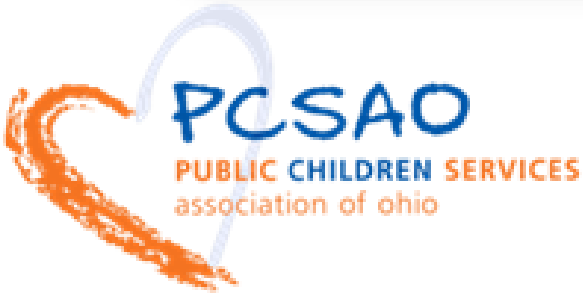

Ohio START
Interim Evaluation Report
October 2018

Evaluation led by:

Questions and More Information

If you have questions or require additional information about this interim evaluation report, please contact Bridget Freisthler, PhD at freisthler.19@osu.edu. If you have questions about the overall project developed and implemented by the Public Children Services Association of Ohio, please contact Fawn Gadel at fawn@pcsao.com.

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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

1. Front-line workers, supervisors, and administrators perceive very strong conditions for START implementation and agree on their PCSA's readiness
2. Collaboration between child welfare agencies and behavioral health providers increased.
3. Family Peer Mentors bridge the gap between parents and child welfare agencies due to the shared experiences between Peer Mentors and parents.
4. Family Peer Mentors work directly with clients to address their specific needs and become an invaluable part of the support system for clients.
5. Trainings were helpful for implementing OhioSTART at the county level, although some felt that they were not learning new information.
6. Interviewees note that more of a planning period, as well as increased clarity on implementation and funding, at the outset would have been helpful.
7. A plan for monitoring fidelity is in development and is intended to balance the need for meaningful information while also being mindful of existing data collection burdens.
8. Seven START participants have also completed the parent survey.
9. Of the 7 survey participants to date, 2 required cell phone minutes in order to complete the survey. Continuing to offer cell phone minutes is important to maintain participation.
10. About half of participants (4) requested emailed gift cards and the other half (3) requested mailed gift cards. Both options should be continued to meet participant needs.

Recommendations

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

1. Training should continue to be monitored and adjusted to provide useful information to caseworkers implementing Ohio START
2. Consider offering additional incentives to encourage participation in the parent survey.

3. Monitor fidelity of intervention implementation and determine places where fidelity can be improved
4. Assess effects on changes in child welfare outcomes (e.g., reunification)

Ohio START continues to be successful in identifying and applying strategies to increase the capacity of the intervention counties to implement the program. As implementation continues and expands to additional counties, utilizing the Needs Portal to enhance and monitor fidelity to the intervention model becomes of primary importance. In order to create sustainable change, Ohio START must continue to receive support for implementation of evidence-based practices.

CONTENTS

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 current conditions for implementing Ohio START. Specifically, we examined four elements of START implementation: readiness, leadership, climate, and compatibility with agency values. We also examined collaboration between behavioral health organizations and public child welfare agencies. This section offers a preview of *preliminary* results of the follow-up assessment of implementation conditions. A more in-depth analysis of county variation in implementation conditions, collaboration, and a comparison with baseline conditions will be prepared in a future report.

Implementation Conditions – Caseworker Survey

Data Collection Procedures

A follow-up implementation survey was conducted in August 2018, several months after PCSAs began serving families through START. We recruited participants from 115 staff employed by 15 PCSAs, identified as 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. Those who agreed to participate clicked on a link to the informed consent, which described the purpose of the survey, risks, benefits, voluntary nature, and other details. 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 consented proceeded with the survey, which took about five minutes to complete.

The survey measured four implementation constructs. Scores could range from one to five, with higher scores denoting stronger or more supportive conditions for implementation.

1. *Readiness* –Perceptions about the PCSA's readiness to implement START.
2. *Compatibility* – Opinions about the compatibility of the compatibility of START with existing agency practices.
3. *Implementation Climate* – Perceptions about the degree to which the PCSA rewards, supports and expects START.
4. *Implementation Leadership* - Perceptions about PCSA leaders/supervisors' support for START implementation.

Preliminary Results. In total, 48% of all eligible staff participated (*n*=55). Participants included front-line caseworkers (42%) and administrators/supervisors (58%). Overall, the participants surveyed reported strong conditions for implementation. Average reports of readiness, compatibility, climate, and leadership fell between "somewhat agree" and "agree" on the rating scales. Although scores range from 2.17 to 5 across the scales, the standard deviations for each measure suggests that individuals' scores did not vary greatly from one another. There were no differences in ratings between front-line workers and administrators/supervisors.

Table 1: Implementation Conditions Survey Results

	Front-Line Workers (*n*=23)	Administrators/ Supervisors (*n*=32)	All
	M (SD)	**M(SD)**	**M(SD)**
Readiness	4.68 (.42)	4.48 (.55)	4.57 (.50)
Compatibility	4.24 (.46)	4.29 (.43)	4.27 (.44)
Climate	4.52 (.36)	4.38 (.53)	4.44 (.46)
Leadership	4.43 (.70)	4.00 (.84)	4.18 (.80)

Summary

- Overall, front-line workers, supervisors, and administrators perceive very strong conditions for START implementation.
- Front-line workers, supervisors, and leaders generally agree on their PCSA's readiness.

Implementation Conditions – Interviews with Key Stakeholders

Data Collection Procedures

In the spring and summer of 2018, the evaluation team conducted 16 interviews with staff (child welfare administrators (6), peer mentors (5), child welfare caseworkers (4), and a behavioral health provider (1) representing six of the participating Ohio START counties.

Preliminary Findings

- Collaboration between child welfare agencies and behavioral health providers increased.
- Family peer mentors bridge the gap between parents and child welfare agencies due to the shared experiences between peer mentors and parents.
- Family peer mentors work directly with clients to address their specific needs and become an invaluable part of the support system for clients.
- Children are less likely to be removed from the home, or, if they are removed, they are more likely to be reunified.
- Interviewees report additional county service needs that are not addressed by Ohio START, such as housing.
- Trainings were helpful for implementing Ohio START at the county level, although some felt that they were not learning new information.

- Interviewees note that more of a planning period, as well as increased clarity on implementation and funding, at the outset would have been helpful.

Impact of Ohio START on the System of Care

The interviews reveal that staff have positive perceptions of the Ohio START model, and Ohio START is having a positive impact on the child welfare system. Specifically, the model is influencing the child welfare system via an intensive, positive, and supportive approach to working with families experiencing substance use disorders and child welfare involvement. Though some interviewees note that it is early to assess the effect of the services, most note positive change in the system of care because of Ohio START. For instance, as one behavioral health provider noted, there is increased collaboration between child welfare agencies and behavioral health providers: "I think that there's been an overall improvement in collaboration amongst service systems, because we're known to each other in a more formalized way than we were in the past." According to several child welfare administrators, an additional positive change resulting from Ohio START is increased and rapid communication and coordination of families' services between child welfare staff and behavioral health providers: "I think we are having a little more communication with our AOD (Alcohol and Other Drugs) providers. We met with them specifically in regard to START and we are just having a lot more open communication with them than in the past and it is very helpful," said one administrator.

Not only is Ohio START having a positive effect on the child welfare system in general, it is also rejuvenating the field. According to one child welfare administrator, caseworkers see that peer mentors—who were previously struggling with a substance use disorder and involved with child welfare—are now in recovery and leading productive lives: "I think that it's motivating for caseworkers to see that parents, some of which were involved with our agency, do recover. They're able to get their children back. And it gives them the opportunity to learn more about recovery and what that looks like and what it entails." Staff then see Family Peer Mentors as key to the success of the program. They are not only providing intensive and supportive services and modeling recovery for parents, but they are also a resource with experience of substance use disorders and, as noted, a source of hope for child welfare staff.

> *"We have been so downtrodden by the lack of success with the families with severe drug abuse issues that seeing the Family Peer Mentor who did it and continues to do it in her life, as well as the effect it is having on these families, I think it is a real boost to our morale."*
>
> – Child Welfare Caseworker

The peer mentors are regarded as essential to providing the intensive services. Before the peer mentors were incorporated, parents were less receptive to their caseworkers. Child welfare staff noted that relationships with START families have improved due to the presence of the peer mentors: "There has not been one case so far that the clients haven't really engaged with the peer mentor." The peer mentors relate to clients through their shared experiences and become a valuable component of their support system. They also have the unique experience of understanding the different challenges faced by both the families and the caseworkers, so they are able to bridge the communication gap between both parties. The peer mentors work directly with clients to address their specific needs, discuss misconceptions and perceptual barriers, and create an individualized experience for the client.

> *"So (it helps), having people who have walked that path (child welfare and substance disorder) for themselves as a model that it is possible to recover. It is possible to get your kids back. It is possible to have a healthy productive family life. It is possible. Recovery is possible and life is possible after. It's not the end. It doesn't have to be."*
>
> – Behavioral Health Provider

However, some obstacles needed to be addressed in terms of accepting the role of the peer mentors. One peer mentor noted that there was a stigma among coworkers surrounding addiction and the recovery process: "There is just so much stigma and so much stereotyping about addicts. I was not prepared for that." However, after the initial adjustment period, many state that the collaborative effort among the child welfare staff and the contributions of the peer mentors are the most notable benefits of the START

program. One child welfare caseworker said, “I think I did not quite expect all the benefits that would come out of this program. For instance, getting to know our family peer mentors the way I have gotten to know them because they are here in the office, I didn’t expect how much our relationships with other agencies and organizations would be strengthened...”

Impact on Families

Although some interviewees believe it is too early in the program to get a full idea of its impact on children, others are already seeing change. Due to Ohio START, child welfare staff are seeing many benefits for the children involved. For example, one child administrator noted that the caseworkers and peer mentors are able to engage with parents earlier, opening up lines of communication they have never reached before: “The impact has already been seen as far as being able to develop more engagement and trust earlier on in our involvement.” This allows them to have a better understanding of the needs of the children and reduce the amount of trauma they experience. According to one behavioral health provider, “The biggest benefit is they (children) are less likely to be removed from the home. And if they are removed from the home, there’s a greater likelihood that they’ll be reunified. When they’re reunified they have greater likelihood that their parents will be in a better position to parent them and nurture them more effectively and fully than they would have been if they were still in the midst of their addiction.”

> *“But I really believe that there is such value, because we see clients responding differently even in a very, very short time. Over time, I can’t imagine that that would decrease; in fact, I think that momentum will help carry us into less time for kids in the system, less family separation, less attachment issues.”*
>
> – Behavioral Health Provider

Interviewees also report additional county service needs. For example, there is a reported shortage of inpatient behavioral health care for women, not enough housing in some communities, and not enough child trauma services in some communities. As noted by one child welfare caseworker, there was an oversight in the program regarding some of these additional needs: “We don’t have in-patient here and that is something I am working on. We don’t have transitional housing. We don’t have so many things that I don’t know that the program took [them] into consideration. For some of the rural counties there is no transportation service out here. Our peer mentors do a lot of transporting of clients to get them where they need to go because they don’t have a driver’s license.”

Trainings

Numerous trainings were provided to prepare for implementing Ohio START at the county level. Interviewees had far more positive than negative perceptions of the provided trainings. The training about child welfare was useful, especially for those who were unfamiliar with the processes involved, as noted by one of the peer mentors: “Then another training that I liked was the child welfare training. It kind of helped me better understand the process of child welfare in general. And how the different counties are similar and different and stuff like that.”

> *“I think the flow charts of how the cases should go has been helpful. All of the training has been very helpful, the screening tools, having all that available and ready to use and training how to use these tools.”*
>
> – Child Welfare Administrator

A criticism of the trainings noted by a few interviewees was that for some staff implementing Ohio START, the content of the trainings was not new information. Also, in the case of child-welfare-specific training and drug screening practices, some interviewees felt that more detailed information would have been helpful, as noted by one child welfare administrator: “I think all of the counties would benefit more from more child-welfare-specific training as it relates to medically assisted treatment and as it relates to drug screening practices for the purposes of influencing clinical decisions for the safety of kids and for holding parents accountable… How drug screens can be used as a clinical tool for child protection to impact safety and risk decisions and… to offer families another tool for accountability and behavior change.”

Interviewee Recommendations

Some interviewees note a longer planning period and increased clarity on implementation and funding at the outset would have been helpful. For example, one child welfare administrator noted that more insight could have sped up the progress of the program: "Earlier I would have liked to have had… better clarity on the funding and the family peer mentors and how those two tied together, because I would have liked to have been where we are today much earlier in the process." Additionally, child welfare staff would like increased flexibility on when families can be included in Ohio START, as noted by one child welfare caseworker: "I think it would be better to be able to just engage them [clients] at any point they are ready, rather than having to do [intake] within the first 30 days of the case."

Several interviewees have also expressed concern about future funding of the program and how this relates to providing more resources for their clients. Due to a multitude of factors, child welfare staff have noted that they have few services and resources such as counseling services, and this impedes their ability to assist their clients. According to one child welfare caseworker, there is not only a lack of resources in general, but also an overextension of the resources that are available: "I think all the resources that we do have are typically overwhelmed, and they have so many people coming there that it has been a challenge as far as getting them into services as soon as possible… getting [services] especially for the children in the trauma that they have been through, we have seen a lot of difficulty." Finally, supports for family peer mentors should be put in place in order to ensure their sobriety can be maintained.

