Webinar Series

Addressing the Needs of Families Affected by Substance Abuse thought FAST: A Voluntary, Non-Judicial Program

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Man: Recording. We are recording right now. We are recording, and we will be broadcasting in 5, 4, 3, 2...

Elizabeth Kramer: Hello, and thank you for joining us.

Today's webinar is brought to you by Child Welfare Information Gateway, the information dissemination service for the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. My name is Elizabeth Kramer, and I'm the Senior Manager for Knowledge Transfer and Information Management at Child Welfare Information Gateway.

This webinar is one of several that we are offering virtually to help ensure that critical information is shared with child welfare and related professionals during the COVID-19 pandemic when we are prevented from gathering in person and challenged to continue to work with children and families in new and innovative ways. Today's presentation was originally scheduled as a breakout section for the 33rd annual Children's Mental Health Policy and Research Conference on Child, Adolescent, and Young Adult Behavioral Health, sponsored by the University of South Florida College of Behavioral Health and Community Sciences.

Just a few notes, we're recording today's webinar, and we will be making this recording available on our website at www.childwelfare.gov. All of our participant phone lines are currently muted, and we ask that you submit questions using the Q&A box. We will answer questions at the end of the presentation. At the end of the webinar, you also will receive an e-mail with a link to a short survey,

and we ask that you please provide us with your feedback on this webinar.

And now I'm excited to introduce our session today: *Addressing the Needs of Families Affected by Substance Abuse through FAST: A Voluntary, Non-Judicial Program.* Our speakers today are Monica Landers with the Department of Child and Family Studies at the University of South Florida, Carlos Cruz and Reana Johnson from Family Support Services of North Florida, and Areana Cruz and Anna Abella with the Department of Child and Family Studies at the University of South Florida, and so now I'm gonna turn things over to Carlos to get us started. Carlos? And, Carlos, if you've started spe-- Oh, now you're off mute. There you go. OK.

Carlos Cruz: Yep. No. For some reason, my video keeps on crashing, so I apologize. I'll just leave it unmuted, and if I lose video, at least I can continue to talk.

Thank you, everybody, for joining. We're really excited to present our project that we've been working towards to help better serve our community in a more scientific way.

We started in 2013 with a focus of methodology that's different from the time. We took a system that had about 3,000 children, and we instituted an idea called foster care redesign, and during that time, we shifted our child protective services to go from reactive to maltreatment and removal to trying to less intrusively impact those families with, and do, preventive services, so we created a service array that allowed us to--

I'm sorry. This is crashing. Let me stop my video. Can you still hear me? OK. Thank you.

Elizabeth Kramer: Sorry, Carlos. We can hear you, and participants can also see the slides.

Carlos Cruz: OK. Great.

So by the use of our service array and the prevention services, we were able to take about half of that population that was in the foster care system or relative care dependency system and were able to serve them in their home through to use of those preventative services. We've been able to sustain that now for about the 7 to 8 years that we've been doing the foster care redesign and the preservation service array, so our next steps were, we wanted to make sure that we were, you know, looking forward to sustainability of this other funding stream, and the waiver for Florida was ending.

As many of you know, the FFPSA is our next step, so we wanted to make sure we were aligning--or trying to get proactive as we could to aligning with the expectations under the Family First Prevention Act, so though this presentation, we're gonna go over what our approach is with the FAST program, or Family Assessment Support Team, which is a non-judicial case-management program.

Our augmentation we've done through the Regional Partnership Grant that we received from the Children's Bureau, and we also will be going over the evaluation that we're currently undergoing, so we can go to the next slide.

In accordance with the RPG program, we wanted to give acknowledgement to the Children's Bureau for

the funding of this study and the augmentation to the service array.

Next slide, please.

As I touched on, our main project is focused on the enhancement of our FAST program and measuring that in a quasi-experimental study.

Next slide, please.

So with the RPG project, we wanted to make sure that we were isolating and enhancing the services around the substance misuse in our community and creatively trying to tailor services that can meet those families where they are but also try to divert those families from the judicial system.

I'll give people a second to read that.

You can go ahead to the next slide.

Now I'll go ahead and hand it off the Reana Johnson, who will be framing what our system of care is currently doing.

Reana Johnson: Thank you, Carlos. Like he mentioned, my name is Reana Johnson. I also work for Family Support Services of North Florida here in Jacksonville, Florida. I'm here in Duval County, so just to kind of-- I'm gonna walk us through our non-judicial program, which Carlos briefly mentioned, FAST, and then how we've used the Regional Partnership Grant to create a project within the FAST program, so just to kind of give a starting point of all of that, about 7 years ago, so in 2013, Department of Children and Families here in Florida adopted ACTION's Safety Practice Model, and one of the primary goals of this model was to move toward investigators and Case Managers to a decision-making skill set that allowed and enhanced the ability for them to make the unsafe/safe determination through assessing parents' behaviors, as opposed to a checklist of what was occurring, and so that's done through the family functioning assessment that DCF completes that our investigators complete during their investigation, and then that leads to them then determining whether the children in the home are safe or unsafe, and that's don't through collecting information, assessing that information, and then coming to a conclusion.

