
| 20 years or longer | 20.3% |
| Length of employment at the current position | |
| 0 to 4 years | 59.3% |
| 5 to 9 years | 20.3% |
| 10 to 14 years | 5.1% |
| 15 to 20 years | 11.9% |
| 20 years or longer | 3.4% |
| Job title | |
| Social worker | 44.1% |
| Therapist/Counselor | 3.4% |
| Program coordinator | 1.7% |
| Mental health counselor/Specialist/Consultant | 1.7% |
| Case manager/Case management aide | 1.7% |
| Behavioral specialist | 1.7% |
| Physician's Assistant | 1.7% |
| Administrative staff | 11.9% |
| Medical doctor | -- |
| Other* | 32.2% |

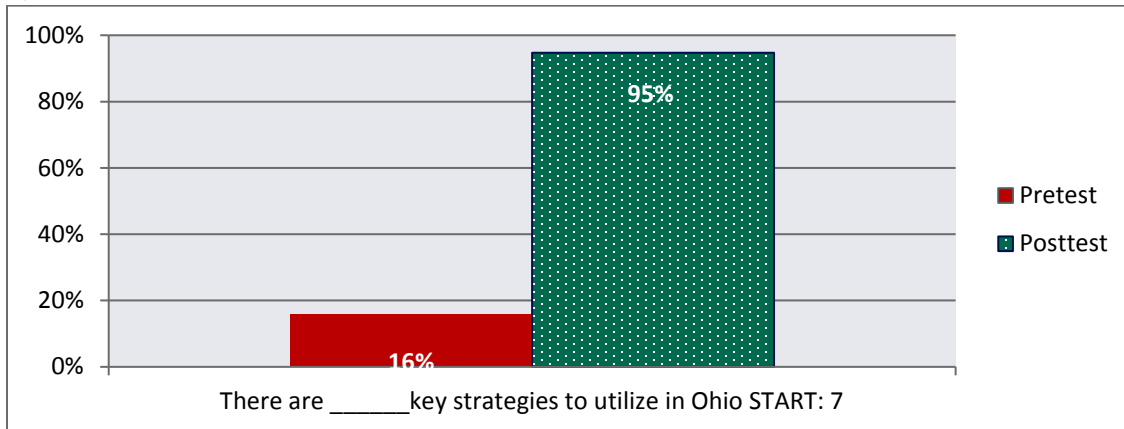
*Responses in this category included BH agency county manager, consultant, deputy director, intake screener, PCSA supervisor, social service caseworker, supervisor, clinical coordinator, clinical director, family peer mentor, AREA manager, business administrator, community behavioral health worker, trainer, fiscal specialist, and assistant director

Findings from Pre- and Post- Training Assessments. The average score of the pre-test for the Foundations I training was 10 (out of a possible 16). At the completion of training, participants scored an average of 11.26 (out of a possible 16), indicating a 12.6% increase in knowledge about START Foundations. The difference between scores at the pre-test ($M = 10$, $SD = 1.67$) and those scores at post-test ($M = 11.26$, $SD = 2.00$); $t(3.19) = 1.26$, $p < .001$ were statistically significant using a paired-sample t-test. The individual question results (and correct answers) used in creating the pre- and post-test scores can be found below. As with comparing averages, we only use the analytic sample ($n=19$) as it contains those people who answered all items at both time points.

