Family Intensive Treatment (FIT) Evaluation Report

February 1, 2015

Florida Department of Children and Families

Office of Substance Abuse and Mental Health Services

Mike Carroll
Secretary

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Governor

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I. Introduction

Specific appropriation 372 of the 2014 – 2015 General Appropriations Act (GAA) directs the Department of Children and Families (Department) to:

> From the funds in Specific Appropriation 372, $5,000,000 from the General Revenue Fund is provided to implement the Family Intensive Treatment (FIT) team model that is designed to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse. Treatment shall be available and provided in accordance with the indicated level of care required and providers shall meet program specifications. Funds shall be targeted to select communities with high rates of child abuse cases located in the department's Central, Northeast, Southern, and SunCoast regions.
>
> The department shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives evaluating the effectiveness of FIT teams in meeting treatment goals established by the department by February 1, 2015. The report shall include an analysis of outcome measures and expenditure data from pilot.[1]

This report describes the Family Intensive Treatment (FIT) teams and their status as of December 31, 2014. It provides information about individuals served, the status of FIT program implementation, and expenses. Lastly, the report provides information on the outputs and outcomes achieved by the FIT teams to date.

The limited time-frame that the FIT teams have been operational poses a challenge to the evaluation of their effectiveness. However, based on the information reported from the FIT providers and the Managing Entities (ME), the Department concludes that the eleven FIT teams in the Department's Central, Northeast, Southern, and SunCoast regions have been implemented and are serving families. Additionally, key partners are establishing linkages required to resolve challenges associated with implementing the FIT model as a new practice that is family focused and integrated across the child welfare, behavioral health and judicial systems.

[1] See, http://www.myfloridahouse.gov/Sections/Documents/appropriations.aspx?SessionId=75&Session=2014, site accessed January 5, 2015.

II. Background

In 2014, the Florida Alcohol and Drug Abuse Association (FADAA) proposed to the Florida Legislature the creation of targeted treatment capacity to serve parents with behavioral health conditions who come in contact with the child welfare system. The proposal can be found in its entirety in Appendix A. The proposal was in part a response to the findings of the *Review of Child Fatalities Reported to the Florida Department of Children and Families* (2013), completed by the Casey Family Programs (CFP).[2] Findings by the CFP indicated that the sample of child deaths reviewed in Florida reflected trends commonly identified in studies of child maltreatment deaths, such as parental substance abuse, chronic mental health problems and domestic violence. In the sample reviewed, 90 percent of deceased children were under the age of five. Further findings indicated that the safety assessment completed during investigations did not adequately explore domestic violence, substance abuse and other family dynamics that increase risk to children.

The FADAA proposal also cited an analysis of FY2010-11 Florida Safe Family Network (FSFN) data which demonstrated that 60 percent of parents in verified child maltreatment cases had evidence of a substance use disorder. Nationally, research indicates that children are more likely to experience abuse and neglect when parents abuse alcohol or drugs.[3] Furthermore, once maltreatment is verified, children of parents who abuse alcohol or drugs are more likely to be placed in out-of-home care and stay in care longer than other children.[4] In 2012, the reason for removal of almost 31 percent of children placed in foster care was parental substance use.[5]

FADAA proposed implementation of seven pilots to create FIT teams that provide intensive interventions targeting high-risk families with child welfare involvement due to behavioral health issues. As currently implemented, the FIT Teams have not been evaluated for efficacy. The FIT model approach is different from current standard practice in that it goes beyond initial screenings and referrals for services. An extensive review of the literature identified critical components of treatment and services that show good outcomes for parents with substance use disorders and their children involved with child welfare. The framework for the FIT model was designed to include these critical components, as illustrated by the promising child welfare practices identified by the Child Welfare Information Gateway, which align with the critical components of the FIT teams.[6]

- **Family engagement.** Engagement strategies that help motivate parents to enter and remain in substance abuse services are critical to enhancing treatment outcomes.
- **Routine screening and assessment.** Screening family members for possible substance use disorders with the use of brief, validated, and culturally appropriate tools as a routine part of child welfare investigation and case monitoring. Once a substance use issue has been identified through screening, alcohol and drug treatment providers can conduct more in-depth assessments of its nature and extent, the impact on the child, and recommended treatment.
- **Individualized treatment and case plans.** Matching parents with evidence-based treatment programs and support services that meet their specific needs. Working collaboratively with families, alcohol and drug treatment professionals, and the courts, to develop and coordinate case and treatment plans.

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[2] *See,* http://www.dcf.state.fl.us/newsroom/pressreleases/docs/20131105_NovCaseyReport.pdf, site accessed January 18, 2015.
[3] Dube, S. R., Anda, R. F., Felitti, V. J., Croft, J. B., Edwards, V. J., & Giles, W. H. (2001). Growing up with parental alcohol abuse: Exposure to childhood abuse, neglect, and household dysfunction. *Child Abuse & Neglect, 25*, 1627-1640.
[4] Barth, R., Gibbons, C., & Guo, S. (2006). Substance abuse treatment and the recurrence of maltreatment among caregivers with children living at home: A propensity score analysis. *Journal of Substance Abuse Treatment, 30*(2), 93-104.
[5] National Data Archive on Child Abuse and Neglect. (2012). Adoption and Foster Care Analysis Reporting System. [Data file]. Ithaca, NY: Author.
[6] Child Welfare Information Gateway. (2014). *Parental substance use and the child welfare system.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

- **Support of parents in treatment and recovery.** Support parents in their efforts to build coping and parenting skills, help them pay attention to triggers for substance-using behaviors, and work collaboratively on safety plans to protect children during a potential relapse.
- **Joint planning and case management.** Helps safeguard against parents becoming overwhelmed by multiple and potentially conflicting requirements of different systems.
- **Wraparound and comprehensive community services.** Address multiple service needs of parents and children, including those related to parenting skills, mental health, health, domestic violence, housing, employment, income support, education, and child care.
- **Flexible financing strategies.** Leverage or combine various funding streams to address the needs of substance abuse treatment for families involved in child welfare.

III. Cross-system Collaboration

According to the Child Welfare Information Gateway, insufficient collaboration has historically hindered the ability of child welfare, substance abuse treatment, and family/dependency court systems to support the large percentage of parents who are investigated in child protection cases and require treatment for alcohol or drug dependence.[7]

Parental substance abuse and often times co-occurring mental health needs of parents pose a challenge to child welfare. As a result, systems-level collaboration and service integration strategies have been increasingly implemented nationally to coordinate services from child welfare, treatment, dependency courts, and other service systems for families affected by substance use; which include the following:[8]

- **Family Drug Courts** use judicial system authority and collaborative partnerships to support timely substance abuse treatment for parents, provision of a wide range of services for families, and monitoring of recovery components;
- **Cross-training** of child welfare and substance abuse treatment professionals to build an understanding of each other's systems, legal requirements, goals, approaches, and shared interests;
- **Collocation of substance abuse specialists** in child welfare offices to assess and engage parents, provide services to families, and offer training and consultation services to child welfare workers;
- **Communication and active collaboration across systems** help ensure that parents in need of substance abuse treatment are identified and receive appropriate treatment in a timely manner, while children's intervention needs are also addressed;
- **Cross-system information sharing** related to screening and assessment results, case plans, treatment plans, and progress toward goals, which can support professionals in each system to make informed decisions;
- **Joint planning and case management** to help safeguard against parents becoming overwhelmed by multiple and potentially conflicting requirements of different systems;
- **Wraparound and comprehensive community services** that address multiple service needs of parents and children, including those related to parenting skills, mental health, health, domestic violence, housing, employment, income support, education, and child care;
- **Flexible financing strategies** that leverage or combine various funding streams to address the needs of substance abuse treatment for families involved in child welfare; and
- **Linked data systems** that track progress toward shared system objectives and achievement of desired outcomes while also promoting shared accountability.

The FIT team model incorporates the above elements with the intent to improve practice. As reflected above, effective implementation of the FIT model requires extensive initial and ongoing cross-system planning to identify and overcome challenges posed by the child welfare, behavioral health and judicial systems that interact, but often do not align. Cross-system collaboration to design and implement new referral, case coordination, and on-going monitoring practices is required as a critical first step to the

[7]See, https://www.childwelfare.gov/catalog/publicationlanding/?chno=11-11305&dynTitle=1, site accessed January 15, 2015.
[8]See, https://www.childwelfare.gov/catalog/publicationlanding/?chno=11-11305&dynTitle=1, site accessed January 15, 2015.

implementation of FIT. Major activities to implement FIT in the state are summarized below. Actions taken to implement FIT at the region and local level are summarized in Appendix B.

III.A. STATE LEVEL CROSS-SYSTEM COLLABORATION

- **Implementation of FIT**
  - All nine (9) FIT provider contracts were executed by September 29th, 2014.
  - As of December 31, 2014, 201 of the total 208 individuals served remained in treatment.
- **Statewide Meetings**
  - August 22, 2014 - Participants included the Department, MEs and CBCs. The FIT program design and expectations for performance were reviewed. In addition, the Guidelines for Planning was provided and discussed, to provide a roadmap through the phases of implementation. The Guidelines for Planning can be found in its entirety in Appendix C.
  - October 22, 2014 - A second statewide meeting was held with the Department, MEs, FIT providers and CBCs to discuss and address barriers to implementation and refine the FIT model. Agreement on assessment and screening tools to be used by all FIT providers was finalized.
  - January 22 – 23, 2015 – A third statewide meeting was held to review service and performance data reported to the FIT SharePoint data system. Effective provider practices related to parental engagement, collaboration, parent/child relationships were also on the agenda for review and discussion.
- **Statewide Conference Calls**
  Statewide conference calls were initially held twice a month to monitor and assist with FIT program implementation. They will continue to be held once a month beginning in February. These calls include the Department, FADAA, MEs, FIT providers and CBCs and the purpose is to identify and address barriers to implementation, such as referrals, coordination across systems, and program and performance requirements. These calls are facilitated by the Department's Substance Abuse and Mental Health (SAMH) and child welfare program offices and FADDA.
- **FIT Expanded Data Set**
  A structured decision making process was used to finalize agreement on an expanded FIT data set in October 2015 for required reporting by all FIT providers. The purpose of creating this data set is to measure the FIT process against outcomes.
  - This data set captures comprehensive information about the entire family, including current and previous child welfare involvement, family composition, placement changes for children during FIT services, and services provided to all family members, including the children, regardless of the funding source.
  - These data elements are not accessible in one existing data system; therefore, local key partners identified strategies to gather and share this information in order to provide a common understanding of the families they are jointly serving. The FIT expanded data set can be found in its entirety in Appendix D.
- **FIT SharePoint Data System**
  On December 5, 2014, the Department contracted with CFBHN to provide statewide access to their FIT SharePoint data system and provide training and technical assistance related to data entry. The CFBHN's SharePoint data system captures performance measure data and required reporting elements included in the *Family Intensive Treatment (FIT) Model Guidelines and Requirements*, in addition to the expanded FIT data set.
  - CFBHN provided initial training to MEs and FIT Providers in mid to late December and continues to provide technical assistance to address challenges of using a new data system.

- The Department, MEs and FIT providers have direct and ongoing access to this data system and can run reports related to performance measures, assessments and services provided as well as comprehensive information about individuals and families they serve.
- A detailed review and discussion of data entered into the system to date was held with FIT providers, MEs and FADAA during the statewide meeting on January 22, 2015. The process to ensure data are entered accurately and that users understand how to use the comprehensive data set will continue as a statewide effort.

IV. The Model

The Department developed the *Family Intensive Treatment (FIT) Model Guidelines and Requirements* document to provide guidance to the MEs related to services, program and process requirements, eligibility, performance measures and reporting requirements.[9] This document was based on the proposal submitted by FADDA during the 2014 legislative session and was used by the MEs to set contract expectations for their FIT team providers. The document can be found in its entirety in Appendix E.

IV.A. ELIGIBILITY

In order to be eligible for FIT team services, parents must meet all of the following criteria:

1. Are eligible for publicly funded substance abuse and mental health services pursuant to s. 394.674, F.S.;
2. Have a substance abuse disorder;
3. Have at least one child between the ages of zero (0) and eight (8) years old;
4. Have been referred by a child protective investigator (CPI), dependency case manager, or community-based care (CBC) lead agency;
5. Are either under judicial supervision in dependency court (both in-home and out-of-home), but for out-of-home cases, only those parents with goal of reunification, or have been assessed as unsafe; and
6. Are willing to participate in the FIT Program.

IV.B. PURPOSE AND DESIRED OUTCOMES

The general purpose of the FIT team model is to provide intensive team-based, family-focused, comprehensive services to families with parental substance abuse served by the child welfare system, and more specifically to:

- Provide designated services at the correct level of treatment, and necessary supports to parents and family members in the child welfare system with substance use disorders;
- Concentrate on the family as a focus for treatment; and
- Integrate the following services and treatments:
  - Treatment for substance use disorders;
  - Parenting interventions, including those that address parental capacity and the child and parent relationship for children infancy to age eight; and
  - Coordination of all services received by all family members regardless of the funding source.

The desired outcomes of the FIT team model include the following:

1. Decrease parental substance use;
2. Increase children's safety and reduce risks;
3. Increase parental protective capacity; and
4. Reduce rates of re-abuse and neglect of children with parents with a substance use disorder.

[9] See, http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities/2014-contracts-docs, site accessed January 3, 2015.

IV.C. CRITICAL COMPONENTS

The FIT team model includes the following critical components, as outlined in the *Family Intensive Treatment (FIT) Model Guidelines and Requirements* document and included in the FIT provider contracts.

- Linkages with CPIs;
- Linkages with CBC Lead Agencies;
- Immediate access to the appropriate level of treatment;
- Comprehensive assessment to address:
  - Addiction and comorbidity; [10]
  - Parenting capacity;[11]
  - Functional assessment;[12] and
  - Adverse childhood experiences[13]
- Comprehensive treatment planning;
- Treatment for addiction and co-occurring mental health, when needed;
- Parenting interventions;
- Care coordination and integration of family services;
- Peer supports for access to recovery and community and natural supports;
- Multi-disciplinary team approach in all aspects of care;
- Access to support services through incidental funds; and
- Strategic transitions at the time of child welfare closure.

IV.D. TREATMENT PROCESS

The MEs, FIT team providers, CBCs, and the Department developed protocols for the FIT treatment process based on local needs, as directed by the *Family Intensive Treatment (FIT) Model Guidelines and Requirements.* The treatment process is summarized below, as reported by the MEs and FIT providers.

IV.D.(1) Referrals

Referrals for FIT services are made by the CPI, the dependency case manager or CBC lead agency, and the dependency court. These key partners are implementing new referral processes that coordinate efforts across agencies and encourage parental engagement in treatment at the critical point of referral. However, locating and engaging parents referred to FIT has posed challenges to the initiation of an initial assessment within five days of the referral and the initiation of treatment services within forty-eight (48) hours of the completion of the assessment, which are current performance measures.

