Guidance 18
Family Intensive Treatment (FIT) Model Guidelines and Requirements

Contract Reference: *Sections A-1.1, C-1.2.3 and Exhibit C2*

Requirement: *Specific Appropriations within the General Appropriations Act*

Purpose: To ensure the implementation and administration of this proviso project, the Managing Entity shall require that Behavioral Health Providers providing FIT services (herein referred to as "FIT Team Providers") adhere to the service delivery and reporting requirements described herein.

I. Authority

Annual Specific Appropriations provide funding "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."

II. Program Goals

The FIT Team model is designed to provide intensive services to families in the child welfare system with parental substance use. Upon successful completion, the family should have the skills and natural support system needed to maintain improvements made during services. The goals of the FIT Team model are to:

1. Provide early identification of at-risk families and immediate access to intensive substance use and co-occurring mental health treatment services for parent(s)/guardian(s) in the child welfare system with early engagement strategies, such as at case initiation or case transfer, when a child in the family has been determined to be "unsafe;"
2. Establish a team-based approach, including Clinicians, Case Managers and Recovery Peer Support Specialists, to planning and service delivery in coordination with Community-Based Care Lead Agencies, Child Welfare Professionals, Managing Entities, and other providers of services;
3. Integrate evidence-based treatment for substance use disorders, parenting interventions, and therapeutic treatment for all family members into one comprehensive treatment approach. This comprehensive approach includes coordinating clinical children's services, which are provided outside of the FIT Team funding;
4. Identify family-driven pathways to recovery and promote sustained recovery through cultural and gender-sensitive treatment and involvement in recovery-oriented services and supports;
5. Promote increased engagement and retention in treatment;
6. Provide 24/7 access for crisis management;
7. Facilitate concurrent planning between child welfare case planning and treatment plan goals, to integrate the family's strengths and needs with their dependency case plan;
8. Advocate for parent(s)/guardian(s) and assist in navigating the child welfare process;
9. Promote treatment completion and continued care through linkage to ongoing support services and natural supports; and
10. In collaboration with Community-Based Care Lead Agencies and Child Welfare Case Management Organizations:

a. Promote safety of children in the child welfare system whose parent(s)/guardian(s) have a substance use disorder;

b. Develop a safe, nurturing, and stable living situation for these children as rapidly and responsibly as possible;

c. Provide information to inform the safety plan, ongoing Family Functioning Assessments (FFA), and any other relevant status updates;

d. Reduce the number of out-of-home placements when safe to do so; and

e. Reduce rates of re-entry into the child welfare system.

III. Eligibility

FIT Team Providers shall accept families referred by the child protective investigator, child welfare case manager or Community-Based Care Lead Agency. Providers and stakeholders working with child welfare families, such as engagement programs and the dependency court system, can also refer eligible parent(s)/guardian(s).

FIT Team Providers shall deliver services to parent(s)/guardian(s) who meet all the following criteria:

1. Are eligible for publicly funded substance abuse and mental health services pursuant to s. 394.674, F.S.; including persons meeting all other eligibility criteria who are under insured;

2. Meet the criteria for a substance use disorder;

3. At the time of referral to FIT:

a. A child in the family has been determined to be "unsafe," with a priority given to families with children 0 – 10 years old,

b. For children in out of home care, the family must have a child welfare case management plan with the permanency goal of reunification, or a concurrent case plan that includes reunification as a permanency goal, and

c. The eligible parent(s)/guardian(s) are willing to participate in the FIT Program or the caregiver is court ordered to participate in FIT services. In either case, enhanced efforts to engage and retain the caregiver(s) in treatment are expected as a critical element of the FIT program.

Network Service Providers may serve families who exceed the financial eligibility while applying a sliding fee scale in accordance with 394.76 F.S. and Chapter 65E-14.018, F.A.C., if no other option for treatment at this level is available.

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

IV. FIT Staffing Requirements

By providing a team-based approach to care, families receive FIT services from consistent and designated staff that have received the required training on the child welfare system and evidence-based programs. FIT staff work collaboratively to meet the needs of FIT families. Below are the essential roles of FIT team members who are considered the "core" team. Adjustments to staff credentials and maximum caseloads must be approved by the Managing Entity with agreement from the Department of Children and Families**.** This includes time-limited plans to address initial implementation of this staffing requirement and vacancies.

