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PIP Item: 1A.3.1 Assess the quality and frequency of family team meetings across regions.

Executive Summary

This is a report on the quality and frequency of family team meetings (FTMs) intended to be used, as one of several inputs by the regions to improve practice and to guide policy development. Kentucky has utilized the FTM in its current structure since at least 2001 and shown a strong commitment to the FTM by surveying clients, community partners, and staff on the FTM; conducting ongoing trainings; hiring facilitators; and developing a FTM strategic plan. This current analysis was based on TWIST (The Worker Information SyTem), the state's child welfare administrative data system, data linked to data from 4,270 unique CQI case quality reviews completed by supervisors and regional staff between January and July 2010. The frequency, quality, and associated effects of the FTM were evaluated for cases served in investigation, in the home, and in out-of-home care (OOHC). The analysis showed an increase in the frequency of FTMs since first systematically measured in January 2005 with current frequencies displayed here.

CASE INDICATOR	INVESTIGATIONS	CASES SERVED IN-HOME	CHILDREN IN OUT-OF-HOME CARE
Any FTM (January 2005)	Not Measured	31.2%	40.7%
Any FTM ever (2010)	43%	54%	78.1%
Average total number of FTMS (2010)	1.38 total FTMs in case	1.73 total FTMs in case	4.15 FTMs in case

Cases are more likely to have a FTM if they are more complex (e.g., have an investigation and the case is opened), if they have higher risks (e.g., substantiated with high risks), if the case is involved with the agency for longer times, or if they have special circumstances (e.g., adoption goals, youth transitioning from care). Cases with these characteristics have higher rates than shown above of any FTM and a higher average number of FTMs.

Essential quality indicators of the FTM from the 2010 CQI case reviews were examined for three types of cases and the summary results are shown here. Overall, fathers were least likely to be engaged in the FTM and youth and the full range of participants including service providers were more likely to be engaged in the FTM for cases served in OOHC.

CQI CASE REVIEW QUESTION	INVESTIGATIONS	IN-HOME	OOHC
60b. Were the following represented at the FTM as appropriate: DCBS, family members, service providers, and caregivers?	92.9%	92.3%	95.6%
60c. Does the FTM documentation capture the	84.2%	85.5%	80.3%

CQI CASE REVIEW QUESTION	INVESTIGATIONS	IN-HOME	OOHC
mother's input?			
60d. Does the FTM documentation capture the father's input?	63.5%	65.3%	57.9%
60e. Does the FTM documentation capture the child's input?	73.4%	72.6%	82.5%
60f. Was a FTM held prior to the most recent case closure?	78.0%	75.0%	80.5%

Because the rate and number of FTMS increase with the complexity of the case, that is, they are selected for a FTM based on need, measuring long-term outcomes is complicated by this bias. Cases with a FTM may appear to have poorer outcomes not because of the FTM but rather because the case is more complex. An alternative idea, however, is that a FTM early in the case may serve to prevent complicating conditions. Such hypotheses are difficult to test and beyond the scope of this current analysis. Because long-term outcomes are influenced by the complexity of the case, in this analysis more proximal or short term outcomes such as family engagement were examined. For each type of case, the FTM was associated with higher quality case work practices such as assessment of family strengths and supports in investigations, better engagement and service delivery for families within in-home cases, and better visitation with the mother and efforts to prevent reentry for children in OOHC. Timing of the FTM in relationship to key decisions in the case is very difficult to measure and no obvious patterns were seen. For example, a FTM for a case with the first finding of substantiation/needs services (n = 400) was held between 24 months before the finding to 9 months after the finding, or not at all. This analysis suggests that conditions rather than the timing in the case are used as the impetus for scheduling a FTM.

Overall, this report finds that the use of the FTM is embedded throughout practice in the state and becoming more frequently used over time. The FTM is associated with better case work practices and used most in more complex and difficult cases. Overall, this analysis suggests that conditions in the case signal the need for a FTM rather than a time frame schedule for a FTM.

Introduction

Background

Kentucky's Department for Community Based Services began the use of Family Team Meetings as a specific intervention within Protection and Permanency in 2001. The use of Family Team Meetings (FTM) was a major strategy for family engagement in Kentucky's first Program Improvement Plan (PIP) and SOP changes were made that required a FTM at many key points in the CPS case. In January 2005, Kentucky renegotiated PIP I to include a single measure of "any FTM in the case" rather than multiple FTMs as originally proposed in PIP I. The use of FTMs measured at a point in time as 'at least one FTM at any time during the life of the case' is displayed here. In this table all cases regardless of the length of service are included

in the analysis; these numbers underestimate the rate for cases active long enough to have a FTM and enter the data into the TWIST system.