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[10] The National Institute on Drug Abuse defines comorbidity as two or more disorders or illnesses occurring in the same person. They can occur at the same time or one after the other. Comorbidity also implies interactions between the illnesses that can worsen the course of both. See, http://www.drugabuse.gov/publications/drugfacts/comorbidity-addiction-other-mental-disorders, site accessed January 3, 2015.

[11] The North East of Scotland Child Protection Committee defines parenting capacity as "the ability of parents or caregivers to ensure that the child's developmental needs are being appropriately and adequately responded to, and to [be able to] adapt to [the child's] changing needs over time. http://www.childprotectionpartnership.org.uk/nmsruntime/saveasdialog.asp?lID=433&sID=320,site accessed January 3, 2015.

[12] By determining a client's specific level of functioning across all major biopsychosocial domains and an overall level of functioning, specific symptom and functional deficit profiles emerge that can then be used for more effective treatment planning. See, http://www.psychosocial.com/dualdx/lof.html, site accessed January 3, 2015.

[13] The Substance Abuse and Mental Health Administration (SAMHSA) states: Adverse childhood experiences (ACEs) are stressful or traumatic experiences, including abuse, neglect and a range of household dysfunction such as witnessing domestic violence, or growing up with substance abuse, mental illness, parental discord, or crime in the home. See, http://captus.samhsa.gov/prevention-practice/targeted-prevention/adverse-childhood-experiences/1, site accessed January 3, 2015.

Difficulties in locating and engaging parents referred to FIT within these time-frames and strategies to address them were discussed at length during the statewide meeting on January 22. As a result of lessons learned, adjustments to current practice and related performance measures will be made to set reasonable time-frames for the referral and assessment processes that align with best practice for timely engagement in treatment services. Initiation of contact within two (2) business days will be required, in addition to documentation of efforts made.

The FIT referral process varies by location based on local needs and includes the following elements, as reported by the FIT providers and MEs:

- Timely staffing of referrals with the Department, CBC, CPI and/or supervisor;
- Ongoing coordination between the referral source and the FIT provider to address barriers in contacting or engaging parents referred for FIT;
- Co-location of the FIT team and the Department;
- Assignment of an ME point person, such as the Child Welfare Integration Coordinator;
- Use of Motivational Interviewing (MI)[14] and Supportive Therapy[15] to engage a parent(s) in treatment;
- Providing families with a flyer that outlines the benefits of participation in the FIT program; and
- An initial joint meeting with the parent(s), FIT provider and CPI or CBC case manager.

IV.D.(2) Assessment

The FIT provider initiates initial assessments within forty-eight (48) hours from the time of referral, to include participation from the parent(s). The FIT providers have initiated contact within 2 business days; however, they have found that location and engagement takes additional time. Assessments to address parental behavioral health, parenting capacity associated with the behavioral health disorder, and the impact of the behavioral health disorder on family functioning are completed within five (5) days from the time of referral.

The Department, FADAA, MEs, and FIT providers used a collaborative decision making process to select the required assessment tools listed below. FIT providers began implementation of the required assessment tools, to include training staff, in October 2014. A detailed description of the screening and assessment tools can be found in Appendix F.

1. **Functional Assessment of Mental Health and Addiction (FAMHA)** [16]
   A 44-item scale documents functional deficits across domains; designed for clinicians as both an indicator of current individual level of functioning for diagnostic assessment, treatment planning and measure of change.

2. **Addiction Severity Index (ASI)** [17]
   Addresses seven potential problem areas; used by clinicians to diagnose substance use disorders, determine level of care, and inform treatment.

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[14] MI is a client-centered style of counseling with the goal of eliciting behavior change by helping individuals explore and resolve ambivalence. See, http://www.nrepp.samhsa.gov/MotivationalInterviewing.aspx, site accessed January 3, 2015.
[15] Supportive psychotherapy is used primarily to reinforce a patient's ability to cope with stressors through a number of key activities, including attentively listening and encouraging expression of thoughts and feelings; assisting the individual to gain a greater understanding of their situation and alternatives; helping to buttress the individual's self-esteem and resilience; and working to instill a sense of hope. See, http://www.caps.utoronto.ca/Services-Offered/Individual-Psychotherapy/Supportive-Psychotherapy.htm, site accessed January 10, 2015.
[16] See, http://www.psychosocial.com/dualdx/lof.html, site accessed January 3, 2015.
[17] See, http://www.psychiatry.yale.edu/pdc/resources/678_175045_ASI.pdf, site accessed January 3, 2015.

3. **American Society of Addiction Medicine (ASAM)** [18]
   Provides placement criteria for adolescents and adults to create comprehensive and individualized treatment plans.

4. **Adult and Adolescent Parenting Inventory (AAPI) – 2**[19]
   Designed to assess the parenting and child rearing attitudes of parents. Responses to the inventory provide an index of risk for practicing behaviors known to be attributable to child abuse and neglect.

5. **Adverse Childhood Experience (ACE) Questionnaire**[20]
   Provides a score based on exposure to trauma; the higher the score, the greater the risk for negative consequences as identified in the ACE study. [21]

In addition to the required assessments and screening tools, some FIT providers reported using the additional tools listed below:

1. **University of Rhode Island Change Assessment Scale (URICA)** [22]
   A self-report measure used to assess an individual's readiness to change when entering addiction treatment and can be used to guide treatment options
2. **Biopsychosocial Assessment**
   A multidisciplinary approach to assessment that includes exploration of relevant biological, psychological, social, cultural, and environmental variables for the purpose of evaluating how such variables may have contributed to the development and maintenance of a presenting problem.

IV.D.(3) Treatment Planning

A good treatment plan is a comprehensive set of tools and strategies that address the client's identifiable strengths as well as her or his problems and deficits. It presents an approach for sequencing resources and activities, and identifies benchmarks of progress to guide evaluation. [23]

Through a treatment planning process, FIT providers develop a comprehensive treatment plan for each family within 30 days of completing the assessment process to guide the provision of FIT services. Treatment plans must meet the following criteria:

- Be developed with the participation of the family receiving services;
- Specify the specific FIT services and supports to be provided under the treatment plan;
- Specify measureable treatment goals and target dates for the FIT services and supports; and
- Be reviewed, revised or updated every three months, or more frequently as needed to address changes in circumstances impacting treatment, with the participation of the parent(s) receiving services.

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[18] See, http://www.asam.org/, site accessed January 3, 2015.
[19] See, https://www.assessingparenting.com/assessment/aapi, site accessed January 3, 2015.
[20] See, http://www.acestudy.org/ace_score, site accessed January 3, 2015.
[21] See, http://www.cdc.gov/violenceprevention/acestudy/, site accessed January 3, 2015.
[22] See, http://alcoholrehab.com/drug-addiction-treatment/university-of-rhode-island-change-assessment-scale-urica/, site accessed January 6, 2015.
[23] See, Center for Substance Abuse Treatment. *Practical Approaches in the Treatment of Women who Abuse Alcohol and Other Drugs.* DHHS Publication No. (SMA) 94-3006. Rockville, MD: Substance Abuse and Mental Health Services Administration

IV.D.(4) Treatment Services and Supports Provided

The FIT model is a family-based treatment approach that integrates parenting interventions, treatment services, and supports for all family members, regardless of the payer and requires close coordination with CPIs and dependency case managers. Treatment services are provided at the level of care recommended by a standardized assessment tool, such as the ASAM and provide for immediate access to substance abuse treatment within 48 hours from the time of initial assessment, if needed. Services and supports provided include the following;

1. **Peer support**
   A peer mentor is available 24 hours per day, seven days per week for crisis intervention/support, referrals, and therapeutic mentoring.
2. **Substance abuse and Co-occurring Treatment Services**
   Both substance use disorders and mental health needs are addressed through an array of services, to include, but not limited to: intensive in-home treatment; counseling and related therapeutic interventions in individual, group or family settings; and crisis stabilization and detoxification services.
3. **Psycho-education**
   Therapeutic and educational interventions may be provided to enhance competency in any the following areas:
   - Parenting skills;
   - Family education and family support network development;
   - Behavior management; and
   - Relapse prevention skill development.
4. **Specialized Care Coordination**
   The specialized care coordinator works with a multi-disciplinary team to promote access to and coordinate a variety of services and supports, including but not limited to:
   - Behavioral health;
   - Domestic violence services;
   - Medical and dental health care;
   - Basic needs such as housing, food, and transportation;
   - Educational and training services;
   - Employment and vocational services;
   - Legal services; and
   - Other therapeutic components of the family's treatment, services, or supports as needed.
5. **Incidental Funds**
   Funds are used to purchase supports for the purpose of removing barriers to treatment and to support the family's recovery or reunification goals. Examples of items purchased include transportation, child care, housing, medical services, and medications.

IV.D.(5) Evidenced-Based Practices

FIT providers are required to be trained in using an evidenced-based practice[24] determined to be effective with families served by the child welfare system. FIT providers worked with their community partners to identify evidenced-based practices that would benefit the target population and reported using one or more that address trauma, recovery, parenting, behavior change, and the learning of new skills. A list of these evidenced-based approaches and a description of each can be found in Appendix G.

[24]EBP is the integration of clinical expertise, patient values, and the best research evidence into the decision making process for patient care. See, http://guides.mclibrary.duke.edu/c.php?g=158201&p=1036021, site accessed January 15, 2015.

IV.D.(6) Discharge

As part of the discharge planning process, the FIT provider holds a multidisciplinary team (MDT) meeting no later than seven days prior to the family's discharge from services, to include participation of the parent(s). The purpose of the MDT is to ensure the family is receiving adequate behavioral health services that address the behavioral health condition and promote relapse prevention and recovery.

In addition to holding an MDT, the FIT provider completes a discharge summary within seven days prior to discharge containing, at minimum the following components:

1. The reason for the discharge;
2. A summary of FIT services and supports provided to the family;
3. A summary of resource linkages or referrals made to other services or supports on behalf of the family; and
4. A summary of each family member's progress toward each treatment goal in the treatment plan.

Research shows that most people with a substance use disorder need at least three months in treatment to reduce or stop their drug use and that longer treatment times result in better outcomes. Recovery from drug addiction is a long-term process that often requires several episodes of treatment and ongoing support from family or community. [25]

The expected length of treatment in FIT ranges from at least (4) months to nine (9) months. The goal of FIT is to provide treatment to families until the time of family reunification and/or child welfare case closure

[25] See, http://www.drugabuse.gov/publications/seeking-drug-abuse-treatment/4-duration-treatment-sufficient, site accessed January 15, 2015.

V. FIT Funding

V.A. FUNDING METHODOLOGY

As directed by Specific appropriation 372 of the FY2014–15 GAA, the Department identified communities in the Central, Northeast, Southern, and SunCoast regions with high rates of child abuse, and specifically those with parental substance abuse.

The Department used the *Verified Most Serious Finding Report (Per Capita Fiscal Year 2013-2014)* to identify areas with high rates of abuse reports with verified findings. Substance Misuse-Verified abuse report data (unduplicated client count by community from July 1, 2013, to February 28, 2014) were used to determine the percentage of funds allocated to each area. Both of these data reports were run from the Florida Safe Families Network (FSFN). Funds were allocated to the targeted regions, based on the percentage of verified reports, as shown in Table 1 below.

Table 1. Allocation Methodology for FIT Funds

County	Number of Verified Substance Misuse Reports	Percentage of Reports	Funds Allocated
Alachua	556	0.0783209	$391,604
Volusia	971	0.1367798	$683,899
Northeast Region			**$1,075,503**
Citrus	285	0.0401465	$200,732
Hernando	418	0.0588815	$294,408
Orange	713	0.1004367	$502,183
Polk	531	0.0747993	$373,996
Central Region			**$1,371,319**
Pasco	1483	0.2089027	$1,044,513
Charlotte	333	0.046908	$234,540
Lee	910	0.1281871	$640,935
SunCoast Region			**$1,919,989**
Miami-Dade	687	0.0967742	$483,871
Monroe	212	0.0298634	$149,317
Southern Region			**$633,188**
Total			**$4,999,998**

V.B. ALLOCATION OF FUNDS

The FIT appropriation was included in the FY2014 –15 budgets of the MEs in the Department's Central, Northeast, Southern, and SunCoast regions, as shown in Table 2 below. Lutheran Services Florida, Central Florida Cares Health Systems, Central Florida Behavioral Health Network, and South Florida Behavioral Health Network consequently executed fixed price contracts with their FIT providers. Three of the four MEs pay their contracted FIT providers in monthly installments, which are calculated by dividing the number of months in the contract by the total amount of the contract. The fourth ME pays their provider $10,000 per family per year; however, the provider may exceed the $10,000 to address the needs of the family. Payments to the FIT providers cover all program expenses such as treatment services and supports, salaries and benefits for staff members, indirect costs and incidental funds. All four MEs monitor actual expenses on a monthly or quarterly basis.

Table 2. Allocation of FIT Funds to MEs and Providers

Managing Entity	DCF Region	County	FIT Provider	Allocation
Lutheran Services Florida	Northeast	Volusia	Stewart-Marchman-Act Behavioral Healthcare	$ 683,899
	Northeast	Alachua	Meridian Behavioral Healthcare	$ 391,604
	Central	Citrus	The Centers	$ 200,732
	Central	Hernando	BayCare	$ 294,408
				$1,570,643
Central Florida Cares Health System	Central	Orange	Aspire Health Partners	$ 502,183
				$ 502,183
Central Florida Behavioral Health Network	Central	Polk	Peace River Center	$ 373,996
	SunCoast	Pasco	BayCare	$1,044,513
	SunCoast	Charlotte	Charlotte Behavioral Health Care	$ 234,540
	SunCoast	Lee	SalusCare	$ 640,935
				$2,293,984
South Florida Behavioral Health Network	Southern	Miami-Dade	The Village South via Guidance/Care-Center	$ 483,871
	Southern	Monroe	Guidance/Care-Center	$ 149,317
				$ 633,188
			Total	**$4,999,998**

V.C. EXPENSES

As requested by the Department, Central Florida Behavioral Health Network, Central Florida Cares Health Systems, Lutheran Services Florida and South Florida Behavioral Health Network reported expenses from July 1, 2014, through November 30, 2014, by category as shown in Table 3 below.