1. **Program Manager** - A Master's or Doctoral degree in behavioral health sciences, such as psychology, mental health counseling, social work, art therapy, or marriage and family therapy; an active license issued by the Florida Board of Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, or Psychology; and a minimum of three years working with adults with substance use disorders.

2. **Behavioral Health Clinician** - A Master's or Doctoral degree in behavioral health sciences, such as mental health counseling, social work, art therapy, psychology, or marriage and family therapy; and a minimum of two years of experience working with adults with substance use disorders. Behavioral Health Clinicians provide evidence-based therapeutic services and incorporate behavioral health goals with Caregiver Protective Capacities and parenting interventions. Clinician caseloads are clinically determined by the Program Manager but **shall not exceed 15 clients**.

3. **Case Manager** – at minimum a Bachelor's degree in counseling, social work, psychology, criminal justice, nursing, rehabilitation, special education, health education, or a related field which includes the study of human behavior and development; and a minimum of one year of experience working with adults with behavioral health needs and child welfare involvement; or a Bachelor's or Master's degree with a major in another field and a minimum of three years of experience working with adults with substance use disorders. This position does not serve as the child welfare case manager and the FIT program does not fund the child welfare case manager. FIT Case Managers assist clients with coordination of provider referrals and follow-up for other needed services. Case manager caseloads are determined by the Program Manager based on the needs of the individuals served but **shall not exceed 20 clients**.

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

V. FIT Programmatic Requirements

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

1. An emergency contact number for parent(s)/guardian(s) to reach FIT Team Provider in case of emergency 24 hours a day, 7 days a week;

2. Recovery peer support services to promote recovery, engagement and retention in treatment, and skill development;

3. Case management services to address the basic support needs of the family and coordinate the therapeutic aspects of services provided to all family members regardless of payer source;

4. Coordination of services and supports with child welfare professionals;

5. Individualized treatment provided at the level of care that is recommended by ASAM or LOCUS placement criteria;

6. Document FIT activities and family's progress in Florida Safe Families Network (FSFN);
7. Intensive in-home treatment, inclusive of individual and family counseling, related therapeutic interventions, and treatment to address substance use disorders, based on individual and family needs and preferences;
8. Group treatment to address substance use disorders, based on individual and family needs and preferences;
9. Trauma-informed treatment services for substance use disorders and co-occurring substance use and mental health disorders;
10. Therapeutic services and psychoeducation in:
    a. Parenting interventions for child-parenting relationships and parenting skills;
    b. Natural support development, including the family when appropriate; and
    c. Relapse prevention skill development and engagement in the recovery community.
11. Care coordination as reflected in the FIT Team's treatment plan, including a Multi-Disciplinary Team (MDT) to promote access to a variety of services and supports as indicated by the needs and preferences of the family, including but not limited to:
    a. Domestic violence services;
    b. Medical and dental health care;
    c. Basic needs such as supportive housing, housing, food, and transportation;
    d. Educational and training services;
    e. Supported employment, employment, and vocational services;
    f. Legal services; and
    g. Other services identified in the FIT Team's case management plan.

VI. Assessment:

All assessment tools should be completed as appropriate in the first 30 days following enrollment to the FIT program. The FIT assessment process includes consideration of the assessment activities that are completed by child welfare professionals, as well as any known behavioral health treatment history. In addition to assessments from child welfare, the FIT Team Provider shall assess parental capacity, functioning, substance use and co-occurring mental health, family history, and trauma. Results of all assessments are included in the Biopsychosocial and inform treatment planning and interventions.

American Society of Addiction Medicine (ASAM) or Level of Care Utilization System (LOCUS) Criteria: Complete the ASAM or LOCUS Criteria to address the parent(s)/guardian(s)' needs, obstacles and liabilities, as well as the caregiver's strengths, assets, resources and support structure to determine level of care **upon admission**.

