FAMILY INTENSIVE TREATMENT (FIT)

INTEGRATING BEHAVIORAL HEALTH AND CHILD WELFARE PRACTICE MANUAL

CONTENTS

PURPOSE OF MANUAL

In 2014 the Florida Alcohol and Drug Abuse Association (FADAA), now the services arm of the Florida Behavioral Health Association (FBHA), proposed the creation of a targeted treatment model to serve parents involved in the child welfare system with behavioral health conditions to the Florida Legislature. The proposed model was identified as the Family Intensive Treatment (FIT) team and designed to provide intensive team-based, family-focused, comprehensive interventions targeting high-risk families with child welfare involvement due to parental substance use and co-occurring mental health disorders. The FIT model was different from current standard practice and a significant philosophical shift in that it went beyond initial referral, screening, assessment, and traditional treatment to an integrated child welfare and behavioral health practice model with a family-centered approach. The framework for the FIT model was designed to include critical components to improve child safety, permanency, well-being, and recovery. System change supporting this philosophical shift focused on implementing a treatment-based service model designed to address behavioral health needs while improving family functioning and strengthening child welfare-related outcomes.

Since the initial implementation of FIT in 2014, stakeholders have established multiple forums to collaborate, communicate, share information, leverage resources, develop common cross-system expectations/deliverables, identify systemic barriers, and mitigate conflicting needs. Forums consist of stakeholders from the Department of Children and Families (DCF), Managing Entities (ME), Child Welfare Community-Based Care (CBC) Lead Agencies, behavioral health providers, FADAA, Child Protective Services, Child Welfare Case Management Organizations (CMO), private providers, and other relevant professionals. As a result, communities and service providers have the ability to pursue quality outcomes and continuous improvement initiatives supporting the mutual goals of all involved. A few of those ongoing collaborations to date include:

- Monthly Statewide Conference Calls
- Monthly Regional Conference Calls
- Annual Statewide Meeting
- Quarterly Provider Meetings
- Annual FBHA and DCF Summit Conference Presentations
- FIT Advisory Group

The FIT Manual was developed by stakeholders involved in the Caregiver Protective Capacity (CPC) and the Clinical Practice Workgroups as a guide for providers with the purpose to transcend vision to practice. Through years of review and experience, the FIT Manual has evolved to serve as a guideline for best practices and assist in further implementation. Continued implementation of the FIT model must be strategic and build upon improvements to the systems of care in place. As integrated systems of care continue to be developed, it is important to recognize that it is an evolving process, encouraged by improvements in communication, coordination, collaboration, and integration. Achieving these gains will require that we look closely at the systems in place and be prepared to modify the infrastructure to reinforce these changes as we go. This will take very strategic work and significant effort to eventually achieve integration of an effective practice and supporting infrastructure.

The FIT Manual provides an outline for this integrated approach to treatment, including an overview of Florida's Child Welfare Practice Model, the core components of the FIT Model, steps for implementing the FIT model, and a guide for integrated treatment planning. To assist in concurrent planning, this manual includes how to create corresponding goals, objective and therapeutic interventions based on

current child welfare assessments. Additionally, the FIT Manual includes a FIT Model Fidelity Assessment Tool for local systems of care to utilize in assessing implementation of the FIT model.

OVERVIEW OF FLORIDA'S CHILD WELFARE PRACTICE MODEL

The Florida Child Welfare Practice Model emphasizes the engagement and empowerment of parents, utilizing a standardized approach to safety decision-making and risk assessment to achieve child safety. The methodology is applied systemically from the Florida Abuse Hotline to Child Protection Investigations. Child Protection Investigators determine if a child(ren) are safe or unsafe in their current placement. If the safety assessment determines that a child is unsafe then the case will be staffed and transferred to the CBC Lead Agency for case management services through a CMO. The implementation of the Florida Child Welfare Practice Model establishes:

- Common language for assessing safety for both CPIs and child welfare case managers;
- A standardized framework for identifying children who are unsafe;
- A common set of constructs that guide safety interventions for unsafe children; and
- A common framework for case planning to address child needs and diminished CPCs.

The key to Florida's Child Welfare Practice Model is ensuring that child welfare professionals have the skills and supervisory support to assess families. The model was developed in conjunction with national experts from the National Resource Center for Child Protection and the Children's Research Center. A key aspect of the model is information collection and analysis. The accuracy of the safety determination of safe or unsafe is based upon the reliability and relevance of the information collected in the Family Functioning Assessment - Investigation (FFA-I) and the proficiency of the CPI in thoroughly assessing CPCs and identifying impending danger. While sufficient information is essential to good decision making, the CPI must use critical thinking skills to analyze - assimilate, integrate and synthesize - all the available information and make the appropriate safety determination. Making good decisions about safety begins with gathering sufficient information using the following six standardized information collection domains throughout the life of a case:

1. Extent of the Maltreatment,
2. Nature of the Maltreatment: Surrounding Circumstances,
3. Child Functioning,
4. Adult Functioning,
5. General Parenting Practices, and
6. Discipline and Behavior Management.

Using established guidelines throughout the Family Functioning Assessment, the family is assessed on personal and caregiving behavioral, cognitive, and emotional characteristics that specifically and directly can be associated with being protective to one's children. CPCs are personal qualities or characteristics that contribute to vigilant child protection. The investigator's assessment of protective capacity represent the parents' overall functioning, and not be based solely on an isolated incident or singular event. While a parent may fail to demonstrate impulse control during a maltreatment incident, a more global, in-depth assessment of functioning evaluates if the parent demonstrates impulse control in other ways. The CPI determines whether or not the CPC is present or not with a "Yes" or "No". During the Family Functioning Assessment – Ongoing (FFA-O), the Case Manager scales the CPC. A scaling of "C" or "D" identifies a deficiency in that area.

The completion of the FFA-I, FFA-O, and Progress Updates assists the FIT staff with formulating their treatment plans. FIT staff treatment plan/updates are either done jointly with the CBC/CMO or shared with the CBC/CMO and progress are provided prior to all judicial reviews.

It is integral that FIT teams understand the Child Welfare Practice Model in order to advocate for families and assist in navigating the system. Additional recommendations for training are included later in the manual, however additional information on the Practice Model can be found at http://centerforchildwelfare.fmhi.usf.edu.

FIT teams have limited access to Florida Safe Families Network (FSFN). This system is the official child welfare record. The information contained in FSFN allows for FIT teams to have prior history on a case, understand the current investigation and circumstances, and sets the foundation for concurrent planning. Access is provided by the Regional Department of Children and Families Office. Please see Appendix IV for detailed information regarding FSFN access.

OVERVIEW OF THE FIT MODEL

The vision of the Family Intensive Treatment Team (FIT) model is to ensure that every family involved in services is supported and engaged with one team and one common planning process so that the family will experience one community-wide system of care. Through the integration of child welfare and behavioral health practice models, FIT is designed to collaboratively engage and assess the entire family at an intense customized level, integrate care to the entire family unit, provide immediate access to services to treat behavioral health needs, and address diminished CPCs. The collaborative model also creates a mechanism of shared accountability across the Provider Agencies, the ME, and CBC/CMO.

As innovative programming between providers and child welfare agencies continues to be implemented, expanded, and assessed, we continue to learn more about promising and effective approaches to holistically address the complex needs of families with substance use disorders. Through both quantitative and qualitative studies by the University of South Florida College of Behavioral and Community Sciences in partnership with Casey Family Programs and the Florida Department of Children and Families, findings show FIT as an effective, high-quality, collaborative, and innovative approach to address child protection for families where substance use is an issue[1][2][3].
Key components of the model include:

1. Provide early identification of at-risk families and immediate access to substance use and co-occurring mental health treatment services with early engagement strategies, such as at case

[1] Robst, J., Armstrong, M., Sowell, C., & Cruz, A. (2018). The Family Intensive Treatment (FIT) Evaluation Phase One Report. Internal University of South Florida College of Behavioral & Community Sciences, Casey Family Programs, Florida Department of Children and Families Report. Unpublished.

[2] Sowell, C., & Cruz, A., Armstrong, M., & Robst, J. (2019). The Family Intensive Treatment (FIT) Team Evaluation Implementation and Practice Study Report. Internal University of South Florida College of Behavioral & Community Sciences, Casey Family Programs, Florida Department of Children and Families Report. Unpublished.

[3] Robst, J., Armstrong, M., Yampolskaya, S., Sowell, C., & Cruz, A. (2019). The Family Intensive Treatment (FIT) Evaluation Phase Two Quantitative Report. Internal University of South Florida College of Behavioral & Community Sciences, Casey Family Programs, Florida Department of Children and Families Report. Unpublished.

initiation or case transfer, for parent(s)/guardian(s) in the child welfare system determined to be unsafe;
2. Establish a team-based approach, including Clinicians, Case Managers and Recovery Peer Support Specialists, to planning and service delivery in coordination with Community-Based Care Lead Agencies, Child Welfare Professionals, Managing Entities and other service providers;
3. Integrate evidence-based treatment for substance use disorders, parenting interventions, and therapeutic treatment for all family members into one comprehensive treatment approach. This comprehensive approach includes coordinating clinical children's services and services provided outside of the FIT Team funding;
4. Identify family-driven pathways to recovery and promote sustained recovery through cultural and gender-sensitive treatment and involvement in recovery-oriented services and supports;
5. Promote increased engagement and retention in treatment;
6. Provide 24/7 access for crisis management;
7. Facilitate concurrent planning between child welfare case planning and treatment plan goals, to integrate the family's strengths and needs with their dependency case plan;
8. Advocate for parent(s)/guardian(s) and assist in navigating the child welfare process;
9. Promote treatment completion and continued care through linkage to ongoing support services and natural supports; and
10. In collaboration with Community-Based Care Lead Agencies and Child Welfare Case Management Organizations:
    a. Promote safety of children in the child welfare system whose parent(s)/guardian(s) have a substance use disorder;
    b. Develop a safe, nurturing and stable living situation for these children as rapidly and responsibly as possible;
    c. Provide information to inform the safety plan, ongoing Family Functioning Assessments (FFA), and any other relevant status updates;
    d. Reduce the number of out-of-home placements when safe to do so; and
    e. Reduce rates of re-entry into the child welfare system.

To successfully support these families while identifying and treating their behavioral health and diminished CPCs, FIT aligns the Child Welfare Practice Model with behavioral health approaches. These changes move away from a system of task-based planning, compliance and diagnosis-driven treatment to an effective, integrated treatment that supports behavioral change and improves CPCs to safely care for children. This philosophical shift results in a treatment-based practice model designed to address behavioral health and diminished CPCs, while improving family functioning, parenting skills, child-parent relationships and related outcomes relying primarily on in-home services. The FIT model establishes an intentional focus on treatment of behavioral health disorders, promotes an extensive understanding of family needs and strengths, offers immediate access to a full-service continuum of services, establishes a multi-disciplinary approach, and develops communication protocols to inform treatment and case management goals. Due to the range of intensive services provided to families, the average length of stay in the FIT Program is approximately six to 12 months of clinical treatment. The length of stay is not be standardized but depends on clinical treatment goals, client progress, input from the entire multi-disciplinary team, and other various factors that may arise during treatment. Transition/Discharge Planning starts at enrollment and includes transitioning the client to the least restrictive treatment recommended and, when active outpatient treatment is completed, continued care services are to be offered to maintain progress and stability.

ELIGIBILITY

FIT Team providers shall accept parents/guardians referred by CPI, child welfare case managers or CBC Lead Agency, Providers of child welfare intervention programs, or the dependency court system. FIT Team providers shall deliver services to parent(s)/guardian(s) who meet all the following criteria:

1. Are eligible for publicly funded substance abuse and mental health services pursuant to s. 394.674, F.S.; including persons meeting all other eligibility criteria who are under insured;
2. Meet the criteria for a substance use disorder;
3. Have at least one child between the ages of 0 and 10 years old; and
4. At the time of referral to FIT:
    a. A child in the family has been determined to be "unsafe," in need of child welfare case management and placed in-home or out-of-home;
    b. For children in out-of-home care, the family must have a child welfare case management plan with the permanency goal of reunification, or a concurrent case plan that includes reunification as a permanency goal; and
    c. The eligible parent(s)/guardian(s) are willing to participate in the FIT Program. Enhanced efforts to engage and retain the parent/guardian(s) in treatment are expected as a critical element of the FIT program.

While eligibility is based on at least one parent/guardian in the home meeting criteria, all members of the household may receive and benefit from FIT services and coordination. This allows for family-focused treatment and ensures that all members of the household are addressing any issues that may impact success from both a behavioral health and child welfare perspective.

THE FIT TEAM

By providing a team-based approach to care, families receive FIT services from consistent and designated staff that have received the required training on the child welfare system and evidence-based programs. FIT staff work with the other FIT team members serving FIT families. Below are the essential roles of FIT team members.

- Program Manager - A Master's or Doctoral degree in behavioral health sciences, such as psychology, mental health counseling, social work, art therapy, or marriage and family therapy; an active license issued by the Florida Board of Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, or Psychology; and a minimum of three years working with adults with substance use disorders.
- Behavioral Health Clinician - A Master's or Doctoral degree in behavioral health sciences, such as mental health counseling, social work, art therapy, psychology, or marriage and family therapy; and a minimum of two years of experience working with adults with substance use disorders. Behavioral Health Clinicians provide evidence-based therapeutic services and incorporate behavioral health goals with Caregiver Protective Capacities and parenting interventions. Clinician caseloads are clinically determined by the Program Manager but shall not exceed 15 clients.
- Case Manager – at minimum a Bachelor's degree in counseling, social work, psychology, criminal justice, nursing, rehabilitation, special education, health education, or a related field which includes the study of human behavior and development; and a minimum of one year of experience working with adults with behavioral health needs and child welfare involvement; or

a Bachelor's or Master's degree with a major in another field and a minimum of three years of experience working with adults with substance use disorders. This position does not serve as the child welfare case manager and the FIT program does not fund the child welfare case manager. FIT Case Managers assist clients with coordination of provider referrals and follow-up for other needed services. Case manager caseloads are determined by the Program Manager based on the needs of the individuals served, but shall not exceed 20 clients.

- Recovery Peer Specialist - Certified by the Florida Certification Board; or an individual who has direct personal experience living in recovery from substance use conditions for at least 2 years with a minimum of one (1) year work experience as a peer recovery specialist. Recovery Peer Specialists are allowed one year from the date of their employment to obtain certification through the Florida Certification Board. Recovery Peer Specialists provide support, assistance, and advocacy for the client. Recovery Peer Specialist caseloads are determined by the Program Manager based on the needs of the individuals served but shall not exceed 20 clients.

Consistent communication within the FIT team is essential. Formal communication, such as weekly staffings, allow teams to discuss cases routinely while informal communication through texts, emails, and phone calls allow for real-time information exchange. Frequent and open communication enables team members to continually share information on their shared families. This includes 24/7 immediate emergency access to FIT team members.

FIT PROGRAMMATIC REQUIREMENTS

The FIT Team Provider shall be trained in the use of evidence-based substance use treatment and parenting practices found effective for serving families in the child welfare system. As part of a comprehensive array of behavioral health services and supports, FIT Team services shall include the following activities, tasks, and provisions:

- An emergency contact number for parent(s)/guardian(s) to reach FIT Team Provider in case of emergency 24 hours a day, 7 days a week;
- Recovery peer support services to promote recovery, engagement and retention in treatment, and skill development;
- Case management services to address the basic support needs of the family and coordinate the therapeutic aspects of services provided to all family members regardless of payer source;
- Coordination of services and supports with child welfare professionals;
- Individualized treatment provided at the level of care that is recommended by standardized placement criteria;
- Document FIT activities and family's progress in FSFN;
- Intensive in-home treatment, inclusive of individual and family counseling, related therapeutic interventions, and treatment to address substance use disorders, based on individual and family needs and preferences;
- Group treatment to address substance use disorders, based on individual and family needs and preferences;
- Trauma-informed treatment services for substance use disorders and co-occurring substance use and mental health disorders;
- Therapeutic services and psycho-education in:
    - Parenting interventions for child-parenting relationships and parenting skills;
    - Natural support development, including the family when appropriate; and

    - Relapse prevention skill development and engagement in the recovery community; and
- Care coordination, as reflected in the FIT Team's case management plan, include a multi-disciplinary team to promote access to a variety of services and supports as indicated by the needs and preferences of the family, including but not limited to:
    - Domestic violence services;
    - Medical and dental health care;
    - Basic needs such as supportive housing, housing, food, and transportation;
    - Educational and training services;
    - Supported employment, employment and vocational services;
    - Legal services; and
    - Other services identified in the FIT Team's case management plan.

CORE COMPONENTS

Core components of the model that are critical and necessary links in developing a *collaborative planning approach* include:

TRAUMA INFORMED PRACTICE

FIT is a trauma-informed practice model that has the capacity to translate trauma-related knowledge into meaningful action and policy/practice change. Understanding and assessing the impact of trauma on both children and adults is essential in meeting the needs of the families. This is a critical core component for implementation of the model and in the engagement of families. Using this knowledge of trauma and recovery is essential to collaboratively designing and delivering services. It is essential that the evidence-based model used by the FIT teams includes a trauma-focused lens.

RECOVERY PEER SPECIALIST

FIT utilizes Recovery Peer Specialist who have direct personal experience living in recovery from substance use and mental health conditions. Peers are an integral part of every FIT team and a great resource to help engage clients. Peers can assist clients in creating a Wellness Recovery Action Plan (WRAP) plan, exploring support group options, finding support groups in the area, introducing them to the sober support process, and providing support during stressful times including court, detox, residential and more. Through shared understanding, respect and empowerment, Recovery Peer Specialist help our families become and stay engaged in the recovery process which can reduce the likelihood of relapse.