Table 3. FIT Provider Expenses

Provider	Salary / Benefits	Purchased Services	Incidentals	Contractual	Supplies	Training	Office Space / Equipment	Employee Expense	Admin./ Indirect	TOTAL
Aspire Health Partners	$25,290	$0	$95	$1,233	$266	$327	$1,157	$0	$9,282	$37,650
Central Florida Cares Health System										**$ 37,650**
Peace River Center	$46,505	$0	$272	$35,870	$676	215	$1,271	$1,627	$10,496	$96,932
BayCare (SC)	$46,872	$42,769	$99	$0	$771	0	$8,129	$1,040	$13,032	$112,712
Charlotte BHC	$40,308	$0	$25	$19,354	$409	1,312	$3,207	$1,025	$1,761	$67,401
SalusCare	$42,217	$0	$6,082	$0	$840	0	$4,810	$970	$14,642	$69,561
Central Florida Behavioral Health Network										**$346,606**
Guidance / Care Center	$39,930	$6,007	$0	$82,348	$2,215	7,100	$13,758	$5,785	$15,714	$172,857
South Florida Behavioral Health Network										**$172,857**
BayCare (Central)	$28,246	$4,030	$0	$0	$0	$0	$3,391	$849	$7,439	$43,956
Meridian	$86,809	$3,883	$53	$0	$456	$23	$25,466	$2,938	$0	$119,628
SMABH	$73,503	$54,219	$1,952	$0	$417	$0	$5,033	$3,302	$31,998	$170,424
The Centers	$41,234	$0	$0	$0	$325	$15	$4,885	$500	$12,842	$59,801
Lutheran Services Florida										**$393,809**
TOTAL	**$470,914**	**$110,909**	**$8,578**	**$138,805**	**$6,375**	**$8,992**	**$71,107**	**$18,036**	**$117,206**	**$950,922**

- The category of Supplies includes what was labeled “computer supplies” and “cell phones.”
- The category of Employee Expense includes what was labeled “mileage” and “travel.”
- The category of Contractual includes subcontracted services and Purchased Services includes those purchased with FIT funds, such as residential treatment and case management services.

Table 4 shows statewide expenditures by ME, Department region, county and FIT provider.

Table 4: Statewide Expenses

Managing Entity	DCF Region	County	FIT Provider	Expenses
Lutheran Services Florida	Northeast	Volusia	Stewart-Marchman-Act Behavioral Healthcare	$170,424
	Northeast	Alachua	Meridian Behavioral Healthcare	$119,628
	Central	Citrus	The Centers	$ 59,801
	Central	Hernando	BayCare	$ 43,956
				$375,911
Central Florida Cares Health System	Central	Orange	Aspire Health Partners	$ 37,650
				$37,650
Central Florida Behavioral Health Network	Central	Polk	Peace River Center	$ 96,932
	SunCoast	Pasco	BayCare	$112,712
	SunCoast	Charlotte	Charlotte Behavioral Health Care	$ 67,401
	SunCoast	Lee	SalusCare	$ 69,561
				$346,606
South Florida Behavioral Health Network	Southern	Miami-Dade	The Village South via Guidance/Care-Center	$172,857
	Southern	Monroe	Guidance Care-Center	
				$172,857
			Total	**$950,922**

VI. FIT Providers

The MEs in the Department's Central, Northeast, Southern, and SunCoast regions selected FIT providers with demonstrated ability to provide a continuum of care and experience working with families served by child welfare. Delays in contract execution and initiation of services for some providers is due to start-up activities, such as obtaining a location, hiring and training staff, and the establishment of referral protocols to identify and refer parents eligible for FIT.

VI.A. ASPIRE HEALTH PARTNERS

Aspire Health Partners merged the following three Central Florida companies:

- Lakeside Behavioral Healthcare,
- Seminole Behavioral Healthcare, and
- The Center for Drug-Free Living.

As one comprehensive, behavioral healthcare organization Aspire is able to provide a full continuum of services for persons with mental health, substance use and co-occurring disorders. In Orange County immediate services are available through the Access Center providing intake screening services for individuals seeking care for themselves or a family member. Emergency and crisis services are available 24-hours a day, 7-days a week. Other services include detoxification, crisis stabilization, inpatient services and outpatient treatment.

1. The FIT catchment area includes Orange County. Six (6) zip codes were added in Orange County in December to include communities with high rates of substance abuse and to expand the referral base.
2. The ME contract amendment for FIT was executed on September 26, 2014. Referrals began on November 3, 2014.
3. As of December 31, 2014, a total of seven individuals have received FIT services.

VI.B. BAYCARE (CENTRAL AND SUNCOAST REGIONS)

BayCare offers a wide range of programs and services to meet the healthcare needs of individuals and communities throughout Florida. BayCare operates throughout the Tampa Bay area including eleven not-for-profit hospitals, in addition to more than 200 facilities that offer a range of physical and behavioral health care services. BayCare provides services for behavioral health problems in children, adolescents and adults of all ages. Serving the community for more than three decades, BayCare has been providing health care services including detoxification, psychiatric crisis facilities, residential treatment, and outpatient treatment for persons with mental and or substance use disorders.

1. The FIT catchment area for BayCare in the Central region includes Hernando County. BayCare in the SunCoast Region includes Pasco County.
2. BayCare/SunCoast Region: ME contract amendment for FIT was executed on August 29, 2014, and referrals began in September 1, 2014. As of December 31, 2014, a total of 46 individuals have received FIT services.
3. BayCare Central Region: ME contract amendment for FIT was executed on September 16, 2014, and referrals began on September 22, 2014. As of December 31, 2014, a total 12 individuals have received FIT services.

VI.C. THE CENTERS

The Centers provides children and adults with inpatient, residential, and outpatient mental health and substance abuse care. The Centers is a private, non-profit organization serving Citrus and Marion Counties since 1972. The Centers operates a fifty-seven-bed acute care facility for child and adult crisis stabilization, a fifty-bed adult residential substance abuse treatment program, a fifteen-bed adolescent residential substance abuse treatment program, a drop-in center and model clubhouse for persons with mental illness, a pre-arrest diversion program, and an extensive array of outpatient mental health and substance abuse services. The Centers serves nearly 13,000 people each year.

1. The FIT catchment area includes Citrus County.
2. The ME contract amendment for FIT was executed on September 26, 2014. Referrals began on November 3, 2014.
3. As of December 31, 2014, a total of ten individuals have received FIT services.

VI.D. CHARLOTTE BEHAVIORAL HEALTH CARE

Charlotte Community Mental Health Services began offering services in June 1969 to provide free or low cost mental health services to the residents of Charlotte County. In 2006, Charlotte Community Mental Health Services changed its name to Charlotte Behavioral Health Care to better reflect the additional programs and services it offers to the community. Today with staffing of over 200 professionals, the agency provides an array of services to persons with mental health and substance use disorders. Services include crisis services, detoxification, residential treatment, and outpatient treatment.

1. The FIT catchment area includes Charlotte County.
2. The ME contract amendment for FIT was executed on September 29, 2014. Referrals began on September 1, 2014.
3. As of December 31, 2014, a total of nine individuals have received FIT services.

VI.E. MERIDIAN BEHAVIORAL HEALTHCARE

Meridian, a private, non-profit organization, began in the 1960's to bring education about mental illnesses and substance use disorders and treatment for those affected to the local level. Meridian provides an array of services including crisis management, residential treatment and outpatient for persons with mental health and substance use disorders including children and adults. Last year services were provided to over 20,000 persons with mild to severe disorders.

1. The FIT catchment area includes Alachua County.
2. The ME contract amendment for FIT was executed on September 19, 2014. Referrals began on September 24, 2014.
3. As of December 31, 2014, a total ten of individuals have received FIT services.

VI.F. PEACE RIVER CENTER

Peace River Center (PRC) is a private, not-for-profit, community mental health organization providing a full range of behavioral health services including substance abuse treatment, crisis

services as well as domestic and sexual violence services in Polk, Hardee, and Highlands Counties. PRC is one of the oldest and largest mental health centers in the State of Florida, having been in operation for over 62 years. Last year the company provided services to over 11,000 individuals. The array of services include: outpatient treatment, residential treatment, Florida Assertive Community Treatment, crisis services, recovery services, psychosocial rehabilitation, Community Action Treatment and school based services.

1. The FIT catchment area includes Polk County.
2. The ME contract amendment for FIT was executed on August 29, 2014. Referrals began on September 1, 2014.
3. As of December 31, 2014, a total of 22 individuals have received FIT services.

VI.G. SALUSCARE

SalusCare, Inc. is the largest comprehensive provider in Southwest Florida for individuals with mental health and substance use issues. SalusCare was incorporated in 2013 after longtime Southwest Florida healthcare providers, Lee Mental Health and Southwest Florida Addiction Services, merged into one new not-for-profit behavioral healthcare organization. Today, SalusCare employs nearly 450 people who provide services to more than 18,000 people each year. SalusCare provides services for children and adults by utilizing one system of behavioral healthcare from multiple locations. Services include outpatient, residential, emergency/crisis services, prevention programming, and community-based services to help individuals living at home. SalusCare has a long-history of working with individuals and families from the child welfare system.

1. The FIT catchment area includes Lee County.
2. The ME contract amendment for FIT was executed on August 28, 2014. Referrals began on September 1, 2014.
3. As of December 31, 2014, a total of 33 of individuals have received FIT services.

VI.H. STEWART-MARCHMAN-ACT BEHAVIORAL HEALTHCARE

Stewart Marchman Act (SMA) has been in operations for over 50 years. SMA provides behavioral healthcare in Flagler, Putnam, St. Johns, and Volusia counties and offers a full range of services for adults and children with mental health and substance use disorders. The range of services includes crisis, residential, outpatient, outreach, and prevention.

1. The FIT catchment area includes Volusia County.
2. The ME contract amendment for FIT was executed on August 21, 2014.
3. As of December 31, 2014, a total 42 of individuals have received FIT services.

VI.I. WESTCARE (VILLAGE SOUTH IN MIAMI-DADE AND THE GUIDANCE / CARE - CENTER IN MONROE)

WestCare is a national network of local organizations having 40 years of experience providing health and human services to individuals and families. WestCare currently operates in 17 U.S.

states, the U.S. Virgin Islands. The Florida WestCare locations include Village South in Miami and the Guidance/Care Center (GCC), Inc. in the Florida Keys.

The Village South, Inc. is a 501(c)(3) private, not-for-profit agency founded in 1973, licensed by the Department, and accredited by the Joint Commission to provide prevention, intervention, residential, and outpatient substance abuse services. Village South has operated for over thirty years providing comprehensive multidimensional treatment to adults and adolescents with chemical dependency, mental illness, dual disorders (mental health and substance use disorders), delinquency and related behavioral problems.

1. The FIT catchment area includes Miami-Dade County (Liberty City and Homestead).
2. Village South is subcontracted by GCC. Date of contract execution was not reported.

Guidance / Care-Center, Inc., was incorporated as a non-profit organization in 1973 and is an independent affiliate of WestCare Florida, Inc. GCC has three sites spanning the Florida Keys located in Key Largo, Marathon and Key West. GCC is licensed by the Department and accredited by the Commission on Accreditation of Rehabilitation Facilities. GCC has operated for over thirty (35) years providing comprehensive multidimensional treatment to adults and adolescents with behavioral health issues. GCC provides community-based services to persons in need of substance abuse and mental health treatment services through a myriad of programs and partnerships including assessment, outpatient, in-home on site, psychiatric, crisis stabilization, detox, psychosocial rehabilitation, diversion, prevention, case management and criminal justice programming.

1. The FIT catchment area includes Monroe County.
2. The ME contract amendment for FIT was executed on August 18, 2014. Referrals began on October 6, 2014.
3. As of December 31, 2014, a total of 17 individuals have received FIT services through the GCC and The Village South.

VII. **Demographic Information**

Demographic information reported by FIT providers included parental age and race and was collected in the FIT SharePoint data system for the period of July 1, 2014, through December 31, 2014. Based on the information reported, the typical parents served by FIT teams are white, ages 30 and under.

Chart 1: Parent Race

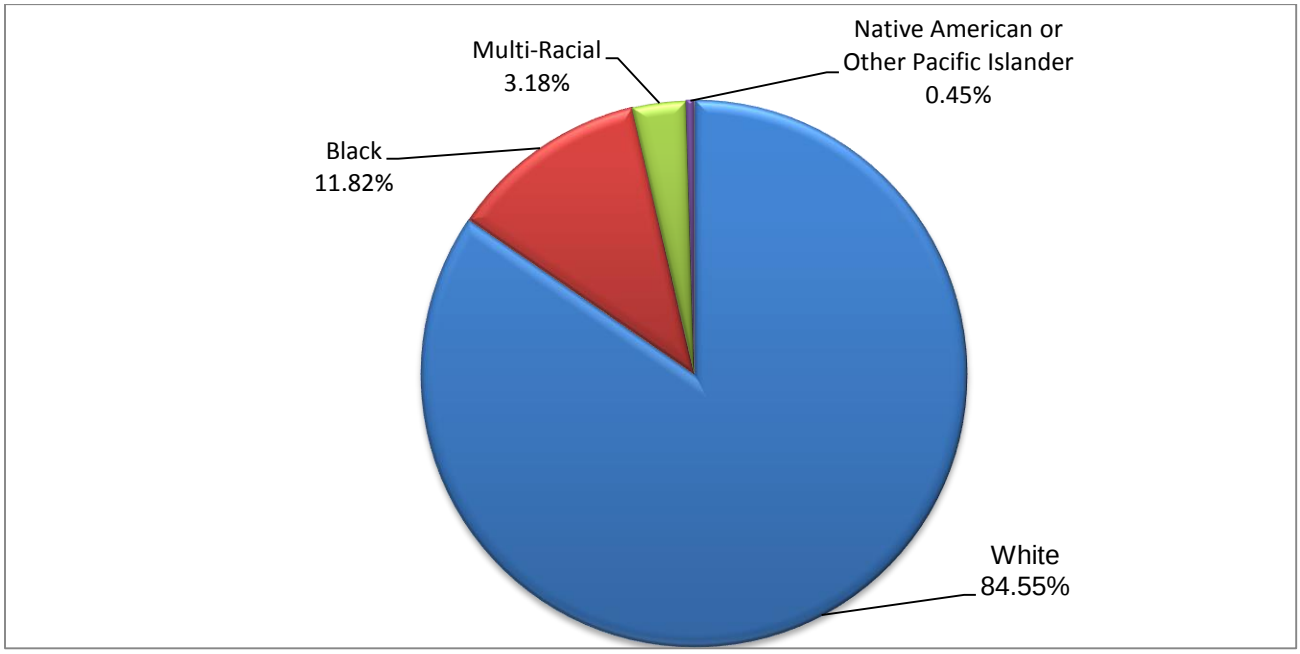
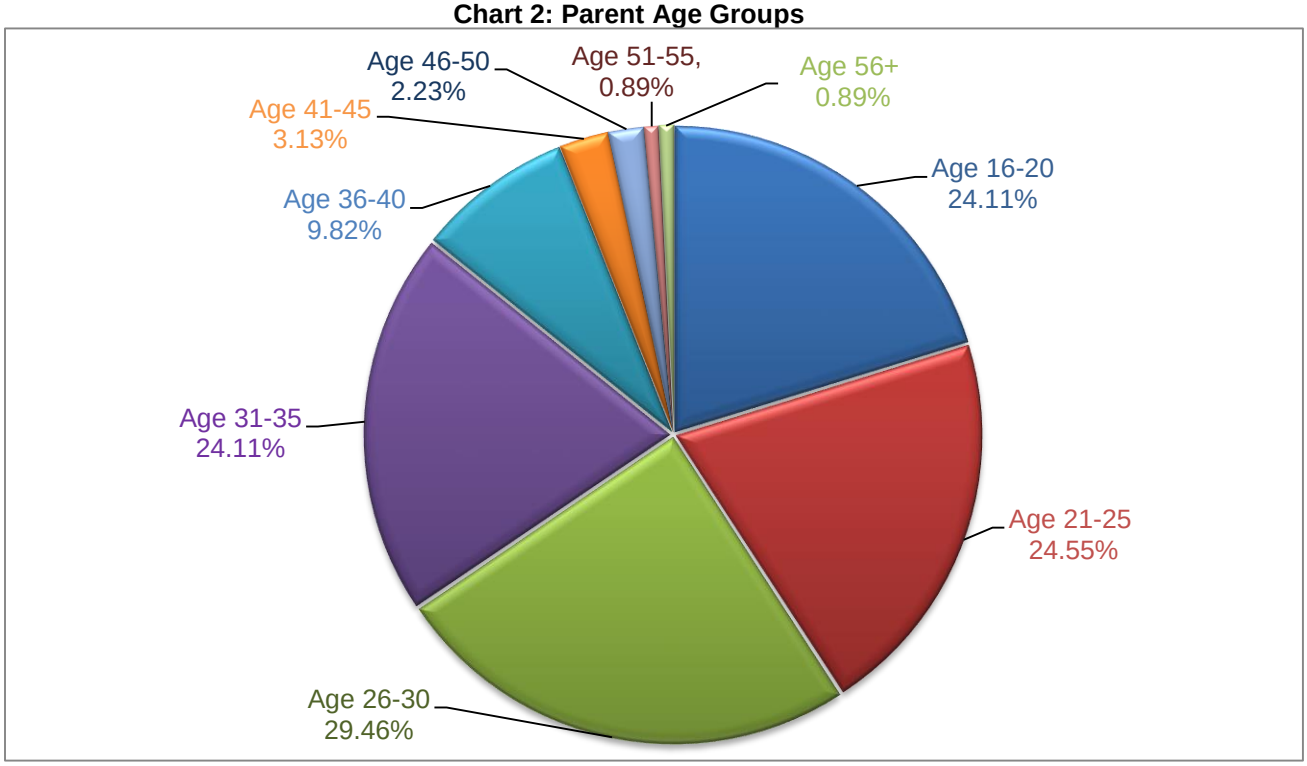