POINT IN TIME INDICATOR (CASES FACT SHEET)	JANUARY 2005 (RENEGOTIATED PIP 1)	JANUARY 2006 (COMPLETION PIP 1)	JULY 2010
Percent of In-home cases with at least 1 FTM	31.2%	43.4%	42.7%
Percent of Out-of-home cases with at least 1 FTM	40.7%	45.3%	64.7%

The rate of ‘any FTM in the case’ for CQI case reviews is higher than shown above because these cases have been active for at least 30 days. The rates identified in this current analysis (see later) are:

- 43% of cases with an investigation and 50.1% of investigations with a substantiated/needs services finding.
- 54% of all cases served in-home
- 78.1% of children in Out-of home care

In 2005, 1,135 DCBS staff, 167 parents in ongoing cases (15% OOHC and 85% in-home), and 771 community partners completed separate surveys on Family Team Meetings. The survey asked about four domains: general satisfaction and perceived benefits of FTMs; barriers to FTMs, outcomes of FTMs and satisfaction with paid facilitators for the FTMs. Parents involved with CPS said (73% agreed) that it was easier to meet all the people at once (at the FTM) rather than go from office to office, that the FTM helped them know what to do to keep children safe and well cared for (52%) and 52% would recommend the FTM to other families. These parents cited their own anxiety about attending and issues of transportation and child care as the biggest barriers to the FTM.

Community partners expressed the highest degree of satisfaction for any group and identified the benefits of FTMs as:

- Helpful to families to coordinate services and expand resources (80%)
- Result in more comprehensive planning and focus on family strengths (65-75%).
- Facilitators were skilled in making the group comfortable and helping them work (80%).

Community partners wanted to receive notices of meetings earlier, have meetings scheduled at times they could attend, and clarification of their role in the FTM. The partners also recommended concerned more efforts to help the family feel comfortable during FTMs.

More than 50% of DCBS staff felt increasingly comfortable with participating in FTMs and perceived that FTMs: expanded resources for families; were helpful to families; and helped coordinate service delivery to families. In contrast, less than 40% of DCBS staff was comfortable facilitating FTMs. The biggest barrier to FTMs, according to DCBS staff was struggling to engage families and community partners in the process with issues of transportation for families or simply failure to attend as most problematic. Staff was very concerned about the need for follow-up after the FTMs to ensure that commitments by the family, DCBS staff, and

community partners were honored. They often commented that it was easy to have the meeting, but much harder to follow-up on action plans.

In September 2007, DCBS developed a strategic plan to expand the quality and frequency of using Family Team Meetings. This plan was completed just prior to the current administration and the onset of a severe budget shortfall. In that plan, it was estimated that 44 additional facilitators would be needed to provide facilitation for all FTMs held at that time. For the strategic plan, data from each region were gathered that demonstrated supports for FTMs in every region with some well developed materials and ideas for engaging families that could be used more consistently throughout the state. The strategic plan included recommendations and guidelines for FTMs.

Purpose

The purpose of this document is to synthesize information on the current quality and frequency of Family Team Meetings in Kentucky at the state and regional level. This document is intended to help the regions conceptualize and develop plans for improving the quality and frequency of the FTM. This analysis expands on previous analysis that found that the FTM was used more often in cases with significant challenges. These differences in using the FTM challenge the analysis of outcomes since complex and high risk cases tended to have poorer outcomes with or without a FTM. Evaluation of FTM long-term outcomes must control for the effects of case complexity. In this analysis, more proximal or short term case work outcomes associated with a FTM were examined.