EVIDENCE-BASED PRACTICE

There are several evidence-based treatment and best practice approaches for adult persons with substance use and mental health disorders which can effectively address behavioral health challenges, child/parent interactions, and increase diminished CPCs that are appropriate to be used for families in the child welfare system. In the FIT program, dedicated behavioral health treatment modalities are used to ameliorate diagnosed behavioral health issues while addressing trauma, child-parent relationships, functional skill development, caregiver capacities, gender-responsive care, and improved family

functioning. When determining which evidence-based treatment modality to use in a FIT team, it is important to look for several factors.

It is essential to find a modality that has been researched and proven beneficial for adults with substance use disorders and families involved in child welfare. It is also important that the approach includes the following components:

- A trauma-focused lens
- Addresses co-occurring disorders
- Services are provided primarily in-home based or community-based
- High fidelity monitoring to ensure quality of treatment

Evidence or research-based parenting programs are also integrated within the FIT treatment approach to improve parent-child relationships, improve CPCs, and prevent the cycle of abuse or neglect. This also provides an integrated approach for parents/guardians to receive substance use or co-occurring services and parenting curriculum from the same team. Parenting services are appropriately staged with respect to the parent/guardian's progress in recovery. It is important that all evidence-based models used have high levels of fidelity ensured through consistent internal monitoring. There may be local or judicial restrictions on the parenting curriculums accepted by dependency courts so it is important to check locally for approved parenting programs when selecting your evidence or research-based parenting program.

Evidence-based and evidence-informed programs currently used by FIT teams are included in Appendix VI.

FAMILY-CENTERED APPROACH

Besides the utilization of an evidence-based model for substance use disorders and parenting, FIT teams adopt a family-centered practice model that requires providers to incorporate new roles, behaviors, and clinical skill sets for their staff. It is imperative that providers put into place strategies to ensure that staff have the skill sets necessary to implement a family-centered practice model as well as provide the ongoing training and supervision necessary to maintain the practice. In addition, FIT services provided to the family are coordinated with any ancillary services provided to the children and other services provided to the family regardless of payor.

The majority of FIT services are provided in the home or non-traditional office settings and can be complemented with additional substance use group services, when clinically necessary. This is an important component to allow the FIT team to observe the family dynamics and environment. Visitations are another opportunity for the FIT team to obtain information on the parent-child dynamic and integrate those observations into treatment planning and progress updates.

Efforts are made to receive input from all service providers and stakeholders serving the family. This allows for all relevant information on the family to be shared, allows for concurrent planning, and provides information to update the comprehensive treatment plan.

ENGAGEMENT

FIT utilizes family engagement as a strength-based and family-centered approach in collaborating with and motivating families in making decisions, establishing and planning goals/objectives/interventions, and in achieving desired outcomes. Engagement is a critical core component of the process in connecting with the family and other team members (teaming) for the purpose of building authentic, trusting, and collaborative working relationships. The entire FIT team is involved in engaging the family, but Recovery Peer Specialists may be integral to this process. A home visit with the FIT team member(s) may be helpful in engaging a family in the treatment process.

When a family reports or exhibits resistance to the process or disengagement, immediate contact is made with the child welfare professional to develop joint strategies to engage the family. Joint visits between the FIT team and the child welfare professional are requested in cases of resistance to engagement or disengagement, as it is a very useful strategy to engage families in the process. If a family stops communicating with the team, home visits, phone calls, and certified letters are just a few methods of contact that FIT teams utilize as diligent efforts for re-engagement.

FIT ASSESSMENT

The FIT assessment process considers and evaluates safety, parenting capacity, parenting style, trauma symptoms, behavioral health needs, and multiple functional capacity areas that identify the needs of the family. Assessment begins at the time of engagement and is an ongoing function throughout the episode of care. It is a continuous process of gathering and analyzing information from multiple sources that support sound planning and intervention. The FIT assessment process includes consideration of the assessment activities that are completed by child welfare professionals, as well as any known behavioral health treatment history.

For example, the FFAs and collateral information from FSFN are critical components of the assessment process in order to identify specific family strengths and needs, which will subsequently guide the planning and interventions. Chosen interventions are inclusive of evidence-based or best practices, suited to support desired behavioral and parenting capacity changes. Results of the assessment inform and support the teaming approach to planning and interventions that will address the unique needs of the family and form the basis for designing services and supports. Ongoing assessment of progress or lack of progress guides further planning and supports any needed change to interventions. In addition to the FFA, FIT utilizes an assortment of bundled assessment tools and incorporates the results of those assessments to formulate the assessment findings and build the plan of care.

ASSESSMENT INFORMATION

Teams funded by the Department of Children and Families must refer to the current Guidance Document for specific assessment information and timelines. Assessments used include assessing parental capacity, functioning, substance use and co-occurring mental health, family history, and trauma. The following assessments are currently utilized by FIT teams.

LEVEL OF CARE

The American Society of Addiction Medicine (ASAM) or Level of Care Utilization System (LOCUS) Criteria

- Provides placement criteria for adults with substance use disorders to create comprehensive and individualized treatment plans.

FUNCTIONING

Daily Living Activities (DLA-20): Alcohol-Drug Functional Assessment or other assessment as designated by the department which will assess the adult functioning levels in areas such as mental health, addictions, criminality, daily living skills, etc.

- Provides information on functioning of the adult assessed in twenty categories of daily living activities related to substance use during the last thirty days.

PARENTAL CAPACITY ASSESSMENT

The FIT team consistently assess parental capacity to give feedback to the child welfare case managers. This can be through observing parent-child interactions, finishing and practicing a parenting curriculum, and/or changes in the client's report of parenting roles and expectations. Collateral information is obtained through child welfare and the client's family.

Family Functioning Assessment

- Completed by the CPI or child welfare case manager
- Review of the findings from the initial and ongoing FFA
- Review the CPCs as baseline for parental functioning
- The CPCs are integrated into the treatment plan goals and evaluated by the team monthly in progress updates and during treatment plan reviews
- Scaling completed by the FIT Team are not to replace the analysis of CPCs completed by the child welfare professional, but to align language for more robust discussion of the parent(s)/guardian(s) progress

BIOPSYCHOSOCIAL

Provider specific bio-psychosocial assessment that describes the biological, psychological, and social factors that may have contributed to the client's need for services. The evaluation synthesizes the results of all assessments administered and include a brief mental status exam, diagnostic/clinical impression and preliminary service recommendations based on those results and interview of the client and family. Refer to your licensing standards and funders for further requirements of the Biopsychosocial Assessment.

TEAMING

The FIT model approach to cross system partnering seeks to reduce communication barriers and enhance collaborative planning between behavioral health and child welfare. One of the most effective core components for FIT collaboration is the concept of Teaming. For FIT families who are facing multiple risks, diminished protective capacities, and an intense level of interventions, planning is more effective when presented within a comprehensive and intensive multi-disciplinary team framework. Services provided in a comprehensive manner support both recovery and permanency for children. Whether teams are small or large, family planning for achieving safety, permanency, and well-being is more effective with genuine teamwork in place and guided by the central principle on achieving unity of effort and commonality of purpose.

Various types of teaming activities will require different levels of collaboration from all involved stakeholders, including the FIT team and other parties external to the FIT team, such as the child welfare professional. It is essential that releases of information are acquired upfront to allow for information sharing to start immediately. Internally, the FIT team meets regularly, at least twice a month, to discuss the status of each family and any necessary actions to be taken. A protocol needs to be established to ensure the successful communication of time-sensitive information between members of the FIT team when joint decision making is appropriate. The FIT team and child welfare professional communicate at least monthly in the form of emails, phone calls or in-person meetings to discuss and coordinate case activities. The FIT team provides formal updates (written report/summary) concerning changes in CPCs and treatment progress at least monthly. Additionally, the FIT team and child welfare case professional communicate in the event of any critical juncture - any event where a significant change will take place for the family (for example, prior to beginning unsupervised visits or reunification, new baby being born, change in residences or household members, relapse, emergent services need such as detox or residential, etc.). The child welfare professional involves the FIT team in review and modification of the child welfare safety plan; this will allow the FIT team to be informed of the current safety measures in place in the home and allow for the FIT team to inform the child welfare professional of any information that impacts the child welfare safety plan. The FIT team is notified in advance of child welfare permanency staffings, dependency court permanency hearings and judicial reviews for FIT involved families in order to provide status updates and to allow for FIT attendance and participation. If attendance from the FIT team is not possible, updates are provided allowing for pertinent information to be considered for decision-making by the judiciary, child welfare professionals, etc.

When the need arises for clinical services to be provided outside the FIT team, the FIT team will engage with those providers directly and regularly to ensure appropriate services are being provided and to receive ongoing updates regarding progress. The FIT team also links families to primary care providers and local health departments, and provide information and referrals for education on nutrition, family planning, diabetes, preventative maintenance, etc.

In addition to the FIT team and child welfare staff, it is imperative that the parent/guardian and their identified support system be included in discussions regarding their treatment. As such, Multidisciplinary Team (MDT) staffings, which include the FIT team, child welfare professional(s), parent/guardian(s), and any other relevant parties such as caregiver(s), foster parent(s), mentor(s), teacher(s), primary health provider(s), and other provider(s), are held following enrollment and at least every 30 days.

Successful teaming collaborations require high levels of trust, serious time commitments from all partners, and a diminished need for fragmentation. The more intense the level of collaboration is, the greater the potential success with mutual outcomes. In a true collaboration, partners will work together to improve each other's capacity. Collaborative teaming goes beyond just coordinating, sharing information or meeting together.

INTEGRATED PLANNING

As part of the core competency of an Integrated Practice Model, it is imperative that behavioral health providers support and address child welfare outcomes by enhancing CPCs. Utilizing the identified diminished CPCs and behavioral health needs, the team will be able to develop appropriate

interventions to address family needs. This practice is in unison with the Child Welfare Practice Model which requires child welfare professionals to identify reunification criteria, objectively evaluate the scaling of CPCs, and assess behavioral changes in the parent/guardian toward enhancing their protective capacities.

The treatment plan and case planning process for FIT are designed to work in tandem. Child welfare professionals and behavioral health providers will have clearly outlined expectations, timeframes, and procedures surrounding how to assess changes which demonstrate increased CPCs. Through this process, child welfare professionals will be able to gain a clear picture of how the safety concerns in the home have or have not been addressed and will be able to use this information to accurately complete and update the FFA-O and Progress Updates. Updates to the assessment will serve to validate, document, and report progress across the multi-disciplinary team to the judicial system, and ultimately will support the decision to reunify a child or pursue alternate permanency options.

The MDT is responsible for the development and ongoing evaluation of the treatment plan and/or case plan, including any alterations that may prove necessary. This evaluation is an ongoing cycle, possibly repeated multiple times throughout the FIT treatment episode. This includes the practice of motivational interviewing, ongoing assessment, continually revisiting progress or lack of progress, adjusting measurable indicators and frequency of interventions, providing continuous engagement and encouragement, celebrating milestones, maintaining current and appropriate documentation and soliciting feedback from the family to express their views on identified goals. There may be times when members of the MDT have a difference of opinion. In those instances, the team will meet together to discuss any differing views and the best resolution to serve the family. The final decision regarding clinical treatment will be made by FIT clinical leadership.

In working with families impacted by substance use, FIT providers and child welfare professionals will need to integrate a variety of strategies and interventions to help meet parents' treatment needs while simultaneously promoting the safety, permanency, and well-being of their children. Feedback from all members of the multi-disciplinary team is considered when determining the family's needs and developing the treatment plan. The FIT Case Manager will provide information for specific community resources and assisting in linking the family for adequate support, both during and following closure of the dependency case and/or treatment. The FIT Case Manager and child welfare case manager work together to coordinate services for the family. The FIT team can also provide necessary feedback regarding the parent/guardian's progress, what would define success in the areas identified as diminished, and how the parent/guardian can best achieve success in these areas.

CAREGIVER PROTECTIVE CAPACITY TREATMENT PLANNING

A key component to be utilized by the clinical and child welfare professionals is the FFA, both the Initial Assessment and the Ongoing. The FFA assess 19 protective factors across three domains: emotional, cognitive, and behavioral. When completing the FFA-I, the CPI determines whether each of the 19 protective capacities is present or not by indicating "Yes" or "No". During the FFA-O, the child welfare case manager scales the CPCs with a letter rating, "A", B", "C" or "D", with scores of "C" or "D" indicating the protective capacity is diminished.

When the first family team conference with a FIT family is conducted following enrollment to the FIT program, the team and the parent(s)/guardian(s) involved are provided a copy of the most recently

completed FFA that identifies the diminished protective capacities. Any section that scored a "No" on an FFA-I or "C" or "D" on an FFA-O are included as an area of focus for Planning and Intervention in the Treatment Plan. Appendix I of this manual outline the three CPC categories: Behavioral, Cognitive, and Emotional. The capacity wording for each section is taken directly from the Child Welfare Practice Model. Additionally, suggested goals, objectives, and interventions are provided that can be incorporated into the family/client Treatment Plan to address the deficient capacities. Remember, these are only suggestions and goals, objectives, and interventions are not limited to those found in this manual. The FIT team will use this information to gather information to create the treatment/case management plan.

Best practice for treatment planning is a joint visit with the family, FIT and the child welfare case manager to complete the treatment plan. In those instances where a joint visit is not able to be made, efforts are be made to include the missing parties via telephone conference. Treatment Plan Reviews and Progress Updates are coordinated to include the entire multi-disciplinary team to monitor progress and identify on-going needs. This will also ensure that the documentation provided in court is consistent and addresses the same goals, objectives, and interventions needed for the desired behavior change. Those involved in the case will be able to follow the family's progress throughout the case.

The FIT treatment plan/case management plan includes individualized strategies to enhance CPCs that are aligned with the child welfare FFA. Information from the adult functioning assessment and trauma screening/assessment is incorporated into the FIT treatment/case management plan and identifies how support services will be provided to help meet the parents' goals. The FIT team will utilize clinical assessments and the CPCs scaling guidelines from the FFA to help identify the behavioral health needs of the parent(s)/guardian(s).

The FIT team reviews and continues to monitor the FFA for any diminished caregiver capacities across the six domains and incorporates this information into the treatment planning process. As a result, a more detailed Treatment Plan can be developed, which in turn will guide the Treatment Plan Reviews and Progress Updates conducted throughout the family's treatment episode with the FIT program.

Continuous monitoring and evaluation of the effectiveness of the treatment plan and interventions is critical to the FIT practice model. The success of FIT planning and interventions also relies on both the child welfare and behavioral health care systems understanding and appreciating the parameters and culture within each sector and how they operate. Behavioral health providers/clinicians need to be aware of and consider the dependency system's legal requirements, judicial processes, and timelines. These events and timelines create a sense of urgency that does not necessarily align with traditional clinical approaches. It may be necessary for treatment to continue after the traditional child welfare dependency services are completed. Equally important, is that child welfare professionals have basic knowledge of mental health and substance use disorders, appreciate the challenges that these disorders create for parents, and the treatment approaches that are of benefit.

The FIT team will also need to assess the child-parent relationship to assess the appropriate protective capacities and add treatment plan goals as needed. This will be an ongoing assessment using a variety of interventions. For example: the initial assessments, home visits, observed visitations, collateral feedback, evidenced-based parenting programs such as Child Parent Psychotherapy, Circle of Security, Nurturing Parenting, family therapy and counseling sessions, etc. FIT can also provide constructive feedback and alternative parenting interventions during observed visits to assist the parents in utilizing

the skills they learn in treatment as well as assessed their ability to implement skills that have been taught. This information will help inform all future scaling of the CPCs as well as treatment planning.

TRANSITION AND DISCHARGE

The successful transition away from formal supports to informal supports is a critical juncture during the FIT episode of care and is addressed as part of the Teaming process. Ensuring long term recovery and stability for the family requires that transition planning begins at admission, is family-centered, and continues throughout the family's treatment. Ongoing consultation with the team and reassessment of the family's changing capabilities and capacities ensures that the comprehensive needs of the family are addressed. Families are apprised of the appropriate community resources available, linked to those services and are key participants in all phases of the transitional care planning process. Referral processes with community providers need to occur in a timely, systematic fashion prior to discharge. The process concludes with the coordination and implementation of services and transition to the least restrictive level of care.

An assessment of adult functioning and CPCs is completed seven calendar days prior to discharge from FIT services, except in the case of unplanned discharge and parents are unavailable. An MDT staffing is held 30 calendar days prior to discharge from the FIT program and includes the FIT team, child welfare professional(s), parent/guardian(s), and any other relevant parties such as caregiver(s), foster parent(s), mentor(s), teacher(s), primary health provider(s), and other provider(s). The discharge MDT staffing addresses the family's behavioral health, relapse prevention and recovery service needs such as Alcoholics Anonymous, Narcotics Anonymous, a faith-based group or other recovery supports; the physical health care needs for the parents and children; support services such as housing supports, supportive employment, financial benefits, etc.; and community services such as child care, early intervention programs, therapies, and community-based parenting programs. Fourteen calendar days prior to discharge the FIT provider makes referrals to ensure linkage for necessary services and supports. A discharge summary is completed summarizing the family's needs and referrals to services and is provided to the family upon discharge. A copy of the discharge summary is provided to the child welfare professional within seven days of discharge. Thirty calendar days after case closure the FIT provider contacts the child welfare professional to inquire if the family is in need of additional services. In the event of an unplanned discharge, the FIT team coordinates an MDT as soon as disengagement is identified to discuss strategies for re-engagement or plan for next steps following discharge. These strategies and steps must be documented in the discharge summary and provided to the child welfare professional within seven days of discharge.