So, just to briefly touch on the safe route, so if a case investigation is closed safe, then there it typically no follow-up. There may be some community resources and referrals that are completed by the investigator, and the investigator closes their case, and, like I said, there's no follow-up on that after that point.

Cases that are closes unsafe, there are few routes that the case can take. One of them is the judicial route, which commonly known as the dependency system where children are legally removed and placed either in a relative, non-relative, or foster-care placement. This has the judicial oversight, so the courts are involved. There's a judge that oversees that case, and then the non-judicial route is the other option. This is the same intensity of ongoing case-management services. However, there is not the judicial system. The children are not legally removed from their parents or caregivers, and there isn't the judge oversight on those cases-- slide, please--and so here in Duval County, we have the family assessment support team, which is the FAST. We refer to it as FAST, and this serves the unsafe population when children are not removed, and so all of our referrals come from DCF, Department of Children and Families, and they all come with a viable safety plan, so to ensure that while the parents are receiving those services that they need moving towards, hopefully, making those positive behavior changes, that the children are under a sufficient safety plan to ensure their safety and well-being.

The goal of the FAST program is, of course, to be in-home, non-judicial, and there's a therapeutic approach to it. They receive-- The families receive a tailored case plan that is structured around their needs, and so often, you hear that cookie-cutter case plan, and that's what the goal of safety practice

was to move away from that, that, you know, you have a family team conference and you work with the family, with some other professionals that may be involved in the case to create the case plan for them, and the FAST cases typically average around 6--I'm sorry--yeah, 6 to 9 months. We do see that some close earlier, and some close a little bit later, but, again, the goal of this ongoing Case Manager is to assess the parents' behavior changes and, again, hoping that that's positive behavior changes so that they can provide a safe and stable home on a long-term basis for their children.

Slide, please.

So the Regional Partnership Grant project, which we named and created into a study called *Preserving Families, Protecting Children*, is works solely within the FAST program, and so we are surveying, again, the unsafe populations, a criteria to be part of the study. There were 3 criteria that must be met, and that is that there has to be one child under the age of 5 years old in the home that is deemed unsafe by Department of Children and Families; of course, if they're unsafe and coming the non-judicial route and they are willing to participate in the FAST program, and then the third and one of the most important criteria is that there is a substance misuse maltreatment that is part of the investigation that led to Department of Children and Families' involvement, and so once the case is referred to FAST and it's identified as a Regional Partnership

Grant case as meeting criteria for it, we reach out to the family. We offer them the opportunity to be part of the study, and it's voluntary, of course, being part of the study is, and once they agree, they are blindly assigned to either the comparison group or the treatment group, and, touching on the comparison group, if they are assigned to comparison group, they receive FAST as usual services, so non-judicial services as usual with no enhancement, no changes. If they are assigned the treatment group, they receive what we call IFAST services, and that's an enhancement through a Peer Specialist who's also a Parent Educator and a Healthcare Coordinator, and they work as a team together. They're paired as a team.

Slide, please.

So the Peer Specialist we refer to, there are a couple of names that they hold the title to, but I'll refer to them-- Just for the sake of not making it so wordy, I'll refer to them as the Peer Specialist. They are trained under the Peer Specialist curriculum. The ones currently working in the program right now is nationally certified under the Peer Specialist model. They come with either or both experience, but they have lived experience in either the child welfare system themselves personally and/or they are currently-- Sorry. Just lost my train of words. They are currently in recovery and have been for a pretty lengthy amount of time, and so that plays a very special, unique role to this project for us because

they are able to bring that experience and use that experience to build a positive rapport with our families that a lot of times, our other professionals, you know, don't have that lived experience to be able to do so, and they're able to help navigate the family through the system, help advocate for them, and help provide just the understanding and that different-experience approach professionally with our families that are battling with substance abuse.

The other big piece of their role is that they are certified and trained in the Nurturing Parenting model that's created by Dr. Bavolek, so they also complete the parenting assessments, go over it with their parents and their Case Manager and any other professional that is needed, and they come up with a parenting plan with the parent, and, again, they're able to use that positive rapport and that lived experience and somewhat relate to the family with navigating them through the Nurturing Parenting modules and the lessons that they provide.

Slide, please.

And the second that I touched on earlier with the Healthcare Coordinator is, they are a certified Licensed Practical Nurse, an LPN, or above. They are also trained in the ages and stages questionnaire, which targets an assessment for child development, and so they complete this assessment with the children. They assess it. They score it, and then they go over it with the family. If there are any areas

where their child is either not developmentally on track or maybe there is a significant delay, then they help the family, the caregivers, or the parents, again, navigate the system, either work with their pediatrician or work with community partners to get referrals completed to provide the parents with the resources to ensure that their child receives the services that they need. They can also provide activities and different resources around the community to help with things like that, too.