Chart 2: Parent Age Groups



VIII. **Performance Indicators**

VIII.A. PERFORMANCE MEASURES

Performance measures were reported by FIT providers for the period of July 1, 2014 through December 31, 2014, into the FIT SharePoint data system. It is important to note that the FIT SharePoint data system has only been operational for approximately two months and there may be a higher rate of user error than would be expected with a system with more experience. Additionally, there have been very few discharges to date and outcomes are affected by the small number of families with outcome data. In sum, it is likely premature to draw definitive conclusions from the data presented.

1. Percentage of parents served living in a stable housing environment.

- Summary: This measure is reported at discharge and the target is 90 percent. At the time of this report writing, there have been a total of seven (7) parents discharged from FIT services statewide.
- Methodology: The numerator is the sum of the total number of parents living in a stable housing environment at discharge. The denominator is the sum of the total number of parents who were discharged from FIT services.
- Outcomes: Statewide, 71 percent of parents served were living in a stable housing environment at time of discharge. Individual providers reported the following:
    - BayCare (SunCoast) reported four (4) discharges with three (3) that met the measure, resulting in 75 percent of parents living in a stable housing environment at time of discharge.
    - Guidance / Care Center reported one (1) discharge with one (1) that met the measure, resulting in 100 percent of parents living in a stable housing environment at time of discharge.
    - SalusCare reported two (2) discharges with one (1) that met the measure, resulting in 50 percent of parents living in a stable housing environment at time of discharge.
- The remaining FIT providers did not report discharges during the reporting period.

2. Percentage of discharge summaries completed within seven days of discharge.

- Summary: This measure is reported after discharge and the target is 85 percent. Although there were a total of seven (7) individuals discharged, only five of those individuals were identified as the “primary” parent. The other two (2) individuals discharged were not identified as the primary parent; therefore, those two (2) families are still open to FIT because the primary parent is still receiving services. The five (5) families discharged from FIT services are expected to have a discharge summary completed and are reported in this measure.
- Methodology: The numerator is the total number of families who received discharge summaries within seven days of discharge. The denominator is the total number of families who were discharged from FIT services.
- Outcomes: Statewide, 40 percent of families discharged had a discharge summary completed within seven (7) days. Individual providers reported the following:
    - BayCare (SunCoast) reported three (3) discharges with one (1) that met the measure, resulting in 33 percent of discharge summaries completed within seven (7) days of discharge.
    - Guidance / Care Center reported one (1) discharge with zero (0) that met the measure, resulting in 0 percent of discharge summaries completed within seven (7) days of discharge.
    - SalusCare reported one (1) discharge with one (1) that met the measure, resulting in 100 percent of discharge summaries completed within seven (7) days of discharge.

3. Percentage of assessments completed within five days of referral.

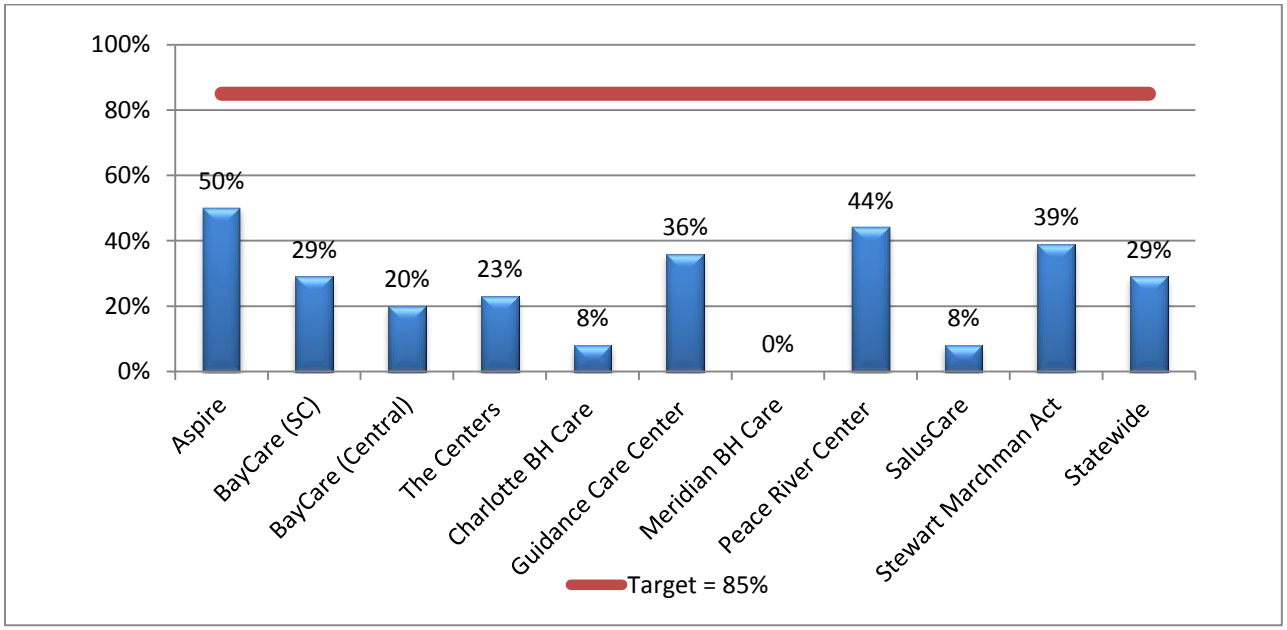
As stated earlier, one of the lessons learned to date is that it takes time to locate families and engage them in treatment. When the family agrees to treatment, the assessment should be initiated immediately. There is an inconsistency in reporting in that some providers reported on individuals referred, while others reported on those enrolled in services for this measure.

At the January 22 FIT meeting in Tampa, the Department, FADAA, MEs and FIT providers decided to make the following changes to address challenges in locating and engaging families, while aligning with best practice to engage parents in treatment as soon as possible. Related performance measures will be adjusted to reflect these changes.

1. It was determined that data would be collected only on families enrolled in services. However, the date families are referred and the efforts to locate and engage them will be collected separately to allow for the tracking of referrals and the analysis of the referral process.
2. Expectations for how quickly the assessment must be completed needs to be re-evaluated and take into consideration successfully locating and engaging families.
3. FIT providers will be required to update all assessments (with the exception of the ASI) within 30 days of admission for individuals transferred from other services. Many individuals transferred from other services have completed these assessments prior to admission to FIT and best practice dictates that assessments be updated as appropriate.

The chart below reflects the challenges in locating families and the actions necessary to get them to engage in treatment.

Graph 1: Assessments completed within five days of referrals, as a percentage.

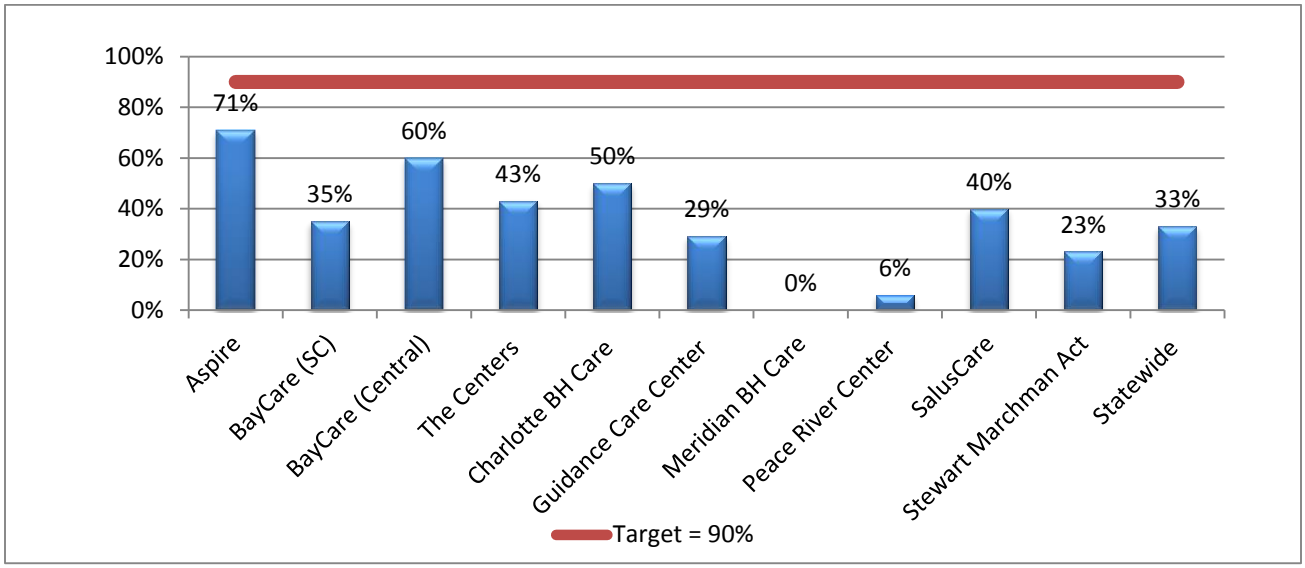


- Summary: This measure is reported within 5 days of referral. If the provider is unable to locate the family or the family is unable to meet during this time frame, the measure will not be met. Individuals served in other programs who were transferred to FIT had assessment dates prior to admission and were not included in this measure.
- Methodology: The numerator is the sum of the total number of families who receive assessments within five (5) days of admission to a FIT team. The denominator is the sum of the total number of families referred to a FIT team.
- Outcome: This measure was not met and as described above, the methodology for determining success requires re-evaluation.

4. Percentage of parents receiving treatment services within 48 hours of completed assessment.

During the January 22 FIT meeting in Tampa, FIT providers, MEs, FADAA and the Department identified improvements to the FIT SharePoint data system that will more accurately report on the assessments of individuals transferred from other services, as these individuals can impact performance measures such as this one. CFBHN will make the recommended modifications to the FIT SharePoint system. Due to the limited time frame that the FIT teams have been operational, the complications of introducing a new approach across multiple systems, and the newness of the FIT SharePoint data, an updated report in the following three months may be beneficial.

Graph 2: Parents receiving treatment services within 48 hours of completed assessment, as a percentage



- Summary: This measure is reported within 48 hours of a completed assessment.
- Methodology: The numerator is the sum of the total number of families who receive treatment services within 48 hours of completed assessment. The denominator is the sum of the total number of families referred to a FIT team during the reporting period.
- Outcome: This measure was not met and as described above, changes to the data reporting system are required.

5. Percentage of Parents who improved their level of functioning as measured by the Functional Assessment Rating Scale (FARS).

- In October, the Department, FADAA, MEs, and FIT providers determined that all FIT providers would use the Functional Assessment of Mental Health and Addiction (FAMHA) instead of the FARS to determine the level of functioning, as it is a more beneficial assessment tool for individuals served by FIT.
- FIT providers have trained their staff on the FAMHA and have begun implementing it. FIT providers have begun reporting results into the FIT SharePoint data system.
- This performance measure will be revised to reflect the use of the FAMHA.
- Due to the limited time the FARS and FAHMA have been used, data are not available to report on this measure at the time of the report writing.

VIII.B. REQUIRED REPORTING

The *Family Intensive Treatment (FIT) Model Guidelines and Requirements* document includes required reporting on an extensive array of services and supports that may be provided to a parent enrolled in the FIT program, as determined by their needs and the needs of their family. The purpose of including this reporting requirement is to document the provision of services and supports as provided; however, not all parents served would be expected to receive all of the services and supports available. For example, of the 208 parents served between July 1, 2014 and December 31, 2014, four (4) were reported to receive inpatient residential treatment at the appropriate level of care. As clarified earlier, providers have just begun to report services into the FIT SharePoint data system and services listed below may be underreported.