Methodology

A random sample of cases for CQI casework quality reviews are selected each month with 4 cases per team reviewed by the supervisor (FSOS) and a subset of these reviewed by the regional specialists. When the random sample is selected from TWIST (TWS M112), extensive data indicators about the case or child (if in OOHC) are uploaded into the case review site (CQI-CARES) and paired with the case review data. This dataset with TWIST data on each case linked to CQI case review results from January 2010 through July 2010 was used in this analysis. Regional CQI case review scores were used if available (738 regional reviews or 17%); when not available, supervisor reviews (3,532 supervisor reviews or 83%) were used. If a case was reviewed twice, the most recent review by regional staff (if available) was used. There were adequate numbers of case reviews for reliable analysis at the regional level, but an inadequate number of reviews for reliable county-level analysis. For this analysis, 4,270 unique cases were reviewed with these components identified (one case could have multiple components):

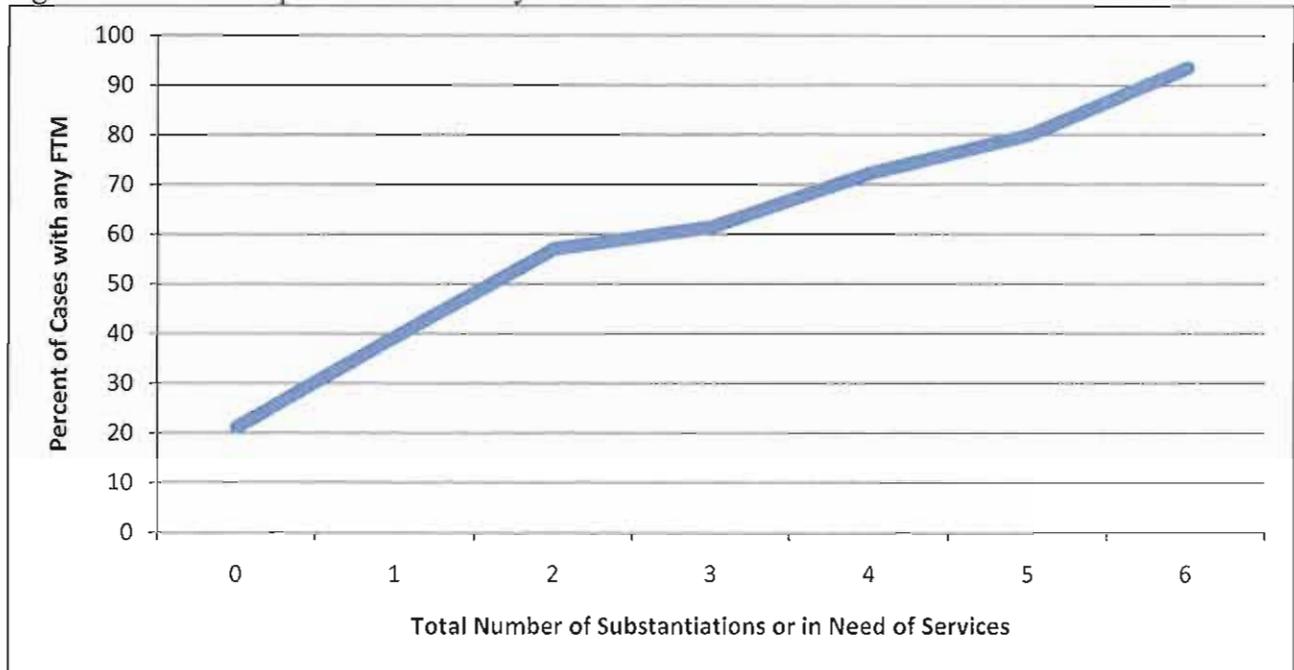
- 2,923 cases with investigations within the past 18 months
- 1,439 children in OOHC
- 2,149 cases served as in-home cases within the past 18 months

Family Team Meetings for Cases with Investigations (n = 2,923)

Frequency of FTM in Investigations

Overall, 43% of cases with an investigation in the past 18 months had at least one FTM during the case. As shown in Figure 1, the more findings of substantiation or in need of services (FINSA) in the case, the more likely that the case had at least one FTM. For example, for cases with 6 substantiations or findings of in need of services (n=31 total cases), more than 93% of those cases had at least one FTM.

Figure 1: Relationship of Cases with any FTM to the Number of Substantiations/Needs Services



The total number of FTMs in the case was also positively and significantly correlated with the number of substantiations/in need of service findings. That is, as there were more findings of abuse/neglect in the case, there were a greater number of total FTMs; cases with 6 findings of substantiated/needs services had an average of 4.84 FTMs. If the child entered OOHC in the same time period, a FTM was held for 75% of cases. This suggests, as found in early analysis, that a FTM is used more often with complex cases that require more coordination and partnership. On the other hand, having a FTM early in the case may prevent more complications, but testing such hypotheses is beyond the scope of this present analysis. For example, a FTM for a case with the first finding of substantiation/needs services (n = 400) was held between 24 months before the finding to 9 months after the finding, or not at all. Thus identifying the timing of the FTM relative to referrals, reports and investigations is difficult; no systematic pattern of timing is suggested by this data. The analysis overall suggests that conditions rather than the timing in the case are used as the impetus for scheduling a FTM.