One of the biggest goals of the Healthcare Coordinator for us was providing a holistic approach in the sense that they are addressing the family as a whole, as opposed to just the child or maybe just the child or the parent with the medical or health care need, but that they are ensuring that they are assessing all of the children. They are addressing any wellness needs or goals that the parents may have, so whether that be a need to stop smoking or tied in with their substance abuse--maybe there are mental health needs that the family may have, whether it be the child or the parent--that they are providing this approach for the family as a whole as to a specific client or participant in the case.

They also provide specialized health care and medical education, depending on, of course, the needs of the family.

Slide.

And now I will pass it off to University of South Florida to go over the evaluation piece.

Areana Cruz: Good afternoon, everyone. My name is Areana Cruz. I'm a member of the evaluation team with the University of South Florida, and we are the evaluators for the PFPC project.

The Preserving Families and Protecting Children Evaluation has been designed to assess implementation of the project, understand the development of the collaborative groups serving and supporting the families identified for the project, and examine the impact of the FAST and enhanced FAST--or IFAST, as it's referred to--services on child and family outcomes.

The presenters from the evaluation team are going to highlight findings from the process evaluation and the outcomes evaluation. The process evaluation includes interviews with stakeholders and a family needs and services survey, and the outcomes evaluation will present a comparative effectiveness study on the extent to which the IFAST program is impacting outcomes related to safety, permanency, well-being, and recovery from substance-use disorders.

Next slide, please.

So I'm going to begin by discussing the stakeholder interviews, and we conducted these interviews with PFPC stakeholders throughout the implementation of the project so far, and these include PFPC leadership; Family Support Systems of North Florida;

the PFPC staff, which would include the Healthcare Coordinator and the Parent Educator; external partners--that would include the substance abuse provider--the oversight coordinators at Family Support Services of North Florida; the family services counselors; and the family services counselor supervisors, and the family services counselors would be equal to a child welfare Case Manager, so so far, the evaluation has completed 18 interviews with stakeholders, and the goal of those interviews was to gather qualitative data related to the implementation strategies, facilitators to implementation, barriers to implementation, quality of services, perceptions of the IFAST model, and recommendations for the project.

Next slide, please.

So this slide includes all of the themes that we have gathered from the qualitative information, and I'm gonna go through these one by one and sometimes share quotes from participants that were powerful or summarized, you know, the general theme, so, starting with understanding of the of the PFPC goals, most respondents indicated that the goal of the project was to provide additional resources and services to families to see if these additions would lead to better outcomes than just services as usual and that this project would ultimately lead to preventing families from re-entering the child welfare system, and when stakeholders were asked about implementation, they were asked how the

implementation of the project impacted their work with families, how they perceived availability of services and supports, and how the project has impacted families' access to services and supports, so stakeholders predominantly described how the implementation of the project increased access to services and supports, and, for example, stakeholders felt that PFPC providers, such as the Healthcare Coordinator or the Parent Educator, were able to identify and provide feedback regarding services that may be helpful for a family, but the Family Services Counselor, or the FSC, might not have recognized either as quickly as the Healthcare Coordinator or the Parent Educator did or might not have recognized at all, so I'm gonna go ahead and move on to the aspect of health care coordination.

So stakeholders saw many benefits to having Healthcare Coordinators work with families. Many respondents pointed out the ways that the Healthcare Coordinators improved families' engagement with health care services such as making doctor's appointments, getting medications that were needed, and accessing specialty services and preventative care.

One stakeholder said, "Because people in crisis or people dealing with stuff, it's hard for them to sometimes navigate all of the systems that they have to navigate, so having someone there the help them navigate those systems at the level in

which a Healthcare Coordinator does produces better outcomes," and stakeholders also reported several benefits to having a Parent Educator.

One stakeholder stated, "I think the Parent Educator has turned out to be a great asset in the home. I think a lot of our parents how cannot maybe relate to a service counselor who maybe has had a lot of the same life experiences do well in talking to the Parent Educator about their situation."

A lot of the stakeholders strongly reported that their families give them positive feedback about their interactions with the Parent Educator and how they are beneficial for those families, so when thinking about sustainability and the impact on outcomes, we made some slight changes from Year One to Year Two in our interview process, and we asked stakeholders which they felt have more impact for families--the Healthcare Coordinator or the Parent Educator, and respondents generally felt that both roles were very important for families to have access to but that it may depend on the case and the needs of the families.

One stakeholder said that they had a family that needed more medical needs, so the Healthcare Coordinator was more helpful for that family than maybe a Parent Educator would have been but that if they need more, you know, assistance through their journey of recovery, that Parent Educators are helpful in those situations, as well, so there's a benefit to both. It's just whether the case has a

higher need for a Healthcare Coordinator or Parent Educator at the time.