Daily Living Activities (DLA-20): Alcohol-Drug Functional Assessment: Complete the DLA-20 to determine the caregiver's level of functioning. To effectively monitor changes in client functioning over time, the DLA-20 shall be **re-administered within sixty (60) calendar days of initial completion and continue to be administered at 60-day intervals throughout the course of FIT services**. A final DLA-20: Alcohol-Drug shall be administered **at discharge**, except in the case of unplanned discharge and parent is unavailable.

Caregiver Protective Capacities: Review the caregiver protective capacity ratings completed by the child protective investigator or child welfare case manager from the most recent Family Functioning Assessment. The FIT Team Provider will complete a baseline rating of the caregiver protective capacities based on information gathered during

the assessment process and integrate the capacities into the treatment plan goals. This will be **evaluated by the FIT team monthly** in progress updates and during treatment plan reviews and **at discharge**. These ratings are not to replace the assessment of caregiver protective capacities completed by the child welfare professional, but to align language for more robust discussion of the parent(s)/guardian(s) progress.

Biopsychosocial Assessment: The Biopsychosocial Assessment shall describe the biological, psychological, and social factors that may have contributed to the recipient's need for services. The evaluation synthesizes the results of all assessments administered and include a brief mental status exam, diagnostic/clinical impression and preliminary service recommendations based on those results and interview of the client and family. Refer to Chapter 65D-30, F.A.C. for further requirements of the Biopsychosocial Assessment.

VII. Treatment Planning Process

As part of the core competency of an Integrated Practice Model, it is imperative behavioral health providers support and address child welfare outcomes by enhancing caregiver protective capacities. Utilizing the identified diminished caregiver protective capacities and behavioral health needs, the team will be able to develop appropriate interventions to address family needs. This practice is in unison with the Child Welfare Practice Model which requires child welfare professionals to identify reunification criteria, objectively evaluate the scaling of caregiver protective capacities, and assess behavioral changes in the parent/guardian toward enhancing their protective capacities.

The FIT team participates in or coordinates MDT staffings, requesting participation from child welfare professional(s), parent/guardian(s), and any other relevant parties such as caregiver(s), foster parent(s), mentor(s), teacher(s), primary health provider(s), and other provider(s), following enrollment and at least every 30 days. The MDT is responsible for the development and ongoing evaluation of the treatment plan and/or case plan, including any alterations that may prove necessary.

VIII. Transition and Discharge

Successful transition planning begins at admission, is family-centered, and continues throughout the family's treatment. Families are apprised of the appropriate community resources available, linked to those services and are key participants in all phases of the transitional care planning process. Referral processes with community providers need to occur in a timely, systematic fashion prior to discharge. The process concludes with the coordination and implementation of services and transition to the least restrictive level of care.

Transfers

Managing Entities must review and approve any plan for a FIT team to transfer a family to another FIT team.

Additionally, Managing Entities must be involved with coordinating transfers when a family plans to move out of the area and continue FIT services. The originating Managing Entity will contact the receiving Managing Entity to determine if there is capacity to accept the transfer and a proposed date of transfer. Once this has been established, the originating FIT team must, with consent, send the receiving team a comprehensive referral packet.

FIT teams are obligated to accept any transfer if the team has capacity. Upon arrival, the receiving team shall review the participant's clinical records, conduct an initial assessment, and develop a new treatment plan.

Discharges

At least 30 calendar days prior to discharge, an MDT staffing to address the family's planned discharge from the FIT program must be held. This discharge MDT staffing must include the FIT team with requested participation from child welfare professional(s), the parent/guardian(s), and any other relevant parties such as caregiver(s), foster parent(s), mentor(s), teacher(s), primary health provider(s), and other provider(s).

The discharge MDT staffing must address the family's behavioral health and any ongoing relapse prevention and recovery services needs, such as: Alcoholics Anonymous (AA), Narcotics Anonymous (NA), any faith-based group or other recovery supports; the physical health care needs of the parents and children; support services such as housing

supports, supportive employment, financial benefits, etc.; and community services such as childcare, early intervention programs, therapies, and community-based parenting programs.