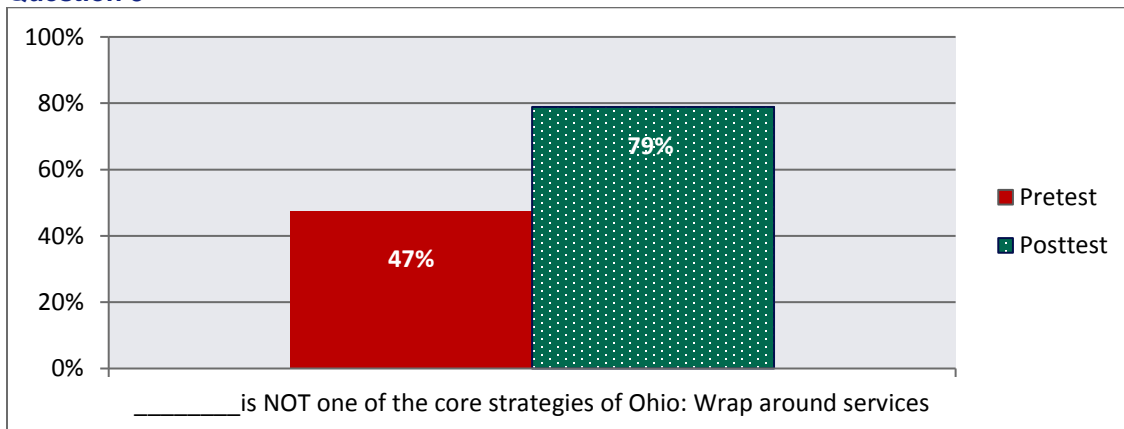
Question 1



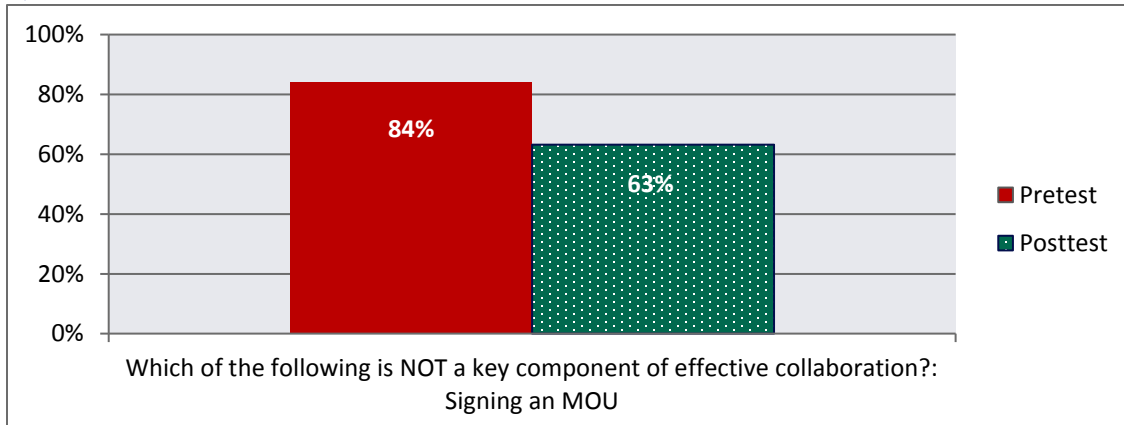
Question 2



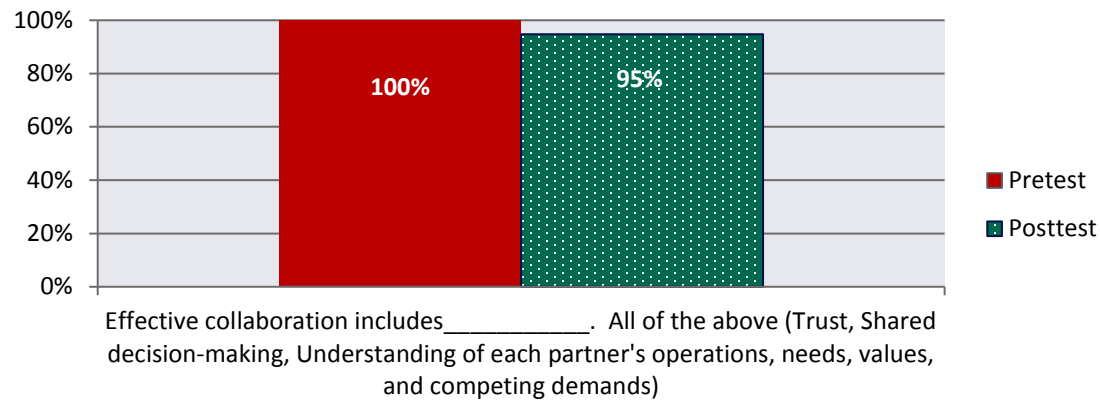
Question 3



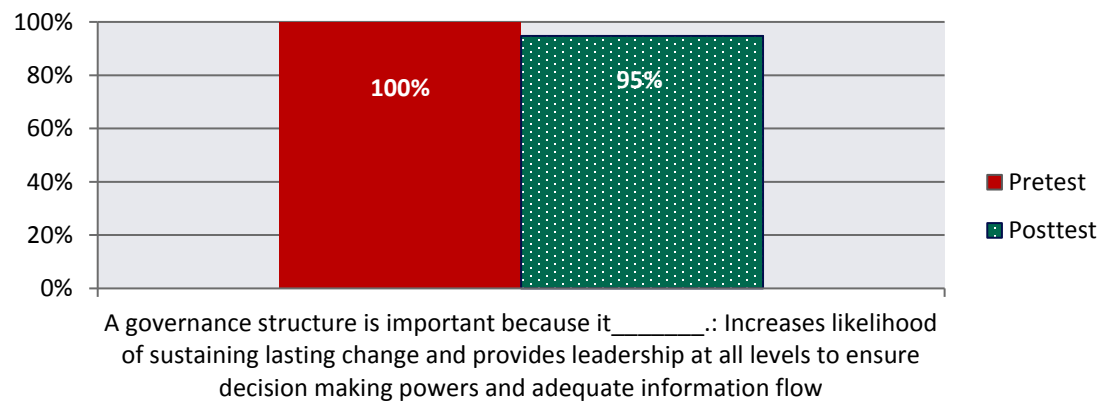
Question 4



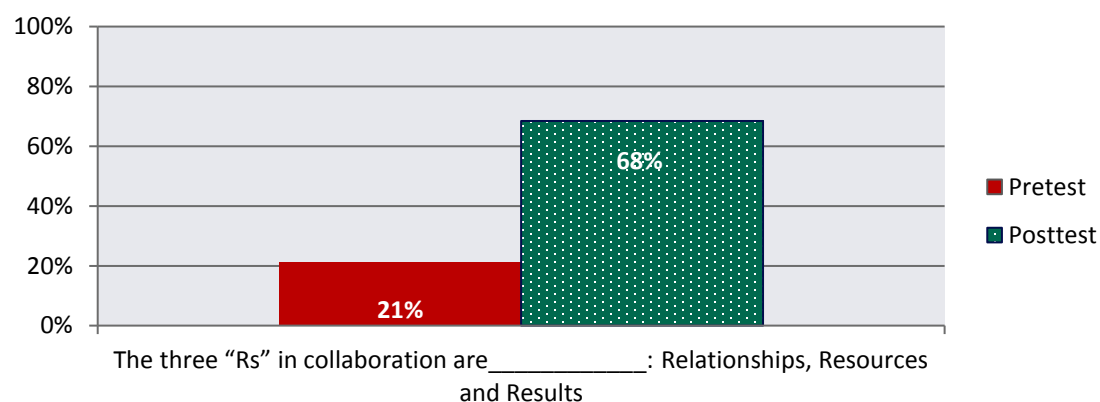
Question 5



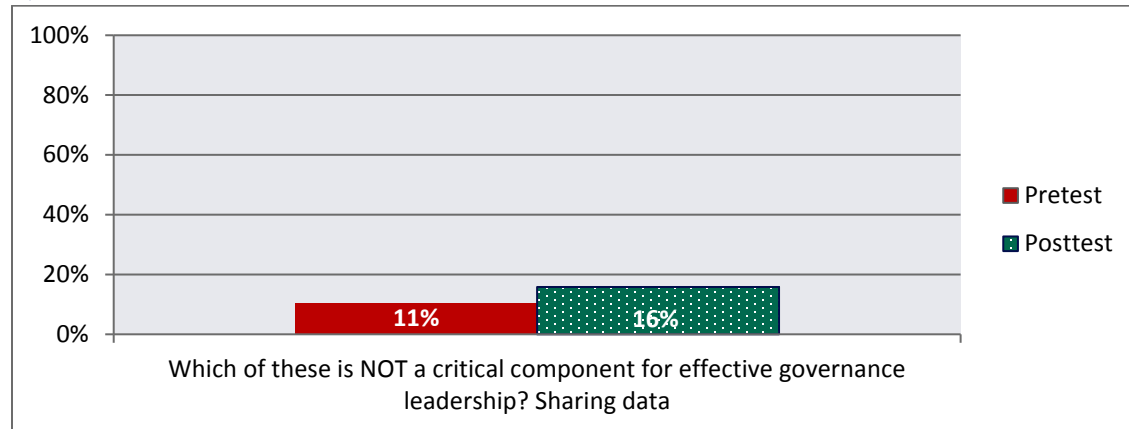
Question 6



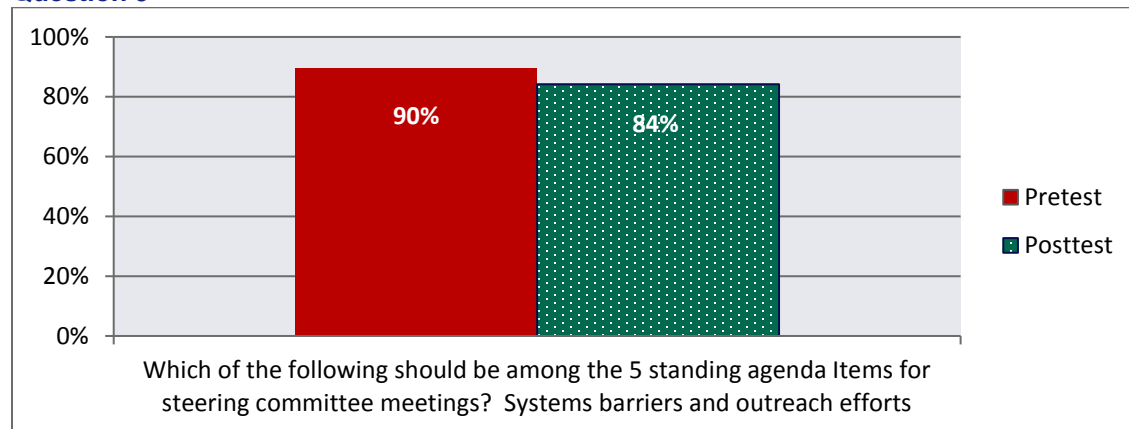
Question 7



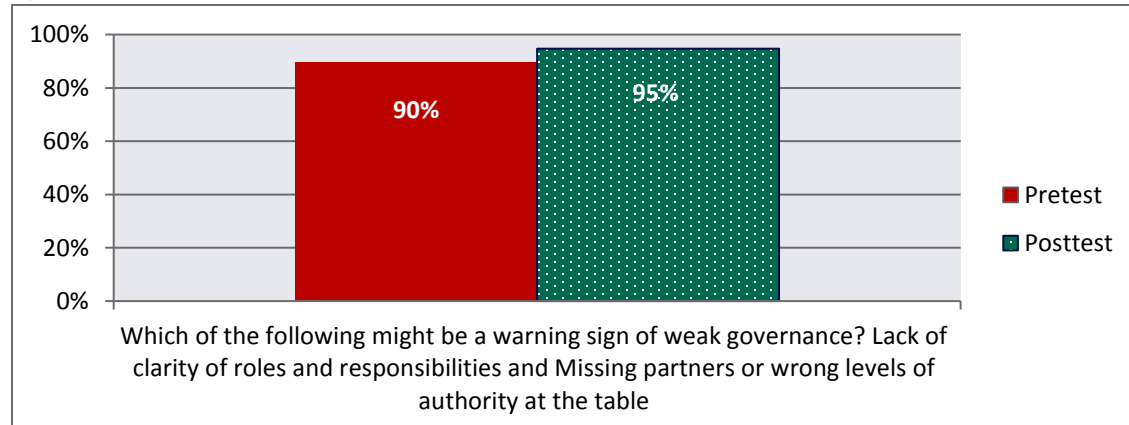
Question 8



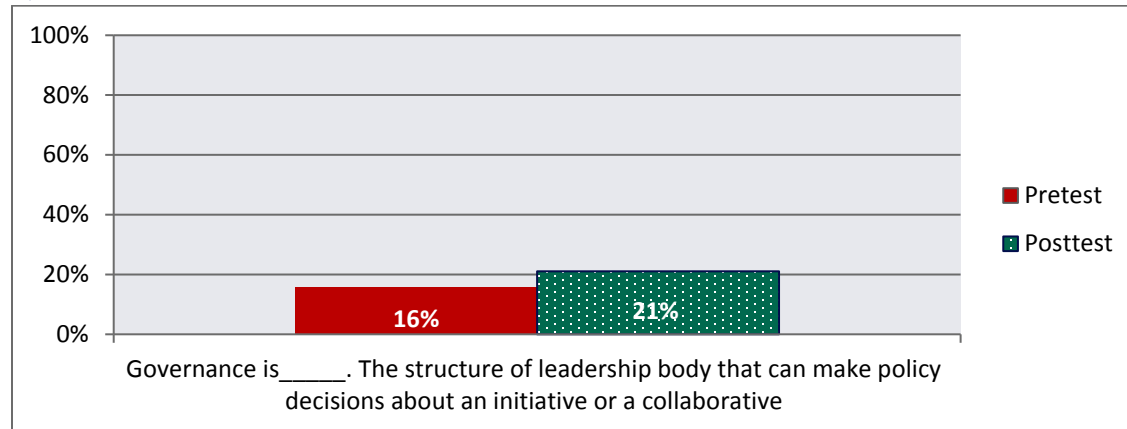
Question 9



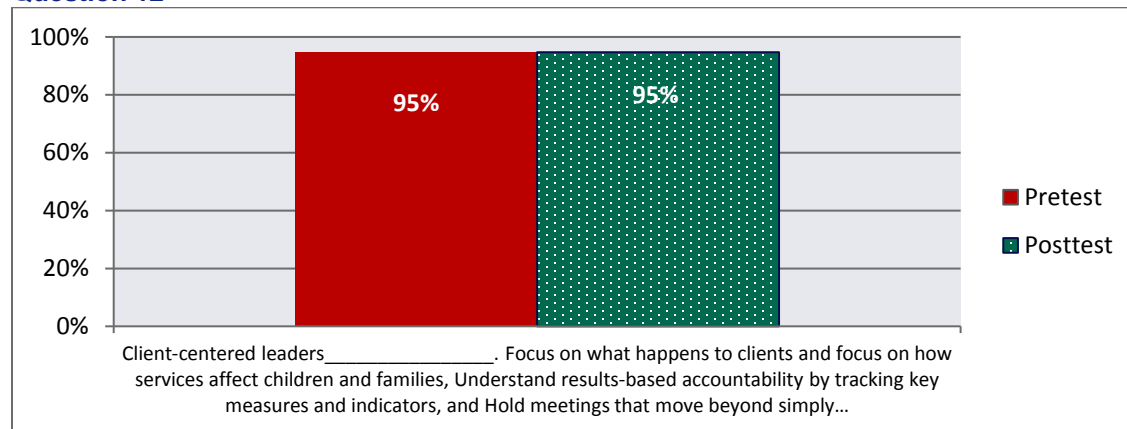
Question 10



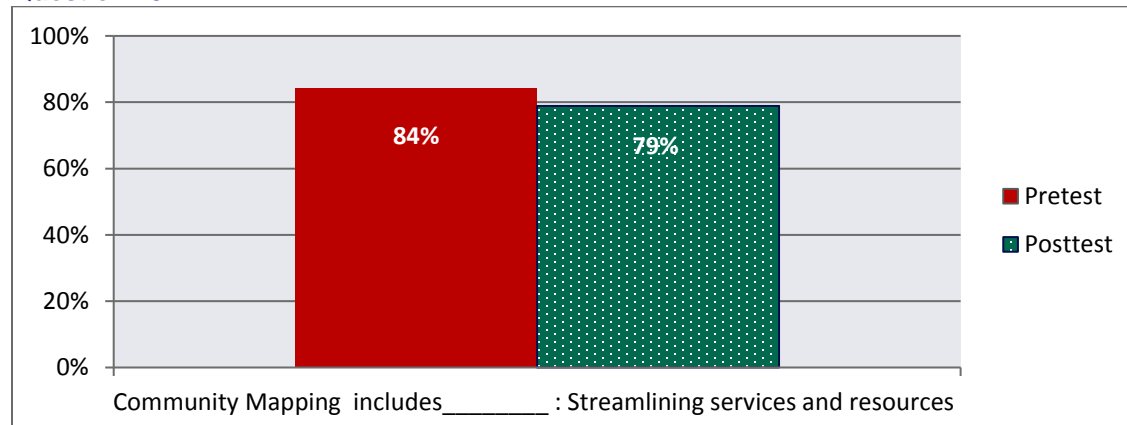
Question 11



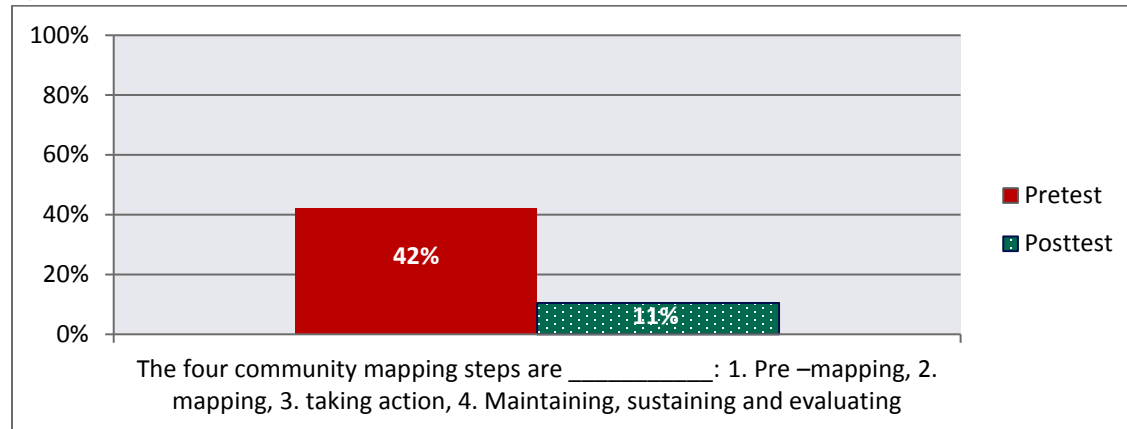
Question 12



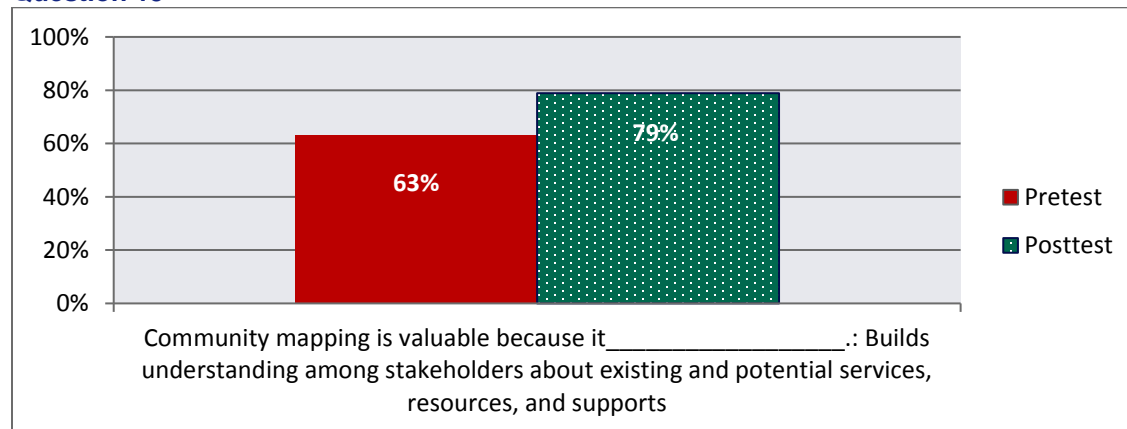
Question 13



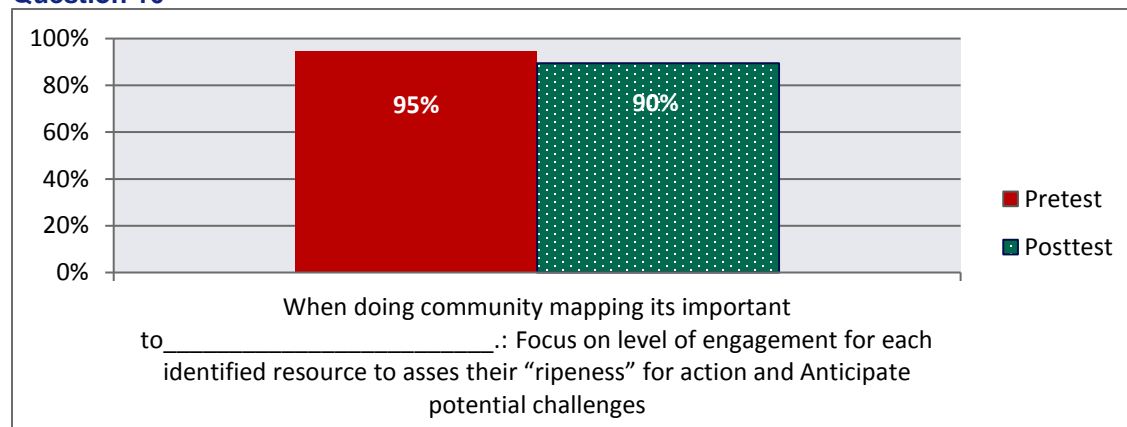
Question 14



Question 15



Question 16



In Appendix 4, we provide this training-specific data in a one-page infographic that provides the information in a visual format.

Implementation Goal 5:

Stronger collaboration established between the PCSA, behavioral health provider, and the juvenile/family court and specified in a signed MOU

In order to assess Implementation Goal 5, we have received seed grant funding from The Ohio State University College of Social Work. At the beginning of the program, we collected all documents related to existing contracts and memorandums of understanding between the local public children's service association and service providers. We have asked the counties to provide any current contracts so we can assess how these agreements may have changed in order to address the cooperation needed to successfully implement Ohio START.

Process Evaluation

With funding from Casey Family Programs, we have refined the Needs Portal, a hybrid web-based resource, referral and Management Information System (MIS) that enables individuals to receive access to social and health services more quickly. This will allow us to better assess the process evaluation outcomes. The Needs Portal will be used to create referrals for Ohio START services (Support Tickets), track dates of service provision, collect socio-demographic information, and record responses to assessments for substance use (UNCOPE) and trauma exposure (Adverse Childhood Experiences-ACES; Children Trauma Assessment Center trauma screening checklist).

Below we provide the specifics of the Needs Portal and changes that have been made to make this tool address the specific objectives of Ohio START.

Primary Users