> *"By the nature (of the program) we had to hire people who had lived experience and struggled with addiction. We are throwing them (the peer mentors) out there, working with families who are actively using, and they were provided with no training before that. It is really putting them at a real risk and their own sobriety at a risk."*
>
> – Child Welfare Administrator

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

Three types of training programs have been held through the end of September 2018. 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 January–September 2018 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.

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 Qulatrics (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: Foundations 2—Working with Family Peer Mentors in Child Welfare

The Foundations 2 training covers the aspects of Ohio START that address working with a Family Peer Mentor in a child welfare setting. As many of the counties do not currently have a practice of working with Family Peer Mentors (FPM), the training addresses how to recruit, train, and prepare individuals for a FMP role. Agencies will also have the opportunity to

Demographic Information of Training Participants. Sixty people participated in the Foundations 2: Working with Family Peer Mentors in Child Welfare training on February 13, 14, and 15 in 2018. Of those, 46 (76.67%) completed both the pre- and post-test information available for inclusion in the analysis.

Table 2 presents the demographic information of the Ohio START Foundations 2 training. All who completed the pre-test are included in the demographics, though not all respondents answered every demographic question.

The age of training participants ranged from 21 to 65 years, with the mean age of 44 years. Most participants were female (89.7%) and white (90.0%). Many participants had a Bachelor's degree (56.9%) or Master's degree (34.5%). Of the participants, 42.4% were at the agency for 0–4 years, while 54.2% were in their current position for 0–4 years. The most common job held by participants was social worker (44.8%).

Table 2: Foundations 2 Training Participants Demographics (*n = 60*)

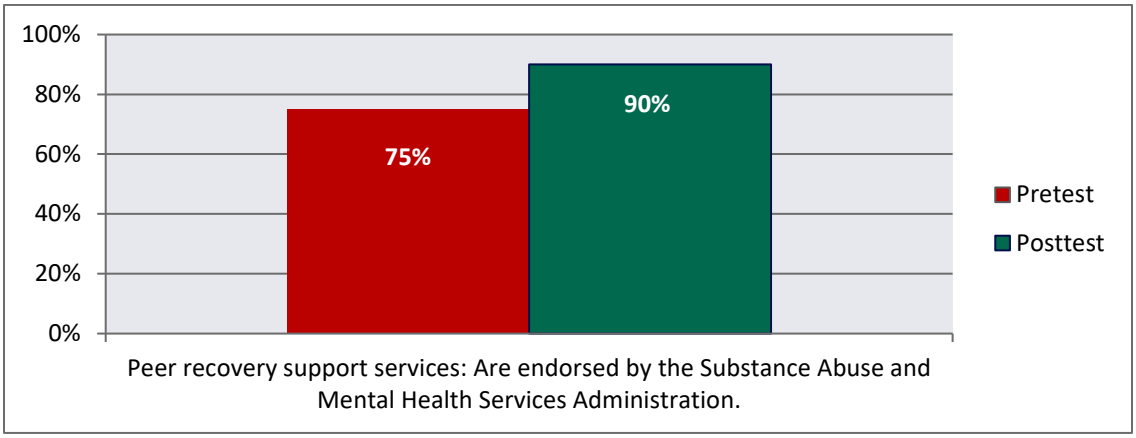
	Mean (SD)/ %
Age (in years)	43.79 (10.9) (n=58)
20-29	10.3%
30-39	27.7%
40-49	31.0%
≥50	31.0%
Sex	
Female	89.7%
Male	10.3%
Race	
Caucasian/White	90.0%
Black/African American	6.7%
American Indian or Alaskan Native	--
Decline to state	--
Other	--
Education	
High school graduate, diploma or the equivalent (e.g. GED)	5.2%
Associate's Degree	3.4%

Table 2: Foundations 2 Training Participants Demographics (*n = 60*)	
Bachelor's Degree (BA, BS, BSW)	56.9%
Master's Degree (MA, MS, MSW)	34.5%
Doctor of Philosophy (PhD)	--
Others	--
Length of employment at the current organization/agency	
0 to 4 years	42.4%
5 to 9 years	6.8%
10 to 14 years	10.2%
15 to 20 years	16.9%
20 years or longer	23.7%
Length of employment at the current position	
0 to 4 years	54.2%
5 to 9 years	15.3%
10 to 14 years	11.9%
15 to 20 years	13.6%
20 years or longer	5.1%
Job title	
Social worker	44.8%
Therapist/Counselor	3.4%
Program coordinator	1.7%
Mental health counselor/Specialist/Consultant	6.9%
Case manager/Case management aide	1.7%
Behavioral specialist	1.7%
Physician's Assistant	--
Administrative staff	17.2%
Medical doctor	--
Other*	22.4%

**Responses in this category included administrator, area manager, child welfare supervisor, director, family peer mentor, fiscal, HIS program consultant, investigator, lead worker, social service worker, intake investigation worker, social services worker*

Pre- and Post-Training Assessments. The average score of the pre-test (*n*=46) for the Foundations 2 training was 11.09 (out of a possible 16). At the completion of training, participants scored an average of 13.09 (out of a possible 16), indicating a 17.8% increase in knowledge about working with family peer mentors in child welfare. The difference between scores at the pre-test (M = 11.09, SD = 2.32) and those scores at post-test (M = 13.09, SD = 2.14); $t(7.80) = 2.00$, $p < .001$ 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 as it contains those people who answered all items at both time points.

Question 1



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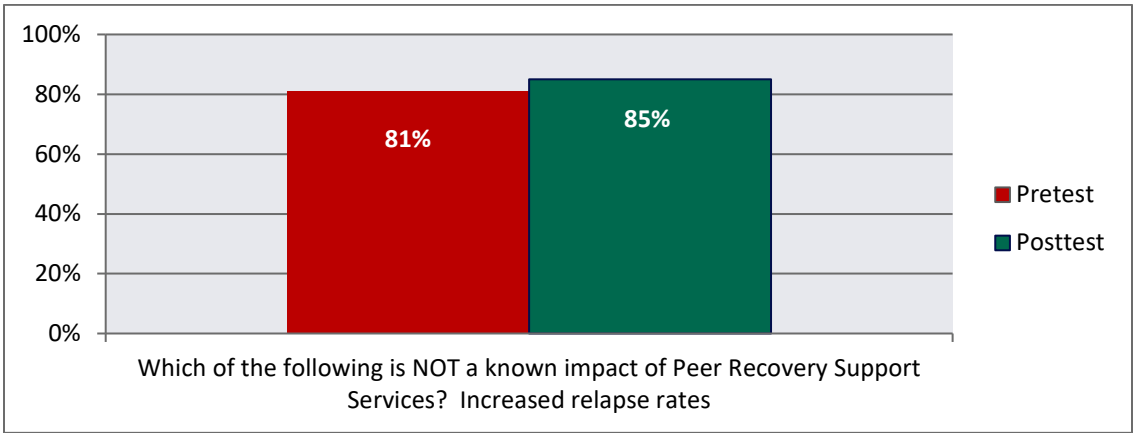

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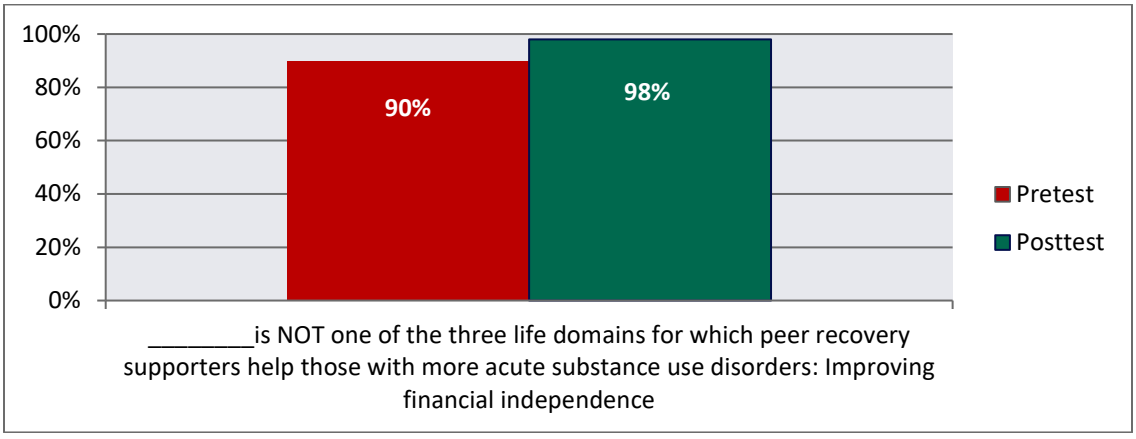
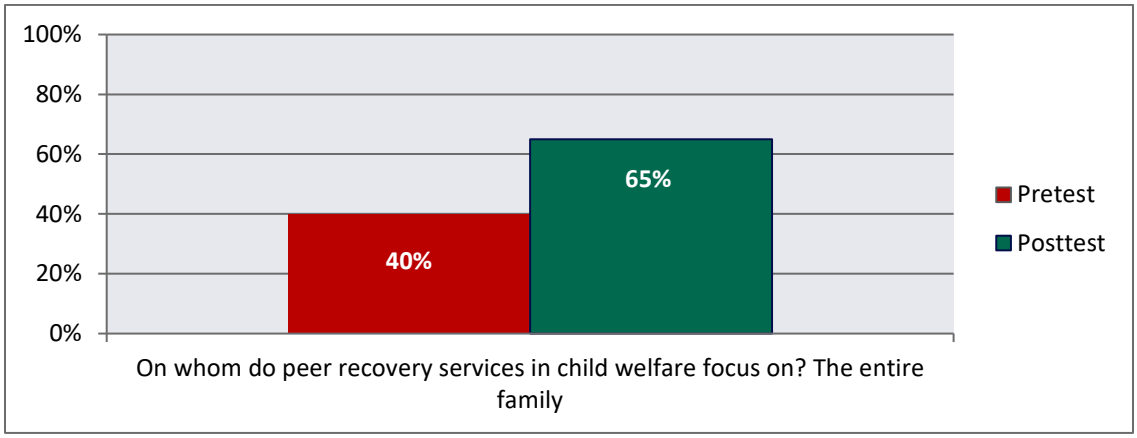
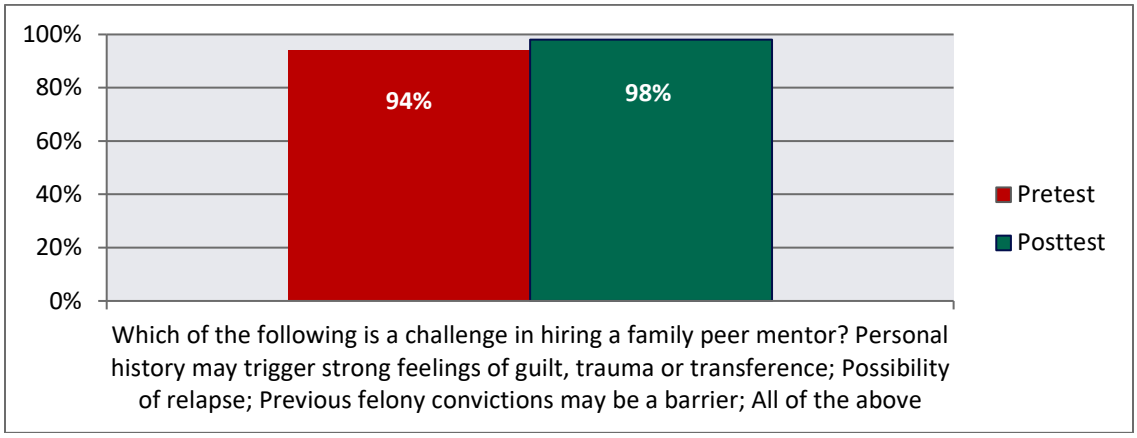