Table 5: FIT Service Provision

Reporting Requirement	Aspire	BayCare (SC)	BayCare (Central)	The Centers	Charlotte	Guidance Care Center	Meridian	Peace River Center	SalusCare	SMA	Statewide
Number of Families Served.	7	46	12	10	9	17	10	22	33	42	208
Number of Parents Receiving an Individualized Treatment plan.	2	20	1	0	0	0	0	19	0	12	54
Number of Parents Receiving Intensive In-Home Treatment and Services.	6	0	0	0	0	0	0	0	0	0	6
Number of Parents Receiving Detoxification Treatment.	1	2	1	0	0	1	0	0	0	0	5
Number of Parents Receiving Crisis Stabilization Services.	1	0	0	0	0	1	0	0	0	0	2

Reporting Requirement	Aspire	BayCare (SC)	BayCare (Central)	The Centers	Charlotte	Guidance Care Center	Meridian	Peace River Center	SalusCare	SMA	Statewide
Number of Parents Receiving Inpatient Psychiatric Services.	0	0	0	0	0	0	0	0	0	0	0
Number of Parents Receiving Residential Treatment.	0	2	1	0	0	1	0	0	0	0	4
Number of Parents Receiving Individual Therapy.	2	43	11	10	0	14	10	21	25	39	175
Number of Parents Receiving Group Therapy.	0	11	0	11	0	1	0	0	0	1	24
Number of Parents Receiving Family Therapy.	1	9	0	0	0	0	0	4	0	0	14
Number of Parents Receiving Medication Services.	0	0	0	0	0	0	0	0	0	0	0
*Number of Parents Receiving Therapeutic Training or Psycho-education.	0	0	0	0	0	9	0	22	0	0	31
Number of Parents Receiving Transportation Support.	2	0	0	0	0	0	0	0	0	0	2

Reporting Requirement	Aspire	BayCare (SC)	BayCare (Central)	The Centers	Charlotte	Guidance Care Center	Meridian	Peace River Center	SalusCare	SMA	Statewide
Number of Parents Receiving Supportive Housing.	0	2	0	0	0	0	0	0	34	0	36
Number of Parents Receiving Supported Employment.	0	0	0	0	0	2	0	0	0	0	2
Number of Parents Receiving Aftercare Services.	0	0	0	0	0	0	0	0	0	0	0

Note: When parenting interventions are provided as part of therapy, the service is included under therapy and not reported separately. At the statewide FIT meeting on January 22, it was decided to include a separate data reporting element in the FIT SharePoint data system to capture patenting interventions.

IX. Conclusion

Given the limited timeframe that the FIT teams have been in operation, it is not possible to provide an unequivocal conclusion as to the efficacy of the FIT model. However, FIT providers have been deployed to implement services. Coordination and planning across agencies critical to the effective implementation of FIT is occurring among the MEs, FIT providers, CBCs, FADAA and the Department. These key partners have accomplished the following:

1. Begun identifying and addressing barriers to referring and serving families across systems;
2. Identified screening and assessment tools for required use by all FIT providers;
3. Developed an expanded data set that provides a comprehensive understanding of the entire family;
4. Begun using and refining a SharePoint FIT data system that provides real-time access to provider and state level data reports for client specific data, program and service data and performance data; and
5. Established a collaborative process to analyze the implementation of the FIT model and make adjustments to align with good clinical practice and incorporate lessons learned.
6. Begun identifying and addressing data reporting issues.

Next Steps

The Department will continue to partner with FADAA, MEs, and FIT providers to effectively implement and sustain the FIT model. The following have been identified for improvement by these key partners:

1. Continue to analyze data entered into the FIT SharePoint data system on an ongoing basis to ensure it is complete and accurate, which includes a run and analysis of performance measures and services provided on a monthly basis.
2. CFBHN in consultation with the other MEs, FIT providers and the Department will continue to refine the FIT SharePoint data system to align it with improvements made to current practice.
3. Update the FIT program requirements and performance measures to reflect the improvement of practice, based on lessons learned and revise the program guidelines and FIT contracts as needed.
4. Review the current data reporting requirements and streamline to eliminate redundancy and target the most important information needed to effectively serve FIT participants.
5. Create a collaborative learning model to share effective practices and resources that improve outcomes.
6. Continue to identify and resolve barriers to referring parents to FIT.

Appendix A Family Intensive Treatment Teams (FADDA Proposal)

Family Intensive Treatment Teams

A Proposal to Create Targeted Treatment Capacity to Effectively Serve Parents with Behavioral Health Disorders in the Child Welfare System

The Casey Family Program reports on child fatalities, other data analyses, research, along with Florida's experience shows us that the current system is not as effective as it could be in working with and treating multi-risk families whose parents are affected by substance use and mental health disorders (behavioral health disorders). Research has consistently documented the increased risk of child maltreatment when parental behavioral health disorders, especially substance abuse, are present.

This proposal is designed to get to the root cause of the issue by: engaging the entire family at a more intensive level, integrating care to the family unit, treating the parents' behavioral health disorder with science based interventions, and creating a mechanism of shared accountability across the provider agencies, the Managing Entities and the Community Based Care organizations.

Premise: This proposal is based upon the following premises:

- Children are dying - the majority of whom are under five years of age
- Parental substance abuse and mental health issues often place children at risk
- There are currently not enough dedicated and targeted resources in the Substance Abuse and Mental Health (SAMH) service delivery system to provide comprehensive and intensive family services
- Current practice is not effective for many families with serious behavioral health disorders
- The best science in behavioral health care and child welfare has not been blended into a comprehensive program of service delivery
- Children and parents are being served individually, but not as a family unit
- Families are not getting family-based integrated care
- The existing business model does not support shared accountability and cost savings

Unaddressed Parental Substance Use and Mental Health Disorders are Placing Children At-Risk

The November 2013 *Casey Family Programs Review of Child Fatalities* report is filled with commentary regarding the dangers that unaddressed parental behavioral health disorders present for children, comments include:

- Parental substance abuse, chronic mental health problems and domestic violence were common in families of children who died due to suspected maltreatment (page 2)
- Asphyxia due to unsafe sleeping arrangement and practices was the most common cause of death in the sample. Most of the parents or caregivers in these "roll-over" deaths had histories of substance abuse and/or tested positive for drugs following the child death (page 3)
- Histories of domestic violence were present in all of the child deaths resulting from physical abuse, along with substance abuse in most of the families (page 2)
- Very few of the parents with substance abuse issues involved in these deaths and in those resulting from other causes, appeared to be in recovery, or even enrolled in treatment programs.

Most of parental substance abuse associated with child deaths was not relapse-related; rather parents with ongoing substance abuse issues, and often family violence, were attempting to raise babies and other children (page 3)

- The vulnerability of infants, other young children and disabled children who died was greatly increased in families with multiple risk factors, including combinations of substance abuse, mental health conditions, family violence, criminal histories and several prior Child Protective Services (CPS) reports (page 4)
- Safety assessments often did not appear to consider the family's prior CPS history or to explore domestic violence, substance abuse and other family dynamics which increase risk to vulnerable children (page 4)
- Safety and risk assessments rarely demonstrated an appreciation of the wide range of safety and risk issues associated with substance abuse, chronic mental health and family violence (page 5)
- Domestic violence and substance abuse dynamics were woefully underexplored (page 5)

Florida Department of Children and Families *Executive Digest* Child Fatality Trend Analysis January 1, 2007 through June 30, 2013 raises the issue of Parental Substance Abuse

- The impact of each prior removal due to parents who have abused alcohol or drugs *increases* the odds of deaths by a multiple of nearly 15. This effect is similar for prior removal due to physical abuse.

Florida Data shows that the Majority of the Parents in the Child Welfare System likely have a Substance Use Disorder (SUD) and Co-occurring Mental Health Disorder

National research shows that between 60% and 80% of substantiated child abuse and neglect cases involve substance abuse by a custodial parent or guardian.[i] An analysis of 2010/11 Florida Safe Family Network (FSFN) data was completed in the summer of 2011 for verified child abuse cases using data elements on the FSFN that showed potential substance use disorders with parents. The two data elements that are the best predictors of potential substance use disorders are whether the allegation included substance use and/or substance use disorders were a contributing factor to out of home placements. The analysis assumed that it was likely that the parent had a SUD if the allegation included possible substance abuse or if the reason for placement was noted as the presence of a parental substance use disorder. The data analysis results showed the following:

- 60% of the parents in verified cases had evidence of SUD
- Although data on parental mental health disorders is not reliably collected in the FSFN system, a high rate of co-occurring substance use and mental health disorders are likely in this population
- 10,229 children age five and under in the child welfare system had a parent with evidence of SUD
- About 383 children under the age of five with a parent with potential SUD in out of home placement had a prior out-of-home placement placing them at a 30% greater chance of death at time of second reunification
- Of the families with children in out-of-home care, the majority had parents with a substance use disorder

- Twice as many children (6,511) with parents with SUD stayed in out-of-home care over 271 days as did those children whose parents did not have an indication of SUD (3,013)
- 7.3% of children from families with potential parental substance abuse had a prior out of home episode and 67% had a prior investigation compared to children without parents with substance use disorders who had prior out-of-home placements of 4.3% and prior investigations of 36%
- About 20,000 families likely had a behavioral health disorder and needed some level of treatment

Unfortunately many parents do not access treatment. Of those that do, research shows that more than 60% of parents in dependency cases do not comply adequately with treatment for substance use disorders with 80% failing to complete treatment[ii].

Current Practices and Funding are Insufficient

Past efforts and the current pilots for the Integration of Substance Abuse, Mental Health and Child Welfare Services focus on the upfront early engagement of families and staff to support their entry into treatment. Early engagement, coupled with evidence-based motivational techniques can very effectively assist parents to enroll in treatment. However, identification and engagement is just the beginning of the process. The achievement of desired results for these families is dependent upon immediate access to family-based assessments, motivational practices, receipt of evidence-based treatment matched to the need and desired outcome, multi-disciplinary practices uniquely designed to meet the needs of families in child welfare. The service system must recognize that behavioral health disorders are chronic conditions and plan for appropriate transition of services and on-going recovery support. The current focus on the increase in child protection investigators only addresses the upfront screening process and is insufficient to address one of the major contributing factors associated with child deaths - the critical need for behavioral health treatment for the parents.

To keep children safe communities must have the necessary resources to address parental behavioral health disorders. The Substance Abuse and Mental Health (SAMH) funding is spread very thin with SAMH providers desperately trying to meet the needs of multiple SAMH priority populations living in their communities combined with meeting the needs of parents referred from the child welfare system. In addition, the present funding protocols are sorely inadequate to meet the intensive treatment and support needs of this population.

Currently it is not possible to accurately determine how many of the parents in the child welfare system received services from SAMH. The SAMH Information System does include a code to identify persons served in SAMH who are also involved in the child welfare system. The average SAMH expenditure in FY 2010/11 for adults in this population was approximately $2,600 per person, well below the rate for an intensive treatment intervention. Data indicates about 11,000 adults received some service. This number of adults includes both Child Welfare diversion and verified cases. Given the estimate of 20,000 parents in need of treatment with verified cases and given the high number of diversion cases routinely handled, it is very likely that the system is presently serving only a small percentage of the need. Parents in the child welfare system with behavioral health disorders often need intensive services over an extended period of time. The current funding structure is woefully inadequate to meet this need.

The Current Business Model Does Not Support Shared Accountability

The fragmentation of the service delivery and lack of shared accountability further exacerbates the problem. Each segment of the service system generally operates independently and the interrelationship of disparate services and family dynamics are not fully appreciated or addressed. For example, several different providers may be working with different family members without appropriate collaboration around assessments, treatment planning and desired treatment outcomes, not only for the individual but also for the family. The parent and child are treated in parallel systems without shared accountability to reduce safety risks, achieve permanency and address well-being within the family. The desired treatment outcomes may not be explicitly related to the overall case plan and in the worst case scenarios may in fact be working in opposition to one another. The performance measures for the different organizations are not complementary which could result in misaligned efforts and perverse incentives.

Current practices are not structured to enhance shared financial risks or gains. The expense of the child welfare services and out-of-home care is covered through contracts with the child welfare agency, while cost of behavioral health care treatment and supports is borne by the substance abuse and mental health system. Cost savings associated with better parental outcomes due to successful treatment for behavioral health disorders, such as diversion from out of home placement or reduced re-entry, are realized by the Community Based Care Lead Agencies and not shared with the SAMH providers. This dynamic creates tension in the system. To be more effective, programs should be planned to ensure that the cost of intensive service delivery is adequately covered while there are mechanisms in place for shared accountability and financial risk. Strengthening mutual responsibilities of the SAMH Managing Entities and the Community Based Lead Agencies is essential to achieve integration of services. If savings are achieved, a portion of the savings should be shared with the substance abuse and mental health system to enable greater provision of services.

Evidence-Based Practices Must Be Available

Science has revealed that there are several evidence-based treatment approaches for persons with substance use and mental health disorders which can effectively address behavioral health challenges and child/parent interactions that are appropriate to be used for parents in the child welfare system. Below is a sample of some of these programs.

- Treatment Programs
  - Seeking Safety
  - Motivational Enhancement Therapy
  - Trauma Focused Cognitive Behavioral Therapy
  - Combined Parent-Child Cognitive Behavioral Therapy
  - Child-Parent Psychotherapy
- Parenting Programs for Parents with SUD
  - Nurturing Parents
  - Strengthening Parents
- System Approaches
  - Dependency Drug Courts
  - Dependency Baby Courts

- Team practices such as Beacon Hill Family Assertive Community Team (emerging practice)

Effectiveness of these approaches is based on implementation of the evidence-based practice with fidelity. Existing treatment resources do not adequately fund the training and level of targeted clinical supervision that guarantees an evidence-based practice is implemented with fidelity.

Team Based Comprehensive Services are Most Effective

For parents in the child welfare system who are facing multiple risks, interventions and treatment approaches are more effective when presented within a comprehensive and intensive multi-disciplinary team framework. Research shows that services that are provided in a comprehensive manner support both recovery and permanency for children. Immediate access to treatment and recovery supports promotes engagement, attendance and completion of treatment, and access to other necessary services to help achieve positive outcomes.

Florida has implemented two approaches that demonstrate the effectiveness of a team approach. FACT, serving individuals with seriously persistent mental illness, is an evidence-based team intervention that demonstrates both the need for appropriate professionals to be part of the team, but also the role peer support plays in supporting the clinical interventions. The new Community Action Teams (CAT), although just over seven months funded, are demonstrating the effectiveness of a team of the appropriate professionals and peer support to change the pathway of adolescents and young adults at risk of mental illness.

Proposal Description

This proposal requests funds for seven pilots to create Family Intensive Treatment Teams to provide intensive treatment interventions targeted to high-risk families due to parental substance use and/or mental health issues. The pilots are designed to demonstrate that rapid identification of parental behavioral health disorders, immediate access to evidence-based practices and multi-disciplinary teaming will result in better outcomes for children. The pilots will operate for three years providing family-based integrated services and document the qualitative and quantitative system components necessary to be responsive to the needs of parents with behavioral health disorders and their young children. The target population is families with verified child abuse cases with preference given to families with children age five and under when the child is placed in out-of-home placement or considered at high risk for placement and the parent has a behavioral health disorder.

The pilots will have the following key features:

- Linkages with the Child Protective Investigators and Family Intervention Specialist (or other staff with similar functions) will be clearly established and services will be closely coordinated.
- Same Day access to assessments will be assured.
- Assessments will include parental behavioral health assessments, assessments of parenting capacity associated with the behavioral health disorder, and family assessments of the impact of the behavioral health disorder on family functioning.