The secure, firewalled website, www.needsportal.com, has been redesigned to address Ohio START protocols. The original Needs Portal was developed with Los Angeles County Department of Children and Family Services in order to provide a more efficient format to provide referrals to agencies for child welfare families. Here, we modify the Needs Portal to better track information about families that will inform their case plan and service use. The primary users of the Needs Portal are caseworkers, service providers, parent mentors, and OSU evaluation and support staff. The user type determines the functions available and level of information accessed on the website. For example, due to confidentiality, parent mentors have limited access to the Needs Portal. They are not permitted to create Support Tickets or view sensitive information (e.g. types of victimization). Table 9 below shows permission levels granted to each user type.

Table 9: *User Permission Levels: Ohio START*

| | Caseworkers | Service Providers | Parent Mentors | Evaluation / Support Staff |
|-------------------------------------|-------------|-------------------|----------------|----------------------------|
| <u>User Actions</u> | | | | |
| Create Support Tickets | Yes | No | No | Yes |
| View Support Tickets: Case Overview | Yes | Yes | No | Yes |
| View Support Tickets: Needs Table | Yes | Yes | Yes | Yes |

| | | | | |
|---|-----|-----|-----|-----|
| View Support Tickets: Demographics, Insurance status, allegations, placements & Special Needs | Yes | Yes | No | Yes |
| Edit Needs Table | Yes | Yes | No | Yes |
| Edit Direct Referral Table | Yes | Yes | No | Yes |
| Share Support Tickets | Yes | Yes | No | Yes |
| Edit Home Visits Table (Share tab) | Yes | No | Yes | Yes |
| Transfer Support Tickets | Yes | No | No | Yes |
| Edit Outstanding Service Needs Table (Transfer Tab) | Yes | No | No | Yes |
| Close Support Tickets | Yes | No | No | Yes |
| Delete Support Tickets | No | No | No | Yes |
| Change user permissions | No | No | No | Yes |
| Note: Access to the Needs Portal is granted to each user individually. Support staff generates user specific registration codes that each user enters in order to register and create an account. | | | | |

Specific Changes Implemented

We made changes to the current structure of the Needs Portal to add the Management Information Systems piece. This allows us to better assess family needs and identify the services they can utilize to prevent further abuse or neglect. The specific programming changes implemented are detailed below.