So stakeholders were also asked what the greatest supports and resources for them through the implementation of the project has been, and stakeholders reported two main supports, one of them being the supports offered for the families through the staff, which would be the Healthcare Coordinator and the Parent Educator, and the other being the partnership meetings and the communication, so Family Support Services of North Florida has a partnership meeting either monthly or bimonthly with their stakeholders, their partners, the family support counselors, the Healthcare Coordinator, the Parent Educator, and that was reported as a strong support for everyone involved in the project.

One partner stated that, "I think with the project director kind of really taking on a lead role and making sure that the collaborations are happening, that the meetings are happening, that has really been an asset for me in my role of having to oversee the programs that are interacting with theirs, making sure that we are all on the same page, and that I'm able to implement with my teams whatever needs to change or happen."

So we also asked about any barriers to implementation, and some interviewees expressed concerns about the equity between the experimental and control groups.

Of course, everybody wanted this program to be available to all of their families. However, they did understand the need of having a study to prove that it is effective, but they did think it was unfair to provide enhanced services to some families and not others.

So we also asked if they had any recommendations for the project, and stakeholders had-- Some had no recommendations at the time. However, some did have a few ideas for making improvements to the project.

Obviously, they wanted this to be available to all the families that they serve and just ensuring that communication remains consistent throughout a case, that it happens all the way through case closure, including the staff on case transfer staffing calls, so having the Healthcare Coordinator and the Parent Educator on the call when the case is transferred from the CPI to the FSC, and developing a system for controlling the number of people entering a family's home.

That's something that you hear often, is that families get overwhelmed by the number of people coming in and out of their home, so when you have a Case Manager, a Healthcare Coordinator, and a Parent Educator coming in at different times multiple times of the week, sometime families involved, so just kind of figuring out a system of ways to make that happen more cohesively would sometimes reduce some burden on the families.

Next slide, please.

So, in summary, stakeholders felt that the project enhanced services for families and it leads to better outcomes, that there is enhanced communication and collaboration between all of the project partners, and that families and Case Managers are benefitting from having a Healthcare Coordinator and Parent Educator involved with cases, so I'm just gonna close with saying that--gonna close with a quote from one of the participants saying that, "I think that the families that have engaged with this program have definitely seen more success and quicker success in their cases. They're getting one-on-one attention. The current people filling the positions"--that would be the Healthcare Coordinator and the Parent Educator--"really seem to care about the families that they're working with, and so the families, in turn, tend to respond a little bit better because they feel like they're being paid attention to and they're cared for, as opposed to being just a number on a caseload."

Next slide, please.

So I'm gonna turn it over to Monica Landers or Anna for the partnership.

Anna Abella: You can move on to the next slide. OK. Thanks.

So we have also been interested in knowing what families' experiences were in this evaluation, so we've done a family needs and services survey to better understand their perspectives and their experiences in these different areas, so this has included families from both the IFAST and the FAST study, and so we've asked all of them some of the same questions, and then, of course, for the families in the IFAST group, they have had the healthcare coordination, peer support, and parent education components that the FAST group hasn't, so overall, though, what it really shows is that there is a high satisfaction rate with all of these different areas, and they're very similar, as you can see, between the two groups, and we have done these surveys mostly through phone, but we've offered preferences for families, so sometimes it's online, and sometimes in a few cases, we've mailed the surveys, but, as you can see, there are very minimal differences, although we do see a slight but relatively consistent difference between all of the areas that both groups were surveyed on, and so the IFAST group has a slightly lower satisfaction rate than the FAST group, although it's so minimal, it's less than half of a point for any of the categories, so it's hard to say if it's a really meaningful difference, and, hopefully, as we continue to do more surveys, we'll be able to tell whether that would be a consistent pattern.

One thing we've sort of hypothesized is that perhaps because there are additional services and we know from this study as well as from other studies in child welfare that a lot of parents feel a burden or services, especially if hey feel like they're not supposed to be there in the first place or not supposed to be getting certain services.

However, on the other hand, we do ask for open feedback, and some of the feedback has shown positive comments about the people they're working with, especially that they feel like--you know, they say they're awesome people or they're really good at their jobs, and then we see from both groups some comments that refer to feeling like they're getting services that they don't need, so, like, and that's sort of a common trend that we see across other studies, as well.

So, hopefully, as we continue on with this survey, we'll be able to sort of tease apart any, you know, meaningful differences between the two groups.

And I think Monica will speak next to the outcomes study on the next slide.

Monica Landers: Hi. So at this point, we've heard what stakeholders have shared about implementation of the FAST program, services offered to families affected by substance abuse. We've also heard a little from clients about their perceptions of the services that they've received.

This evaluation also includes an outcomes study where we more closely examined the impact of FAST and the enhanced FAST services on child and family outcomes, so this table here shows the outcomes we are looking at and the way in which we are assessing or measuring those outcomes.