- Behavioral Health assessment providers will have engagement specialists available to assist the parent/family to immediately access the appropriate level of treatment matched to their individual needs and desired outcomes.
- The selected Circuit(s) will implement the "Speed Pass" concept similar to the system currently used in the Suncoast Region. If a parent is identified as needing treatment, using a voucher or case rate payment method, they will have immediate access to services (preferably same day but not greater than 3 days) by a licensed or accredited provider at the level of care that is recommended by a standardized assessment and has been vetted by the treatment and family service team.
- The program will have access to funds for incidental needs such as medication, housing assistance, assistance in obtaining child care and other support services.
- The parent will have a specialized care coordinator to work with a multi-disciplinary team to coordinate behavioral services, domestic violence issues, physical health care and other therapeutic components of the family's treatment, services and supports.
- Peer support staff will be a critical element of the team and will be available to the family around the clock to guide and assist in recovery support and conflict management.
- The behavioral health care treatment will be comprehensive, integrated and provided to the family as the unit.
- The behavioral health care providers will work with the child welfare staff, other community entities such as domestic violence professionals, early child interventionists and practitioners and the family as part of a multi-disciplinary team handling the case. The team will ensure that the parental and children services are comprehensive and coordinated.
- The behavioral health team will be trained in evidence-based practice found effective for serving families in the child welfare system.
- Funding will cover times for multi-disciplinary team meetings and coordination with practitioners.
- At the time of reunification and/or child welfare case closure, the team will hold a multi-disciplinary team meeting to ensure that behavioral health care services are in place to provide the ongoing treatment and support for the chronic condition.
- The parent will be engaged in recovery support services and their condition will be monitored for one year after the closure of the child welfare case. This service will be voluntary.
- The Community Based Care Organization, Managing Entity, and contracted treatment providers will operate as an integrated operational unit wherein joint decision making will be the norm.

Evaluation

The pilot will include an evaluation component that will:

- Have data collection methods in place to ensure uniform collection of data with the pilot sites;
- Complete a baseline level of performance for identified measures;
- Provide information to determine future need by identifying the percentage of parents needing services, type of services provided, outcomes of the treatment versus treatment goals, evidence-based treatment practices most effective with this population, on-going services provided after child welfare closure, and identified barriers and recommendations for improvement; and

- Evaluation of the pilot process to determine the needed infrastructure and implementation functions necessary to replicate the pilot.

Cost

The cost components include the following:

- Behavioral Health Care and Family Assessments assessment;
- Intensive engagement of services from time of assessment to treatment entry;
- Immediate access to evidence-based treatment matched to the level of need and desired outcomes. This proposal is founded on the knowledge that the most appropriate services must be provided when needed and that the array of services must be coordinated and address the required levels of care including services such as detox, residential care, intensive outpatient programs, individual and group therapy, peer support, parent education and in-home treatment;
- Medicaid will be utilized for Medicaid compensable services when parents are Medicaid enrollees; Family Intensive Treatment Teams funding will provide wrap-around services not covered by Medicaid;
- Specialized care coordination for the family to integrate behavioral and physical health care needs; to assist in arranging for concrete services; and to assist with the management of the therapeutic components of therapy for the family and multi-disciplinary activities. The specialized care coordinator will work in tandem with the child welfare case manager;
- Incidental funds for concrete needs on a temporary basis such as transportation, child care, medications and housing;
- Transitional services, recovery support and monitoring of the chronic condition for one year after child welfare closure; and
- Evaluation.

The per recipient estimated cost for the family intensive treatment team model is anticipated to be $10,500 annually, a comparable cost to FACT and CAT team interventions. Funding is requested for a pilot in each of the 7 Managing Entities to serve a total of 1,400 families per year for a total annual cost of $14.7 million dollars. The allocations to the Managing Entities will be based upon the pro-rata share of the total verified cases of child abuse for the previous fiscal year.

The annual cost for the evaluation is $100,000 per year.

Florida Intensive Treatment Teams
Actual Budget Allocation for FY 2014-2015 - $5 million

BUDGET PROVISO: From the funds in Specific Appropriation 372, $5,000,000 from the General Revenue Fund is provided to implement the Family Intensive Treatment (FIT) team model that is designed to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse. Treatment shall be available and provided in accordance with the indicated level of care needed; providers shall meet the specifications of the program. Funds shall be targeted to selected communities with high rates of child abuse cases located in the department's Central, Northeast, Southern, and Sun Coast regions. Funds shall be tracked and outcomes measured and analyzed. The department shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives evaluating the effectiveness of FIT teams in meeting treatment goals established by the department by February 1, 2015.

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Florida Alcohol and Drug Abuse Association, 4-25-14

Shared Accountability and Cost Savings Business Model

The program will be structured to ensure that the services are provided in conjunction with the child protection agency and the family with the first consideration always for the safety of the child. The contract and interagency agreements will be structured to create mutual accountability among the Department of Children and Families, Management Entities, the Community Based Care (CBC) Lead Agency and contracted licensed substance abuse provider or accredited mental health centers. To ensure continuity of care for the chronic condition, the selected array of service providers must have the following capacity:

- Member on SAMH Managing Entities provider network
- Licensed as a Florida substance abuse provider and have a national behavioral health care accreditation with Joint Commission, Commission on Accreditation of Rehabilitation Facilities, or Council on Accreditation
- Demonstrated ability to work with Medicaid Health Plans in the relevant geographical area
- Co-occurring capable and have experience in providing trauma based/focused services
- Have evidence-based practices in place to provide the necessary services or be able to have the capacity to provide these services within 3 months of the pilot implementation
- Provide the full array of services at multiple levels of care or be able to coordinate/integrate the array of parental services
- Demonstrated ability and commitment to work with a multi-disciplinary family team

The proposal requires Department, CBC Lead Agency, the Managing Entity and the substance abuse and mental health providers to perform in a holistic manner with the focus on the family unit rather than their individual client such as the parent or child. The performance agreements and overall measures will be designed to ensure that there is mutual engagement and commitment from all parties to "bend the curve" of system performance in the following areas:

- Increased screenings and identification of parental behavioral health care needs
- Improved immediate access to evidence-based services at appropriate level of care
- Improved retention in behavioral health services
- Increased successful completion of treatment
- Reduced number of out-of-home placements
- Improved involvement in recovery services and monitoring of chronic condition
- Reduced rates of re-entry

Using the Mark Friedman's Results Based Accountability methodology[iii],each component of the system will be responsible for program performance on each of the established system measures listed above. Any cost savings will be shared by the involved parties in accordance to a pre-established shared accountability and financial agreement.

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[i] Young, N., Boles, S., and Otero, C. (2007). Parental substance use disorders and child maltreatment: Overlap, gaps, and opportunities. *Child Maltreatment, 12,* 137-149.

[ii] Oliveros, A., And Kaufman, J. (2011). Addressing substance abuse treatment needs of parents involved with the child welfare system. *Child Welfare, 90,* 25-41.

[iii] Freidman, M. (2005). *Trying Hard Is Not Good Enough.* Bloomington, IN: Trafford Publishing. Note: Results Based Accountability is used when a group of partners assume the responsibility to collectively achieve desired outcomes sometimes referred to as the population improvement. A data collection and reporting system is established to measure baseline and subsequent performance over time. The goal is to "bend the curve" on the graphic representation of progress in the desired direction. Additionally each involved partner has specific measures that are "drivers" for the overall desired outcome (population measure). The specific performance of the specific provider is called the provider performance measure and that performance contributes to the overall outcome. The individual provider is accountable for their specific performance but is not fully responsible for the overall outcome. The responsibility for "bending the curve" is shared by the partners. Friedman cautions against prematurely setting a goal for improvement other than agreeing to "bend the curve" in the correct direction. The partners meet regularly to review performance and use continuous quality improvement techniques to improve performance.

APPENDIX B: REGIONAL AND LOCAL CROSS-SYSTEM COLLABORATION

The statewide FIT meeting in August 2014 laid the ground work for structured planning at the region and local levels that included key partners, such as MEs, FIT providers, the Department and CBCs. Initial and continued collaboration at the region and local levels has allowed the FIT model to be implemented consistent with the intended core components, while addressing local needs and circumstances. Region and local level activities reported by the MEs and FIT providers are summarized below.

Lutheran Services Florida (LSF) – Northeast and Central Regions

Implementation

- LSF hosted weekly calls with providers to provide direction and plan for implementation.
- Provider planning included establishment of a FIT workflow, ongoing meetings with key partners to plan implementation of major program components, such as the referral process
- Ongoing meetings are held bi-weekly or monthly with key partners regarding implementation

Coordination of Care

- Referrals are staffed with the Department, CBC, CPI and/or Supervisor.
- FIT team attends family staffing with the CPI, family team conferences with the child welfare case manager and external meetings held by other agencies serving the family.
- FIT counselors document notes in FSFN.
- Joint staffing with CBCs at least bi-weekly
- FIT Case Manager or Therapist conduct joint meetings with CPIs or dependency case worker to enhance engagement of the parent in treatment, when needed.
- Monthly progress reports are provided to dependency case managers and frequent phone contact is made regarding the current status of the family.

Central Florida Cares Health Systems (CFCHS) - Central Region

Implementation

- The CBC, Family Intervention Specialists (FIS) and the Department were engaged at time of first implementation to develop the referral process.
- CFCHS held implementation meetings with Aspire Health Partners following the statewide meeting in August 2014 to outline the delivery of the FIT program, including:
    - Service tracking,
    - Payment methodology, and
    - Referral sources.
- The FIT Clinical Manager made presentations on the FIT program criteria and services to the referral sources within the community, including:
    - Diversion specialists,
    - Dependency case managers, and
    - FIS case managers.

Coordination of Care

- Referral sources are invited to family staffing at admission, monthly, at discharge, and following any critical incidents.
- FIT Counselors and the Care Coordinator communicate with the referral sources and other community service providers throughout the week regarding the families' progress.
- All referral sources are encouraged to attend initial sessions with the parent to provide warm handoffs to the FIT team.

- FIT Counselors and the FIT referral sources conduct joint visits, when needed to enhance engagement with the individuals referred.

Central Florida Behavioral Health Network (CFBHN) – SunCoast Region

Implementation

- CFBHN facilitated regional face to face meetings, conference calls, and webinars to discuss processes, data submission, evidenced-based assessments, eligibility, successes, and barriers. The calls included FADAA, Department staff from Central and Suncoast regions, CBCs CPI's, and providers.
- CFBHN holds conference calls with and webinars for their four contracted FIT providers and includes stakeholders from the four counties.
- CFBHN receives a weekly provider reports that includes:
    - New referrals received,
    - Number of assessments completed,
    - Number of families currently enrolled,
    - Number of families discharged successfully, and
    - Number of families discharged unsuccessfully.
- CFBHN holds face to face meetings with providers and other stakeholders as needed to discuss the referral process between agencies, successes, and barriers.

Coordination of Care

- Bi-weekly meetings are held at the county level with FIT providers and referral sources to review referrals.
- There is ongoing communication with the FIT providers, CPIs and the three CBCs to ensure that family needs are being met.

South Florida Behavioral Health Network (SFBHN) – Southern Region

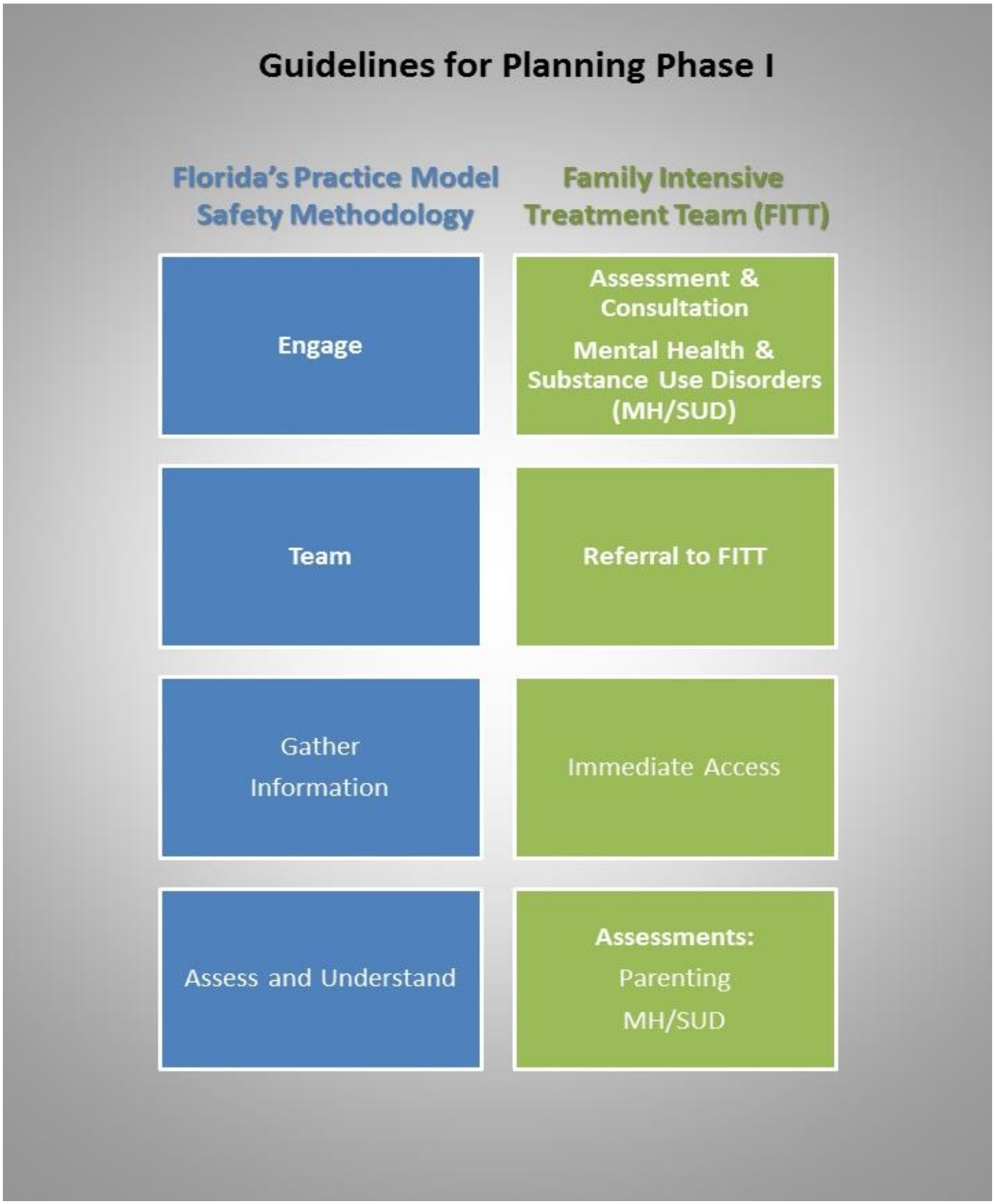
Implementation

- Multiple planning meetings were held with all stakeholders to develop the FIT program's documentation criteria and referral structure.
- On-going meetings are held with the CBC, the Department and CPIs to map out a referral process.
- A FIT flyer was developed by the FIT provider and SFBHN and provided to the CBCs, CPIs, the Department and community providers.
- A FIT Flyer was developed for families to provide details of the program benefits.
- Key stakeholders (SFBHN, FIT providers, and CBC) have met with one dependency drug court Judge and plan to meet with the others in January to coordinate referrals to FIT.