Case Overview

- 1) UNCOPE assessment: Required for all Support Tickets generated.
 - Automated threshold notices generated to alert caseworkers that: 1) all clients scoring 2 or higher must be referred to behavioral health services for further assessment and 2) all clients scoring 3 or higher qualify for participation in Ohio START
- 2) Option to select case type: Ohio START only, Service referral only, or Ohio START and service referral

Demographic Report

- 1) Option to indicate types of victimization for each household member
- 2) Option to indicate Special Needs of each household member
- 3) ACEs questionnaire automatically generated for each adult member of the household
- 4) CTAC (0 -5) and/or CTAC (6-18) automatically generated for each minor based on age

Service Request

- 1) Option to make referrals directly to participating services providers
- 2) Inclusion of a list of other direct services provided to families (e.g., information, personal advocacy, emotional support, safety)

Share Support Tickets

- 1) Caseworkers able to share Support Tickets with parent mentors and update/edit simultaneously
- 2) Parent mentors indicate dates and relevant notes for each home visit

Email Notifications

Caseworkers:

- Email notification when service providers “accept” direct referrals
- Email notification when service providers are “unable to accept” direct referrals
- Email notification if no response to direct referral after three days

Service Providers:



- Separate email notifications for direct referrals and service requests
- Parent Mentors
- Email notification for requests to “share” Support Ticket

Flow of Information between Caseworkers, Providers and Parent Mentors

Figure 5 shows the web programming changes implemented to facilitate and manage the flow of information between caseworkers, service providers, and parent mentors. We provide a copy of the “quick start guide” for caseworkers in Appendix 5 that outlines these steps. When a caseworker receives a new case (family), he/she must create a case plan that addresses the problems that contributed to abusive and neglectful parenting practices.

The caseworker logs in to the Needs Portal website (www.needsportal.com) and creates an electronic referral called a “Support Ticket”⁵ for the family. Caseworkers may use the Support Ticket to:

- 1) Generate a request for services and/or
- 2) Make a direct agency referral

Each Support Ticket describes the overall reasons that brought the family into the child welfare system, the types of services being requested, UNCOPE assessment, socio-demographic information (e.g., types of victimization, age, gender, race/ethnicity), trauma screenings and assessments (ACES, CTAC), residential zip codes, and insurance status of each member of the household.

Service requests (Path A on Figure 5). Providers are notified via email when a Support Ticket in their subscribed content area is created. In other words, an agency that only provides substance abuse services will only receive an email notice when a Support Ticket has been opened asking for substance abuse services. One email is sent daily, in the digest format. The digest format provides a summary email with all new, updated, and closed tickets in the agencies’ service area. This is done to reduce the number of emails a given agency or individual receives each day and ensures that person or agency is receiving tickets for cases where they have the capacity to provide services.

Service providers comment on a discussion thread on the Support Ticket when they can assist the family. In the thread, they note the types of services they can provide. After comments have been received, the caseworker presents the list of agencies able to provide services to the family and works with the family to determine the best options for services. After the client selects the best service options, the caseworker closes the Support Ticket and indicates which (if any) of the responding agencies the family has selected.

Direct agency referrals (Path B on Figure 5). Specific providers are notified via email. Providers may “accept” the direct referral or indicate reasons why they are “unable to accept” a direct referral.

Ohio START participants (Path C on Figure 5). For Ohio START participants, caseworkers “share” Support Tickets with assigned parent mentors who then edit the Support Ticket after each home visit to indicate the date, persons present, and relevant notes. Once families are linked to services, providers also update the Support Ticket to include a contact person and for service requests the initial intake and service initiation date.

⁵ The terminology “Support Ticket” is borrowed from Information Technology (IT) services where IT professionals have users create a “ticket” when they are having problems with their computer, want to download new software, are unable to log on to the internet, etc. The Needs Portal uses this same approach because it is terminology familiar to caseworkers and service providers.

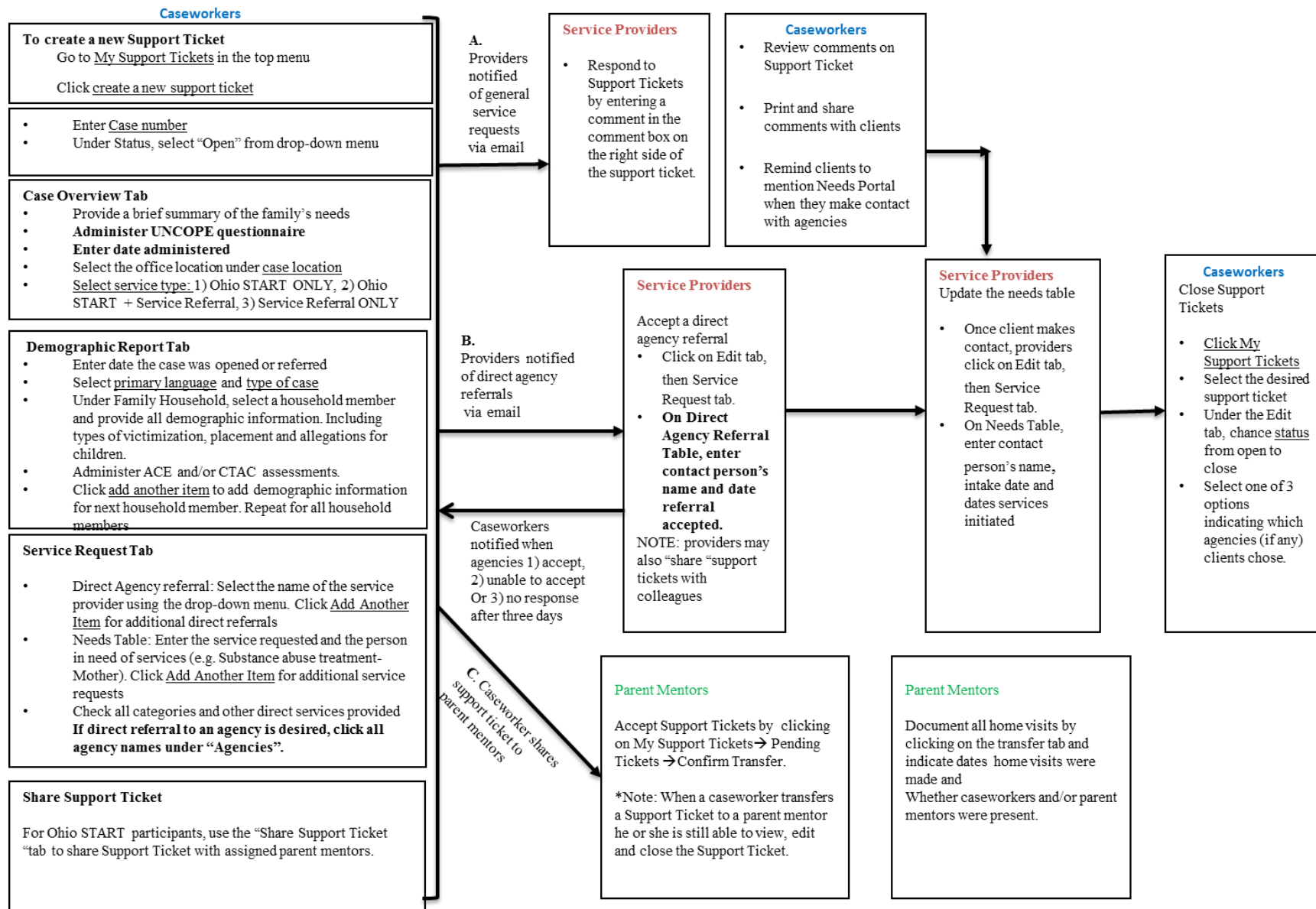


Figure 5. Ohio START: Flow of Information between Caseworkers, Service Providers, and Parent Mentors

Child Well-Being Evaluation

In support of the child well-being evaluation, we have received funding from The Ohio State University College of Social Work seed grant program. To date, we have developed the survey instruments to be used with parents and caregivers. These instruments will be reviewed by the steering committee when completed. We have also develop protocols for recruiting parents to participate in the survey.



SUMMARY & CONCLUSIONS

Below we provide the summary of our findings for the implementation and process evaluation. These are the two evaluation types that have received the most attention, given the current stage of the project.

Implementation Evaluation

Major Findings and Successes

- Overall, workers perceive a very high level of readiness for START implementation, although readiness varied across counties.
- Workers identified 55 behavioral health partners that deliver mental health or substance use treatment services to adults and children.
- Respondents tend to have the most referral partnerships with, and refer most frequently to, children's mental health organizations.
- There were significant increases in test scores at post-test in three out of the four trainings (i.e., Foundations I, Child's Trauma, Screening and Intervention of Substance Use Disorders)—suggesting the training improved the primary knowledge related to the Ohio START program

- ❖ The Screening and Intervention of Substance Use Disorders (UNCOPE and ACE) training increased knowledge by 15%
- ❖ The Children's Trauma Screen training increased knowledge by 26%
- ❖ The Ohio START Foundations I training increased knowledge by 13%

Areas for Improvement

- In particular, workers in two county PCSAs may need more support, training, or resources to feel committed and able to implement START.
- The fewest partnerships are with children's substance use treatment providers.
- No significant improvement in the understanding of Family Team Meeting (FTM) was found after the training, suggesting either a high-level of knowledge prior to taking the FTM training or a potential mismatch between training content and training needs.
- There were considerable missing data either because:
 - participants completed only the pre-test or post-test (missing ranging from 7%-18%) or
 - participants skipped some of the questions pre-test or post-test (missing ranging from 14%-68%).

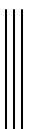
Future training assessments should strive to collect more complete data by encouraging participants to complete both pre- and post-tests and answering all questions.

Process Evaluation

Major Successes

- Modifications have been made to the Needs Portal to enable better tracking of Ohio START participants and process evaluation measures.
- The Needs Portal will allow counties to more easily pull reports that incorporate the information needed for the Victims of Crime Act funding.

Areas for Improvement



- Counties need to be trained on using the Needs Portal.
- Worker feedback needs to be incorporated into the Needs Portal.

Recommendations for Next Steps

Given our preliminary findings and previous experience, we have some next steps that should be considered as implementation of Ohio START moves forward.

Next Steps

- ❖ **Reevaluate the Family Team Meeting training**
- ❖ **Booster or refresher trainings**
- ❖ **Provide coaching that is individualized to county needs**
- ❖ **Monitor effects on changes in child welfare outcomes (e.g., reunification)**

Reevaluate the Family Team Meeting training. Given the lack of statistically significant increase in knowledge related to the family team meeting, this training should be reevaluated to determine: (1) whether the training provides new, useful information to the counties; (2) what gaps in knowledge around family team meetings currently exist among caseworkers; and (3) if the training content includes the information necessary to successfully implement family team meetings.