Using only cases with at least one finding of substantiation/in need of services, the service regions varied in the percent of cases with any FTM as displayed in Table 1.

Table 1: Investigations with ≥ 1 finding substantiation /needs services and at least one FTM

		No FTM	At least one FTM in the case	Total # of cases
Cumberland	# of Cases	145	128	273
	%	53.1%	46.9%	
Eastern Mountain	# of Cases	136	182	318
	%	42.8%	57.2%	
Jefferson	# of Cases	97	87	184
	%	52.7%	47.3%	
Northeastern	# of Cases	105	125	230
	%	45.7%	54.3%	
Northern Bluegrass	# of Cases	87	92	179
	%	48.6%	51.4%	
Salt River Trail	# of Cases	142	85	227
	%	62.6%	37.4%	
Southern Bluegrass	# of Cases	146	91	237
	%	61.6%	38.4%	
The Lakes	# of Cases	63	114	177
	%	35.6%	64.4%	
Two Rivers	# of Cases	181	202	383
	%	47.3%	52.7%	
Total State	# of Cases	1102	1106	2208
	%	49.9%	50.1%	

Quality Indicators of FTM for Investigations

For cases with a FTM, several questions on the case review tool specifically measure the quality of the FTM. For this analysis, cases where the reviewer checked that a FTM was documented in the case were used (so that it was clear that the reviewer knew that a FTM was held and reviewed the casework specific to it).

Table 2: FTMs with Investigations (N=1260 cases with Q. 60a indicating a FTM)

CQI CASE REVIEW QUESTION	PERCENT USING BEST PRACTICE
60b. Were the following represented at the FTM as appropriate: DCBS, family members, service providers, and caregivers?	92.9%
60c. Does the FTM documentation capture the mother's input?	84.2%
60d. Does the FTM documentation capture the father's input?	63.5%
60e. Does the FTM documentation capture the child's input?	73.4%
60f. Was a FTM held prior to the most recent case closure?	78.0%

Comparing Short-term or Proximal Outcomes with and without the FTM in Investigations

The use of Family Team Meetings logically should make a difference in the case. Earlier analysis in Kentucky, this analysis, and national research show that FTMs are used in more complex cases where measurement of long term outcomes such as reunification rates or recurrence of child abuse and neglect is confounded by multiple other variables. On the other hand, a failure to hold a FTM may result in more complexity in the case. Testing such hypotheses is beyond the scope of this analysis. Measuring long-term outcomes is complicated requires controlling for the effects of multiple confounding and selections variables. In this analysis, the hypothesis that the use of FTMs would be associated with short term or proximal outcomes such as improved case planning and engagement of the family was tested. To test this hypothesis, CQI case review quality for investigation cases with and without any FTM (as indicated by TWIST data) were compared on indicators thought to be associated with the FTM. In the comparisons displayed in Table 3, there were significantly better short-term or proximal outcomes for investigative cases with a FTM compared to cases without a FTM. This finding may reflect casework that is generally of higher quality (including using FTM) and/or may be a true benefit of the FTM. There were, however, no significant differences with or without a FTM for the quality of case work for interviewing collaterals, assessing safety or developing a prevention plan.

Table 3: Best Practices in Assessment and Family-centered practice with and without a FTM

CQI CASE REVIEW QUESTION	INVESTIGATIONS WITH ANY FTM (N = 1184)	INVESTIGATIONS WITHOUT ANY FTM (N = 1586)
35. Is the family's use of support systems included in the assessments?	97.0%	93.9%
37a. Are the following included in the assessment of the family? Strengths	90.0%	87.8%
21a. Does the assessment include a thorough description of what immediate safety factors were present in the home?	92.6%	89.9%

Family Team Meetings for Cases Served In-Home (n = 2,149)

Frequency of FTM for In-Home Cases

On average, a FTM was held at any time in the case for 54% of all cases served in-home. Within the cases served in-home, some cases (n = 196) had children that were in out-of-home during the previous 18 months. Families with children at home either before or after OOHC might be considered as having more complex needs. For these cases with an OOHC episode, an average of 80.6% had at least one FTM during the life of the case with regional variations displayed in Tables 4 and 5.