PROGRAM IMPLEMENTATION

RECOMMENDED EDUCATION AND TRAINING

In order for the FIT teams to implement collaborative and comprehensive planning and intervention, this Manual was designed and built upon the knowledge and skills gained from multiple sources. Accordingly, it is strongly recommended that providers become educated and competent with the outlined prerequisite knowledge and skills as these are essential core competencies for successful implementation. All prerequisite recommendations are structured below to accommodate sequential learning.

1. The below subjects are cumulatively known as FIT Core Competency. Each FIT team member is expected to receive training on and understand each area.
   - ✓ Family-Centric Practice
   - ✓ Integrated Practice Model
   - ✓ Cross-System Training
   - ✓ Shared Accountability
   - ✓ Collaborative Communication and Planning
   - ✓ Co-Occurring and Trauma-Informed Practice
   - ✓ Evidenced-Based Practices to include Parenting Intervention
   - ✓ Rapid Access to Full Continuum of Care
   - ✓ Comprehensive Screening and Assessment
   - ✓ Targeted Engagement and Retention Practices
2. Family Intensive Treatment Team (FIT) Guidance Document

   The FIT Guidance Document provides an overview of FIT expectations and deliverables, an understanding of the importance of treating families entering the child welfare system with a holistic and family-centered approach. Adherence to this document is required for all teams receiving funding from the Department of Children and Families.

3. Florida Safe Families Network (FSFN) Access and Training

   All documentation regarding the families served in the FIT program, from the investigation following an abuse report to the discharge from the FIT program, is entered into the Florida Safe Families Network (FSFN) system. Therefore, the FSFN access application and training is completed by all FIT staff as soon as possible following hire.

4. Florida Child Welfare Practice Model In-Depth Training

   The Florida Child Welfare Practice Model Training provides an understanding of the standardized guidelines established for use in the decision-making involved in identifying unsafe children. This includes definitions and scoring of the CPCs that can be directly associated with being protective of the children in the home.

5. Children's Dependency Legal System

   "Module One: Primer on CW and Dependency Court Systems for Substance Use Disorder Treatment Professionals" provides an understanding of the legal processes involved in child welfare cases. Once the dependency court has received the report resulting from the Family Functioning Assessment, these findings will be used to develop a Case Plan for the parent(s) involved. What can and cannot be legally included in a Case Plan is limiting. A good understanding of this process and the role of stakeholders is crucial to develop a full picture of how to integrate the child welfare and clinical systems of care.

6. Integrating the Family Functioning Assessment and Treatment Plans

   A client's Case Plan often stipulates that the client follow the clinical treatment recommendations. The Treatment Plan must therefore reflect goals, objectives, and

interventions that address the diminished CPCs noted on the FFA-O. The Treatment Plan Reviews and Progress Updates will document the client/family's progress in these areas during the course of treatment with the FIT program and be reported in dependency court judicial review hearings. The use of the same verbiage in the FFA-O, Progress Updates, and the Treatment Plan allows for judges, attorneys, and all involved in the case to better understand the family needs and progress, or lack of progress, and thus make more informed decisions regarding the status of the case.

Please refer to Appendix V: Training for further resources on the Recommended Training and Education.

This manual will become a valuable tool for FIT teams after the recommended prerequisite learning has been completed. The Appendices of this manual also provide sample planning documents.

ESTABLISH A REFERRAL PROTOCOL

Referrals can be made by child welfare professionals, including CPIs, CMOs, and the CBC Lead Agency. Providers and stakeholders working with child welfare families, such as engagement programs and the dependency court system, can also refer eligible parents/guardians. Ideally referrals to FIT are timely to the opening of an investigation once all eligibility criteria are identified. Best practices include FIT referrals and participation during Case Transfer Staffings and/or shelter. FIT is intended to be a long-term, treatment program that is initiated at the beginning of a child welfare case. In order for the FIT program to have adequate time for treatment and to demonstrate behavior change with the parent/guardian(s), there are child welfare case management services involved throughout the course of treatment.

FIT teams continually educate the referrals sources on the FIT referral process, including how to make a referral, eligibility criteria, and capacity of the program. The FIT referral process is consistent with a specific referral form for child welfare and single route of entry, including a designated email address and point of contact. If the referral does not meet criteria for the program or the team is at capacity, the case is staffed with the referral source and recommendations and linkage to appropriate services are made and documented. This referral process is established and understood by all referring partners.

ESTABLISH COMMUNICATION PROTOCOL

Each FIT Team has communication plan in place with their child welfare team members at the inception of their FIT Program. An essential component to this communication plan is ensuring the appropriate releases of information are signed up front to remove barriers to information sharing. The communication plan will also ensure timely, consistent, and thorough communication between the FIT providers and the child welfare team. Examples of times when this communication can take place are: case staffings, critical, case closures, continued care planning, and judicial reviews. Staffings involve an MDT to offer varied experiences and perspectives. Any party who is providing services to the family, is relevant to the outcome of the case, or can provide subject matter expertise is invited to participate in MDT staffings. Examples include parent/guardian(s), caregivers, foster parents, mentors, teachers, primary health providers, child welfare professionals, and other providers.

Ongoing communication is critical throughout the case and treatment. The child welfare professional enters all notes in FSFN and ensure the FIT team is immediately notified of any changes to the case. Immediate team interventions occur at any critical junctures, such as relapse, court orders, changes to treatment or case plans, etc. FIT teams are not only made aware of the planned child welfare activities in advance of the action but are part of the decision-making process. This expectation must be addressed and coordinated upfront with the CBC Lead Agency and CMOs in order to have a successful and integrated system of care.

A minimum of monthly communication between FIT and the child welfare case manager would be expected through encrypted emails, phone calls and/or face to face meetings. Immediate communication is expected at critical junctures, including disengagement from treatment.

Regarding dependency court, FIT will provide clinical information related to progress, impact of behavior change, communicate safety concerns, and be available to provide support to the family if needed. This will be provided in the form of notes in FSFN, monthly progress notes, or in-person testimony. In-person testimony is prompted through court subpoena or judicial request with appropriate release or court order. FIT team members are not expected to appear at all court hearings; however, the FIT team is aware of all judicial updates and hearings and is encouraged to attend to advocate for and support the best interest of the family.

PLAN FOR QUALITY ASSURANCE

An ongoing quality improvement process will be implemented by each FIT provider to ensure fidelity to the core components of FIT. The quality assurance process ensures alignment with the FIT Guidance Document, the FIT Manual, the provider's evidence-based practice, requirements for licensing, funding and credentialing, and other identified practices utilized within the FIT model, i.e. parenting, engagement and re-engagement activities, etc.

The core components of FIT all require diligent efforts on behalf of the FIT teams. These practices are captured quantitatively by performance measures, but an ongoing quality assurance processes validates the caliber of services provided using documentation and client feedback. The state of practice implementation and understanding of core components can be assessed through the use of staff interviews, training completion, peer reviews, and utilization of the FIT Model Fidelity Assessment Tool annually. While the FIT provider has internal processes of quality assurance, the MEs and DCF are also integral monitors of FIT services. The quality assurance process includes the following:

1. Fidelity to evidence-based models being practiced
2. Ongoing trainings and completion of Recommended Education and Training
3. Documentation in required systems, such as FSFN and clinical files or electronic health records
4. Adherence with the communication protocol to engage and re-engaging clients
5. Timeliness of service delivery
6. Clinical monitoring of intensity of treatment and length of stay
    a. Internal file reviews
    b. Peer file reviews
    c. MEs continually monitor length of stay for clinical appropriateness
    d. MEs review client documentation for clinical justification for treatment exceeding 12 months

7. Engagement and involvement of families and stakeholders in treatment
8. Feedback from FIT families
9. Teaming with child welfare and other providers in the community

FIT PROCESS OVERVIEW

1. At time of referral, the FIT provider will:
    a. Review the referral to ensure it meets FIT eligibility criteria. This can include staffing with the referral source. If the referral does not meet criteria, the FIT team will staff the case with the referral sources and recommendations and linkage to appropriate services are made and documented;
    b. Access the Initial and/or Ongoing FFA from the FSFN system;
    c. Review the FFAs for the diminished CPCs;
    d. Contact the referral source to acknowledge receipt of the referral and receive any additional information;
    e. Review the case plan, when available;
    f. Review FSFN for any prior investigations; and
    g. If FIT program is full, a waitlist is maintained. All referred families are contacted, given information about status on waitlist and provided referrals for interim services to meet any immediate needs. Weekly phone contact is maintained for all clients on FIT waitlist
2. Upon accepting a referral, the FIT provider will:
    a. Assign the referral to a specific FIT Team (Counselor, Case Manager and Recovery Peer Specialist);
    b. Immediately (within two business days) contact family to answer questions about FIT and set up enrollment meeting;
    c. Ensure that initial and recurring efforts to contact and engage the referred parent(s)/guardian(s) are documented; and
    d. Determine which FIT Team member(s) will participate in the enrollment meeting.
3. Upon enrollment, the FIT provider will:
    a. Meet with family and complete all consents required by provider agency;
    b. Ensure that a release of information is completed for the child welfare professional and any other formal and informal providers and supports involved with the family;
    c. Contact the child welfare professional to provide disposition of referral, schedule an MDT staffing, and arrange to be present at all Teaming activities, such as case planning conference, mediation, staffings, urgent/emergent staffing, or court hearings, etc.
4. Within the first 30 days after enrollment, the FIT provider will:
    a. Complete required FIT initial assessments;
    b. Complete a Biopsychosocial based on all child welfare information, results of FIT assessments, and interview with the parent/guardian and family;
    c. Develop a treatment plan with the family, FIT team, the child welfare professional, and other providers involved with the family based on the clinical assessments and identified diminished CPCs;
    d. Begin substance use treatment to include relapse prevention planning utilizing an evidence-based model;
    e. Coordinate specialized services; for example: joint home visits, in-home interventions, parenting programs, child services, peer services, incidental funding, etc.;

f. Evaluate family's need for housing or to apply for eligibility for food, cash and medical assistance or use of incidental funds; and
g. Complete all required FSFN documentation, at a minimum a monthly progress notes and update at any critical juncture.

5. During ongoing treatment, the FIT provider will:
   a. Complete additional assessments as appropriate or required;
   b. Coordinate frequent (at least monthly) MDT staffings which include the FIT team, child welfare professional(s), parent/guardian(s), and any other relevant parties such as caregiver(s), foster parent(s), mentor(s), teacher(s), primary health provider(s), and other provider(s);
   c. Review treatment plans, FFA-O, Progress Updates, and scaling of CPCs. Any section scaled as a "C" or "D" is included as an area of focus in the Treatment Plan;
   d. Continue to evaluate family's need for housing or to apply for eligibility for food, cash and medical assistance or use of incidental funds;
   e. Participate in Teaming activities, such as case planning conference, mediation, MDT staffings, urgent/emergent staffing, or court hearings, etc.; and
   f. Complete all required FSFN documentation, at a minimum a monthly progress note and update at any critical juncture;
6. During Continued Care, the FIT provider will offer ongoing continued care services once clinical treatment services are determined to be completed as needed. This can be done through individual and/or group Aftercare services, as defined by 65E-14.021(4)(a) and is typically provided by the FIT Case Manager or Recovery Peer Specialist.
7. During Transition and Discharge, the FIT provider will:
   a. Complete updated assessments, such as the DLA-20: Alcohol-Drug and scaling of the CPCs.
   b. Provide progress updates to inform the child welfare case manager's ongoing assessments of CPCs.
   c. Consult with the child welfare professional(s) to determine the appropriate time for case closure. This includes agreement that the caregivers have enhanced their Caregiver Protective Capacities to the point where there are no longer danger threats within the home and the children are safe. Families may be transitioned if there is a goal change to Termination of Parental Rights (TPR), however the family does not have to be discharged at this time if actively engaged and expresses a desire for continued FIT services. Families may be transitioned at any time the family declines ongoing treatment with the FIT Team;
   d. Coordinate an MDT staffing 30 calendar days prior to discharge to discuss case transition with the FIT team, child welfare professional(s), parent/guardian(s), and any other relevant parties such as caregiver(s), foster parent(s), mentor(s), teacher(s), primary health provider(s), and other provider(s), except in the case of unplanned discharge and the parents are unavailable;
   e. Coordinate linkage with community resources to ensure any ongoing care/aftercare 14 calendar days prior to discharge, except in the case of unplanned discharge; and
   f. Assist with coordination of follow up services, complete the discharge summary and provide to the child welfare professional within seven days of discharge and complete all required FSFN documentation.

APPENDIX I: CAREGIVER PROTECTIVE CAPACITIES

BEHAVIORAL PROTECTIVE CAPACITY MATRIX

I. Protective Capacity: The parent/legal guardian/caregiver demonstrates impulse control.

Deficiency C: Parent/Caregiver routinely (weekly/monthly) acts upon urges/desires, is influenced by outside stimulation, thinks minimally before taking action, resulting in actions having negative effects on the children and family.

Deficiency D: Parent/Caregiver frequently (daily) acts upon urges/desires, is highly influenced by outside stimulation, does not think before taking action, and do not plan. Parent/Caregiver's inability to control impulses results in negative effects on the children and family.

Long Term Goal	Short Term Objectives	Therapeutic Interventions
The parent/legal guardian/caregiver will demonstrate increased impulse control.	• Develop 2 to 3 ways to become more mindful when caring for children and making life choices. • Identify the specific behaviors/triggers that lead to lack of impulse control. • Learn self-talk techniques and be able to report to therapist at least one situation weekly when these skills were used • Learn how to step back and observe what is going on around you to report learned cause and effect to therapist • Learn about and demonstrate Restatement and reflection / speaker/listener/ active listening. • Be able to identify distorted thinking/irrational thought patterns (squirrely thinking). • Accurately identifying the emotions experienced (self-soothing exercises). • Increase stress management skills to reduce irritability • Increase relationship skills such as assertiveness, communicating feelings, or compromise to get needs met. • Maintain healthy respect for others, including personal space, property, and basic human rights (from Anger management) • Discontinue self-directed harmful behaviors • Identify the specific behaviors/triggers that lead to lack of impulse control	• Focus exercises • CBT – reframing, playing the tape all the way through • Thought stopping exercises • DEAR MAN exercise • Behavior chain analysis • Request the client to identify his/her history of anger management problems including lost relationships, legal problems, or outbursts. • Provide the client, family, or caretaker with an anger journal or log to track frequency, intensity, duration, and consequences of anger expression difficulties. • Expand the client's understanding of the issues of loss of control due to severe and persistent mental illness symptoms and the attempt to regain control through temper outbursts.

II. Protective Capacity: The parent/legal guardian/caregiver takes action.		
Deficiency C: Parent/Caregiver regularly is not able to take action, be assertive and responsive, and/or physically respond to caregiving needs. Parent/Caregiver needs assistance on a regular basis (weekly). Parent/Caregiver may have a physical limitation, and on a regular basis is not able to accommodate those physical limitations in order to take action.		
Deficiency D: Parent/Caregiver is not able to take action, be assertive and responsive, and/or physically respond to meeting caregiving needs of children. Parent/Caregiver requires assistance routinely (daily). Parent/Caregiver may have a physical limitation, and routinely is not able to accommodate that physical limitation in order to take action		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
The parent/legal guardian/caregiver will take action to become physically able, assertive, and responsive and utilize resources to meet basic needs.	• Develop a self-care plan to enable me to increase the care and well-being of my children • Improve Self-esteem (get a job, go to school, etc.) • Learn to articulate the positive (self and child) • Identify the needs (physiological, psychological, behavioral) • Obtain the necessary transportation to work, medical appointments, leisure opportunities, or other desired destinations • Identify, attain, and manage adequate sources of financial income • Arrange for an evaluation of the client by a physician for a prescription for psychotropic medication • Educate the client about the proper use and the expected benefits of psychotropic medication • Monitor the client for compliance with the psychotropic medication that is prescribed and for its effectiveness and possible side effects.	• Identify their motivation to change (motivational interviewing, decisional balancing). • Solution focused therapy (magic wand question, scaling).

III. Protective Capacity: The parent/legal guardian/caregiver sets aside her/his needs in favor of a child.		
Deficiency C: Parent/Caregiver recognizes the need to place the child's needs as a priority; however, is not able to set aside own needs in favor of the child's needs, resulting in the child being maltreated and/or exposed to danger.		
Deficiency D: Parent/Caregiver does not recognize the need to place the child's needs as a priority and does not set aside own needs in favor of the child's, resulting in the child being maltreated and/or exposed to danger on regular occasions.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
The parent/legal guardian/caregiver will set aside her/his needs and adjust to accept the children's needs as a priority.	• Identify the needs of my children and rate them in order of importance shopping, role play • Identify a need versus a want • Develop a budget based on resources and needs • Plant a garden	• CBT– reframing, changing thought process. • Motivational Interviewing- developing discrepancies. • Education on access to food, water shelter • Education on developmental milestones • Educate client on developing a daily gratification log.