Continuing Education. Three of the four trainings were effective in increasing knowledge about Ohio START and the screening and assessment tools to be used. However, as shown by Thomas and colleagues (2015), one time trainings are generally not sufficient for long-term behavior change. Moses and colleagues (2004) suggests booster or refresher trainings, consulting with agencies and training participants to implement the tools and program components. This will help ensure long-term change.

Individualized Coaching. The worker survey identified differences in readiness for implementation of Ohio START. Two counties may need more support, resources, or training. This is likely only one example of how implementation may differ by county. By providing individualized coaching or training, counties can receive help and support they need that accounts for their current cultural climate.

Reducing Child Abuse and Neglect. Ultimately, the overall goal of Ohio START is to change child welfare outcomes. Thus, examining how maltreatment has changed due to the implementation of Ohio START will provide stronger evidence for the use and expansion of this model.

Overall Conclusion

Ohio START was successful in identifying and applying strategies to increase the capacity of the intervention counties to implement the program. This is an important first step in ensuring that substance-affected families are able to reduce child maltreatment and address trauma across the life course. In order to create sustainable change, Ohio START must continue to receive support for implementation of evidence-based practices.



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- Thomas, B., Scott, B., Pooler, D. (2015). Increasing the use of trauma-sensitive lens for school case managers: A Training assessment. *Journal of Adolescent and Family Health*, 7(1), 1-20.



Screening and Intervention Training Summary

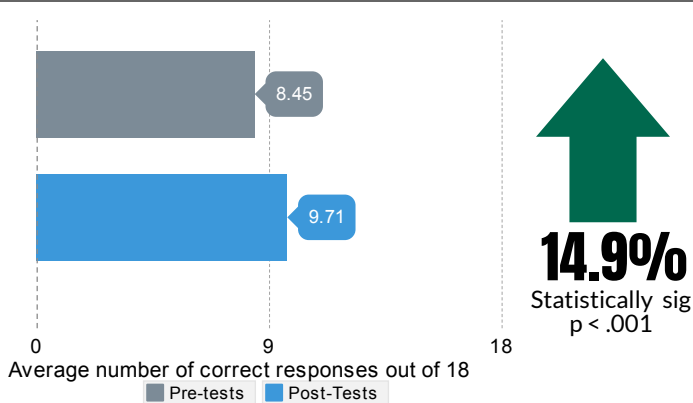


Purpose

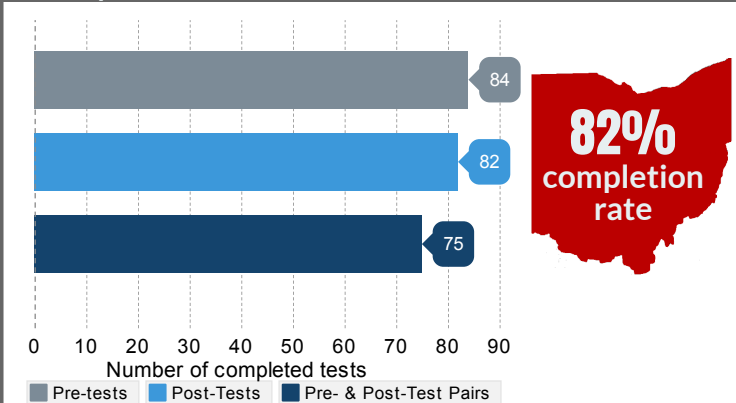
This training assisted workers with using evidence-based screening tools (UNCOPE) and (ACE), interpreting the results, providing feedback to the parent and offering recommendations to seek further assessment for treatment services. Participants also became familiar with the assessment process, treatment levels of care, Medication-Assisted Treatment and realistic expectations for aftercare, relapse and/or recovery.

Results

Overall Knowledge Change



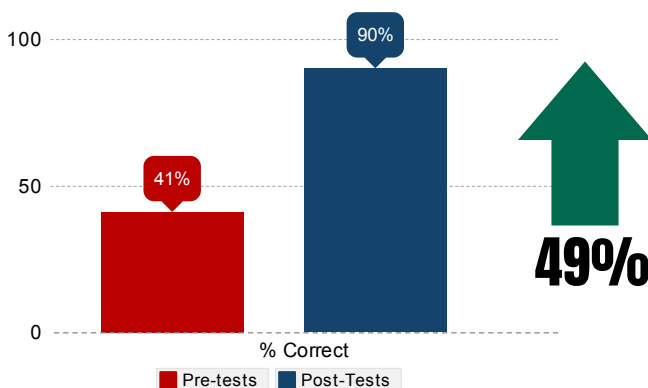
Completed Pre & Post Tests



Key Findings

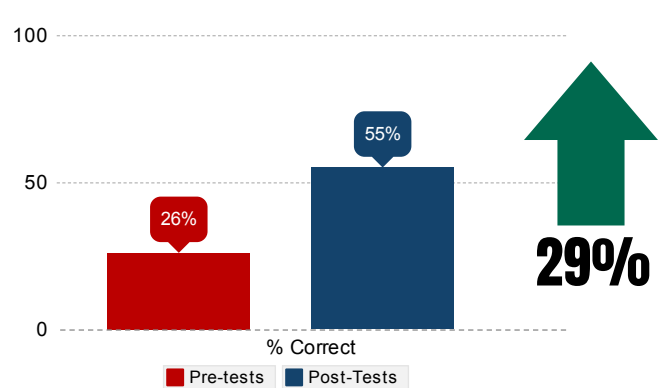
Question 4

In terms of severity, substance use disorders can be classified as: Mild, moderate severe.



Question 5

How many DSM criteria must be met to diagnose a substance use disorder? Two.



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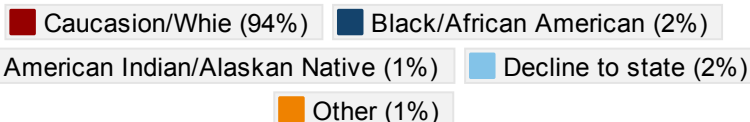
Voinovich School of
Leadership and Public Affairs

Trainee Demographics

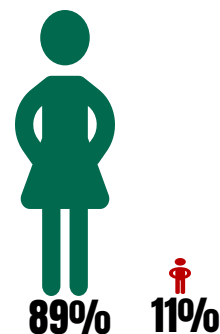
Avg Age

39

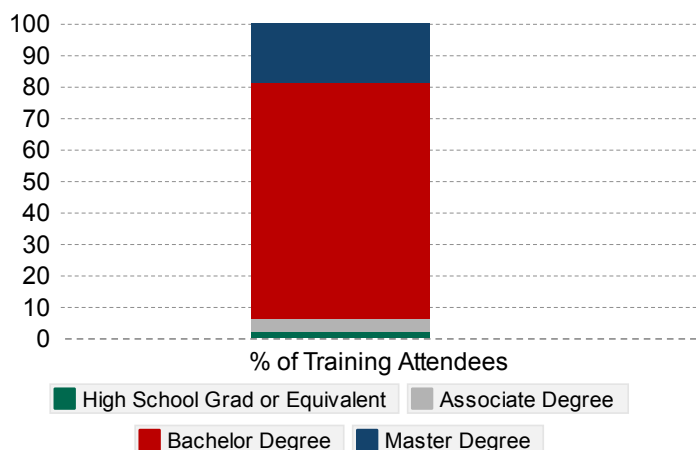
Race



Gender

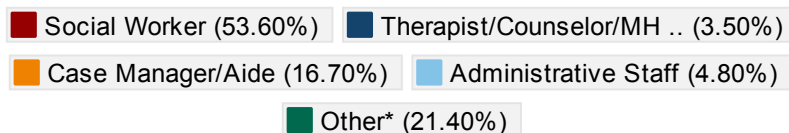
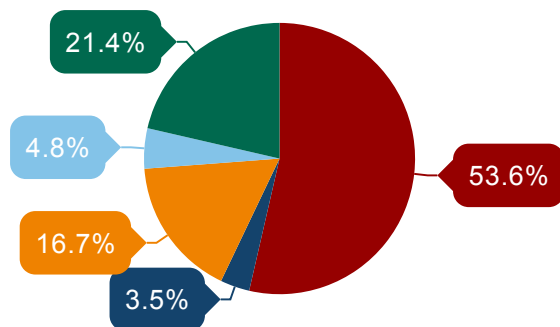


Education



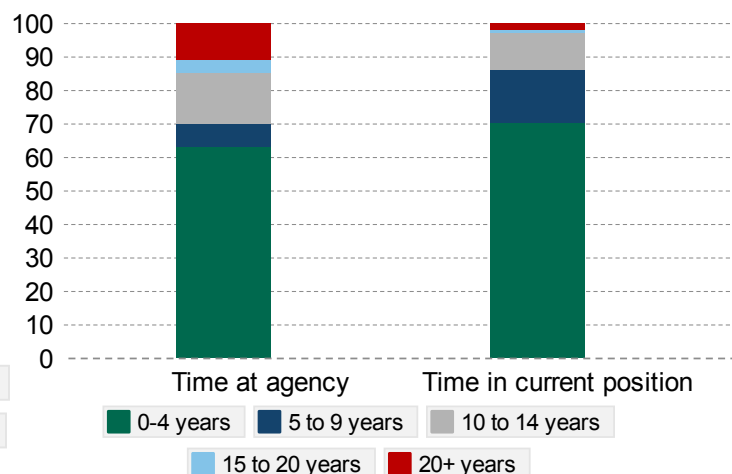
Trainee Employment Demographics

Job Title



*Other includes Program Coordinator as well as write-in responses. See narrative write-up for more details.