A discharge summary must be completed that summarizes the family's needs and confirms all referrals to community-based services. The discharge summary must be provided to the family upon discharge. A copy of the discharge summary must also be provided to the child welfare professional within seven (7) calendar days of discharge.

In the event of an unplanned discharge, the FIT team must coordinate an MDT staffing as soon as disengagement is identified to discuss strategies for re-engagement or plan for next steps following discharge. These steps must be documented in the discharge summary and provided to the child welfare professional within seven (7) calendar days.

Discharge Definitions

COMPLETED TREATMENT: Participant made significant progress toward rehabilitation goals and engagement in community-based care is optimal.

GOAL CHANGE: Participant is discharged due to a goal change in the child welfare case. This discharge definition is used when the permanency goal is changed and the participant chooses to discharge because there is no longer a requirement for them to continue treatment. If the participant made significant progress toward rehabilitation goals and is agreeable to transfer to community-based care, this discharge will be defined as completed treatment.

TRANSFER TO A HIGHER LEVEL OF CARE: Participant requires transfer to a higher level of care (such as inpatient care). This reflects that maximum benefit has been achieved at the current level of care and yet a higher level of care is needed. If the participant refuses to transfer and disengages, the discharge will be defined as disengaged.

TRANSFER TO ANOTHER FIT PROVIDER: Participant is discharged due to transfer to another FIT Team Provider where they continue services.

MOVED: Participant moved out of the service area. This discharge definition is used if the participant is not transferring to another level of care or to another FIT team provider.

JAIL/PRISON: Participant is discharged due to incarceration.

DISENGAGED: Participant requests discharge or chooses not to participate, despite best efforts by the FIT team.

DIED: Participant is discharged due to death.

IX. FIT Process

1. At time of referral, the FIT Team Provider will:
    - **a.** Review the referral to ensure it meets FIT eligibility criteria
        - **i.** This can include staffing with the referral source
        - **ii.** If the referral does not meet criteria, the FIT Team Provider will staff the case with the referral source and recommendations and linkage to appropriate services are made and documented
    - **b.** Access the initial and/or ongoing FFA from the FSFN system, if completed
    - **c.** Review the FFAs for the diminished caregiver protective capacities
    - **d.** Contact child welfare professional to acknowledge receipt of the referral and receive any additional information
    - **e.** Review case plan, when available
    - **f.** Review FSFN for any prior investigations

g. If FIT program is full, a waitlist is maintained. All referred families are contacted, given information about status on waitlist and provided referrals for interim services to meet any immediate needs. Weekly phone contact is maintained for all clients on FIT waitlist

2. Upon accepting a referral, the FIT Team Provider will:

a. Assign the referral to FIT Team (Counselor, Case Manager and Recovery Peer Specialist)

b. Contact the family as soon as possible (within two business days) to explain the Fit Team approach, answer questions about FIT and set up enrollment meeting

c. Ensure that initial and recurring efforts to contact and engage the referred parent(s)/guardian(s) are documented

d. Determine which FIT Team member(s) will participate in the enrollment meeting

3. Upon enrollment, the FIT Team Provider will:

a. Meet with family and complete all consents required by provider agency

b. Ensure that a release of information is completed for the child welfare professional and any other formal and informal providers and supports involved with the family

c. Contact the child welfare professional to provide disposition of referral, schedule an MDT staffing, and arrange to be present at all Teaming activities, such as case planning conference, mediation, staffings, urgent/emergent staffing, or court hearings, etc.

4. Within the first 30 days after enrollment, the FIT Team Provider will:

a. Complete required FIT initial assessments

b. Complete a Biopsychosocial based on all child welfare information, results of FIT assessments, and interview with the parent/guardian and family

c. Based on the clinical assessments and identified diminished caregiver protective capacities, a treatment plan is developed with the family, FIT team, the child welfare professional, and other providers involved with the family

d. Begin substance use treatment to include relapse prevention planning utilizing an evidence-based model

e. Coordinate specialized services; for example: joint home visits, in-home interventions, parenting programs, child services, peer services, incidental funding, etc.

f. Evaluate family's need for housing or to apply for eligibility for food, cash and medical assistance or use of incidental funds

g. Complete all required FSFN documentation, at a minimum a monthly progress notes and update at any critical juncture