IV. Protective Capacity: The parent/legal guardian/caregiver demonstrates adequate skill to fulfill caregiving responsibilities.		
Deficiency C: Parent/Caregiver has minimal skills related to providing for the basic needs of child. Parent/Caregiver lacks the ability to consistently feed, and/or care, and or/supervise child resulting in maltreatment and/or danger. Parent/Caregiver recognizes the need for assistance; however, does not act to seek resources to assist in fulfilling caregiving responsibilities.		
Deficiency D: Parent/Caregiver has little to no skills related to providing for basic needs of child. Parent/Caregiver does not feed, and/or care, and/or supervise child, resulting in child being maltreated and/or in danger. Parent/Caregiver does not recognize the need to provide for basic needs of child, and/or the parent/caregiver will not or cannot seek resources to assist in fulfilling caregiving responsibilities.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
The parent/legal guardian/caregiver will demonstrate adequate skill to fulfill caregiving responsibilities.	• Identify the routines and needs of my children • Develop a family schedule (daily, weekly, monthly) that includes daily living tasks • Register for GED, college, certificate, classes, etc. • Prepare an inventory of positive/negative experiences with attempting to perform ADLs • Identify and discuss fears/ disappointments related to gaps in employment history • Contact One Stop Career Center and attend groups • Obtain occupational skills that are necessary to gain entry level positions in the workplace • Complete (3) job applications per week and follow up • Learn skills for identifying and resolving problems with coworkers and supervisor • Develop a list of priorities that he/she sees as most important to address when developing a parenting plan and then develop parenting methods that are designed to meet those priorities	• Educate on developmental milestones • Educate on family activities for a family night • Educate on ADL's • Teach the parent to be present with child—model this behavior • Use role playing, modeling, and behavioral rehearsal to help the client practice implementation of new parenting skills • Teach the client basic housekeeping skills, utilizing references such as *Mary Ellen's Complete Home Reference Book (*Pinkham and Burg) or *The Cleaning Encyclopedia* (Aslett)

V. The parent/legal guardian/caregiver is adaptive as a caregiver.		
Deficiency C: Parent/Caregiver lacks flexibility in most situations, including routine caregiving responsibilities. Parent/Caregiver struggles with adapting to meet child needs, including identifying solutions for ways of behaving or caretaking that does not result in maltreatment and/or danger to child. Parent/Caregiver acknowledges struggle with flexibility and adaptation; however, has not sought assistance in changing behavior.		
Deficiency D: Parent/Caregiver is not flexible and/or adaptive in caregiving duties, resulting in children being maltreated and/or in danger. Parent/Caregiver cannot or will not acknowledge lack of flexibility and/or adaptability in caregiving. Parent/Caregiver has not sought assistance in changing behavior.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
The parent/legal guardian/caregiver is adaptive as a caregiver.	• Demonstrate flexibility and adaptability • Exploring cultural belief systems • Developmental expectations • Explore rigidity versus flexibility – role play • Review different parenting styles • Explore what motivates child • Exploring what the behavioral outcome/goals are • Develop a relationship with a specific staff at a local bank branch to assist with managing personal bank account • Discuss the bus schedule and available public transportation and schedule a ride-along with Recovery Peer Specialist for first time riding the city bus • Identify two areas in which you have been successful in becoming more independent in the community • Identify triggers and causes for anger outbursts • Verbally express angry emotions in a controlled, assertive, safe manner • Identify the negative impact of anger outbursts on others.	• The ANT activity (automatic negative thoughts). • Focus on developing a level of trust with the client. Provide support and empathy to encourage the client to feel safe in expressing his/her angry emotions. • Request that the client develop a list of all situations, events, people, and so on, that cause anger, irritation, or disappointment. Review the list and prompt the client about areas that seem to be missing. • Educate the client on how to use his/her language to communicate emotions accurately.

VI. Protective Capacity: The parent/legal guardian/caregiver demonstrates a history of protecting.		
Deficiency C: Parent/Caregiver has demonstrated minimal ability to raise children without exposure to danger or maltreatment. Parent/Caregiver has had frequent (three or more) contacts with the child welfare system due to repeated exposure to maltreatment and parental conduct. Parent/Caregiver is not able to articulate how they have protected their children in the past and/or how they could take protective measures to ensure that their children are protected.		
Deficiency D: Parent/Caregiver has not been able to raise children without exposure to danger and/or maltreatment. Parent/Caregiver has had repeated contact with child welfare system (three or more reports within 1 year) due to repeated exposure to maltreatment and parental conduct.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
The parent/legal guardian/caregiver will demonstrate clear and reportable evidence of increased history of protective capacity through interventions and experiences.	• Review /Develop individualized safety plan • Review case plan • Exploring parent's history as a child and as a parent	• Educate on safety

COGNITIVE PROTECTIVE CAPACITY MATRIX		
I. Protective Capacity: The person is self-aware as a parent/legal guardian/caregiver.		
Deficiency C: Parent/Caregiver is able to understand the cause-effect relationship between his/her own actions; however, are not able to relate actions to the effects on the child. Parent/Caregiver is not open in reflecting own thoughts, emotions, and/or behavior in relation to providing for care of the children, resulting in children being maltreated and/or in danger. Parent/Caregiver recognizes the need for understanding the causal relationship and the effects on child.		
Deficiency D: Parent/Caregiver is not able to understand the cause-effect relationship between his/her own actions and is not able to relate those actions to the effects on the child. Parent/Caregiver is not open in regard to own thoughts, emotions, and/or behavior, resulting in child being maltreated and/or in danger. Parent/Caregiver does not recognize the need for understanding the causal relationship of his/her actions and the effects on child.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/Caregiver is able to demonstrate understanding of the cause-effect relationship between his/her own actions and effects on child.	• Identify 3 beliefs about parenting that negatively impact children • Create a job description of a parent • Identify positive and negative parenting styles • Develop a genogram or family tree to display the various patterns within the family • Develop a timeline of important events regarding parenting and compare these events with milestones that are related to the substance use • Review current concerns regarding parenting, including the child's challenging behaviors and the approach taken with the child • Focus on the successes and positive traits of children • Discuss personal experience with substance use and how it has affected ability to parent effectively • Identify two painful experiences in which rejection was experienced (e.g., broken relationships, loss of employment) due to the lack of performance of basic ADLs • Visualize or imagine the possible positive changes that could occur from increased attention to appearance and other daily living skills	• REBT • Direct the client to develop a list of family members and other individuals who can provide short term supervision to the client's child when the client is feeling overwhelmed by his/her parenting responsibilities • Help the client brainstorm diversionary activities that can relieve parenting stress • Help the client learn and implement relaxation techniques as well as other stress relieving skills to decrease the normal strain of parenting • Review with the client the medical risks (e.g. dental problems, risk of infection, lice, etc.) that are associated with poor hygiene or lack of attention to other ADLs • Provide the client with regular feedback about progress in his/her use of self-monitoring to improve personal hygiene.

II. Protective Capacity: The parent/legal guardian/caregiver is intellectually able/capable.		
Deficiency C: Parent/caregiver lacks essential knowledge regarding caregiving and child development and does not correlate the lack of knowledge to the responsibility for child safety and development. Parent/caregiver may have a cognitive delay that affects ability to increase his/her knowledge regarding caregiving and safety, and the lack of resources or supports for his/her cognitive delay is a contributing factor to the parent/caregiver intellectual capacity. Parent/caregiver is not or will not seek assistance in increasing knowledge. Maltreatment has occurred as a result of the parent/caregiver's knowledge capacity.		
Deficiency D: Parent/caregiver lacks essential and basic child development knowledge in regards to caregiving needs and child safety. Parent/caregiver may have a cognitive delay that is debilitating and is not being addressed through informal or formal supports. The parent/caregiver knowledge is such that it leaves children in danger and has resulted in maltreatment. Parent/caregiver is not or will not seek assistance in increasing knowledge or accessing supports to develop knowledge regarding child development and child safety.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/caregiver possesses essential knowledge regarding caregiving and child development.	• Learn development milestones for my children at this time and identify 3 safety needs at each phase of their development • Learn physical development stages (American Academy of Pediatrics healthychildren.org) • Demonstrate family scheduling to establish routines and realistic expectations • Learn cultural and societal norms and expectations for parents and children • Identify community resources for support and assistance with parenting	• CBT

III. Protective Capacity: The parent/legal guardian/caregiver recognizes and understands threats to the child.		
Deficiency C: Parent/caregiver frequently is not aware of surroundings and life situations. In particular, this occurs when presented with dangerous and/or threatening situations. Parent/caregiver is not able to recognize the correlation with child safety and mental awareness, resulting in children being maltreated and/or unsafe. Parent/caregiver is not or will not access resources to increase mental awareness without assistance.		
Deficiency D: Parent/caregiver is not aware of surrounding and life situations, particularly when caring for children. Parent/caregiver does not recognize dangerous and/or threatening situations/people, resulting in children being maltreated and/or unsafe. Parent/caregiver may have an unmanaged mental health condition that affects ability to be aware. The unmanaged mental health condition is known to the parent/caregiver and he/she has not or will not seek assistance to manage the mental health condition.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/caregiver is attuning with his/her surroundings, in particular to perceptions regarding life situations, recognizing dangerous and threatening situations and people.	• Identify 5 specific situations that would endanger children and demonstrate an understanding of the impact of these threats on children • Read the allegations and safety plan together and identify the safety concerns for the children • Demonstrate understanding of safety plan • Abstain from illicit mood altering substances including alcohol • Gain an understanding of the negative impact of substance use on psychiatric symptom and the effectiveness of psychotropic medications • Establish a recovery/ relapse prevention plan • Attend (3) AA/ NA meetings per week • Contact (3) support members per week	• REBT

IV. Protective Capacity: The parent/legal guardian/caregiver recognizes the child's needs.		
Deficiency C: Parent/caregiver does not identify with the child's needs, strengths, and/or limitations resulting in the parent/caregiver acting in ways that have resulted in the child being maltreated and/or unsafe. The parent/caregiver is able to recognize inability to identify with children and is open to assistance in increasing parenting capacity.		
Deficiency D: Parent/caregiver does not identify with the child's needs, strengths, and/or limitations that have resulted in the child being maltreated and/or unsafe. The parent/caregiver does not see value in the capabilities of the child and are not sensitive to the child and his/her experiences. Parent/caregiver's view of the child is incongruent to the child and how others view the child. Parent/caregiver is not able to recognize inability to identify with child and the child's needs and are not willing or able to seek assistance in increasing parenting capacity.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/caregiver consistently recognizes the child's needs, strengths and limitations.	• Identify 5 needs, strengths, and limitations of children based on their struggles, what they are asking for, and developmental stage • Identify children's preferences • Learn developmental stages and appropriate behaviors for each stage (AAP Healthy Children) • Make a list of activities enjoyed with children	• REBT

V. Protective Capacity: The parent/legal guardian/caregiver understands his/her protective role.		
Deficiency C: Parent/caregiver does not value and/or believe that the primary responsibility is to protect the child. Parent/caregiver may have an internal sense for being protective; however, does not or cannot internalize the primary responsibility for protection of the child. Parent/caregiver does not or cannot accept responsibility for child protection, resulting in children being maltreated and/or unsafe.		
Deficiency D: Parent/caregiver does not recognize and/or value the responsibility to protect children as a primary role of a caregiver. Parent/caregiver does not have an internal sense for being protective and takes no responsibility for keeping children safe, resulting in children being maltreated and/or unsafe.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/caregiver is unwavering in his/her protective role and is able to articulate the significance of his/her role.	• List 5 ways to protect children • Describe 5 ways your parent(s) did/did not protect you and how that affected your parenting • Make a list of at least 25 words and actions you can use to protect your children • Write a description of your role in your safety plan • Identify 5 situations that can leave a child unsafe and develop a plan for how to respond protectively	

VI. Protective Capacity: The parent/legal guardian/caregiver plans and is able to articulate a plan to protect children.		
Deficiency C: Parent/caregiver does not recognize the need to plan for child safety and has not developed a plan in the past or has developed plans that were unrealistic to ensure safety, thus resulting in maltreatment and/or children being unsafe. Parent/caretaker may have cognitive limitations that affect ability to conceptualize a plan for protection and are open to assistance in developing plans and/or accessing resources.		
Deficiency D: Parent/caregiver does not recognize the need to develop a plan to ensure child safety and has not developed a plan in the past or has developed plans that were unrealistic, resulting in children being maltreated and/or unsafe. Parent/caretaker does correlate the inaction of developing a plan and children being maltreated and/or unsafe. Parent/caretaker may have cognitive limitations that affect ability to conceptualize a plan for protection. Parent/caregiver is unwilling or unable to seek assistance in developing plans and/or accessing resources to assure child safety. Parent/caregiver is unrealistic and unaware of the necessity as parents/caregivers to develop and execute plans for protection of children.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/caregiver is aware of danger and is focused on processing and development of a plan for safety.	• Develop a safety plan for children while in my care • Role play unsafe situations and how to keep children safe in those situations • Create a script for protecting children in identified situations • Create a list of emergency contacts to build a family safety network • Create a script for preventing potential impending threats that allows the setting of healthy boundaries with other people that have an impact on children • Identify 3 agencies in the community that can provide safety in emergencies	• CBT

EMOTIONAL PROTECTIVE CAPACITY MATRIX		
I. Protective Capacity: The parent/legal guardian/caregiver is able to meet own emotional needs.		
Deficiency C: Parent/caregiver shows limited understanding and recognition of own emotional needs. Parent/caregiver often seeks to satisfy own emotional needs through means that take advantage of others, primarily the children. Parent/caretaker uses avenues to satisfy own emotional needs that are unacceptable, resulting in children being maltreated and/or unsafe.		
Deficiency D: Parent/caregiver does not recognize own emotional needs, resulting in needs being unmanaged and interfering with ability to parent children. The unmanaged needs results in children being maltreated and/or unsafe.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/caregiver recognizes and understands own emotional needs and effectively manages needs in ways that do not interfere with ability to parent and does not take advantage of others.	• Identify 3 situations in which you thought through your actions instead of acting impulsively • Identify 3 persons you see as a positive parenting role model and interview them regarding their parenting styles and techniques • Make a list of at least 5 positive people that can serve as a support for you • Engage in at least 3 adult leisure activities that support positive parenting • Make 3 new friends that are positive and can support your recovery • Engage in 1 date night per month that does not involve substance use or negative behaviors • Identify successes and challenges in his/her relationships • Identify at least two ways in which his/her relationships have been affected by substance use • Attend a support group for individuals with substance use issues and addiction	• Individual/couple therapy to address emotional needs • Educate about healthy sexual relationships • Educate the client and his/her partner about the symptoms of addiction • Teach the client (and his/her partner) specific skills for healthy communication, such as expressing positive and negative emotions, making requests, communicating information clearly, giving "I" messages, and using active listening • Role play with the client how to implement assertive communication techniques, such as "I" messages and active listening • Teach the client about anger control techniques • Clarify any patterns to the client's behavior that contribute to positive and negative relationship and interactions. • Assist the client to express emotions related to impaired performance in ADLs (e.g. embarrassment, depression, low self-esteem, etc.)

II. Protective Capacity: The parent/legal guardian/caregiver is resilient as a caregiver.		
Deficiency C: Parent/caregiver, when faced with adversity/challenges, is not able to recover or adjust. Recovery and adjustment requires frequent interventions by support and resources. Parent/caregiver cannot focus his/her role during these times to caretaking, resulting in children being maltreated and/or unsafe.		
Deficiency D: Parent/caregiver does not respond to adversity/challenges and recovery or adjustment is not existent. Parent/caregiver does not respond to interventions by supports and resources, and children are maltreated and/or unsafe due to the parent/caregivers responses.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/caregiver has demonstrated that he/she is able to recover from or adjust easily to misfortune and/or change.	• Report 3 times when I was able to reframe a situation from negative to positive • List 5 personal strengths and how I can use them to reach my case plan goals	• REBT

III. Protective Capacity: The parent/caregiver is tolerant as a caregiver.		
Deficiency C: Parent/caregiver frequently cannot or will not maintain temper and/or patience while providing care for children. Parent/caregiver is aware of decreased tolerance; however, is not able to correlate the need for tolerance in parenting. Parent/caregiver's lack of tolerance has resulted in children being maltreated and/or being unsafe. Parent/caregiver is willing to access resources and/or supports to increase tolerance as a caregiver.		
Deficiency D: Parent/caregiver cannot or will not maintain temper and/or patience while providing care for children. Parent/caregiver is not aware of decreased tolerance and is not able to correlate the need for tolerance in parenting. Parent/caregiver's lack of tolerance has resulted in children being maltreated and/or being unsafe. Parent/caregiver cannot or will not access resources and/or supports to increase tolerance as a caregiver.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/caregiver recognizes the need for tolerance as a caregiver and works to ensure that he/she is open minded and understanding as a caregiver.	• Identify 3 personal biases and how they impact my children and me • Develop a disciplinary/consequence plan that is age-appropriate for my children	• Educate client on child development milestones

IV. Protective Capacity: The parent/legal guardian/caregiver expresses love, empathy and sensitivity toward the child and experiences specific empathy with regard to the child's perspective and feelings.		
Deficiency C: Parent/caregiver frequently cannot or will not relate to the children's feelings. Parent/caregiver does not express love, empathy, and/or sympathy for the child on a frequent or consistent basis. Parent/caregiver is able to recognize the absence of relating to the child's feelings. The parent/caregiver's feeling towards the child result in the child being maltreated and/or unsafe.		
Deficiency D: Parent/Caregiver is not able to relate to the child's feelings. The parent/caregiver does not express any love, empathy, and/or sympathy for the child. The parent/caregiver's lack of feelings towards the child results in the child being maltreated and/or unsafe.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/caregiver is able to relate to his/her child and demonstrates actions that are reflective of expressing love, affection, compassion, warmth, and sympathy for the child and his/her experiences.	• Identify and demonstrate 3 age appropriate loving behaviors with child (Developmental Milestone Checklist, role play activities that support age appropriate behaviors) • Acknowledge child's emotions, validate, and model self-soothing techniques (breathing exercises, meditation, journaling, active listening, role playing validating feelings) • Learn and use reflective listening skills at least once a day • Process feelings or lack thereof and learn 3 techniques to express positive regard to children (journaling, Feeling Faces Worksheet) • Rebuild important family relationships (family conflicts) • Behave in a direct, assertive, and loving way toward family members (family conflicts) • Describe healthy and positive relationships in the family system • Decrease incidents of aggressive acting out toward the family	• CBT • Reinforce the need for the client to accept, without judgement, the feelings that the child experiences. Reassure the client that these feelings are not a personal attack. • Request that the client list and describe positive relationships. • Utilize solution-focused techniques to help the client identify how he/she has facilitated positive interactions in the past.