Coordination of Care

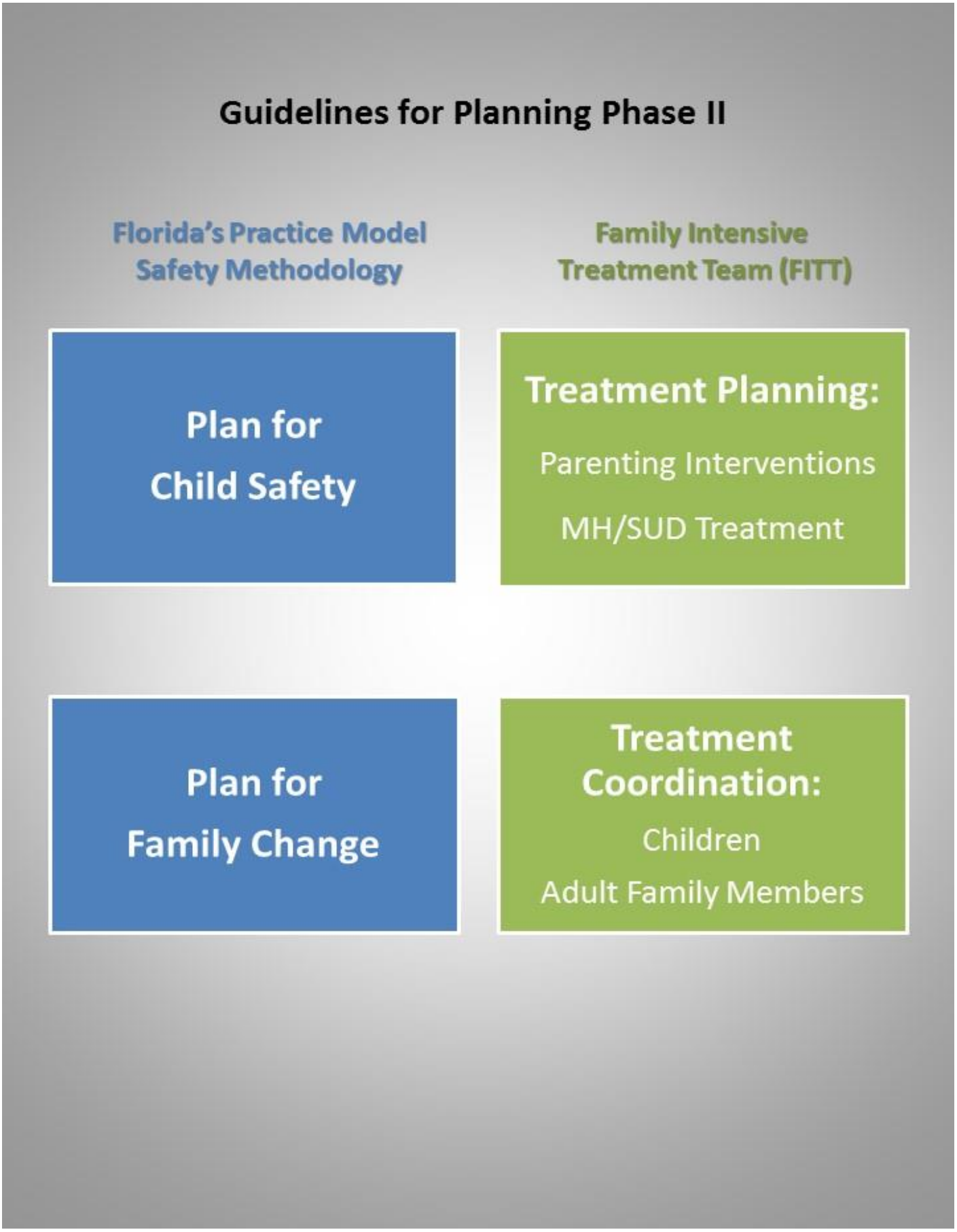
- A substance abuse and mental health progress note is entered into the FSFN data system as a means to communicate information to the child dependency case worker.
- SFBHN's Child Welfare Integration Coordinator is assigned as the point person and has daily contact with FIT providers and other stakeholders to provide support and trouble-shoot challenges.

Appendix C Guidelines for Planning



Guidelines for Planning Phase I

- How will the Child Protective Investigators make a decision to refer to FITT?
  - When in the investigation/case transfer process will the referral to FITT occur?
  - What factors/characteristics will guide the referral?
- How will the behavioral health provider ensure that the family has immediate access to assessment?
- How will the behavioral health provider become part of the team in the investigative process?
- How will the behavioral health provider assist in planning for the child's safety?
- How will the behavioral health provider assist in determining how the behavioral health disorders impact on the parent's protective capacity?
  - How will this assessment be completed?
  - With what tools/observations?
- How will the behavioral health provider assess the child-parent relationship?
- How will the behavioral health assessments (both on parental protective capacities and behavioral health disorders) inform the CPIs gathering information and Family Functional Assessment?
- How will the CPIs completion of the FFA assist the behavioral health care provider's on their comprehensive approach?
- What issues or concerns have you identified? What are your recommendations?


Guidelines for Planning Phase II
Florida's Practice Model Safety Methodology
Family Intensive Treatment Team (FITT)
Plan for Child Safety
Treatment Planning:
Parenting Interventions
MH/SUD Treatment
Plan for Family Change
Treatment Coordination:
Children
Adult Family Members

Guidelines for Planning Phase II

- As part of the team, how will the behavioral health provider work with the CPI/Case Manager and family to develop and refine a plan for the child's safety?
- How will the behavioral health provider work with the CPI/Case Manager and family and other providers to develop and refine the Plan for Family Change?
- What process will the behavioral health care provider use to complete the treatment planning process?
  - What role will the CPI/Case Manager have in this process?
  - What role will the family have?
  - What role will the other providers have – domestic violence, children's therapist or teachers etc.?
- What will be the ongoing communication pattern be between the dependency case manager and the FITT? With other providers not working directly for the behavioral health organization?
- What type of evidence based interventions will be used to address parenting issues?
- What type of evidence based interventions will be used to address the mental health and substance use disorders?
- How will the behavioral health care provider measure behavioral change?
  - In mental health and substance abuse disorders
  - In parenting protective capacity
  - In child-parenting relationships
- How will the treatment coordination occur?
  - For children served by the behavioral health care provider?
  - For children not served by the behavioral health care provider?
  - For other family members?
- How will family members/natural supports be engaged in service delivery?
- How will visitations be used to support the parenting interventions? How will they be coordinated with the behavioral health care provider?
- How will the behavioral health provider work with Managed Medical Assistance Health Plans for family members receiving services through the health plans?
- What other issues should be addressed in your planning? What are your suggestions?


Guidelines for Planning Phase III
Florida's Practice Model Safety Methodology
Family Intensive Treatment Team (FITT)
Monitor and Adapt
Service Provision & Coordination:
Support Coordinator
Incidental Funds
Peer Support
Parent Intervention
Evidence-Based Treatment

Guidelines for Planning Phase III

- How will the behavioral health care provider assign staff to the various functions?
- How will the following functions be addressed?
  - Case coordination
  - Peer Support
- What process will be put in place for the use of incidental funds?
- How will the case coordinator work with the dependency case manager? Managed care health plans?
- How will the work of the peer support and the case coordinator be part of the team approach- integrated with treatment?
- How will parenting interventions be provided? How will these be coordinated with the CBC providers? Integrated with treatment?
- If there are issues with child-parent relationships how will these be addressed? How will therapeutic services for the child-parent relationships be integrated with the other treatment approaches?
- How will physical health care needs be addressed and coordinated?
- How will the behavioral health care provider monitor progress and adapt the treatment and support services if needed?
- What communication process will be put in place to ensure that the behavioral health provider assists the dependency case manager in monitoring and adapting services for the family?
- What are the expectations for the dependency case manager to keep the FITT aware of progress or problems in the case?
- If team members have different views about how certain aspects of the case should be handled, how will potential disputes be addressed?
  - Within the behavioral health care staff?
  - With other providers such as domestic violence providers, other family members providers etc.
  - With the behavioral health care provider and the dependency case manager?
- Will the FITT have a role with the dependency court? What are the expectations?
- How will the behavioral health care provider be involved in key decisions in the case such as visitations, removal, reunification, decisions to close the case, termination of parental rights etc?
- What other issues have you identified that must be addressed? What are your recommendations?


Guidelines for Planning Phase IV
Florida's Practice Model Safety Methodology
Family Intensive Treatment Team (FITT)
Child Welfare Care Closure
Transitions
Planning for Future:
Wellness Planning
Care for Chronic Conditions
Continuity of Physical & Behavioral Health Care for Family Members

Guidelines for Planning Phase IV

- How will FITT be involved in the decision to close the Child Welfare case?
- What actions will the FITT and other providers take during the intervention process to prepare the family for independently addressing the child and families needs?
- How much lead time will the team be given before closure of the Child Welfare case?
- What process will be put in place to plan for transition of the case with the following components:
  - Parents need for on-going medical care and monitoring
  - Parents need for on-going recovery management and periodic check-ups
  - Continuation of child's therapeutic needs (mental health)
  - Continuation of child's medical care including handoff to another primary care practitioner if necessary
  - Continuation of supports for child-parent relationships if necessary
  - Quality child care
  - Concrete needs such as housing, transportation etc.?
- How will the Managed Medical Assistance health plans be involved in the transitional planning?
- What planning will take place for families to ensure that they can keep the child safe in light of the parent's substance use disorder?

Appendix D FIT Expanded Data Set

FIT Expanded Data Set
Demographic Information
1. Identification of the target family
2. Identification of target parent(s)
3. FSFN case number
4. Name of children in families/ID number
5. FSFN number of each of the children
6. For parent: birth date, Sex, Race, behavioral health disorder (specific diagnosis), presence or history of domestic violence, medical disorder, criminal history
7. Parent Medicaid Eligible
8. Parent Health Plan assignment
9. Children Medicaid Eligible
10. Children's assigned Health Plan
11. Level of Care for treatment required
12. For each child: birth date, sex, race, medical, developmental, social/emotional/behavioral health issues,

13. Zip code of family home
14. Past history with the dependency system
15. Findings/Allegations
16. In-home or out-of-home placement at the time of the initiation of FIT services
17. If out-of-home, what placement are the children in: licensed foster home, specialized foster care, relative care, other
18. If applicable, date of most recent removal of children
Process Outputs/Outcomes
19. Referral Source to FIT
20. Referral Date to FIT
21. Date of Assessment: Substance Abuse and Mental Health Assessment, Parent Capacity Assessment(s) and Family Functioning
22. Results of Parenting Capacity Assessment
23. Date Treatment Plan completed
24. Date SA Treatment Initiated
25. Date parenting interventions initiated

26. Family members who received services

27. Services Delivered:
• Outpatient Treatment
• Acute Care- CSU or Detox
• Residential
• Parenting interventions
• Peer Specialist services
• Care Coordination
  ○ Medical
  ○ Coordination of care for family
  ○ Access to concrete services
• Incidentals
• Other

28. Services for the targeted parent received by another payer: • Medical hospitalization • Medical care • Housing supports • Vocational Rehabilitation/Supported Employment • Domestic Violence assistance • Services provided to the children • Community recovery programs
29. Date of transition plan
30. Services in place at the time of the transition from FIT
Process Outputs/Outcomes - Program Implementation
31. Date of Contract signed with ME and Provider
32. Date of first referral to the program
33. Number of referrals per each month of operation
34. Number of families served by each month
35. The specific Evidence Base Practices used

36. Trainings provided to staff
37. Statewide coordination activities
Outcomes
38. Children change in living status during FITT service in-home and out-of-home care.
39. Targeted Parents who completed recommended treatment.
40. Days that targeted parents were in treatment
41. Targeted Parents who dropped out of treatment
42. Parents who re-engaged in treatment
43. Increase in target parent (s) functional ability as compared to baseline
44. Increase in parenting capacity as compared to baseline
45. Increase in family functioning as compared to baseline
46. Parents engaged in community recovery programs
47. Stable Housing
48. Employment at the time of transitioning
50. Number of removals during the course of treatment
51. Number of children to achieve permanency during course of treatment: o Reunification

○ Case closure with child in home ○ TPR with adoption
52. Time from transfer of case to CBC to permanency
53. If children in out of home care- number of days per child in out of home care.

Appendix E FIT Model: Guidelines and Requirements

Program Guidance for Contract Deliverables
Incorporated Document 32

Family Intensive Treatment (FIT) Model
Guidelines and Requirements

Requirement: Specific Appropriation 372 of the General Appropriations Act for Fiscal Year 2014-2015

Frequency: N/A

Due Date: Ongoing

Description

From the funds in Specific Appropriation 372, the recurring sum of $ 5,000,000 is provided to implement the Family Intensive Treatment (FIT) team model that is designed to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse. Treatment shall be available and provided in accordance with the indicated level of care required and providers shall meet program specifications.

To ensure the implementation and administration of this proviso project, the Managing Entity shall require that Network Service Providers providing FIT services adhere to the staffing, service delivery and reporting requirements described in this Incorporated Document.

FIT services shall:

1. Provide intensive treatment interventions targeted to families with high-risk child abuse cases;
2. Integrate treatment for substance abuse disorders, parenting interventions and therapeutic treatment for all family members (regardless of the payer for service) into one comprehensive treatment approach;
3. Improve involvement in recovery services;
4. Increase immediate access to substance abuse and co-occurring mental health services for parents in the child welfare system;
5. Help substance abusing parents overcome addictions;
6. Increase percentage of substance abusing parents who enter treatment;
7. Increase treatment retention rates;
8. Increase abstinence rates;
9. Decrease absenteeism from scheduled treatment sessions;
10. Increase program completion rates; and
11. In collaboration with the child welfare Community Based Care lead agency and dependency case management agency partners:

a. Increase safety and reduce risk of children in the child welfare system whose parents have a substance abuse disorder;
b. Develop a safe, nurturing and stable living situation for these children as rapidly and responsibly as possible (as part of safety services);
c. Participate as a provider in an in-home safety plan (as part of safety services);
d. Reduce the number of out-of-home placements;
e. Reduce the time a child remains in child welfare system; and
f. Reduce rates of re-entry into child welfare system.

Client Eligibility

The Network Service Provider shall deliver services to parents who meet all of the following criteria:

1. Are eligible for publicly funded substance abuse and mental health services pursuant to s. 394.674, F.S.;
2. Have a substance abuse disorder;
3. Have at least one child between the ages of zero (0) and eight (8) years old;
4. Have been referred by a child protective investigator, dependency case manager, or community-based care lead agency;
5. Are either under judicial supervision in dependency court (both in-home and out-of-home), but for out-of-home cases, only those parents with goal of reunification, or have been assessed as unsafe; and
6. Are willing to participate in the FIT Program.

Referral Source

The Network Service Provider shall accept families referred by the child protective investigator, dependency case manager or community-based care lead agency.