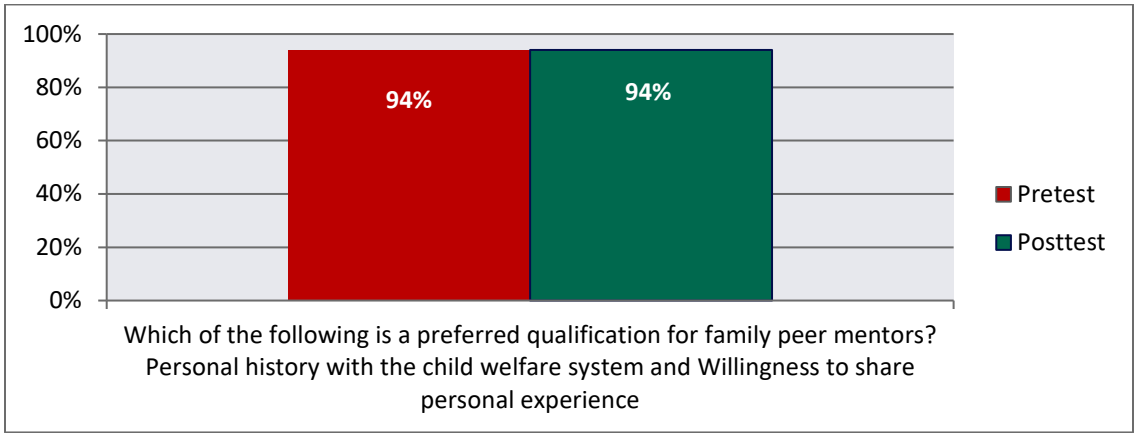
Question 4



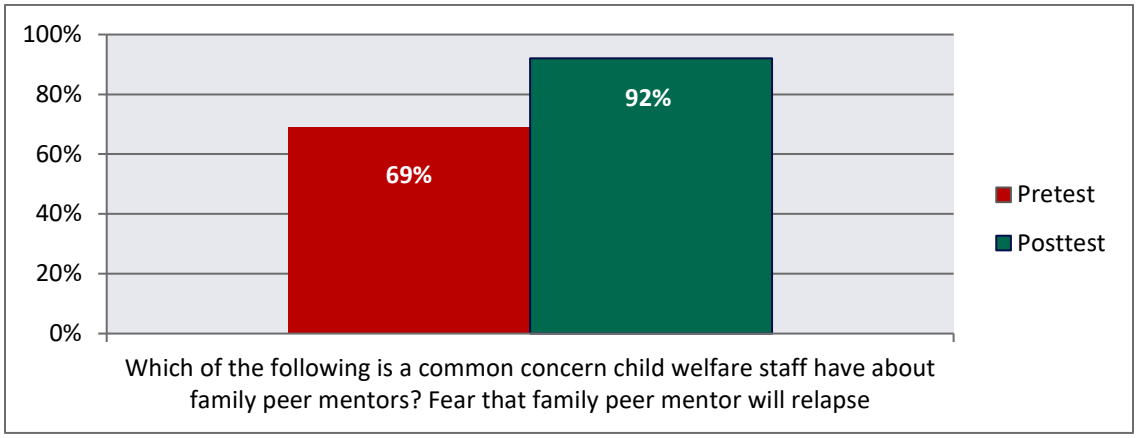
Question 5



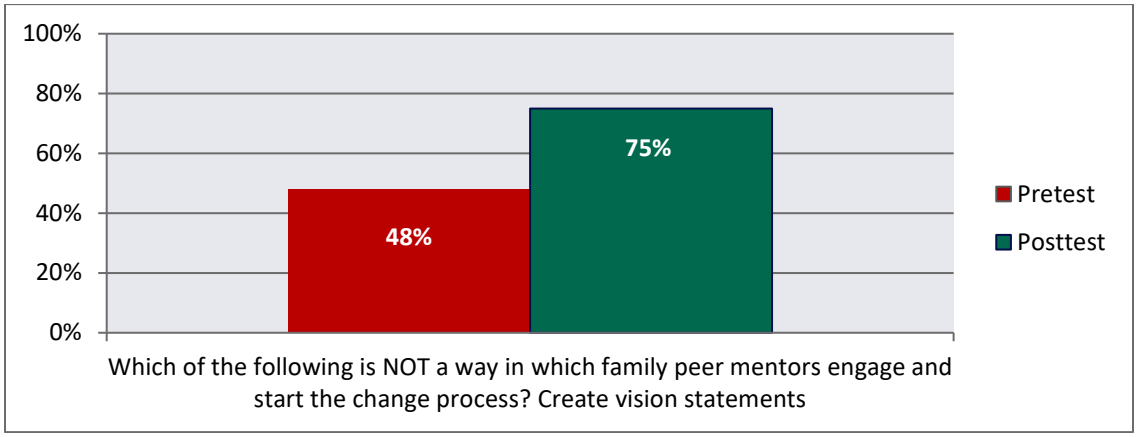
Question 6



Question 7



Question 8



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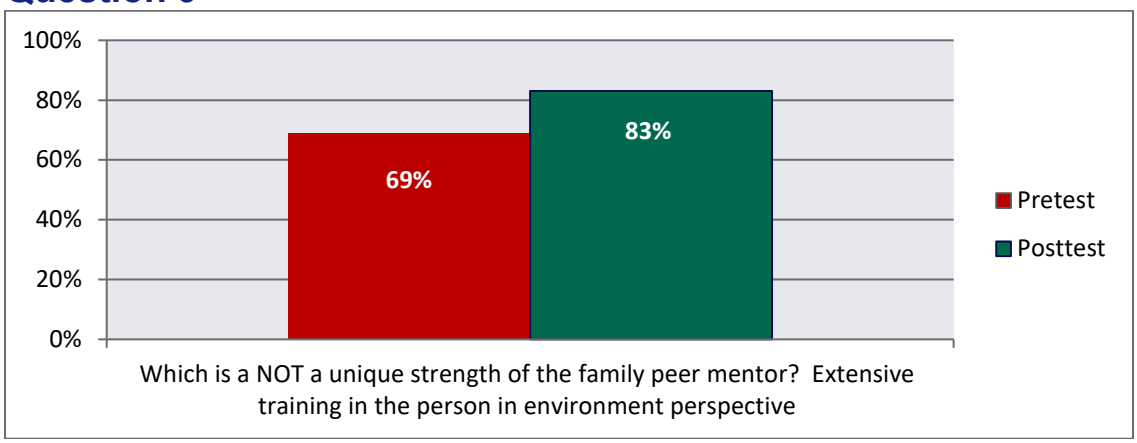

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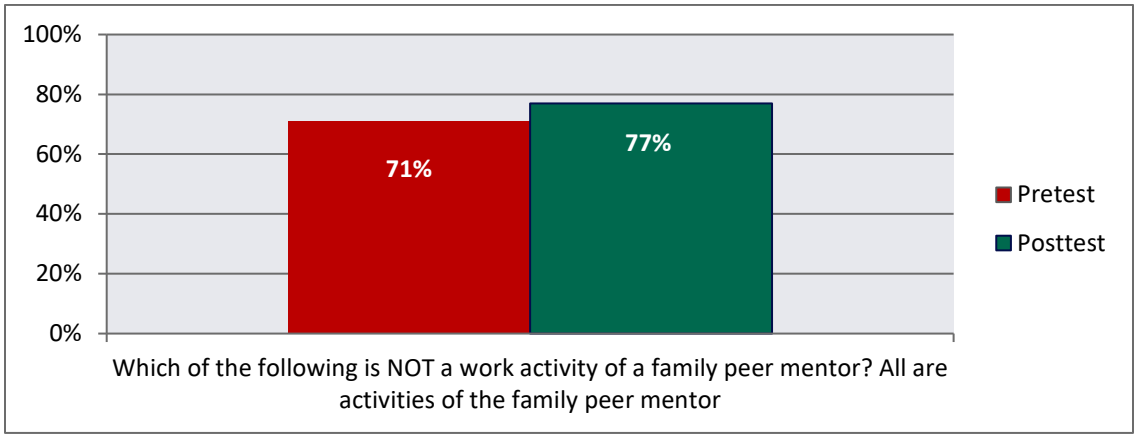
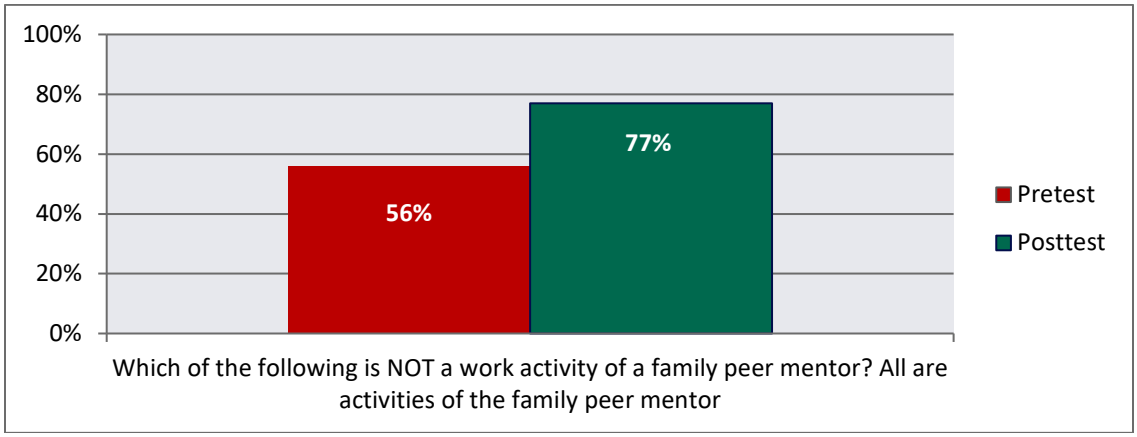
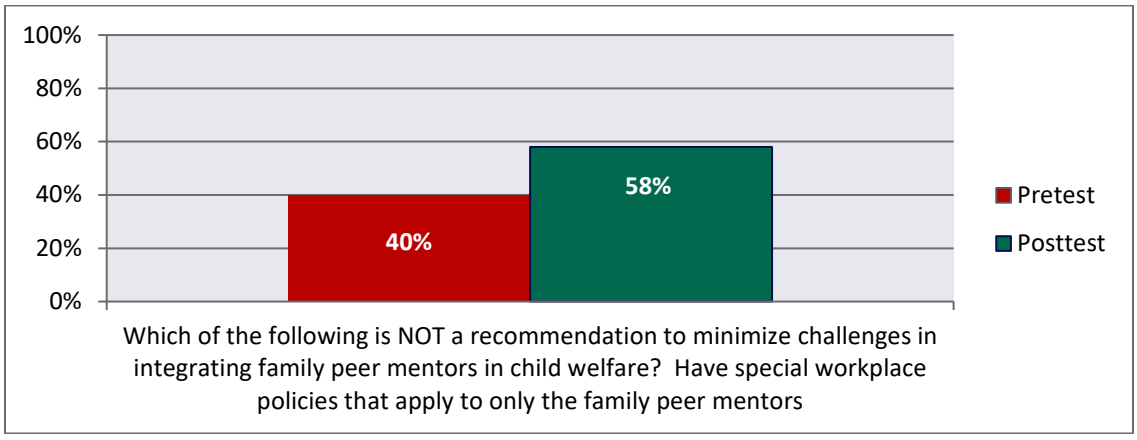