V. Protective Capacity: The parent/caregiver is stable and able to intervene to protect children.		
Deficiency C: Parent/caregiver is frequently not able to maintain emotional stability during daily routines, resulting in the child's needs not being met. Parent/caregiver is aware of instability; however, is immobilized in taking action to access resources or supports to provide for child safety, resulting in child being maltreated and/or unsafe.		
Deficiency D: Parent/caregiver is not able to maintain emotional stability during daily routines and challenging life events. Parent/caretaker is not aware of instability and has taken no action to access resources and/or supports to ensure for child safety, resulting in child being maltreated and/or unsafe.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/caregiver is motivated in ensuring own mental and emotional stability, and energy is sufficient to ensure that the child is safe.	• Keep all medication management appointments and take medications as prescribed • Identify past and present symptoms/behaviors • Learn 3 self-care/self-soothing techniques and use them daily (deep breathing, guided imagery, meditation, journaling, exercise, hobbies) • Develop an overall health and wellness plan for self-care (nutrition support, establish a schedule, routine sleep, exercise) • Have a safety plan in place if feeling overwhelmed or unstable that includes emergency contacts	• Individual counseling • Training in emotional regulation techniques

VI. Protective Capacity: The parent/caregiver is positively attached to the child.		
Deficiency C: Parent/caregiver frequently does not demonstrate attachment to the child. This is evidenced by the ordering of his/her life, lack of affectionate regard for the child, and the parent identifying other relationships as being the primary relationship. Child has suffered maltreatment and/or is unsafe as a result of the parent/caregiver's lack of attachment to the child.		
Deficiency D: Parent/Caregiver has no attachment to the child and shows no regard for the child and the parent/caregiver relationship. Parent/caregiver does not identify self as a parent/caregiver. Parent/caregiver cannot or will not seek resources and/or supports to enhance the attachment and does not recognize the correlation between the lack of attachment and maltreatment.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/caregiver demonstrates his/her attachment to the child through actions such as ordering his/her life according to what is best for the child, displays affectionate regard for the child and the child's experiences, and identifies closeness with the child exceeds other personal relationships.	• Identify, encourage, and nurture child's talents and unique abilities • Develop a Behavior chart and Reward system for children • Role play child-led activities • List 3 positive characteristics about each child • Engage in age appropriate activity of child's choosing for 1 hour each day • Create a schedule that allows one-on-one time for each child in the home • Develop an Activity Log • Hold infant child at least 1 hour three times daily during feedings • Set specific times to spend alone with each child and treat this as a priority	• PCIT • Reinforce the client's increased involvement with the child • Reframe irrational beliefs regarding spoiling • Educate on eye and skin contact • Basic infant care education

VII. Protective Capacity: The parent/legal guardian/caregiver is supportive and aligned with the child.		
Deficiency C: Parent/caregiver does not identify with the child through his/her actions and lacks compassion for the child. Parent/caregiver is infrequently non-responsive to the child when the child needs to be calmed, pacified, and/or appeased. The parent/caregiver acknowledges inability to align with the child; however, cannot or will not take actions to increase alignment with the child. The parent/caregiver's actions have resulted in children being maltreated and/or unsafe.		
Deficiency D: Parent/caregiver is not aligned with the child as demonstrated by non-responsiveness to the child and the lack of compassion for the child. Parent/caregiver does not express concern and/or does not acknowledge the lack of alignment with the child. The lack of parent/caregiver actions has resulted in the child being maltreated and/or unsafe.		
Long Term Goal	**Short Term Objectives**	**Therapeutic Interventions**
Parent/caregiver demonstrates that he/she is strongly related and/or associated with the child, thus showing compassion for the child by calming, pacifying, and appeasing the child as needed.	• Engage in active listening with each child every day for at least 15 minutes • Establish a relationship with each child's teacher at school • Learn 3 active listening skills during individual sessions with my therapist to be able to utilize in the home with my children (I Statements, Speaker Listener Technique, Reflective listening, parroting) • Identify children's state of distress • Establish a reward-based system, including age appropriate allowances, and review with child daily	• CBT

APPENDIX II: INITIAL FAMILY FUNCTIONING ASSESSMENT

FLORIDA SAFETY DECISION MAKING METHODOLOGY
Information Collection and Family Functioning Assessment

Case Name: Jones, Mary
Worker Name: Henry, Amanda
FSFN Case ID: 123456

Initial Intake Received Date: 1/1/2015
Date Completed: 5/16/xx
Intake/Investigation ID: 456789

I. MALTREATMENT AND NATURE OF MALTREATMENT

What is the extent of the maltreatment? What surrounding circumstances accompany the alleged maltreatment?

Summary of Allegations:

On Jan 30, 2017, the following was reported: "The mother is a "drug addict; she is around the baby while high on drugs." Mom uses "narcotics" in the home. Mom has a warrant for drugs. Mom used "narcotics" during pregnancy. There is a "possibility" of alcohol use in the home. It is unknown if the father uses drugs. The incidents have been ongoing for a year. No other information is known. The home is "unfit" for Star. There is a possibility of drug paraphernalia inside the home. The father is on probation. The grandmother is in poor health. No other information is known. "

Maltreatment: This case involves substance misuse - illicit drugs. Both parents have a substance abuse issue that has been going on for years, that includes injection of methamphetamine and abuse of prescription medications. Fresh track marks were observed on both of Mary's hands/arms. She also provided a UA which yielded positive for cocaine, benzodiazepines, THC (which she denied) and methamphetamine. Mary signed an admission statement admitting to using "cocaine, benzos and meth." The father, Tom Miller, also provided a UA which yielded positive results for cocaine, amphetamines, opiates, THC and methamphetamine. Their substance misuse is pervasive and they have not been able to maintain sobriety despite their family's attempts to get them help. Tom, in addition to abusing illegal substances also drinks excessively-at least 12 cans of beers daily. Both parents provide primary care to Star and reside with the maternal grandmother, Julie. Tom works during the day and Mary is a stay at home mother. Julie helps on occasion but reports not being a primary caregiver. Upon commencement, Star was at her uncle's home and was observed clean and fee of marks/bruises; however, it was learned that when she arrived at the uncle's home, her diaper was badly soiled, she had a foul odor to her and her clothes were really dirty. She also did not have any shoes on. Thus, the uncle had to clean her up and provide clean clothes for her to wear.

Nature of Maltreatment: Mary began using methamphetamine on and off for approximately eight years ago. Mary has had periods of time where she has been sober, with the last time being approximately 3 years ago. Mary began using intravenously at her friend's prompting soon after she and Tom got together. Both Tom's and Mary's drug use is pervasive. Tom and Mary have been using substances since they were in high school and once they began their relationship two years ago, the use of illegal substances escalated. Mary does not provide a reason for her use, other than it makes her feel better about herself and that she has fun with Tom and friends when she is using. Tom, may have some untreated mental health issues per his own disclosure. During CPI's initial visit, on Jan 30th, 2017 several needles and other paraphernalia were found in the home in what appeared to be Mary's belongings. That same day, Tom submitted a UA that rendered positive results for cocaine, amphetamines, opiates, marijuana and methamphetamines after stating that he would only test positive for marijuana.
Tom is known to have anger issues and can be violent at times. During case commencement, CPI was informed that the child had voluntarily been placed in the care of the paternal uncle, James Miller. The father aske the uncle to care for Star because he had reason to believe that he was going to be sent to jail for violation of probation and the mother had taken off and was not able to be located. Tom had provided a power of attorney letter to his brother. It was reported to CPI that Mary had taken Julie's (grandmother) vehicle and fled two days prior to the report being received. Attempts to locate and contact her through Tom were unsuccessful. At one point, contact was established through social media and Mary agreed to return home and speak to CPI but failed to do so. It was later discovered that Mary had been arrested and taken into custody. CPI then met with her at the Land O Lakes county jail and she completed the UA which was positive for multiple substances.

Prior Summary: The mother, Mary has had two previous removals for substance abuse. Her parental rights were terminated for her oldest child who is now an adult. She also had her older son, Jay removed from her care and placed in the custody of the child's biological father. Mary has supervised visitation however does not exercise it. In 2009, there was a case closed with verified findings of substance abuse with mom as caregiver responsible.

Analysis: Star is an active, friendly, vulnerable one-year-old child, who is developing on target and meeting all of his age appropriate milestones; despite the family dynamics in which she lives. She has good motor skills and is starting to walk. She has limited social interaction and does not have any emotional or behaviors issues.

Source: Mary Jones/mother, Tom Miller/father, James Miller/paternal uncle, Julie Jones/maternal grandmother, Dept. priors, CPI observations.

Related Child Functioning Impending Danger Threats: Based on case information specific to the Child Functioning Assessment domain, indicate Yes, Impending Danger exists or No, Impending Danger does not exist.	Impending Danger Threat? Yes	No
Child shows serious emotional symptoms requiring intervention and/or lacks behavioral control and/or exhibits self-destructive behavior that the Parent/Legal Guardian or Caregiver are unwilling or unable to manage to keep the child safe	☐	☒

III. ADULT FUNCTIONING

How does the adult function on a daily basis? Overall life management. Include assessment and analysis of prior child abuse/neglect history, criminal behavior, impulse control, substance use/abuse, violence and domestic violence, mental health; include an assessment of the adult's physical health, emotion and temperament, cognitive ability; intellectual functioning; behavior; ability to communicate; self-control; education; peer and family relations, employment, etc.

Mary Jones: Mary Jones, age 38, was born in Rhode Island and moved to Florida 25 years ago. She was raised by her mother and father. She admits to using drugs since she was a teenager. She states that she has been addicted to opiates since she was 24 years of age. Recently, she has been using whatever she can get her hands on. She completed a UA which yielded positive results for cocaine, benzodiazepines, marijuana and methamphetamine. She has been in a relationship with Tom for two years. She feels that Tom and her mother are her only sources of support. She finished high school and obtained her diploma and wanted to pursue something in the medical field but says she no longer has that option because she is a felon. She says she is not able to maintain employment because of issues with clothing, transportation and housing. She denies any previous mental health diagnosis and is in good health. She has previously been arrested for failure to appear, probation violation, drug possession-control substance without prescription, possession of Hydrocodone and DUI. At the time of the removal, she was currently incarcerated for possession of controlled substances- Alprazolam. Mary's drug addiction continues to escalate and she continues to put her own needs before those of Star. Her substance misuse has led to her not having a relationship with her two other children and she did not make any efforts to see Star when she was at the uncle's residence. Mary has recognized that her substance misuse has taken over her life and that she loves Star very much. She even believed that life could be different with this child but she feels that "life gets in the way" and prevents her from staying sober. Mary had a current warrant for her arrest andwas arrested during this investigation. Her criminal history includes possession of controlled substances, probation violations, burglary, DUI and failure to appear.

Analysis: Mary, by her own admission has clear substance abuse issues. Additionally, there are clear mental health concerns that need to be evaluated, addressed and treated. Candle has expressed feeling that her life is "out of control". Further she states that "life" prevents her from maintaining sobriety. She demonstrates no self-control and lacks self-discipline. She appears to be unable to take responsibility for any of her actions and fails to see the negative impact her behavior has had on her own life and the life of her children.

Tom Miller: Tom is a thirty-five-year-old male who was born and raised in New Port Richey FL. He has a high school diploma. He works in the field of construction as a general contractor performing various tasks. He has been in a relationship with Mary for two years and he has no other children other than Star. He admits to having a long history of alcohol abuse from which he states he has recovered. He submitted a UA that rendered positive results for cocaine, amphetamines, opiates, marijuana and methamphetamine although he continues to deny he has any addiction to substances. Additionally, he acknowledges that he has some mental health issues that need to be evaluated and treated. He has threatened to kill various family members such as his father and his brother on various occasions. Because of such behavior he does not have a close relationship with his family. He sees Mary and her mother, Karen as his only support. Tom has been arrested for disorderly intoxication, resisting arrest, failure to appear, driving while suspended/revoked, and probation violation, burglary with assault/battery, criminal mischief and drug possession-LSD. He also has an out of state history to include an additional DUI. He is reportedly healthy and not currently prescribed any medication although he has been diagnosed bipolar in the past but not receiving treatment. Tom's mother passed away when Tom was younger and it is believed that this may be a reason for his escalating substance misuse. Prior to her death, Tom was receiving mental health treatment but did not continue services after his mother died.
Analysis: Tom is in denial that he even has a drug addiction and his behavior continues to spiral out of control. He has not been able to control his impulses as noted by the variety of substances he is taking. He also has an extensive history of severe anger issues and is expected to be arrested for violating his probation. Throughout the investigation, it was discovered that his mother's death was very hard on him and might potentially be an important factor that may need to be addressed. Tom, loves Star and recognized that she will need a stable environment when he is arrested. He was able to put a plan in place by having his brother care for Star. However, he continues to put his needs for substances before those of Star and has not taken any action regarding addressing his mental health needs.
Sources: Tom/father, Mary/mother, maternal grandmother, paternal uncle and paternal grandfather.

Related Adult Functioning Impending Danger Threats: **Based on case information specific to the Adult Functioning Assessment domain, indicate Yes, Impending Danger exists or No, Impending Danger does not exist.**	**Impending Danger Threat?** **Yes**	**No**
Parent/Legal Guardian or Caregiver is violent, impulsive, cannot or will not control behavior or is acting dangerously in ways that have seriously harmed the child or will likely seriously harm to the child.	☒	☐

IV. PARENTING

General – What are the overall, typical, parenting practices used by the parents/legal guardians? Discipline/Behavior Management – What are

Mary Jones: Mary is the biological mother of Rianna West (adult child), Jay Jones and Star Miller. Due to a long history of substance abuse, both Rianna and Jay have been removed from her custody. Her parental rights were terminated for Rianna and the child was adopted. Jay is in the custody of his father, Jeremy Cole. Mary has supervised visitation which she does not exercise. She states that her children have always been important to her but that "life seems to get the best" of her. She fears that she will also lose custody of Star. She states that she always wanted to be a mother and that she enjoys just cuddling with her and watching movies with her and just playing with her in general. She believes that her mother was a good role model and that despite her support she became involved with drugs because of her friends. She does not believe that using drugs has impacted the way she parents Star. She feels her mother is a big help in parenting Star as well (sometimes she leaves when she is going to use).
Discipline: Due to Star's young age, she really does not discipline. Mary utilized time out and grounding with her older children. She reports that when she was a child she was grounded and sent to her room when disciplined.
Analysis: Mary does not understand the impact that her use of substances has on her children. She disengages and leaves the home many times when she is using. She clearly is not able to control her impulses nor put her children's needs ahead of her own as demonstrated by her drug history, prior removals and unknown whereabouts. She is not currently able to meet her own needs. Star has no routine such as set feeding or naptimes. She clearly feels overwhelmed and "out of control of her own life" which she stated on several occasions during interview.

Tom Miller: Tom is the biological father of Star Miller. He has no other children. He states that he loves being a father and says he wants to "do right by her". He loves spending time with her and enjoys just watching her grow and learn. He believes that Star helps him be a better man. He recognizes that she deserves better but does not recognized that his substance misuse affects his parenting.
Discipline: Tom states that Star is really too little to discipline at this time. He sometimes takes things away from her if she grabs something she is not supposed to, or if she attempts to put things in her mouth that she shouldn't. In the future he wants to be able to use time out, taking toys away, or grounding as discipline and doesn't think he will turn to corporal punishment unless he absolutely has no other option.
Analysis: When Tom is using his parenting he is non-engaged. He does not seem to understand the impact using substances is having on his life or his parenting practices because he can work and provide for his family. He went from alcohol to drugs and even after having positive UA continues to deny that he has any "substance abuse issues". When Star was brought to the uncle's residence, she appeared unattended; with a heavily soiled diaper, unkempt hair and dirty clothes. Tom does not recognize his use of substances had anything to do with how Star is parented. In addition, there are some mental health issues that have been unaddressed.

the disciplinary approaches used by the parents/legal guardians, and under what circumstances?