FIT Process Requirements

The Network Service Provider shall deliver an array of behavioral health services to eligible families. FIT team providers shall:

6. Accept families referred by the child protective investigator, child welfare case manager or community-based care lead agency.
7. Within 48 hours of a family's referral to services, the Network Service Provider shall commence initial assessments to guide the development of a treatment plan. The Network Service Provider shall ensure that the initial assessment process includes participation by the parent(s).
8. Complete behavioral health and parenting assessments within five (5) days of referral.
9. Assessments should include the following elements:
    a. Parental substance use disorder assessment, such as the Global Appraisal of Individual Need (GAIN);
    b. Mental health assessment, if required;
    c. Parenting capacity;
    d. Family functioning.
10. Each family shall have a comprehensive treatment plan which is completed no more than 30 days after completion of assessments to guide the provision of FIT services. At a minimum, the treatment plan shall:
    a. Be developed with the participation of the family receiving services;
    b. Specify the specific FIT services and supports to be provided under the treatment plan;
    c. Specify measureable treatment goals and target dates for the FIT services and supports; and

   d. Be reviewed, revised or updated every three months, or more frequently as needed to address changes in circumstances impacting treatment, with the participation of the parent(s) receiving services.
11. Immediate access to substance abuse treatment within 48 hours of the assessment being completed, if necessary.
12. No later than seven (7) days prior to a family's discharge from services:
    a. Review the family's treatment during a multidisciplinary team meeting to ensure that the family is receiving adequate behavioral health services that address the behavioral health condition and promote relapse prevention and recovery;
    b. Complete a FIT services Discharge Summary containing:
        1) The reason for the discharge;
        2) A summary of FIT services and supports provided to the family;
        3) A summary of resource linkages or referrals made to other services or supports on behalf of the family; and
        4) A summary of each family member's progress toward each treatment goal in the treatment plan.
13. On a monthly basis, provide a list of the families being served to the proper community-based care lead agency.

FIT Programmatic Requirements

FIT team services shall include the following activities, tasks, and provisions:

14. Peer support for crisis intervention, referrals, and therapeutic mentoring; support must be available 24 hours per day, seven days per week.
15. Coordinate services with child protective investigators and dependency case managers.
16. Treatment will be provided at the level of care that is recommended by standardized placement criteria.
17. Intensive in-home treatment available to families, when appropriate.
18. Counseling and related therapeutic interventions in an individual, group or family setting.
19. Wraparound services for Parent(s) whose treatment services are covered by third party insurance.
20. Substance use or abuse interventions and treatment services for co-occurring substance abuse and mental health.
21. Therapeutic training or psycho-education in any of the following:
    a. Parenting skills;
    b. Behavior modification;
    c. Family education and family support network development;
    d. Behavior management; and
    e. Relapse prevention skill development.
22. Specialized care coordination with a multi-disciplinary team to promote access to a variety of services and supports, including but not limited to:
    a. Domestic violence services;
    b. Medical and dental health care;
    c. Basic needs such as housing, food, and transportation;
    d. Educational and training services;
    e. Employment and vocational services;
    f. Legal services; and
    g. Other therapeutic components of the family's treatment, services, or supports as needed.

23. The substance use disorder treatment provider will be trained in an evidence-based practice found effective for serving families in the child welfare system.
24. The Network Service Provider may provide Incidental Expense services, as defined in Ch. 65E-14.021, F.A.C., to or on behalf of specific individuals receiving services under this Contract, to the extent the primary need for such services demonstrably removes barriers and supports the family's recovery or reunification goals as documented in the family's treatment plan.

Administrative Tasks

Staffing

The FIT Team must include the following general functions:

a. Program Manager
b. Behavioral Health Clinician
c. Specialized Care Coordinator
d. Family Support/Peer Mentor

This is not to mandate that the FIT Team be composed of these positions, rather that each team should have these functional roles.

Monthly Progress Report
The Managing Entity shall submit a Monthly Progress Report using Exhibit A detailing the services provided for the previous month.

Each FIT provider shall provide services to all families referred. At a minimum, the FIT provider shall provide services to at least one family for every $10,000 allocated to the provider.

Performance Measures for the Acceptance of Deliverables

For the acceptance of deliverables, the Network Service Provider shall attain a minimum of 100 percent of the target for the number of families served each month.

In the event the Provider fails to achieve the minimum performance measure, the Managing Entity shall apply appropriate financial consequences.

Performance Evaluation Methodology

1. For the performance measure - At discharge, 90% percent of parents served will be living in a stable housing environment:

    a. The numerator is the sum of the total number of parents living in a stable housing environment at discharge; and
    b. The denominator is the sum of the total number of parents receiving FIT services.
    c. The percentage of parents living in a stable housing environment at discharge will be equal to or greater than 90%.

2. For the performance measure - 80% percent of parents served will improve their level of functioning as measured by the Functional Assessment Rating Scale (FARS):
   a. Measure improvement based on the change between two assessments completed using the Functional Assessment Rating Scales (FARS).
   b. The numerator is the number of parents whose most recent score is less than their previous assessment score. Scores are calculated by summing the score for 16 questions per person captured on the FARS. A decrease in score from the most recent assessment score to the previous assessment score indicates that the level of functioning has improved. The most recent score must occur within the reporting fiscal year. The "previous assessment score must have occurred within the 12 previous months of the “most recent score.”
   c. The denominator consists of all parents with two assessments.
   d. To establish the percentage, the total number of parents with improved scores is divided by the total number of parents with two qualifying assessments.
   e. The percentage of parents who improve their level of functioning will be equal to or greater than 80%.

3. For the performance measure - The Network Service Provider will complete 85% of Discharge Summaries within seven (7) days of discharge from services:
   a. The numerator is the total number of families who received Discharge Summaries with seven days of discharge; and

   b. The denominator is the total number of families who were discharged from FIT services.

   c. The percentage of families who receive a Discharge Summary within seven days of discharge during the reporting period will be equal to or greater than 85%.

4. For the performance measure - The Network Service Provider will complete 85% of behavioral health and parenting assessments within five (5) days of referral:
   a. The numerator is the sum of the total number of families who receive assessments within five (5) days of admission to a FIT team during the reporting period; and

   b. The denominator is the sum of the total number of families referred to a FIT team during the reporting period.

   c. The percentage of families who receive assessments within five (5) days of referral to a FIT team during the reporting period will be equal to or greater than 85%.

5. For the performance measure - The Network Service Provider initiate 90% of the parent(s) into treatment services within 48 hours of completed assessment:
   d. The numerator is the sum of the total number of families who receive treatment services within 48 hours of completed assessment during the reporting period; and

   e. The denominator is the sum of the total number of families referred to a FIT team during the reporting period.

   f. The percentage of families who receive treatment services within five (5) days of admission to a FIT team during the reporting period will be equal to or greater than 90%.

EXHIBIT A

FAMILY INTENSIVE TREATMENT SERVICES MONTHLY PROGRESS REPORT				
Provider Name				
Contract Number				
Reporting Period	**From**		**To**	
Reporting Requirement	**Annual Target**	**This Period**	**This Quarter to Date**	**Year to Date**
OUTPUTS AND OUTCOMES				
Number of families served. *Minimum families served by June 30, 2015 shall be one family for every $10,000 allocated to the provider.____.*				
Percentage of parents served living in a stable housing environment.	90%			
Percentage of parents served who improve their level of functioning as measured by the Functional Assessment Rating Scale (FARS).	80%			
Percentage of Discharge Summaries completed within seven days of discharge.	85%			
Percentage of Assessments completed within five (5) days of referral.	85%			
Percentage of parents receiving treatment services within 48 hours of completed assessment.	90%			
Number of Child Welfare Cases Closed.	NA			
Number of Family Reunifications.	NA			

Reporting Requirement	This Period	This Quarter to Date	Year to Date
Number of Parents Receiving an Individualized Treatment plan.			
Number of Individuals Receiving Child Welfare Services.			
Number of Parents Receiving Intensive In-Home Treatment and Services.			
Number of Parents Receiving Detoxification Treatment.			
Number of Parents Receiving Crisis Stabilization Services.			
Number of Parents Receiving Inpatient Psychiatric Services.			
Number of Parents Receiving Residential Treatment.			
Number of Parents Receiving Individual Therapy.			
Number of Parents Receiving Group Therapy.			
Number of Parents Receiving Family Therapy.			
Number of Parents Receiving Medication Services.			
Number of Parents Receiving Wraparound Services Only.			
Number of Parents Receiving Therapeutic Training or Psycho-education.			
Number of Parents			

Receiving Transportation Support.			

Reporting Requirement	This Period	This Quarter to Date	Year to Date
Number of Parents Receiving Supportive Housing.			
Number of Parents Receiving Supported Employment.			
Number of Parents Receiving Aftercare Services.			
TBD			
ATTESTATION			
I hereby attest the information provided herein is accurate, reflects services provided in accordance with the terms and conditions of this contract, and is supported by client documentation records maintained by this agency.			
Authorized Name, Title, and Agency Name *(please print)*			

Appendix F Screening and Assessment Tools

Screening Tool Assessment	**Description**	Purpose of Assessment	Substance Use	Physical Health	Employment	Mental Health	Legal Issues	Interpersonal Skills	Child Functioning	Parenting	Activities of Daily Living	Administration
Functional Assessment of Mental Health and Addiction (FAMHA)	44-item scale documents functional deficits across domains; designed for clinicians as both an indicator of current individual level of functioning for diagnostic assessment, treatment planning and measure of change; assumes in-depth clinical knowledge of client	Functional Level	x	x	x	x	x	x	x			Diagnostic assessment at admission Periodic measure of change during treatment Treatment Outcomes at discharge
Addiction Severity Index (ASI)	ASI: To understand the relationship and functionality of data collected to making substance abuse or dependence diagnosis, patient placement decisions(i.e. level of care recommendations), assessing criminogenic risk and treatment planning	Substance Abuse	x	x	x	x	x	x Family Social			x	Initial Evaluation at admission Follow-up interviews on indicators for treatment planning
American Society of Addiction Medicine (ASAM)	ASAM: Provides placement criteria for adolescents and adults to create comprehensive and individualized treatment plans.	Level of Care	x			x						Screening and assessment for treatment planning or placement upon admission and discharge
Adult and Adolescent Parenting Inventory (AAPI) – 2	Inventory designed to assess the parenting and child rearing attitudes of adolescents and adult parent and pre-parent populations. Provides an index of risk for practicing behaviors known to be attributable to child abuse and neglect.	Parental Capacity Family Functioning	x			x		x		x		Inventory of parenting attitudes upon admission and discharge (pre and post results)
Adverse Childhood Experience (ACE)	Assess associations between childhood maltreatment and later-life health and well-being. Importance of identifying trauma and addressing it to provide context.	Additional										One-time screening tool to identify risk and protective factors at admission

Appendix G Evidence Based Approaches

EBP	Brief Description
Active Parenting Now (*in NREPP it's just Active Parenting*)	Active Parenting (4th Edition) is a video-based education program targeted to parents of 2- to 12-year-olds who want to improve their parenting skills. The program teaches parents how to raise a child by using encouragement, building the child's self-esteem, and creating a relationship with the child based upon active listening, effective communication, and problem solving.
Adolescent Community Reinforcement Approach (A-CRA)	A-CRA is a behavioral intervention that seeks to replace environmental contingencies that have supported alcohol or drug use with prosocial activities and behaviors that support recovery. This outpatient program targets youth 12 to 22 years old with DSM-IV cannabis, alcohol, and/or other substance use disorders. A-CRA includes guidelines for three types of sessions: adolescents alone, parents/caregivers alone, and adolescents and parents/caregivers together.
Cognitive Behavioral Therapy	Cognitive behavioral therapy (CBT) is a form of treatment that focuses on examining the relationships between thoughts, feelings and behaviors. By exploring patterns of thinking that lead to self-destructive actions and the beliefs that direct these thoughts, people with mental illness can modify their patterns of thinking to improve coping.
Family Behavior Model	Family Behavior Therapy (FBT) is an outpatient behavioral treatment aimed at reducing drug and alcohol use in adults and youth along with common co-occurring problem behaviors such as depression, family discord, school and work attendance, and conduct problems in youth. Treatment typically consists of 15 sessions over 6 months; sessions initially are 90 minutes weekly and gradually decrease to 60 minutes monthly as participants progress in therapy.
Hazelden's Living in Balance Treatment Program	Living in Balance (LIB): Moving From a Life of Addiction to a Life of Recovery is a manual-based, comprehensive addiction treatment program that emphasizes relapse prevention. LIB consists of a series of 1.5- to 2-hour psychoeducational and experiential training sessions. The manual includes 12 core and 21 supplemental sessions. LIB can be delivered on an individual basis or in group settings with relaxation exercises, role-play exercises, discussions, and workbook exercises.
Moral Reconation Therapy (MRT)	Moral Reconation Therapy (MRT) is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Its cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments. Participants meet in groups once or twice weekly and can complete all steps of the MRT program in a minimum of 3 to 6 months.
Motivational Interviewing	Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal
Nurturing Parenting	The Nurturing Parenting Programs (NPP) are family-based programs for the prevention and treatment of child abuse and neglect. The programs were developed to help families who have been identified by child welfare agencies for past child abuse and neglect or who are at high risk for child abuse/neglect.
Solution-Focused Therapy	Solution-Focused Group Therapy (SFGT) is a strengths-based group intervention for clients in treatment for mental or substance use disorders that focuses on building solutions to reach desired goals. It emphasizes what the client wants to achieve through therapy rather than the client's problems and failings in the past.

Seeking Safety Curriculum	Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on coping skills and psychoeducation and has five key principles.
Systematic training for Effective Parenting (STEP)	Systematic Training for Effective Parenting (STEP) provides skills training for parents dealing with frequently encountered challenges with their children that often result from autocratic parenting styles. For parents of children birth through adolescence.
Trauma Focused Cognitive Behavioral Therapy	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment.
Research Supported Programs	**Brief Description**
1-2-3 Magic	This program presents an effective and positive way to discipline children ages 2 through 12 without arguing, yelling, or spanking. This simple, yet powerful, approach to disciplining kids is said to have won rave reviews from parents, educators and professionals alike.
Art/Expressive Therapy	Expressive arts therapy is a multimodal approach to therapy that is similar to its cousin's drama therapy and music therapy. It may incorporate writing, drama, dance, movement, painting, and/or music. Clients are encouraged to explore their responses, reactions, and insights via pictures, sounds, explorations, and encounters with art processes.
NAADAC'S Conflict Resolution in recovery	This is a therapeutic training that is skilled-based and focused on the brain; how the brain works in conflict and strategies to affect the quality of recovery in relationships.
Stages of Change Model	The idea behind the Stages of Change Model is that behavior change does not happen in one step. Rather, people tend to progress through different stages on their way to successful change. 5 stages: precontemplation, contemplation, preparation, action, maintenance, relapse
Supportive Therapy	Supportive psychotherapy is used primarily to reinforce a patient's ability to cope with stressors through a number of key activities, including attentively listening and encouraging expression of thoughts and feelings; assisting the individual to gain a greater understanding of their situation and alternatives; helping to buttress the individual's self-esteem and resilience; and working to instill a sense of hope.