Length of Employment



Child Trauma Screening Training Summary

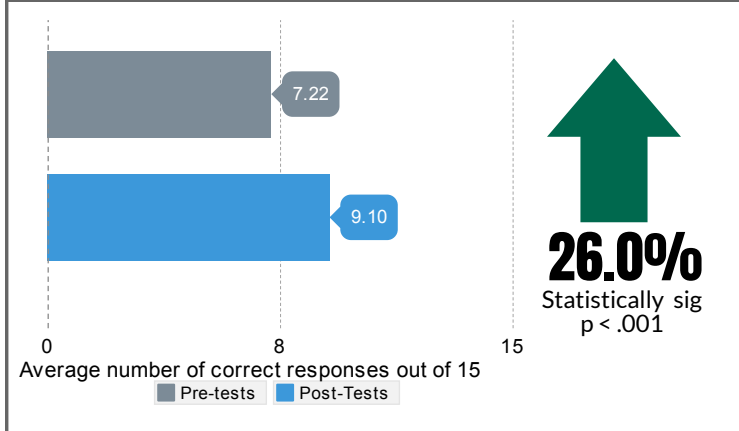


Purpose

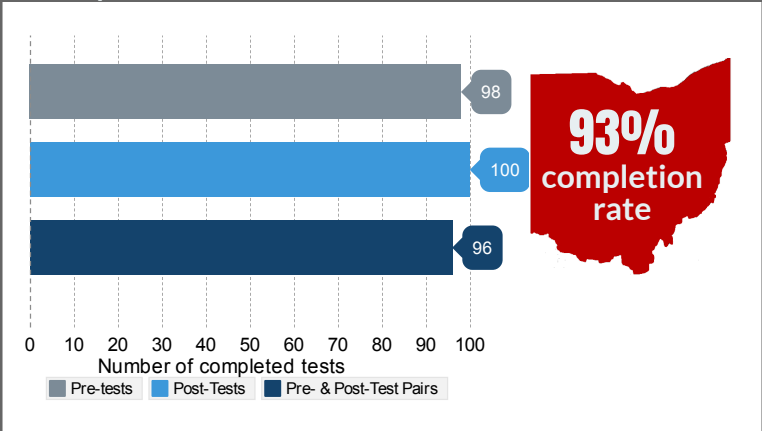
This training addressed a screening tool for children who have experienced trauma and adverse childhood experiences. The tool supports appropriate triaging of services and/or referrals. This tool was chosen for use in the OhioSTART initiative to help caseworkers better identify trauma exposure in the children they serve.

Results

Overall Knowledge Change



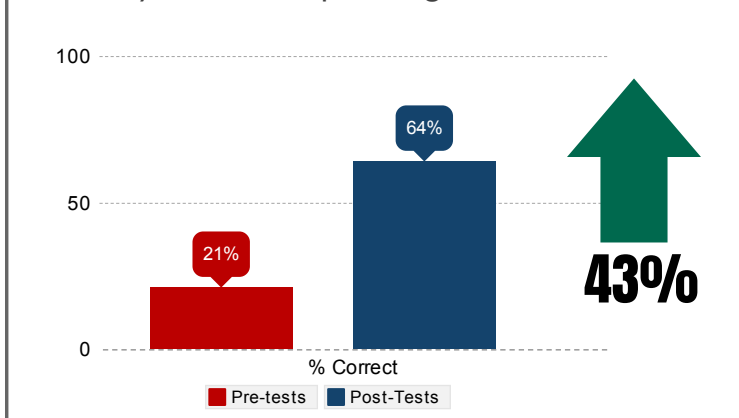
Completed Pre & Post Tests



Key Findings

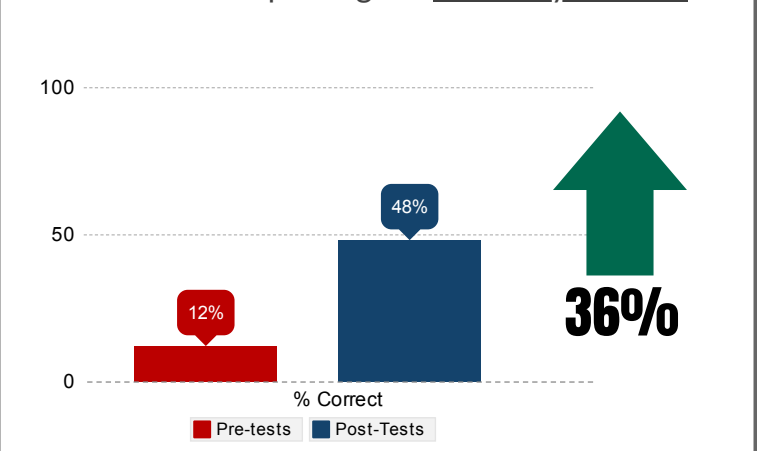
Question 1

Which of the following is NOT a key component of resiliency-based case planning? Self-control.



Question 2

Trauma-informed paradigm is resiliency-focused.



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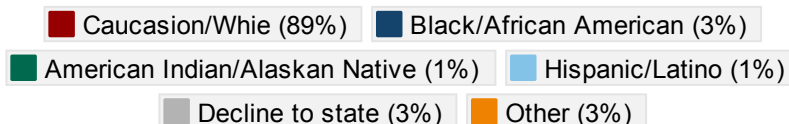
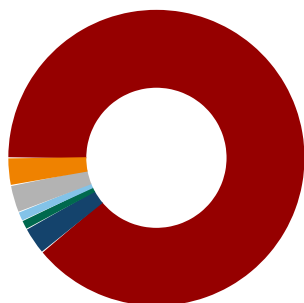
Voinovich School of
Leadership and Public Affairs

Trainee Demographics

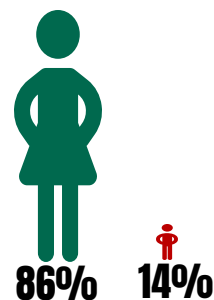
Avg Age

41

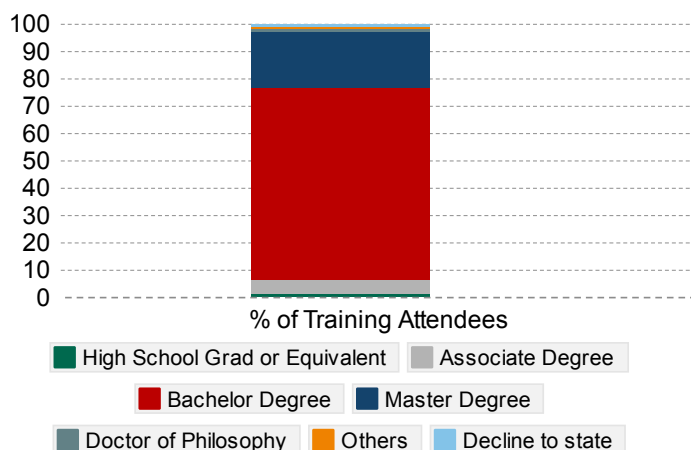
Race



Gender

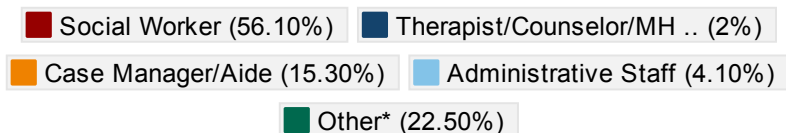
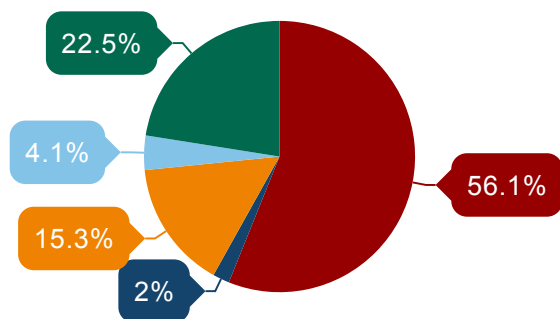


Education



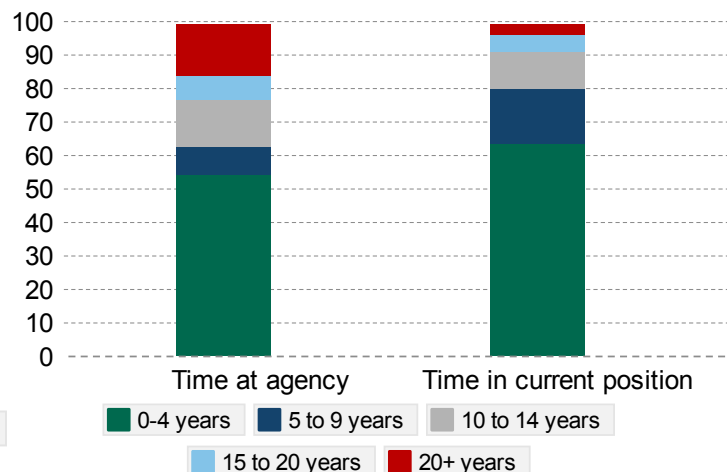
Trainee Employment Demographics

Job Title



*Other includes write-in responses. See narrative write-up for more details.

Length of Employment



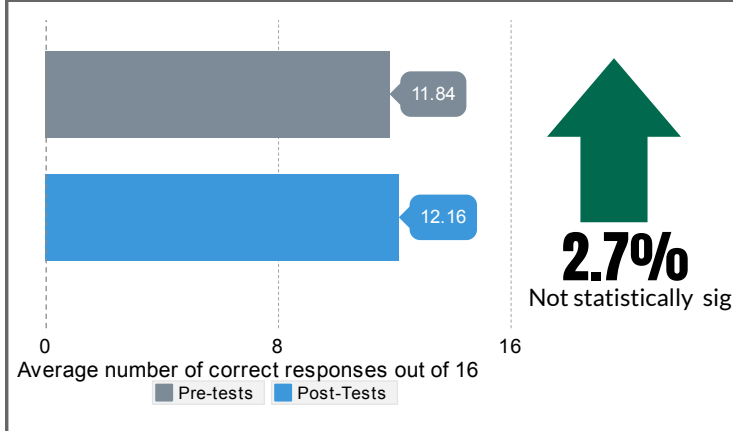
Family Team Meeting Training Summary

Purpose

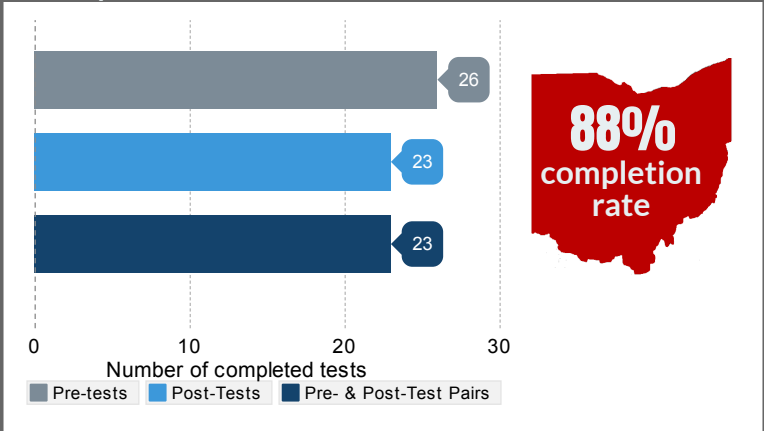
This training provided an overview of the teaming process of the Family Team Meeting (FTM) to meet the needs of the family including: preparing families and providers for participating in Family Team Meetings; the basic structure and guidance for facilitating Family Team Meetings; and guidance for handling challenges that may arise in the teaming process.