Mainly, we're interested in outcomes related to permanency, safety, improved child well-being, enhanced family functioning, and, of course, adult recovery since these families do have a substance abuse maltreatment.

We won't report findings from each of these assessments in the interest of time, but this gives you an idea of how comprehensive the evaluation is in what we measure.

Slide.

This figure just shows a snippet of our research design. We began with a pool of families eligible for the FAST program. As Reana mentioned earlier, these are families who have a child 5 years of age or younger who is unsafe in the home due to the parent's substance misuse.

Recall that the FAST program is designed specifically to address the needs of these families and these children by safely serving them and supporting them in the home, so after we start with this pool of eligible families, we then randomly assign these families to either the FAST program as usual or the enhanced FAST program call IFAST which augments the array of FAST services and supports with peer support and health care coordination, which have been mentioned.

The assessment that were shown in the previous slide were administered to families at baseline, or when they enter the program, and again at discharge from the program to assess how safety, permanency, child well-being, and family functioning changed over time over the course of the treatment.

Our evaluation also includes a comparison of safety and permanency outcomes specifically of FAST families to those in the dependency system as usual, so keep an eye out for follow-up presentations on our reporting of that comparative effectiveness, but for this presentation, we're just gonna highlight findings from the randomized control trial illustrated here.

Slide.

This table presents that characteristics of the families included in the outcomes study. We see

that mothers were the primary caregiver for almost all of the families served in both IFAST and FAST, and the majority of focal parents are the maltreating parent, and both group identify as white.

Although parents in the control group, or FAST, were slightly older than the parents in IFAST-- so in FAST, the parents were a little over 30 years of age, on average, and IFAST, they're little over 29 years of age, on average--there was not a significant difference here.

We also see that families in FAST also had more children, on average, but, again, this difference was not significant.

The focal children of IFAST families were about 25.9 months older, on average, compared to FAST children, who were 21.6 months old.

Across all demographics and everything shown here, there were no significant differences observed between IFAST families and FAST families at program entry.

Slide.

One of the measures included to assess family functioning or parent well-being is the Center of Epidemiological Studies' depression scale, also called the CES-D for short. With the CES-D, parents rate responses to statements indicating various

symptoms of depression, so at baseline, or program entry here, average scores for FAST and IFAST parents are fairly similar, with average scores of about 15 out of a possible 60. Higher scores on the CES-D represent increased levels of depression or increased depression symptoms.

We see that scores decrease significantly following treatment for both IFAST and FAST families, indicating a reduction in those depressive symptoms, which is what we would want to observe. Although parents receiving the enhanced FAST reported slightly higher depression scores at discharge than the parents who received FAST as usual, the difference between those two groups at discharge was not significant, so we see some very meaningful changes over time for both groups, but at discharge, the difference between IFAST and FAST families was not significant.

The CES-D also has a clinical cutoff score of 16 or greater, which indicates significant levels of depression symptoms, so if we look back at baseline for both groups, we saw, on average, it was about 15, so just under that clinical cutoff.

For IFAST parents, the proportion of parents who scored at or above that cutoff fell from 39.3% at baseline to 14.3% at discharge, and a proportion of parents who scored at or above that clinical cutoff for the FAST families also reduced considerably from 47.6% at program entry to 19% at discharge, so overall, we see significant improvement for both

groups here where we're looking at depressive symptoms.

Slide.

We also wanted to highlight findings from another family functioning assessment--the AAPI.

This tool is a risk-assessment tool for potentially abusive parenting attitudes. Scores on each of the subscales, including the AAPI, indicate a level of risk for child maltreatment, so there are 5 subscales, shown here with "A" through "E."

A decrease in scores from program entry to discharge corresponds with a decline, or worsening, of parenting attitudes we would want to see, and an increase in scores indicate improvement in conventional parenting attitudes, so we are looking to see scores increase over time.

Here, we see parenting attitudes improved for families who were receiving that enhanced FAST, IFAST, over all 5 of the subscales, including the AAPI. Significant improvements were observed pertaining to that first subscale, Inappropriate Expectations of Children, Belief in the Use of Corporal Punishment, and Reversing Parent-Child Family Roles.

Remember that these families benefitted from the peer-led Nurturing Parenting curriculum, the parenting curriculum, in addition to the existing array of FAST services.

That last column for families who received FAST as usual, improvement in parenting attitudes was observed for really just the first subscale--Inappropriate Expectations of Children, but then we see decreases in scores for the remaining subscales, on average, so those parenting attitudes worsened over time. For many of them, it showed just slight decreases, but for one subscale--Belief in the Use of Corporal Punishment, "C"--the decrease was significant over time.

Slide.

And I have two more slides on the outcomes study, and these findings give us an idea of the safety and permanency outcomes for these families. We want to see that children are safe in home and that there is no recurrence of maltreatment.