Related Parenting Impending Danger Threats: **Based on case information specific to the Parenting General and Parent Discipline Assessment domains, indicate Yes, Impending Danger exists or No, Impending Danger does not exist.**	**Impending Danger Threat?** **Yes**	**No**
Parent/Legal Guardian or Caregiver is not meeting child's basic and essential needs for food, clothing, and/or supervision AND the child is/has already been seriously harmed or will likely be seriously harmed.	☐	☒
Parent/Legal Guardian or Caregiver is threatening to seriously harm the child and/or parent/legal guardian or caregiver is fearful he/she will seriously harm the child.	☐	☒
Parent/Legal Guardian or Caregiver views child and/or acts toward the child in extremely negative ways AND such behavior has or will result in serious harm to the child.	☐	☒

V. PARENT/LEGAL GUARDIAN PROTECTIVE CAPACITIES ANALYSIS

If there are more than five Parent/Legal Guardians to assess, complete Appendix A – Parent/Legal Guardian Protective Capacities Analysis

	Capacity Categories and Types																		
Adults	Behavioral						Cognitive							Emotional					
	Controls Impulses	Takes Action	Sets aside own needs for child	Demonstrates adequate skills	Adaptive as a Parent/Legal Guardian	History of Protecting	Is self-aware	Is intellectually able	Recognizes threats	Recognizes child's needs	Understands protective role	Plans and articulates plans for protection	Meets own emotional needs	Is resilient	Is tolerant	Is stable	Expresses love, empathy, sensitivity to the child	Is positively attached with child	Is aligned and supports the child
Mary Jones	N	N	N	N	N	N	Y	Y	N	Y	Y	N	N	Y	Y	N	Y	Y	Y
Tom Miller	N	Y	N	Y	Y	Y	N	Y	N	Y	Y	Y	N	Y	Y	N	Y	Y	Y

Parent/Legal Guardian Protective Capacity Determination Summary:	Yes	No
Protective capacities are sufficient to manage identified threats of danger in relation to child's vulnerability?	☐	☒

VI. CHILD SAFETY DETERMINATION AND SUMMARY

If there are more than five children to assess, complete Appendix B – Child Safety Determination and Summary

Child	Safety Determination
Star Miller	☐ Safe – No impending danger safety threats that meet the safety threshold. ☒ Unsafe
	☐ Safe – No impending danger safety threats that meet the safety threshold. ☐ Unsafe
	☐ Safe – No impending danger safety threats that meet the safety threshold. ☐ Unsafe
	☐ Safe – No impending danger safety threats that meet the safety threshold. ☐ Unsafe

Child Safety Analysis Summary:

Star has spent the last year of her life living with her parents who are addicted to methamphetamine, cocaine and other substances. During this time Star's mother has left and her whereabouts were unknown for periods of time. Her mother was recently incarcerated and the father believes he will be arrested soon as well. When under the influence their actions are focused on their needs rather than those of Star. Both parents are not able and/or willing to put the needs of their child before their own needs and are currently not able to control impulses. Additionally, they are not able to meet their own emotional needs as demonstrated by the unaddressed mental health concerns.

VII. IN-HOME SAFETY ANALYSIS AND PLANNING

	Yes	No
The Parent/Legal Guardians are willing for an in-home safety plan to be developed and implemented and have demonstrated that they will cooperate with all identified safety service providers.	☐	☒
The home environment is calm and consistent enough for an in-home safety plan to be implemented and for safety service providers to be in the home safely.	☒	☐
Safety services are available at a sufficient level and to the degree necessary in order to manage the way in which impending danger is manifested in the home.	☒	☐
An in-home safety plan and the use of in-home safety services can sufficiently manage impending danger without the results of scheduled professional evaluations.	☐	☒
The Parent/Legal Guardians have a physical location in which to implement an in-home safety plan.	☒	☐

If "Yes" to all of SECTION VII. above – Child(ren) will remain in the home with an In-Home Safety Plan

☐ **In-Home Safety Plan**

The child(ren) is/are determined "unsafe," but through in-home safety analysis above, an in-home Impending Danger Safety Plan is executed which allows a child to remain in the home with the use of in-home safety management and services in order to manage the way in which impending danger is manifested in the home while treatment and safety management services can be determined and initiated.

- A safety plan must be implemented, monitored, and actively managed by the Agency.
- The case will be opened for safety management and case management services

If "No" to any of SECTION VII above – Out of Home Safety Plan is the only protective intervention possible for one or more children. Out of Home Safety options should be evaluated from least intrusive (e.g. family-designated arrangements as a task or condition of the Out of Home Safety Plan) to most intrusive (e.g. agency removal and placement).

Given family dynamics and circumstances, also evaluate and determine if In-Home Safety Plan needs judicial oversight to facilitate court accountability. Refer to administrative code and operating manual for guidance.

☒ **Out-of-Home Safety Plan**

- An impending danger safety plan must be implemented, monitored, and actively managed by the Agency.
- The case will be open for safety management, case management, and reunification services

If an Out-of-home Safety Plan is necessary, summarize reason for out of home safety actions and conditions for return. Conditions for return should be related to reasons for removal and behaviorally based. These are parent/legal guardian actions and behaviors that must be demonstrated to sufficiently address the impending danger and allow for the child to safely return home with an In Home Safety Plan and continued safety and case plan services and management.
Currently, Mary Jones is incarcerated and during the investigation she refused to meet with the CPI until after she became incarcerated. Mary was not willing for an in home plan to be implemented. In addition, there were concerning behaviors learned about Tom. He was noted to be violent and threatening to kill family members. So much so, that the grandfather reports keeping a baseball bat by his door in case Tom tries to break in. It is noted that he has unresolved grief due to the death of his mother and also poly substance abuse issue. He also reported having mental health issues that are untreated but it is not clear what he was diagnosed with. Therefore, until a professional evaluation can be completed an in home safety plan cannot be implemented. Conditions for Return: Mary Jones will demonstrate a willingness for an in home safety plan to be developed by ensuring she is consistently available to child welfare professionals and demonstrates cooperative behaviors with her case manager and safety services providers. Tom will have a professional evaluation completed that will provide insight as to his mental health condition and how his substance use impacts his mental health condition. This evaluation needs to include how his mental health and substance abuse may be impacting his behaviors, especially his potential to become violent and threatening.

FLORIDA SAFETY METHODOLGY
Family Functioning Assessment - Ongoing

Case Name: Jones, Mary **FSFN Case ID:** 123456 **Date of Most Recent Safety Plan:**

Worker Name: Rhoads, Ashton

I. HOUSEHOLD COMPOSITION

Child Name	Date of Birth	Primary Goal	Concurrent Goal	Current Placement
Miller, Star	10/01/2015	Reunification with parent(s)		Non-relative Placement

Parent/ Legal Guardian(s)/ Other Adult Household Members in Caregiving Role:	
Name	Date of Birth
Jones, Mary	10/29/1978
Miller, Tom	07/10/1981

Family Support Network	
Name	Role

II. MALTREATMENT AND NATURE OF MALTREATMENT

What is the extent of the maltreatment? What surrounding circumstances accompany the alleged maltreatment?

Summary of Allegations:

On Jan 30, 2017, the following was reported: "The mother is a "drug addict; she is around the baby while high on drugs." Mom uses "narcotics" in the home. Mom has a warrant for drugs. Mom used "narcotics" during pregnancy. There is a "possibility" of alcohol use in the home. It is unknown if the father uses drugs. The incidents have been ongoing for a year. No other information is known. The home is "unfit" for Star. There is a possibility of drug paraphernalia inside the home. The father is on probation. The grandmother is in poor health. No other information is known. "

Maltreatment: This case involves substance misuse - illicit drugs. Both parents have a substance abuse issue that has been going on for years, that includes injection of methamphetamine and abuse of prescription medications. Fresh track marks were observed on both of Mary's hands/arms. She also provided a UA which yielded positive for cocaine, benzodiazepines, THC (which she denied) and methamphetamine. Mary signed an admission statement admitting to using "cocaine, benzos and meth." The father, Tom Miller, also provided a UA which yielded positive results for cocaine, amphetamines, opiates, THC and methamphetamine. Their substance misuse is pervasive and they have not been able to maintain sobriety despite their family's attempts to get them help. Tom, in addition to abusing illegal substances also drinks excessively-at least 12 cans of beers daily. Both parents provide primary care to Star and reside with the maternal grandmother, Julie. Tom works during the day and Mary is a stay at home mother. Julie helps on occasion but reports not being a primary caregiver. Upon commencement, Star was at her uncle's home and was observed clean and free of marks/bruises; however, it was learned that when she arrived at the uncle's home, her diaper was badly soiled, she had a foul odor to her and her clothes were really dirty. She also did not have any shoes on. Thus, the uncle had to clean her up and provide clean clothes for her to wear.
Nature of Maltreatment: Mary began using methamphetamine on and off approximately eight years ago. Mary has had periods of time where she has been sober, with the last time being approximately 3 years ago. Mary began using intravenously at her friend's prompting soon after she and Tom got together. Both Tom's and Mary's drug use is pervasive. Tom and Mary have been using substances since they were in high school and once they began their relationship two years ago, the use of illegal substances escalated.

Mary does not provide a reason for her use, other than it makes her feel better about herself and that she has fun with Tom and friends when she is using. Tom, may have some untreated mental health issues per his own disclosure. During CPI's initial visit, on Jan 30th, 2017 several needles and other paraphernalia were found in the home in what appeared to be Mary's belongings. That same day, Tom submitted a UA that rendered positive results for cocaine, amphetamines, opiates, marijuana and methamphetamines after stating that he would only test positive for marijuana.
Tom is known to have anger issues and can be violent at times. During case commencement, CPI was informed that the child had voluntarily been placed in the care of the paternal uncle, James Miller. The father aske the uncle to care for Star because he had reason to believe that he was going to be sent to jail for violation of probation and the mother had taken off and was not able to be located. Tom had provided a power of attorney letter to his brother. It was reported to CPI that Mary had taken Julie's (grandmother) vehicle and fled two days prior to the report being received. Attempts to locate and contact her through Tom were unsuccessful. At one point, contact was established through social media and Mary agreed to return home and speak to CPI but failed to do so. It was later discovered that Mary had been arrested and taken into custody. CPI then met with her at the Land O Lakes county jail and she completed the UA which was positive for multiple substances.

Prior Summary: The mother, Mary has had two previous removals for substance abuse. Her parental rights were terminated for her oldest child who is now an adult. She also had her older son, Jay removed from her care and placed in the custody of the child's biological father. Mary has supervised visitation however does not exercise it. In 2009, there was a case closed with verified findings of substance abuse with mom as caregiver responsible.

The mother and baby Jay both tested positive at delivery for cocaine. Another case in 2009 was closed not substantiated for substance misuse with mother as caregiver responsible. In 2010, a case was closed with verified findings for substance misuse with mother as caregiver responsible and another case resulted in verified findings of substance abuse and not substantiated findings for inadequate supervision. In 2015, there was a case closed with no indicators of substance misuse and inadequate supervision. Finally, in 2016, a case was closed with not substantiated findings of substance misuse illicit drugs and no indicators of inadequate supervision that pertained to Star and both her parents as alleged perpetrators.
Findings: Verified findings for substance misuse illicit drugs with both caregivers responsible.

Analysis: Mary's and Tom's pervasive substance abuse has resulted in their inability to properly and safely care for Star. Due to their substance use and pending criminal charges, Star had to be cared for by her uncle. Mary lacks insight into the affects her substance has on Star, as well as her own functioning. Tom has demonstrated some ability to recognize that Star will need to be cared for in his absence and arranged for the uncle to be her caregiver while he is in jail but has been unable to recognize how his substance misuse has impacted Star, relationships with his family or his own functioning.

Sources: Police report & Department priors, maternal grandmother, paternal uncle & grandfather, neighbor; and medical professionals.

Additional Ongoing Information:

Related Impending Danger Threats	Impending Danger Threat?	
Based on case information specific to the Extent of Maltreatment and Circumstances Surrounding Maltreatment Assessment domains, indicate Yes, Impending Danger exists or No, Impending Danger does not exist.	**Yes**	**No**
Parent's/Legal Guardian's or Caregiver's intentional and willful act caused serious physical injury to the child, or the parent/legal guardian or caregiver intended to seriously injure the child.	☐	☒
Child has a serious illness or injury (indicative of child abuse) that is unexplained, or the Parent's/Legal Guardian's or Caregiver's explanations are inconsistent with the illness or injury.	☐	☒
The child's physical living conditions are hazardous and a child has already been seriously injured or will likely be seriously injured. The living conditions seriously endanger the child's physical health.	☐	☒

There are reports of serious harm and the child's whereabouts cannot be determined and/or there is a reason to believe that the family is about to flee to avoid agency intervention and/or the family refuses access to the child to assess for serious harm.	☐	☒
Parent/Legal Guardian or Caregiver is not meeting the child's essential medical needs AND the child is has already been seriously harmed or will likely be serious harmed.	☐	☒
Other. Explain:	☐	☒

III. CHILD FUNCTIONING

How does the child function on a daily basis? Include physical health, development; emotion and temperament; intellectual functioning; behavior; ability to communicate; self-control; educational performance; peer relations; behaviors that seem to provoke parent/caregiver reaction/behavior; activities with family and others. Include a description of each child's vulnerability based on threats identified.

Miller, Star

Star is a 16 month old Caucasian female. She attends medical services with Dr. Booth at Children's Medical Center. She was seen on 3/15/17 for her physical examination where she was diagnosed with a double ear infection and prescribed Amoxicillin for 10 days. She was again taken to the doctor's on 3/30/17 where she was again diagnosed with a double ear infection and re-prescribed the Amoxicillin for another 10 days. Star is very prone to ear infections and tubes may be recommended in the future. An ENT referral has not been made by the pediatrician as of the writing of this report. She is too young to require dental services and she is current on immunizations. Star is a very active child. She is independent in the sense that she prefers to do things on her own time and in her own way. She is adjusting very well in the home of her caregivers, who are her paternal uncle and aunt. She especially enjoys the dogs in the home. Star currently is attending day care at the Learning Ladder. Day care staff do not report any concerns with Star's behavior or adjustment. They also do not report any concerns with her development at this time. Since her removal from her parents, she has begun walking and she talks especially well for her age. She is also able to use her fingers to pick up small pieces of food. Star has been described as "difficult to soothe" from time to time. This is likely associated with her ear infections and the fact that she is also teething. A referral for Early Steps is being made to assess if there are any behavioral concerns that are not age-appropriate. Star is also now able to maintain her feeding and bedtime routines regularly.

ANALYSIS:

Star is an active, energetic 16 month old child. She is a vulnerable child due to her age and need for constant care and supervision She is meeting her developmental milestones at this time. She can be difficult to soothe at times but this may be associated to her frequent ear infections and/or that she is teething. While a referral has been made to further assess her behaviors, her caregivers have been able to manage her behaviors and keep her safe. She does not have any unmet medical needs at this time.

Sources: Maternal grandmother, paternal aunt and uncle and medical professionals

Related Child Functioning Impending Danger Threats: **Based on case information specific to the Child Functioning Assessment domain, indicate Yes, Impending Danger exists or No, Impending Danger does not exist.**	**Impending Danger Threat?** **Yes**	**No**
Child shows serious emotional symptoms requiring intervention and/or lacks behavioral control and/or exhibits self-destructive behavior that the Parent/Legal Guardian or Caregiver are unwilling or unable to manage to keep the child safe	☐	☒

IV. ADULT FUNCTIONING

How does the adult function on a daily basis? Overall life management. Include assessment and analysis of prior child abuse/neglect history, criminal behavior, impulse control, substance use/abuse, violence and domestic violence, mental health; include an assessment of the adult's physical health, emotion and temperament, cognitive ability; intellectual functioning; behavior; ability to communicate; self-control; education; peer and family relations, employment, etc.

Jones, Mary

Mary is 38 year old Caucasian, female who was born in Rhode Island and moved to Florida 25 years ago. She was raised by her mother and father. She completed high school and obtained her diploma. She has previously indicated a desire to work in the medical field but indicated this is no longer an option as a result of her felony record. She has previously been arrested for failure to appear, probation violation, drug possession- control substance without prescription, possession of Hydrocodone and DUI. At the time of the removal, she was currently incarcerated for possession of controlled substances- Alprazolam. Mary is in a relationship with the father of her child, Tom Miller. They have been together for approximately two years and they have a positive relationship with no domestic violence. Mary and Tom live together and reside in the home of Mary's mother. Mary reports that her mother is a big support to her but she often feels that her mother parents her like she is a young child still. She feels that her mother and Tom are her only supports. Mary is not currently employed and she has not been employed for some time. She is beginning to recognize that many of these issues (DCF involvement, lack of supports and employment) are directly related to her substance abuse. Mary reports that she has been using substances since she was a teenager and she has been addicted to opiates since she was 24 years old. Mary also had her two other children removed by the Department. Mary has previously participated in services with the methadone clinic which included the time that she was pregnant with Star. A few months after Star was born, she indicated that she felt great and felt that she didn't need the methadone any longer and instead of weaning herself off the methadone, she abruptly quit. As her body detoxed and she became ill which led her to begin using substances from the street. Recently, Mary admits that she has been using whatever she can get her hands on. She completed a drug screen with CPI which yielded positive results for cocaine, benzodiazepines, marijuana and methamphetamine. On 3/27/17 Mary begun the color code system and her color is purple. She has also been participating in services with the FITT program. She successfully completed detox through the Harbor on 3/15/17-3/19/17. She was then admitted into the CRC residential treatment program; however Mary left against the advice of her treatment team soon after arrival. When this decision was discussed with Mary she reported that her PTSD was triggered while at the facility and she felt that she needed to leave the facility as a result. Mary initially denied having any mental health diagnosis but has since indicated that she has anxiety and PTSD. She denies taking any medication at this time and does not report any health concerns at this time.

ANALYSIS:
Mary recognizes that substance misuse has drastically affected her life and feels that her mental health issues has impacted her continued drug use. These issues have severely impacted Mary's ability to be an independent and functioning adult, ability to keep her children safe, maintaining her own housing and securing stable and consistent income. Mary recently left treatment against advice of her treatment team because she felt triggered while there. Mary continues to struggle with self-control and taking action. Although she has indicated a willingness to initiate substance abuse treatment and address her mental health concerns, she appears to be unable to take responsibility for any of her actions and fails to see how her immediate actions drastically impact her future, as well as the life of her child.

Sources: Mary, maternal grandmother, FITT and medical professionals.

Miller, Tom

Tom Miller is a 35 year old Caucasian male. He was born and raised in New Port Richey, FL by both his mother and father. Tom reports having a positive childhood where his parents were good role models for him. Tom received his high school diploma by attending alternative education. Tom has had a difficult time maintaining consistent employment. He reports having work experience in the construction field as a general contractor and has been employed by his father and his father's company on numerous occasions but is often fired for a variety of reasons, including not showing up. Tom is in a relationship with the mother of his only child, Mary. He and Mary have been in a relationship for approximately two years. Tom reports having a positive relationship with Mary. He loves her and feels protective of her. Tom and Mary currently reside with Mary's mother. He believes that this is temporary as they would like to secure their own housing for when the child is returned to their care.