5. During ongoing treatment, the FIT Team Provider will:

a. Complete additional assessments as appropriate or required

b. Participate in or coordinate frequent (at least monthly) MDT staffings, requesting participation from child welfare professional(s), parent/guardian(s), and any other relevant parties such as caregiver(s), foster parent(s), mentor(s), teacher(s), primary health provider(s), and other provider(s)

c. Review treatment plans, FFA-Ongoing, Progress Updates, and scaling of caregiver protective capacities. Any section scaled as a "C" or "D" is included as an area of focus in the Treatment Plan

d. Continue to evaluate family's need for housing or to apply for eligibility for food, cash and medical assistance or use of incidental funds

e. Participate in Teaming activities, such as case planning conference, mediation, MDT staffings, urgent/emergent staffing, or court hearings, etc.

f. Complete all required FSFN documentation, at a minimum a monthly progress notes and update at any critical juncture

6. During Continued Care, the FIT Team Provider will offer ongoing continued care services once clinical services are determined to be completed. This can be done through individual services and/or attendance at an aftercare group and is typically provided by the FIT Case Manager or Recovery Peer Specialist.

7. During Transition and Discharge, the FIT Team Provider will:

a. Complete updated assessments, such as the DLA-20: Alcohol-Drug and rating of the caregiver protective capacities

b. Provide progress updates to inform the child welfare case manager's ongoing assessments of caregiver protective capacities

c. Consult with the child welfare professional(s) to determine the appropriate time for child welfare case closure. This includes agreement that the caregivers have enhanced their caregiver protective capacities to the point where there are no longer danger threats within the home and the children are safe

i. Families may be transitioned if there is a goal change to Termination of Parental Rights (TPR), however the family does not have to be discharged at this time if actively engaged and expresses a desire for continued FIT services

ii. Families may be transitioned at any time the family declines ongoing treatment with the FIT Team

d. Participate in or coordinate an MDT staffing 30 calendar days prior to discharge to discuss case transition with the FIT team, requesting participation from child welfare professional(s), parent/guardian(s), and any other relevant parties such as caregiver(s), foster parent(s), mentor(s), teacher(s), primary health provider(s), and other provider(s), except in the case of unplanned discharge and the parents are unavailable

e. Coordinate linkage with community resources to ensure any ongoing care/aftercare 14 calendar days prior to discharge, except in the case of unplanned discharge

f. Assist with coordination of follow up services

i. Complete discharge summary and provide to the child welfare professional within seven days of discharge

ii. Complete all required FSFN documentation

X. Incidental Expenses

Per, 65E-14.021, the following use of incidentals are approved: "transportation, childcare, housing assistance, clothing, educational services, vocational services, medical care, housing subsidies, pharmaceuticals and other incidentals as approved by the department or Managing Entity." Incidentals should only be used to cover "temporary expenses incurred to facilitate continuing treatment and community stabilization when no other resources are available" and must be "associated with a treatment plan goal."

Prior to utilizing Incidentals, the FIT provider explores all other resources with the family, including eligibility for food, cash and medical assistance through the Department of Children and Families Automated Community Connection to Economic Self Sufficiency (ACCESS) program. More information on ACCESS can be found at http://www.myflorida.com/accessflorida/.

XI. Third-Party Services

Services provided by the core FIT Team staff and funded by FIT contract dollars cannot be billed to any third-party payers. At minimum, the FIT Team Provider must be licensed for outpatient substance abuse services pursuant to Chapter 65D-30, F.A.C. If additional service components, for which the FIT Team Provider is not licensed, are needed for individualized treatment (including detoxification; residential; crisis stabilization; medication management; aftercare; or other specialized service), the FIT Team shall refer to the appropriate level of care or service provider. The FIT Team shall work in concert with any other providers, the individual and the family to integrate services into overall treatment and to monitor progress toward treatment goals.