The average length of stay for IFAST families was 4.8 months, on average, compared to 4.1 month for FAST families. There was not a significant difference between the length of stay for IFAST and FAST families.

We also see that for IFAST families, the enhanced FAST, 62% of families completed the program successfully, but 13.5%, or 5 of the 37 children, were removed and placed in out-of-home care.

The other discharge outcomes you see,

Other--24.3%, those other discharge outcomes included families who were unresponsive during treatment, those who moved out of the area, or were unable to be located during treatment.

For FAST families, those who received the usual array of service and supports, half of the families completed the program successfully, and 21.9%, or 7 of those 32 children, were removed and placed in out-of-home care. The other discharge outcomes for these families included those who moved out of the area or were transferred to another agency or program, mainly.

Slide.

We were also able to look at recurrence of maltreatment 6 months after program discharge, so there were many families who had been discharged at least for 6 months. For both FAST and IFAST families, there was one incident of maltreatment leading to the family re-entering the FAST program within 6 months, so it's one out of 20 for IFAST families and one out of 18 for FAST families.

We're also looking at follow-up, recurrence of maltreatment at a year, but only 9 families so far have been discharged for a year longer, so as time passes and we gather more data and more families reach that milestone, we'll have a better idea of the lasting impact of FAST and IFAST on child and family permanency.

So now I'll turn it over to Carlos, who will bring it all together for us and leave us with some concluding thoughts.

Carlos Cruz: Thanks, Monica.

So our next steps, obviously, this PRG project is a grant, and, you know, one of the big convictions that we have on any type of grant is to focus on sustainability as early as possible. This is a pretty costly enhancement to our program, given that it's 4 staff members plus a supervisor plus the evaluation, so next step's we're trying to align our programming on the FAST program and also the enhancement piece to be able to fall under the FFPSA guidelines, but there's a lot of, you know, unknown that's still with this new funding stream and what to expect and how that's gonna look, but one of the biggest pieces that, you know, helped us align with that is this evaluation, you know, and pursuing it becoming evidence-based or at least increasing the evidence base of the outcomes of this study--or of this program, so as we, you know, go through this process, we're enhancing our manuals. We're, you know, trying to structure around it so this can be, you know, eventually replicatable, you know, under those new guidelines.

The other piece that we're looking for in sustainability is, the peer services is not a Medicaid-billable service, and we're trying to see if we can offset some of the cost of providing those services to our community with Medicaid billing and also for the pieces that our Healthcare Coordinators can do to try to offset some of those, so we're trying to think outside the box. We're trying to make sure

that we're serving the community as dynamically as possible.

You know, these types of exposed families are our most vulnerable population in FAST, although, you know, you get an even smaller sample of our programming, at any given time, you have right around 500 families open, and RPG probably has 40 or 50 families open at a time, and they're all--you know, a majority of it's substance-misuse cases, so, yeah, next slide.

We wanted to give a special acknowledgement to all the project staff that have been, you know, working so hard on this project, and I'm making sure that, you know, we're using our cross-site evaluation but also our local evaluation's needs, the family support counselors and their supervisors, which are our community--case-management organizations in the community. Of course, our partners at USF and the evaluation team have really, been, you know, an amazing team to work with, and, of course, our local and federal RPG partners with the Children's Bureau.

Our next slide, please.

The main contacts will be Reana Johnson, who's or Project Supervisor, and Monica Landers at USF.

Next slide.

I think there's a little bit of time for questions if there are any.

Elizabeth Kramer: Yeah, Carlos. Thank you all so much. That was really a lot of information and a really interesting program that you all are offering, so I am going to go and open up the Q&A now and also the chat box. We do have some comments, so first comment or question is from someone that is in New York and wants to be trained as a parent advocate, and so what would be some recommended next steps? And, Carlos, it looks like you talked about that a little bit in the chat, but if you'd maybe like to talk about it aloud, as well, that would be fantastic.

Carlos Cruz: Yeah, absolutely. So we do have a Florida model for what a peer support--or Certified Peer Specialist, rather, is expected to know. They're trained in the WRAP model. They're trained in a couple other curriculums to make sure that they are able to protect their own sobriety while also helping the community, so one of the first things that I provide is the national certification process because I'm not familiar with New York's expectation, expectation of the certification process. Also, the second part of that peer educator role is the Nurturing Parenting curriculum, and I shared the web link for the training opportunities, and they usually are on a pretty cyclical timeframe, not sure if they're doing a little different stuff right now with COVID, but those are our two expectations or, you know, training approaches to our peers, so I'm not so sure if I answered your question directly or if there's any additional--

Elizabeth Kramer: OK. If there's follow-up to the question, feel free to go ahead and put it in either the Q&A or the chat box. Someone had asked also in the Q&A if you'd be able to receive the PowerPoint, and the answer is yes. We will post that on our website with the recorded webinar, and I can also include that in the e-mail that you all will receive with a link to the survey, so those are two different ways that you'll be able to get a copy of the slides. We'll also have the contact information for our speakers today. I had one question, and you could probably talk about this, you know, forever, but if you could just give us an overview--I'm just curious--how did the COVID pandemic really impact your work in this program? Did you have to sort of stop altogether, or were you able to adapt and continue to offer services in some ways? How did you address that?