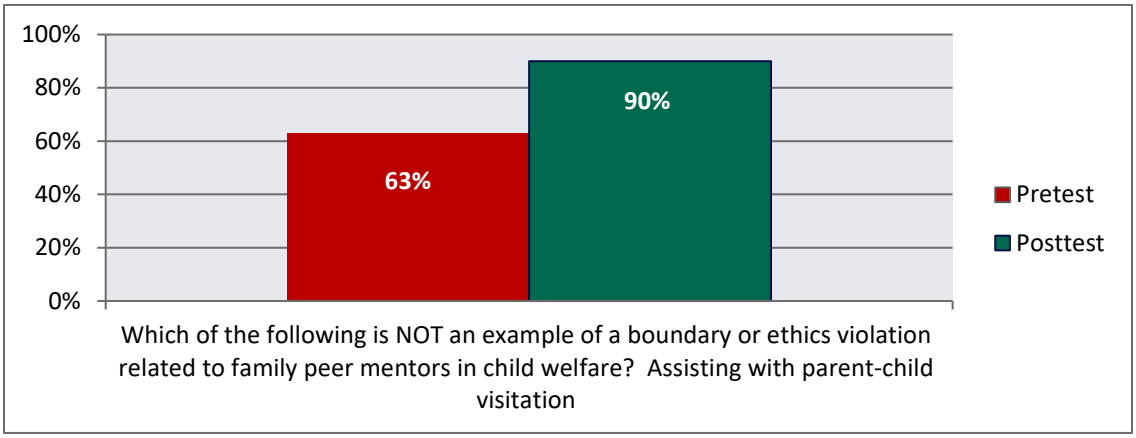
Question 11



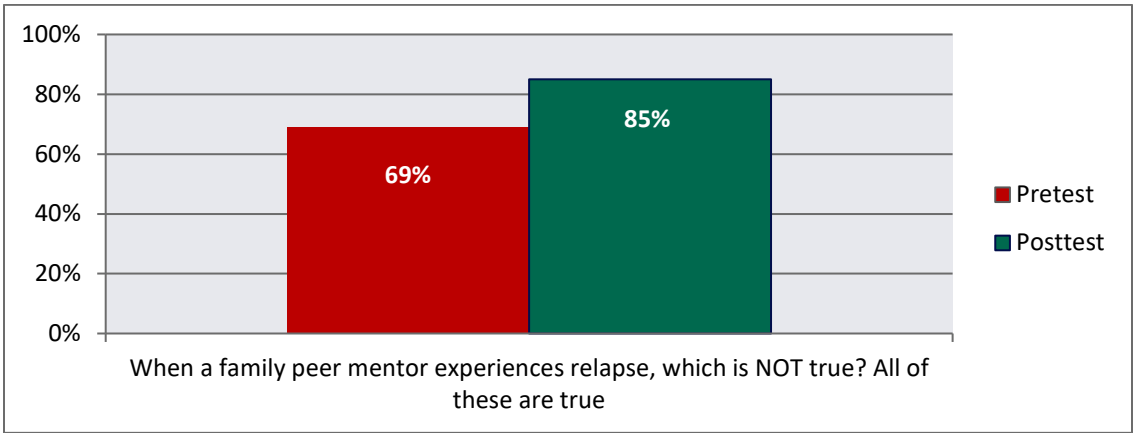
Question 12



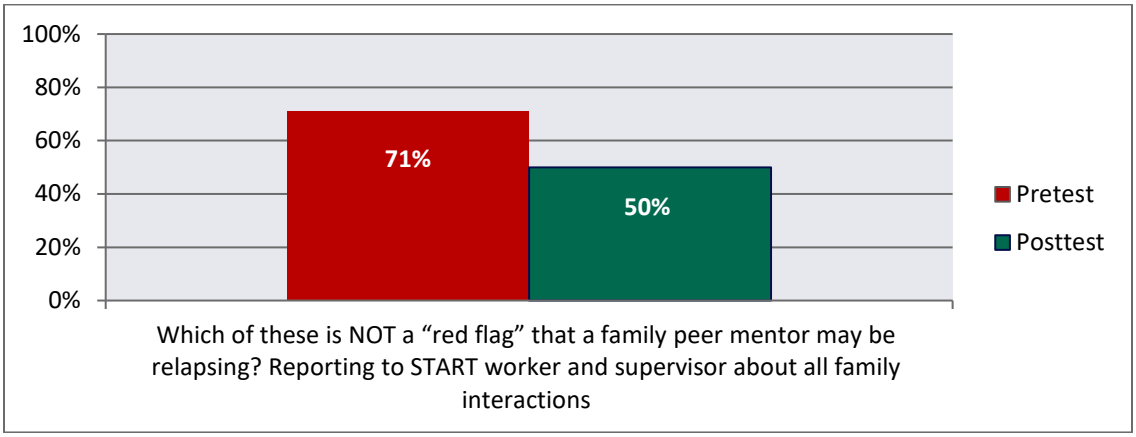
Question 13



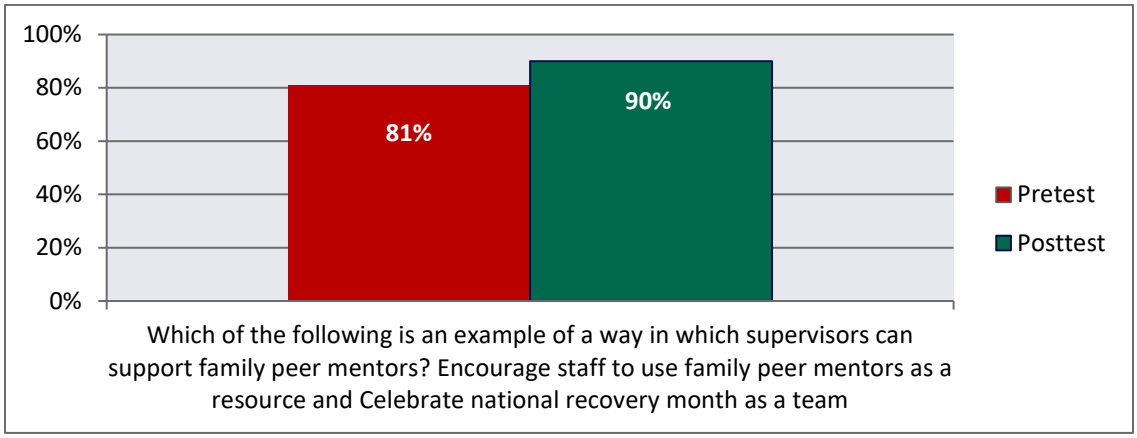
Question 14



Question 15



Question 16



2. Training 2: Foundations 3—START Case-Management and Practice

Foundations 3 training for Ohio START focuses on understanding the long-term outcomes for the project (e.g., higher rates of sobriety, reduced foster care) by examining the specific practices that result in these changes. These practices include greater collaboration with behavioral health providers, earlier screening of substance misuse, and family-centered services.

The age of training participants ranged from 23 to 69 years, with the mean age of 42 years. Most participants were female (86.9%) and white (95.1%). Many participants had a Bachelor's degree (43.3%) or Master's degree (40%). Just over half (52.5%) of the participants were at the agency for 0–4 years, while 68.3% were in their current position for 0–4 years. The most common job held by participants was social worker (39%).

Table 3: Foundations 3 Training Participants Demographics (n = 61)

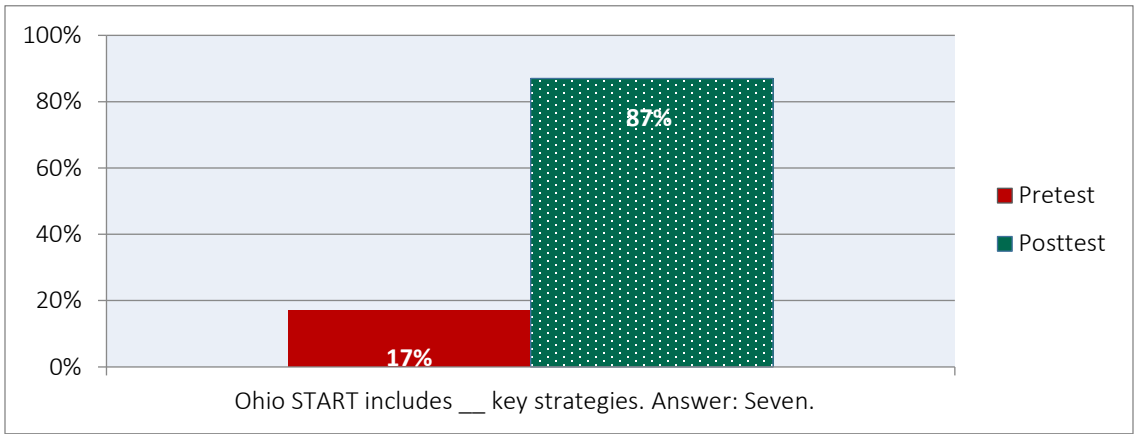
	Mean (SD)/ %
Age in years	41.6 (11.36)
18-24	1.7%
25-34	31.7%
35-44	23.3%
45-54	28.3%
55-64	11.7%
65-74	3.3%
Sex	
Female	86.9%
Male	13.1%
Race	
Caucasian/White	95.1%
Black/African American	3.3%
Asian/Pacific Islander	1.6%
Decline to state	--
Other	--
Education	
High school graduate, diploma or the equivalent e.g. GED	10%
Associate's Degree	5%
Bachelor's Degree BA, BS, BSW	41.7%
Master's Degree MA, MS, MSW	40%
Doctor of Philosophy PhD	3.3%

Table 3: Foundations 3 Training Participants Demographics (n = 61)	
Others	
Length of employment at the current organization/agency	
0 to 4 years	52.5%
5 to 9 years	13.6%
10 to 14 years	6.8%
15 to 20 years	11.9%
20 years or longer	15.3%
Length of employment at the current position	
0 to 4 years	68.3%
5 to 9 years	15%
10 to 14 years	8.3%
15 to 20 years	3.3%
20 years or longer	5%
Job title	
Social worker	39%
Therapist/Counselor	1.7%
Program coordinator	6.8%
Mental health counselor/Specialist/Consultant	5.1%
Case manager/Case management aide	5.1%
Behavioral specialist	--
Physician's Assistant	--
Administrative staff	6.8%
Medical doctor	--
Other*	35.6%

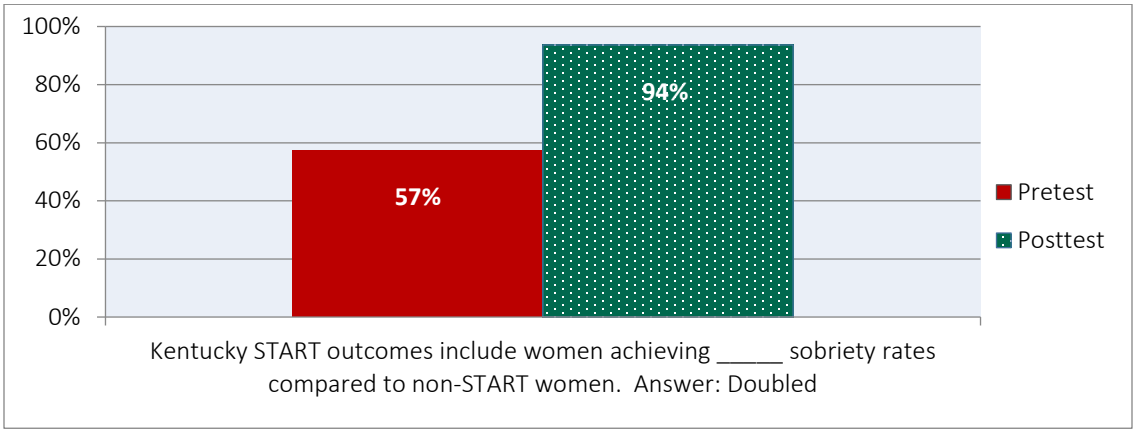
**Responses in this category included Anti-Human Trafficking Coordinator, Assistant Director, Clinical Supervision, CPS Supervisor, Family Mentor, Family Peer Mentor, Ohio State Case Worker, Peer Mentor, Project Manager, CPS Intake Supervisor, Social Service Supervisor, Supervisor, Trainer, Wraparound/parent mentor*

Pre- and Post-Training Assessments. The average score of the pre-test for the Foundations 3 training was 10.06 (out of a possible 14) (*N*=47). At the completion of training, participants scored an average of 11.79 (out of a possible 14), indicating a 17.2% increase in knowledge about Ohio START. The difference between scores at the pre-test (M = 10.06, SD = 1.634) and those scores at post-test (M = 11.79, SD = 1.667); t(46) = -7.214, 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 as it contains those people who answered all items at both time points.

Question 1

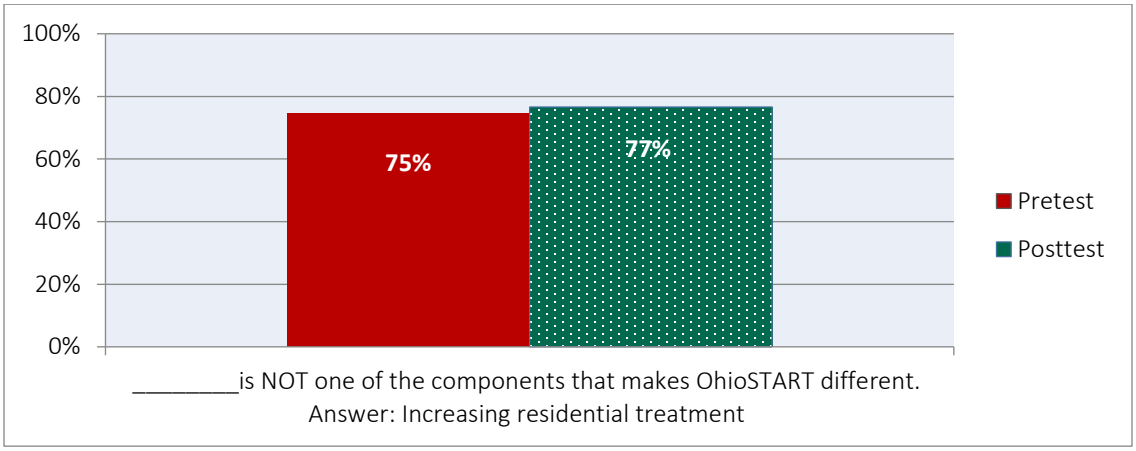


Question 2



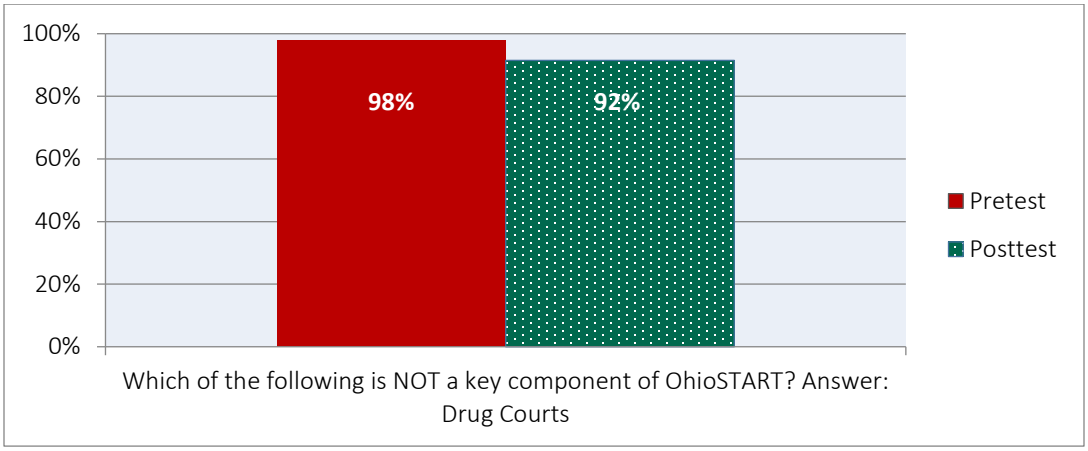
Kentucky START outcomes include women achieving _____ sobriety rates compared to non-START women. Answer: Doubled