Results

Overall Knowledge Change



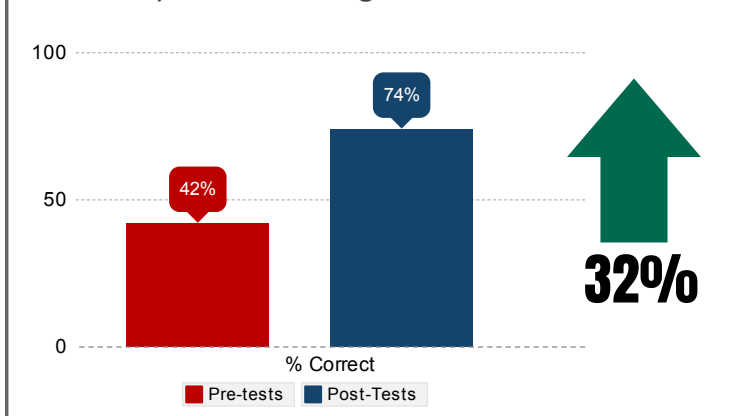
Completed Pre & Post Tests



Key Findings

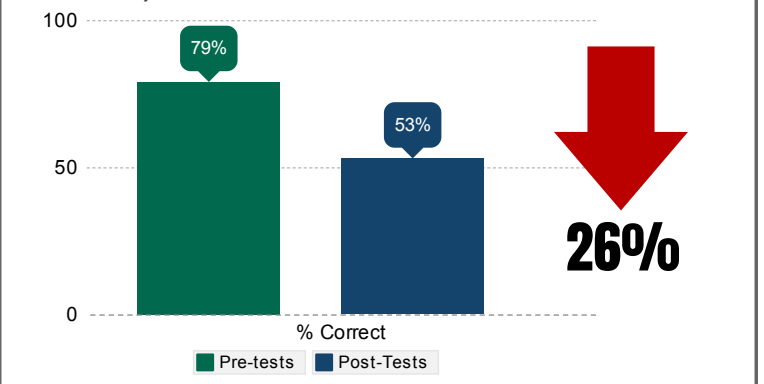
Question 2

Permanency is one of the core principles of Child and Family Team Meetings.



Question 13

After the Child and Family Team Meetings it is important to continue to confer in order to support the family.



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THE OHIO STATE UNIVERSITY
COLLEGE OF SOCIAL WORK



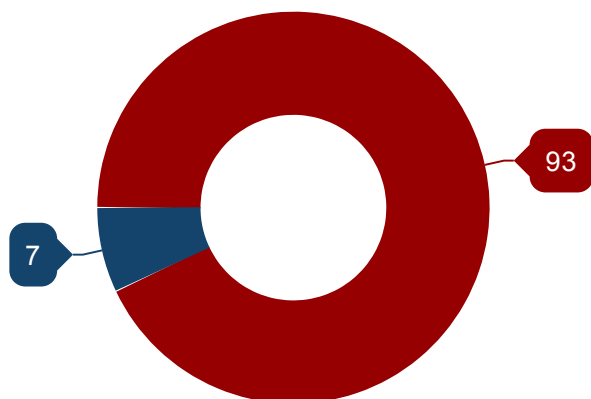
OHIO UNIVERSITY
Voinovich School of
Leadership and Public Affairs

Trainee Demographics

Avg Age

37

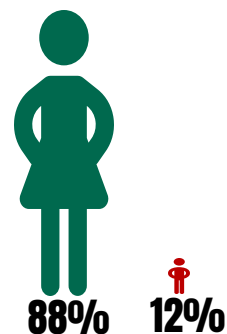
Race



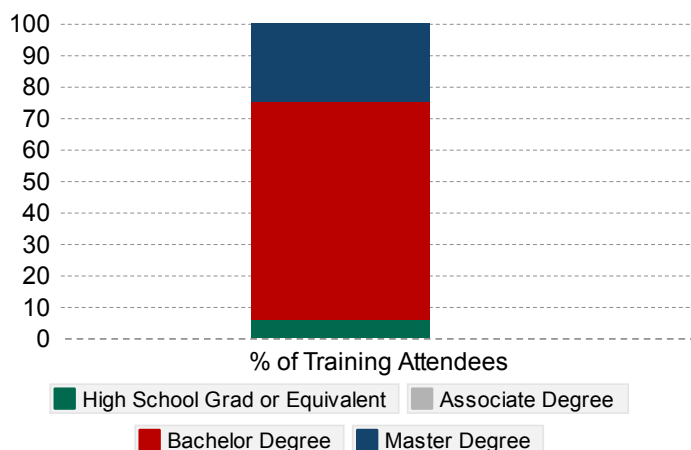
■ Caucasian/White (93%) ■ Black/African American (7%)

*No other reported responses to race

Gender

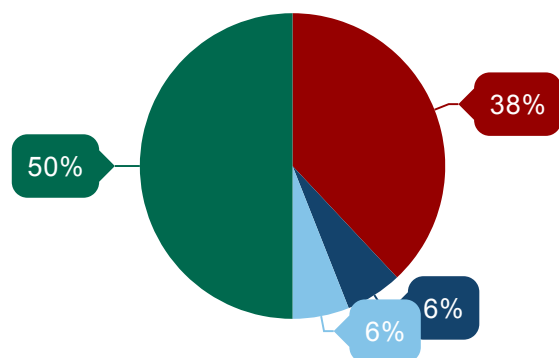


Education



Trainee Employment Demographics

Job Title

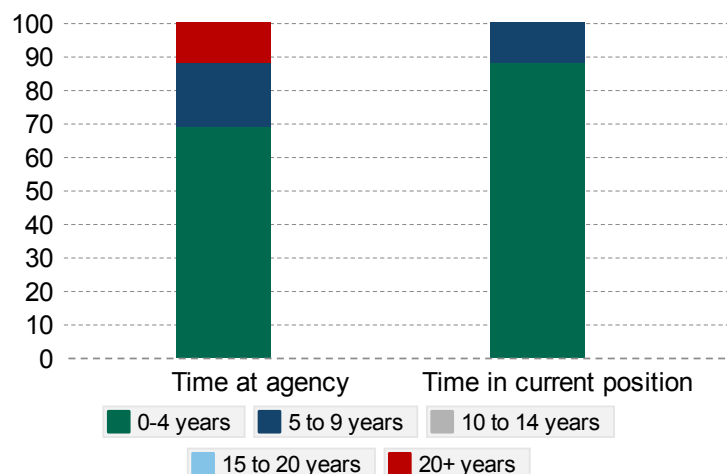


■ Social Worker (38%) ■ Therapist/Counselor/MH.. (6%)

■ Administrative Staff (6%) ■ Other* (50%)

*Other includes write-in responses. See narrative write-up for more details

Length of Employment



Foundations Training Summary

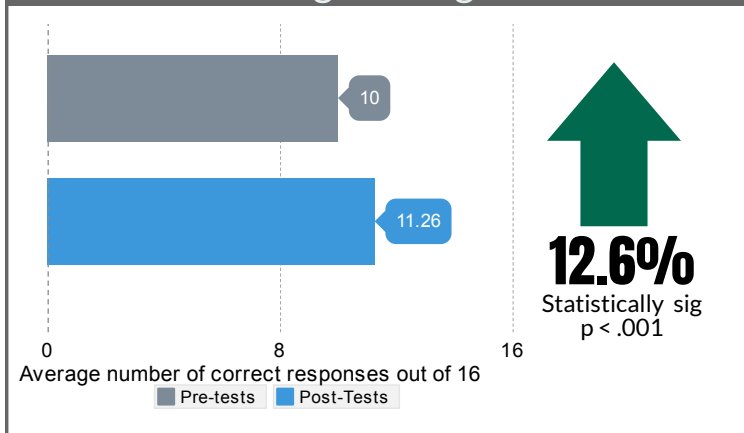


Purpose

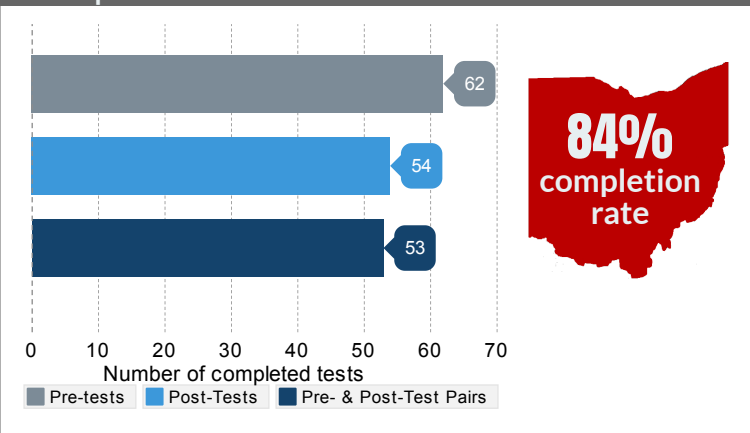
This training included an overview of the critical elements of collaborative practice that are necessary for the successful implementation of OhioSTART. Components of the OhioSTART model include: using universal screening tools for substance use and trauma screening, developing protocols for quick access to treatment, information sharing with treatment partners and courts, focus on family centered services, implementing family team meetings and decision-making, and integrating recovery support into the entire process.