Table 4: Regional frequency of Cases Served In-home cases with and without a FTM

REGION		NO FTM	AT LEAST ONE FTM IN THE CASE	TOTAL
Cumberland	# of Cases	143	134	277
	%	51.6%	48.4%	
Eastern Mountain	# of Cases	135	211	346
	%	39.0%	61.0%	
Jefferson	# of Cases	53	84	137
	%	38.7%	61.3%	
Northeastern	# of Cases	107	136	243
	%	44.0%	56.0%	
Northern Bluegrass	# of Cases	89	95	184
	%	48.4%	51.6%	
Salt River Trail	# of Cases	144	89	233
	%	61.8%	38.2%	
Southern Bluegrass	# of Cases	93	92	185
	%	50.3%	49.7%	
The Lakes	# of Cases	41	118	159
	%	25.8%	74.2%	
Two Rivers	# of Cases	177	208	385
	%	46.0%	54.0%	100.0%
Total State	# of Cases	982	1167	2149
	%	45.7%	54.3%	100.0%

Table 5: Frequency of any FTM in Cases Served In-home with an OOHC episode

SERVICE REGION		NO FTM	AT LEAST ONE FTM IN THE CASE	TOTAL
Cumberland	# of Cases	5	25	30
	%	16.7%	83.3%	100.0%
Eastern Mountain	# of Cases	1	27	28
	%	3.6%	96.4%	100.0%
Jefferson	# of Cases	1	4	5
	%	20.0%	80.0%	100.0%
Northeastern	# of Cases	2	14	16
	%	12.5%	87.5%	100.0%
Northern Bluegrass	# of Cases	7	13	20

	%	35.0%	65.0%	100.0%
Salt River Trail	# of Cases	11	13	24
	%	45.8%	54.2%	100.0%
Southern Bluegrass	# of Cases	6	13	19
	%	31.6%	68.4%	100.0%
The Lakes	# of Cases	1	19	20
	%	5.0%	95.0%	100.0%
Two Rivers	# of Cases	4	30	34
	%	11.8%	88.2%	100.0%
Total State	# of Cases	38	158	196
	%	19.4%	80.6%	100.0%

As found in other analyses, the frequency of a FTM is associated with case complexity. Specifically, cases served in-home with more findings of substantiation/needs services also had more FTMs; 96.4% of in-home cases with 6 findings of substantiated/needs services had at least one FTM and an average of 5.4 FTMS. In contrast, 47% of families with one finding of substantiated/needs services had any FTM with an average of 1.4 FTMs. When a family had one FTM, 60% also had a second or more FTM.

Quality Indicators of FTM for In-Home Cases

Table 6: FTMs with Cases Served In-Home (N=1212 cases with Q. 60a indicating a FTM)

CQI CASE REVIEW QUESTION	PERCENT USING BEST PRACTICE
60b. Were the following represented at the FTM as appropriate: DCBS, family members, service providers, and caregivers?	92.3%
60c. Does the FTM documentation capture the mother's input?	85.5%
60d. Does the FTM documentation capture the father's input?	65.3%
60e. Does the FTM documentation capture the child's input?	72.6%
60f. Was a FTM held prior to the most recent case closure?	75.0%

Comparing Short-term or Proximal Outcomes In-Home Cases with and without the FTM

As conducted with investigation cases, this analysis compared CQI case work quality with and without a FTM for in-home cases. The theorized relationships were that the FTM would be associated with greater effectiveness of service delivery, more appropriate services and greater family engagement in decisions. These case work outcomes were considered more proximal or short term outcomes. Significant differences are displayed in Table 7. All differences examined were statistically significantly different between cases with and without a FTM perhaps reflecting overall better casework, but also reflecting improved proximal outcomes of the FTM. The differences are also visibly different with 5 to 20 percentage point higher scores associated with even one FTM in the case.