Question 3



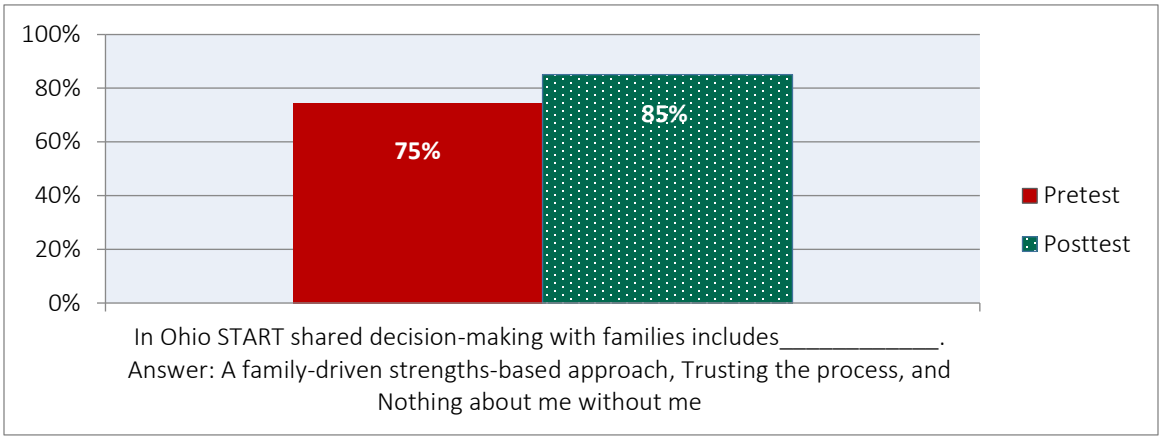
_____is NOT one of the components that makes OhioSTART different. Answer: Increasing residential treatment

Question 4

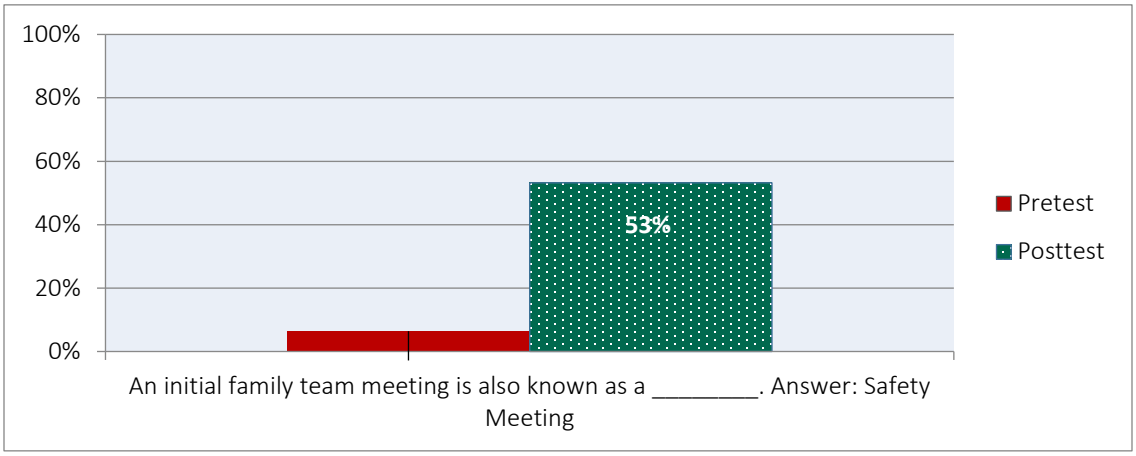


Which of the following is NOT a key component of OhioSTART? Answer: Drug Courts

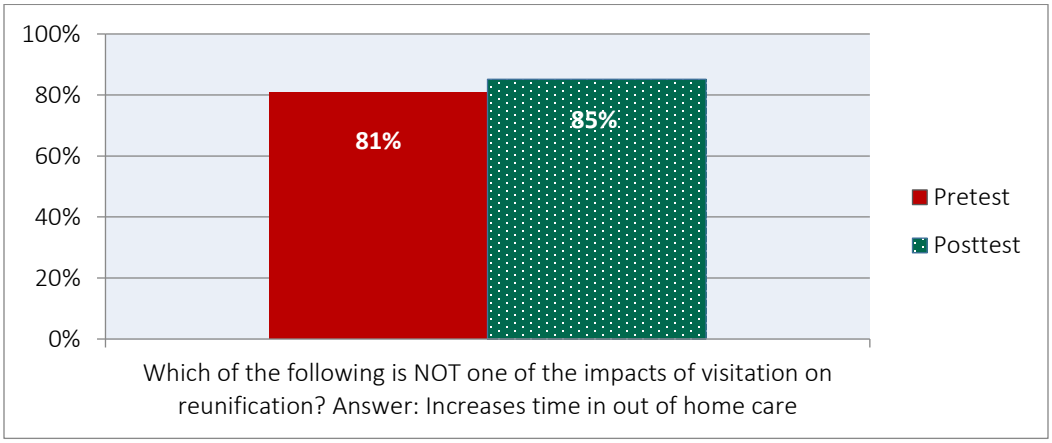
Question 5



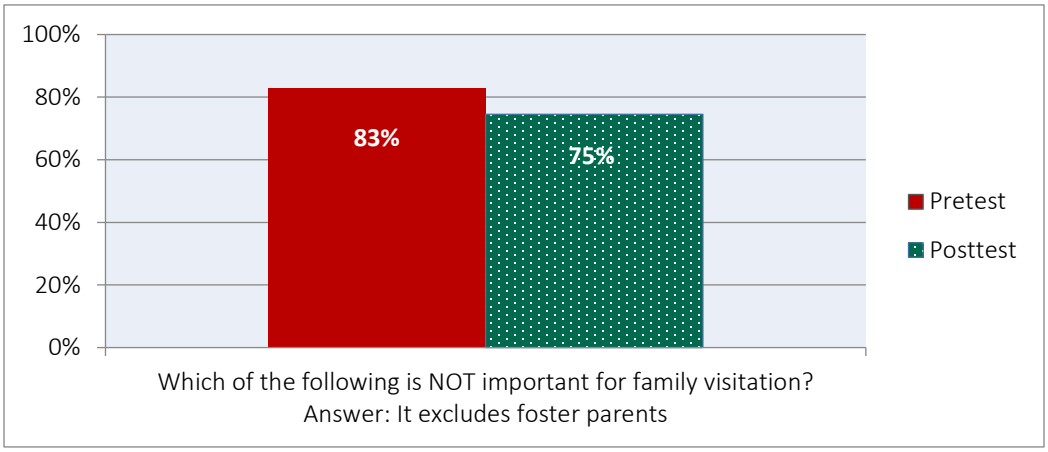
Question 6



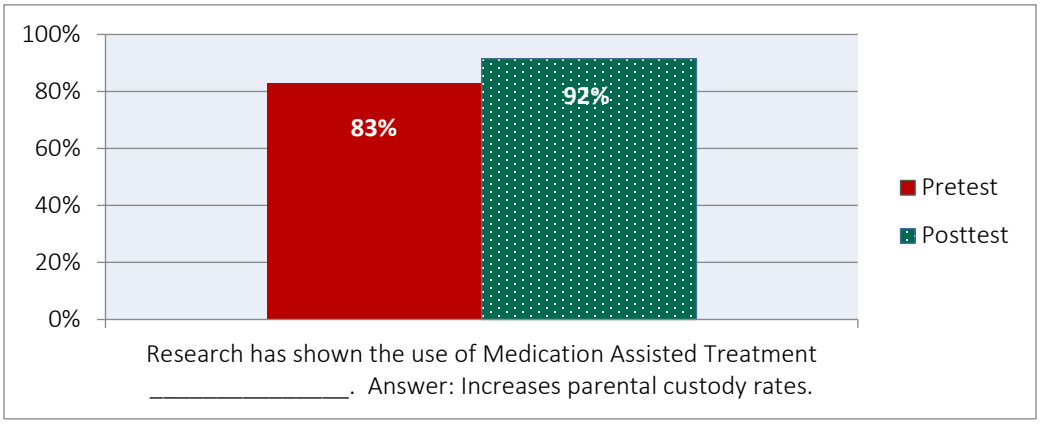
Question 7



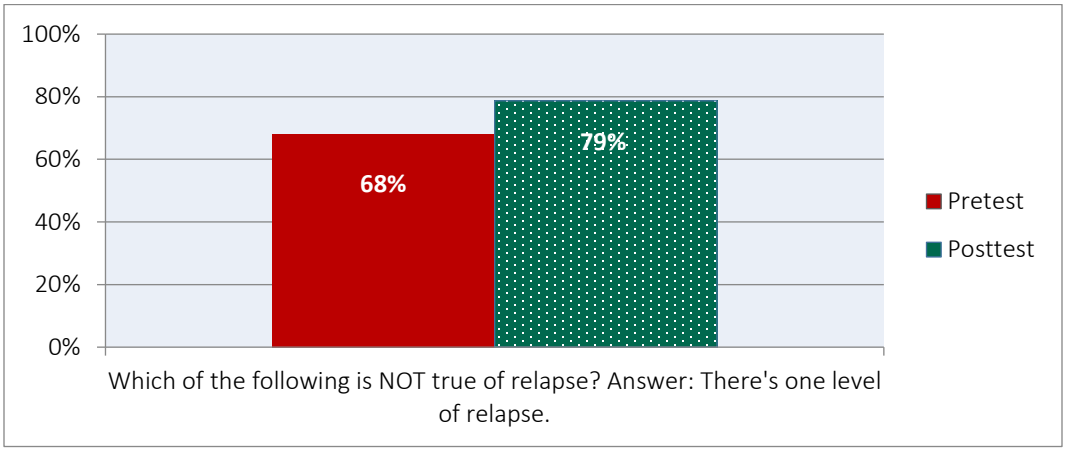
Question 8



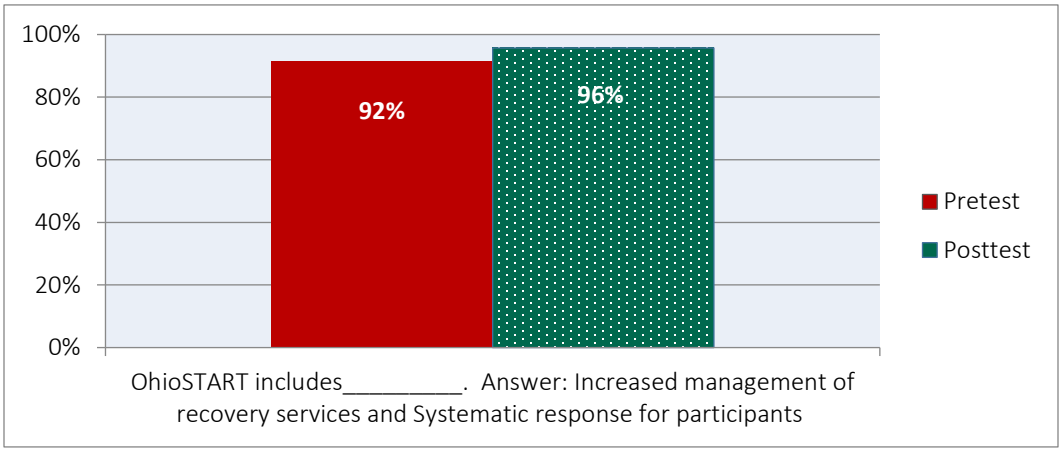
Question 9



Question 10

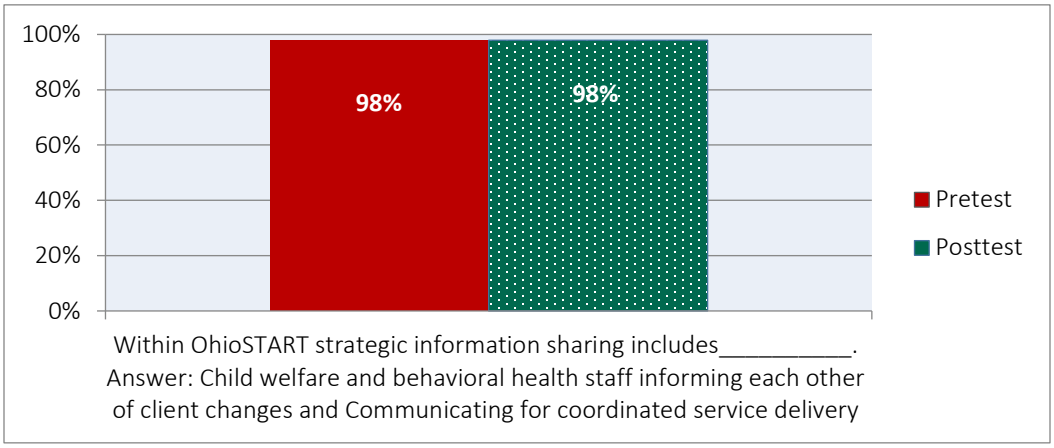


Question 11



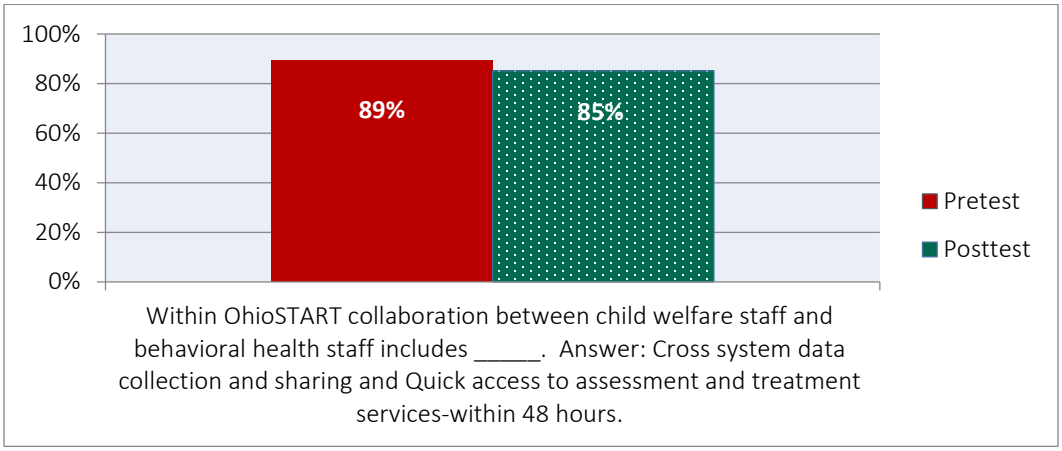
OhioSTART includes_____. Answer: Increased management of recovery services and Systematic response for participants