For services provided outside of the core FIT Team staff, the FIT Team Provider shall seek reimbursement for services provided to individuals from any third party payer, when available, including: commercial insurers, TRICARE, Medicare, Health Maintenance Organizations, Managed Care Organizations (MCOs), or other payers liable, to the extent that they are required by contract or law, to participate in the cost of providing services to a specific individual. FIT Team Providers shall also seek reimbursement for any Medicaid reimbursable service from Medicaid (or MCOs) when an eligible individual is a Medicaid enrollee. Additionally, the FIT Team Provider shall assist families who may be eligible for Medicaid to complete the program's application process and assist with the required eligibility documentation, pursuant to Chapter 65E-14,014(2), F.A.C. The FIT Team remains responsible for immediate access to services for admitted individuals, regardless of payer.

XII. Reporting and Performance Measures

The Department shall provide the Managing Entities with Access databases for each FIT Team Provider. Managing Entity subcontracts shall require the FIT Team Provider to enter all client data into the Access database and export the data on a monthly basis. The Managing Entity shall submit FIT data to the Department no later than the 18th day of each month following service delivery.

Monthly and yearly service targets should be determined by the Managing Entity, taking into account capacity of the FIT Team Provider, needs of families served, as well as geographical considerations. The targets should assume that families will remain in treatment and after care for several months.

In the event the FIT Team Provider fails to achieve the minimum performance measures, the Managing Entity may apply appropriate financial consequences.

Programmatic Performance Measures and Methodologies

The Managing Entity shall include the following performance measures and methodologies in each FIT Team Provider subcontract:

1. Upon successful treatment completion, 95 percent of eligible parent(s)/guardian(s) served will be living in a stable housing environment:

a. Stable housing is defined as: Independent Living (Alone, with Relatives, with Non-Relatives), Dependent Living (with Relatives, with Non-Relatives), Foster Care/Home (including Extended Foster Care for ages 18-21) or Supported Housing.

b. The numerator is the sum of the number of eligible parent(s)/guardian(s)discharged as Completed Treatment during the reporting period who are living in a stable housing environment.

c. The denominator is the sum of the total number of eligible parent(s)/guardian(s)discharged as Completed Treatment during the reporting period.

d. The percentage of eligible parent(s)/guardian(s)living in a stable housing environment at treatment completion should be equal to or greater than 95 percent.

2. Upon successful treatment completion, 95 percent of eligible parent(s)/guardian(s) served will have stable employment:

a. Stable employment is defined as: Active military, overseas; Active military, USA; Full Time; Unpaid Family Worker (A family member who works at least 15 hours or more a week without pay in a family-operated enterprise. If an individual refuses to work because that are making money through illegal activities, the client must be coded as Unemployed); Part Time; Retired; Homemaker (Manages household for family members); Student; or Disabled.

b. The numerator is the sum of the number of eligible parent(s)/guardian(s)discharged as Completed Treatment during the reporting period who have stable employment.

c. The denominator is the sum of the total number of eligible parent(s)/guardian(s)discharged as Completed Treatment during the reporting period.

d. The percentage of eligible parent(s)/guardian(s)with stable employment at treatment completion should be equal to or greater than 95 percent.

3. Upon successful treatment completion, 90 percent of eligible parent(s)/guardian(s)served will improve their level of functioning, as measured by the Daily Living Activities (DLA-20): Alcohol-Drug Functional Assessment.

a. Measure of improvement is based on change in the average score of the DLA-20. Improvement is based on the change between results from the initial score to the last recorded score.

b. The numerator is the sum of the number of eligible parent(s)/guardian(s) discharged as Completed Treatment during the reporting period with an overall functioning score that is higher than the initial recorded score.

c. The denominator is the sum of the number of eligible parent(s)/guardian(s) discharged as Completed Treatment with more than one DLA-20 score during the reporting period.

d. The percentage of eligible parent(s)/guardian(s)who improve their level of functioning at treatment completion should be equal to or greater than 90 percent.

4. Upon successful treatment completion, 90 percent of eligible parent(s)/guardian(s)served will improve their Caregiver Protective Capacities as rated by the FIT Team Provider.

a. Measure of improvement is based on improvements to the Caregiver Protective Capacities ratings.

b. The numerator is the sum of the number of eligible parent(s)/guardian(s) discharged as Completed Treatment during the reporting period with Caregiver Protective Capacities that are higher than the initial recorded rating.

c. The denominator is the sum of the number of eligible parent(s)/guardian(s) discharged as Completed Treatment with more than one Caregiver Protective Capacities rating during the reporting period.