Carlos Cruz: Yeah. I can take that.

You know, we try to take everything with a little bit of grace and, you know, with some flexibility in these really trying times. Because the FAST program, we're all encouraged to talk with one person who aren't the RPG staff, because of the unsafe nature of the cases in FAST, we had to make sure that child safety is our paramount focus, so those FSCs, or Family Service Counselors, based off of the screening tool, if they didn't have any high-risk indicators on the COVID side, we did, and are still continuing to do, home visiting. It may look a little different. Like, we do many--just do it outside so we're socially distant. If the home's big enough, then we can go inside, especially in those cases where we want to make sure that the home environment is being addressed. You know, we're trying to be as flexible as we can with that, so some of those home visits do happen over Zoom, WeChat, whatever the platform the family's familiar with.

On the RPG side, because they are not tied to immediate child safety, they're focusing on their specialty, whether it be health care coordination or the peer services. We leaned a little harder on telecommuting or televisiting, which has proven to be a little bit more challenging than in person. Doing a parenting curriculum over technology's a little tougher than, you know, that warm contact and observation.

Elizabeth Kramer: Sure, well, and with the children, too--I think you called them the focal child--I mean, they're so young, too, so I think that maybe makes it a little bit more difficult, too, to observe the parent-child interaction with a very young child that that maybe just doesn't work so well with the technology.

Carlos Cruz: Absolutely, you know, and there's cases that are really tricky around that. We try to go ahead and make that visit as long as it's safe to do so.

Elizabeth Kramer: Mm-hmm. Mm-hmm. So I just want to open it up one more time. If we have any other questions, go ahead and type them into the Q&A or into the chat box.

So we have a question--"What screening tools are used to determine the family's level of risk with regard to substance abuse?"

Carlos Cruz: I can answer that, as well.

All our cases are coming from our Department of Children and Families child protective investigators. They use a tool called the Family Functioning Assessment, which is a-- It doesn't only look at the maltreatment or the [indistinct] maltreatment. It looks at the family as a whole and, as such, their functioning, from their parenting to their own mental health and well-being, the child mental health and well-being, and the family as a whole and their well-being.

If there are any, you know--

In these cases, they all are, you know, either substantiated or, you know, significant enough amount of concern around the drug use. We do partner with a couple of our behavioral health facilities in town to make sure they're getting the correct drug-treatment services, so they are getting those assessment from the people that specialize in those.

Elizabeth Kramer: OK, and a follow-up question--"Where are the parents drug-screened?" and it doesn't say, but I'm assuming throughout the program or at any point in the program.

Carlos Cruz: So our partners at the behavioral health facilities do drug-screen and the FAST workers do, as well. The RPG staff are not drug-screened because part of the model for peer specialty, and there shouldn't be a punitive approach if they're partnering so they can counsel them into submitting to the drug screen if they're resisting that, but we don't want to put them in a position to be in a punitive posture.

Elizabeth Kramer: OK. All right.

Other questions, go ahead and type them into either the chat or into the Q&A. I'm looking at both, and someone else had had, "Can you speak more to how or what you're allowed to bill Medicaid for the Healthcare Coordinator service?" so how are you able to do that, or what are you able to bill with regard to that service?

Carlos Cruz: So that ones gonna be a little trickier, and--I'll be honest--we haven't gotten that far to it onto that piece.

For the peer piece, we're pretty cut and clear for the billable activities. The health care coordination, we're trying to see if we're gonna be able to back into it. Us adding that ancillary, I just want to be able to say, you know, "We're trying to explore every option to offer sustainability."

Elizabeth Kramer: Mm-hmm. So I have a question, and this is both for the sort of program-services piece but also for the evaluation piece. Knowing what you know now, if you could go, you know, back and talk to yourself at the beginning, what would you--is there anything you wish you had done differently, or is there any advice you would give to yourself before all of this program that maybe would have made things go a little bit smoother?

Monica Landers: I'm just kind of mulling that over, the question.

Carlos Cruz: Just while you're thinking, Monica, I just want--

Look. From our side, you know, we're Child Welfare Services. We're focused on child safety, and, you know, that's what we do best.

When we went after this in partnership with USF after the grant, we knew there was gonna be a heavy burden or a heavy lift with evaluation. You know, we would prepare with that with our USF partners. The cross-site evaluation that comes with these federal grants is so large that, you know, we're acclimating to it, but that was our biggest learning curve, I think, on our side was because it attacks both our control group and our treatment group, so, turns out, it was my biggest--

Elizabeth Kramer: OK.