Question 12



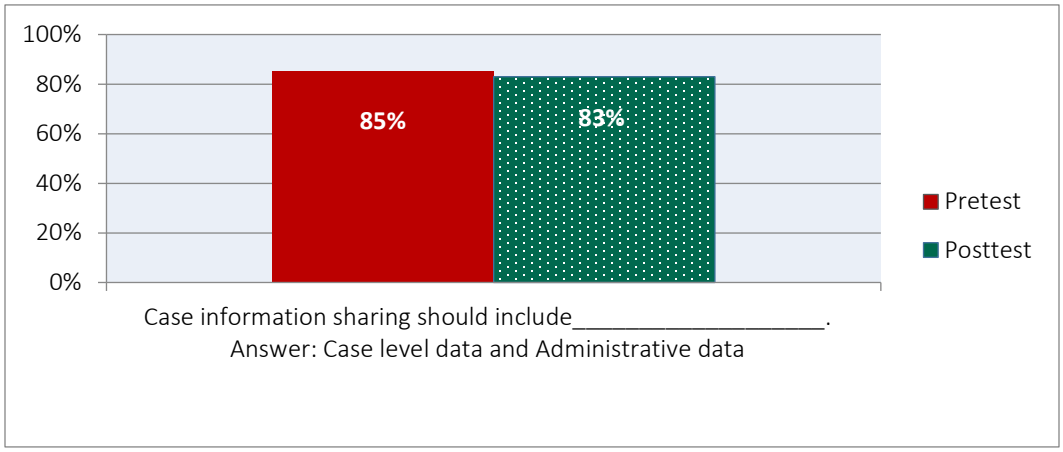
Within OhioSTART strategic information sharing includes_____. Answer: Child welfare and behavioral health staff informing each other of client changes and Communicating for coordinated service delivery

Question 13



Within OhioSTART collaboration between child welfare staff and behavioral health staff includes _____. Answer: Cross system data collection and sharing and Quick access to assessment and treatment services-within 48 hours.

Question 14



3. Training 3: Motivational Interviewing Knowledge and Confidence

This is an advanced Motivational Interviewing (MI) course designed to provide practitioners with concrete skills for utilizing MI in their work. These skills include how to address resistance, how to identify and utilize change talk, and operationalize individual goals for clients. This is an interactive course that uses case studies.

Demographic Information of Training Participants. Since the last report, 33 people participated in the Motivational Interviewing training on March 13 and April 20, 2018. Table 4 presents the demographic information of the Ohio START Motivational Interviewing training. All who completed the pre-test are included in the demographics, though not all respondents answered every demographic question. It should also be noted, that due to a copying error, several demographics questions were inadvertently omitted for several trainees. This reduced the sample size for the matched pre- to post-analysis to 16.

The age of training participants ranged from 25 to 56 years, with the mean age of 37 years. Most participants were female (76.5%) and white (83.3%). Many participants had a high school diploma or GED (55.6%). Of the participants, 94.4% were at the agency for 0–4 years, while 90.9% were in their current position for 0–4 years. Jobs held by participants varied widely.

Table 4: Motivational Interviewing Training Participants Demographics (n = 33)

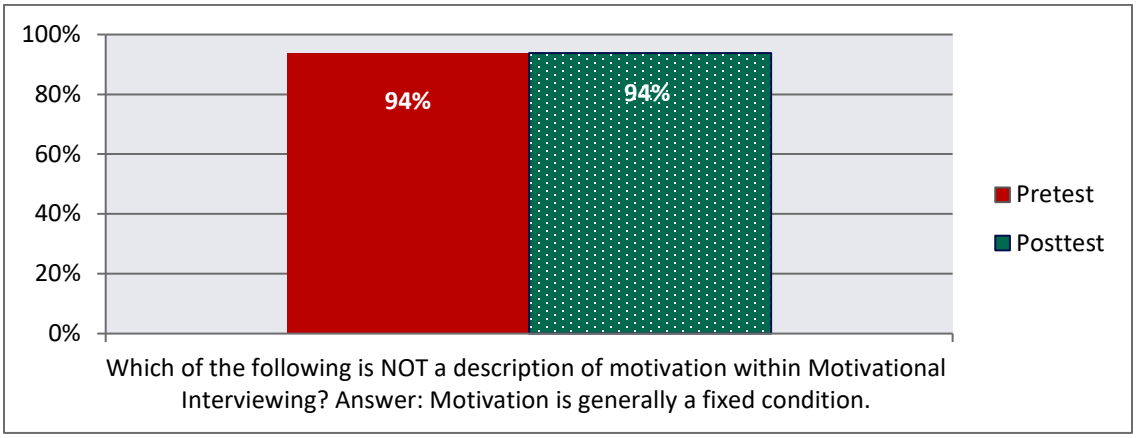
	Mean (SD)/ %
Age in years	36.6 (9.21) (n=18)
25-34	66.7%
35-44	11.1%
45-54	16.7%
55-64	5.6%
Sex	
Female	76.5%%
Male	23.5%
Race	
Caucasian/White	83.3%
Black/African American	11.1%
Hispanic/Latino	5.6%
Decline to state	--
Other	--
Education	
High school graduate, diploma or the equivalent e.g. GED	55.6%

Table 4: Motivational Interviewing Training Participants Demographics (n = 33)	
Associate's Degree	5.6%
Bachelor's Degree BA, BS, BSW	22.2%
Master's Degree MA, MS, MSW	16.7%
Doctor of Philosophy PhD	--
Others	--
Length of employment at the current organization/agency	
0 to 4 years	94.4%
5 to 9 years	5.6%
10 to 14 years	--
15 to 20 years	--
20 years or longer	--
Length of employment at the current position	
0 to 4 years	90.9%
5 to 9 years	9.1%
10 to 14 years	--
15 to 20 years	--
20 years or longer	--
Job title	
Social worker	21.2%
Therapist/Counselor	--
Program coordinator	--
Mental health counselor/Specialist/Consultant	--
Case manager/Case management aide	12.1%
Behavioral specialist	--
Physician's Assistant	--
Administrative staff	--
Medical doctor	--
Other*	66.7%

**Responses in this category included Certified Peer Support Specialist, Family Mentor, Family Peer Mentor, Intern, Lead Support/Supervisor Ohio Start, Peer Support, Project Manager, Supervision, Trainer/Consultant*

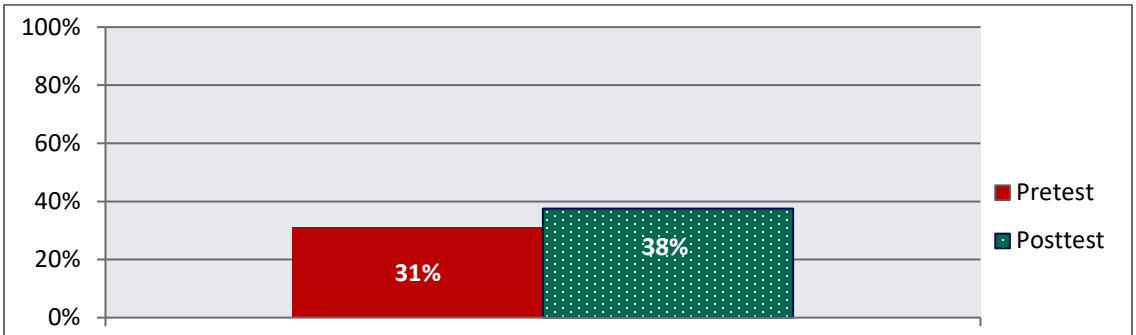
Pre- and Post- Training Assessments Knowledge. The average pre-test score for the Motivational Interviewing training was 8.31 (out of a possible 12) (*N* = 16). At the completion of training, participants scored an average of 9.00 (out of a possible 12), indicating an 8.3% increase in knowledge about Motivational Interviewing. The difference between scores at the pre-test (M = 8.31, SD = 1.493) and those scores at post-test (M = 9.00, SD = 1.549) were 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.

Question 1



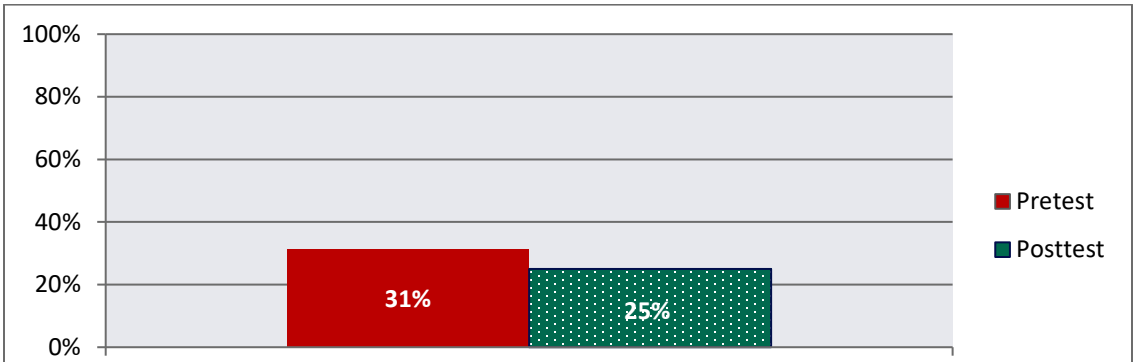
Which of the following is NOT a description of motivation within Motivational Interviewing? Answer: Motivation is generally a fixed condition.

Question 2



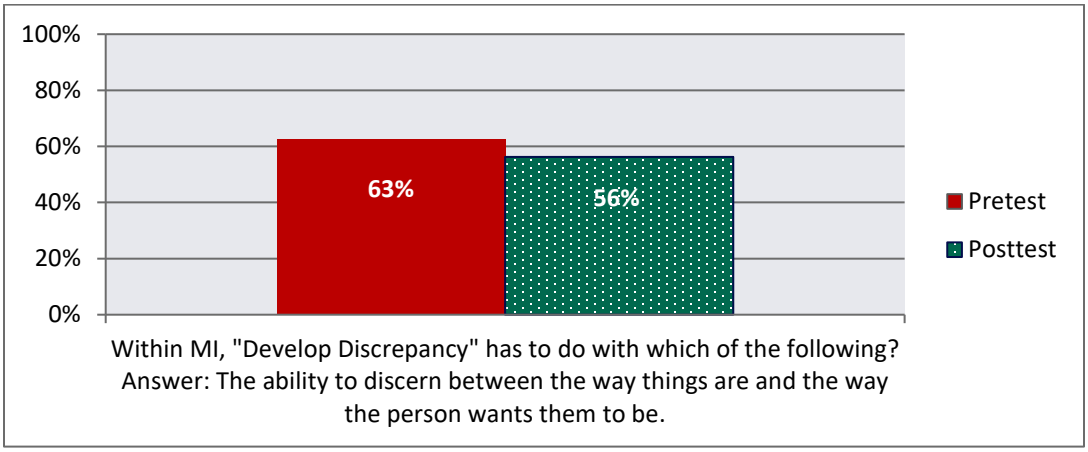
Roughly, 50% of people entering treatment for a substance use disorder are in either the contemplation or precontemplation stage of change. Answer: False