XIII. Additional Resources

1. Department of Children and Families Learning and Resource Network

My FL Learn Training Portal

https://www.myflfamilies.com/my-fl-learn

The My FL Learn training portal is available to all FIT teams and Managing Entities. This portal offers a vast selection of free trainings from written content, prerecorded broadcasts or live training opportunities.

FIT teams can access My FL Learn by creating an account as an external user. Topics in the My FL Learn training portal include:

Florida Safe Families Network (FSFN) - Florida's Statewide Child Welfare Information System

Child Protective Investigative Process

Child Welfare System of Care

Collaboration, Partnership and Multidisciplinary Teams

Child Welfare and Substance Use Disorders

Co-Occurring Mental and Substance Use Disorders

Child Development and Safety Planning

Human Trafficking and Sexual Abuse

Dependency Courtroom Training

FSFN Training (Three-Part Prerecorded FSFN Training)

FIT teams can also access My FL Learn to complete a prerecorded FSFN training series.

Part 1:

FSFN & Policy: Navigating FSFN for CPIs and Case Management

1. Introduction to FSFN
2. Navigation & Commence Investigations Desktop
3. Case Notes

Part 2:

FSFN & Policy: Navigating FSFN for CPIs and Case Management

1. Investigative Assessments
2. File Cabinet
3. Closing Investigations

Part 3:

FSFN: System for CPIs and Case Management 2022 – Simulation

2. Office of the State Courts' Legal Resource Guide

Dependency Court Benchbook

https://www.flcourts.gov/Resources-Services/Office-of-Family-Courts/Family-Court-in-Florida/Dependency/Dependency-Benchbook

The Dependency Court Benchbook is a compilation of promising practices as well as a legal resource guide. This comprehensive tool provides information regarding legal and non-legal considerations in dependency cases.

FIT teams and other stakeholders can access the Dependency Court Benchbook. Topics in the Dependency Court Benchbook include:

Dependency Case Management Flowchart

Family-Centered Practice in Dependency Court

Trauma and Child Development

Service and Treatment Considerations in Dependency Court

Child Safety Considerations

3. National Center on Substance Abuse and Child Welfare (NCSACW)

Tutorials for Substance Use Disorder Treatment Professionals

https://ncsacw.samhsa.gov/tutorials/tutorialDesc.aspx?id=26

This course is divided into five modules. Each module builds on the previous one. After passing the knowledge assessment at the end of the course, you will be able to print a certificate of completion. This certificate can be submitted to NAADAC, the Association for Addiction Professionals, for 4.5 Continuing Education Units (CEUs).

Module One: Primer on CW and Dependency Court Systems for Substance Use Disorder Treatment Professionals.

Module Two: Engaging Child Welfare-Involved Families in Treatment

Module Three: Effective Treatment for Child Welfare-Involved Families

Module Four: Special Considerations for Children Whose Parents Have Substance Use Disorders

Module Five: Collaborative Strategies to Effectively Serve Child Welfare Families Affected by Substance Use Disorders

4. The Florida Alcohol and Drug Abuse Association (FADAA)

Child Welfare & Family Court Opioid Use Disorder Trainings

https://www.training.fadaa.org/

These comprehensive modules focus on increasing understanding of the opioid crises in Florida, the effects on family systems, and how to engage recovery resources. The trainings were funded by the federal State Targeted Response to the Opioid Crisis (O-STR) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Training Topics include:

- Opioid Training Module
- Child Welfare System Case Studies Applying Motivational Interviewing
- Other Training Modules for Judicial System Representatives
- Other Training Modules for Child Welfare Representatives

5. FIT Integrating Behavioral Health and Child Welfare Practice Manual

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

The FIT Manual provides an outline for this integrated approach to treatment, including an overview of Florida's Child Welfare Practice Model, the core components of the FIT Model, steps for implementing the FIT model, and a guide for integrated treatment planning.