Monica Landers: And with this evaluation, there was some time built in for pre-planning or pre-implementation, but I'm a big proponent of getting buy-in from the stakeholders in how the evaluation should go, so more of, like, a community-based, a little more participation, and we did take some time to talk with the FSCs that were mentioned and other stakeholders about the evaluation, but having a little more time to really discuss the different elements with them, I think, would--that's one thing that I would change and would think would probably benefit the evaluation when you have improved buy-in from the stakeholders in the beginning.

Elizabeth Kramer: OK. Excellent.

So, Carlos, I know you talked about this a little but, but someone has asked, "How is it transitioning families to virtual services during COVID-19?" so I didn’t know if there was more you wanted to add to sort of what you had spoken to a little bit earlier about this.

Carlos Cruz: Well--and if anybody wants to chime in, Areana, I know it's your staff--but overall, as a system, I think families kind of are aware that this is really unusual times, and I think families have been very open to it and understanding.

I know we're really, really gonna be monitoring, you know, the safety of these kids and how it's impacting the trajectory of these cases, but overall, I think everybody just knows, you know, how serious of a time we're in and how dynamic it is, so I think overall, the system and as a community, people have been pretty open to, you know, either allowing people to come to the house when it's appropriate or trying to figure out a way that works through technology.

Elizabeth Kramer: Mm-hmm. Mm-hmm. It's good to hear.

Reana Johnson: Yeah. I have to agree with Carlos with when it comes specifically to the RPG staff and the clients that they're working with that, you know, a lot of our clients don't want people that could potentially expose them into their home, but then they are willing to be flexible.

Of course, you have some technology barriers there with some of our clients with which we've been fortunate enough to be able to work through. I would say the only barrier--I think I kind of heard that was part of the question--is that we are still receiving new cases, of course, and so there's a lot more effort that goes into building a rapport through video chat or over the phone, as opposed to in person. There's just such an impact you can have on somebody when you meet them face to face, so I would say that that's probably the only--the biggest difference, of course, and then what you already touched on was, you know, providing parenting and not being able to see that true parent-child interaction with children running in and out of the screen or over the telephone, but overall, our families have been very receptive to the virtual sessions.

Elizabeth Kramer: OK, and sort of related follow-up question, the question is, "Do you think it affected your outcomes?" and I think what the question is is, do you think the COVID pandemic affected your outcomes?

Reana Johnson: I can let Monica speak more on this. I don't know that we have enough information or data right now since COVID. We've started transitioning to working from home mid March. Hopefully, Monica can take it up a little bit on that.

Monica Landers: It's too early to say how it's affected outcomes. Even over these last 4 months that things have really changed for us in Florida, there's only so much data that we have gathered from at least the outcomes evaluation.

We do plan on talking with stakeholders and possibly even clients more specifically about how COVID has impacted them and how it's impacted their services, but when it actually comes to the assessments and the outcomes, it's too early to tell right now.

What I can say is that we are tracking our process because our process for actually getting the assessments completed has changed a little bit. In some ways, I think it's improved for the better, and we're able to improve the response rate in some ways, and getting those assessments completed can be a lot easier for the folks on ground in Jacksonville doing the program, so that's definitely something we're keeping our eyes on, but not something that we can really comment on with any certainty just yet.

Elizabeth Kramer: OK. Great.

Another question--"With each state's health plan being slightly different, what billable activities are the PE able to use in Florida?

Carlos Cruz: Sorry.

PE, I'm assuming, will be the Parent Educator, so the Nurturing Parenting piece will not be one of the billable opportunities, but the activities on the Peer Specialist component can fall under the billable services for that role, so we would, you know, be only able to after they do something involving the peer-support activities. Then that is a billable service in Florida.

Elizabeth Kramer: OK. All right. Excellent.

Just one more time, any other questions, go ahead and put them in our Q&A box or in our Zoom chat.

"I'm also curious about any future partnerships with the public-benefits side of social services, such as self-sufficiency programs or those receiving cash assistance and may be struggling with SUDs who would benefit from this program.

Carlos Cruz: So Florida is a community-based care system, so Family Support Services receives the bulk of the funding for people that are--families that are involved with investigations or in the Department of Children and Families, and, you know, we provide the foster care or the subcontracts for that and the other direct client services.

This grant is focused specifically on the FAST program, but we do have a service array that leans more towards community activity. It's just not this project, so, you know, we are ramping up some activities to do more primary prevention in the community, but most of our service array right now is geared at that secondary prevention.

Elizabeth Kramer: Got it. OK. Great.

So one more call out there to anyone who has any questions, and sort of while I'm giving folks a little bit of time to think of any last questions and pop them in, I just want to take a moment again to thank all of you for pulling all this information together and for your willingness to present via this platform.

I know you had originally planned this as an in-person presentation at a conference, and this is a little bit diff--