Question 3



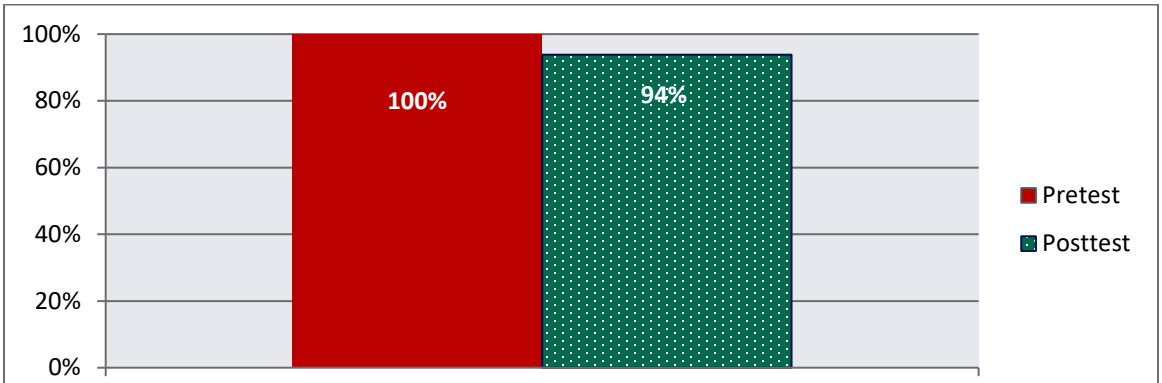
A person who has decided to make changes and is considering how to make them is in which stage of change? Answer: Comtemplation

Question 4



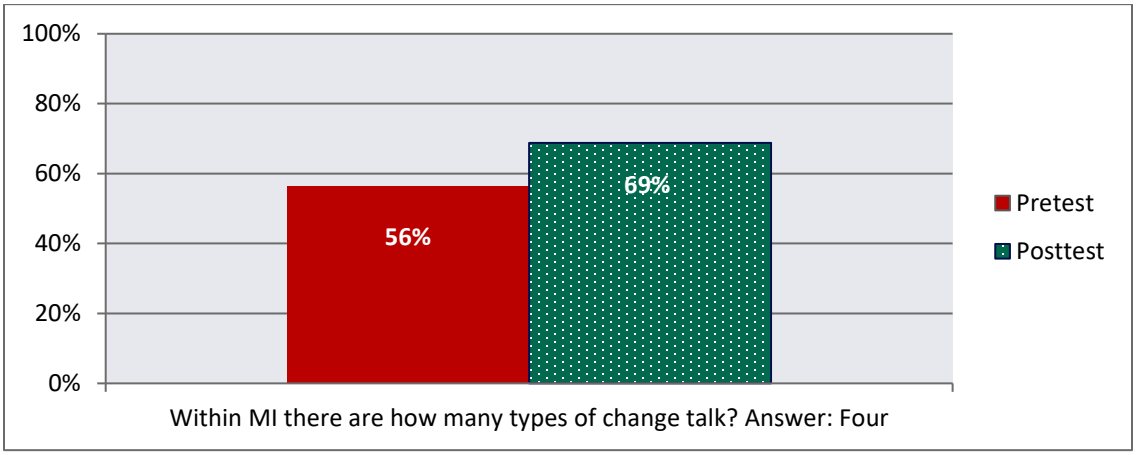
Within MI, "Develop Discrepancy" has to do with which of the following? Answer: The ability to discern between the way things are and the way the person wants them to be.

Question 5



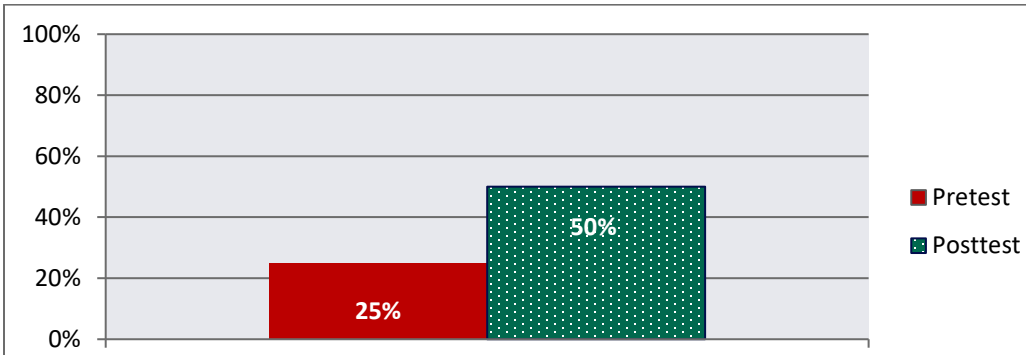
Reflecting is NOT a key component of MI. Answer: False

Question 6



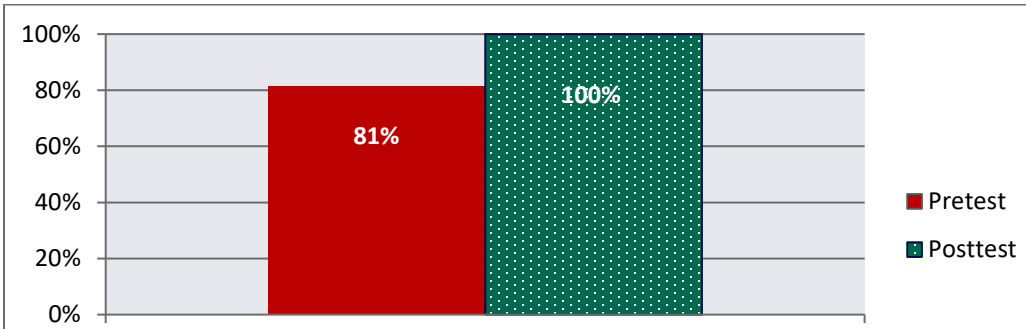
Within MI there are how many types of change talk? Answer: Four

Question 7



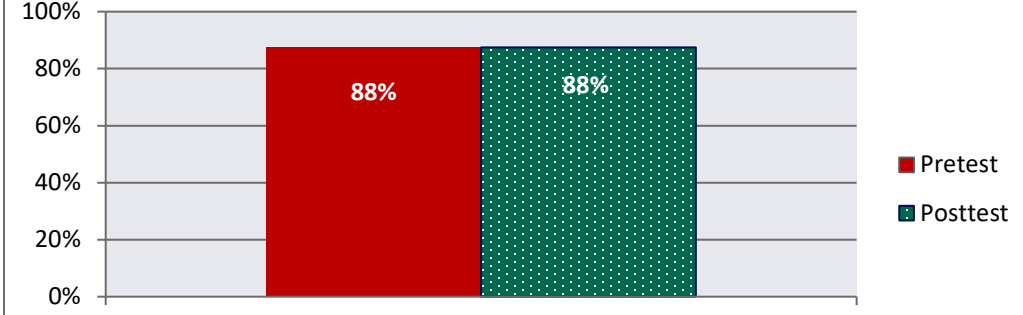
The "Readiness Ruler" in MI is used to asses which of the following?
Answer: Importance and Confidence

Question 8



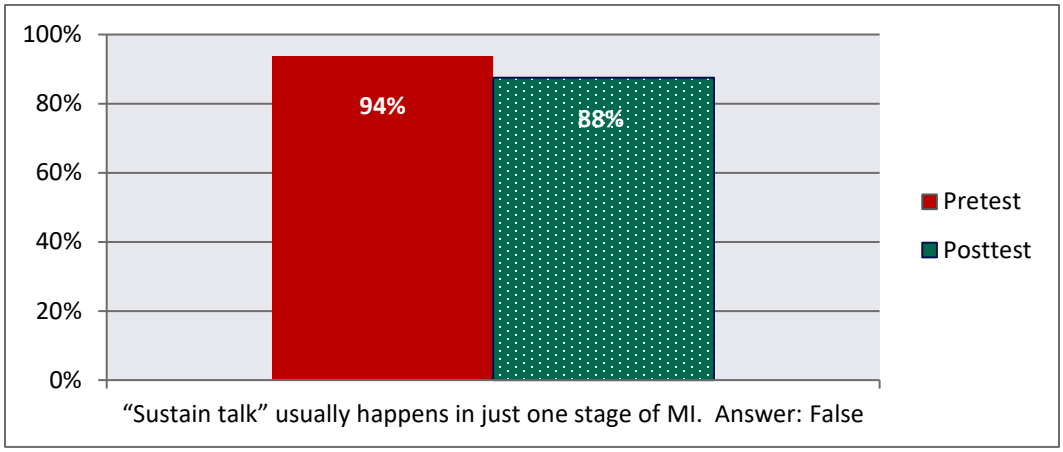
8. What is the acronym for the following steps? Ask open-ended questions, Affirm the client, Listen reflectively, Provide summaries.
Answer:OARS

Question 9



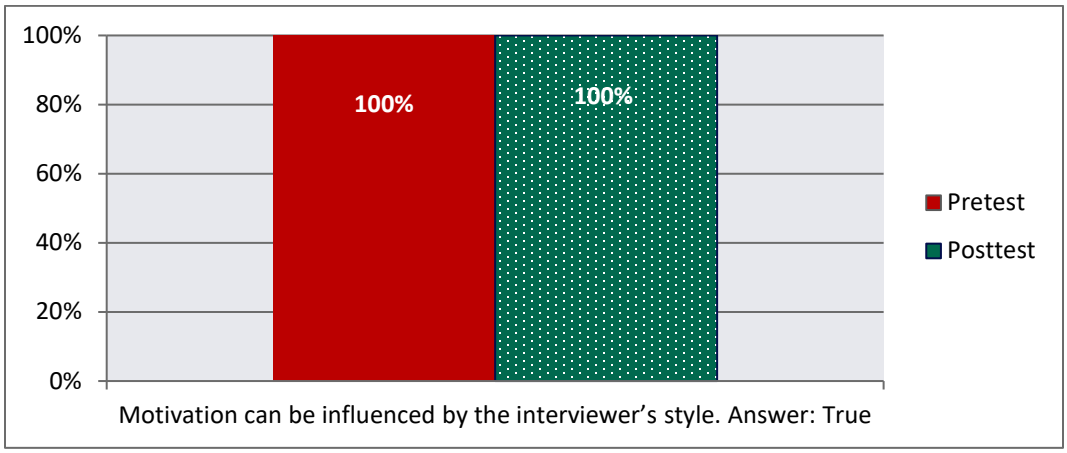
Which of the following is NOT a core principle of MI? Answer: The client needs approval to make changes.

Question 10



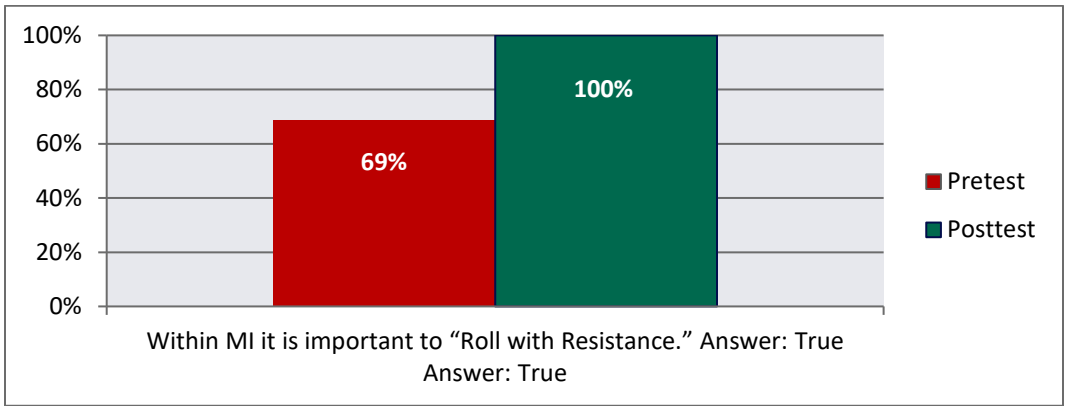
"Sustain talk" usually happens in just one stage of MI. Answer: False

Question 11



Motivation can be influenced by the interviewer's style. Answer: True

Question 12



Within MI it is important to "Roll with Resistance." Answer: True
Answer: True

Pre- and Post- Training Assessments: Confidence. The average score of the pre-test for the Motivational Interviewing Confidence scale was 46.78 (out of a possible 60). At the completion of training, participants scored an average of 53.71 (out of a possible 60), indicating a 14.81% increase in confidence about Motivational Interviewing. The difference between scores at the pre-test (M = 46.78, SD = 5.85) and those scores at post-test (M = 53.71, SD = 5.42); $t(28) = -5.88$, $p < .000$ were statistically significant using a paired-sample t-test. The individual question results (means by question) 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.

Analysis of change from pre to post by individual question is included below. A numeric value from 1 to 5 was applied with 1= Strongly Disagree through 5=Strongly Agree. Many individual item means improved from "Agree" to "Strongly Agree".

Table 5: Mean Responses Pre to Post for Confidence Level MI Questions

I feel confident…….	Mean Pre	Mean Post
...I can effectively identify "preparatory change talk" among Ohio START parents.	3.7	4.4
...I can identify parents' ambivalence and support hope that change is possible.	4.0	4.5
...I can effectively identify parents' "sustain talk."	3.9	4.5
...I can effectively establish a culturally sensitive working alliance with parents in the Ohio START program.	4.4	4.5
...I can effectively use MI throughout the skill-building process in order to maintain parents' readiness to change.	3.8	4.4
...I know the stages of change.	3.9	4.4
...I can effectively use reflection in the MI process with Ohio START parents.	3.9	4.4
...I can effectively use the MI Readiness Rulers with Ohio START parents.	3.7	4.5
...I can effectively use the OARS process with Ohio START parents.	3.5	4.5
...I can effectively implement MI with Ohio START parents.	3.8	4.5
...I can effectively support Ohio START parents' self-efficacy.	4.1	4.5
...I can express acceptance and understanding without judging Ohio START parents.	4.3	4.6

Response options: Strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), Strongly Agree (5)

Implementation Goal 4:

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 4, 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).