Results

Overall Knowledge Change



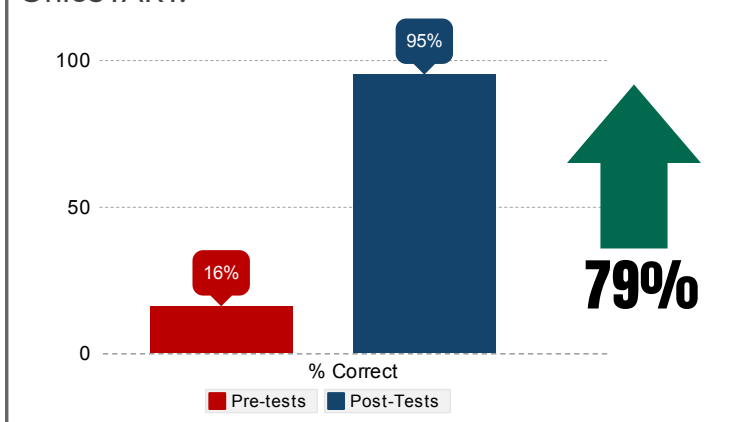
Completed Pre & Post Tests



Key Findings

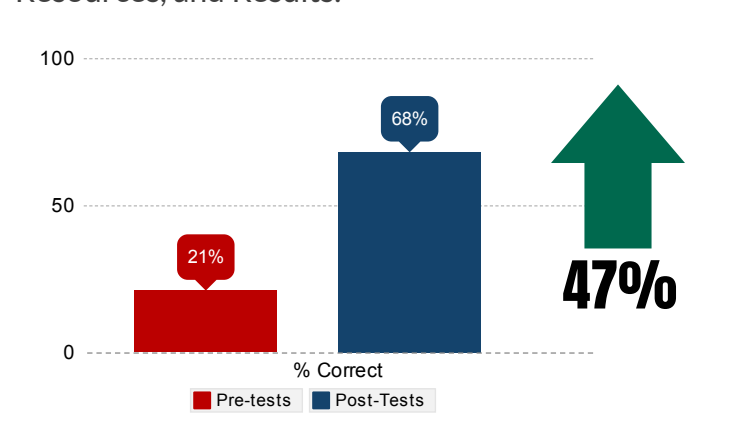
Question 2

There are seven key strategies to utilize in OhioSTART.



Question 7

The three "Rs" in collaboration are: Relationships, Resources, and Results.



Evaluation Conducted By



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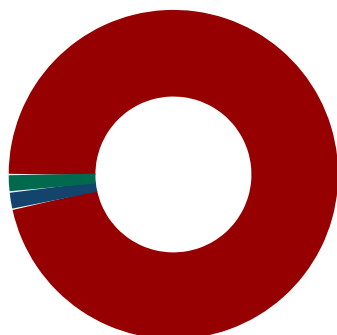
OHIO
UNIVERSITY
Voinovich School of
Leadership and Public Affairs

Trainee Demographics

Avg Age

45

Race

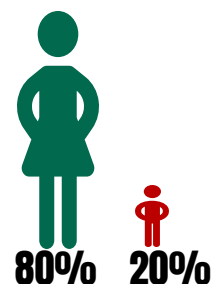


Caucasian/White (96.60%) Black/African American (1.70%)

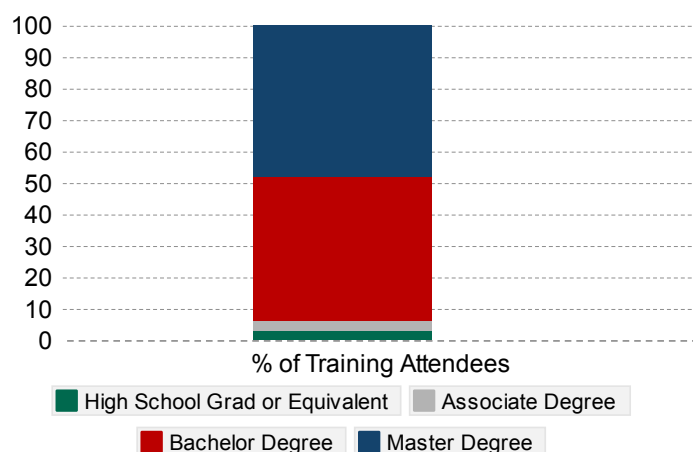
Latino/Hispanic (1.70%)

*No other races reported.

Gender



Education



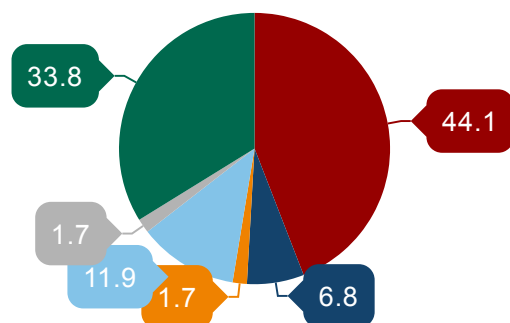
% of Training Attendees

High School Grad or Equivalent Associate Degree

Bachelor Degree Master Degree

Trainee Employment Demographics

Job Title



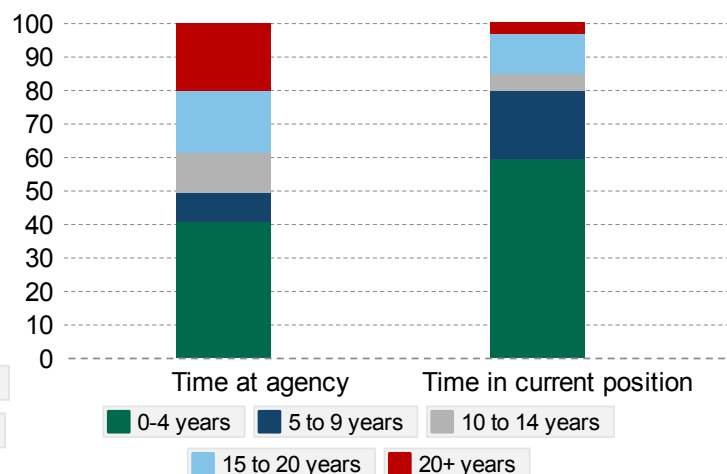
Social Worker (44.10%) Therapist/Counselor/MH .. (6.80%)

Case Manager/Aide (1.70%) Administrative Staff (11.90%)

Physician/Physician Asst (1.70%) Other* (33.80%)

*Other includes Program Coordinator as well as write-in responses. See narrative write-up for more details.

Length of Employment



Time at agency

Time in current position

0-4 years 5 to 9 years 10 to 14 years

15 to 20 years 20+ years

The Needs Portal: Quick Start Guide for Caseworkers

www.needsportal.com

Before getting started, you'll need the following information:

1. Case Number
2. For each member of the household: Gender; Race/Ethnicity; Age; Date of Birth; Zip code; Allegations (child only); Types of Victimization (child only); Health Insurance.

Case Overview Tab

1
Enter the case number

2
Select open from the drop-down menu

3
Select the county where case is located

4
Select the service type

5
Administer the UNCOPE

6
Write a few sentences about the needs of the family.

Case Number *

Case Status *

Open

Case Location *

Select a value

Service Type *

Select a value

Case Overview Demographics Report Service Request Share Support Ticket Transfer Support Ticket

UNCOPE

Help UNCOPE file

Score

Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom? *

No

Yes

Date administered *

Date

E.g., 02/28/2018

What are the Service Needs of the Family *

More information about text formats

Demographic Report Tab

7
Click on demographic report tab.

- Enter date the case
- Select the primary language for family
- Select the type of case

For each member of the household enter

- Gender
- Types of Victimization
- Special classification of individuals
- Date of Birth
- Zip code
- Insurance
- Race/ethnicity
- Allegation (child only)
- Home Placement

*For children administer the CTAC questionnaire
*For adults administer the ACES questionnaire

Case Opened *

Date

E.g., 02/28/2018

Primary Language *

Select a value

Type of Case *

Select a value

Family Household *

Individual

Child

Gender *

No

Male

Female

Other

Types of Victimization

(check all that apply boxes)

Adult Physical Assault (Includes Aggravated and Simple Assault)

Adult Sexual Assault

Adult Sexually Abused/Assaulted as Children

Anxiety

Bullying (Verbal, Cyber, or Physical)

Burglary

Family Household *

Date of Birth *

Format: mm/dd/yyyy

Age

Zip Code *

Insurance

None

Race/Ethnicity *

check all that apply

American Indian/ Alaska Native

Asian

Black/African American

Hispanic/Latino

Native Hawaiian/ Other Pacific Islander

White Non-Latino/ Caucasian

Some Other Race

Not Reported

Multiple Races

(Child Only) Allegation

Use "Tab" on your keyboard to select multiple entries.

General Neglect

At-Risk Sibling Abuse

Emotional Abuse

Physical Abuse

Severe Neglect

Sexual Abuse

(Child Only) Home Placement

Select a value

Service Request Tab

8

Click on the Service Request Tab

Make a direct agency referral using the **Direct Agency Referral Table**.

- Select a provider from the drop-down menu
- Enter who needs the service
- Select services needed from the drop down menu

Click on the gray **"Add another item"** button to make another direct referral

Make a general service request using the **Needs Table**.

- Enter the service you're requesting and the household member who needs it (e.g. Child Care-Mother)

Click on the gray **"Add Another Item"** to make another general service requests.

Be sure to check off all the service categories the family needs.

Be sure to Indicate all other direct services provided.

Share Support Ticket

9

Click on the Share Support Ticket tab

To share the Support Ticket with a parent mentor:

- Select a parent mentor from the drop-down menu
- Add any notes for the parent mentor

10

You're ready to publish!

Check your work and click on the gray **"Publish"** button to send your support ticket to providers

Questions? Email us at
needsportal@gmail.com