Tom has minimal support outside of Mary and her mother, Julie. This is due to him threatening to kill various family members, such as his father and his brother, on various occasions. Because of such behavior, he does not have a close relationship with his family and is not on speaking terms with many of them. Tom was very close to his mother and she was a big support in his life and so he has taken her passing very hard. Tom, has begun to attend church with Star's uncle as a way to increase positive social interactions but has not yet been able to refrain from drinking alcohol and using substances.
Tom acknowledges that he has some mental health issues that have contributed to his relationship issues with his family as well as triggered his ongoing substance misuse. While he denied any known diagnosis outside of having high blood pressure, it was previously reported by the CPI that Tom also has a previous diagnosis of bipolar disorder which has not been verified. Tom does admit to having a long history of alcohol abuse, from which he states he has recovered. He acknowledges that he has misused other substances since quitting drinking. In fact, he submitted a drug screen that rendered positive results for cocaine, amphetamines, opiates, marijuana and methamphetamine when the case was initiated. He too has been referred to color code and was assigned to the color Purple. Tom also completed detox at the Harbor in March and was enrolled in a sober living facility on later in the month. Like Mary, he chose to leave against advice of his treatment team. Tom is currently enrolled in services through FITT where he was assessed and was open about his substance use. Tom noted that his substance abuse has had a negative effect on his life such as the removal of his child, DUIs, loss of employment and poor finances. Tom has been arrested for disorderly intoxication, resisting arrest, failure to appear, driving while suspended/revoked, probation violation, burglary with assault/battery, criminal mischief and drug possession-LSD. He also has an out of state history to include an additional DUI. He is currently prescribed blood pressure medication, a muscle relaxer to address back pain, and a mood stabilizer.

ANALYSIS:
Tom admits that he struggles both mentally and with his substance abuse issues. He also acknowledges that his behavior continues to be out of control and drastically impacts his relationships with his family and his ability to focus on things that matter such as his work and family; beginning to recognize threats. Tom has been unable to maintain consistent, stable income for long period of time and he has been unable to secure independent housing. Tom feels ready to participate in services in order to regain custody of his daughter. His recent decision to leave the sober living housing against the advice of his entire treatment team demonstrates his lack of impulse control and self-discipline. However, Tom is able to articulate how behaviors like this may negatively impact his family and he is now identifying triggers to his substance misuse but has not taken the needed actions to change his behaviors in order to be protective of Star.

Sources: Tom, Uncle, CPI, police reports, FITT counselors and other medical professionals.

Related Adult Functioning Impending Danger Threats: **Based on case information specific to the Adult Functioning Assessment domain, indicate Yes, Impending Danger exists or No, Impending Danger does not exist**	**Impending Danger Threat?** **Yes**	**No**
Parent/Legal Guardian or Caregiver is violent, impulsive, cannot or will not control behavior or is acting dangerously in ways that have seriously harmed the child or will likely seriously harm to the child.	☒	☐

V. PARENTING

General – What are the overall, typical, parenting practices used by the parents/legal guardians? Discipline/Behavior Management – What are the disciplinary approaches used by the parents/legal guardians, and under what circumstance.

Jones, Mary

Mary is the biological mother three children; Bree (20) Jay (8) and star (1). Due to a long history of substance abuse, both Bree and Jay were previously removed from her custody. Her parental rights were terminated for Bree and the child was adopted by the paternal grandparents. Mary did not have any contact with Bree until she reached adulthood. Jay is in the custody of his father, Jay Calver Sr. Mary has supervised visitation with the child. Mary reports that the father keeps Jay from her but the father reports that Mary does not exercise the supervised visitation. Mary has reported that her children have always been important to her but that "life seems to get the best" of her. She has a relationship with her daughter now after her daughter found her once she turned 18 years old. She does not try to parent her daughter as she understands that this is a new relationship and that she has missed a great deal of her daughter's life. She believes that her past involvement with DCF has caused PTSD and she has been triggered on numerous occasions as a result of this case; however this diagnosis has not yet been confirmed. She fears that she will also lose legal custody of Star. Mary recalls being excited when she learned she was pregnant with Star but regrets that Star was born positive for substances at birth as a result inability to stay sober and kept in the NICU for some time for monitoring. When Star was taken to the uncle's home for caregiving, she was filthy, had dirt inside her diaper and the diaper was soiled and had clearly gone unaddressed for some time. It was also not clear when she was last fed when she arrived at the uncle's house. Now, Mary is attentive during supervised visitations. Mary does a good job of partnering with Tom when they visit Star and she responds to her child's cues adequately. She has consistently attended visitations and reports that she enjoys cuddling with her daughter, watching movies, and playing with her.

Discipline:
Due to Star's young age, she really does not discipline her. She utilized time out and grounding with her older children as being grounded and sent to her room when she was a child was how she was disciplined. Mary admittedly believes that corporal punishment is inappropriate and will never use this on her own children. She reports this being a technique used by her parents as well.

Analysis:
Mary is the biological mother of three children. She has had child welfare involvement with all three children, for one of which she has lost parental rights to and was later adopted. Mary does not fully understand the impact that her lifestyle and substance misuse has on her children. Mary has reported feeling overwhelmed by circumstances in her life and feels her life is out of control. While she was providing care and loves her children, Mary does not demonstrate impulse control nor the ability to put the needs of her child before her own.

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Miller, Tom
Tom is the biological and legal father of Star Miller. He has no other children. He states that he loves being a father and says he wants to "do right by her". He believes that Star helps him be a better man. Star's caregiver reported that when they received the child from the parents before the shelter order was issued, Star was filthy. Tom left most of the parenting duties to Mary and was not attentive. Tom is now very attentive during visitations with Star. He is energetic and playful with her. He responds to her cues appropriately and does not get overwhelmed or frustrated when she becomes difficult to soothe. Tom partners well with Mary, whom he is in a relationship with. He states that he loves spending time with her cuddling, singing, watching movies, and reading books. He enjoys just watching her grow and learn. Discipline: Tom states that Star is really too little to discipline at this time. He states that sometimes he might have to take things away from her if she grabs something she is not supposed to, or if she attempts to put things in her mouth that she shouldn't. He admits that he believes in using corporal punishment as an appropriate means for discipline. However, in speaking with the worker, it is believed that he is open to hearing more appropriate techniques that would be more beneficial. ANALYSIS: Tom loves his daughter but does not yet fully understand the impact of using substances is having on his life and the life of his daughter. Tom does not demonstrate impulse control nor the ability to consistently put the needs of his child before his own. Tom admitted that he did not realize how his or Mary's actions may affect Star's development but took Star over to the uncle's home for caregiving when he thought he may get arrested. Sources: Mary, visitation personnel, Tom, prior depot reports, Uncle, FITT personnel, medical professionals, and the grandmother.

Related Parenting Impending Danger Threats: **Based on case information specific to the Parenting General and Parent Discipline Assessment domains, indicate** **Yes, Impending Danger exists or No, Impending Danger does not exist.**	**Impending Danger Threat?** **Yes** **No**
Parent/Legal Guardian or Caregiver is not meeting child's basic and essential needs for food, clothing, and/or supervision AND the child is/has already been seriously harmed or will likely be seriously harmed.	☐ ☒
Parent/Legal Guardian or Caregiver is threatening to seriously harm the child and/or parent/legal guardian or caregiver is fearful he/she will seriously harm the child.	☐ ☒
Parent/Legal Guardian or Caregiver views child and/or acts toward the child in extremely negative ways AND such behavior has or will result in serious harm to the child.	☐ ☒

VI. REASON FOR ONGOING INVOLVEMENT

Danger Statement (Develop in collaboration with the family)

Mary and Tom have significant substance abuse and unaddressed mental health concerns. Despite the mother's numerous experiences with child welfare, both parents have demonstrated lack of impulse control, putting their own needs before the needs of their child.

VII. FAMILY CHANGE STRATEGY

Family Goal: Describe how the family will be functioning when all children are safe and the family is able to independently meet the needs of their children. (Developed in collaboration with the family.)

Tom and Mary will be sober, residing in their own residence, and able to financially support themselves.

Ideas: Describe ideas parent/legal guardian, worker, child or other network members have for moving toward the Family Goal.

Parents are participating in services with FITT. Tom expresses significant desire to seek employment.

Potential Barriers: Describe things that could get in the way of change from the family's perspective and/or the family team's perspective.

None identified at this time.

VIII. CHILD NEED INDICATORS

Children	Child Needs									
	Emotional/ Trauma	Behavioral (e.g. risk taking behavior, runaway, etc)	Development	Education	Physical Health/ Disability	Family Relationships	Peer/ Adult Relationships	Cultural Identity	Substance Awareness	Life Skills Development
Miller, Star	C	B	B	------	C	B	B	B	B	------

IX. PRIORITY NEEDS

Miller, Star	Rating	Include in Case Plan?
Emotional/Trauma	C	Y
Physical Health/Disability	C	Y

If the parent is meeting the need, describe their actions. If the parent needs support or assistance to meet the needs of the child, the need will be addressed in the Case Plan.

Star has been observed to be difficult to soothe. She will often cry for long period of time for no known reason. Mackenzie has had numerous ear infections and is currently teething. Her behavior may be a result of these ailments or may be a result of trauma. Star's caregivers are following up with her medical provider and the case manager has referred the child for Early Steps for an evaluation.

Further evaluation is needed to further address how to best assist Star.

X. PROTECTIVE CAPACITIES

Adults	Capacity Categories and Types		
	Behavioral	Cognitive	Emotional

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	BEHAVIORAL						COGNITIVE						EMOTIONAL						
	Controls Impulses	Takes Action	Sets aside own needs for child	Demonstrates adequate skills	Adaptive as a Parent/Legal Guardian	History of Protecting	Is self-aware	Is intellectually able	Recognizes threats	Recognizes child's needs	Understands protective role	Plans and articulates plans for protection	Meets own emotional needs	Is resilient	Is tolerant	Is stable	Expresses love, empathy, sensitivity to the child	Is positively attached with child	Is aligned and supports the child
Jones, Mary	D	C	D	B	C	D	B	B	C	B	B	B	D	C	B	C	B	B	B
Miller, Tom	D	C	D	B	B	B	B	B	C	B	B	B	D	B	B	C	A	A	B

XI. PRIORITY NEEDS

Jones, Mary	Rating	Include in Case Plan?
Controls Impulses	D	Y
Sets aside own needs for child	D	Y
History of Protecting	D	Y
Meets own emotional needs	D	Y
Takes Action	C	Y
Adaptive as a Parent/Legal Guardian	C	Y
Recognizes threats	C	Y
Is resilient	C	Y
Is stable	C	Y
Miller, Tom	**Rating**	**Include in Case Plan?**
Controls Impulses	D	Y
Sets aside own needs for child	D	Y
Meets own emotional needs	D	Y
Takes Action	C	Y
Recognizes threats	C	Y
Is stable	C	Y

If a diminished protective capacity will not be addressed in the Case Plan, describe the assessment process to reach this conclusion.

XII. MOTIVATION FOR CHANGE

Adult	Motivation
Jones, Mary	Preparation
Miller, Tom	Preparation

XIII. IN-HOME SAFETY ANALYSIS AND PLANNING (removal home)

The Parent/Legal Guardians are willing for an in-home safety plan to be developed and implemented and have demonstrated that they will cooperate with all identified safety service providers.	No
The home environment is calm and consistent enough for an in-home safety plan to be implemented and for safety service providers to be in the home safely	Yes
Safety services are available at a sufficient level and to the degree necessary in order to manage the way in which impending danger is manifested in the home.	Yes
An in-home safety plan and the use of in-home safety services can sufficiently manage impending danger without the results of scheduled professional evaluations.	No
The Parent/Legal Guardians have a physical location in which to implement an in-home safety plan	Yes

In-Home Safety Plan is determined. Summarize the conditions that have changed since last safety analysis to support reunification with an In-Home Safety Plan.

Out-of-Home Safety Plan is the only protective intervention possible for one or more children (whether family designated arrangement or removal/placement).

Summarize reason for Out-of-Home Safety Plan or Removal/Placement (if applicable), and Conditions for Return. Conditions for return should indicate what must change for an In-Home Safety Plan to be executed which would allow a child to return home with the use of in-home safety services in order to manage the way in which impending danger is manifested in the home while treatment and safety management services are implemented.

Currently, Both Mary and Tom have left their inpatient programs and have not yet demonstrated that they can cooperate with an in home safety plan. In addition, there were concerning behaviors learned about Tom. He was noted to be violent and threatening to kill family members. So much so, that the grandfather reports keeping a baseball bat by his door in case Tom tries to break in. It is noted that he has unresolved grief due to the death of his mother and also poly substance abuse issue. He also reported having mental health issues that are untreated but it is not clear what he was diagnosed with. Therefore, until a professional evaluation can be completed an in home safety plan cannot be implemented.

Conditions for Return:

Mary Jones and Tom Miller will demonstrate a willingness for an in home safety plan to be developed by ensuring they are consistently available to child welfare professionals and demonstrates cooperative behaviors with her case manager, service providers and safety services providers.

Tom will have a professional evaluation completed that will provide insight as to his mental health condition and how his Substance use impacts his mental health condition. This evaluation needs to include how his mental health and substance abuse may be impacting his behaviors, especially his potential to become violent and threatening.

XIV. CURRENT SAFETY PLAN ASSESSMENT FOR SUFFICIENCY

- ☒ Safety plan is sufficient, no need for changes to the plan at this time.
- ☐ Safety plan is not sufficient, not controlling for child safety or no longer applicable; change in safety plan is needed.
- ☐ Safety plan is no longer needed.

APPENDIX IV: FREQUENTLY ASKED QUESTIONS

a. How do I get access to FSFN?
The Department's Security Awareness and Health Insurance Portability and Accountability Act (HIPAA) trainings will need to be completed at http://www.myflfamilies.com/general-information/dcf-training prior to receiving access. Please note, the trainings must have been completed within the last year. Upon completion of the training, the DCF Access Authorization Request Form and Security Agreement form must be completed and signed by you and your supervisor. Indicate both FSFN and Aventail access on the DCF Access Authorization Request Form. These two forms and the certificates for both the Security Awareness and HIPAA training are scanned to your identified regional systems access person. Contact your Managing Entity and local DCF office for details on routing or further assistance.

b. What is the appropriate use of drug testing?
Alcohol and other drug use can impair a parent's judgment and ability to provide the consistent care, supervision, and guidance that children need. Drug testing can refer to the use of various biologic sources such as urine, saliva, sweat, hair, breath, blood and meconium to determine the presence of specific substances and/or their metabolites in an individual's system. Child welfare professionals, which includes CPIs and child welfare case managers utilize drug testing to access if parents are currently and continue to use illegal substances. After case is transferred to a CBC/CMO the frequency of drug testing is typically determined by court order. For substance use disorder providers drug testing may be used as a tool to help assess, monitor progress and support recovery. Specifically, substance use disorder providers may use drug testing to:
   - Monitor use and progress;
   - Provide an opportunity to address denial, inability, or unwillingness to recognize a need for intervention or treatment;
   - Address motivation and stage of change to stop using;
   - Provide collateral measure of accountability for monitoring treatment;
   - Present use or non-use evidence to the courts, child welfare agencies, etc.

   Please refer to your agency's policy on the use of drug testing and ensure there is consistent understanding around the use of drug testing with child welfare professionals, the court system, and parents.

c. As a provider, what is my role in the child welfare safety plan?
The provider's role is to be aware of the safety plan in place for the family, assist the family in being able to maintain the safety plan through skill building and clinical interventions, and provide immediate feedback to CPI/CMO regarding any safety concerns identified by the FIT team.

d. What happens if I get a mental health only client who was referred to FIT?
Under current guidelines, individuals without a substance use diagnosis cannot be served under FIT unless co-occurring addiction issues are identified. Referrals that do not meet FIT criteria are staffed with the CPI/CBC/CMO and recommendations and linkage to appropriate services are made and documented.

e. What can I use incidentals for?
Per, 65E-14.021, the following use of incidentals are approved: "transportation, childcare, housing assistance clothing, educational services, vocational services, medical care, housing

subsidies, pharmaceuticals and other incidentals as approved by the department or Managing Entity." Incidentals should only be used to cover "temporary expenses incurred to facilitate continuing treatment and community stabilization when no other resources are available" and must be "associated with a treatment plan goal."
Prior to utilizing incidentals, the FIT provider explores all other resources with the family, including eligibility for food, cash and medical assistance through the Department of Children and Families Automated Community Connection to Economic Self Sufficiency (ACCESS) program. More information on ACCESS can be found at http://www.myflorida.com/accessflorida/.

f. Am I required to transport clients?
Transportation is often a barrier for many families receiving FIT services. While FIT services should be provided in-home or in the community to address this barrier, the FIT team should also assist in ensuring all other services required for the family's success are accessible. Incidental funds may also be utilized for assistance with transportation if it directly ties to their treatment plan goals and no other resources are available. Please refer to your agency's policy on transportation of clients.

APPENDIX V: TRAINING

In-person trainings can be coordinated through your Regional DCF office. Attending portions of the CPI pre-service training may also be helpful in understanding the Florida Child Welfare Practice Model. Community-Based Care Lead Agencies and Managing Entities can also assist with cross-system training.

FLORIDA'S CENTER FOR CHILD WELFARE

Hosts online references and training videos that can be useful to members of the FIT team.