Fidelity Indicators

To examine implementation of Ohio START, a fidelity assessment is planned. *Fidelity* is one of the primary outcomes of implementation efforts and is defined as the degree to which an intervention is used successfully and as intended within an organization (Proctor et al., 2011). Fidelity reflects adherence to the intervention and is often assessed by examining the content delivered (e.g., core components or "key ingredients" of an intervention that make it effective), how often it is delivered (frequency), and for how long (duration) (Carroll et al., 2007). Therefore, monitoring fidelity is useful for assessing quality over time, and identifying specific areas of practice that require adjustment or further support. To prepare for fidelity monitoring, the evaluation team began collaborating with the PCSAO and the Ohio START Steering Committee to define fidelity indicators that will be measured by each participating PCSA. Ohio START fidelity indicators have been developed using a stepped and collaborative process.

1. Developed a Logic Model to Identify Core Components

To identify the core components of Ohio START, we began by developing a logic model. Logic models identify resources, activities, outputs, and expected outcomes. Logic models are intended to articulate the theory of change or the explanation of the resources and activities (core components) needed to produce expected outputs and outcomes. We refined the activities specified in the logic model by comparing them with the main intervention components described in prior guidance and documents to ensure consistency (see Appendix 1).

2. Specify Indicators

After developing the logic model, we focused on the activities that were identified. As a group, we developed at least one indicator for each activity that reflected whether each core component has been delivered as often and/or as long as intended. This process resulted in a list of 55 distinct indicators that reflect the full scope of Ohio START practice. Recognizing the need for developing a list of indicators that would be feasible to measure over time, and generate meaningful information, the group narrowed this list to 17 core indicators. These core indicators reflect the most essential elements of the intervention (see Table 6).

Table 6: List of Core Fidelity Indicators

	Name	Description
1	CPS Report Date	Date family reported to CPS
2	UNCOPE Screen Date	Date UNCOPE screen administered to parent
3	Date of first shared decision-making meeting	Date of first meeting with family; this is the meeting where UNCOPE scores are shared, consents obtained, family peer mentor introduced, etc. (for parents who score 3 or higher)
4	ACE Screen Date	Date ACE screen administered to parent
5	CTAC Screen Date	Date CTAC administered to child
6	Parent Referral Date	Date screened in parent is referred to behavioral health treatment (as a result of UNCOPE and ACE screens)

7	Child Referral Date	Date child is referred to behavioral health treatment (as a result of CTAC screen)
8	Date Parent Treatment Recommendations Received	Date that the child welfare case worker receives parent's treatment recommendations from behavioral health provider
9	Date Child Treatment Recommendations	Date that the child welfare case worker receives child's treatment recommendations from behavioral health provider
10	First Date of Parent's Treatment	Date that the parent first receives behavioral health treatment (that results from screen and treatment recommendations)
11	First Date of Child's Treatment	Date that the child first receives behavioral health treatment (that results from screen and treatment recommendations)
12	Date of first home visit with the family	Date of the first visit that case worker and/or family peer mentor has with family
13	Date of Family Teem Meetings	Date of each family team meeting, and attendees
14	Dates of Family Peer Mentor meetings with the family	Date of any meetings held between FPM and family
15	Dates of Caseworker meetings with the family	Date of any meetings held between caseworker and family
16	Date Closed	Date START case closed
17	Closure reason	Reason why the case was closed

3. Identify Data Sources

Potential data sources for each of the core set of fidelity indicators were discussed and identified. These data sources include the Needs Portal, SACWIS, and a locally-developed spreadsheet. The group was focused on minimizing data collection burden where possible while balancing the need for consistent and high-quality data. At this time, the group continues to refine the list of indicators and define consistent methods for capturing these data.

4. Next Steps

The group will continue to refine the fidelity monitoring plan by narrowing down the list of indicators to those that are most essential to Ohio START, develop a feasible plan for measuring each indicator, and supporting each PCSA to gather high-quality fidelity data.

Needs Portal

The secure, firewalled website, www.needsportal.com, has been redesigned to address Ohio START protocols. As of mid-October, 93 cases had been entered into the Needs Portal. The number of tickets by county can be found in Table 7.

Table 7: Number of Ohio START cases in the Needs Portal by County

County	# Support Tickets	# Closed Tickets
Athens	27	
Brown		
Clinton	8	
Fairfield	13	
Fayette		
Franklin		
Gallia	4	2
Hamilton		

Highland		
Hocking	4	4
Jackson		
Lawrence	8	
Meigs	4	1
Pickaway	5	
Ross	10	2
Vinton	5	
Warren	5	

The Needs Portal acts as an information system and tracks data related to the fidelity indicators presented above. As of October 2018, all counties were required as part of their MOU to use the Needs Portal to track all of their cases. These data will be placed in a Data Dashboard that allows counties to access their fidelity and outcome data on a regular basis.

Summary:

- A plan for monitoring fidelity has been developed and is intended to balance the need for meaningful information while also being mindful of existing data collection burdens.
- 65% of counties are utilizing the Needs Portal for information management

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 developed protocols for recruiting parents to participate in the survey.

1. Description of Procedures/Methods

The primary aim of the family survey is to determine if the Ohio START program promotes protective factors, positive parenting, and child well-being. The family survey uses a pre- and post-test survey research design: The pre-test baseline survey is conducted at the time of the intervention to collect information about parenting behaviors, family protective factors, child developmental outcomes (i.e., emotional symptoms, conduct problems, hyperactivity/inattention, peer relation problems, prosocial behavior), and demographics. A follow-up survey will be conducted 6 months after the initial survey to collect post-intervention data. Information learned from the family survey will inform strategies to improve services for child welfare-involved families affected by opiates and child maltreatment. Additionally, this study will provide information about the feasibility of collecting pre- and post-test data from highly vulnerable populations (i.e., substance using, child welfare-involved parents).

The OSU College of Social Work works together with PCSAs to identify potential participants of the family survey. As families begin working with their child welfare caseworker delivering the START intervention, parents are asked for permission to be contacted by the OSU research team to take a survey. The OSU team calls the parents who agreed to be contacted to summarize the study and obtain consent for participation. Parents who consent participate in two telephone surveys (1 at the time of consent and 1 six months later) administered by OSU research assistants. Parents who do not have enough cellphone minutes to complete the survey, are provided with additional minutes. The OSU research assistants send them a $15 e-gift card with which they can buy additional minutes. Each survey takes approximately 30-45 minutes. Study participants receive a $25 gift card to a local retail store for participation in each survey (for a total possible amount of $50).

The survey data includes three measurement tools: (1) Adult Adolescent Parenting Inventory [AAPI], (2) Protective Factors Survey [PFS], and (3) Strengths and Difficulties Questionnaire [SDQ]). Additionally, the

participants are asked about their demographic information (race, education level, marital status, age, and sex), activity spaces questions (where the respondent goes for school, work, medical care, shopping, child care, etc.), and a child behavioral health service utilization questionnaire (i.e., a series of questions about the type, frequency, and length of behavioral health services the child has received). At the post-test survey, participants are also asked a series of questions about their experience in the Ohio START program.

2. Sample Information

Participants of the family survey include parents who have been involved with the child welfare system for reasons of substance use-related child maltreatment and who receive the Ohio START intervention. As of August 2018, a total of 7 counties [Athens, Ross, Highland, Galia, Meigs, Fairfield, Pickaway] have participated in sending the family contact information for the Ohio START Family Survey. We have received the contact information for 23 eligible families and successfully engaged 7 families so far in completing the survey, which represents a response rate of 30.4% (completed surveys divided by the number of eligible respondents). The remaining 16 were unable to be reached for the following reasons: no option to leave a voicemail; number had calling restrictions; number has been changed or disconnected.

Summary:

- Of the 23 START participants who agreed to have their contact information shared with the OSU research team, 16 were unable to be reached despite several (6) contact attempts at varied times and different days. When we are able to reach families, they are consenting to participate in the survey. It may be beneficial to ask for a back-up way to contact participants, as phone numbers may be unreliable over time.
- Of the 7 survey participants to date, 2 required cell phone minutes in order to complete the survey. Continuing to offer cell phone minutes is important to maintain participation.
- About half of participants (4) requested emailed gift cards and the other half (3) requested mailed gift cards. Both options should be continued to meet participant needs.

SUMMARY & CONCLUSIONS

Below we provide the summary of our findings for the implementation, process and child well-being evaluations. 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.
- There were significant increases in test scores at post-test in two out of the three trainings (i.e., Foundations II, and Foundations III)—suggesting the training improved the primary knowledge related to the Ohio START program
- Greater collaboration between substance use and child welfare agencies

- ❖ The Ohio START Foundations II training increased knowledge by 17.8%
- ❖ The Ohio START Foundations III training increased knowledge by 17.2%

Areas for Improvement

- Training should continue to be monitored and adjusted to provide useful information to caseworkers implementing Ohio START
- Identify supports for family peer mentors in order to help them maintain their own sobriety.
- A longer planning period, as well as increased clarity on implementation and funding, at the outset would have been helpful.

Process Evaluation

Major Successes

- The majority of counties are utilizing the Needs Portal for information management
- A project logic model with associated fidelity indicators has been created that will better allow counties to track their success in meeting specified benchmarks for START

Areas for Improvement

- Monitor fidelity of intervention implementation and determine places where fidelity can be improved using a data dashboard
- Conduct quality assurance of Needs Portal records to ensure counties are entering data correcting in order to provider feedback

Child Well-Being Evaluation

Major Successes

- Procedures have been developed to contact current participants in Ohio START in order to assess how child well-being has changed.
- The procedure to provide increased phone minutes with potential survey respondents has been successful
- Seven individuals have participated in the survey

Areas for Improvement

- Many parents are not responding when we reach out. It may be beneficial to ask for a back-up way to contact participants, as phone numbers may be unreliable over time.
- About half of participants (4) requested emailed gift cards and the other half (3) requested mailed gift cards. Both options should be continued to meet participant needs.

RECOMMENDATIONS & 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

- Well-being of family peer mentors
- Assessing fidelity
- Encouraging parents to participate in surveys
- Monitor effects on changes in child welfare outcomes (e.g., reunification)

Well-being of family peer mentors. The qualitative interviews with stakeholders found that some caseworkers are concerned about the long-term well-being of family peer mentors. As these individuals are currently in recovering and have been through the child welfare system, the new role as a family peer mentor may introduce additional stressors. Increasing the services and supports available to family peer mentors will be an important endeavor as the program continues to expand. Similarly, identifying a pipeline to recruit and train new family peer mentors will also

Assessing fidelity. As implementation of Ohio START continues, we will want to more closely monitor benchmarks related to fidelity of the intervention across sites. The development of a logic model aided in the identifying important markers for assessing fidelity. The goal for the next phase of implementation will be to work with counties to identify how to increase fidelity to the Ohio START model

Encouraging parents to participate in surveys. The long-term goals of Ohio START remain the same: reducing maltreatment, increasing reunification. Intermediate goals such as increasing child-well being through reducing trauma symptoms and promoting healthier attachment between parent and child are also important in understanding the multi-faceted ways START helps families. To that end, identifying ways to encourage greater participation of parents in the parent survey will allow us to better assess how child well-being changes as a part of the START intervention.

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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Appendix 1
Ohio START Logic Model

Inputs	Outputs		Outcomes		
	Activities	*Participation*	*Short*	*Medium*	*Long*
AG's office	Family Team Meetings	Parents	Increased parenting time between child and parent	Increased awareness of impact of addiction on children	Reduced maltreatment recidivism; increase in children remaining safely in the home; decreased time in out of home care; increased reunification; improved child well-being
PCSAO		Children			
Family peer mentors		Family Peer Mentor			
Behavioral health service providers	Screening (UNCOPE, CTAC, ACE)	Behavioral Health	Establishing relationship with family peer mentors	Improved caregiver well-being (includes supports, protective factors, resilience)	Improved family stability
		Child welfare			
OU and OSU evaluation team	Assessment	Courts	Increased shared decision making between CW, FPM, BH, and families	Increased referrals for children's behavioral health	Improved child-parent relationship/ attachment
IHS		Community Partners			
VOCA , Casey Families Foundation, United Health Care, Health Path Foundation, OHMAS	Family peer mentors providing services in each county: weekly meetings, role modeling, ongoing support		Increased frequency of face-to-face contacts between caseworker and parent	Increased referrals to substance use treatment; timely access to substance use treatment; reduced substance use; compliance with treatment	Enhanced capacity of parents to access services on their own
PCSAs	Intensive Case Management				Enhanced resources and coordination of resources for families
Courts	Behavioral health treatment and recovery supports				
Americorps					
Local ADAMH and Recovery Boards	Steering committee meetings				
	MOUs, Parenterships				