Table 7: Best Practices in Engagement and Service Delivery with and without a FTM

CQI CASE REVIEW QUESTION	IN-HOME CASES WITH ANY FTM (N = 982)	IN-HOME CASES WITHOUT ANY FTM (N = 1167)
57a: Were services provided to the mother based on needs identified in the assessment?	91.1%	82.9%
57b: Were services provided to the father based on needs identified in the assessment?	71.7%	66.2%
57c: Were services provided to the child/children based on needs identified in the assessment?	95.2%	89.3%
62a. Have the services provided by the agency enhanced the mother's capacity to provide for the children's needs?	83.5%	76.4%
62b. Have the services provided by the agency enhanced the father's capacity to provide for the children's needs?	71.1%	64.7%
62c. Have the services provided by the agency enhanced the child's capacity to function within the family unit?	92.7%	87.7%
66a. Was the mother actively involved in the case planning / decision making process?	87.0%	78.2%
66b. Was the father actively involved in the case planning and decision-making process?	65.9%	57.3%
66c. Were any child(ren) age 7 or older involved in the case planning / decision making process, based on their capacity and development as appropriate?	73.2%	56.6%
66 d. Were foster parent / kinship / relatives involved in the case planning / decision making process?	84.2%	71.7%
66e. Were community partners involved in the case planning / decision making process?	57.2%	31.5%

Family Team Meetings for Children in OOHC (n = 1,439)

The children in OOHC included in the CQI case reviews had these characteristics that are consistent with the total population of children in OOHC in Kentucky:

- 17% were African American; 79.4% were Caucasian
- 50.4% were males
- 30% were 5 years of age or less when entering OOHC
- 31.4% were ages 14-16 years when first entering OOHC
- 20% were in OOHC for 4 months or less.

- 20% were in OOHC for 38 months or more
- 28.5% had reentered OOHC at least once
- 60% had two or fewer placements
- 10% had 8 or more placements
- Permanency goals for those with complete data were as follows:

Adoption	25.9%
Emancipation	10.9%
Legal Guardianship	0.6%
Permanent Relative Placement	2.5%
Planned Permanent Living Arrangement	6.6%
Return to Parent	53.6%

Overall, 78.1% of these children had at least one FTM with Regional Distribution shown in Table 8.

Table 8: Frequency of Any FTM for children in OOHC

REGION		NO FTM	AT LEAST ONE FTM IN THE CASE	TOTAL
Cumberland	# of Cases	32	140	172
	%	18.6%	81.4%	100.0%
Eastern Mountain	# of Cases	13	105	118
	%	11.0%	89.0%	100.0%
Jefferson	# of Cases	31	138	169
	%	18.3%	81.7%	100.0%
Northeastern	# of Cases	28	91	119
	%	23.5%	76.5%	100.0%
Northern Bluegrass	# of Cases	47	62	109
	%	43.1%	56.9%	100.0%
Salt River Trail	# of Cases	71	125	196
	%	36.2%	63.8%	100.0%
Southern Bluegrass	# of Cases	27	131	158
	%	17.1%	82.9%	100.0%
The Lakes	# of Cases	23	141	164
	%	14.0%	86.0%	100.0%
Two Rivers	# of Cases	43	191	234
	%	18.4%	81.6%	100.0%
Total State	# of Cases	315	1124	1439
	%	21.9%	78.1%	100.0%

In Table 9, the timing of the most recent FTM in relationship to the most recent entry in OOHC is displayed. As shown here, the most recent FTM tended to be held after the child was in OOHC for at least 31 days. However, for the group with 'a FTM at least 31 days after entering care' the child had an average total number of 5.0 FTMS, showing that multiple FTMs are generally held. Similarly those with the most recent FTM held within 30 days of entering care had an average of 2.5 FTMS and those with the most recent FTM 31 days or more before OOHC had an average number of 2.94 FTMS. It is very difficult to associate the specific FTM with any specific decision in the case.

Children served in OOHC are the most likely to have at least one FTM and also have the largest number of FTMS. On average:

- investigations had 1.38 total FTMS,
- In-home cases had 1.73 total FTMS;
- And children in OOHC had 4.15 FTMS.

Table 9: Timing of most recent FTM and entry to OOHC.