Caregiver Protective Capacities
http://centervideo.forest.usf.edu/video/summit17/focusandchange/Caregiver%20Protective%20Capacity%20Reference.pdf

FSFN Trainings
FSFN 101 (08/18/2016): http://centervideo.forest.usf.edu/fsfn/fsfn101/start.html
FSFN Basic Functionality for Child Welfare Partners (07/19/2017):
http://centervideo.forest.usf.edu/video/center/fsfnfunction/start.html
Additional FSFN eLearning Modules:
http://centerforchildwelfare.fmhi.usf.edu/fsfnwebtrain.shtml

Plans of Safe Care
http://centervideo.forest.usf.edu/video/center/safecare/start.html
http://centerforchildwelfare.fmhi.usf.edu/kb/subabuse/planofsafecaresustanceaffectedinfants.pdf
Integrating Behavioral Health and The Child Welfare Practice Model: Finding a Common Language:
http://centervideo.forest.usf.edu/familiesfirst2017conf/integratingbh/start.html

NATIONAL CENTER ON SUBSTANCE ABUSE AND CHILD WELFARE (NCSACW)

Tutorial for Substance Use Disorder Treatment Professionals
https://ncsacw.samhsa.gov/tutorials/tutorialDesc.aspx?id=26
Module One: Primer on CW and Dependency Court Systems for Substance Use Disorder Treatment Professionals.
Module Two: Engaging Child Welfare-Involved Families in Treatment
Module Three: Effective Treatment for Child Welfare-Involved Families
Module Four: Special Considerations for Children Whose Parents Have Substance Use Disorders
Module Five: Collaborative Strategies to Effectively Serve Child Welfare Families Affected by Substance Use Disorders

FLORIDA CERTIFICATION BOARD

Register and click Available Courses:
Motivational Interviewing for Behavioral Health Professionals
New Perspectives on Recovery
Creating a Culture of Engagement in Behavioral Health Services
Welcoming Services and Service Coordination for Women with Substance Use and Co-occurring Disorders

APPENDIX VI: EVIDENCE-BASED/EVIDENCE-INFORMED PRACTICES

The following are practices currently used by FIT Programs:

Practices for Substance Use and Mental Health Disorders

Cognitive Behavioral Therapy
Cognitive Processing Therapy
Dialectical Behavior Therapy
Eye Movement Desensitization and Reprocessing Therapy (EMDR)
Motivational Enhancement Therapy (MET)
Family Behavior Therapy
Living in Balance
Motivational Interviewing
Multi-dimensional Family Therapy
Seeking Safety
Trauma-Focused Cognitive Behavioral Therapy

Practices for Parenting/Parent-Child Relationship

Active Parenting
Child Parent Psychotherapy
Circle of Security
Nurturing Parenting Program
Parent Child Interaction Therapy
Parenting Wisely

Practices for Case Management

High Fidelity Wraparound

APPENDIX VIII: FIT MODEL FIDELITY ASSESSMENT TOOL

Family Intensive Treatment Team (FIT) Model
Fidelity Assessment Tool

Introduction

The purpose of the Family Intensive Treatment (FIT) Model fidelity assessment tool is to provide a method for documenting the extent to which the core components of the FIT model are being implemented as intended. The FIT model as described in the guidance document[4] is "*designed to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse."* Assessing fidelity helps to identify and understand implementation and practice strengths, challenges, and need for adaptations to the program model. Establishing fidelity is also essential to evaluating program outcomes and effectiveness. The main elements are organized by the domains of: **Program Staffing; Staff Education and Training; Internal Teaming; Referral; Parent Outreach and Engagement; Assessment; Comprehensive Treatment and Case Management Planning; Substance Use and Mental Health Services; Parenting Intervention Services and Supports; Integration; Multidisciplinary Staffings; Discharge Planning; Quality Assurance; and System-wide Implementation and Collaboration**. FIT by design is an integrated service approach that relies on collaboration and teaming between FIT program leadership and staff, child protective investigations, child welfare case management, community-based care lead agencies, children's behavioral health providers, social service agencies, and other services and supports necessary for a family's successful treatment when parental substance use is present for a child welfare involved family. While FIT providers are the primary entity responsible for establishing and implementing a FIT program that is aligned with the core components of the model, successful implementation requires that all system partners have responsibility for understanding the core components of the FIT model and accountability for implementing reciprocal collaboration and communication practices.

Instructions

The Fidelity Assessment Tool should be completed by a team representing all system partners, including the FIT provider, Managing Entity, Community-Based Care Lead Agency, Case Management Organizations, Child Welfare Investigations, the Department of Children and Families Regional Office and any other significant partner involved in implementation of the FIT program. The assessment tool should be completed at least once every year. When completing the assessment consider FIT families served in the prior year and current system practices. The team completing the assessment should discuss each item to gain consensus on the rating. Justification for each rating should be noted in the comments section. If there are outlier cases with extenuating circumstances that have prevented usual practice these can be documented in the comments section. If consensus cannot be gained for an item rating, make a note in the comments section. It is understood that FIT providers do not have control over adhering to practice standards that require reciprocal collaborative practices by system partners. Findings from the assessment tool should be shared and discussed with leadership from system partners to gain input on identified areas of practice strength and areas of needed improvement. Strategies to improve items rated as a one *(1)* or two *(2)* should be developed jointly to successfully implement the main elements of the model. If agreed upon adaptations are made to the FIT model due to clarification or refinement of best practices, the Fidelity Assessment Tool should be modified to align with these changes.

[4] Florida Department of Children and Families, Office of Substance Abuse and Mental Health Services. (July 2018). Guidance Document 18, Family Intensive Treatment (FIT) Model Guidelines and Requirements, Program Guidance for Managing Entity Contracts.

Name of FIT Organization:		Date of Fidelity Assessment (Month/Year):	
Date of initial FIT Program Implementation (Month/Year):		FIT Program Monthly Capacity of Families Served:	
Geographic Area(s) Served by FIT Program:			
Person(s) Completing Fidelity Assessment:			

Program Staffing	
Rating	
3	The FIT program meets a full staffing pattern to provide services, including a Licensed Program Manager with oversight of services, Master's level Behavioral Health Clinician, Bachelor's level Case Manager, and Certified Recovery Peer Specialist (or working toward certification in first year of employment). Caseloads for the Behavioral Health Clinicians do not exceed 15 clients and caseloads for the Case Manager and Recovery Peer Specialists do not exceed 20 clients.
2	The FIT program has the key roles of a Program Manager, Behavioral Health Clinician, Case Manager and Recovery Peer Specialist; however not all members of the team meet staff credentials and/or caseload maximums are exceeded.
1	The FIT program is missing key roles needed to provide FIT services.

Rating: _____

Comments: _____

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FIT Staff Education and Training	
List evidence-based practice(s) being used by the FIT program:	
List the parenting intervention provided by the FIT team:	
Rating	
3	All FIT program staff and management have completed training in trauma-informed practices and have completed formal training in the evidence-based program being used by the FIT program to treat substance use and mental health challenges. FIT staff providing parenting interventions with enrolled parents are trained in one or more evidence-based parent intervention curriculum. All FIT program staff have participated in child welfare-specific trainings on topics including the Child Welfare Practice Model and Safety Methodology, Child Legal Services, and Florida Safe Families Network.
2	All FIT program staff have received some trainings, but not all essential trainings.
1	All FIT program staff have not received essential training and/or are not formally trained in an evidence-based program.

Rating: _____

Comments: _____

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Internal FIT Teaming	
Rating	
3	The FIT team meets formally at least twice a month to discuss the status of each family and plans for action as needed. There is a process for the FIT team to communicate time-sensitive information with each other as needed to jointly develop plans for action.
2	The FIT team meets to discuss the status of families, but it is not formal or scheduled.
1	The FIT team does not regularly discuss the status of families and communicate time-sensitive information with each other.

Rating: _____

Comments: _____

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Referral to FIT	
Rating	
3	The FIT program has an established referral protocol, including specific referral form for child welfare and single route of entry, a designated email address and point of contact, to receive FIT referrals from child welfare professionals and other referral sources. There is a process for the FIT provider to inform the referral source on the status of the referral and when contact is initiated with referred families. The protocol includes closing the loop with the referral source for referrals that do not meet criteria for the program or in the case that the program is at capacity. This process is established and understood by all referring partners.
2	The referral process contains some elements of the referral protocol but is missing key elements, such as closing the loop with the referral source.
1	There is not an adequate referral process and/or referral sources are not clear on how to make a referral.

Rating: _____

Comments: _____

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Parent Outreach and Engagement	
Rating	
3	The FIT provider immediately contacts eligible parent(s)/guardian(s) referred for FIT services (within two business days) to begin the engagement and enrollment process. The FIT provider utilizes strategies to initiate and maintain parent engagement in FIT services such as in-person visits to the home and/or community setting. The FIT provider notifies the child welfare professional and other referral sources if a parent cannot be engaged in services. The engagement process for hard to reach parents includes involvement from and joint response with the child welfare professional and other referral sources.
2	The FIT provider utilizes some engagement strategies (in-person visits, notification to child welfare) but does not involve child welfare partners to engage hard to reach parents.
1	The FIT provider utilizes minimal to no engagement strategies to enroll parents.

Rating: _____

Comments: _____

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Assessment	
Rating	
3	Child welfare family assessments (Family Functioning Assessment – Initial and Ongoing) completed by child welfare professionals are shared with or available to the FIT provider. The FIT provider completes an addictions/substance use level of care assessment (e.g., ASAM) to determine appropriate level of substance use disorder treatment upon enrollment and substance use and mental health disorder diagnostic codes are documented. A comprehensive bio-psychosocial assessment is completed for each parent as part of the initial assessment process to determine appropriate substance use and mental health services and includes results of an adult functional assessment (e.g., Daily Living Activities-20: Alcohol-Drug), trauma screening/assessment, and caregiver protective capacities.
2	The FIT provider completes required assessments but does not utilize the assessments results or the Family Functioning Assessment in the bio-psychosocial.
1	The FIT provider does not thoroughly assess all areas outlined and integrate results of child welfare and FIT assessments in the bio-psychosocial.

Rating: _____

Comments: _____

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FIT Comprehensive Treatment and Case Management Planning	
Rating	
3	The FIT treatment plan/case management plan is developed with the participation of the family receiving services and child welfare professional. It is reviewed at least monthly with the family to assess progress toward goals and ensure relevance to needs and capacities. The FIT treatment plan/case management plan includes individualized strategies to enhance caregiver protective capacities that are aligned with the child welfare family functioning assessment, helps parents address the child(ren)'s therapeutic, medical, and educational needs, and coordinate clinical services received by the child(ren) with the parents' clinical services, if the child is receiving services. Information from the adult functioning assessment and trauma screening/assessment is incorporated into the FIT treatment/case management plan and the plan identifies how support services will be provided to help meet the parents' goals.
2	The FIT treatment plan/case management plan contains some elements listed, including participation from the family, but does not seek input from the child welfare professional or incorporate all strategies to address the family's overall needs based on results of assessments.
1	The FIT treatment plan/case management plan is not adequate in addressing the family's goals and does not include strategies to address those goals.

Rating: _____

Comments: _____

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FIT Substance Use and Mental Health Services	
Rating	
3	FIT treatment services provided are consistent with the recommendations of the level of care assessment using an evidence-based model to fidelity. Services are provided in in-home or on-site. FIT services are provided to each family by a consistent FIT team including peer support services to promote recovery, skill development, and engagement and retention in treatment, and case management services to address the basic support needs of the family and coordinate the therapeutic aspects of services. Substance use-related support and educational services are provided or referred to when indicated to meet the parent and family's treatment needs.
2	FIT treatment services are evidence-based and provided by a consistent FIT team but are not provided to fidelity or not provided in-home or on-site. Families enrolled in FIT are offered peer support services and case management.
1	FIT treatment services are not evidence-based, provided by a consistent FIT team, or provided in-home or on-site. Families are not offered key elements of FIT treatment services, such as peer support and case management.

Rating: _____

Comments: _____

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Parenting Intervention Services and Supports	
Rating	
3	The parenting intervention services are individualized and aligned with the strengths and needs identified in the child welfare assessment of caregiver protective capacities. Children and other family members are included in treatment with the parent when clinically appropriate to promote child-parenting relationships, parenting skills, and the development of natural supports. The parenting intervention services and supports are provided at times and locations that are accessible to the parent(s).
2	Parenting interventions are provided but not aligned with the caregiver protective capacities and/or are not provided in settings accessible to parents that allow for generalizing the information learned to a natural setting.
1	Parenting interventions are not provided to families enrolled in FIT or are not adequate in addressing the needs of the families.

Rating: _____

Comments: _____

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Integration of FIT, Child Welfare, and Children's Mental Health Related Services	
Rating	
3	The FIT team and child welfare professional communicate at least monthly in the form of emails, phone calls or in-person meetings to discuss and coordinate case activities and the FIT team shares formal monthly updates (written report/summary) concerning changes in caregiver protective capacities and treatment progress. The FIT team and child welfare professional communicate in the event of a critical juncture - any event where a change will take place for the family (e.g., prior to beginning unsupervised visits, prior to reunification, new baby being born, change in residences, relapse, anyone moving into or out of home, emergent services need such as detox or residential). The child welfare professional involves the FIT team in review and modification of the child welfare safety plan. Child welfare informs the FIT team in advance of child welfare permanency staffings, dependency court permanency hearings and judicial reviews for FIT involved families to attend and/or provide status updates. The FIT team engages external services providers for the parents' and child(ren)'s mental health service provider to coordinate services.
2	The FIT team and child welfare professional communicate routinely but there are not formal monthly updates provided by the FIT team. There is not routine communication at critical junctures, or the communication is informal. There is not a process in place for child welfare to inform the FIT team of permanency staffings, hearings and judicial reviews.
1	The FIT team and child welfare care manager do not communicate routinely and updates are not shared between the FIT provider and child welfare.

Rating: _____

Comments: _____

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Multidisciplinary Staffings	
Rating	
3	A multidisciplinary team (MDT) is established for each FIT family that includes the FIT team, child welfare professional(s), parent/guardian(s), and any other relevant parties such as caregiver(s), foster parent(s), mentor(s), teacher(s), primary health provider(s), and other provider(s). MDT staffings including all team members are convened at least monthly to discuss treatment progress, needs and status and develop collaborative strategies to address service and support needs of the family.
2	MDT staffings occur but not routinely and do not engage all team members working with the family.
1	MDT staffings are rare or do not occur.

Rating: _____

Comments: _____

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Discharge Planning	
Rating	
3	An assessment of adult functioning and caregiver protective capacities is completed at discharge from FIT services, except in the case of unplanned discharge and parents are unavailable. A multidisciplinary team (MDT) staffing is held prior to discharge from the FIT program and includes the FIT team, child welfare professional(s), parent/guardian(s), and any other relevant parties such as caregiver(s), foster parent(s), mentor(s), teacher(s), primary health provider(s), and other provider(s). The discharge MDT staffing addresses the family's behavioral health, relapse prevention and recovery service needs such as Alcoholics Anonymous, Narcotics Anonymous, a faith-based group or other recovery supports; the physical health care needs for the parents and children; support services such as housing supports, supportive employment, financial benefits, etc.; and community services such as child care, early intervention programs, therapies, and community-based parenting programs. Prior to discharge the FIT provider makes referrals and ensures linkage for necessary services and supports. A discharge summary is completed summarizing the family's needs and referrals to services and is provided to the family upon discharge. A copy of the discharge summary is provided to the child welfare professional within seven days of discharge.
2	MDT staffings do not occur prior to discharge but discharge recommendations are made with family involvement. The FIT team and child welfare professional discuss the family's status and needs prior to discharge. Needs for continued services are identified and referred and a discharge summary is completed and shared with the child welfare professional.
1	Discharge planning is not completed with the family's input and/or not discussed with the child welfare professional.

Rating: _____

Comments: _____

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Quality Assurance (QA)	
Rating	
3	The FIT provider has QA procedures in place to continually assess the FIT program, including peer review of FIT case files and review of monthly data reports on a regular basis. The QA process includes a method for obtaining feedback from parents and FIT families, FIT staff, and child welfare partners on the quality of FIT services provided on a regularly scheduled basis. The FIT provider regularly reviews QA findings and makes policy and practice adjustments as needed. The FIT provider has a process in place to share QA findings and related program adjustments with system of care partners and stakeholders.
2	There is a QA process in place to ensure requirements of the program are met but feedback from FIT families, staff, and child welfare partners is not solicited. QA findings are not shared with system of care partners and stakeholders.
1	There is not a QA process in place that adequately addresses program improvement.

Rating: _____

Comments: _____

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System-Wide Implementation and Collaboration	
Rating	
3	A system wide planning group/committee meets on a regular basis to discuss and make decisions based on system-wide outcomes, successes, needs, and strategies for families involved in the child welfare, mental health, substance use, and social support service systems. Parent representatives and advocates are members of the system-wide planning group/committee.
2	Outcomes, successes, needs, and strategies for families involved in the child welfare, mental health, substance use, and social support service systems are discussed as part of an agenda at other system-wide meetings. Decisions for program changes based on outcomes or needs are not generally made at these meetings. Parent representatives and advocates are not members of the system-wide planning group/committee.
1	There is no formal discussion/group/committee with system partners to review outcomes, successes, needs, and strategies for families involved in the child welfare, mental health, substance use, and social support service systems.

Rating: _____

Comments: _____

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Areas for Improvement (Scored a "1" or "2"):

☐Program Staffing
☐Staff Education and Training
☐Internal Teaming; Referral
☐Parent Outreach and Engagement
☐Assessment
☐Comprehensive Treatment and Case Management Planning
☐Substance Use and Mental Health Services
☐Parenting Intervention Services and Supports
☐Integration
☐Multidisciplinary Staffings
☐Discharge Planning
☐Quality Assurance
☐System-wide Implementation and Collaboration