Service Region		FTM => 31 days AFTER entering OOHC	FTM within +/- 30 days of entering care	FTM => 30 days BEFORE entering OOHC	No FTM (percents are higher than Table 8 due to missing dates)	Total
Cumberland	# of Children	110	17	12	33	172
	Percent	64.0	9.9	7.0	19.2	
Eastern Mountain	# of Children	84	13	6	15	118
	Percent	71.2	11.0	5.1	12.7	
Jefferson	# of Children	111	17	10	31	169
	Percent	65.7	10.1	5.9	18.3	
Northeastern	# of Children	69	15	2	33	119
	Percent	58.0	12.6	1.7	27.7	
Northern Bluegrass	# of Children	35	17	8	49	109
	Percent	32.1	15.6	7.3	45.0	
Salt River Trail	# of Children	96	16	11	73	196
	Percent	49.0	8.2	5.6	37.2	
Southern Bluegrass	# of Children	102	20	7	29	158
	Percent	64.6	12.7	4.4	18.4	
The Lakes	# of Children	108	20	8	28	164
	Percent	65.9	12.2	4.9	17.1	
Two Rivers	# of Children	163	16	12	43	234
	Percent	69.7	6.8	5.1	18.4	
State Total	# of Children	878	151	76	334	1439

Service Region	Percent	FTM => 31 days AFTER entering OOHC	FTM within +/- 30 days of entering care	FTM => 30 days BEFORE entering OOHC	No FTM (percent are higher than Table 8 due to missing dates)	Total
		61.0	10.5	5.3	23.2	

The rate of any FTM in the cases increases with longer stays in OOHC so that by 10 months in OOHC, 90.6% have had at least one FTM and by 32 months in care almost 100% have had at least one FTM. Children more likely to have a FTM are these:

- Have a goal of adoption, emancipation, or planned permanent living
- Have reentered OOHC with nearly 90% of these children having at least one FTM
- Be older with more than 90% of youth on extended commitment having at least one FTM

There were no differences in the likelihood of receiving a FTM based on gender, race, and age at entry or age (except for 18-20 y/o) at the time of the review.

Quality Indicators of FTM for Children in OOHC

Table 10: FTMs with Children Served in OOHC (N=1141 children with Q. 60a indicating a FTM)

CQI CASE REVIEW QUESTION	PERCENT USING BEST PRACTICE
60b. Were the following represented at the FTM as appropriate: DCBS, family members, service providers, and caregivers?	95.6%
60c. Does the FTM documentation capture the mother's input?	80.3%
60d. Does the FTM documentation capture the father's input?	57.9%
60e. Does the FTM documentation capture the child's input?	82.5%
60f. Was a FTM held prior to the most recent case closure?	80.5%

Comparing Short-term or Proximal Outcomes for OOHC with and without the FTM

This analysis compared cases with and without a FTM on associated case work quality for OOHC cases. Perhaps because of the larger number of FTMS, the greater frequency of FTMs, and the differences in parental involvement with children in OOHC, there were no statistically significant differences in OOHC cases with and without a FTM on measures of service delivery, service effectiveness, or parental engagement. The FTM for children in OOHC was more likely to be associated with efforts to prevent reentry, and involve the parents especially the mother with the child. Table 11 displays the only case work practices with significant differences between cases with and without a FTM.

Table 11: Best Practices in Engagement and Service Delivery with and without a FTM

CQI CASE REVIEW QUESTION	OOHC WITH ANY FTM (N = 982)	OOHC WITHOUT ANY FTM (N = 1167)
101. If the child re-entered care during the period under review, were concerted efforts made to avoid re-entry?	91.8%	70.6%
128b. Did the department make adequate efforts to facilitate the involvement of both parents by: facilitating transportation so that parents can participate in events, activities, or appointments	61.3%	55.9%
128e. Did the department make adequate efforts to facilitate the involvement of both parents by: encouraging and facilitating contact with incarcerated parents or parents living far away from the child	60.4%	51.4%
133a. Is there a current appropriate visitation agreement with mother?	84.8%	79.1%
134f. The visitation between the child and the mother was of sufficient quality to maintain or promote the continuity of their relationship.	80.3%	71.6%

Conclusions

Overall, this report finds that the use of the FTM is embedded throughout practice in Kentucky with overall increase in the frequency of FTM over time in investigations, in-home and OOHC cases. The FTM is associated with higher quality of case work in several domains and used most in more complex and difficult cases. Overall, this analysis suggests that conditions in the case signal the need for a FTM rather than a time schedule for a FTM. It is suggested that policy incorporate support for the FTM, and guidelines of engaging families and community partners, but limit prescriptive use of the FTM based on timing and consider conditions in the case that support the need for a Family Team Meeting.